A Thesis Submitted in Partial Fulfilment of the Requirements of the Degree of Doctor of Clinical Psychology (DClinPsych)



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Abstracts

Systematic Review of the Literature: Treatment seeking for substance misuse in currently serving military personnel: A systematic review of characteristics of those who seek treatment, as well as barriers and facilitators to engagement.

Aim: The aim of this systematic review was to synthesise the literature on (a) the characteristics of currently serving military personnel who engage with substance misuse treatment, (b) what facilitates engagement in substance misuse treatment among this population and (c) barriers to seeking substance misuse treatment among this population. Method: The search was conducted across five databases and 5461 studies were screened for title and abstract relevance. 116 were screened at a full text level. Ten studies were included in the final review. The quality of the studies were assessed using the Critical Appraisal Skills Programme checklist. Results: Only two studies outlined characteristics of those who engage in substance misuse treatment. Both studies suggested that males in this population may be more likely to engage than females. Facilitators of engagement included referral trends, AUDIT scores and confidentiality. However, conclusions were limited due to heterogeneity between the aims, methodology and samples of the studies included. There was limited consistent evidence to conclude the barriers to engagement due to conflicting findings within demographics, and the poor quality of stigma studies. Conclusion: Results of the studies, their relation to behaviour change literature and the limitations of the current study are discussed. Future research is needed to explore help seeking for substance misuse in currently serving military personnel.

Service Improvement Project: The Impact of Anti-Racism Training: Behaviour Change in Clinical Psychologists, A Service Improvement Project using the COM-B System.

This service improvement project evaluates an anti-racism training run by The Oxford Institute of Clinical Psychology Training and Research (OXICPTR). The evaluation aimed to identify what psychological and behavioural changes had occurred as a result of the training and what facilitated and prevented those changes both in the content of the training itself and the context of services that participants worked. Nine psychologists who had attended the anti-racism training participated in individual semi-structured interviews. These were transcribed and reflexive thematic analysis was conducted. Five themes were developed from the coded data. The analysis showed that clinicians outlined psychological changes that they had experienced following the training, but that examples of concrete behaviour change were less common. The importance of professional relationships in the process of change was highlighted and behaviour change was portrayed by clinicians as a relational process. Clinicians often removed self-responsibility in anti-racist behaviour change, and instead placed responsibility in 'the system' including wider NHS trusts. Barriers to the initiation of behaviour change included feelings of powerlessness both within services and in the wider issue of anti-racism. Self-identity was also seen to both facilitate change and create barriers to change. Recommendations to facilitate behaviour change following anti-racism training are outlined in relation to the COM-B model of behaviour change.

Theoretically Driven Research Project: The role of ethnicity and racial identity functioning in supervision: An investigation of how clinical psychologists rate cultural responsivity in supervision

Aim: The affect of ethnicity and racial identity of the supervisor on cultural responsivity in supervision is poorly understood. The aim of the study was to investigate if the ethnicity of a clinical supervisor affects their ratings of cultural responsivity in supervision. The secondary aim of this study was to understand the role of racial identity functioning as a mediator, which may explain the variability in the primary aim. Method: A repeated measures cross-sectional design was used. 50 clinical psychologists (26 White and 24 ethnic minority) watched two video vignettes of a cross cultural supervision session and rated the supervisor in the videos on their cultural responsivity using The Multicultural Supervision Inventory (MSI) supervisor form. One video depicted 'low' cultural responsivity and one 'high' cultural responsivity. Racial identity functioning was measured using the ethnic group membership questionnaire (EGMQ). Results: Both White and ethnic minority participants rated the 'high' cultural responsivity vignette as significantly higher than the 'low' cultural responsivity vignette. Ethnicity did not significantly affect ratings of cultural responsivity in either condition. Years of supervision experience and previous anti-racism training also did not affect cultural responsivity ratings. Discussion: Findings in relation to previous research and a model of supervisory relationships were discussed, along with limitations of the present study and areas for further research.

Systematic Review of the Literature: Treatment seeking for Substance Misuse in Currently Serving Military Personnel: A Systematic Review of Characteristics of Those Who Seek Treatment, as well as Barriers and Facilitators to Engagement.

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Proposed Journal: The Journal of Substance Use & Addiction Treatment (JSAT). This journal accepts papers that advance the field of substance misuse research in any context. It has a particular interest in papers within addiction health services. It has many systematic reviews and allows for up to 7500 words.

Abstract

Aim: The aim of this systematic review was to synthesise the literature on (a) the characteristics of currently serving military personnel who engage with substance misuse treatment, (b) what facilitates engagement in substance misuse treatment among this population and (c) barriers to seeking substance misuse treatment among this population. Method: The search was conducted across five databases and 5461 studies were screened for title and abstract relevance. 116 were screened at a full text level. Ten studies were included in the final review. The quality of the studies were assessed using the Critical Appraisal Skills Programme checklist. Results: Only two studies outlined characteristics of those who engage in substance misuse treatment. Both studies suggested that males in this population may be more likely to engage than females. Facilitators of engagement included referral trends, AUDIT scores and confidentiality. However, conclusions were limited due to heterogeneity between the aims, methodology and samples of the studies included. There was limited consistent evidence to conclude the barriers to engagement due to conflicting findings within demographics, and the poor quality of stigma studies. Conclusion: Results of the studies, their relation to behaviour change literature and the limitations of the current study are discussed. Future research is needed to explore help seeking for substance misuse in currently serving military personnel.

Keywords: Military, Help Seeking, Substance Misuse, Systematic Review

Treatment seeking for Substance Misuse in Currently Serving Military Personnel: A Systematic Review of Characteristics of Those Who Seek Treatment, as well as Barriers and Facilitators to Engagement

Substance misuse (SMU) is defined by the Substance Abuse and Mental Health Services Administration (2010, p. 1) as "when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems… and failure to meet major responsibilities". Literature has consistently outlined that globally, military personnel have significantly higher levels of alcohol misuse than the general public (Department of Defense, 2018; Fadum et al., 2019; Fear et al., 2007; Hooper et al., 2008; Stevelink et al., 2019). Alcohol misuse is typically measured using the Alcohol Use Disorders Identification Test (AUDIT) (World Health Organisation, 2001). The prevalence of drug misuse is lower. The most recent Health Related Behaviours Survey (HRBS) in the United Kingdom (UK) shows that only 1.1% of active duty personnel report illicit drug use, and 1.8% report prescription drug misuse, compared to 30.5% reporting binge drinking and 8.5% reporting heavy drinking (RAND Corporation, 2021). Research around drug misuse is therefore less available in relevant literature. The National Institute of Drug Abuse (2019) suggest that the low rate of drug use may be because the HRBS is self-reported and only has an 8.6% response rate. Substance misuse behaviour has been shown to be generalisable across substances. (Department of Defence, 2018; Prochaska & DiClemente, 1986).

Reasons for and the impact of increased substance misuse in the military

Reasons for SMU in the military are well reviewed and include service type, stress relief, social bonding and social pressures (Irizar et al., 2020; Jones & Fear, 2011; Osborne et al., 2022). A review of fifteen papers by Osborne et al. (2022) summarised the relationship between military service and alcohol use and included the military

characteristics associated with excessive alcohol use. These included demographics and other service-related factors such as service type or rank. The review found conflicting evidence in gender differences and alcohol consumption. One older study indicated that there was more hazardous drinking amongst men (67%) compared to women (49%) in the UK military (Fear et al., 2007), whereas another more recent study found that high alcohol consumption did not differ between men and women in the military in Norway (Fadum et al., 2019). This difference may reflect the expectation for women to conform to gender norms in military settings, or that research may have evolved over time to include more women, narrowing the gender gaps (Diacone et al., 2025; Eichler, 2022; Fine et al., 2020; Santos et al., 2022). It may also reflect a difference in geographical settings. Most papers in the review suggested that alcohol use was greatest during deployment and particularly prevalent in those with adverse combat experiences (Besse et al., 2018; Browne et al., 2008; Cerdá et al., 2014; Skipper et al., 2014). These papers were all based in the United States of America (USA). This review did not include illicit substances, despite research suggesting that substance misuse behaviour is generalisable across drugs and alcohol. A qualitative study by Vest et al. (2020) found that currently serving US soldiers reported being reluctant to use illicit substances due to random drug testing and seeing the military as a path to success and fulfilment. Participants reported heavier use of illicit substances post-service to relieve stress and enable sleep. However, a study by Arif et al. (2024) suggests that amongst US currently serving personnel, deployment status may effect drug use. Previously deployed soldiers had the highest measurements of risk-taking/impulsivity and drug use, whereas never deployed soldiers had the highest rates of increased likelihood of illicit drug use and risk-taking/impulsivity, and moderate to high risk-taking/impulsivity.

The impact of alcohol misuse in this population is well documented, but research in other substances appear sparce. Alcohol misuse in the UK military has been shown to lead to greater difficulties at home, during and post deployment (Browne et al., 2008; Irizar et al., 2020). Alcohol misuse has also been associated with suicidal behaviours in the US army, and found to be the most significant predictor of suicide risk in Lithuanian military personnel when used as a means to supress difficult thoughts and emotions (Bryan et al., 2016; Mazulyte-Rasytine et al., 2023). Rona et al. (2010) found that alcohol dependence in UK armed forces was associated with all five items of the Short Form Questionnaire-36 (SF-36) which measures functional impairment. The five items were “interfering with social activities”, “cut down on time in work”, “accomplished less”, “limited in the kind of work” and “difficulty performing”. However nearly half of those indicating alcohol dependence in this study also had a possible psychiatric comorbidity indicated by measures of Post Traumatic Stress Disorder (PTSD) and general health. These comorbidities within substance misuse research highlight the difficulty in disentangling the impact of substance misuse in isolation, but the high prevalence itself remains enough of a concern.

Psychological understanding of help-seeking

Help-seeking can be understood through various psychological theories of behaviour change. The ‘stages of change’ is a model of behaviour change (widely used in substance misuse services) which outlines an individual’s readiness for change (Prochaska & DiClemente, 1986). In the pre-contemplation phase, the individual is unaware of a problem and has no intention of change. In the contemplation phase, the individual becomes aware of a problem but is ambivalent to change. In the preparation phase, an individual becomes intent on behaviour change, and usually develops beliefs that change is positive. The action phase involves making active changes in behaviour, and maintenance

and possible relapse phases follow. This is not a linear process but rather cyclical. Although this is a widely used model, it internalises the process of change to just the individual. The 'COM-B system' (Michie et al., 2011) outlines three conditions that are needed for change, including capability, opportunity and motivation. Capability lies within the individual and can include psychological and physical capability (as in the stages of change), whereas opportunity lies outside of the individual and includes physical and social opportunity. Motivation is impacted by both capability and opportunity. The three factors within the COM-B system can change independently and have subsequent effects on other parts of the model. The COM-B system is used widely in behaviour change research, including research on help seeking in the military (Born & Frank, 2022; Walker et al., 2022; Woning, 2021).

Help-seeking for substance misuse in the military

The UK Ministry of Defence (2024) state that most personnel seeking help for mental health difficulties do so through their GP, but that more specialist mental health care providers are also available. The annual summary and trends over time show that rates of seeking specialist mental health care have declined since 2015/16, with a statistically significant decrease in 2023/4 to 1/50 (2%) (Ministry of Defence, 2024).

The UK Ministry of Defence (2013) outlines a general policy for military personnel who misuse substances. They outline education, awareness and regulation are necessary, as well as medical support through intervention, rehabilitation and wellbeing support. Those who are unwilling to engage in support for substance misuse are considered for discharge from service. As per the policy, The Ministry of Defence have shown efforts to ensure the continuation of research and treatment for substance misuse. Addiction, namely gambling, alcohol and other substance misuse was outlined as one of the nine priority themes in The Defence People and Wellbeing Strategy, 2022-2027 (Ministry of

Defence, 2022. Similarly, The Kings Centre of Military Health Research (KCMHR) and the Academic Centre for Defence Mental Health (ADMMH) were established by Kings College London in 2004 to bring focus to mental health research in the military. The KCMHR outlined help seeking behaviour as a primary area of focus in military research. Despite this, there appears to be no suitable systematic review exploring military help seeking behaviour in substance misuse.

It is important to consider engagement as an aspect of help seeking behaviour. 'Engagement' is an umbrella term within help seeking that summarises the interaction between an individual and an intervention, taking into account both internal and external factors such as individual characteristics, motivation and access to services and or intervention (Drieschner et al., 2004; Holdsworth et al., 2014). 'Substance misuse treatment' is an umbrella of services and interventions, including screening and identification, medical intervention, assessment, diagnoses, social and psychological support (Institute of Medicine, 1990).

In an anonymous survey, 20% of active US military members reported engaging in mental health treatment, but only 1.6% with alcohol treatment (Bray et al., 2009). Substance Abuse and Mental Health Services Administration (2010) and The Institute of Medicine (2013) acknowledge stigma towards SMU treatment, and include lack of access to services, lack of confidentiality and fear of negative consequences among this population as potential barriers to treatment. However, the review of alcohol use in the military by Osborne et al. (2022) identified only one paper which suggested that self-stigma led to treatment reluctance in the UK veterans (Kiernan et al., 2018). Hom et al. (2017) reviewed help seeking behaviours for mental health support among military personnel. They acknowledged two US papers showing personnel were 'disinclined' to seek support for SMU but reported no further detail (Fink et al., 2015; Gibbs & Rae

Olmsted, 2011). A review by Larson et al. (2012) outlined an idealised self-image of strength, which may contradict help-seeking amongst US military personnel (Tanielian et al., 2008). They also highlight public and self-stigma as barriers in US and Canadian military (Greene-Shortridge et al., 2007; Hoge et al., 2004; Tanielian et al., 2008). However, this review is dated and does not follow any systematic approach such as the PRISMA guidelines (Shamseer et al., 2015).

Research has more recently explored what facilitates engagement in SMU treatment in this population, but this has not yet been explicitly explored through a systematic review. For example, Coughlin et al. (2022) evaluated the engagement of US national guards in booster sessions following a brief web-based intervention for alcohol misuse. They found that peer led booster sessions had greater engagement (59%) than web-based booster sessions (44%). Similarly, Walker et al. (2017) conducted a randomised control trial with an adapted telephone version of motivational interviewing plus feedback (MIF) in high-risk sample of non-treatment-seeking US soldiers versus a control group with no treatment. All participants in the treatment group reported significantly fewer drinks per week than control participants and suggest that adaptations for remote treatment may compliment pre-existing interventions for alcohol misuse in the military.

Overall, literature has shown that alcohol misuse is higher in military personnel than the general public. Psychological theory allows for the generalisation of substance misuse treatment across alcohol and illicit drugs. There is substantial research on the reasons for substance misuse and the significant negative impact of this in this population. It has been identified that engagement with substance misuse treatment within the military is low, and there has been a call for focus in this area from Kings College London and the Ministry of Defence. Despite this, there appears to be no suitable systematic review exploring the characteristics of those engaging with substance misuse treatment or

reviewing barriers or facilitators to engagement in substance misuse treatment. The current review seeks to fill this gap, in hopes to contribute to policy and practise to encourage more engagement in substance misuse treatment for this population.

Research Questions

1. What are the characteristics of currently serving military personnel who engage with substance misuse treatment?
2. What facilitates engagement in substance misuse treatment amongst currently serving military personnel?
3. What are the reported barriers to seeking substance misuse treatment amongst currently serving military personnel?

Method

Search strategy

The review was registered with PROSPERO (code: CRD42023448892) by the first author, Z.F. Systematic searches were conducted on 8th July 2024 and updated on 7th May 2025. The search strategy was developed with the support of the Bodleian Library, University of Oxford. Searches were conducted on CINHAL, Embase, Medline, PsycInfo and Social Policy and Practise. Search terms relating to 'military personnel' or other related terms, 'substance abuse' or 'drug* use' or 'alcohol use' and other related terms, and 'treatment' or 'intervention' or 'help seek*' and other related terms were used (see Appendix A for full search strategy). The Preferred Reporting Items for Systematic Reviews and Meta-Analysis, PRISMA (Page et al., 2021) flowchart outlines the process of the systematic review (Figure 1).

Study eligibility

Inclusion criteria:

- Original, peer-reviewed research articles using either qualitative or quantitative methods.
- Studies reporting demographics or military characteristics (for example, service type and rank) of military personnel help seeking for substance misuse, and/or studies investigating barriers and/or studies investigating facilitators of help seeking including internal and external factors.
- Papers published in English.
- Studies published from 2004 onwards (research following the establishment of the Kings Centre of Military Health Research).
- Participants that are currently serving military personnel, aged 16 years and over. Currently serving military personnel is defined in this review as those currently employed by the military service, regardless of deployment status. This does not include veterans or reserves. The military service includes army, royal navy and royal air force, as defined by the Armed Forces Network (2024).
- Any type of illicit drug misuse or alcohol misuse.

Exclusion criteria:

- Studies with participants under the age of 16.
- Papers not written in English.
- Papers with military reserves or veterans where results are not reported separately to currently serving personnel (as these populations are incomparable to the currently serving population).
- Papers that include comorbidities where substance misuse results are not reported separately.
- Summary/guidance papers, proposed models, manuals and book chapters.

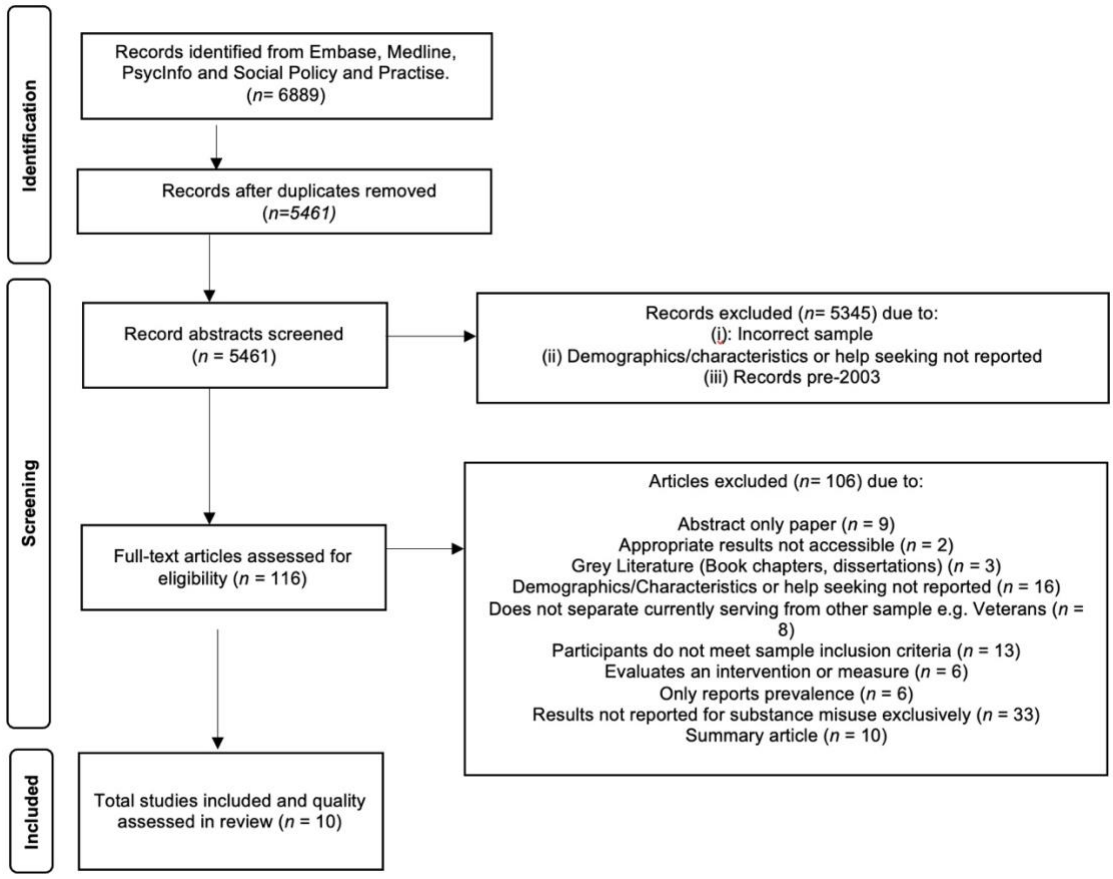
- Abstract/Research posters.
- Grey literature (as this is not peer reviewed).
- Evaluation of an intervention or validation of a measure.
- Studies that focus on prevention of substance misuse.
- Studies investigating patterns of substance misuse with no information on treatment seeking patterns.

The eligibility criteria were piloted on a small selection of studies and refined by Z.F. As shown in Figure 1. 5461 papers were screened for eligibility by Z.F., according to titles and abstracts. Studies that failed to meet inclusion criteria at title and abstract were rejected. A second author (V.M.) independently screened 25% of these and was blind to the first author decisions. A strong level of agreement was met between the authors at this stage ($k = 0.86$). Discrepancies were discussed and resolved between authors, and papers that were included by both authors were advanced for full text screening.

There were 116 papers entered for full text screening. Z.F screened all studies and V.M. screened 25% of these studies independently. Discrepancies at this stage were resolved through discussion, and a 'perfect' level of agreement was met ($k = 1$). 106 of the studies were rejected, leaving 10 that met full criteria

Figure 1.

PRISMA flow chart



Data extraction and quality assessment

A standardised data extraction table was developed and used by both authors to extract relevant data in a systematic way. The first author reviewed and extracted data from all 10 studies, and the second author extracted data from 50% of the studies. The extraction was compared, and differences were discussed and resolved.

The quality of the included studies was assessed using the appropriate Critical Appraisal Skills Programme checklist for each study (CASP). The questions on the checklist differed slightly depending on study design (Appendix B, C, D). Each checklist item was rated with a 'Yes', 'No' or 'Can't Tell'. The first author quality assessed all 10 studies, and

the second author independently assessed 50% of these studies. There was a strong agreement found between the two-quality ratings k = 0.96.

Data Synthesis

There was heterogeneity in study design and analytic methods across the studies included in this review, as well as a lack of reported effect sizes in some. Therefore, a meta-analysis was not possible. Instead, the review was reported in accordance with the nine reporting items outlined by the Synthesis Without Meta-analysis (SWiM) reporting guideline, as recommended by PRISMA guidelines (Campbell et al., 2020; Page et al., 2021).

Findings were synthesised using a narrative approach, organising the data into five variables of interest that emerged during the data extraction and preliminary analysis: (1) demographics, (2) job role–related factors, (3) service-related factors, (4) treatment-related factors, and (5) level of alcohol use. These variables of interest allowed for the grouping of studies in a way that answered the research questions of the review, to identify the characteristics of those who engage, facilitators and barriers to engagement in SMUT. The synthesis followed the method of qualitative case descriptions outlined by Light and Pillemer (1984), in which each study was presented narratively to highlight the context, methodology, and outcomes. This method allowed for deeper interpretation across heterogeneous study designs (Popay et al., 2006). Benefits and limitations to this approach are acknowledged in the discussion.

Results

Description of included studies

Table 1 shows a summary of the 10 studies included in this review. All studies were published between 2011-2022. Two of the studies were qualitative (Gibbs & Rae Olmsted, 2011; Holt et al., 2017) and eight were quantitative (Clinton-Sherrod et al., 2011; Gray et al.,

2021; Griffith, 2017; Hurt, 2015; Rae Olmsted et al., 2011; Reed et al., 2019; Taillieu et al., 2020; Wooten et al., 2013). Age of participants was not reported in all studies, but in those that were, the age ranged from 18-60. Three studies did not report the participants ethnicity (Gibbs & Rae Olmsted, 2011; Griffith, 2017; Taillieu et al., 2020). One study did not report total participant gender or ethnicity as demographics, these were only included within the context of other analysis (Hurt, 2015). Similarly, one study only included gender in the context of analysis and did not report a total figure (Taillieu et al., 2020).

In the studies that did report ethnicity and gender, the greatest percentages of participants were White and male (Clinton-Sherrod et al., 2011; Gray et al., 2021; Holt et al., 2017; Rae Olmsted et al., 2011; Reed et al., 2019; Wooten et al., 2013). Full details of the participants gender and ethnicity can be found in Appendix E. Nine of the studies were conducted in the USA (Clinton-Sherrod et al., 2011; Gibbs et al., 2011; Gray et al., 2021; Griffith, 2017; Holt et al., 2017; Hurt, 2015; Rae Olmsted et al., 2011; Reed et al., 2019; Wooten et al., 2013) and one study was conducted in Canada (Taillieu et al., 2020). Nine studies included alcohol misuse only (Clinton-Sherrod et al., 2011; Gibbs et al., 2011; Gray et al., 2021; Griffith, 2017; Holt et al., 2017; Hurt, 2015; Rae Olmsted et al., 2011; Reed et al., 2019; Taillieu et al., 2020) , and one study included alcohol and drugs including opioid dependence, sedative, hypnotic, and anxiolytic dependence (Wooten et al., 2013).

Three studies used the Alcohol Use Disorders Identification Test (AUDIT) or revised Alcohol Use Disorder Identification Test-Consumption (Babor et al., 2001) (AUDIT-C) to identify alcohol misuse (Clinton-Sherrod et al., 2011; Hurt, 2015; Reed et al., 2019). One study used an idiosyncratic measure with similar content to the AUDIT (Griffith, 2017). The AUDIT measure is a validated 10-question alcohol harm screening tool with each item scoring between zero and four. A total score of eight or higher indicates hazardous or harmful alcohol use and possible alcohol dependence. Clinton-Sherrod et al. (2011) also used the

TICS measure which is a ‘two-item conjoint screen for alcohol and other drug problems’ (Brown et al., 2001). Other measures of alcohol use relied on diagnostic criteria. These included the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM, 1979) (Gray et al., 2021; Wooten et al., 2013), the World Health Organisation’s version of the Composite International Diagnostic Interview (WHO-CIDI, 1990), which is based on criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (Taillieu et al., 2020), and the Agency for Healthcare Research and Quality Clinical Classification (Wooten et al., 2013). Rae Olmsted et al. (2011) used two idiosyncratic survey questions to measure of alcohol use which asked if counselling or therapy had been sought in the last 12 months, and what this was for.

Seven of the studies used a cross-sectional design, one study used a longitudinal study design, and two studies were qualitative. Six of the studies conducted retrospective quantitative data analysis using historic survey data (Clinton-Sherrod et al., 2011; Gray et al., 2021; Griffith, 2017; Hurt, 2015; Taillieu et al., 2020; Wooten et al., 2013). The responses in these studies were all collected between 2008-2013. Two studies analysed quantitative data collected through surveys (Rae Olmsted et al., 2011; Reed et al., 2019).

There were two qualitative studies included in this review. One study conducted “thematic matrices” rather than thematic analysis, which authors state is due to a small population size of n=80 (Gibbs & Rae Olmsted, 2011) . One study conducted thematic analysis based on individual interviews and focus groups with a sample size of n=87 (Holt et al., 2017).

Table 1

Summary table of all included studies

Citation	Country	Sample	Gender	Ethnicity	Study design	Substances	Research question(s)	Summary of relevant findings
Clinton-Sherrod et al. (2011)	USA	Active-duty soldiers administered in February-December 2008 (n= 43342)	90.1% male 9.9% female	65.6% white 18.2% black 11.3% Hispanic 4.9% Other	Quantitative Cross-Sectional	Alcohol	• How do the number of soldiers meeting criteria for alcohol abuse and mental health risk compare to the number of soldiers referred and enrolled into each type of treatment? • What are the referral methods for substance abuse treatment entry for soldiers indicating alcohol abuse risk following deployment? • Do certain soldier characteristics predict	• Soldiers who were male (OR = 1.57, $p < .05$), single (OR = 1.41, $p < .05$), and of a lower pay grade (OR = 0.37, $p < .05$) were significantly more likely to be enrolled in substance misuse treatment than those who were female, married, and of a higher pay grade. • Soldiers who indicated alcohol abuse risk were significantly more likely to end up in treatment through medical referral ($p < .05$) or command directed breathalyser ($p < .05$) compared to those who did not indicate risk. Effect size was not reported. • Those who indicated no alcohol abuse risk were significantly more likely to end up in treatment through a commander or

							likelihood of alcohol abuse and mental health risk and treatment entry?	supervisor referral compared with those who did indicate alcohol abuse risk ($p < .01$). Effect size was not reported.
Gibbs & Rae Olmsted (2011)	USA	Soldiers in CATEP (n=80)	Not reported	Not reported	Qualitative Interviews	Alcohol	• To what extent did confidentiality influence soldiers' decisions to seek treatment and explored whether there were any negative aspects of confidentiality. • Were any negative aspects of confidentiality? • How did soldiers and clinicians respond to evening and weekend treatment hours is any modification to the program warranted?	• Participants reported that they would not have entered treatment without confidentiality. • Participants reported that they appreciated being able to attend treatment or evenings and weekends without being absent from their jobs, so that their performance and reputation did not suffer as a result: able to attend treatment in civilian clothes, which relaxed the tenor of group meetings and diminished social barriers based on pay grade. • Participants noted that the off-duty hours were the times when they would have been most likely to drink, so that being occupied with group during this time was helpful. • Participants offered numerous suggestions for ways in which the program could be better publicized, including better command awareness, staff briefings, posters in on-post

								• How soldiers and clinicians responded to evening and weekend treatment hours and explore here whether any modification to the program may be warranted.	retail stores in which alcohol is sold, personal stories from soldiers who had completed treatment and continued their military careers. • Participants felt that self-referral to treatment, even in the absence of an infraction, would raise questions about soldiers' performance and ability to handle job stress. • Participants reported that they were not "on the radar" as having drinking problems, although a few had been encouraged by command to seek treatment.
Gray et al. (2021)	USA	Active-duty soldiers (n= 4726)	Male: 94.8% Female: 5.2%	White/non-Hispanic: 54.8 % Hispanic: 11.8% Black, non-Hispanic: 16.2% Asian or Pacific Islander: 14.7% American Indian or Alaska Native: 2% Other: 0.6%	Quantitative Cross Sectional	Alcohol	• To identify the rates and predictors of substance use treatment initiation and engagement among active-duty soldiers who were identified with a post-deployment AUD diagnosis in the first 150 days after completing a	• Senior Enlisted soldiers were less likely to initiate in treatment compared to Junior Enlisted (probability decrease of MEM = 0.043, SE = 0.016, $p < .05$).	

							post-deployment health reassessment survey. • To examine the association of meeting the HEDIS substance use treatment engagement criteria with military retention, defined as a negative separation from the military within two years of the post-deployment AUD diagnosis.	
Griffith (2017)	USA	Active-Duty Soldiers (n= 4567)	Not reported	Not reported	Quantitative Cross Sectional	Alcohol	• What are problems of returned reserve soldiers seeking services in the community? • How do reservists respond to these problems in	• Soldiers were significantly more likely to have used alcohol programs if they also reported feelings of isolation (OR = 1.65, p < .001), lack of social support (OR = 1.24, p < .01), or suicidal ideation (OR = 1.29, p < .001).

							terms of seeking help? • To what extent do reserve soldiers reporting problems actually seek help?	
Holt et al. (2017)	USA	Active-duty military personnel (n=87)	Male 59% Female 41%	Non-Hispanic White: 41.4% Hispanic/Latino: 29.9% Black or African American: 13.8% Asisan or Asian American: 6.9% American Indian/Alaska Native: 2.3% Other: 3.4% Missing: 2.3%	Qualitative Interview	Alcohol	To assess: • Potential barriers for conducting a large-scale prevention trial in the ED • Attitudes toward SBIRT services • Potential solutions to any barriers • Special issues related to military populations that might be addressed in a modification of the SBIRT intervention • Logistical considerations	• Superiors supportive of efforts to receive such support (18%) • Preference of civilian counsellors rather than military counsellors (55%) due to concerns around confidentiality • Concerns around confidentiality (55%): “mental health records aren’t sealed and can be accessed by superiors.” • Civilian counsellors with familiarity or experience with military culture would be a good fit (13%) • (3%) suggested having a supportive unit and supervisor who regard treatment seeking as a means of self-improvement is instrumental in terms of encouraging seeking help. • One-quarter mentioned treatment resources abound

							for delivering the intervention • Use of civilian vs. military health educators to recruit for and deliver SBIRT and concerns with stigma surrounding issues of problematic drinking in the military and how they might be overcome.	within military settings, making it easier for those ready to pursue help to do so. • Stigma: worries that peers and superiors view people who seek help as incompetent and unstable (28%). • Marines and other junior personnel suggested as being less open to therapy. • Fear of repercussions of help seeking (21%): stigma, effect on evaluations and career advancement, worries about work absences reflecting poorly.
Hurt (2015)	USA	All active component service personnel - Army, Navy, Air Force, Marine Corps. (n=936,475)	Totals not reported as demographics, only within data.	Totals not reported as demographics, only within data.	Quantitative Cross Sectional	Alcohol	• To describe the results of the alcohol use screens and to assess whether appropriate treatment was being recommended by the healthcare providers reviewing these assessments. To assess: • Potential barriers for	• Service members working in armour/motor transport occupations were the most likely to have received a referral. • PDHRA respondents with severe risk scores and not already under care had a higher percentage of behavioural health referrals than primary care referrals. This was consistent across most demographic and military characteristics except for: service members aged 45 years and older, marines, senior officers, and pilots/air

				conducting a large-scale prevention trial in the ED • Attitudes toward SBIRT services • Potential solutions to any barriers • Special issues related to military populations that might be addressed in a modification of the SBIRT intervention • Logistical considerations for delivering the intervention • Use of civilian vs. military health educators to recruit for and deliver SBIRT • Concerns with stigma surrounding issues of problematic drinking in the	crew who were all more likely to receive a referral to primary care than to specialty care. • % of Referrals to behavioural specialty care were highest among females, black non-Hispanics, those younger than 20 years of age, sailors, junior enlisted personnel, and service members working in healthcare occupations • Service members working in armour/motor transport occupations were the most likely to have received a referral.

							military and how they might be overcome.	
Rae Olmsted et al. (2011)	USA	Soldiers (n=1436)	90.2% male 9.8% female	White non-Hispanic: 67.6% African American non-Hispanic: 13.4% Hispanic: 14.3% Other non-Hispanic: 4.7%	Quantitative Cross Sectional		• To compare perceptions of stigma among soldiers who have received mental health or substance abuse treatment in the past 12 months with those who have not received any treatment in the past 12 months.	• Participants who had received any treatment in the past 12 months reported a greater mean stigma score compared with those who had received no treatment in the past 12 months. • Participants who received substance abuse (SA) treatment only reported significantly higher MH treatment stigma than those who received no treatment ($p = .034$, $\beta = 4.34$). • Those who received SA treatment only were similar to those who received MH treatment only in terms of perceived MH treatment stigma ($p = .20$, $\beta = -2.78$). • No differences between treatment groups were noted regarding perceptions of stigma for SA treatment.
Reed et al. (2019)	USA	Service members (n=787)	73.3% male 26.7% female	White: 54.4% Hispanic/Latino: 18.6% African	Quantitative Cross Sectional	Alcohol	• To test the relationship between self-efficacy, readiness to	• Participants who indicated greater readiness to change their drinking were significantly more likely to be risky drinkers ($p = < .001$, no

				American: 18.4% Other: 8.7%			change, treatment success and levels of drinking risk as measured by the AUDIT.	effect size reported) suggesting the assumption risky drinkers deny their problematic drinking habits may not be tenable.
Taillieu et al. (2020)	Canada	Canadian Air Force (n=6692)	Totals not reported as demographics only within data	Not reported	Quantitative Cross Sectional	Alcohol	• To compare the prevalence, correlates, help-seeking behaviours, perceived need for care, and barriers to care for AUDs in the Canadian Armed Forces (CAF) and the Canadian general population (CGP).	• Military personnel were significantly more likely to report that their job had interfered with their getting help (OR = 7.07, $p < .01$). • Potentially meaningful differences were seen for most other barriers though none of these achieved statistically significance, likely due to limited power.
Wooten et al. (2013)	USA	Active-duty military personnel (n=152,477)	90.4% Male 9.6% Female	Male: 61.5% white, 15.8% black, 17.1% Asian, 5.6% other. Female: 39.2% white, 35.7% black, 16.6%	Quantitative Cross-Sectional	Alcohol and drugs including opioid dependence, sedative, hypnotic, and anxiolytic dependence	• What are the SUDX rates in Army men and women in their military lifetime? • What are the SUT utilization rates in the year	• Prevalence of SUT utilization in the year prior to deployment was low for both Army women (2.1%) and Army men (3.2%). • Less than one percent of Army men and women received inpatient SUT and the rate of receiving two or more outpatient SUT visits was

	Asian, 8.6% other.	prior to deployment? • Do the odds of receiving SUT differ for Army men and women after adjusting for the propensity to receive a military lifetime SUDX?	2.4% (n = 3,270) for men and 1.5% (n = 214) for women.

NB: USA = United States of America, n= number of participants, CATEP = Confidential Alcohol Treatment and Education Pilot, ED = Emergency Department AUD = Alcohol Use Disorders, HEDIS = Healthcare Effectiveness Data and Information Set, MEM = Marginal Effect at the Mean, SE = Standard Error, ED = Emergency department, SBIRT = Screening, brief intervention and referral to treatment, SA = Substance abuse, CAF = Canadian armed forces, CGP = Canadian general population, SBRIT = screening, brief intervention and referral to treatment, PDHRA = Pre or Post-Deployment Health Reassessment, AUDIT = Alcohol Use Disorders Identification Test.

Quality of studies

Quality of studies was evaluated using critical appraisal checklists from the Critical Appraisal Skills Programme (CASP). A summary of scores can be seen in Table 4 and a full breakdown of item scores can be seen in Appendix F. Seven of the studies were evaluated using the cross-sectional studies checklist, one with the cohort study checklist and two with the qualitative checklist. There are several strengths and limitations in the sample, methods, and measures to note.

None of the studies including in this review included a-priori power analysis, therefore it is unclear if sample sizes produced a reliable estimate of help seeking. Studies analysing historical data did not often report initial recruitment strategies so conclusions cannot be drawn about the appropriateness of these (Clinton-Sherrod et al., 2011; Gray et al., 2021; Griffith, 2017; Hurt, 2015; Taillieu et al., 2020; Wooten et al., 2013). Studies that collected new data relied on convenience samples and did not appear to recruit in a confidential way. Three of the studies used military staff or treatment providers to recruit participants (Gibbs & Rae Olmsted, 2011; Rae Olmsted et al., 2011; Reed et al., 2019) and one study recruited participants by approaching them in an emergency department of a naval medical centre (Holt et al., 2017). This may have led to sample bias. Nine of the ten studies included in this review reported that recruitment was conducted in a single military setting which may reduce the generalisability of results to other cohorts. Griffith (2017) did include multiple units (n=50), but the authors suggest that results are only representative of those Army National Guard (ARNG) units which had deployed in 2010.

Most of the studies in this review depended on historic data (Clinton-Sherrod et al., 2011; Gray et al., 2021; Griffith, 2017; Hurt, 2015; Taillieu et al., 2020; Wooten et al., 2013). All historic data that was analysed in these studies was collected from 2008-2013, meaning that help seeking information gathered in these studies are older than publication

dates may suggest. Use of historical data methodology could be considered appropriate as they allowed for large sample sizes in a being 'hard to reach' population (Bush et al., 2013). Most of the studies included in this review were cross-sectional, meaning that causality of facilitators or barriers to help seeking cannot be assumed.

The two qualitative studies included in this review conducted both individual interviews and focus groups (Gibbs & Rae Olmsted, 2011; Holt et al., 2017). Both studies interviewed military personnel about specific treatment programmes, so may not be generalisable to engagement in treatment overall. Interviews in groups hold potential for bias, although Gibbs and Rae Olmsted (2011) note that they found minimal differences between responses from focus groups and individual interviews. Additionally, both qualitative studies failed to acknowledge the relationship between the researcher and the participants, which may have led to demand characteristics or bias.

In most of the studies that used historical data, official military databases were used to establish prevalence of help seeking or active-duty status between certain time periods. Three of these studies also obtained data from a historic Pre or Post-Deployment Health Reassessment (PDHRA) form, which is a standardised form used to collect information about physical and mental health status and includes the validated AUDIT tool for alcohol use (Clinton-Sherrod et al., 2011; Gray et al., 2021; Hurt, 2015). Having official sources of data provides consistency and comparability across these studies.

Neither of the studies that collected new quantitative data used validated measures of help-seeking (Rae Olmsted et al., 2011; Reed et al., 2019). Limitations of this were not acknowledged in either of these papers.

Table 4.

Critical Appraisal Skills Programme (CASP) Scores

Citation	**Method**	**Quality Assessment Score - CASP**	**Quality Assessment Score – Percentage**
Clinton-Sherard et al. (2011)	Cross-Sectional	10/11	90.9%
Griffith et al. (2017)	Cross-Sectional	8/11	72.7%
Hurt (2015)	Cross-Sectional	8.5/11	77.2%
Rae Olmsted et al. (2011)	Cross-Sectional	8/11	72.7%
Reed et al. (2019)	Cross-Sectional	9/11	81.8%
Taillieu et al. (2020)	Cross-Sectional	8.5/11	77.2%
Wooten et al. (2013)	Cross-Sectional	9.5/11	86.4%
Gray et al. (2021)	Cohort	7/8	88%
Gibbs & Rae Olmsted (2011).	Qualitative	7/11	63.6%
Holt et al. (2017).	Qualitative	6/11	54.5%

Studies assessed characteristics of those who engage in SMUT, facilitators and barriers to engagement in SMUT across four main variables of interest: (1) demographics, (2) job role related factors, (3) service-related factors, (4) treatment related factors, and (5) level of alcohol use. Summary of the studies methodology and findings can be seen in Table 1.

Demographics

Two papers included in this review (Clinton-Sherrod et al., 2011; Wooten et al., 2013) looked at gender in relation to engagement with SMUT. Wooten et al. (2013) analysed data collected from army service members upon return from deployment in 2010. The prevalence of substance misuse treatment (SUT) was low for both army men and women, falling at just 1% for both genders in inpatient treatment, and 2.4% for men and 1.5% for women in outpatient treatment. When substance misuse diagnosis was adjusted for, women still had lower rates of engaging with SUT than men. This study had the second highest quality assessment rating in this review (86.4%). Data for alcohol use was coded from the ICD-9-CM, and data for engagement was sourced through number of encounters with inpatient or outpatient visits. These measures provided consistency and validity. Similarly, Clinton-Sherrod et al. (2011) analysed data collected in 2008 through the PDHRA survey (given 3-6 months deployment) and the Army's Drug Administration and Management Information System (DAMIS), and found that soldiers who were male were significantly more likely to be enrolled in substance misuse treatment than those who were female, married and of a higher pay grade. This study had the highest quality assessment rating in this review (90.9%) and used the validated AUDIT form to measure alcohol use. Odds ratio is shown in Table 1, but no standardised effect size was reported.

Hurt (2015) analysed referrals made to alcohol misuse treatment three to six post-deployment, in relation to AUDIT-C scores (revised AUDIT form) and demographic information. Those with 'severe' risk scores on the AUDIT-C (score of 8-12) and not already receiving treatment had a higher percentage of specialty care referrals (including behavioural health in primary care, mental health specialty care and substance abuse programme) than primary care referrals. This was consistent over most demographics, but not in those aged 45 and over, who

more likely to receive a referral to primary care than specialty care. Those who were younger had less documented referrals overall. Referrals to behavioural specialty care were highest among females, black non-Hispanics and those younger than 20 years of age. Total demographics were not reported for the total sample of this study, only reported within the output of the data analysis. It is therefore not possible to assume that these results were based on a representative sample.

Job role related factors

Hurt (2015) found that those working in armour or motor transport roles were the most likely to have been referred for treatment overall however as mentioned above, it is not possible to assume that these results were based on a representative sample due to a overall sample demographics not being reported. Gray et al. (2021) found that senior enlisted soldiers were significantly less likely to engage in treatment compared to junior enlisted soldiers. However, a standardised effect size was not reported in this data, instead, only a marginal effect at the mean was presented (see Table 1), which limits the interpretation of its practical significance. On the other hand, Hurt (2015) found that compared to others, services members who were younger and officers (particularly junior officers) had fewer documented referrals for substance misuse treatment. Similarly, during interviews, participants felt that marine corps and other junior personnel would not be receptive to treatment (Holt et al., 2017). No further information regarding the reason for this was reported. Other job role related factors associated with less documented referrals included those working in pilot or air crew roles (Hurt, 2015).

Military Service-Related Factors

Holt et al. (2017) conducted interviews with military personnel already in treatment. Having a supportive unit and supervisor was suggested by three percent of respondents as encouraging help seeking, and 18% said that their supervisors were supportive of them receiving support. This study had a good variation in ethnicity and gender across participants (see Table 1), however it had the lowest quality assessment score in this review (54.3%) due to lack of reported information on recruitment, data collection, ethics and data analysis.

Two papers included in this review mentioned stigma explicitly as a barrier to engaging in substance misuse treatment. 28% of participants in the qualitative study by Holt et al. (2017)

expressed concerns around stigma, highlighting that peers and supervisors view those who seek support as incompetent and unstable. They also found that 22% of participants worried about repercussions at work, namely stigma, how absences may reflect poorly and how treatment may affect employment evaluations and career advancement. Rae Olmsted et al. (2011) found that those who had received treatment for substance misuse in the past 12 months had a greater mean stigma score compared to those who had not received treatment. However, this was calculated without controlling for demographic differences and only through a regression. B coefficients are presented in Table 1, but no standardized effect sizes were reported. Regression also found that those who received substance misuse treatment reported significantly higher mental health treatment stigma than whose who received no treatment, but that there was no difference between the groups in reported substance misuse treatment stigma when controlling for gender and pay grade. Rae Olmsted et al. (2011) state that this is likely due to small participant numbers in the group that received substance misuse treatment only. This study scored 72.7% in quality assessment, however this study only used idiosyncratic measures of alcohol use and substance misuse treatment, which reduces the validity.

On the note of stigma but perhaps less explicit, concerns about how individuals would be viewed in the workplace was a barrier to engaging in substance misuse treatment. In interviews, participants shared concerns that self-referral to treatment may raise questions about an individual's performance, ability, and how they are able to handle the stress of the job (Gibbs & Rae Olmsted, 2011). Gibbs & Rae Olmsted (2011) interpreted that this reflects "stigma in terms specific to the military" (p.107). Taillieu et al. (2020) found that compared to the general Canadian population, Canadian armed forces were significantly more likely to report that their "job had interfered" with getting help (8.3% versus 41.2%). Odds ratio is shown in Table 1, but no standardised effect size was reported. No further information about which parts of the job had interfered was reported. Armed forces personnel were also more likely to report that they were afraid of what others would think of them. This difference did not reach statistical significance although Taillieu et al. (2020) state that this is likely due to underpowered models, and that the differences likely reflect the stigma that is associated with help seeking.

Treatment-related factors

Confidentiality was outlined in two qualitative studies as a facilitator of engagement. Gibbs and Rae Olmsted (2011) found that participants already in Confidential Alcohol Treatment and Education Pilot (CATEP) treatment felt they would not have entered treatment without confidentiality. However, the quality assessment rating for this study was the second lowest in this review (63.6%) and no demographics of the sample were reported, therefore generalisability cannot be assessed. Holt et al. (2017) interviewed active-duty military personnel about how best to adapt screening, brief intervention and referral to treatment (SBRIT) and reported that 55% of participants stated a preference for civilian counsellors rather than miliary counsellors) due to reported concerns around confidentiality. Lack of confidentiality was outlined by these 55% as a barrier to engagement as participants stated that "mental health records aren't sealed and can be accessed by superiors". Additionally, 13% of participants said holding familiarity or experience with military culture would be important if civilian counsellors were used.

Participants in the Gibbs and Rae Olmsted (2011) qualitative study also highlighted several practicalities of CATEP that facilitated their engagement. These including having sessions during off-duty hours evenings and weekends as it allowed them to not miss working hours and tended to fall within the time that participants would be using alcohol. Participants reported that CATEP occurring outside of work hours meant that their performance and reputation did not suffer. This practical element was noted by Gibbs and Rae Olmsted (2011) to increase confidentiality which they say is consistent with other literature which suggests that stigma represents a barrier to treatment.

Participants also highlighted that being able to attend treatment in civilian clothes felt more relaxed due to the social barriers of pay grade not being present. Having personal stories from soldiers who had completed treatment and continued their military careers was also suggested. Suggestions were also provided for ways to better publicise support available for alcohol misuse, including better command awareness, staff briefings, and posters at the many on-post retail stores in which alcohol is sold. On a similar practical note, one-quarter of participants in the study by Holt et al. (2017) said that having treatment within military settings would make it easier to engage

in help for those ready to do so. These suggestions may not be generalisable due to the qualitative nature and lower quality assessment ratings of these studies.

Level of alcohol use and referral

Three studies examined how the level of alcohol indicated by the AUDIT screening tool use may affect engagement in substance misuse treatment. Engagement here was defined as referral into treatment, following the definition of engagement which includes access to services and or intervention, and the definition of 'substance misuse treatment' which includes screening, identification, assessment and diagnoses (Drieschner et al., 2004; Holdsworth et al., 2014; Institute of Medicine, 1990). Clinton-Sherrod et al. (2011) analysed AUDIT scores collected three to six months post deployment and found that where alcohol misuse was not indicated through the AUDIT, military personnel were typically referred through a commander whereas if alcohol misuse was indicated through the AUDIT, personnel were typically referred for treatment through a medical referral. No further information about what the referral process entailed was reported. Effect sizes are also not reported. Hurt (2015) also analysed referrals made to alcohol misuse treatment three to six post-deployment, in relation to AUDIT-C scores (revised AUDIT form) and demographic information. Those with 'severe' risk scores on the AUDIT-C (score of 8-12) and not already receiving treatment had a higher percentage of specialty care referrals (including behavioural health in primary care, mental health specialty care and substance abuse programme) than primary care referrals. This was consistent over most demographics, apart from those aged 45 and over, marines, senior officers and pilots or air crew, who were more likely to receive a referral to primary care than specialty care.

Reed et al. (2019) looked at military personnel who were recruited to participate in a treatment trial and found that that those with greater readiness to change their alcohol misuse had significantly higher risk measured with the AUDIT than those with less readiness to change. This is in line with the stages of change theory by (Prochaska & DiClemente, 1986). This study had an 81.8% quality assessment rating however it used only a single idiosyncratic measure of readiness to change (a one to four rating scale) which may reduce the validity of results. Effect size of this significant result was also not reported.

Gibbs and Rae Olmsted (2011) touched upon some participants feeling that problem alcohol use was "not on the radar". This was highlighted within the theme 'Confidentiality Is Often a Critical Factor for Treatment Entry' although the meaning of this statement was not explained any further in this study. Lastly, Griffith (2017) found through regression analysis that soldiers with indicated alcohol misuse on the AUDIT were significantly more likely to use services if a lack of social support, suicidal ideation or feelings of isolation was also indicated, suggesting the comorbidities alongside level of alcohol use should be considered. Odds ratio is shown in Table 1, but no standardised effect size was reported.

Discussion

The aim of this systematic review was to critically examine the characteristics of military personnel who engage with substance misuse treatment, what facilitates engagement in substance misuse treatment amongst military personnel, and what the barriers are to seeking substance misuse treatment amongst military personnel. Ten studies were included, and the results and quality of these were examined. The studies identified begin to answer the research questions in this review, situated within key factors of interest identified in the results.

Characteristics of military personnel who engage with substance misuse treatment

Characteristics in this review were defined as demographics and military characteristics such as rank or service type, following a definition from a previous review by Osborne et al. (2022). There is some evidence from two studies included in this review that males are more likely than females to engage in substance misuse treatment (Clinton-Sherrod et al., 2011; Wooten et al., 2013). These studies were based in the USA. The USA National Institute on Drug Abuse (2020) states that in the general population, more men than women seek treatment for substance misuse. These studies are two of the oldest studies in this review and may not reflect changes toward gender equality in the military.

For example, more recent research highlights that females are expected to confirm to masculine gender norms within the military (Diacone et al., 2025; Eichler, 2022; Fine et al., 2020; Santos et al., 2022). Two participants from a qualitative study by Lawn et al. (2024) specified that this includes alcohol use. Despite this, the most recent review on gender differences in the general population suggests that women may present to services more quickly than men but that there is also evidence of treatment underutilisation amongst women misusing alcohol (Alvanzo et al., 2014; Cohen et al., 2007; Khan et al., 2013). Similarly, the UK Government (2023) statistics show that between April-March 2022, 67% of those in substance misuse treatment were men compared to 33% who were women. This varies by substance group, and in alcohol treatment men accounted for 58% and women for 42%. There are only two studies regarding gender identified in the current review, so there is limited evidence available to draw conclusions from. However, these two studies also had the two highest quality assessment rating scores in this review, and it does appear that there are consistencies between the studies included in this review and with the general population. This suggests a general trend that male currently serving military personnel may be more likely to engage in substance misuse treatment than women.

One study included in this review suggested that those who were younger and those who were working in armour or motor transport roles had less documented referrals to treatment overall, but further detail as for the reasons for this were identified (Hurt, 2015). This study also found that percentages of referrals to behavioural specialty care were highest among females, black non-Hispanics, and those younger than 20 years of age (Hurt, 2015). This study was based on a large sample size (n=936,475), although there was no overall sample demographics reported, therefore it is not possible to comment on the representativeness of these results. Gray et al. (2021) found conflicting results to Hurt

(2015) regarding junior versus senior status, and the two studies did not differ greatly in quality assessment ratings, therefore it is also difficult to make conclusions from these studies.

Facilitators of engagement in substance misuse treatment amongst military personnel

Facilitators of engagement in substance misuse treatment amongst military personnel in this review include level of alcohol use indicated by the AUDIT screening tool, and military service related factors of having a supportive supervisor and unit (Clinton-Sherrod et al., 2011; Griffith, 2017; Holt et al., 2017; Hurt, 2015). The findings of these studies may suggest that the journey into engagement with substance misuse treatment for active military personnel is supported by other people, either through direct referrals by professionals or supervisors, or through support from colleagues. However, the level of involvement of the military personnel in the referral process was not made clear in the studies, so it remains unclear how much others may facilitate or inhibit the early stages of engagement in SMUT which include screening, access and referral (Drieschner et al., 2004; Holdsworth et al., 2014; Institute of Medicine, 1990).

Treatment related factors such as confidentiality and other practical elements were also named as facilitators of engagement in SMUT. The facilitators identified suggest increased physical and social opportunity for substance misuse treatment may be a facilitator of engagement, based on the COM-B model of behavioural change (Michie et al., 2011). However, the conclusions that can be drawn from the literature is limited due to heterogeneity between the aims, methodology and samples of the studies included in this review. The studies differ widely in quality assessment ratings. Generalisability is particularly limited as all but one study sits within a single military setting in the USA.

Barriers to seeking substance misuse treatment amongst currently serving military personnel

Stigma appeared to be a barrier when measured both explicitly and in themes of the two qualitative studies identified (Gibbs & Rae Olmsted, 2011; Holt et al., 2007; Rae Olmsted et al., 2011) This is consistent with previous reviews from Larson et al. (2012) and Osborne et al. (2022), which identified studies showing both public and self-stigma as barriers to engagement (Greene-Shortridge et al., 2007; Hoge et al., 2004; Kiernan et al., 2018; Tanielian et al., 2008). However, the review by Osborne et al. (2022) was not systematic and did not evaluate quality of the studies included, therefore it is difficult to compare this literature to the limited literature identified in the current review.

Limitations

There were several limitations of the current review. Studies of poor quality were included due to the limited number of papers included in this review. Additionally, the research questions include potential for subjectivity particularly within the term 'engagement'. Some of the studies included in this review explored screening and referral processes as these were not specified as exclusion criteria. Had this review been conducted by different authors, these terms may not have constituted "full engagement" in substance misuse treatment, particularly when being compared to papers in this review that included full treatment programmes such as CATEP and SBIRT. There is also a lack of consistency in what constitutes as 'currently serving' military personnel. Some studies included in this review analysed data from at a pre-deployment time frame and some studies measured at post-deployment. Although these participants in these studies are all by definition 'currently serving' (not veterans or reserves), the differences between these timeframes were not considered prior to conducting the review. Additionally, only one study measured 'readiness to change', which could be a key factor that has been missed in research in the facilitation to engagement in substance misuse services, based on psychological theory (Prochaska & DiClemente, 1986). The age of participants was not reported in all studies,

meaning that we cannot be sure that all participants included in this review who were below the age of 18, as set in the exclusion criteria. Lastly, meta-analysis was not possible in this review. The use of qualitative case descriptions allowed for deeper understanding of each study's context, rather than relying solely on reported results (Popay et al., 2006). However, this approach may have led to subjectivity in the interpreting findings and may results in over or underestimation of studies effects due to the absence of effect sizes or statistical tests.

Implications and directions for further research

All but one paper included in this review included alcohol use only. This review is therefore unable to contribute to the literature which suggests that substance misuse behaviour is generalisable across substances, as suggested by theories such as the cycle of change (Department of Defence, 2018; Prochaska & DiClemente, 1986). Further research should include other substances outside of alcohol use. Many of the papers excluded in both the abstract and title screening and the full text screening in this review did not separate veteran and currently serving military populations in the results. Further research of currently serving military personnel is needed to expand the limited knowledge regarding characteristics of those who engage in substance misuse treatment, facilitators and barriers to engagement. Additionally, nine of the studies included in this review were based in the USA, and one in Canada. Despite the initiative from Kings College London in 2004 to widen the research around substance misuse and help seeking in the military, it appears that this area has not yet advanced in UK literature outside of comorbidities such as PTSD and functional impairment. Further research is needed to explore help seeking for substance misuse in the UK military exclusively, given the high prevalence and negative consequences in the UK military.

Conclusions

In conclusion, this systematic review fills a gap in current literature by providing an up-to-date synthesis of the existing research regarding engagement in substance misuse treatment in currently serving military personnel. There is limited consistent evidence to conclude the characteristics of those who engage in SMUT, facilitators and barriers to engagement amongst military personnel. This review highlights the lack of consistency in research in this area and more widely a lack of research applied to the UK military. Synthesis of this topic has allowed for recommendations for further research in this area. This review particularly recommends further research to separate currently serving military personnel from the veteran population and from comorbid conditions. This would allow for a development in understanding of the facilitators and barriers to engagement and for subsequent influence on policy and practise for the unique population of currently serving military personnel.

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Service Improvement Project: The Impact of Anti-Racism Training: Behaviour Change in Clinical Psychologists, A Service Improvement Project Using the COM-B System

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Proposed Journal: Cultural Diversity & Ethnic Minority Psychology. This journal seeks to advance the psychological science of ethnicity and race from a theoretical perspective on psychological issues that have been historically underrepresented, including education and training of psychologists. Recent publications include papers that contribute to the understanding of developing anti-racism and cultural competence within psychologists and counsellors.

Disclaimer: Language throughout this paper has been written in accordance to the current UK Government guidance on writing about ethnicity. The term ‘ethnicity’ is recommended instead of ‘race’. The term ‘ethnic minority’ is used to refer to all ethnic groups except the White British group. Ethnic minorities include White minorities such as Gypsy, Roma and Irish Traveller groups. The author of this paper acknowledges that terms relating to ethnicity are dynamic and complex and although the term ‘ethnic minority’ is not universally accepted, it is often used in research. This term can be generic and not representative of the unique identities/experiences of people.

Abstract

This service improvement project evaluates an anti-racism training run by The Oxford Institute of Clinical Psychology Training and Research (OXICPTR). The evaluation aimed to identify what psychological and behavioural changes had occurred as a result of the training and what facilitated and prevented those changes both in the content of the training itself and the context of services that participants worked. Nine psychologists who had attended the anti-racism training participated in individual semi-structured interviews. These were transcribed and reflexive thematic analysis was conducted. Five themes were developed from the coded data. The analysis showed that Clinicians outlined psychological changes that they had experienced following the training, but examples of concrete behaviour change was less common. The importance of professional relationships in the process of change was highlighted and behaviour change was portrayed by clinicians as a relational process. Clinicians often removed self-responsibility of anti-racist behaviour change, and instead placed responsibility in 'the system' including wider NHS trusts. Barriers to the initiation of behaviour change included feelings of powerlessness both within services and in the wider issue of anti-racism. Self-identity was also seen to both facilitate change and create barriers to change. Recommendations to facilitate behaviour change are outlined in relation to the COM-B model of behaviour change.

The Impact of Anti-Racism Training: Behaviour Change in Clinical Psychologists, A Service Improvement Project using the COM-B System

Introduction

A sequence of high-profile events in recent years have led to a surge in conversations about antiracism. These include the 2018 Windrush scandal, Brexit, the murder of George Floyd in 2020, and the COVID-19 pandemic. Mental health professions in the UK did not shy away from examining their position in anti-racist practise during these times. The Mental Health Services Data Set (2022) showed that Black patients were five times more likely than White patients to be detained under the Mental Health Act. According to the latest demographics, 88% of psychologists are White (British Psychological Society, 2015), a demographic which has been maintained since the 1970s (Goodbody & Burns, 2011). According to Clearing House (2017), White British applicants have a one in five chance of being shortlisted for interview on psychology doctorate training programmes (DClinPsych) compared with one in 13 for applicants from ethnic minority backgrounds. Ahsan (2020) outlines several systemic barriers including institutional racism as an explanatory factor to the inequalities within these professions.

The mental health implementation plan from NHS England set a target for an additional 2520 psychological practitioners to be in post by 2023/24. They also commissioned a 60% increase in DClinPsych courses and released an action plan to improve equity of access and inclusion for ethnically diverse entrants to clinical psychology training. DClinPsych courses across the country had the freedom to use their funding in a way they saw beneficial for their course. The Oxford Institute of Clinical Psychology Training and Research (OXICPTR) course commissioned and provided an anti-racist training for course staff and supervisors.

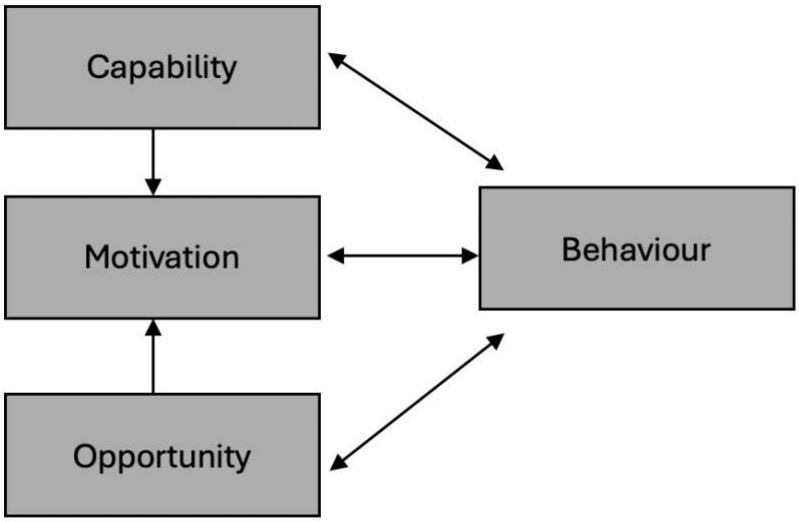
Anti-racism training falls within the category of a social-norm behaviour intervention, which is defined as providing information on the behaviour and opinions of other people to influence behaviour change (Miller & Prentice, 2016). Research in anti-racism training has not yet been specific to professionals in psychology. Trends in prejudice reduction research over the last decade show that two-thirds of study outcomes measure attitudes or beliefs, but only 7% of outcomes are behavioural (Paluck et al., 2021). Paluck et al. (2021) conducted a review of diversity training programmes, defined as self-identified diversity training or programmes on related topics such as cultural competence. Six experimental studies were identified and only one study tested the behavioural outcomes of a training programme as it would be implemented in daily life (Chang et al., 2019). Paluck et al. (2021) could not draw broad conclusions on the efficiency of such training. They argue that for evidence-based training to be successful, psychological change as well as behaviour change must be evident.

Based on a systematic search of databases, and consultation with behaviour change experts, Michie et al. (2011) developed a behaviour system, termed the 'COM-B system'. This involves three essential conditions for behaviour change: capability, opportunity, and motivation. Capability is defined as the individuals psychological and physical capacity to engage in the change. Opportunity is defined as factors that lie outside of the individual that make change possible. Here, physical opportunity and social opportunity are distinguished. Motivation is affected by both the capability and opportunity of an individual. This includes reflective processes such as plans and evaluations, and automatic processes such as impulses or emotions. An intervention can change one or more components in the system, and the causal links within the system can enhance or decrease the effect of the intervention on behavioural change (see Figure 1). The system gives equal

importance to each component but allows the identification of which component(s) effect the desired behaviour change.

Figure 1.

The COM-B System, Recreated from Original Model (Michie et al., 2011)



Service context

In response to the NHS action plan, the OXICPTR course used the funding for the commissioning, development and delivery of anti-racism training to all psychologists who were supervising trainee clinical psychologists. This included supervisors from Berkshire NHS Foundation Trust and Oxford Health NHS Foundation Trust. Participants attended a full training day, followed by a reflective session for half a day. In between these sessions, participants were split into smaller groups for mandatory online, peer led reflective sessions. These were to provide a space for reflection on any learning from the training and the application of the learning in practice. OXICPTR hoped that this training would allow for consistency of anti-racist practice amongst the supervisors of trainee clinical psychologists and to outline further interventions that may be needed to improve regional

anti-racist practise. A full outline of the topics covered in the training content can be found in Appendix I.

This service improvement project was guided by the Plan, Do, Study, Act (PDSA) cycle for developing, testing and implementing changes leading to improvement (NHS England, 2021). In the process of developing the training, the equality and diversity (EDI) lead of OXICPT attended a conference with the Group of Trainers in Clinical Psychology, where many courses raised that they did not know where to start with developing anti-racist interventions. The EDI lead described the OXICPT training as an initial step to create a space for clinicians to explore their relationship to anti-racist practice and begin to learn how to effectively address this within their supervisory relationships. The 'plan' stage of the PDSA cycle in this project involved consultation the EDI lead, the lead for supervision training, and the facilitator of the training. To meet the 'do' stage of the PDSA (testing change) it was agreed that it would be useful to identify any changes in anti-racism practise post-training, areas that helped to facilitate change, and any barriers to change. Synthesis of these outlined areas of interest allowed for the 'study' phase of the PDSA, where findings could be used to reflect on the impact of the antiracism training in relation to behaviour change and what was learned from this. Finally, following the 'act' stage of the PDSDA, recommendations were made to inform future anti-racism training run by OXICPT and other courses, dependant on future funding from NHS England. The PDSA cycle could then start again following implementation of recommendations.

Aims/questions

We aimed to evaluate the training systematically by exploring the experiences of the psychologists who had participated in the training. The research aims were to identify:

1. What psychological and behavioural changes (if any) occurred as a result of the anti-racism training.

2. What in the content of the training facilitated and prevented change.
3. What in the context of services facilitated and prevented change.
4. Could specific changes be made to the training to improve behaviour change following the training?

Method

Design

Following similar studies based on the COM-B system (Boyd et al., 2020; Timlin et al., 2021), a qualitative, semi-structured interview design was used to explore the research aims. A qualitative approach was taken to provide a rich understanding of the context that may influence behaviour change in relation to the training (Jando & Dionne, 2024). As the topic of anti-racism is sensitive, the approach also allowed for rapport to be built during the interview process, creating a safe space for the participants to reflect on the questions. Data collection took place between December 2023 and January 2024.

Recruitment and participants

OXICPTR provided a list of attendees to aid with recruitment. There were a total number of 43 attendees and all were sent written information about the study via email (Appendix J). Those who volunteered to take part were contacted to arrange an online interview. There were nine participants in total.

Data collection

Participants completed a brief, online demographic questionnaire pre-interview, which included age, gender, ethnicity and professional status (EG. Consultant psychologist, principal psychologist). A semi-structured interview schedule was designed in collaboration with OXICPTR and a focus group of experts by experience. The focus group consisted of four supervisors of trainee clinical psychologists and two research

supervisors. Three were from an ethnic minority background, and three were White British. The final interview schedule (Appendix K) explored participants experience of the training, any psychological and behavioural changes identified post-training, aspects of the training that facilitated or acted as a barrier for change, and aspects of the wider context (service and/or individual) that facilitated or acted as a barrier for change.

The interviews were conducted approximately three months post-training. All interviews lasted between 30-50 minutes. An information sheet was given, and informed consent was obtained from all participants before conducting the interviews. Participants were given a unique ID code to ensure their data was stored anonymously. Interviews were conducted and recorded via Microsoft Teams video call, on a password-protected NHS Trust device. The transcripts were checked for accuracy then uploaded to an encrypted server before the recordings were deleted.

Data analysis

Demographic characteristics were explored through descriptive statistics. The topic of this project integrates a complex relationship between ethnicity, anti-racism and working as a psychologist in the NHS. The primary and secondary researchers and participants hold values and assumptions within these topics which may have influenced each other during the data collection and data analysis process. Therefore, a reflexive thematic analysis method was chosen as this accounts for researcher subjectivity and reflexivity (Braun & Clarke, 2021). Reflexive, inductive thematic analysis was conducted following the six phases outlined by Braun and Clarke (2006). The first stage involved familiarisation with the data through thoroughly reading interview transcripts and taking initial notes. The second phase involved generating initial codes of the data in which parts of the data were highlighted and labelled in relation to the identified questions of this project. Thirdly, the codes were used to search for and identify themes which determined

meaningful patterns within the data. The fourth stage involved reviewing these themes to ensure that they effectively captured the data within them and that they were distinct from one another. The fifth stage involved naming and providing definitions of the themes to ensure they captured their content effectively. Finally, in the sixth phase, the report was written to present findings with clear examples from the data.

A constructionist approach and critical orientation was taken, as this acknowledges that the individual constructs meaning and knowledge through both subjective and inter-subjective experiences. This approach allowed for acknowledgement that participants experiences may be located in the wider sociocultural context of racism and the NHS. The research questions also focused less on participant experiences, and more on a construction of social reality.

Analysis used a primarily 'bottom up' inductive approach to promote reflexivity, rather than fitting meaning into pre-existing theories or themes. However, a degree of deductive analysis was used to ensure that the open-ended coding created themes that were relevant to the research questions and COM-B system. The flexibility of thematic analysis allowed for both semantic (descriptive) and latent (implicit) meanings to be included in the analysis as appropriate.

The primary researcher transcribed and coded all data. Although not mandatory to reflexive thematic analysis, inter-researcher consistency was ensured by discussing codes and themes with a second researcher. Researcher subjectivity was reflected on and discussed, but not avoided entirely, due to it being a resource for the production of the results (Braun & Clarke, 2021). The primary researcher was from an ethnic minority background and worked as a trainee clinical psychologist for the NHS trust that developed the training. Both factors were considered as having an impact on the interviews and data

analysis of this study. A statement further exploring the researchers positioning can be found in appendix L.

Results

Demographic characteristics of the sample

Nine participants took part. Table 1 displays the demographics of the participants.

Table 1.

Participant Demographics, Total Number (n), Means (M) and Standard Deviations (SD)

Sample Characteristics	**n**	**M**	**SD**
Gender			
Male	2		
Female	7		
Ethnicity			
White British	5		
White Other	1		
Ethnic Minority	2		
Professional Status			
Clinical Psychologist	2		
Principal Psychologist	3		
Highly Specialist Psychologist	4		
Age		40.77	6.49
18-24	0		
25-34	1		
35-44	6		
45-55	1		
55-65	1		

Thematic Analysis

A total of five themes were developed from the coded data, 1) Psychological Change, 2) Relational Change, 3) The System: A Diffusion of Responsibility, 4) But What Now?, and 5.) Self-identity. These corresponded to elements of the COM-B model which are shown in table 2 below. Within the theme of 'relational change' there were two subthemes, 2.1) MDT matters and 2.2) Learning together. Theme descriptions can be found in Table 2.

Table 2.

Thematic Analysis Results from Semi-Structured Interviews

Theme	**COM-B Model Factor(s)**	**Theme Description**	**Subthemes**
Psychological Change	Motivation	This theme describes the psychological changes participants outline following the anti-racism training.	
Relational Change	Opportunity	This theme highlights participants experiences of how other people have affected their own change process following the anti-racism training.	2.1 MDT Matters 2.2 Learning from Others
The System: A Diffusion of Responsibility	Capability and Opportunity	This theme encompasses ideas that reflect the perceived responsibility for change falling within the wider system of the NHS.	
But What Now?	Opportunity and Motivation	This theme collates participants acknowledgement that anti-racism practise is their responsibility, but describes the barriers identified to actioning this.	
Self-Identity	Capability	This theme summarises participants views around the impact of self-identity on psychological and behaviour change.	

Theme 1: Psychological change

Clinicians outlined several psychological changes they experienced following the training. Most of the clinicians said that the training had increased their awareness of issues of racism. Clinicians did describe some pre-existing knowledge of racism and anti-racism but felt that the training brought this more to their immediate attention "I felt like I'd had blinkers relieved, and that hasn't gone away, and I am still seeing things in a different way" (P4).

Many clinicians said that the training had increased their "self-awareness" (P2, P6). Clinicians also spoke about an increase in confidence following the training: "thinking it's actually better to try… than not try" (P7). Clinicians demonstrated frequent self-reflexivity in the context of the training content, speaking to their own ethnic backgrounds, their own feelings about ethnicity and racism, and their previous ignorance or assumptions. One clinician highlighted that the training had "something de-shaming about it, [which] makes it more possible to engage directly with" (P6).

Theme 2: Relational change

Clinicians spoke about the importance of their professional relationships in effecting if and how change had occurred following the anti-racism training.

Subtheme 2.1: MDT matters

All of the clinicians highlighted the importance of support from their teams in the behaviour change process. Clinicians placed value on the support from their multidisciplinary teams (MDTs) to attend the training "supporting people to go on training like this" (P1) and some clinicians encouraged other colleagues to attend the next training date. Clinicians also spoke about the importance of their MDT supporting them to create changes within their teams following the training. "I'm really appreciative that I work in a really supportive team who are really open to this sort of stuff and are quite keen to make

changes" (P8). Many clinicians shared that their MDT were open to facilitating conversations about diversity and anti-racism following the training, which was seen as "useful" (P2).

Alternatively, some clinicians shared that following the training, they had not raised any conversations about anti-racism or their learning with their MDT. Clinicians spoke about a fear of creating conflict or offending others: "I'm not good at rocking the boat… I fear of upsetting people" (P7). Some clinicians shared that speaking about their learning from the training may be seen as directly challenging the way that the MDT currently work. Clinicians also outlined worries about how they would come across as professionals if they raised such issues, describing "anxiety about being potentially being exposed" (P5) or leaving them to "being in a possible vulnerable state" (P4). Participants often expressed the difficulty in balancing behavioural change and preventing conflict "I think it's how we challenge things and maintain relationships" (P3).

Subtheme 2.2: Learning from others

Clinicians portrayed behaviour change as a relational process. Almost all of the clinicians spoke about the importance of the reflective groups that occurred throughout the training process and how this had helped to maintain their learning. Clinicians named it as "helpful" (P4) and "really valuable" (P6). Some clinicians expressed that it felt easier to have these conversations with people outside of their immediate MDTs and said that it helped them to share ideas. Many clinicians highlighted the facilitator of the training as an asset that helped to increase engagement. They were described as "engaging" (P2), "inspiring" (P3) and "refreshing" (P8).

Following the training, clinicians described continuing to learn with others. Some clinicians had joined diversity groups in their service, and many had noted an increase in their conversations about ethnicity and culture in supervision. Some clinicians spoke about

a need for an ongoing group to discuss anti-racism, or a need for joint up working with other services. Both diversity groups and supervision may reflect a contained space for discussion, rather than just raising conversations with the MDT as described in subtheme 2.1.

Theme 3: The System: A diffusion of responsibility.

Clinicians often appeared to remove self-responsibility from behavioural change, and instead placed responsibility in 'the system', which here is used as an overarching term to describe services, local NHS trusts, and the NHS as an organisation more generally.

Most of the clinicians spoke about not having enough time or capacity to implement things they would like to. "Because we're doing it on top of our nine to five, time hasn't been made to think carefully about like 'now I've been on this training, what can I implement?'" (P8). Many also noted a lack of funding as a barrier to implementing change. Clinicians were not always specific to what that funding would facilitate, but one clinician named the need for a funded equality and diversity lead, and another named the need for an anti-racism resource list.

Many clinicians described becoming aware of the whiteness (meaning lack of diversity) of the NHS as a barrier to making changes, suggesting that change on an individual level may not make much difference: "Where I'm still left kind of scratching my head is how to really use this work when working in a context where both my colleagues and my service users are overwhelmingly White-British, so there's a lack of diversity" (P6). The whiteness of psychology colleagues specifically was also raised: "the barriers are systemic ones… which is that we have an under representation of people of colour within psychology" (P9). Some clinicians felt that anti-racism was more of a "tick box" exercise they complete with trainees for the purpose of meeting their competencies for the doctorate

course. Clinicians noted that anti-racism is not often discussed in their daily work, and some suggested it is not a priority in their service “not that my clinical supervisors would be opposed to having those kinds of conversations, but it's not something that we tend to talk about regularly.” (P8).

Some clinicians felt that the training was directed more towards the system, making it difficult to know how to make changes on a smaller, service scale or at an individual level. The training content was described as “organisation-wide kind of approaches, of like the ethos of the trust, and I don't really feel like I have an input into that” (P8). Those clinicians all suggested that a smaller scale, service or individualised approach to the anti-racism training would help to facilitate more change: “maybe having a kind of ‘these are things that you can do’ in a sort of first steps before that are kind of more basic” (P7).

Theme 4: But what now?

Clinicians commonly showed an awareness of self-responsibility in practising anti-racism following the training “recognising that something might not be my fault, but it is my responsibility” (P6). However, despite the psychological motivation shown in theme one, clinicians outlined barriers that prevent self-responsibility from leading to action.

Although many clinicians acknowledged that psychologists hold a position of power in services, they still frequently portrayed that they did not feel able to implement changes in their service. This reflected feelings of powerlessness within anti-racism practise, related to service structure and perceived authority. “What can I implement in my role? Well, I'm not part of management. I'm not part of the trust, you know, board or anything like that. I don't have those sorts of links” (P8). “I'm an 8B clinical psychologist, but I'm still quite aware of working in systems that can be very hierarchical and not feeling I necessarily have the autonomy or the power to be as proactive as I would like to be” (P6).

Feelings of powerlessness were also conveyed as clinicians often spoke about racism as a wider systemic issue: “The UK has been a deeply racist place… and I just want to own and recognise that, and we won't be able to fix that here between us” (P2). Although the training had created motivation, many clinicians highlighted that the training overall was less practical than they had hoped for, and they expressed that that they did not know where to start with making changes. “You know when you do moving and handling training, it's like ‘here’s how to pick up a box safely’ like literally ‘here's how to do it’. With this… It doesn't”. (P5). Clinicians often spoke about “under confidence” (P6). Many clinicians spoke about “the potential for getting it wrong” (P9), which was highlighted as contributing to anti-racist practise feeling “uncomfortable” (P4,9,5&6).

Theme 5: Self-identity

Despite responsibility being placed in the system, clinicians often reflected on their own self-identity as facilitating change or creating barriers to change. Many clinicians shared that their pre-existing values had enabled them to engage in the training and in changes following this. Named values included fairness, justness, legalism, compassion and being non-judgemental.

Clinicians frequently reflected on their ethnicity. This was often in the context of anxiety about how others may perceive them, and how this has prevented them from engaging in any change. White-British clinicians spoke about how their own visible identity as ‘White’ creating feelings of anxiety or awkwardness when trying to engage in anti-racism work, for fear of engaging in “White saviourism” (P6). “With Black people in my team, for example… I still felt very conscious of the trauma that they might have experienced and wanted to be very sensitive about that and not sort of barge in sort of saying, ‘well, I've learned loads more of what you might have experienced, how is it affecting you’” (P4). Both of the clinicians of an ethnic minority described how their

ethnicity had created pre-existing motivation before the training, and they both spoke about anti-racism work they have already engaged in in the past. However, one of these clinicians spoke about not wanting to be "typecast" (P8) as someone of ethnic minority who frequently advocates for change, and described anti-racism work as very "tiring" (P8). Other barriers to change included clinicians' self-perception as being a quiet person, being a perfectionist, and feeling desensitised to issues of racism.

Discussion

Summary of findings

This study used semi-structured interviews to provide a qualitative analysis of barriers and facilitators to behaviour change in the three months following an anti-racism training. The study aimed to look at the training content as well as service context. The themes identified sit within the theoretical COM-B framework of behaviour change. This formed a 'study' stage in the PDSA cycle to reflect on the impact of the anti-racism training on the desired behaviour change outcomes, allowing for learning from outcomes to inform the 'act' stage of the cycle to plan the next change cycle, for service improvement. Below is a summary of the key results, addressing the three research aims, in turn (see aims/questions).

Aim one

Clinicians outlined psychological changes following the anti-racism training, which included an increased awareness of racism and increased self-awareness of their own backgrounds, feelings about racism, ignorance and assumptions. Behavioural changes following the anti-racism training were less prominent in the data. Those identified included some clinicians who had joined diversity groups in their service, and some

clinicians who noted an increase in their conversations about ethnicity and culture with colleagues.

Aim two

The reflective groups within the training were highlighted as helpful spaces to maintain learning between sessions and share ideas with people outside of participants' own MDT. The facilitator of the training was frequently named as making the training engaging. Many clinicians felt that the training was less practical than they would have hoped. Some clinicians felt that the training was aimed more at wider organisational change rather than individual or service level development. The training also highlighted systemic issues such as the whiteness of the NHS and psychology, and the deep-rooted history of racism. Increased awareness of this appeared to be a barrier to change following the training, due to feelings of powerlessness.

Aim three

Services who showed explicit support of anti-racist work was named as a facilitator of change. Other facilitators included teams who were open to conversations about anti-racism, teams who had pre-existing diversity groups, and supervision where clinicians were able to raise conversations about anti-racism. Services without an explicit stance on anti-racism appeared to be a barrier to change. For example, some clinicians felt worried about conflict or offending others in their MDT. Some felt anti-racism wasn't a priority in their service and that conversations about anti-racism were done more with trainees for the competencies of the doctoral course, rather than with other members of their teams. Lack of service funding and lack of time were also named as barriers.

Findings in relation to the literature

The research questions in this project focused on individual clinician's experiences of change. However, it was clear that relational aspects both during the training and

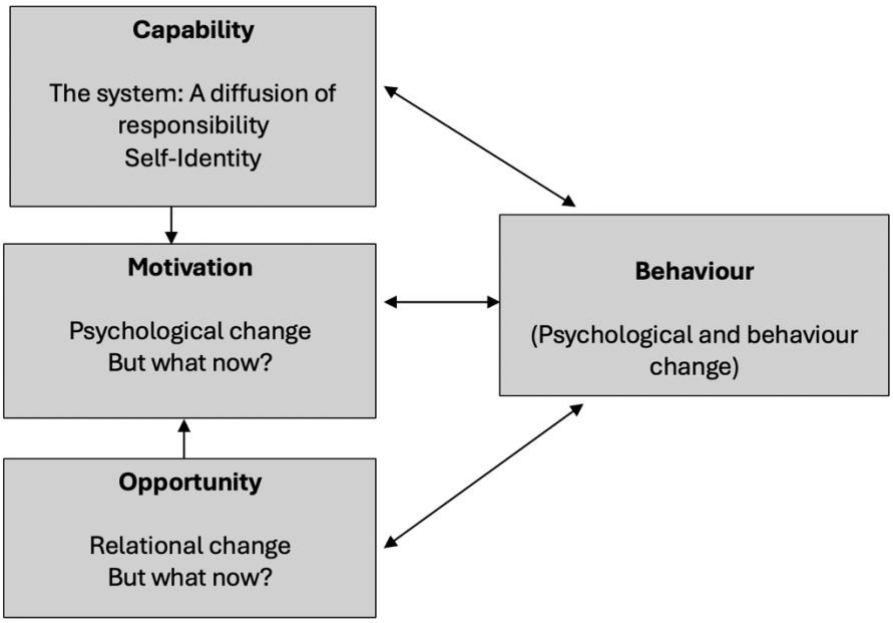
following the training was a key part of behaviour change. Recent research on social-norm interventions argue for the consideration of both individual and social group processes when designing interventions which challenge social norms (Prentice & Paluck, 2020). This is based on social proof theory, which outlines that other people will determine appropriate behaviour by examining the behaviour of others (Cialdini et al., 1999). In organisational change, individuals tend to seek the information about social norms from the bottom of the 'status hierarchy', rather than from the top (Dannals et al., 2020). It is therefore important that implementation of anti-racism training considers not only the individual change, but also group processes that occur both during the training and once the participants return to their services, where they will 'reality test' and process the information (Prentice & Paluck, 2020). Further research on anti-racism training should explore social group processes in more detail, perhaps through thematic analysis.

As shown in Figure 2, the themes identified in the thematic analysis reflected all three components of the COM-B system, with indication of an interactive effect between these components (Michie et al., 2011). Individuals' perceptions of their opportunity, capability and motivation varied, and effected outcomes in behaviour change. 'The system: A diffusion of responsibility' may indicate a perceived reduction in feelings of both psychological and physical capability, which then decreased motivation for behaviour change. 'Self-identity' appeared to both increase and decrease feelings of capability depending on the individual, again having an impact on motivation. Motivation could be seen to be directly increased by 'psychological change'. The 'but what now?' theme suggests both an increase in motivation due to participants recognition of self-responsibility, but also a decrease in motivation due to the feeling of helplessness was outlined. Lastly, 'relational change' appeared to give participants increased social opportunity, whereas the powerlessness in the 'but what now' theme may indicate a

perceived lack of both physical and social opportunity to make changes due to the perceived lack of practical direction from the training. Within 'behaviour', both psychological and behavioural change appeared to be evident following the anti-racism training, which from the perspective of Paluck et al. (2021), argues that the training was successful.

Figure 2.

The COM-B System, Recreated from Original Model (Michie et al., 2011) in relation to themes in the reflective thematic analysis



Recommendations

In accordance with the 'act' stage of the PDSA cycle, recommendations for service improvement were made, outlined in Table 3. Key recommendations include implementing explicit role specific knowledge and behaviour change plans into the training, implementing motivational interviewing techniques into the training, implementing discussions about behaviour changes in teams into the training, developing relationships between services for joint working on anti-racism and sharing the development of the

training and this report more broadly. The findings and recommendations were discussed with the training facilitator and the relevant staff at OXICPT and were received well. These were shared with the course senior leadership team and equality and diversity lead. The training facilitators are in the process of implementing the recommendations for future training sessions, with view to restart the PDSA cycle (NHS England, 2021) through the 'plan' stage to begin to see if these recommendations increase behaviour change as hoped.

Table 3.

Recommendations for Areas of Service Development

Finding	**Recommendation**
Psychologists expressed that the training felt directed to a wider service or trust. They highlighted not knowing how this translates to their work, feelings of powerlessness within their roles, and lack of time or resources to engage in additional work.	1. Within the training, provide explicit, role specific knowledge and behaviour change plans needed to translate the learning into the day-to-day role of a psychologist. Implementation of anti-racism in the 'everyday' tasks of a psychologists should be clear, emphasising that this is not an add on to their '9-5' role.
Psychologists described self-reflective, individual barriers that may hold them back from implementing change, including their ethnicity, personality traits and values.	2. Implement motivational interviewing techniques/exercises. Cover 'why (not) me and why (not) now?' to encourage participants to recognise their positioning and strengths in behaviour change.
Psychologists felt the training was not as practical as they had hoped. There was also a high prevalence of concerns about relational issues that could arise if they were to share knowledge with their team.	3. Implement discussion on how participants can share learning with their teams. This could include practical examples such as sensitive ways to start a conversation, role plays, trouble shooting, and other named examples of desired behaviour change in practise.

Psychologists raised barriers such as not knowing where to start, the need for an EDI lead, the need for resources, and joined up working with other services.	4. Develop relationships between services to allow for joint working. This should include the development of a central resource for anti-racism materials. Materials in this may include 'where to get more support' (E.G. regional EDI workers and contact details). Resources and regional initiatives should be regularly shared across services through this resource.
The EDI lead of OXICPTR shared that Doctorate courses across the country are not sure where to start in developing anti-racism training.	5. Share the development process of the anti-racism training, resources used, and the outcome of this report with other doctorate courses to begin to develop consistency in the training being provided.

Strengths and limitations

The use of experts by experience in the development of this project ensured that the interview questions were focused to the research aims, but not biased by the researchers positioning in the project. Despite a small sample size, the use of semi-structured interviews allowed for rich data, appropriate for the constraints of this project. Participants worked in a wide range of services which allowed for a vast insight into the effects of the training.

Because the primary researcher was working for the trust that commissioned and developed the training, and because of the sensitive nature of the topic, there was the potential for social desirability bias. This may have been reduced if the methodology had allowed for complete anonymity, for example, through an online questionnaire. The sample may also be biased by clinicians who were particularly interested or impacted in the anti-racism training. There were also only two clinicians of an ethnic minority, so the data may not be representative of the overall impact of the training.

Given the methodology of reflexive thematic analysis, the analysis is the researchers interpretation of the data and other findings are possible.

Conclusion

In conclusion, this service improvement project aimed to identify what psychological and behavioural changes occurred as a result of the anti-racism training run by OXIPTR, and what in both the content of the training and the context of services facilitated and prevented change. Through reflective thematic analysis, key themes were identified and discussed in relation to the COM-B system (Mitchie et al. 2011). Although these themes appeared to both facilitate and prevent behaviour change in relation to the COM-B system, both psychological and behaviour change were present following the training, indicative that the training was successful by literature definition (Paluck et al. 2021). Recommendations were given to the service to improve the training based on the themes present, and the service are working to implement these in accordance with the 'act' stage of the PDSA cycle (NHS England, 2021). There is a view to start the planning stage again following this project to see if these recommendations lead to desired outcomes of the service.

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Theoretically Driven Research Project: The Role of Ethnicity and Racial Identity Functioning in Supervision: An Investigation of How Clinical Psychologists Rate Cultural Responsivity in Supervision

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External supervisor**:** Dr Bianca Vekeria

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Proposed Journal: The Clinical Supervisor. This journal is the only international journal dedicated to the art and science of supervision. As this journal is multidisciplinary, findings can be disseminated across other types of clinical supervision. Cultural responsiveness is listed as a key issue of interest.

Disclaimer: Language throughout this paper has been written in accordance to the current UK Government guidance on writing about ethnicity. The term 'ethnicity' is recommended instead of 'race'. The term 'ethnic minority' is used to refer to all ethnic groups except the White British group. Ethnic minorities include White minorities such as Gypsy, Roma and Irish Traveller groups. The author of this paper acknowledges that terms relating to ethnicity are dynamic and complex and although the term 'ethnic minority' is not universally accepted, it is often used in research. This term can be generic and not representative of the unique identities/experiences of people.

Abstract

Aim: The impact of ethnicity and racial identity of the supervisor on cultural responsivity in supervision is poorly understood. The aim of the study was to investigate if the ethnicity of a clinical supervisor affects their ratings of cultural responsivity in supervision. The secondary aim of this study was to understand the role of racial identity functioning as a mediator, which may explain the variability in the primary aim. Method: A repeated measures cross-sectional design was used. 50 clinical psychologists (26 White and 24 ethnic minority) watched two video vignettes of a cross-cultural supervision session and rated the supervisor in the videos on their cultural responsivity using The Multicultural Supervision Inventory (MSI) supervisor form. One video depicted 'low' cultural responsivity and one 'high' cultural responsivity. Racial identity functioning was measured using the ethnic group membership questionnaire (EGMQ). Results: Both White and ethnic minority participants rated the 'high' cultural responsivity vignette as significantly higher than the 'low' cultural responsivity vignette. Ethnicity did not significantly affect ratings of cultural responsivity in either condition. Years of supervision experience and previous anti-racism training also did not affect cultural responsivity ratings. Discussion: Findings in relation to previous research and a model of supervisory relationships were discussed, along with limitations of the present study and areas for further research.

The role of ethnicity and racial identity functioning in supervision: An investigation of how clinical psychologists rate cultural responsivity in supervision

Introduction

The supervisory relationship

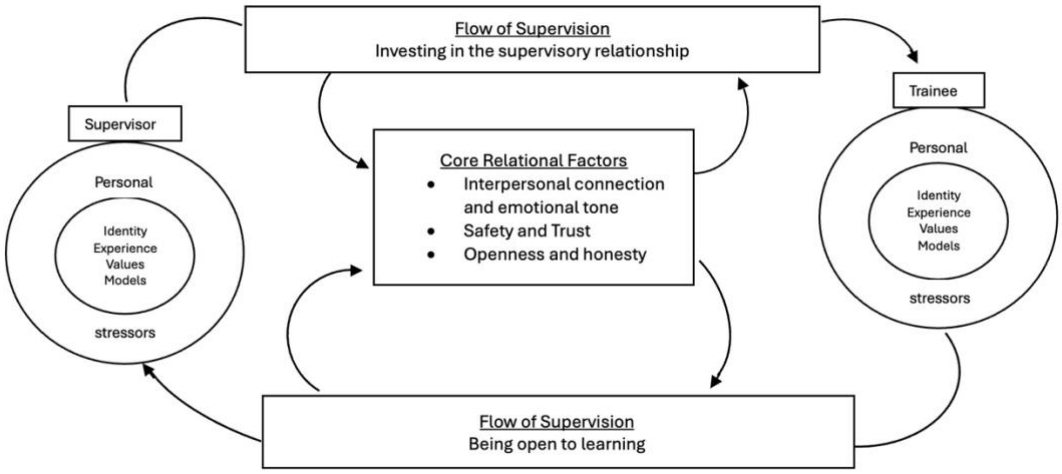
The British Psychological Society (2017) states that clinical supervision is vital in providing good psychological work and that all clinical supervision should provide guidance, support, and encouragement. The existing literature surrounding clinical supervision highlights the quality of the supervisory relationship as a key factor for successful supervision (Jackson et al., 2019).

The Oxford Supervision Research Group developed a model of the supervisory relationship as seen in Figure 1 (Clohessy, 2008). This model incorporates both the perspective of the supervisor and the 'trainee'. It identifies three factors that are important in the quality of the supervisory relationship including contextual influences, the flow of supervision and core relational factors from both parts of the supervisory dyad. Within contextual influences, identity is described as the individual's ethnicity, culture, and gender. Experience includes how much experience they have in their role as a supervisor or supervisee. Values includes their professional values, and therapeutic models outlines their preferred way of working in therapy. Personal stressors include aspects such as poor health and coping with stressful life events. These contextual influences then impact the 'flow of supervision'. This includes how much the supervisor invests in the relationship through responding to the individual needs of the trainee and encouraging learning, and how open the trainee is to learning. The flow of supervision then impacts the core relational factors of the supervisory relationship including interpersonal connection, emotional tone, safety and trust, and openness and honesty. Clohessy (2008) developed this theory based on qualitative interviews from 12 clinical psychologists with experience

of supervising trainees. They acknowledge that the small number of participants prevented further exploration of some potential areas of interest in their study including that of ethnicity and culture within the contextual factor of identity.

Figure 1.

Model of the Supervisory Relationship, Recreated from Clohessy (2008)



Ethnicity and cultural responsivity in supervision

Literature also explores the influence of culture and identity on the supervisory relationship. Cultural responsivity is defined as the recognition and utilisation of the social-cultural views of others which are needed in working with multicultural populations (Giovanangeli & Oguro, 2016). Throughout literature, cultural responsivity encompasses cultural knowledge, cultural sensitivity, cultural empathy, cultural guidance and cultural humility (Hook et al., 2013; Tseng, 2004). It assumes that a clinician's cultural background affects their clinical practise and supervision (Arthur & Collins, 2009). When utilised in supervision, cultural responsivity includes reflective discussion, modelling cultural

competence and facilitating reflective discussions (Ancis & Marshall, 2010; Sue et al., 2022).

Attending to cultural opportunities in supervision can be done by broaching cultural issues. Day-Vines et al. (2007) conceptualised broaching as an ongoing attitude and behaviour typically used in a counselling context to address cultural factors that may impact a client's presentation in therapy. The concept has since been applied to supervision, in raising and responding to cultural context in conversation. Supervisors are encouraged to broach cultural issues to "validate and affirm" the supervisee's "sociocultural and socio-political realities" (Day-Vines et al., 2013, p. 153). Day-Vines et al. (2013) found that psychologists with six to ten years of experience rated themselves as less confident on a broaching subscale compared with those with more than 15 years of experience, suggesting that confidence in broaching may develop over-time.

In the context of Clohessy's (2008) model, cultural responsivity can be viewed as an aspect in the 'flow of supervision' as it involves investment from the supervisor in the supervisory relationship, encompassing both the recognition of socio-cultural views and utilisation of these (Giovanangeli & Oguro, 2016). Research from the 'trainees' perspective of the model is well saturated and supports Clohessy's (2008) contextual influence of 'identity' in relation to ethnicity and its impact on the flow of supervision. Studies show that in ratings of their supervisors cultural competence, students perceive supervisors of an ethnic minority as more multiculturally competent, and more influential in the development of their multicultural competence than White supervisors (Ladany et al., 1997; Pope-Davis, 2003; Wilcox et al., 2022). A qualitative study by Burkard et al. (2006) found that when students perceived their supervisors as more culturally responsive, they reported a more positive relationship with their supervisor and increased satisfaction in supervision. Where supervisors were perceived as less culturally responsive, a weaker

working alliance was reported by the trainee. Specific to psychology, Vekaria (2021) compared supervision between clinical psychologists and trainee clinical psychologists in those of a racial/ethnic minority (REM) and White ethnic group, defined as British, White Irish, and any other White background. REM supervisees in dyads with White supervisors perceived their supervision as less culturally responsive and of a lower quality than White supervisees in dyads with White supervisors and White supervisees with REM supervisors.

Crawford (2020) found through interviews with Black supervisors that their racial identity was saliant in how they navigate supervision. They self-reported a high awareness of their own identity and worked intentionally with supervisees to create meaningful conversations about race in supervision. Research on the supervisor's role in cultural responsivity is less saturated. One study by Hird et al. (2004) found through a survey that White supervisors self-reported less cultural competence than ethnic minority supervisors, although this has not yet been operationalised.

The existing research on cultural competence and responsivity relies on self-report measures, or ratings of another clinician. These both measure perceptions of cultural competence/responsivity, rather than directly observing the behaviour. This is likely due to ethical and practical constraints of observing live behaviour as well as Hawthorne effects and observer bias (Adair, 1984). However, self-reports are subject to social desirability bias and possible overestimation (Moleiro et al., 2011). For example, self-report and observable cultural competence ratings by clients have been shown to differ amongst family therapists (Mayorga, 2008), perhaps due to self-report measures measuring self-efficiency rather than actual abilities (Constantine et al., 2002). Ratings of others, such as trainee's perceptions of their supervisor's cultural responsivity, may reduce self-report bias. However, the existing studies outlined draw from real supervisory relationships, where interpersonal and contextual factors are not considered, making it difficult to isolate

cultural responsivity. To address this, literature in related topics have used video vignettes to measure perceptions, allowing control for extraneous factors and isolate identified factors, however this approach has not yet been applied literature around cultural responsivity in supervision (Arif et al., 2017; Hassan et al., 2024; Saha & Beach, 2020).

Measuring perceptions of cultural responsivity is situated within the 'recognition' and 'knowledge' aspect of the definition of cultural responsivity, allowing for determination of an individual's perception of what is and is not culturally responsive behaviour (Giovanangeli & Oguro, 2016; Hook et al., 2013; Tseng, 2004). Understanding how ethnicity influences these perceptions is an important step in this field, as perceptions may shape the 'utilisation' component within the definition of cultural responsivity, which occurs in live supervision. This follows the assumption that a clinician's cultural background affects their clinical practise and supervision (Arthur & Collins, 2009).

The complexity in identity

Ethnic identity is complex and encompasses more than just ethnicity at birth. Phinney (1993) acknowledged that people from the same ethnic background may share or differ in their cultural background/experiences and therefore their social identity. Luhtanen and Crocker (1992) define a person's identity in a social context as falling into three factors, including private feelings about one's own ethnicity, beliefs about the public regard for one's ethnic group and the importance of ethnicity to one's identity. Vekaria (2021) found that the cultural identity development in supervisees did not significantly differ in those who viewed their supervision as culturally responsive versus those who did not. However, this only looked at orientation towards one's cultural group, rather than private and public regard towards the cultural group. The study acknowledged that although supervisors tend to hold more power in the supervisory relationship, varying identity development may impact cultural responsivity in supervision. In progressive

supervision, supervisors may be further along in their identity development than supervisees (Cook, 1994).

Racial identity functioning (RIF), originally termed by Helms and Cook (1999) is defined as "the developmental process of forming one's attitudes and beliefs about people with whom one shares the same racial designation" (Day-Vines et al., 2022, p. 5). This includes private and public regard, as well as identity centrality (Contrada et al., 2001). In supervision, trainees with lower levels of 'racial identity functioning' (RIF) self-reported endorsing avoidant broaching attitudes and behaviours. Trainees with higher levels of RIF endorse 'infusing broaching attitudes and behaviours', meaning that ethnic/cultural broaching is more integrated into their professional identity (Day-Vines et al., 2022). This has not yet been investigated in supervisors.

The present study

To our knowledge, the ethnicity and the racial identity functioning of the supervisor in relation to how they perceive cultural responsivity in supervision has not yet been investigated. The primary aim of this study is to investigate if the ethnicity of a clinical supervisor affects their ratings of cultural responsivity in supervision. The secondary aim of this study is to understand the role of racial identity functioning as a mediator, which may explain the variability in the primary aim.

Research Questions and Hypotheses

Does the ethnicity of a clinical supervisor affect their ratings of cultural responsivity in supervision?

H1a: In the high cultural responsivity conditions, both the White group and the ethnic minority group will rate the supervision sessions shown in the video vignettes as significantly more culturally responsive than the low responsivity condition.

H1b: In the low cultural responsivity condition, the White group will rate the video vignettes as significantly more culturally responsive than the ethnic minority group.

Does racial identity functioning affect ratings of cultural responsivity in supervision?

H2: Attitudes that supervisors hold towards their own racial identity (racial identity functioning) will mediate the relationship between the ethnicity of the supervisor and their ratings of cultural responsivity, in both low and high cultural responsivity vignettes.

Method

Procedure

Two video vignettes depicting a supervision session were developed before the main study occurred. One video vignette was designed to depict 'high cultural responsivity', and one for 'low cultural responsivity' from the supervisor. Scripts for the video vignettes were written in collaboration with experts by experience which included three trainee clinical psychologists and two qualified psychologists of an ethnic minority. The criteria for 'high' and 'low' cultural responsivity were scripted in accordance to the items in a measure of cultural responsivity, the Multicultural Supervision Inventory (MSI) (Pope-Davis et al., 1999). After scripts were developed, the video vignettes were recorded and closed captions were added to increase accessibility. According to the latest demographics, 88% of psychologists are White (British Psychological Society, 2015), Therefore, power dynamics and cultural norms were controlled for by having a White supervisor and a trainee of an ethnic minority in these videos. The sensitivity of the manipulation between the two videos were tested through a pilot study. This involved 10 trainee clinical psychologists who were recruited through social media. They watched the videos in a counterbalanced order and filled out the MSI after each video. A paired-

samples t-test was conducted to compare scores in the high and low responsivity conditions. Participants reported significantly higher scores in the high responsivity condition (M = 92.50, SD = 16.30) compared to the low responsivity condition (M = 47.60, SD = 16.30), $t(10) = -7.83$, $p < .001$. This indicates an appropriate difference between the two vignettes, supporting their use in the main study.

The recruitment poster for the main study (Appendix M) was advertised on social media platforms (X (formerly known as Twitter), Facebook, LinkedIn and Instagram) by the primary author in July 2024. The poster was given out during two training events run by Oxford Institute of Psychiatry and Psychology for clinical supervisors. Trainees and assistants were also asked to circulate to appropriate supervisors. This poster included a link to the online study where participants could take part online.

The main study used a repeated measure, cross-sectional design. The study was completed by participants following an online link to the Qualtrics platform. Participants were shown the information sheet and asked to provide their consent. They then completed a demographic survey. Participants were shown the first video vignette and were then asked to rate the supervisor in this video using the MSI. Participants were then shown a second video vignette and again asked to rate the supervisor in this video on the MSI questionnaire. Participants were blind to the conditions of the video vignettes, and these were shown in a counterbalanced order. Participants then completed the The Ethnic Group Membership Questionnaire (EGMQ, Contrada et al., 2001). Finally, participants were shown the debrief sheet.

Sample

An a priori power analysis was conducted using the 'G* Power' software to determine the sample size needed to detect the interaction effect predicted in H1a//H1b. (Faul et al. 2007). Using a repeated measure, within-between interaction, with an alpha

level of .05, power 0.8 and effect size (f) of 0.2, the required sample size was 52, meaning 26 in each group. A small to moderate effect size was used in this calculation to allow for a suitable number to be recruited as there were no similar studies to base this on. Inclusion criteria for participants included a qualified psychologist (HCPC registered), capable of supervising a trainee psychologist, trainee CBT therapist or assistant psychologist, 18 years-old and over, able to read and understand English and provide informed consent for the study. Definitions of ethnicity were taken in accordance with the UK government (2024) and allowed individuals to select which ethnicity they identified with - 'White' (excluding white ethnic minorities) or 'ethic minority' including White ethnic minorities (Gypsy, Roma and Irish Traveller groups) Black, Asian, Mixed, or Other ethnic group.

Measures

The Multicultural Supervision Inventory (MSI) supervisor form

(Pope-Davis et al., 1999). The MSI consists of 18-items in parallel supervisor and supervisee forms. Items on the supervisor form are rated on a 7-point Likert scale ranging from one (never) to seven (always). Total scores range from 18-126 with high scores indicating self-report of multicultural responsivity in supervision. Multiple-group analysis has shown limited evidence for factorial invariance across the supervisor and supervisee forms. The supervisor scale shows good reliability (α =.90) and internal consistency reliability (.88) (Ortega-Villalobos, 2007). Convergent validity tests show positive relationships between MSI scores and multicultural counselling competence scores, supervisory working alliance scores, the amount of time and quality of discussions addressing cultural variables in supervision, supervisors' intentionality, direct guidance, perceived importance given to multicultural issues in supervision, and multicultural training and experience (Ortega-Villalobos, 2007). In collaboration with experts by

experience, the phrasing of the questions were changed from rating oneself (EG. 'I') to rating the supervisor in the video vignette (EG. 'the supervisor'). Therefore, this measure operationalised participants ratings of cultural responsivity. A copy of the MSI can be seen in Appendix N.

The Ethnic Group Membership Questionnaire (EGMQ)

(Contrada et al., 2001). This is a 12-item self-report measure of racial identity functioning. Items are rated on a 7-point Likert scale ranging from one (strongly disagree) to seven (strongly agree). This measure consists of three subscales; private feelings, public regard, and identity centrality. A total score is computed as the mean of these three subscales, with a higher score indicating a more positive feeling about being a member of their ethnic group. The questionnaire has been shown to have acceptable to high internal consistency, .65 for White participants, and .91 for non-White participants (Contrada et al., 2001). A copy of the EGMQ can be seen in Appendix O.

Demographic data

A demographic questionnaire was used to collect participants' gender, ethnicity, years of experience facilitating clinical supervision, any prior training in cultural competency in supervision, and the sector that participants work for (IE. the NHS, 3rd sector, privately or a hybrid of these).

Ethical considerations

Ethical approval was given from the Medical Sciences Interdivisional Research Ethics Committee (IDREC). Full ethical approval can be seen in Appendix P. Informed consent was obtained from all participants following the presentation of the information sheet on the study link (Appendix Q). However, some deception was required to reduce priming effects. Participants were told that this study was looking at 'supervision styles and

cultural identity'. They were debriefed on the true purpose of the study immediately after the study had been completed. The full debrief sheet can be seen in Appendix R.

Patient and public involvement (PPI)

This study was developed with a patient and public involvement (PPI) group from psychologists (supervisors) and trainee clinical psychologists from the Thames Valley region. Their involvement included giving feedback on the study method, adapting the measures appropriately for supervisors, and co-development of scripts for the video vignettes.

Data analytic strategy

Data analysis was conducted using IBM SPSS Statistics for Windows, Version 30.0 (IBM Corp, Armonk, NY, USA). Three minor outliers were identified using boxplots, but no extreme outliers were identified (Appendices S and T). Follow up analysis removing the outliers did not change the significance of the results, so the outliers were kept in for the main analysis. Histograms and Q-Plots were used to determine normality of residuals (Appendix U). Visual inspection of these plots showed slight skew, so the Shapiro-Wilk tests were conducted for both conditions. Results showed that residuals were normally distributed in both the high condition, $W = .957$, $p = .066$, and the low condition, $W = .965$, $p = .149$. Therefore, parametric tests were used.

To examine if the ethnicity of a clinical supervisor affects their rating of cultural responsivity in supervision (research question one) a mixed model ANOVA was conducted, with 'ethnicity of the participant' (ethnic minority and White) and the 'video condition' (high cultural responsivity and low cultural responsivity) as the independent variables, and 'ratings of cultural responsivity' as the dependent variable. Exploratory analysis was conducted to determine the effect of 'years of experience'; a correlation was conducted between 'years of experience' and 'ratings of cultural responsivity' and as one

result was significant, a mixed model ANCOVA was conducted to control for 'years of experience' in the relationship between 'ethnicity' and 'cultural responsivity'. Exploratory analysis was also conducted to determine the effect of previous anti-racism training; independent t-tests were conducted between previous anti-racism training (yes, no) and each video condition separately (high/low). As the results of the primary research question were nonsignificant, there was no further mediation analysis necessary to determine the second research question.

Results

Descriptive data

Participants

110 participants followed the Qualtrics link to the online survey, however only 50 participants had complete data and were included in the analysis. 26 (52%) of participants were White, and 24 (48%) of participants were of an ethnic minority. 88% of participants were female, 10% were male and 2% were 'other' gendered. All participants were qualified clinical psychologists. Full participant demographics can be seen in table 1.

Table 1.

Participant Demographics

	Ethnic Minority Group (n=24)	White group (n=26)	Total (n=50)
Gender			
Female	21	23	44
Male	3	2	5
Other	0	1	1
Age Range			
18-24	0	0	0
25-34	8	8	16
35-44	9	14	23
45-54	6	3	9
55-64	1	1	2
65-74	0	0	0
75-84	0	0	0

Previous Anti-Racism Training			
Yes	14	18	32
No	10	8	18
Employment Sector			
NHS Only	8	13	21
Private Only	1	0	1
NHS and Private	9	12	21
Third Sector Only	0	0	0
NHS and Third	2	0	2
Sector			
Private and Third	2	0	2
Sector			
Other	2	1	3

An independent samples t-tests revealed no significant difference between the ethnic minority group (M= 7.71, SD = 6.60) or the white group (M=6.19, SD= 5.84) for years of experience t(48) = -.86, p = .39. No significant difference was seen between groups for age t(48) = -.49, p = .62, gender t(48) = .29, p = .80, previous anti-racism training t(48) = -.79, p = .43 or employment sector t(48) = -1.49, p = .14.

A summary of the measures can be found in Table 2. The MSI showed excellent internal consistency. The EGMQ showed acceptable internal consistency.

Table 2.

Cronbach's alpha (α), Mean (M) and Standard Deviation (SD) for measures used

Measure	**α for total sample**	**α for White group**	**α for ethnic minority group**	**Mean for total sample**	**Standard Deviation for total sample**
The Multicultural Supervision Inventory (MSI) supervisor form					
High Condition	0.95	0.91	0.97	84.50	18.30
Low Condition	0.93	0.93	0.94	43.80	14.80
The ethnic group membership questionnaire (EGMQ)	0.76	0.74	0.83	58.28	9.59

Research Question One - Does the ethnicity of a clinical supervisor affect their rating of cultural responsivity in supervision?

Primary Analysis

To examine whether ethnicity affects the cultural responsivity ratings, a mixed model ANOVA was conducted. In the low responsivity condition, Leven's test was non-significant, $F(1, 58) = 1.29$, $p = .26$, showing that the assumption of homogeneity of variance was met. In the high responsivity condition, Levene's test was significant, $F(1,46) = 5.48$, $p = .02$, showing that the homogeneity of variance assumption was violated. The ANOVA was considered robust enough to proceed with due to the relatively equal group sizes. There was a significant main effect of the vignette conditions $F(1, 47)= 147.60$, $p = <.001$, $\eta^2 = .75$, indicating that all participants rated the high condition as significantly higher than the low condition. The main effect of ethnicity was not significant $F (1, 47) = 0.00$, $p = .99$. The interaction between vignette condition and ethnicity was also not significant $F (1, 47) = .34$, $p= .56$, $\eta^2 = .007$, suggesting that ethnicity did not significantly affect the ratings of cultural responsivity. Means and standard deviations can be seen in Table 3.

Table 3.

Means (M) and Standard Deviations (SD) from ANOVA

Condition	White group M (SD)	Ethnic minority group M (SD)
High Cultural Responsivity	60.12 (9.14)	58.71 (16.1)
Low Cultural Responsivity	29.35 (9.56)	30.75 (11.16)

Exploratory Analysis

To examine if years of experience influenced the results of the ANOVA, a correlation was run between years of experience and the video vignette conditions. In the

low condition, there was a significant positive correlation between years of experience and cultural responsivity ratings r(48) = .31, p = .03. In the high condition, there was no significant correlation between years of experience and cultural responsivity r(48) = -.03, p = .86.

As years of experience was shown to significantly influence the cultural responsivity ratings in the low condition, a mixed model ANCOVA was conducted to understand whether ethnicity had any effect on cultural responsivity ratings when controlling for years of experience. The main effect of the video condition was significant F (1, 47) = 83.70, p = <.001, η^2 = .64. The main effect of ethnicity was not significant F (1, 47) = .03, p = .88, η^2 = .001. The main effect of years of experience was not significant F (1, 47) = 1.62, p = .21, η^2 = .03, indicating that years of experience did not significantly affect participants' cultural responsivity ratings. The interaction effect of ethnicity and vignette condition after controlling for years of experience was also not significant F(1, 47) = .03, p= .88 , η^2 = .004.

To examine if previous anti-racism training influenced the results of the ANOVA, independent samples t-tests were run between previous anti-racism training (yes, no) and the video vignette conditions separately. In the low responsivity condition, homogeneity of variance was assumed based on Levene's test. There was no significant difference between those who'd had previous training (M=30.22, SD=8.80) and those who had not had previous training (M=29.67, SD=12.80), t(48)=.18, p = .86. In the high condition, homogeneity of variance was not assumed based on Levene's test, so results were based on the 'equal variances not assumed' output. There was no significant difference between those who'd had previous training (M=61.81, SD=8.01) and those who had not had previous training (M=55.22, SD=18.20), t(20.76)=1.46, p = .16.

Research Question Two - Does racial identity functioning affect ratings of cultural responsivity in supervision?

The result of the primary analysis was not significant, therefore mediation analysis with racial identity functioning was not explored. However, exploratory analysis was conducted to compare racial identity scores between White and ethnic minority participants. An independent-samples t-test revealed that ethnic minority participants reported significantly higher scores of racial identity functioning (M = 24.72, SD = 3.94) than White participants (M = 22.38, SD = 3.45), $t(48) = -2.24$, $p = 0.03$.

A Pearson correlation coefficient was computed to determine the relationship between racial identity functioning (RIF) and cultural responsivity ratings. There was a weak, negative correlation between the ratings in the high cultural responsivity condition and RIF, but this was non-significant, $r(48) = –.21$, $p = .14$. There was a very weak, negative correlation between the ratings in the low cultural responsivity condition and RIF but this was non-significant, $r(48) = -.11$, $p = .46$.

Discussion

The primary aim of the current study was to investigate if the ethnicity of a supervisor would affect ratings of cultural responsivity in supervision. In support of hypothesis 1a, both White and ethnic minority participants rated the 'high' cultural responsivity vignette as significantly higher than the 'low' cultural responsivity vignette. Contrary to hypothesis 1b, ethnicity did not significantly affect ratings of cultural responsivity in either condition, as indicated by a lack of a significant interaction effect between ethnicity and vignette condition. Exploratory analysis also found that years of supervision experience and previous anti-racism training did not affect cultural responsivity ratings. The secondary aim of the current study was to understand the role of racial identity functioning as a mediator. As the results of the primary question were not

significant, the mediation of racial identity functioning (hypothesis 2) was not explored. Exploratory analysis found that that ethnic minority supervisors have a significantly stronger racial identity functioning than White supervisors. However, there was no significant correlation between racial identity functioning and ratings of cultural responsivity in either condition.

In the current study, ethnicity and its effect on the 'knowledge' and 'recognition' aspect within the definition of cultural responsivity was measured (Constantine et al., 2002; Giovanangeli & Oguro, 2016). Supervisors were able to accurately rate and recognise high versus low levels of cultural responsivity in supervision, regardless of their ethnicity. Research surrounding cultural responsivity in supervision from a supervisor perspective is scarce, making comparisons with previous literature difficult. The results of the present study are inconsistent with one study which found that White supervisors self-report less cultural competence than ethnic minority supervisors (Hird et al., 2004). However, as acknowledged in the literature review, comparison of self-report literature and perceptions of cultural responsivity are difficult, due to self-report measuring self-efficiency rather than actual abilities. The results of the current study are also inconsistent with previous supervisee studies, which suggest that supervisees from an ethnic minority would be better equipped at recognising differences in the quality of cultural responsivity in supervision than White supervisees (Ladany et al., 1997; Pope-Davis, 2003; Vekaria, 2021; Wilcox et al., 2022). In relation to Clohessy's (2008) model, previous supervisee literature suggests that ethnicity as a stand-alone factor affects the flow of supervision (ratings of cultural responsivity), but the present study suggests that neither ethnicity or previous years of experience affect the flow of supervision (ratings of cultural responsivity) from the supervisor perspective.

The current study also found that ethnic minority supervisors have significantly higher racial identity functioning than white supervisors. This is consistent with racial identity theory, which outlines differences in development of racial identity in White individuals versus ethnic minority individuals (Helms, 2003). Trainee research in this area also shows that racial identity development and ethnic identity is stronger in ethnic minority trainees than the White trainees (Borkowska et al., 2023; Moffitt & Rogers, 2022). This has been suggested as a protective mechanism due to racism in society and has been linked to a greater sense of wellbeing amongst those of an ethnic minority (Smith & Silva, 2011; Stets & Fares, 2019). Helms and Cook (1999) found that generally, a higher racial identity status was positively related to higher self-report cultural competence, however the current study found that racial identity functioning and ratings of cultural responsivity were not significantly correlated. These results are consistent with supervisee literature, which found that the cultural identity development in supervisees did not significantly differ in those who viewed their supervision as culturally responsive versus those who did not (Vekaria, 2021). These findings may suggest that racial identity functioning only influences self-perceptions of cultural responsivity, rather than external perceptions or recognition of cultural responsivity, however further research is needed to explore this. The role of racial identity functioning in live supervision has also not yet been explored, where personal values and lived experiences may be expressed more explicitly.

Further research is required to determine if ratings of cultural responsivity are consistent with how culturally responsive supervisors are when providing live supervision, translating the 'knowledge' and 'recognition' aspect of the definition of cultural responsivity to the 'utilisation' aspect, as the link between these two aspects remains unclear (Giovanangeli & Oguro, 2016; Hook et al., 2013; Tseng, 2004) . Further research could also explore other individual factors within Clohessy's (2008) model including

values, models and personal stressors in relation to cultural responsivity ratings. Further research could also determine the effect of potential discrepancies between racial identity functioning in supervisors and supervisee dyads, and subsequent ratings of cultural responsivity. Other dyadic comparisons could also be made in relation to the factors mentioned in Clohessy's (2008) to further explore the discrepancies between supervisee literature and the results of the current study.

Although the present study begins to test factors within cultural responsivity, there were several limitations. Firstly, the study sample size was limited due to recruitment difficulties in the ethnic minority group. The latest demographics indicate that the majority of psychologists are White, which may have contributed to difficulty in recruitment (British Psychological Society, 2015). However, wider issues such as fear of prejudice and racism lead to an under presentation in ethnic minority individuals in research more generally (Farooqi et al., 2022). Farooqi et al. (2022) provide a toolkit for increasing participation in research amongst ethnic minority participants which was followed in this study. The present study focused particularly on the use of experts by experience were used in the development, and engagement with key communities within the field such as groups for ethnic minority clinicians. Future research should consider use of this toolkit. Secondly, participants' ethnicities were not separated further than the two ethnic groups 'White' or 'Ethnic Minority'. Cultural responsivity ratings could differ depending on the cultural background of individuals in the 'White' group. This study could have been strengthened had this group been specific to the 'White British' population instead of including all 'White' ethnicities. Similarly, the 'ethnic minority' group was not separated by ethnicity, so it is not possible to determine if there was over representation of any ethnic minority group. Thirdly, although both measures used in the present study showed acceptable to strong internal consistency, they were selected from a scarce area of research,

so they hold limitations in generalisability and validity more broadly. The MSI supervisor form (Pope-Davis et al., 1999) has been validated for this population but it has not been used widely in research. Similarly, the EGMQ (Contrada et al., 2001) was validated in the United States for a White sample and does not specify if this validation extends to other ethnic groups. Finally, the video vignettes themselves hold limitations to the generalisability of the study results. While video vignettes hold credibility and strengths in research, (Cox et al., 2023) they still do not account for the complexity of an actual supervisory relationship, nor do they allow for complete control in relational factors such as tone and body language in the videos. Additionally, only one dyad example was used in the videos (White supervisor, ethnic minority supervisee), and ratings may have differed had different dyads been used. Additionally, as all supervisors were able to determine 'high' versus 'low' cultural responsivity, more nuanced videos (EG. 'high', 'mid', 'low') may have been useful to determine the effect of more subtle differences between vignettes.

Although previous anti-racism training did not significantly affect cultural responsivity ratings in the present study, there is emerging evidence of improvement of knowledge and awareness of cultural competence in NHS staff, driven by a push in the NHS of anti-racism initiatives (Okeahialam et al., 2025). The present study indicates that psychologists have a baseline knowledge of what constitutes as high and low cultural responsivity in others, regardless of their ethnicity. Most participants in the present study worked for the NHS which suggests potential improvement in culturally responsivity within clinical psychologists more generally. We suggest that supervision training should build upon existing knowledge within supervisors to translate the evident recognition of cultural responsivity in others to active cultural responsivity in live supervision. Video vignettes can be seen as useful training tool to model 'high' cultural responsivity, but also to raise awareness of culturally unresponsive supervision and its impact on supervisees.

In conclusion, this study has found no significant effect of ethnicity on cultural responsivity ratings from a supervisor's perspective. This is inconsistent with previous supervisee literature and suggests that the individual factors of ethnicity and experience within the model of the supervisory relationship (Clohessy, 2008) may not impact the flow of supervision (ratings of cultural responsivity) from the supervisor's perspective. The limitations of this study highlight the complexity of research in this area. Further research should consider other aspects within the model of supervision including racial identity functioning, values, models and personal stressors and translating research in this area to live supervision.

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Executive Summary

Why did we do this study?

Clinical supervision is a key part of being a clinical psychologist. This involves a qualified psychologist/psychological practitioner, trainee or assistant psychologist (supervisee) meeting with a more senior, qualified psychologist (supervisor) regularly to discuss their work with clients and other parts of their role. Research has started to recognise 'cultural responsivity' as an important factor in supervision. This includes having discussions about culture and ethnicity in supervision. This happens because an individual's culture and ethnicity can effect the way that they work.

Research has shown that having more cultural discussions leads supervisees to view their relationship with their supervisor as of a better quality. A recent study shows that supervisees of an ethnic minority rate their supervision as less culturally responsive when being supervised by a White supervisor. It has not yet been investigated if the way that White supervisors and ethnic minority supervisors rate their cultural responsivity is different. Testing this may help us to know more about why supervisees of an ethnic minority are less satisfied in cross cultural supervision, which can bring us closer to making supervision better for all supervisees.

What did we do in this study?

This study was developed with supervisors and supervisees of an ethnic minority. We showed both ethnic minority and White supervisors two videos, one of good culturally responsive supervision 'high cultural responsivity' and one which is not so good 'low cultural responsivity'. They rated both videos on how culturally responsive they thought the supervisor in the video was. They also filled out a questionnaire which determined their feelings about being a member of the ethnic group that they belong to, because

research has previously suggested this may play a part in how culturally responsive they are.

What was the outcome of this study?

50 clinical psychologists (26 White and 24 ethnic minority) took part in this study. Most of the participants were female and worked for the NHS.

Results were different to what we predicted – we found that ethnicity did not affect the supervisors' ratings of cultural responsivity on the videos. We also found that years of experience that the supervisor had did not affect the results, nor did whether they had previous training in anti-racism or not. Because these results were different to what we expected, we did not test if feelings about being a member of the ethnic group they belong to affect the results.

What were the conclusions of this study?

We conclude that ethnicity is not key to how supervisors rate cultural responsivity, and neither is their experience or previous anti-racism training. This is different from past research with supervisees. Further research could look at other factors that might affect ratings of cultural responsivity including supervisors values and their feelings of being a member of the ethnic group they belong to. These could be compared to supervisees, because a difference between these could be why supervisees of an ethnic minority are less satisfied with supervision when working with a White supervisor.

Connecting Reflective Narrative

My papers share a theme of improving psychology for minoritised populations, a topic very close to me. My mum immigrated from Jamaica to England when she was 17, with little education and qualifications. Her dream was to work in the national health service, which she has since achieved, and she now thrives in her career. She has strived to provide my siblings and I with the education I have today to ensure that we have better opportunities. I attended an esteemed primary school as only one of three children of an ethnic minority. My mum supported us to get into a grammar school, a place where I was privileged enough to obtain a fantastic education, whilst at times still queueing for free school meals. The latest statistics show that 88% of psychologists are of a white ethnic background, a demographic that has been maintained since the 1970s. As an aspiring clinical psychologist from a mixed race, working-class background, I was aware of my privilege in my educational background while also remaining aware of the disparities that ethnic minority clinicians face within the field of clinical psychology. I started my clinical psychology journey in the Covid-19 pandemic as a crisis support worker. I saw first-hand the disparities within the health care system for those with an ethnic minority background, both in physical and mental health. I then went on to work as an assistant psychologist with individuals struggling with substance misuse where I found my passion for behaviour change work and supporting individuals who slip through the net of statutory services. Supporting minoritised individuals is an area I am so proud to have contributed to research in and I look forward to continuing to be an advocate for a more inclusive work force as my qualified career begins.

Systematic review of literature

I first encountered the difficulties of substance misuse in the military in my first-year placement at Turning Point in Oxford. I had the opportunity to visit the local barracks

for an outreach day to provide psychoeducation and signposting for substance misuse. The military members were interested in our work and willing to talk about alcohol use, but this was generally brushed under the carpet as part of the military culture and not at all viewed as a concern. This sparked my interest in help seeking for substance misuse in the military.

I had never conducted a systematic review of literature before, but I enjoyed the process of learning as I went. The most difficult part was making the search terms, as there are endless words that could fit into 'engagement' with substance misuse services. The Oxford librarians were particularly helpful to liaise with about this process. The screening process at times felt disheartening, but an important part of this was recognising that currently serving military and veteran literature are not often separated despite being very different populations. Finally, using the CASP quality assessment tools were helpful as later when I was writing my TDRP, I had more knowledge on what qualifies as good quality research.

Service improvement project

The service improvement project was my first project of the doctorate and my favourite project to complete. As described above, anti-racist practise in psychology is a very important topic to me. Connecting my own passion for the topic with current events and theoretical literature was an enjoyable part of this project. It allowed me to combine 'art and science', terms that are often used by the Oxford course to describe clinical psychology. The reflexive nature of the thematic analysis allowed me to tap into my own viewpoints on the topic and how this could affect the research. Recruitment for this study was fairly easy as staff were keen to be involved in anti-racism research. This made the interviews particularly rewarding as I could see first-hand the enthusiasm of staff in considering their behaviour change and revisiting the learning from the anti-racism

training. Working with Andrez Harriot (the facilitator of the training) was a privilege – we had fantastic conversations about anti-racist practise in psychology and it was an inspiration to learn from him.

Theoretically driven research project

This project was the most daunting for me to start, as I came into training with little experience in quantitative research. This topic came about after my first mid placement review, where my cultural competency was being evaluated. My supervisor and I realised that perhaps we had both missed opportunities to discuss culture, however, the responsibility had been framed in the evaluation forms as falling purely on myself as a trainee. Through developing the project, I found that this is mirrored in the literature, which is vastly surrounding trainee perspectives of culturally responsive supervision.

Choosing an appropriate theoretical model and valid measures were challenging due to the lack of research around supervisors cultural responsivity. This issue holds complexity which make it difficult to fit into a model and test neatly within research. Additionally, recruitment for ethnic minority participants was very challenging which in itself speaks volumes about the lack of diversity within clinical psychology. My supervisor, Ciorsdan, provided unwavering passion and support for this project and encouraged me to remain resilient to find my way through this tricky field of research. The project has developed my awareness of culturally responsive supervision from a supervisor perspective, which will be pertinent to my practise as a qualified psychologist.

Further research

I hope to disseminate the findings of my doctoral research through publications and conferences. As a qualified psychologist, I hope to continue research to improve equality within the field of psychology for both staff and clients. I wish to continue research in the areas of my doctoral research, and I hope that this would support further improvement in

supervision for ethnic minority trainees and further develop anti-racism training within the NHS. The ongoing demands of clinical work bring barriers to continuing research however, I endeavour to work for services that see value in this as part of the role of a clinical psychologist.

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Finally, to my mum. You are my biggest inspiration. I wouldn't be where I am without your endless support and patience. Thank you for all the hours you spent teaching yourself so that you could teach me, from times tables on the swings to non-verbal reasoning. Thank you for encouraging me to peruse my dreams, for always listening and for providing me with guidance and love – this is for you.

Appendices

Appendix A

Search Terms for Systematic Review of Literature

“military” OR “armed forces” OR “navy” OR “marines” OR “army” OR “air force” OR “soldier” OR “soldiers”
AND
“substance-related disorders” OR “alcohol-related disorders” OR “amphetamine-related disorders’ OR “cocaine-related disorders” OR “marihuana abuse” “heroin dependence” OR “opium dependence” OR “narcotic-related disorders” OR misuse” OR “substance abuse” OR “substance misuse” OR “substance use” OR “alcohol” OR “illicit drug*” OR “illegal drug*” OR “drug misuse” OR “drug abuse” OR “drug use” OR “addiction*” OR “alcohol abuse” OR “alcohol use disorder*” OR “addict*”
AND
“treatment” OR “psychotherapy” OR “psychoanalytic therapy” OR “psychotherapeutic processes” OR “socioenvironmental therapy” OR “intervention” OR “help-seeking” OR “help seeking behaviour” OR “program*” OR “programme*” OR “therapy” OR “seek* help” OR “seek*” OR “treatment seek*”
AND
“characteristic*” OR “predictive” OR “predictor*” or “moderate*” OR “moderator*”

Appendix B

SRL: CASP Checklist – Cross Sectional Study

Section A: Are the results valid?	
1. Did the study address a clearly focused issue?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: A question can be 'focused' in terms of • the population studied • the risk factors studied • is it clear whether the study tried to detect a beneficial or harmful effect • the outcomes considered	
2. Did the authors use an appropriate method to answer their question?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • Is a descriptive/cross-sectional study an appropriate way of answering the question • did it address the study question	
3. Were the subjects recruited in an acceptable way?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: We are looking for selection bias which might compromise the generalisability of the findings: • Was the sample representative of a defined population • Was everybody included who should have been included	
4. Were the measures accurately measured to reduce bias?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: Look for measurement or classification bias: • did they use subjective or objective measurements • do the measurements truly reflect what you want them to (have they been validated)	

5. Were the data collected in a way that addressed the research issue?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • if the setting for data collection was justified • if it is clear how data were collected (e.g., interview, questionnaire, chart review) • if the researcher has justified the methods chosen • if the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted?)	
6. Did the study have enough participants to minimise the play of chance?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • if the result is precise enough to make a decision • if there is a power calculation. This will estimate how many subjects are needed to produce a reliable estimate of the measure(s) of interest.	
7. How are the results presented and what is the main result?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • if, for example, the results are presented as a proportion of people experiencing an outcome, such as risks, or as a measurement, such as mean or median differences, or as survival curves and hazards • how large this size of result is and how meaningful it is • how you would sum up the bottom-line result of the trial in one sentence	
8. Was the data analysis sufficiently rigorous?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • if there is an in-depth description of the analysis process • if sufficient data are presented to support the findings	
9. Is there a clear statement of findings?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • if the findings are explicit	

• if there is adequate discussion of the evidence both for and against the researchers' arguments • if the researchers have discussed the credibility of their findings • if the findings are discussed in relation to the original research questions	
10. Can the results be applied to the local population?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • the subjects covered in the study could be sufficiently different from your population to cause concern. • your local setting is likely to differ much from that of the study	
11. How valuable is the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • one descriptive/cross-sectional study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making • if the researcher discusses the contribution the study makes to existing knowledge (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature?) • if the researchers have discussed whether or how the findings can be transferred to other populations	

APPRAISAL SUMMARY: List key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.		
Positive/Methodologically sound	**Negative/Relatively poor methodology**	**Unknowns**

Appendix C

SRL: CASP Checklist – Qualitative Study

Section A Are the results valid?	
12. Was there a clear statement of the aims of the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • what was the goal of the research? • why was it thought important? • its relevance	
13. Is a qualitative methodology appropriate?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the right methodology for addressing the research goal?	
14. Was the research design appropriate to address the aims of the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)	
15. Was the recruitment strategy appropriate to the aims of the research?	☐ Yes ☐ No ☐ Can't Tell

CONSIDER: • If the researcher has explained how the participants were selected • If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study • If there are any discussions around recruitment (e.g. why some people chose not to take part)	
16. Was the data collected in a way that addressed the research issue?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • If the setting for the data collection was justified • If it is clear how data were collected (e.g. focus group, semi-structured interview etc.) • If the researcher has justified the methods chosen • If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide) • If methods were modified during the study. If so, has the researcher explained how and why • If the form of data is clear (e.g. tape recordings, video material, notes etc.) • If the researcher has discussed saturation of data	
17. Has the relationship between researcher and participants been adequately considered?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location • How the researcher responded to events during the study and whether they considered the implications of any changes in the research design	
Section B: What are the results?	
18. Have ethical issues been taken into consideration?	☐ Yes ☐ No ☐ Can't Tell

CONSIDER: • If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained • If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study) • If approval has been sought from the ethics committee	
19. Was the data analysis sufficiently rigorous?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • If there is an in-depth description of the analysis process • If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data • Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process • If sufficient data are presented to support the findings • To what extent contradictory data are taken into account • Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation	
20. Is there a clear statement of findings?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • If the findings are explicit • If there is adequate discussion of the evidence both for and against the researcher's arguments • If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst) • If the findings are discussed in relation to the original research question	
Section C: Will the results help locally?	
21. How valuable is the research?	☐Yes ☐ No ☐ Can't Tell

CONSIDER:
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

APPRAISAL SUMMARY: List key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.

Positive/Methodologically sound	**Negative/Relatively poor methodology**	**Unknowns**

Appendix D

SRL: CASP Checklist – Cohort Study

Section A: Are the results valid?	
22. Did the study address a clearly focused issue?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: A question can be 'focused' in terms of • the population studied • the risk factors studied • is it clear whether the study tried to detect a beneficial or harmful effect • the outcomes considered	
23. Was the cohort recruited in an acceptable way?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • Look for selection bias which might compromise the generalisability of the findings: • was the cohort representative of a defined population • was there something special about the cohort • was everybody included who should have been	
24. Was the exposure accurately measured to minimise bias?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: Look for measurement or classification bias: • did they use subjective or objective measurements • do the measurements truly reflect what you want them to (have they been validated) • were all the subjects classified into exposure groups using the same procedure	
25. Was the outcome accurately measured to minimise bias?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: Look for measurement or classification bias: • did they use subjective or objective measurements • do the measurements truly reflect what you want them to (have they been validated) • has a reliable system been established for detecting all the cases (for measuring disease occurrence) • were the measurement methods similar in the different groups	

• were the subjects and/or the outcome assessor blinded to exposure (does this matter)	
26. (a) Have the authors identified all important confounding factors?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • list the ones you think might be important, and ones the author missed	
b) Have they taken account of the confounding factors in the design and/or analysis?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • look for restriction in design, and techniques e.g. modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors	
27. a) Was the follow up of subjects complete enough?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • the persons that are lost to follow-up may have different outcomes than those available for assessment • in an open or dynamic cohort, was there anything special about the outcome of the people leaving, or the exposure of the people entering the cohort	
b) Was the follow up of subjects long enough?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • the good or bad effects should have had long enough to reveal themselves	
Section B: What are the results?	
28. What are the results of this study?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • what are the bottom line results • have they reported the rate or the proportion between the exposed/unexposed, the ratio/rate difference • how strong is the association between exposure and outcome (RR) • what is the absolute risk reduction (ARR)	

29. How precise are the results?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • look for the range of the confidence intervals, if given	
30. Do you believe the results?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • big effect is hard to ignore • can it be due to bias, chance or confounding • are the design and methods of this study sufficiently flawed to make the results unreliable • Bradford Hills criteria (e.g. time sequence, dose-response gradient, biological plausibility, consistency)	
Section C: Will the results help locally?	
31. Can the results be applied to the local population?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • Is a cohort study the appropriate method to answer this question • If the subjects covered in this study could be sufficiently different from your population to cause concern • If your local setting is likely to differ much from that of the study • If you can quantify the local benefits and harms	
32. Do the results of this study fit with other available evidence?	☐Yes ☐ No ☐ Can't Tell
33. What are the implications of this study for practice?	☐Yes ☐ No ☐ Can't Tell
CONSIDER: • one observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making • for certain questions, observational studies provide the only evidence • recommendations from observational studies are always stronger when supported by other evidence	

APPRAISAL SUMMARY: List key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.		
Positive/Methodologically sound	**Negative/Relatively poor methodology**	**Unknowns**

Appendix E

SRL: Additional Study Information: Demographics and Measures

Citation	Gender	Ethnicity	Alcohol measure used	Substance misuse treatment measure used
Clinton-Sherrod et al. (2011)	90.1% male 9.9% female	65.6% white 18.2% black 11.3% Hispanic 4.9% Other	• Two items taken from the Two-item Conjoint Screen for Alcohol (TICS; Brown, Leonard, Saunders, & Papasouliotis, 2001). • Three-item Consumption subscale taken from the Alcohol Use Disorders Identification Test (AUDIT-C; Saunders, Babor, de la Fuente, & Grant, 1993).	• Army's Drug Administration and Management Information System (DAMIS) data provided information on whether each soldier was screened for and enrolled in substance abuse treatment.
Gibbs & Rae Olmsted (2011)	Not reported	Not reported	Qualitative data	Qualitative data
Gray (2021)	Male: 94.8% Female: 5.2%	White/non-Hispanic: 54.8 % Hispanic: 11.8% Black, non-Hispanic: 16.2% Asian or Pacific Islander: 14.7% American Indian or Alaska Native: 2% Other: 0.6%	• Primary and secondary ICD-9CM diagnoses established in the HEDIS specification	We used the NCQA-certified initiation and engagement in SUD treat ment measures as specified within the HEDIS performance measurement set (NCQA, 2012).
Griffith (2017)	Not reported	Not reported	Three idiosyncratic survey items similar in content Disorders Identification Test (AUDIT; Babor et al. 2001).	Idiosyncratic: list of services for which they sought help including alcohol/drug use.

Holt (2017)	Male 59% Female 41%	Non-Hispanic White: 41.4% Hispanic/Latino: 29.9% Black or African American: 13.8% Asisan or Asian American: 6.9% American Indian/Alaska Native: 2.3% Other: 3.4% Missing: 2.3%	Qualitative	Qualitative
Hurt (2015)	Totals not reported as demographics, only within data.	Totals not reported as demographics, only within data.	AUDIT-C (World Health Organisation, 1992).	The Defence Medical Surveillance System (DMSS) administrative records for all medical encounters of military service members who are hospitalized or receive ambulatory care at military treatment facilities or through civilian purchased care.
Rae Olmsted (2011)	90.2% male 9.8% female	White non-Hispanic: 67.6% African American non-Hispanic: 13.4% Hispanic: 14.3% Other non-Hispanic: 4.7%	2 survey items – idiosyncratic.	2 survey items – idiosyncratic.
Reed et al. (2019)	73.3% male 26.7% female	White: 54.4% Hispanic/Latino: 18.6%	AUDIT (Babor et al., 2001).	Idiosyncratic readiness to change measure.

		African American: 18.4% Other: 8.7%		
Taillieu et al. (2020)	Totals not reported as demographics only within data	Not reported	• Those who met WHO-CIDI criteria for alcohol abuse or alcohol dependence (World Health Organization's version of the Composite International Diagnostic Interview (WHO-CIDI) based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria)	2 idiosyncratic survey questions
Wooten et al. (2013)	90.4% Male 9.6% Female	Male: 61.5% white, 15.8% black, 17.1% Asian, 5.6% other. Female: 39.2% white, 35.7% black, 16.6% Asian, 8.6% other.	• Agency for Healthcare Research and Quality Clinical Classification codes for alcohol abuse, substance abuse, personal history of alcohol abuse or substance abuse codes, • Additional ICD-9-CM codes for acute drug abuse, acute alcohol disease, chronic alcohol disease, opioid dependence, and sedative, hypnotic, and anxiolytic dependence. • Major diagnostic code (MDC) of 20 (alcohol/other drug use or alcohol/drug induced mental disorders).	• Major diagnostic code (MDC) of 20 (alcohol/other drug use or alcohol/drug induced mental disorders) captures detoxification and non-rehabilitation procedures as well as rehabilitation and therapeutic counselling. • Number of outpatient SUT ambulatory encounters among those who had at least one such encounter, defined by encounters assigned MDC 20. • Dependent variable was any SUT utilization measured as one or more inpatient (IP) admissions

			or outpatient (OP) encounters assigned a major diagnostic code (MDC) of 20 (alcohol/other drug use or alcohol/drug induced mental disorders).

NB: ICD-9 = International Classification of Disease, ninth revision, ICD-9-CM=International Classification of Diseases, Ninth Revision, Clinical Modification, AUDIT=Alcohol Use Disorders Identification Test, AUDIT-C = Alcohol Use Disorders Identification Test for Consumption, WHO-CIDI = World Health Organization's version of the Composite International Diagnostic Interview, MDC= Major diagnostic code, SUT= Substance misuse treatment.

Appendix F

SRL: Quality Assessment for Cross Sectional Studies

	Clinton-Sherrod et al. (2011)	Griffith (2017)	Hurt (2015)	Rae Olmsted et al. (2011)	Reed et al. (2019)	Taillieu et al. (2020)	Wooten et al. (2013)
1) Did the study address a clearly focused issue?	1	1	1	1	1	1	1
2) Did the authors use an appropriate method to answer their question?	1	1	1	1	1	1	1
3) Were the subjects recruited in an acceptable way?	1	0.5	0.5	0.5	1	0.5	0.5
4) Were the measures accurately measured to reduce bias?	1	0.5	0.5	0.5	0.5	0.5	1
5) Were the data collected in a way that addressed the research issue?	1	0.5	1	1	0.5	0.5	1
6) Did the study have enough participants to minimise	0.5	0.5	0.5	0.5	0.5	0.5	0.5

	the play of chance?							
7)	How are the results presented and what is the main result?	1	1	1	1	1	1	1
8)	Was the data analysis sufficientl y rigorous?	1	1	1	1	1	1	1
9)	Is there a clear statement of findings?	1	0.5	1	1	1	1	1
10)	Can the results be applied to the local population ?	1	1	0.5	0	1	1	1
11)	How valuable is the research?	0.5	0.5	0.5	0.5	0.5	0.5	0.5

NB: 1 = Yes, 0.5= Can’t Tell, 0= No.

Appendix G

SRL: Quality Assessment for Cohort Study

	Gray et al. (2021)
1) Did the study address a clearly focused issue?	1
2) Was the cohort recruited in an acceptable way?	0.5
3) Was the exposure accurately measured to minimise bias?	0.5
4) Was the outcome accurately measured to minimise bias?	1
5) (a) Have the authors identified all important confounding factors?	1
6 a) Was the follow up of subjects complete enough?	1
b.) Can the results be applied to the local population?	0.5
7.) Do the results of this study fit with other available evidence?	1
8.) What are the implications of this study for practice?	0.5

NB: 1 = Yes, 0.5= Can't Tell, 0= No.

Appendix H

SRL: Quality Assessment for Qualitative Studies

	Gibbs & Rae Olmsted (2011).	Holt et al. (2017).
1) Was there a clear statement of the aims of the research?	0.5	1
2) Is a qualitative methodology appropriate?	1	1
3) Was the research design appropriate to address the aims of the research?	1	0.5
4) Was the recruitment strategy appropriate to the aims of the research?	1	0.5
5) Was the data collected in a way that addressed the research issue?	1	0.5
6)		
7) Has the relationship between researcher and participants been adequately considered?	0	0
8) Have ethical issues been taken into consideration?	0.5	0.5
9) Was the data analysis sufficiently rigorous?	0.5	0.5
10) Is there a clear statement of findings?	1	1
11) How valuable is the research?	0.5	0.5

NB: 1 = Yes, 0.5= Can't Tell, 0= No.

Appendix I

SIP: Topics Covered in the Anti-Racism Training

Day 1

- Exploring disproportionality across systems and the impact upon minoritised communities.
- Exploring intergenerational experiences of minoritised communities within the UK.
- Exploring Allyship.
- Exploring the adultification of minoritised children.
- Exploring the transmission of intergenerational trauma.
- Mobilising privilege for good.
- Exploring how the experiences of minoritised patients and colleagues are understood within organisations.

Reflective Spaces (lead within the organisation)

Day 2 (group reflection)

- Creating antiracist and zero-tolerance statements within organisations.
- Personal and professional experiences following the previous full day of training.
- Exploring Power, role, authority, and the task within the Anti-racist organisation.
- Mobilising personal autonomy to support system change.
- Changing systems

Appendix J

SIP: Recruitment Email

Dear___

Thank you for attending the anti-racism training held by XXX on behalf of Oxford Institute of Clinical Psychology Training and Research.

I am now looking to evaluate this training as a service improvement project. I would like to invite you to participate in a 1-1 interview with myself to provide your feedback on this training.

This will be via Microsoft Teams and take between 30-60 minutes. All feedback will be anonymised before being summarised for the trust through a thematic analysis.

Please see the link below to express your interest in participating. Once interest is expressed, I will send a separate link to confirm your availability.

Link

We hope that this project will shape future training and allow for the continued development of anti-racism interventions within NHS services. If you have any further questions, please contact me via email.

Best wishes,

Zara Fenlon

Trainee Clinical Psychologist

zara.fenlon@worc.ox.ac.uk

Appendix K

SIP: Final Interview Schedule

Prompts used only where needed EG. If question is answered too briefly or not understood.

Preface statement: "With these questions I'd like to encourage you to reflect on how the training has or has not impacted on you in a professional setting."

1. How did you feel when you received the email inviting you to the anti-racism training?

2. Can you tell me how you found the training?

   If needed – prompts: can you tell me a little bit more about that (if meets part of COM-B system or research questions)?

3. What did you take from the training if anything?

   Prompt: Anything you've learnt or that stands out from the training.

4. Has any of your learning from the training been put into place in your professional life?

   Prompt: What influence has the training had on the way that you work? EG. Supervision, Clinical work.

5. Did anything within the training content help you to do this?

6. (If suitable based on Q.5 Answer) In terms of your own professional self, what helped you to implement your learning into your professional work?

Prompts: For example, your personality.

7. In terms of your own professional self, what hindered you from implementing your learning into your professional work?

Prompts: For example, your aspects of yourself/personality.

8. What opportunities were there within your service to implement some of your learning into your professional work?

Prompts: For example, supervision opportunities, space, funding or time to implement anti-racism practise, peer support.

9. What were the obstacles that you identified within your service to implementing some of your learning into your professional work?

Prompts: For example, physical barriers like supervision opportunities, time.

10. What else might your service be able to do to support you in implementing your learning into your professional work?

11. Is there anything the training content could add that may have helped you to implement your learning into your professional work?

Appendix L

SIP: Researcher Positioning

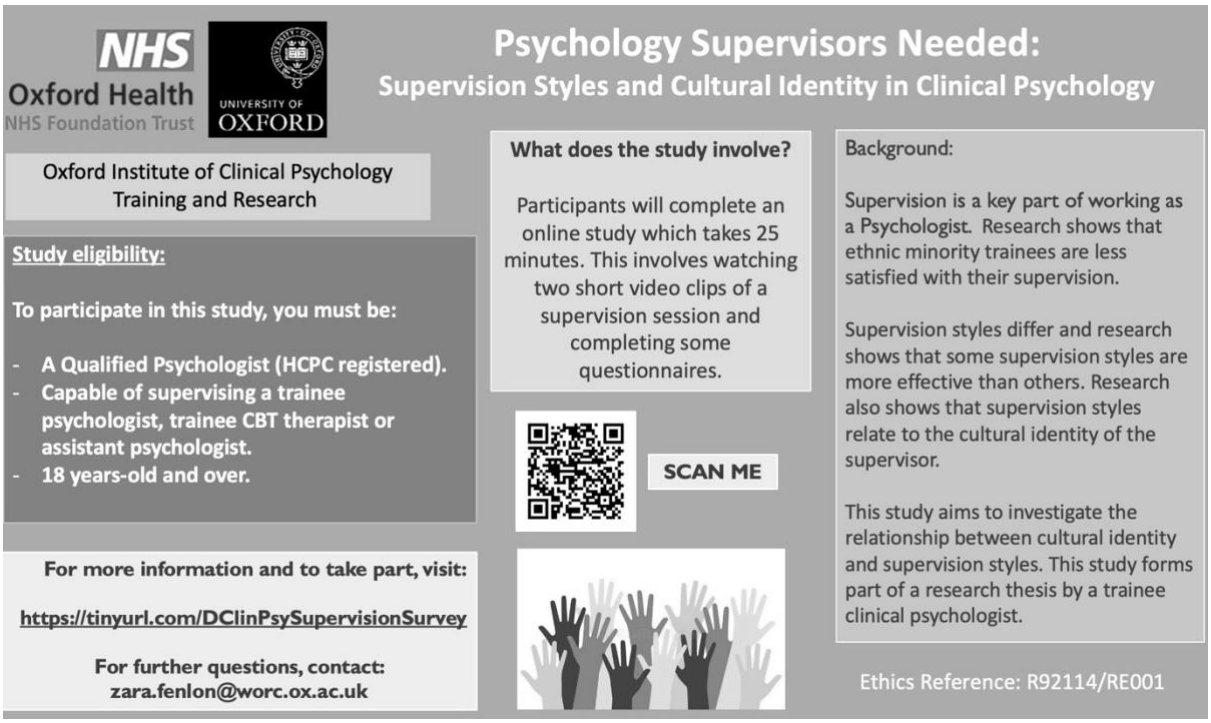
When considering the outcomes of this reflexive thematic analysis, it is important to consider the researchers background and positioning. The primary researcher conducted all of the semi-structured interviews, analysis, and write-up of this project. They are a female of a mixed white-Asian ethnicity.

As someone from an ethnic minority background, anti-racism was an important topic to the researcher. Their mixed heritage meant that they are sometimes viewed as a white clinician, and sometimes as a clinician of an ethnic minority background, depending on the context. Their experience of a mixed ethnic professional in psychology helped them to develop and deliver the research questions in a sensitive way for both white and ethnically diverse clinicians. However, it is important to consider that this visible characteristic may have influenced how participants of the interviews responded, and how able they felt to feedback in an entirely transparent way. This may have differed depending on participants own ethnicity.

The primary researcher was also a trainee clinical psychologist working for the NHS Trust that delivered the anti-racism training. This may have led to social desirability in the answers that the participants gave. The primary researcher used a reflexive journal and supervision whilst conducting this project. This helped to highlight bias throughout the project and reduce the impact of this on the results.

Appendix M

TDRP: Recruitment Poster



Appendix N

TDRP: The Multicultural Supervision Inventory-B (Ortega-Villalobos, 2011)

Multicultural Supervision Inventory-B

In this inventory the terms "culture/cultural" refer to race, ethnicity, gender, class, religion, sexual orientation, and physical disability. In completing this inventory consider that the process of developing multicultural competencies is an ongoing endeavor; therefore, it is understood that most practicing supervisors may have areas of limited experience.

Instructions: Read the following questions regarding your current or most recent multicultural supervision experience. Please consider the interactions with only one supervisee when answering each question (if you had more than one supervisee, select one). Because the term "culture" has been defined broadly, when answering questions about cultural matters please consider only those dimensions that were meaningful.

Please use the following rating scale:

1= Never 2= Rarely 3= Ocassionally 4= Sometimes 5= Often 6= Very Often 7= Always

		Never			Sometimes			Always
1.	I demonstrated that I respected my supervisee's cultural beliefs and practices.	1	2	3	4	5	6	7
4.	I encouraged my supervisee to think about cultural issues when working with clients.	1	2	3	4	5	6	7
12.	I helped my supervisee think of how their cultural identity is relevant to their identity as a counselor.	1	2	3	4	5	6	7
14.	I helped my supervisee understand how cultural communication styles might affect their interactions with his/her clients.	1	2	3	4	5	6	7
17.	I am knowledgeable about groups who are different from me culturally.	1	2	3	4	5	6	7
21.	I helped my supervisee identify other opportunities for multicultural counseling experience.	1	2	3	4	5	6	7
13.	I interacted with my supervisee in ways that did not stereotype him/her.	1	2	3	4	5	6	7
26.	I informed my supervisee about resources he/she can use to learn more about cultural issues in counseling.	1	2	3	4	5	6	7

1= Never 2= Rarely 3= Ocassionally 4= Sometimes 5= Often 6= Very Often 7=Always

		Never			Sometimes			Always
28.	I am aware of how cultural issues may have influenced our supervisory relationship.	1	2	3	4	5	6	7
29.	My supervisee felt comfortable talking to me about differing opinions due to cultural matters.	1	2	3	4	5	6	7
33.	I helped my supervisee understand how the major theoretical orientations in psychology have value related assumptions relevant to multicultural counseling.	1	2	3	4	5	6	7
34.	I understood how cultural communication styles might affect the interactions between my supervisee and myself.	1	2	3	4	5	6	7
39.	I fostered a collaborative working relationship with my supervisee.	1	2	3	4	5	6	7
35.	I was aware of certain cultural beliefs and norms that are (were) important to my supervisee.	1	2	3	4	5	6	7
38.	I encouraged my supervisee to express his/her opinions and concerns about client conceptualization freely	1	2	3	4	5	6	7
NEW.	In evaluating my supervisee's counseling skills, I took into account their performance in multicultural situations.	1	2	3	4	5	6	7
40.	I valued learning from my supervisee and our supervisory relationship.	1	2	3	4	5	6	7

Adaptation examples:

1. "The supervisor in the video respected the supervisees cultural beliefs and practises".
28. "The supervisor in the video is aware of how cultural issues may influence the supervisory relationship"

Appendix O

TDRP: The Ethnic Group Membership Questionnaire (EGMQ): Contrada et al. (2001)

We are all members of different (various) social groups or social categories. Some of such social groups or categories pertain to *gender, race, religion, nationality, ethnicity,* and *socioeconomic class.* We would like you to consider your membership in your ETHNIC GROUP and respond to the following statements on the basis of how you feel about your ETHNIC GROUP and your membership in it. There are no right or wrong answers to any of these statements; we are interested in your honest reactions and opinions. Please read each statement carefully, and respond by using the following scale:

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Disagree Somewhat	Neutral	Agree Somewhat	Agree	Strongly Agree

1. ___ I often regret that I belong to the ethnic group that I do.
2. ___ Overall, my ethnic group is viewed positively by others.
3. ___ Overall, my ethnic group has very little to do with how I feel about myself.
4. ___ Most people consider my ethnic group to be more effective than other ethnic groups.
5. ___ The ethnic group that I belong to is an important reflection of who I am.
6. ___ Overall, I often feel that being a member of my ethnic group is not beneficial.
7. ___ In general, others respect my ethnic group.
8. ___ The ethnic group that I belong to is unimportant to my sense of what kind of person I am.
9. ___ I feel good about my ethnic group.
10. ___ In general, others think that my ethnic group is unworthy.
11. ___ In general, belonging to my ethnic group is an important part of my self-image.
12. ___ In general, I'm glad to be a member of my ethnic group.

Appendix P

TDRP: Full Ethical Approval

MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE
Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB
Tel: +44(0)1865 616575
ethics@medsci.ox.ac.uk

CONFIDENTIAL

Dr Ciorsdan Anderson & Zara Fenlon
Oxford Institute of Clinical Psychology Training & Research
Isis Education Centre
Warneford Hospital
Oxford

23 April 2024

Dear Dr Anderson and Zara,

Research Ethics Approval - CUREC 1

Ethics Approval Reference: R92114/RE001

Study title: The role of ethnicity and racial identity in supervision: An investigation of the cultural responsivity of clinical psychologist supervisors

Short title: Supervision Styles and Cultural Identity in Clinical Psychology

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted from **23rd April 2024** until **22nd October 2025.**

Insurance-provided indemnity arrangements are in place for the duration of the approval stated above. It is your responsibility to ensure that you request an extension to the end date for indemnity to remain in place should you continue the research beyond the dates covered.

Amendments

Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely

DocuSigned by:
Leah Butts
9F14889D2BC549A...

Mrs Leah Butts
Research Ethics Administrator

for
Dr Helen Barnby-Porritt
Research Ethics Manager

Appendix Q

TDRP: Participant Information Sheet

Oxford Institute of Clinical Psychology Training and Research
Isis Education Centre, Warneford Hospital, Oxford
oxicpt-admin@hm.ox.ac.uk

Primary Researcher: Zara Fenlon, Trainee Clinical Psychologist
zara.fenlon@worc.ox.ac.uk

Supervision Styles and Cultural Identity in Clinical Psychology

PARTICIPANT INFORMATION SHEET

Central University Research Ethics Committee Approval Reference: R92114/RE001

You are being invited to take part in a research project. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact us if there is anything that is not clear or if you would like more information.

Why is this research being conducted?

Supervision between a qualified psychologist (supervisor) and a trainee or assistant psychologist (supervisee) is a mandatory part of working clinically. It supports the supervisee to develop professionally and supports effective working with clients. Supervision styles differ, and research shows some supervision styles to be more effective than others. Supervision styles have also been shown to relate to the cultural identity of the supervisor. This study aims to investigate the relationship between cultural identity and supervision styles. This study forms part of a research thesis by a trainee clinical psychologist.

Why have I been invited to take part?

We are aiming to recruit qualified psychologists who are capable of facilitating supervision with a trainee or assistant psychologist, or trainee CBT therapist. We are recruiting HCPC registered psychologists from a 'White' ethnic background and those from a non-white ethnic minority.

Do I have to take part?

No. It is up to you to decide whether to take part. You can withdraw yourself from the research, without giving a reason and without negative consequences by advising us of this decision. If you participate in this study but then wish to withdraw your information or data later, this can be done before the deadline of the submission of this project, which is 23/05/2025. If you decide to withdraw, your data will be destroyed.

What will happen to me if I take part in the research?

After reading this information sheet, you are entitled to a pre-research call to answer any additional questions you may have. If you would like to book this, please contact our primary researcher Zara Fenlon (zara.fenlon@worc.ox.ac.uk). If you would like to continue without this, you can press 'next' at the bottom of this page after reading this form. This will take you to the consent form. A unique ID code will then be generated for you.

This research will take place through this same link after signing the consent form. The research session should take no longer than 25 minutes. We ask that you complete this study from a quiet and confidential space, where you can work with no distractions. You will need a device with a

speaker or headphones, preferably a laptop or PC. You will firstly be given some pre-research questionnaires. You will then be shown a video clip of a supervision session. This video clip cannot be skipped or paused so please give it your full attention. You will then be asked to complete a questionnaire based on what you saw. This will happen twice with 2 different video clips. You will then be given an online debrief sheet. This will also give you the chance to contact the researcher to ask any further questions.

What are the possible disadvantages and risks in taking part?

In this study, you will be asked some questions about your ethnic and cultural identity. This may be a sensitive topic for some participants. If you would like to talk to researchers about anything you find difficult during the study, you will be able to do this by contacting either of the researchers via email.

Are there any benefits in taking part?

While there are no immediate personal benefits to participating in this study, it is hoped that this research will contribute towards expanding the literature around cultural identity and supervision styles, with hopes to improve supervision for trainee and assistant psychologists.

What information will be collected and why is the collection of this information relevant for achieving the research objectives?

Your name will be asked for the consent form, but in any data collection following that you will be given a unique ID code to use on your questionnaires so that your information remains anonymous. We would only re-match your name to your ID code if we need to identify and withdraw your data for any reason.

In this study, we are interested in how cultural identity affects supervision styles. To help with this, we will ask you for your ethnicity, gender and years of experience as a supervisor. All of your personal data along with your questionnaire answers will be stored on a secure server from the University of Oxford. It will be deleted once the study has been written up. Your consent form will be stored for a minimum of 3 years on this server and will then be deleted. The researcher and the research team at OXICPT will have access to the research data.

Will the research be published? Could I be identified from any publications or other research outputs?

The findings from the research will be written up part of a doctorate thesis and may later be published to a scientific journal. Participants will not be identifiable from the outputs or data analysis.

Data Protection

The University of Oxford is the data controller with respect to your personal data, and as such will determine how your personal data is used in the research. The University will process your personal data for the purpose of the research outlined above. Research is a task that is performed in the public interest. Further information about your rights with respect to your personal data is available from the University's Information Compliance web site at https://compliance.admin.ox.ac.uk/individual-rights.

Who has reviewed this research?

This research has received ethics approval from a subcommittee of the University of Oxford Central University Research Ethics Committee. (Ethics reference: R92114/RE001).

Who do I contact if I have a concern about the research or I wish to complain?

If you have a concern about any aspect of this research, please contact Zara Fenlon (zara.fenlon@worc.ox.ac.uk) or Ciorsdan Anderson (ciorsdan.anderson@hmc.ox.ac.uk) and we will do our best to answer your query. We will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with. If you remain unhappy or wish to make a formal complaint, please contact the Chair of the Research Ethics Committee at the University of Oxford who will seek to resolve the matter as soon as possible:

The Chair, Medical Sciences Interdivisional Research Ethics Committee;
Email: ethics@medsci.ox.ac.uk; Address: Research Services, University of Oxford, Boundary Brook House, Churchill Drive, Headington, Oxford OX3 7GB

Further Information and Contact Details

If you would like to participate in this research, please email the primary researcher below. Equally, if you would like to discuss the research with someone beforehand, please contact:

Zara Fenlon
Oxford Institute of Clinical Psychology Training and Research
Isis Education Centre, Warneford Hospital, Oxford
zara.fenlon@worc.ox.ac.uk

Appendix R

TDRP: Participant Debrief Sheet

Oxford Institute of Clinical Psychology Training and Research
Isis Education Centre, Warneford Hospital, Oxford
Primary Researcher: Zara Fenlon, Trainee Clinical Psychologist
zara.fenlon@worc.ox.ac.uk

Supervision Styles and Cultural Identity in Clinical Psychology

DEBRIEF

Thank you for taking part in this study, we really appreciate your help!

Initially on your information sheet, we explained that this study aimed to investigate the relationship between cultural identity and supervision styles. The true aims of this study were to investigate to investigate if the ethnicity of a clinical supervisor effects their ratings of cultural responsivity in supervision. Within this, we also aimed to understand the role of the attitudes supervisors hold towards their own racial identity. Slight deception of the aims of the study were necessary, as if you were aware that we were assessing your perception of cultural responsivity, this may have influenced your answers and made the research less valid. The full title of this study is: The role of ethnicity and racial identity in supervision: An investigation of the cultural responsivity of clinical psychologist supervisors.

The results from your questionnaires are helpful in supporting us to answer the above questions - thank you! To remind you, all your data is anonymous and confidential. We store the results on an encrypted server, which can only be accessed by the research team. We will not keep any of your personally identifiable information, like the telephone number or email address you may have supplied to us to take part in this study. This information will be destroyed as soon as this study comes to a close in October 2024.

If you know anyone who may like to participate in this study, you are welcome to provide them with the email address of the primary researcher: zara.fenlon@worc.ox.ac.uk. We ask that you please keep the true aims of this study confidential, to not influence the responses of future participants.

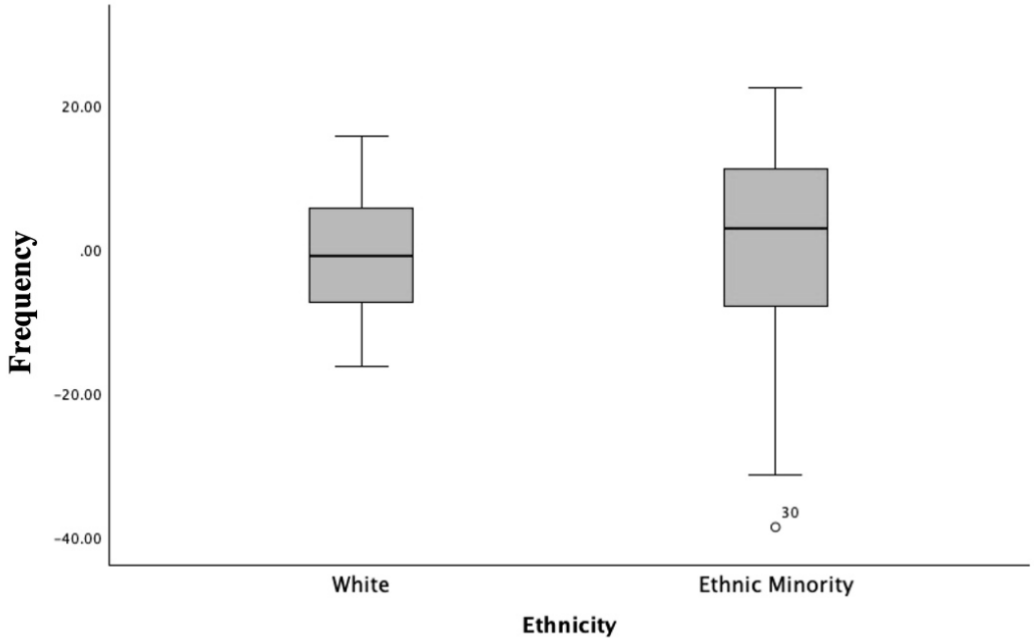
Further questions

If you have any more questions about any aspect of this project, please speak to the researcher Zara Fenlon (zara.fenlon@worc.ox.ac.uk) or their supervisor Ciorsdan Anderson (ciorsdan.anderson@hmc.ox.ac.uk) who will do their best to answer your query.

If you have any concerns, or wish to make a formal complaint, please contact the relevant Chair of the Research Ethics Committee at the University of Oxford: Chair, Medical Sciences Inter-Divisional Research Ethics Committee; Email: ethics@medsci.ox.ac.uk; Address: Research Services, University of Oxford, Wellington Square, Oxford OX1 2JD.

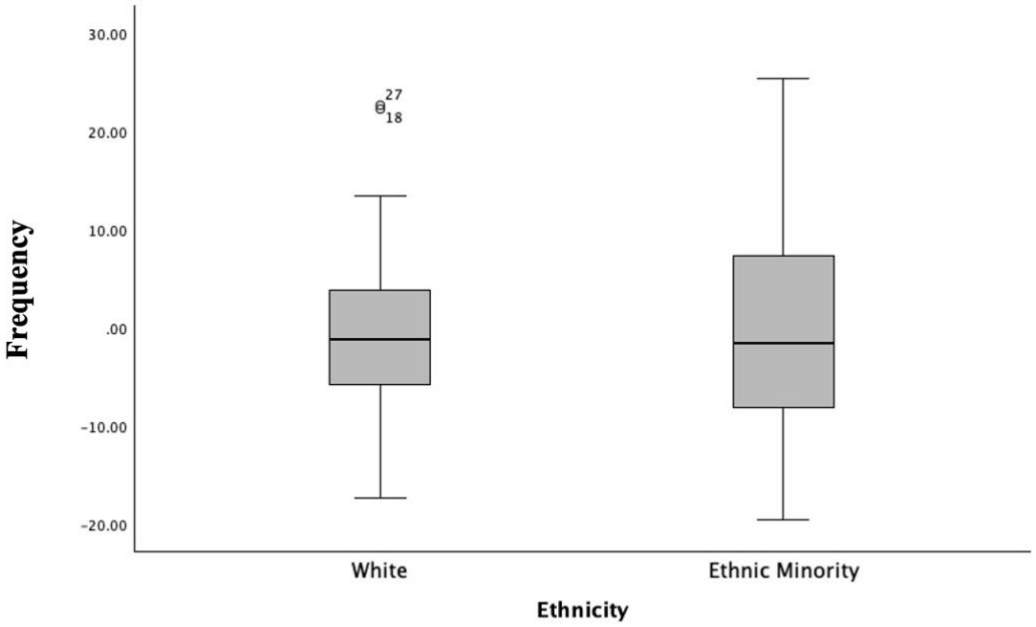
Appendix S

TDRP: Boxplot for High Condition Indicating Outliers



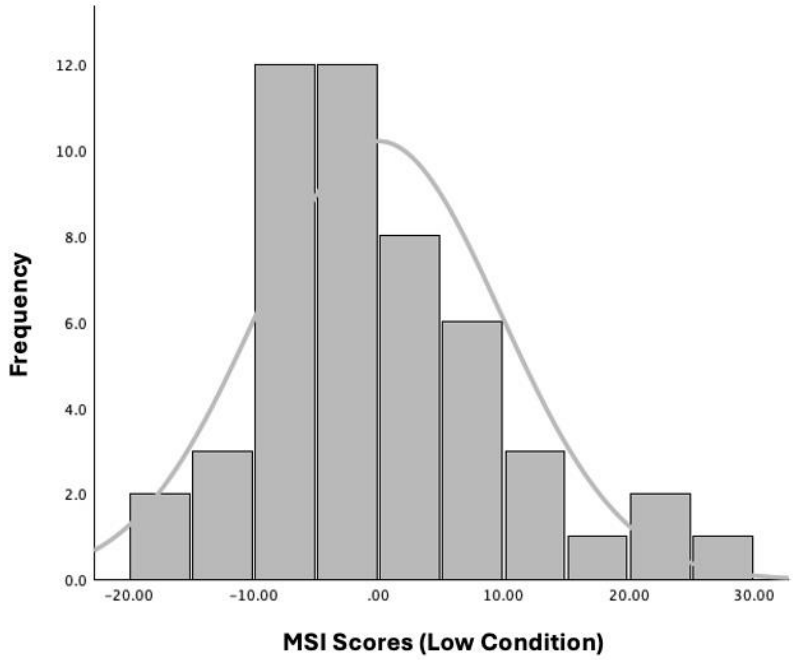
Appendix T

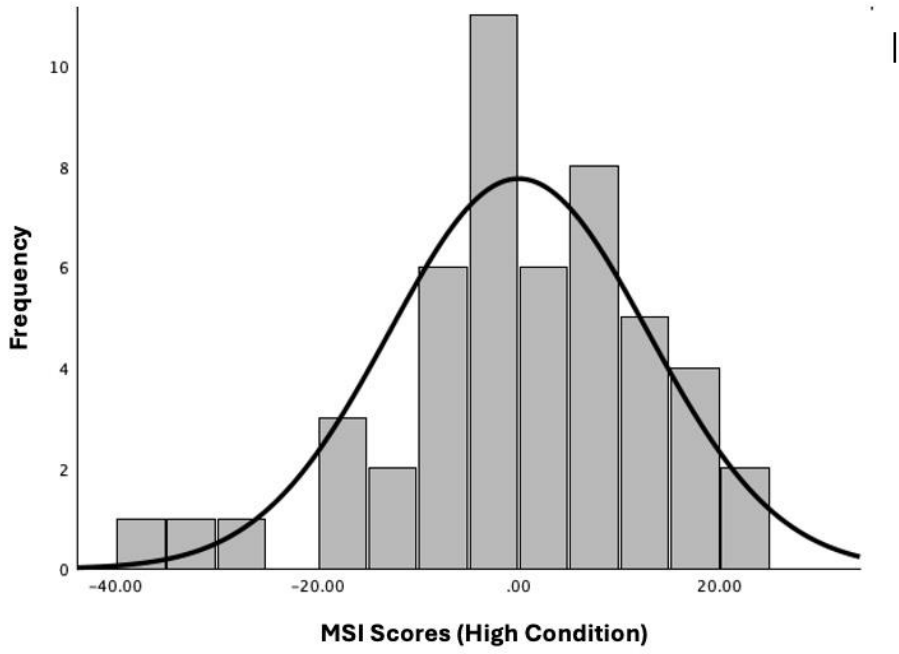
TDRP: Boxplot for Low condition Indicating Outliers



Appendix U

TDRP: Histogram for Low and High Conditions to Determine Normality of Residuals





Appendix V

SRL: The Journal of Substance Use & Addiction Treatment (JSAT) – Author Guidelines

Reference style

Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Seventh Edition (2020) ISBN 978-1-4338-3215-4.
The reference list should be arranged alphabetically and then chronologically. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

Writing and formatting

File format

We ask you to provide editable source files for your entire submission (including figures, tables and text graphics). Some guidelines:

- Save files in an editable format, using the extension .doc/.docx for Word files and .tex for LaTeX files. A PDF is not an acceptable source file.
- Lay out text in a single-column format.
- Remove any strikethrough and underlined text from your manuscript, unless it has scientific significance related to your article.
- Use spell-check and grammar-check functions to avoid errors.

We advise you to read our Step-by-step guide to publishing with Elsevier.

Title page

You are required to include the following details in the title page information:

- Article title. Article titles should be concise and informative. Please avoid abbreviations and formulae, where possible, unless they are established and widely understood, e.g., DNA).
- Author names. Provide the given name(s) and family name(s) of each author. The order of authors should match the order in the submission system. Carefully check that all names are accurately spelled. If needed, you can add your name between parentheses in your own script after the English transliteration.
- Affiliations. Add affiliation addresses, referring to where the work was carried out, below the author names. Indicate affiliations using a lower-case superscript letter immediately after the author's name and in front of the corresponding address. Ensure that you provide the full postal address of each affiliation, including the country name and, if available, the email address of each author.
- Corresponding author. Clearly indicate who will handle correspondence for your article at all stages of the refereeing and publication process and also post-publication. This responsibility includes answering any future queries about your results, data, methodology and materials. It is important that the email address and contact details of your corresponding author are kept up to date during the submission and publication process.
- Present/permanent address. If an author has moved since the work described in your article was carried out, or the author was visiting during that time, a "present address" (or "permanent address") can be indicated by a footnote to the author's

name. The address where the author carried out the work must be retained as their main affiliation address. Use superscript Arabic numerals for such footnotes.

Abstract

You are required to provide a concise and factual abstract which does not exceed 350 words. The abstract should briefly state the purpose of your research, principal results and major conclusions. Some guidelines:

- Abstracts must be able to stand alone as abstracts are often presented separately from the article.
- Avoid references. If any are essential to include, ensure that you cite the author(s) and year(s).
- Avoid non-standard or uncommon abbreviations. If any are essential to include, ensure they are defined within your abstract at first mention.

Keywords

You are required to provide 1 to 7 keywords for indexing purposes. Keywords should be written in English. Please try to avoid keywords consisting of multiple words (using "and" or "of").

We recommend that you only use abbreviations in keywords if they are firmly established in the field.

Highlights

You are required to provide article highlights at submission.

Highlights are a short collection of bullet points that should capture the novel results of your research as well as any new methods used during your study. Highlights will help increase the discoverability of your article via search engines. Some guidelines:

- Submit highlights as a separate editable file in the online submission system with the word "highlights" included in the file name.
- Highlights should consist of 3 to 5 bullet points, each a maximum of 85 characters, including spaces.

We encourage you to view example article highlights and read about the benefits of their inclusion.

Graphical abstract

You are encouraged to provide a graphical abstract at submission.

The graphical abstract should summarize the contents of your article in a concise, pictorial form which is designed to capture the attention of a wide readership. A graphical abstract will help draw more attention to your online article and support readers in digesting your research. Some guidelines:

- Submit your graphical abstract as a separate file in the online submission system.
- Ensure the image is a minimum of 531 x 1328 pixels (h x w) or proportionally more and is readable at a size of 5 x 13 cm using a regular screen resolution of 96 dpi.
- Our preferred file types for graphical abstracts are TIFF, EPS, PDF or MS Office files.

We encourage you to view example graphical abstracts and read about the benefits of including them.

Units, classifications codes and nomenclature

This journal requires you to use the international system of units (SI) which follows internationally accepted rules and conventions. If other units are mentioned within your article, you should provide the equivalent unit in SI.

Math formulae

- Submit math equations as editable text, not as images.

- Present simple formulae in line with normal text, where possible.
- Use the solidus (/) instead of a horizontal line for small fractional terms such as X/Y.
- Present variables in italics.
- Denote powers of e by exp.
- Display equations separately from your text, numbering them consecutively in the order they are referred to within your text.

Tables

Tables must be submitted as editable text, not as images. Some guidelines:

- Place tables next to the relevant text or on a separate page(s) at the end of your article.
- Cite all tables in the manuscript text.
- Number tables consecutively according to their appearance in the text.
- Please provide captions along with the tables.
- Place any table notes below the table body.
- Avoid vertical rules and shading within table cells.

We recommend that you use tables sparingly, ensuring that any data presented in tables is not duplicating results described elsewhere in the article.

Figures, images and artwork

Figures, images, artwork, diagrams and other graphical media must be supplied as separate files along with the manuscript. We recommend that you read our detailed artwork and media instructions. Some excerpts:

When submitting artwork:

- Cite all images in the manuscript text.
- Number images according to the sequence they appear within your article.
- Submit each image as a separate file using a logical naming convention for your files (for example, Figure_1, Figure_2 etc).
- Please provide captions for all figures, images, and artwork.
- Text graphics may be embedded in the text at the appropriate position. If you are working with LaTeX, text graphics may also be embedded in the file.

Artwork formats

When your artwork is finalized, "save as" or convert your electronic artwork to the formats listed below taking into account the given resolution requirements for line drawings, halftones, and line/halftone combinations:

- Vector drawings: Save as EPS or PDF files embedding the font or saving the text as "graphics."
- Color or grayscale photographs (halftones): Save as TIFF, JPG or PNG files using a minimum of 300 dpi (for single column: min. 1063 pixels, full page width: 2244 pixels).
- Bitmapped line drawings: Save as TIFF, JPG or PNG files using a minimum of 1000 dpi (for single column: min. 3543 pixels, full page width: 7480 pixels).
- Combinations bitmapped line/halftones (color or grayscale): Save as TIFF, JPG or PNG files using a minimum of 500 dpi (for single column: min. 1772 pixels, full page width: 3740 pixels).

Please do not submit:

- files that are too low in resolution (for example, files optimized for screen use such as GIF, BMP, PICT or WPG files).
- disproportionally large images compared to font size, as text may become unreadable.

Figure captions

All images must have a caption. A caption should consist of a brief title (not displayed on the figure itself) and a description of the image. We advise you to keep the amount of text in any image to a minimum, though any symbols and abbreviations used should be explained.
Provide captions in a separate file.

Color artwork

If you submit usable color figures with your accepted article, we will ensure that they appear in color online.
Please ensure that color images are accessible to all, including those with impaired color vision. Learn more about color and web accessibility.

Generative AI and Figures, images and artwork

Please read our policy on the use of generative AI and AI-assisted tools in figures, images and artwork, which can be found in Elsevier's GenAI Policies for Journals. This policy states:

- We do not permit the use of Generative AI or AI-assisted tools to create or alter images in submitted manuscripts.
- The only exception is if the use of AI or AI-assisted tools is part of the research design or methods (for example, in the field of biomedical imaging). If this is the case, such use must be described in a reproducible manner in the methods section, including the name of the model or tool, version and extension numbers, and manufacturer.
- The use of generative AI or AI-assisted tools in the production of artwork such as for graphical abstracts is not permitted. The use of generative AI in the production of cover art may in some cases be allowed, if the author obtains prior permission from the journal editor and publisher, can demonstrate that all necessary rights have been cleared for the use of the relevant material, and ensures that there is correct content attribution.

Supplementary material

We encourage the use of supplementary materials such as applications, images and sound clips to enhance research. Some guidelines:

- Supplementary material should be accurate and relevant to the research.
- Cite all supplementary files in the manuscript text.
- Submit supplementary materials at the same time as your article. Be aware that all supplementary materials provided will appear online in the exact same file type as received. These files will not be formatted or typeset by the production team.
- Include a concise, descriptive caption for each supplementary file describing its content.
- Provide updated files if at any stage of the publication process you wish to make changes to submitted supplementary materials.
- Do not make annotations or corrections to a previous version of a supplementary file.
- Switch off the option to track changes in Microsoft Office files. If tracked changes are left on, they will appear in your published version.

Video

This journal accepts video material and animation sequences to support and enhance your scientific research. We encourage you to include links to video or animation files within articles. Some guidelines:

- When including video or animation file links within your article, refer to the video or animation content by adding a note in your text where the file should be placed.
- Clearly label files ensuring the given file name is directly related to the file content.

- Provide files in one of our recommended file formats. Files should be within our preferred maximum file size of 150 MB per file, 1 GB in total.
- Provide "stills" for each of your files. These will be used as standard icons to personalize the link to your video data. You can choose any frame from your video or animation or make a separate image.
- Provide text (for both the electronic and the print version) to be placed in the portions of your article that refer to the video content. This is essential text, as video and animation files cannot be embedded in the print version of the journal.

We publish all video and animation files supplied in the electronic version of your article. For more detailed instructions, we recommend that you read our guidelines on submitting video content to be included in the body of an article.

Research data

We are committed to supporting the storage of, access to and discovery of research data, and our research data policy sets out the principles guiding how we work with the research community to support a more efficient and transparent research process.

Research data refers to the results of observations or experimentation that validate research findings, which may also include software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Please read our guidelines on sharing research data for more information on depositing, sharing and using research data and other relevant research materials.

For this journal, the following instructions from our research data guidelines apply.

Option B: Research data deposit, citation and linking

You are **encouraged** to:

- Deposit your research data in a relevant data repository.
- Cite and link to this dataset in your article.
- If this is not possible, make a statement explaining why research data cannot be shared.

Data statement

To foster transparency, you are encouraged to state the availability of any data at submission.

Ensuring data is available may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you can state the reason why (e.g., your research data includes sensitive or confidential information such as patient data) during the submission process. This statement will appear with your published article on ScienceDirect.

Read more about the importance and benefits of providing a data statement.

Data linking

Linking to the data underlying your work increases your exposure and may lead to new collaborations. It also provides readers with a better understanding of the described research.

If your research data has been made available in a data repository there are a number of ways your article can be linked directly to the dataset:

- Provide a link to your dataset when prompted during the online submission process.
- For some data repositories, a repository banner will automatically appear next to your published article on ScienceDirect.
- You can also link relevant data or entities within the text of your article through the use of identifiers. Use the following format: Database: 12345 (e.g. TAIR: AT1G01020; CCDC: 734053; PDB: 1XFN).

Learn more about linking research data and research articles in ScienceDirect.

Research Elements

This journal enables the publication of research objects (e.g. data, methods, protocols, software and hardware) related to original research in Elsevier's Research Elements journals.

Research Elements are peer-reviewed, open access journals which make research objects findable, accessible and reusable. By providing detailed descriptions of objects and their application with links to the original research article, your research objects can be placed into context within your article.

You will be alerted during submission to the opportunity to submit a manuscript to one of the Research Elements journals. Your Research Elements article can be prepared by you, or by one of your collaborators.

Article structure

Article sections

- Divide your article into clearly defined and numbered sections. Number subsections 1.1 (then 1.1.1, 1.1.2, ...), then 1.2, etc.
- Use the numbering format when cross-referencing within your article. Do not just refer to "the text."
- You may give subsections a brief heading. Headings should appear on a separate line.
- Do not include the article abstract within section numbering.

Glossary

Please provide definitions of field-specific terms used in your article, in a separate list.

Footnotes

We advise you to use footnotes sparingly. If you include footnotes in your article, ensure that they are numbered consecutively.

You may use system features that automatically build footnotes into text. Alternatively, you can indicate the position of footnotes within the text and present them in a separate section at the end of your article.

Appendix W

SIP: Cultural Diversity & Ethnic Minority Psychology Journal Author Guidelines

Title page
The title page should contain the complete title of the manuscript, names and affiliations of all authors, institution(s) at which the work was performed, and name, address, telephone and fax numbers of the author responsible for correspondence.
Please include the word count of the text and abstract.
Authors should also provide a short title of not more than 45 characters (including spaces), and up to 5 key words, that will highlight the subject matter of the article.

Abstract and keywords
All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. For commentaries and special section/issue introductions, the abstract is limited to 150 words. For research and review articles, the abstract is limited to 250 words and the following headings are required:

- **Objectives:** Study aims or hypotheses. The abstract must begin with this heading (i.e., no sentences should precede the objectives heading)
- **Methods** : Sample description (including size, race or ethnicity, gender, average age) and research design
- **Results:** Results that pertain to study aims or hypotheses
- **Conclusions:** Implication of findings
- After the abstract, please supply up to five keywords or brief phrases. Phrases are limited to three words maximum.

Manuscript preparation
Review APA's Journal Manuscript Preparation Guidelines before submitting your article.
If your manuscript was mask reviewed, please ensure that the final version for production includes a byline and full author note for typesetting.
APA Ethical Principles state that authors should "take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed" and that authorship should "accurately reflect the relative scientific or professional contributions of the individuals involved" (Standard 8.12). Each submitted manuscript must include a paragraph (not included in the word count), after the body of the main text and before any acknowledgments, that states each author's contribution.
Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the Manual. Additional guidance on APA Style is available on the APA Style website.
Below are additional instructions regarding the preparation of display equations, computer code, and tables.
Display equations
We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In online supplemental material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the text of the article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's insert table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Appendix X

TDRP: The Clinical Supervisor Journal – Author Guidelines

Preparing Your Paper

Structure
Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).
Word Limits
Please include a word count for your paper.
A typical paper for this journal should be no more than 30 pages, inclusive of the abstract, tables, references, figure captions.
Style Guidelines
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