Minority Voices

Research into the access and acceptability of services for the mental health of young people from Black and minority ethnic groups

by

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1. EXECUTIVE SUMMARY

Overview

In 2001, YoungMinds decided to focus its next national research study on exploring the awareness and experiences of young people from Black and minority ethnic groups in using child and adolescent mental health services (CAMHS). A particular aim was to look at the barriers preventing these young people from accessing help.

At the time, a growing body of literature and research was raising concern about the appropriateness of mental health services to meet the needs of people from Black and minority ethnic groups. Whilst much of this material referred to adults, quite clearly many of the concerns were relevant to children and young people too. For example, some of the identified barriers preventing Black and minority ethnic groups from accessing services included language problems, poor staff training, limited information, racism, fear and mistrust of services, inappropriate provision/interventions and issues such as socio-economic disadvantage. In addition, research on the ‘risk factors’ for young people developing mental health problems had highlighted that young people from Black and minority ethnic groups may be disproportionately affected - particularly with reference to the numbers excluded from school, being looked after or accommodated by a local authority or being homeless.

There was also a growing awareness of the dearth of information from young people themselves about CAMHS, and that this ‘user’ perspective is crucial in developing services that effectively address young people’s needs and concerns and are delivered in ways that are acceptable to them.

The study objectives

- To give a ‘voice’ to young people aged between 12 and 25, drawn from a range of Black and minority ethnic backgrounds, regarding their awareness and experience of and wishes for mental health services.
- To review activity across Tier 1 CAMHS that promotes access for such young people.
- To identify and analyse the barriers to effective access to appropriate services.
- To identify examples of promising and innovative practice in this area.

This report

This research report describes the aims and methodology of the Minority Voices study, presents the key themes and issues emerging from the data collected, and draws from this some of the implications for improving service provision and, in particular, access for this client group. The data have been gathered from:

- A mapping of services across England and Wales primarily focused on Tier 1, but also drawing in services across all tiers that appeared to be focused on young people from Black and minority ethnic groups.
- An in-depth study in four sample areas of services for the mental health of Black and minority ethnic young people in both the statutory and voluntary sectors.
- Focus groups and individual interviews with young people - both users of mental health services and young people in high risk groups - and with staff working with them.

The report is aimed at policy-makers in government, service commissioners and those working with young people from Black and minority ethnic communities. The report has been structured so that the research findings themselves comprise the central part of the document with each of the three main chapters focusing on a specific aspect of the information gathering. In each, where possible, quotes from young people and staff have been used to illustrate the points raised. Tables are presented that summarise areas of unmet need and also
factors that study participants identified as helpful in service provision and in facilitating access to mental health support and engagement with staff.

A complementary report, *Minority Voices: A guide to good practice in planning and providing services for the mental health of young people from Black and minority ethnic communities*⁶ is based on the findings of this study.

**Key findings**

*From the mapping of services:* a very mixed picture of activity emerges, suggesting that some parts of the country are quite active in developing services for young people from Black and minority ethnic groups - and of forging links with community services - whereas others have little or no specific provision.

*From the in-depth study of four sample areas:* a wide range of concerns about existing mental health service provision and problems in accessing services was reported by both young people and staff alike. It is salient to note that many of these concerns, difficulties and areas of unmet need echo those documented in the literature. This suggests that although clearly in some parts of the country progress is being made, the impact of the significant investment in CAMHS in recent years has yet to be felt amongst many young people from Black and minority ethnic communities. More positively the fieldwork also revealed examples of innovative practice that were proving effective in promoting service access for young people and plenty of ideas and suggestions for how services should be developed in the future.

**Key issues**

The issues emerging from the *Minority Voices* study can, to some extent, be presented in two categories:

- How to reach and engage with young people from Black and minority ethnic groups who may require help from mental health services.
- What needs to happen to aid the development of effective service provision for young people from Black and minority ethnic groups.

*Reaching young people*

Throughout the study, a recurrent problem was actually making contact with young people from Black and minority ethnic groups. This was either because only a few were presenting to services (noted by a considerable number of CAMHS staff), or because of a fear, expressed by many young people, of talking about their experiences. Concerns about confidentiality, having insufficient time to get to know and to trust staff and the stigma of accepting help from mental health services were the reasons often given. For some CAMH services struggling with high numbers of referrals, only limited time could be given in helping the research team to make contact with young people which also affected the number who were eventually recruited to the study.

Another difficulty encountered was that of voluntary sector projects working with young people closing down, often due to funding instability. On a number of occasions the research team identified and made contact with services that appeared to be supporting young people from minority ethnic groups only to find that either the service had already closed or was trying to find alternatives for its clients since it was facing this threat. As one might expect in such circumstances, maintaining contact with some young people was extremely difficult to achieve.

From the interviews undertaken, it was apparent that many young people had very limited awareness or understanding of CAMHS and thus, how they might access these services. Their understanding of what is meant by ‘mental health’ was poor, with many talking of mental health in terms of madness, or very serious illness, and as such, something that they did not see as applicable to them. Some also expressed a mistrust of services and professionals and/or fear of being labelled ‘mad’ as a result of accessing support. These difficulties
encountered by the researchers provide a vivid illustration of the challenge facing service providers in this field.

For many of the young people who were interviewed it would seem that often their route into CAMHS or other mental health support had been by luck, coming about through them making contact with a proactive professional with knowledge of available services. The data collected also indicate that many only reached help at a critical point in their difficulties, sometimes after an emergency referral. In addition the study findings highlight the need to work with parents, and also through communities since parental and community perceptions of a child’s difficulties and of mental health service approachability and usefulness are clearly an important influence on many young people.

It should be noted that many of these concerns could be seen to apply to all young people requiring help. However there was an impression of these concerns and difficulties being intensified when young people from minority ethnic groups come into contact with staff who feel that they do not have sufficient skills or understanding of differences in culture or ethnic background, or who are perceived by young people as lacking these skills.

### What sort of service provision is needed?

The range of data collected through the study provides some important indications:

- Many staff highlighted a lack of joined-up activity and limited knowledge of existing services as a key problem in improving information sharing and thus access to services.

- In particular, the lack of partnership working between CAMHS and voluntary sector provision in many areas of the country was highlighted, also that a considerable amount of innovative work in the voluntary sector is being lost due to funding instability.

- Staff interviews also revealed concerns about a lack of training in race equality and cultural competence (for both administrative and clinical staff in CAMHS).

- Young people made many suggestions for how services could be improved. These included: more flexible hours when services are available, more opportunities to drop-in or self-refer; a greater choice of venues and the need for more interpreters/resources for those who do not read/speak English. Greater professional awareness of the cultural context of issues that impact on young people from Black and minority ethnic groups, and those with refugee or asylum-seeking status, was also mentioned.

- Better information sharing through a wider range of outlets (especially non-traditional routes such as the radio, media or church/faith groups) was emphasised and should include self-help information, advice on strategies to deal with difficulties and information about how CAMHS operate.

- The importance of staff being informed and aware of local mental health services and able to support young people in seeking help was a prominent theme. A number of young people suggested that some sort of ‘befriending’ role would be highly useful for young people who are fearful of approaching CAMHS or other mental health services, also peer support in raising awareness.

- Knowledge of religious and cultural needs, and showing an interest in these, were identified as important staff attributes by many of the young people interviewed.

- Both young people from Black and minority ethnic groups and staff identified the need for provision for young people to address issues of grief, past loss, trauma and bereavement. Support and information for parents from minority ethnic groups in order to help them understand CAMHS and to try and reduce the stigma/fears connected with their child receiving help from these services, was also highlighted.
Study recommendations

- The lack of awareness and understanding and the poor perception of services that promote mental health, amongst many young people from Black and minority ethnic groups and their parents, must be addressed. New sources of information about CAMHS are needed, to be disseminated more widely, including through ‘non-traditional’ routes that young people may be more interested in using such as the internet, media/radio, social and local faith groups. It will be important to consider that this information is made available in a variety of languages, addresses the information needs of parents and is accompanied by education and training at the primary care level to improve the early recognition of mental health difficulties and the appropriate referral on to CAMHS.

- Within CAMHS, understanding of different cultural and religious needs is still variable and requires attention. The provision of training to address CAMHS staff limitations in these areas is needed, including developing the knowledge base of culturally competent practice and methods for evaluating this.

- The important role of the voluntary sector needs to be recognised and developed. This includes: building effective links between CAMHS/health service providers and voluntary sector providers; involving the voluntary sector in the commissioning of services; sharing good practice and, crucially, attention being given to providing more sustainable funding of voluntary sector projects.

- CAMH services need to explore options for developing more flexible and proactive approaches to their delivery. Whilst many CAMHS are struggling with increasing demand around the country, there are examples of innovative practice that indicate there is scope for improvement and greater flexibility despite these pressures. The importance of timing, of young people being able to build up trust in the staff member they are seeing, and providing continuity of care, are other issues requiring attention.

Other project outputs

In addition to this report and the guide for good practice, the following have been produced:

- A new YoungMinds booklet explaining CAMHS, including the different staff groups who work in these services and what they do.

- The translation into Arabic and Bengali of YoungMinds booklets on psychosis, eating disorders and in-patient adolescent mental health units.

- A range of local service information leaflets for young people covering four areas of England plus a leaflet on internet, email and telephone sources of support and information.

- A YoungMinds Spotlight that summarises the background to the study, the data collected, the key findings and the study recommendations.

All of these materials are available for download from the YoungMinds website. Visit - www.youngminds.org.uk/minorityvoices
2. INTRODUCTION

“For decades the disparities and inequalities between Black and minority ethnic groups and the majority white population in the rates of mental ill health, service experience and service outcome have been the focus of concern, debate and much research. However, there is little evidence that such concerns have led to significant progress, either in terms of improvement in health status or a more benign service experience and positive outcome for Black and minority ethnic groups. If anything, the problems experienced by minority ethnic groups within our mental health services may be getting worse.”

Inside Outside, National Institute for Mental Health in England (NIMHE), 2003

Background to the Minority Voices study

In 2001, when YoungMinds started to plan the Minority Voices study, there were concerns about the barriers facing many young people seeking help from mental health services. Research in progress around this time by the CAMHS Innovation Projects and by YoungMinds was highlighting this as an area of ongoing serious concern and was also illustrating the importance of seeking the views of young people themselves. Similarly, work by the King’s Fund and the Social Exclusion Unit was drawing attention to the fragmented nature of mental health services and the particular problems facing Black and minority ethnic groups. Overall there were also worries about a significant increase in the prevalence of disorders amongst young people.

At this time FOCUS, a Research Unit within the Royal College of Psychiatrists, was undertaking a survey looking at the extent to which specialist CAMHS were offering an appropriate service to young people from Black and minority ethnic communities, including the clinical aspects of working with such young people once they start to receive help. This survey involved interviewing commissioners and Tier 3 CAMHS managers about current planning and provision of CAMHS for Black and minority ethnic groups.

YoungMinds’ overarching aim was to build upon previous studies, including the FOCUS project, and to examine the issues relating to access which may prevent young people from Black and minority ethnic communities receiving appropriate and effective help.

Study objectives

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- To review activity across Tier 1 CAMHS that promotes access for such young people.
- To identify and analyse the barriers to effective access to appropriate services.
- To identify examples of promising and innovative practice in this area.

The specific aim of the study has been to make a contribution to the understanding of why many young people from Black and minority ethnic groups do not use CAMHS - or only approach them when they have reached crisis point - and to explore their views and suggestions, alongside those of professionals working in this field, as to how service access and acceptability may be improved.
Concerns about the provision of mental health services for Black and minority ethnic communities

Since 2001 awareness of the particular difficulties facing Black and minority ethnic communities has been considerably heightened through the publication of a number of important reports and consultation documents, including:

- *Inside Outside* published by NIMHE\(^{14}\) (see initial quote above) which also states: “At present, there is no national strategy or policy specifically intended to improve either the mental health of minority ethnic groups or their care and treatment within mental health services. Previous approaches taken to address these problems have been either fragmented or selective. As a result, the ‘ethnicity agenda’ within mental health services has tended to become either marginalised or ignored.”

- *Breaking the Circles of Fear* by the Sainsbury Centre for Mental Health which highlights that “the care pathways of Black people are problematic and influence the nature and outcome of treatment and the willingness of these communities to engage with mainstream services.”\(^{15}\) This document also notes “the need for changes to mental health care and treatment of Black people is widely recognised and long overdue. There is compelling research and statistical evidence which shows that Black and African Caribbean people are over-represented in mental health services and experience poorer outcomes than their White counterparts.”

- The FOCUS report, which highlights the importance of recognising “the diversity of individual needs and cultures” if we are to truly understand and address the needs of minority ethnic groups.\(^{16}\) This work also draws attention to the complexities of defining ethnicity, the limitations of census data, and the paucity of epidemiological research in the field of ethnicity and mental health in children and adolescents.

- *Delivering Race Equality: a Framework for Action*, which states in the foreword: “improving the provision of services to Black and minority ethnic communities, and ensuring that those communities are not only informed, but also willing and able to work in partnership with services, are not merely matters of fulfilling statutory obligations, important though those are. They are essential if we are to achieve our overall goals in modernising the health and social care system.”\(^{17}\)

This report sets out the following - that people from Black and minority ethnic communities are more likely to experience:

- Problems in accessing services
- Lower satisfaction with services
- Cultural and language barriers in assessments
- Lower GP involvement in care
- Inadequate community-based crisis care
- Lower involvement of service users, family and carers
- Inadequate support for Black community initiatives
- An aversive pathway into mental health services:
  - higher compulsory admission rates to hospital
  - greater involvement in legal system and forensic settings
  - higher rates of transfer to medium and high secure facilities
- Higher voluntary admission rates to hospital
- Lower satisfaction with hospital care
- Lower effectiveness of hospital treatment
- Longer stays in hospital
- Less likelihood of having social care/psychological needs addressed within care planning/treatment processes
- More severe and coercive treatments
- Lower access to talking treatments/therapies
Delivering Race Equality also states that the Sainsbury Centre for Mental Health has identified that:

- Many people, particularly in the Black African and Caribbean communities, do not believe that mainstream mental health services can offer positive help, so they delay seeking help.

- They therefore are not engaging with services at an early point in the cycle when they could receive less coercive and more appropriate services, coming instead to services in crisis when they face a range of risks including over and mis-diagnosis, police intervention and use of the Mental Health Act.

- These aversive care pathways further influence both the nature and outcome of treatment and the willingness of communities to engage with mainstream services.

In addition, the literature concerning the needs of young refugees and asylum seekers resident in the UK has grown, describing the considerable trauma they may have experienced and their difficulties in accessing appropriate support, including mental health services.18

Furthermore, in the aftermath of the Stephen Lawrence Inquiry, more attention must now be paid to tackling institutional racism across all services, including education and social services,19 alongside a growing literature on the importance of developing cultural competence in service provision.20
3. CONTEXT OF THE STUDY

Various areas of the research literature are highly relevant to the Minority Voices study. In addition there is a growing knowledge base about what works and is effective in improving mental health outcomes for children, young people and families more generally, including those who are in contact with child and adolescent mental health services (CAMHS). The importance and difficulties of inter-agency working and the concerns about an overall upward trend in the numbers of young people identified with mental health problems are other important areas of literature relevant to all young people.

Areas of specific relevance to the study are:

- Studies concerning the understanding of ethnicity, cultural awareness, cultural sensitivity, cultural competence and socially inclusive practice.
- Literature focused on the mental health needs of young people from Black and minority ethnic groups and on the ‘risk factors’ that disproportionately affect them.
- The literature discussing the provision of mental health services for Black and minority ethnic groups, including studies comparing pathways to services and those examining progress, or the issues that must be addressed, to achieve race equality in service provision. Whilst predominantly focused on adults, clearly many of the concerns apply to young people.
- Analysis of the factors that can affect the access by young people from Black and minority ethnic groups to mental health services, including research into help-seeking behaviours, the identification of mental health needs, service engagement and comparative views of parents from different ethnic groups and their perceptions and expectations of services.

In this report, only a brief overview of this literature is presented. However, in the Appendix, a glossary of some key documents is provided.

Literature search methodology

Searches were limited to English language publications and search terms included: ethnic; health promotion; ethnic mental health young people; ethnic minority; mental health; mental health services; CAMHS; somatisation mental health; user mental health; adolescent mental health; racism, ethnic mental health; ethnic adolescence health; transition from child to adult services; young people views services; young people awareness mental health; barriers, services, ethnic; access mental health, minority.

The following databases were searched: Medline; Electronic Library for Social Care; PsychINFO; NHS National Research Register (NRR); Department of Health Research Findings Electronic Register (ReFeR). The team also undertook a number of internet web searches, hand searches of relevant journals and followed up word of mouth recommendations.

The population of Black and minority ethnic young people

The national census has revealed that the minority ethnic population of the UK was 4.5 million in 2001, 7.6% of the population of the UK. Indians were the largest minority group followed by Pakistanis, then Black Caribbeans, Black Africans and those of mixed ethnic backgrounds. Census data indicates that minority ethnic groups were more likely to live in England than in the other countries of the UK. Forty-five per cent of minority ethnic people live in London where they comprise 29% of all residents, a substantial proportion of London’s 7.2 million people. Across the rest of the UK, ethnic groups show variation in geographical distribution and concentration. Two per cent of the population of England and Wales are Indian, the majority of whom live in Leicester. Bangladeshis make up 0.5% of the population of England and Wales with the highest proportion in the London Borough of Tower Hamlets (33.4%). Just over 1% of people in England and Wales are Black Caribbean, 0.9% are Black African and a further 0.2% are from Other Black groups.
Black and minority ethnic groups generally have a younger age structure than the ‘White’ population in England and Wales, though the extent of this differs between ethnic groups according to history and immigration patterns. In England, there are approximately 3 million children aged under 5 years, 6.4 million aged 5-14 years and 3.1 million aged between 15 and 19 years.\textsuperscript{27} Children and young people from Black and minority ethnic backgrounds make up about 20% of the total population aged under 20.

The number of ethnic groups in the UK is diverse and some studies have made a distinction between ‘visible’ ethnic minorities including Black Caribbean, Pakistani, Indian, Bangladeshi, Chinese and Travellers, and other groups commonly referred to as ‘other’. The largest ‘other’ groups are estimated to be Iraqis, Somalis and Yemenis, followed by Iranians, Kurds, Bosnians, Algerians, Tamils and Vietnamese.\textsuperscript{28}

\section*{Understanding ethnicity, cultural competence and socially inclusive practice}

In recent years, there has been increasing recognition of the complexities of defining ethnicity, that "the way ethnicity is perceived and defined is, among other things, influenced by social, political, historical and economic circumstances,\textsuperscript{29}" of the importance of understanding ethnicity as "a process by which people create and maintain a sense of identity,\textsuperscript{30}" that "ethnicity is something that we all have. In its widest sense it involves our culture, lifestyle, language and religion as well as our roots and origins.\textsuperscript{31}

This literature highlights the limitations of current census categories - that these do not provide information about identity; that "profiles of broad groups also obscure enormous differences between their members"\textsuperscript{32} - and that this needs to be borne in mind in the planning, provision and monitoring of services. Furthermore census data is lacking for some groups, there may be important differences between generations and the information that is needed about ethnicity "for administrative purposes is likely to be different to that needed for providing effective clinical interventions.\textsuperscript{33}

Also evident in the literature concerning the delivery of health and welfare services more broadly, has been a growing interest in services being ‘culturally competent’ and ‘socially inclusive’ and what this might mean. Recognition of the increasingly diverse backgrounds of children, young people and families presenting to services - and the limitations of some services, including mental health, to work effectively in cross-cultural situations - lies behind this interest.\textsuperscript{34 35} In addition, some of the literature discusses the important distinction between cultural awareness (which refers to knowledge about various cultures) and cultural sensitivity (which refers to experiences that challenge individuals to explore their personal cultural issues).\textsuperscript{36}

\section*{The mental health needs of young people from Black and minority ethnic groups}

Understanding the prevalence of mental illness among different ethnic groups is acknowledged to be both a "controversial and complex field of inquiry"\textsuperscript{37} and considerable caution is needed in interpreting results, not least because many studies are based on very small sample sizes, lack consistency in how ethnicity is defined and have often used measures developed from White populations.\textsuperscript{38} However, "existing research suggests that, as with physical health, there are important and possibly large differences in mental health across ethnic groups,..." and it is possible that there are "important cultural differences in the way in which people experience and express mental illness.\textsuperscript{39}

The following gives a ‘snapshot’ of some of the findings in this area:

- The Office for National Statistics Survey of the mental health of children and adolescents in Great Britain (1999) revealed that nearly 10% of White children and 12% of Black children were assessed as having a mental health problem. The prevalence rates among Asian children were 8% of the Pakistani and Bangladesh and 4% of the Indian samples.\textsuperscript{40}
• A measure of general psychiatric morbidity in the Fourth National Survey of Ethnic Minorities showed that a much higher proportion of Bangladeshis may suffer from psychiatric illness (2.5 for men and 2.4 for women); in contrast, compared with the population, a considerably lower proportion of Chinese men and women were likely to be affected in this way (0.33 for men and 0.35 for women).\(^41\)

• Studies done in the 1970s, 1980s and 1990s have uniformly shown that Indian children appear to show a lower prevalence rate of mental disorder compared with African Caribbean, Pakistani, Bangladeshi or White indigenous children.\(^42\)

• Some studies have found overall low rates of mental disorder for South Asians. The study of ethnic minority psychiatric illness in the community (EMPIRIC) found that this in fact only applied to those who migrated in late childhood or adulthood and that the second generation did not have lower rates.\(^43\)

• A study of common mental disorders found that the prevalence of anxiety and depression was similar in African Caribbeans and White Europeans, and that also there was no difference in medical help-seeking.\(^44\) Another study found that autism, psychosis and conduct disorders were more common in the second generation African Caribbean children in the study, whereas emotional disorders were more common in the indigenous White children.\(^45\)

• Young African Caribbean men are more likely than others to be referred to mental health services through the criminal justice system, rather than through their GPs.

• Suicide rates are high in young Indian men and in East African men and women (using suicide data 1988-92 and country of birth).\(^46\) Young Asian women have higher rates of suicide compared to other young women.\(^47\) Rates of self-harm are also of particular concern amongst this group.\(^48\) A national clinical survey of patient suicides in England and Wales, suggests that different suicide prevention measures are needed for different ethnic groups.\(^49\)

• People from Black and minority ethnic backgrounds are more likely to be given 'physical treatments', eg. drugs and electric shock treatment, than their White counterparts.\(^50\)

• Young refugees and asylum seekers have significant mental health needs, arising from their past experiences of trauma, bereavement, loss and grief.\(^51\)\(^52\) Many also experience racial harassment on arriving in the UK.\(^53\)

### Factors affecting access to mental health services by young people from Black and minority ethnic groups

**Help-seeking behaviour**

Data on the help-seeking behaviour of young people from minority ethnic backgrounds are sparse. The WHO Study of Psychological Disorders in General Health Care is the largest WHO Collaborative Project that monitors frequency of psychological disorders seen in general health care settings. Though the results of the research cannot necessarily be extrapolated to how young people from Black and minority ethnic backgrounds may behave in the UK, the findings illustrate the ethnic differences in the pathway to mental health care and it is fair to conclude that different people seek help in different ways.\(^54\)

In a study of help-seeking among minority ethnic students in a Los Angeles public high school, 50% expressed the need for help with personal, emotional or behaviour problems but only one-quarter reported having gone for professional help, 11% having done so frequently. Even among those reporting high levels of psychological distress, only about one-third went to see a professional. Among those using professional help, school-based sources were used with a high frequency.\(^55\) The study looked at on-campus professional services offered free to students and concluded that “improving access to service is a necessary but insufficient condition for increasing the likelihood that people will seek out professional help when they need it.”\(^56\)
Help-seeking behaviour is determined by a variety of personal/individual and social/cultural factors, including level of psychological distress, personal problem-solving skills and environmental factors. Some studies suggest that adolescents under-utilise professional services because of their negative attitudes towards mental health professionals and their own preferences for informal sources of help through friends and family members. Others have highlighted that where appropriate services are set up, people will use them, a finding certainly borne out in the Minority Voices study which shows that services that young people thought helpful were over-subscribed.

It is also important to recognise that some studies in this area contradict each other. For example in a study of the degree to which religious coping strategies were perceived to be effective in the face of depressive and schizophrenic symptoms, prayer was perceived as particularly effective among African Caribbean Christian and Pakistani Muslim groups. However another study found that, relative to other kinds of help for depression, religious activity was not seen as particularly helpful, but that Muslims believed more strongly than other groups in the efficacy of religious coping methods for depression. They were most likely to say that they would use religious coping behaviour and least likely to say that they would seek social support or professional help.

**Engagement with mental health services**

Indian and Pakistani children make more use of general practitioners’ services for general health problems (not specifically mental health) than other children, but Indian, Pakistani, Bangladeshi and Chinese children are less likely to be referred to outpatient clinics. A case analysis of all the referrals to the Child and Family Consultation Service at the Royal London Hospital in 1997 found that Bangladeshi families were less likely to attend the initial appointment, but once a family became engaged, service drop-out rates were unaffected by ethnicity. This study found a difference in attendance rate depending on the source of the referral and highlighted the importance of communication between the referrer, the family and the service. This study also found that nine out of ten Pakistani mothers would be more likely to use a service if a therapist visited them in their own home or if they could see them within the local community, illustrating the importance of appropriate referral routes that match well with local needs.

Even when levels of awareness of services are similar across different ethnic groups there may still be differences in willingness to access a service. One study found that one in 40 White British mothers were unwilling to utilise a child and adolescent mental health service, compared to one in four mothers of Pakistani origin. The latter tended only to consider referrals for severe problems. These disparities may be due to misunderstandings about the structures of services. In one child psychiatry team it was found that South Asian families living in close contact with their extended family did not invite them to the assessment, suggesting that they understood clinicians to expect only the nuclear family to attend. Routine treatment options, for example a weekly parenting skills and support group, were not enthusiastically embraced by South Asian parents. A major concern of adolescents with mental health problems is the relationship with the doctor and the degree of approachability. An understanding and supportive relationship is valued.

**Research on risk factors**

Young people from ethnic minority groups disproportionately experience many of the known risk factors for developing mental health problems, including exclusion from school, being looked after and homelessness.

A Commission for Racial Equality Investigation Report found that in Birmingham, African Caribbean pupils were four times more likely to be excluded from school for fewer and less serious offences than White children and were less likely to re-enter the mainstream. The lack of real progress in addressing the exclusion and achievement disparities has been attributed to institutionalised racism, based on assumptions and unquestioned practice.

Data from the Fourth National Survey show that minority ethnic groups have a lower income than white people in the same class. Unemployed individuals remain unemployed for longer
and some minority groups have poorer quality housing. Poor wages, long working hours, overcrowding and bad housing all increase health risk and have an impact on children’s psychological development. Research has shown that families living in poverty make less use of health services, particularly preventative services, and have poorer health and social outcomes. The 2001 Census revealed that households headed by an ethnic minority person had a lower disposable income than households headed by ‘White’ groups.

**Language barriers**

Various studies have highlighted the potential problems posed by language. One study of case notes held by a child psychiatry team found that although the clinical team was aware of the potential for communicational difficulties, efforts to overcome such problems were not often mentioned in case notes.

The qualitative part of the EMPIRIC study found that in GP consultations not conducted in the patient’s first language, the level of participation by the patient was reduced, and that all the South Asian respondents who reported accessing counselling or therapeutic services were able to speak English.

**Racism**

Many of the experiences of minority populations may be characterised by discrimination and disadvantage that is likely to have a bearing on the mental health of these individuals. Racism is a factor that contributes to mental health difficulties in adults and children. A recent study from the United Kingdom showed that victims of discrimination were more likely to have respiratory illness, hypertension, anxiety, depression and psychosis. People have spoken of how ‘tiring’ it is to cope with racism - in handling the situation itself and in coping with its ‘internal’ (or personal) consequences and moving on.

Racial stereotyping occurs on many levels and concerns about racism in Britain’s mental health services are not new. For example, one study found that psychiatrists were more likely to ask Black patients whether they had a social worker or had received learning support at school, whereas they were more likely to ask White patients about problem drinking. However it is institutional racism that has a greater impact in generating inequalities in mental health services, with the report *Inside Outside* defining this as:

“a feature of institutions where there are pervasive racist attitudes and practices, assumptions based on racial differences, practices and procedure which are discriminatory in outcome, if not in intent, and a tolerance or acceptance of such differences.”

**Stigma**

Whilst it has been suggested that there is no evidence that majority White groups find mental illness and mental health support less stigmatising, a number of studies have highlighted the variations in views towards stigma amongst different cultures. For example, based on some small local studies, some researchers have described Chinese societies as shame-orientated, liable to adapt their behaviour, particularly care-seeking behaviour, in order to ‘save face’. This may mean that Chinese are very reluctant to seek help outside the family and are fearful of criticism and stigma and of ‘losing face’ in their society. There may also be conflict between the service user and the family.

**Identification of mental health needs**

Research in several inner-city GP surgeries shows that Black and minority ethnic patients are less likely to have psychological problems identified. It is well known that both Asian and Caribbean populations do not consult their GPs for mental disorders. Some researchers suggest that this may be due to the nature of GP-patient interaction and poor communication. Other reasons may include greater somatisation/presentation of physical illness to GPs in patients from some Black and minority ethnic groups. *Inside Outside* mentions fear of misdiagnosis and a lack of trust in services/professionals as possible reasons for some groups not consulting. And some studies have drawn attention to the limited time
often available for assessing patients who present in emergency situations as a factor affecting the identification of needs.\textsuperscript{84}

Ethnicity is not the only factor affecting diagnosis of a mental health problem by clinicians. Secondary analysis of the British General Health Survey 91-94 revealed that there were no significant differences in the use of health services by children and young people of different ethnic groups.\textsuperscript{85} Recognition of psychiatric disorders by GPs has generally failed to take into account the role that ethnicity plays. To understand and address the mental health needs of minority ethnic groups, professionals need to recognise the diversity of individual needs and cultures.\textsuperscript{86}

There is much debate around the extent to which an illness is culturally shaped. The EMPIRIC study, for example, has caused much controversy with its findings that emotional experiences of distress appeared to be broadly universal and that physical symptoms and idioms were common across all groups. However, some specific symptoms and some experiences, such as loss of confidence or self-esteem, guilt or shame, were not universal. This study gives no support to the claim that Asian patients, rather than others, somatise.\textsuperscript{87} Similarly, a study of Punjabi and English people visiting their general practitioner found that Punjabi cases were not more likely to have somatic symptoms. However, GPs were more likely to assess Punjabis with common mental disorders as having ‘physical and somatic’ symptoms.\textsuperscript{88}

A study of the prevalence of anxiety and depressive illness and help-seeking behaviour in African Caribbeans and White Europeans found that most people of both ethnicities had consulted their doctor, but most presented with somatic, rather than psychological, symptoms. What resulted however, was that GPs recognised a psychological problem in 27\% of African Caribbeans and 52\% of White Europeans.\textsuperscript{89}
4. METHODOLOGY

The study method

The project started in May 2003, with funding from The Diana, Princess of Wales Memorial Fund. Essentially, this was a national study, with the mapping of Tier 1 activity and ‘good practice’ across England and Wales. It was intended to work in depth in six sample areas, selected to include differing characteristics: urban and rural areas; areas with high and low prevalence of young people from minority ethnic groups; and areas where there was known to be specific service development for this client group as well as where there was little known targeted activity.

Subsequent funding difficulties meant that the research team were only able to work in four sample areas. However, funds were made available for the project from The Henry Smith Charity, the Department of Health, NIMHE and the Children and Young People’s Unit (CYPU) and this support allowed the research team to produce more extensive resources for young people than originally planned (all of which are available for downloading from the YoungMinds website - www.youngminds.org.uk/minorityvoices).

A mixed methods approach

- Qualitative methods were developed to meet the study aims and objectives, with semi-structured interviews and focus groups being used as the main methods of collecting data from young people, families and the staff working with them. In some cases however, due to problems organising face to face meetings, telephone interviews or postal questionnaires had to be used instead. As much as possible, the interviews and focus groups aimed to give the participants the opportunity to express and explain their own opinions, ideas and priorities. The methodology was awarded London Multi-Centre Research Ethics Committee approval on 4th November 2003.

Data were collected from two main sources:

- A mapping of activity across England and Wales. Whilst primarily focused on Tier 1, with an aim of providing a national overview of services at this tier addressing the needs of young people from Black and minority ethnic groups, some information about services at other tiers was also gathered.

- An in-depth study in four sample areas drawn from across England and Wales. In these areas, largely qualitative data were gathered from both young people with experience of using mental health services and those without, and staff working with them. Several additional focus groups were carried out in other areas of the country where the research team found services for groups of particular interest, such as those for asylum seekers.

Mapping of Tier 1 activity and postal questionnaires

The mapping of activity focused on services supporting young people from Black and minority ethnic groups, and identification of services possibly demonstrating ‘good practice’ was based on a number of different methods of information gathering, including:

- Internet searches.

- Postal questionnaires to Primary Care Trusts (PCTs), Looked After Children (LAC) teams, Connexions services, and Youth Offending teams (YOTs).

- Telephone interviews and some site visits.

- Calls for information in several journals/specialist mental health magazines and on the YoungMinds website and the FOCUS noticeboard.
Fieldwork in the four sample areas also generated some information from practitioners about activity within CAMHS and about services working with BME communities.

The mapping process included reviewing all available service paperwork such as service annual reports, evaluation reports, leaflets for parents/young people and information for referrers. As far as possible, information was gathered from across all regions of England and Wales.

**In-depth study**

- **The sample areas**

  The sample areas in which the main data gathering took place were drawn from across England and Wales and were selected for a number of reasons. In each area it was hoped to gather information from around 15 young people (both those with experience of using mental health services and those without) and 8-10 staff working in services for young people, from both statutory and voluntary sector services.

  Of the four areas selected one was in Wales, where it was known that there were likely to be only very small numbers of young people from minority ethnic groups - although in recent years, there have been increasing numbers of young refugees and asylum seekers, a trend that will have posed new challenges for service providers in the area. This area was also selected on the basis of encompassing both urban and rural areas.

  Another was selected on the basis of having an established, strongly multi-cultural population (24% minority ethnic groups). A number of the wards in this area have been identified as some of the most socially deprived in the country (and with significantly higher than average percentage of people from minority ethnic groups). This area was also selected on the basis of having a good track record of services working in partnership around ethnicity issues and due to its location in the south of England. The remaining two sample areas were selected on the basis of being in the north of England and having significant groups of people from Black and minority ethnic groups. In both areas it was also known that there were active voluntary sector organisations working with Black and minority ethnic communities.

- **Interview and focus group schedules**

  Throughout, there was a flexible approach to data gathering, in order to make the research 'young person friendly' and to maximise the participation of young people from minority ethnic groups. Young people were usually invited to participate in the study via a member of staff already known to them (from a CAMHS, voluntary sector or education setting they were using).

  **Young people:** Significant amending and refining of the schedules was necessary as the study progressed due to the considerable diversity of needs and different situations presented by the young people. As the widespread lack of understanding of mental health and about CAMHS emerged, it was also necessary to adjust some of the questions for some young people and to explore more broadly young people’s perceptions of well-being and where they might go for help.

  The interview and focus group schedules for young people covered the following areas: their ethnic background; their sources of social support; their use of services and for what reasons; how they had initially contacted services; how long it took to access help; practical problems in accessing help; their views of staff within services, service settings and locations and general views about the help they received.

  Young people were also asked if there was help that they felt they needed that they had not received; the other types of services they had heard of or were interested in and their family’s understanding of their difficulties and of the source of help available. Specific questions explored how they thought services could be improved, and how information about services might be improved and more effectively disseminated.
**Staff:** The interview schedules for staff covered many of the above areas. In addition, they sought information on:

- The range of services provided by the organisation; how the service was targeted or promoted to young people from Black and minority ethnic groups; how staff thought services could be promoted more effectively.
- Staff knowledge and skills to address the mental health needs of young people from Black and minority ethnic groups, including their views about available training opportunities, their suggestions for improving training and whether they felt sufficiently supported in their work.
- Whether and how staff thought the physical space of their service reflected a multi-ethnic context.
- The systems in place to enable effective communication with young people and their families/carers (including access to interpreters and translated materials).
- Whether and how young people and other members of local Black and minority ethnic communities were involved in the planning of services.

**Data collected**

In mapping services working with young people from Black and minority ethnic groups, information was received about nearly 300 services. On checking it was often found that the services were for adults or were not particularly focused on minority ethnic groups. Worryingly, a number of services were also found to have recently closed due to funding difficulties.

Questionnaires were returned from 22 PCTs, 32 from LAC teams, 21 questionnaires from Connexions services, and 37 from the YOTs. Overall, the information gathered revealed a very mixed picture of activity, with an impression of clusters of services in some parts of the country, whereas other areas had little or no specific provision.

In the in-depth part of the study 76 young people were interviewed or took part in a focus group discussion. They were drawn from a range of ethnic and religious backgrounds, with a number of young people specifying that they had no religion; 24 were refugees. Most were in the age range 16-18 and some were looked after by social services. Forty-four staff, from a range of professional backgrounds, were interviewed.

**Data analysis**

Information gathered from the interviews and focus groups was analysed using thematic analysis. The prominent themes emerging from the data were considered by the four members of the research team independently, with the team then agreeing the key findings and the issues to be presented in the research report.

Consideration of the views and experiences of both young people and staff with regard to areas of unmet need, service barriers and the factors that promote service acceptability and accessibility, together with the background literature, formed the basis for the discussion and examples of ‘good practice’ in this field of mental health service provision.

**Data limitations**

The response rate to the postal questionnaires sent to Connexions teams, Looked After Children teams, Youth Offending teams and Primary Care Trusts was quite low and only limited conclusions can be drawn from the data collected.

Considerable problems were encountered during the study in making contact with young people from Black and minority ethnic groups. This was particularly true for those with experience of actually using statutory mental health services. As such, whilst the study did
gather information from 76 young people, it must be acknowledged that much of this data has come from young people who have not actually used statutory mental health services.

**Support to the project**

The research team was supported by several external groups which assisted in refining the interview and focus group schedules, identifying key issues to be explored in the study and designing the project outputs.

- **Steering groups of young people**
  
  To ensure that the interview and focus group schedules picked up on the issues relevant to young people from Black and minority ethnic groups, used appropriate and accessible language and produced materials of relevance to young people at the end of the project, the research team attempted to work with a number of small groups of young people at different stages during the study. Several organisations working with specific groups of young people were approached and meetings were subsequently held with a group of young Chinese people who regularly attended the Islington Chinese Association, and with a group of young people who were being supported by Liverpool Social Services leaving care team. In total seven young people helped the project and the meetings generated a range of useful suggestions including young people's views on how the focus groups might be facilitated, the preferred length of interviews and recording information.

- **Project advisory group**

  A small group of professionals with experience of working with young people from Black and minority ethnic groups, or with research experience in this area, was in regular contact with the research team throughout the duration of the study.

- **Work with The Mellow Campaign (TMC)**

  Ensuring that the project outputs were attractive to young people, and were disseminated through avenues likely to reach young people from Black and minority ethnic groups and their families, became a priority as the study progressed. For this reason, in the summer 2004, YoungMinds approached The Mellow Campaign (TMC), a project that is sponsored by the East London & City Mental Health Trust, to seek their involvement in producing some of the *Minority Voices* materials.

  The Mellow Campaign works to develop alternative responses to working with and supporting young African and Caribbean men with mental health problems, including organising community events that have employed performing and visual artists to promote mental well-being and challenge stigma. As a result of the YoungMinds and Mellow collaboration five new information leaflets for young people were produced. A feedback and launch event for young people was also organised in London featuring performances and displays from young people themselves.
5. STUDY FINDINGS I: MAPPING OF ACTIVITY AT TIER 1

Overview
Postal questionnaires were mailed to approximately 120 Looked After Children (LAC) Teams, 120 Youth Offending Teams (YOTs), 120 Connexions Teams and 120 Primary Care Trusts, drawn from across England and Wales. These questionnaires asked for information about any local strategies for improving access to mental health services for all young people and also whether there were any specific activities to improve access for young people from Black and minority ethnic groups. The questionnaire also asked for information about any projects (statutory, voluntary or independent) in a respondent’s area that were working with Black and minority ethnic groups that should be included in the mapping of provision.

In total, the following completed questionnaires were received:

• 32 from LAC teams
• 37 from YOTs
• 21 from Connexions
• 22 from PCTs

These came from a fairly even spread of areas on the North, South, East and West of England including a range of London Boroughs. In terms of areas of the country where very little information was gathered, very few completed questionnaires were received from:

• Authority areas in Wales
• Authority areas in the East of England
• Authority areas to the West of Bristol (i.e. Somerset, Devon and Cornwall)

The limited information from a number of the completed questionnaires was often because the service was located in an area with very small numbers of young people from Black and minority ethnic groups and received only very low numbers of referrals.

Information from the postal questionnaires
The overall impression from the data gathered is that across the country there are considerable variations in levels of service activity focused on young people from Black and minority ethnic groups. Some respondents indicated that they were not aware of any specific initiatives to promote access or particular projects for such young people, whilst others sent in detailed information of a range of services working in their locality. In a number of the returned questionnaires respondents also noted that general pressures of work and high referral rates meant that their service had not been able to develop specific strategies to promote access for those groups of young people who were known to be under-represented amongst those referred. Others mentioned difficulties in obtaining funding to develop such work:

"the service has put together a number of joint proposals to various funding streams with voluntary sector organisations working with young people in an attempt to improve services and access to ethnic minority groups in the borough - to date unsuccessfully..." (PCT respondent)

In terms of the concerns raised, long wait times and general problems accessing CAMHS were frequently mentioned. Many respondents also added that these difficulties applied to all young people, not just those from Black and minority ethnic groups.

Particular concerns about unmet needs were noted with regard to the following:

• Support for young people needing help with grief, trauma, loss and bereavement.
• Support for young people with mental health problems and drug and alcohol problems.
• Support for young people with dual diagnosis.
• Provision for young people in the 16-18 year age group.
• How to engage with socially isolated young people.

**Identified unmet needs specific to young people from Black and minority ethnic groups**

A number of the YOT respondents acknowledged the lack of support for young people needing help with grief, past traumatic experiences and bereavement, and noted that these issues may be especially marked for young refugees and asylum seekers. A lack of understanding with regard to entitlement to services also made these young people particularly wary of asking for help until often a crisis point was reached.

Other problems affecting access to mental health support were as follows:

• Language barriers and social isolation, particularly for young refugees and asylum seekers.
• A lack of interpreter services and translated materials for those who had got as far as making contact with services.
• For young Asian people, there were some suggestions that their fears of being ‘labelled’ are very marked since seeking help is viewed as ‘going outside of the family’.
• The lack of younger staff from Black and minority ethnic groups in CAMHS was thought to deter some young people from minority ethnic groups from feeling that they could talk about their difficulties.
• Problems in service co-ordination - notably between education services and mental health services. This was recognised as underlying some young people’s sense of being ‘passed around’ when they had tried to get help.

The need for information for parents and support for young people from Black and minority ethnic groups in dealing with inter-generational issues and pressures from parents was also noted by a number of respondents. The complexity of these issues is highlighted by the following quote:

"We have had requests for support from young people who are trying to contend with cultural expectations of different generations and who are very stressed by the experience. They ask for help in negotiating with parents but then are often too scared to let this happen in case it makes things worse..." (Connexions respondent)

**Identified strategies for promoting access for young people from Black and minority ethnic groups**

Services reported a number of strategies aimed at promoting their work. These included more home visiting, outreach work and liaison work with community groups and parents to improve understanding of the principles of treatment and assessment by mental health services. Various health promotion strategies to raise awareness more generally in the local community were also reported.

Ethnic monitoring was reported to be in place in just under half of the services who responded, with others indicating that targets were being put in place to develop better information systems, including ethnic monitoring.

A number indicated that, where possible, the service employed staff from different minority ethnic groups and tried to ensure that the staff group reflected the local community. Several also highlighted that this was often very difficult to achieve:

"Statutory services, including Connexions, have difficulties recruiting professionals from BME communities: this reflects negatively on young people’s perceptions and aspirations...” (Leaving Care Team respondent)
In a number of areas attempts to improve the availability of interpreters and to develop advocacy support and staff training on cultural awareness were reported.

**Mapping of services for young people from Black and minority ethnic groups**

During the course of the service mapping, and subsequently during the fieldwork in the sample areas, information about nearly 300 different services working in the mental health field was received - although subsequent checking revealed that many of these were for adults (and thus, although encompassing the 18-25 age group included in the Minority Voices sample age range, were often not particularly 'young people focused’) or were not, in any way, targeted on people from Black and minority ethnic communities.

The research team also found that a number of services, most notably those that were focused on young people from Black and minority ethnic groups, had recently closed or were under threat of doing so, due to funding insecurities.

This loss of provision is particularly worrying given the serious problems with funding highlighted in recent research into the funding of the Black Voluntary and Community Sector more generally, despite government recognition of the “distinctive skills, expertise and experience that the BME voluntary and community sector holds.”

More detailed information about services that seemed to be targeted at young people from Black and minority ethnic communities, or that seemed in some way innovative or well integrated with other services (statutory and voluntary) or well used by young people, was then sought by means of telephone interviews. Comparison of this material, alongside the information gathered from young people and staff during the fieldwork, allowed the research team to identify a number of different dimensions of service delivery that appear to constitute ‘good practice’ in working with this client group.

The provision identified, and that is currently operational, spans a wide range of different approaches across the tiers of CAMHS provision, including:

- Mental health projects based on a community development approach, sometimes working with a defined Black and minority ethnic community or group and encompassing a range of treatment and support approaches, as well as raising awareness and understanding of mental health.

- General support projects for young people run by voluntary sector organisations, often with a focus on housing (including direct provision), education or the provision of social activities but where specific aspects of the provision have subsequently been developed in response to client needs, to provide mental health support for identified groups of young people.

- School-based provision, including lunch time drop-ins, residential trips, one-to-one and group-based counselling.

- Targeted provision or specialist teams within existing CAMHS/NHS services offering staff that represent the different ethnic groups in that area, or workers with expertise in working with Black and minority ethnic groups - and offering support for young people experiencing difficulties as a result of racism and ethnic identity issues, alongside other problems that can face all young people such as anxiety and family relationship difficulties.

- Telephone helplines and web-based advice and information, some aimed at specific ethnic groups and others about specific mental health problems such as depression, eating disorders and self-harm.

- Volunteering, peer counselling, befriending and mentoring projects.

- Support for young offenders from Black and minority ethnic groups and those excluded from school.
• Family therapy and family support based projects including generic help with benefits and legal rights.

• Projects focused on young refugees and asylum seekers, sometimes with funding from national government initiatives that aim to promote social cohesion and tackle discrimination.

• Campaigns that aim to demystify mental health service provision and challenge stigma through the targeted use of the media and the use of ‘non-traditional’ routes for sharing information such as local sports and community radio stations, music events, cinema tickets and advertisements in bus shelters.

Information supplied by some of the projects/services also indicated that a number of organisations were trying to build local networks to improve the knowledge and information base; some were acting as the link between the statutory and voluntary sectors in trying to improve the coordination of services for young people from Black and minority ethnic groups, and several noted that part of their work involved the development of a local database of mental health/other relevant services in their area.
6. STUDY FINDINGS II: YOUNG PEOPLE’S EXPERIENCES AND VIEWS

**Key Findings**

- Amongst the young people who took part in the study there was generally very limited understanding of mental health and of mental health services
- Even when young people (and their families) recognised that they needed help many did not know where to go - or were wary of seeking help due to worries about stigma and confidentiality
- Many young people are only accessing help at a critical point in their difficulties. Often this access only occurs if the young person has come into contact with and formed a trusting relationship with a professional with knowledge of local mental health services
- For young people from Black and minority ethnic groups the influence of parents and parents’ perceptions of services, and the wider influence of Black and minority ethnic communities, is often underestimated or not fully understood
- The importance of considering diverse religious and cultural needs was highlighted and crucially, of professionals not making assumptions about young people on the basis of these factors
- The social isolation and lack of a general understanding of the working of UK health and welfare systems is marked amongst young refugees and asylum seekers and creates a significant barrier to them accessing specialist mental health services

As noted in Chapter 4, young people were invited to participate in the Minority Voices study either by taking part in an individual interview and/or a focus group held in each of the sample areas.¹

In total 76 young people (43 male, 33 female) shared their experiences and views about mental health services with the research team. They came from a wide range of minority ethnic backgrounds of which the largest groups were young people who described themselves as Black African (25 young people) and White and Black Caribbean (12 young people). These categories are based on the 2001 census categories. The young people were also drawn from various religious backgrounds with a number specifying that they had no religion. Most were in the age range 16-18 years and 24 were young refugees or seeking asylum in the UK.

**Issues raised by young people**

Whilst the data gathered indicated some geographic variations and also some differences amongst young refugees and asylum seekers that were related to their migration status, across the different sample areas, and in both the individual interviews and the focus groups, there was considerable consistency in some of the prominent issues and concerns raised by young people. For this reason, the following material does not attempt to break down the information by either focus group or interview but rather, presents a discussion of the key themes emerging from the data overall. Any differences between those who had experience of using CAMHS/statutory mental health services and those without are noted under the particular issues discussed.

A general point to note is that many of the concerns and views expressed about mental health provision have much in common with the information often obtained from all young people, irrespective of their ethnic background.² However where there were indications of variations in the extent of the difficulties encountered or factors that are perhaps specific to young people from minority ethnic groups, these are also highlighted in the discussion of each of the issues raised.

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¹ Two additional focus group meetings were held in non-sample areas - the first in response to a request by a group of young refugees to share their experiences with the research team and the second, a meeting with young people supported by social services after leaving care.

² For example, a significant proportion of the young people in this study found the issue of confidentiality to be important, but this concern was raised by more of the young people from Black and minority ethnic groups than from White young people.
As noted at the start of this report one of the central objectives of the *Minority Voices* study was to explore the barriers to effective access to appropriate mental health provision and, the ‘flip-side’ of this, what facilitates access and engagement with services. The aim of the following discussion therefore, drawing upon young people’s perceptions and experiences, is to highlight the issues, concerns and current gaps in provision that providers of mental health services need to consider which, if unaddressed, may constitute a barrier.

Young people’s views on what sort of support has worked well and their suggestions for improving mental health services, including specialist CAMHS, underpin the analysis of what may improve access to and engagement with services - an important dimension of ‘good practice’ in considering service development in this field. On this point it was positive to find that some young people had found themselves in specialist services that had ‘finally understood’ them and felt that they had been helped through the interventions and support offered.

*Table 1: Ethnic background of study participants*

<table>
<thead>
<tr>
<th>Ethnic Category</th>
<th>Numbers of young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>White - British</td>
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</tr>
<tr>
<td>White - Irish</td>
<td>1</td>
</tr>
<tr>
<td>White - Other</td>
<td>1</td>
</tr>
<tr>
<td>Mixed - White &amp; Black Caribbean</td>
<td>12</td>
</tr>
<tr>
<td>Mixed - White &amp; Asian</td>
<td>4</td>
</tr>
<tr>
<td>Mixed - Other</td>
<td>1</td>
</tr>
<tr>
<td>Asian/Asian British - Indian</td>
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</tr>
<tr>
<td>Asian/Asian British - Pakistani</td>
<td>6</td>
</tr>
<tr>
<td>Asian/Asian British - Bangladeshi</td>
<td>4</td>
</tr>
<tr>
<td>Other Asian/Asian British</td>
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</tr>
<tr>
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<tr>
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<tr>
<td>Not given</td>
<td>8</td>
</tr>
</tbody>
</table>

**A wide range of worries and concerns**

At the most general level the information gathered through the study highlighted the diversity of needs presented by many young people and thus the challenge facing many services in addressing these - or being able to ‘signpost’ young people to appropriate sources of help. It appears that many young people may initially approach services seeking help with practical problems such as housing and, having established a relationship with staff, may then begin to talk about issues connected to their mental well-being. At this point staff understanding of mental health and their knowledge of local provision becomes critical since they can play a key role in facilitating access to specialist provision. A lack of knowledge at this ‘frontline’ level clearly constitutes a potential barrier to young people accessing appropriate help.

The interviews and focus groups touched on the following: education and employment; physical health; discrimination and racism; family relationships; inclusion in local community; money and finances. For young refugees and those seeking asylum, past traumatic experiences, worries about their legal status and how long they might stay in the UK were prominent. These young people also talked of difficulties accessing help and support from services to deal with the past traumatic experiences, losses and grief many had experienced - a finding which echoes the concern noted by a number of the professionals who returned mapping questionnaires.
Awareness of mental health and mental health service provision/CAMHS

"You can’t talk about your worries and ask someone for help unless you know them. If I had friends, I might talk to them but I don’t so I keep it to myself...” (Young refugee)

This was a recurrent theme in the interviews and focus groups. Fears of stigma and general reluctance to talk about their worries, unless it was with someone they knew and trusted, were widely held views. Mental health was also seen as madness or very serious illness, and as such, not applicable to them. Others indicated that they would not talk about their difficulties for fear of being seen as silly or stupid - as one young person explained, talking to friends was impossible because:

"They might laugh...I would laugh at my friends.” (Young refugee)

A number of young people talked about considerable difficulties in finding out where to go once they (or their families) had realised that they had problems, with several saying that they had tried telephoning the emergency services (999). Some suggested that they thought that GPs only dealt with practical or physical problems or were for older people only. Others had similar beliefs about Connexions, thinking this dealt with issues such as education and housing only.

Apart from a lack of information about where to go and what to expect, quite a few of the young people we met had encountered problems in trying to get help. These included:

- Long wait times for appointments.
- Having to travel some distance to get to a service.
- No interpreter and being told they would have to return at a later date if they required this support.
- Sense of being ‘passed around’ with no explanation as to why they were being referred on.
- Having to re-tell their story to different professionals.
- Services only being available at times that were not convenient for them (clashes with college or school).

For those who had received help from mental health services/CAMHS the following were noted:

- A lack of information about what different CAMHS staff did, who they would see and what would happen.
- A lack of information about medication - especially what might happen when the dose is reduced or stopped.
- A lack of support post discharge from a service - suggesting a need for much better links and information about other services that young people can continue to get support from if they feel they still need this.

"I was in hospital after taking an overdose and the hospital said I had to stay until I saw a psychiatrist. I didn’t know what a psychiatrist was or what they would do, I thought they worked with mad people, not me.” (Young person with experience of using CAMHS)

Confidentiality

"It was daunting because I didn’t like to think anyone would see me going into the CAMHS, especially as it is very close to where I live. Didn’t want people to think I was mad or weird, it’s a stigma. Telling people in CAMHS about problems was difficult at first, they may have thought I was mad or told other people...” (Young person with experience of using CAMHS)

Many young people highlighted their concerns about the stigma of being in contact with mental health services and services did not appear to have communicated their confidentiality policies clearly. Young people were worried that friends and family would find out about their
difficulties and for those living in close knit communities, these concerns extended to members of the community in general:

"Didn’t tell anyone about problems because I thought they would think I was a freak. Stigma is more of an issue in the Asian community so I needed to keep it quiet, but then my parents noticed and said I needed to get help." (Young person with experience of using CAMHS)

■ A lack of local provision

Although having provision too close to home or a young person’s local area may be a problem for some, a more widespread concern - and a serious problem for young refugees lacking knowledge of their local area and transport system - is the lack of local services in some parts of the country. This, as well as not being able to self-refer and get help promptly, was raised in several of the focus groups as a real stumbling block to accessing provision. This finding is given further weight when the results of the study mapping are considered, namely that the distribution of services that are either targeted on Black and minority ethnic groups, or who have developed strategies for improving access, is very patchy across England and Wales.

There was much support for drop-in types of provision - and for much greater flexibility over opening times and the use of different venues, the latter being linked to worries about stigma and confidentiality and also a view noted by some of the respondents that hospital based provision is ‘daunting’.

■ The continuity of treatment and care

Young people frequently highlighted the importance of information sharing and being able to get to know staff and build up trusting relationships with them. They felt this would encourage them to talk about their difficulties and engage with the support that services were offering. Many felt it was distressing to have to re-tell their experiences when a member of staff changed or they were constantly referred on. For some young people, in particular young refugees and asylum seekers unfamiliar with how the UK health system works, these changes appeared especially confusing.

Some young people felt that these repeated changes made it very hard to build up any sort of relationship with professionals and often forced them to re-visit experiences they thought were behind them:

"Having to tell your story over and over is very hard, it sets you back.” (Young person with past experience of using CAMHS)

■ Choice

Many of the young people talked about how important it was to feel that they had some choice in their own care. Although they recognised the limitations in services, a major barrier is being offered no choice in who they see. Some of the important issues here include:

- The gender of the staff member (a few young people raised this).
- Cultural background of the staff member - some might want to see someone from their culture, whereas others want the opposite (for fear of someone in their community hearing about their problems or concerns about being misunderstood).

Of key importance to young people was having staff who were interested and aware of religious and cultural differences and needs and who did not make assumptions about their situation or needs:

"They should work with you in partnership so that they can learn about your needs” (Focus group member)

Though choice is important for all young people, it may affect those from Black and minority ethnic groups differently as, at the current time, it is not possible for many CAMH services to offer a choice of staff from different cultural backgrounds. The importance of this is illustrated by the following viewpoint:
“The therapist I was seeing was Asian and so was more aware of Asian community values. A White professional would not have had the same understanding about what the Asian community thinks about mental health.” (Young person with experience of using CAMHS)

**Age appropriate provision**

The provision of age appropriate services emerged as a major concern for the 16 plus age group and picks up on earlier research findings on what young people want from mental health services. A number of the young people had received some care through adult mental health services and had found their experience of being amongst people who were much older than them quite daunting.

For those young people from Black and minority ethnic groups who had experienced in-patient care on adult wards, some specific issues concerning contact with members of the opposite sex were noted, with one young person highlighting how “very uncomfortable” she had felt because of sharing a ward with an older Asian man and an older Somali man, especially since:

“The staff did not seem to be aware of Asian male attitudes towards young Asian females and about the issues of males and females having contact...” (Young Asian female with experience of adult in-patient services)

Another talked of the failure of in-patient CAMHS to adequately meet dietary requirements and day-to-day social interaction:

“My dietary requirements were not considered. I was the only Asian person there and staff didn’t seem to know what to expect of me. They (staff and other clients) talked about things that were unfamiliar to me, for example socialising and everyday things, so I couldn’t fully participate in interacting with them...” (Young person with experience of Tier 4/in-patient CAMHS)

**The role and influence of parents**

Whilst the role and views of parents are generally accepted to be an important influence for all young people, a number of the focus group participants and those interviewed on a one-to-one basis suggested that in some Black and minority ethnic communities the views and influence of parents on young people’s views and behaviour is perhaps more powerful. They also thought that how young people and parents talk to one another may differ from young White people and their parents.

Several noted that the stigma of mental health services amongst parents of certain ethnic backgrounds is particularly marked, also their understanding of mental health problems and mental health services may be different. This influences their views of their child being in contact with such services:

“Asian parents don’t understand eating disorders. So White professionals need to be aware of this and the fact that young Asians can’t always talk to parents in the same way that White young people might be able to.” (Young person with experience of using CAMHS)

The different dynamics and roles within families from some Black and minority ethnic groups also emerged as an important factor to be considered in terms of which CAMHS interventions may be appropriate and how to engage families in these. For example family therapy approaches may pose particular difficulties if only male relatives of the young person wish to speak for the family. Staff in CAMHS need to appreciate these differences. Various points were also made about some groups having different attitudes towards being asked questions and heightened worries of being seen as complaining if discussing difficulties. This tended to result in problems going unmentioned until they were at crisis point.

A theme that emerged in a number of the individual interviews was that young people who are worried about the views of their parents and who don’t know where to go for help anyway, will often try to ignore or hide their difficulties, feeling that in some way it is their fault and that no-one can do anything for them:

“I talk to myself; I’m the only one who can help myself...” (Focus group member/no CAMHS experience)
Confusion over cultural identity

For some young people, the data collected suggested that one of the reasons why they had not sought help with mental health problems was that they were confused as to whether some of their feelings reflected their culture and different views towards problems they had encountered:

"How much is my personality? How much is my culture?" (Focus group member/no CAMHS experience)

This issue was closely linked to a range of concerns expressed by young people about professionals making assumptions about them on the basis of their ethnic group, with a number of them highlighting that it was often apparently forgotten that they had been born in Britain. Another important consideration relates to responding to questions about ethnicity; young people may be very clear about the factors that inform their ethnic identity but are unclear about which aspects professionals see as relevant when asking the question. The complexity of this is highlighted by the following comment, made by a respondent who said this question was always confusing due to not knowing what the professional wanted to know:

"I am a British Asian Muslim from Mirpur in Pakistan and speak Punjabi." (Young person with experience of using CAMHS)

The key message from young people on this matter was the need to understand them as a person and to appreciate the diversity of their needs and situations. It is also important to make clear why the question about ethnicity is being asked and what information is actually required.

Staff understanding of religious and cultural needs

A prominent theme linked to the previous point was that all staff in mental health services must develop an understanding and take account of different needs:

"Staff should be aware of all cultures and needs. Otherwise they do things that are normal for their culture... which are not familiar to people like me..." (Young person with CAMHS experience)

However a number of young people also stated that they did not have any particular religious or cultural needs. This returns us to the important point that staff should not make assumptions but rather the important approach is one of:

"Talking to people as if they are people...thinking about their interests and skills and about how their illness affects their everyday lives..." (Young person with experience of adult in-patient mental health care)

Table 2: Summary of unmet needs/service deficits identified by young people from Black and minority ethnic groups

- Services unable to respond promptly and not local/easy to get to
- Lack of information about CAMHS - staff roles, treatment and medication, confidentiality
- Lack of information about other sources of help - where and what they offer; self-help advice
- Lack of help with past trauma, bereavement, grief and loss
- Poor continuity of care - sense of being ’passed around’
- Lack of age-appropriate resources
- Staff with only limited or no awareness and understanding of different ethnic, religious and cultural needs
- Interpreter support - not available or long wait times
- Post-discharge support often not available
- Information and support for parents unaddressed
Suggestions from young people for improving access and service provision

Information

Young people made a wide range of suggestions about information - the type of information they want, the routes through which this should be shared and the level/presentation of information.

Types of information

Young people wanted specific information on the following:

• What mental health is and how mental health problems may affect you.
• What CAMHS/mental health services do - who works in them, what treatment they offer and how to access them.
• Information on drug and alcohol problems.
• Information about how you can help yourself including strategies for managing anxiety and depression, exercise and relaxation techniques.
• Information about how past experiences can affect how you feel in the present and information about how stress can affect you.
• Information about how different services - for example, health and social services, work together and how and what information is shared between them.
• Information about services in your local area including voluntary sector projects and drop-in resources.

Routes for information sharing

Schools, colleges and local youth and sports clubs were seen as good places to disseminate information about mental health services to large numbers of young people through workshops or drop-in sessions. Sharing information through these routes was also seen to be non-stigmatising:

"It would be good if someone came in at Year 10 or 11 to explain various situations that young people can find themselves in and how and where to get help." (Interviewee with experience of CAMHS)

The importance of young people being involved in this sharing of information, and taking into account their points of view, was also highlighted:

"Young people’s points of view are important and they can communicate with other young people and that can make more of a difference than older people talking to you..." (Interviewee with experience of CAMHS)

Various non-traditional routes for sharing information were also suggested by the young respondents, including the media (radio and television); through churches and local faith groups; other venues used by young people for socialising and via email, internet and text messaging. The use of video for education about mental health was also recommended.

How to present information

The following points were noted:

• Information should be shared both verbally and through distribution of written materials.
• Information leaflets/booklets should be short and in simple, jargon-free language. Pictures or illustrations are important in making the material look interesting.
• Videos and CD-ROMs were also suggested as useful ways of sharing information.
• Information should be in different languages, especially for parents.
• Professionals need to know what is in the information and to be able to answer any questions.
• Information should be portable, eg. small enough to fit into a wallet.

With specific reference to CAMHS it was suggested that once a young person has been referred, a phone call from someone in the team to explain the service and who they will see would be very useful in alleviating some of the anxiety felt by young people at this stage.

■ Style of specialist mental health service delivery

Many suggestions were noted about how and where support and treatment from specialist mental health services are delivered, with a prominent theme being that services need to be more flexible and welcoming to young people.

It was suggested that access to CAMHS would be improved by staff working in different venues, including in young people’s own homes, and being open at different times, notably in the early evening and at weekends. The use of school and college facilities was again raised, with a general viewpoint that such venues are usually easy for young people to get to. However it was also acknowledged that for some young people with worries about confidentiality and about what their friends might think, these might be too ‘visible’ and that venues are also needed that provide a degree of anonymity (and which may therefore need to be a little further away).

Apart from venues and opening times, young people also suggested that services needed to be more flexible about the frequency and length of appointments, including the provision of appointments or drop-in times for crises or urgent situations. Having to wait for an appointment was the source of much concern and seen as a major barrier to accessing help.

Other recommendations included:

• CAMHS should ensure that interpreters and translated materials are available if needed.
• Staff should offer support to young people if they have to be referred on to another service (with some suggestions of staff undertaking a sort of befriending role in assisting the young person through the handover to the new service). Peer support and involvement was also thought to be helpful.
• The provision of information on self-help strategies and techniques for managing difficulties if they occur between appointments.

■ Staffing in CAMHS

A variety of comments were noted from the young people who participated in the study about the importance of staff groups in CAMHS being representative of the local community they are serving. Again the availability of interpreters and staff with understanding of different religious and cultural needs was highlighted.

Table 3: Features of services that young people identified as helpful

| • Age appropriate information, available in a range of different forms and through young person friendly outlets | • Different venues, flexible opening times and appointment schedules, available to help/offer advice between appointments |
| • Diverse staff groups, able to communicate in different languages and who show appreciation of different religious and cultural needs and norms | • Availability of interpreters - and staff experienced in working with them |
| • Staff empathetic to young people’s individual circumstances, worries about stigma, confidentiality, peer and family pressures | • Befriending approaches - and where referral on to another service required, staff support through this process |
| • Young people feeling involved |  |
7. STUDY FINDINGS III: INFORMATION AND VIEWS FROM STAFF WORKING WITH YOUNG PEOPLE FROM BLACK AND MINORITY ETHNIC GROUPS

Key Findings

- The importance of targeted promotion of services was highlighted in terms of improving access to and use of services by young people from Black and minority ethnic groups.

- There is acknowledgement by many CAMHS that young people from Black and minority ethnic groups are under-represented. The high demands facing CAMHS, and the lack of multi-cultural staff mean that this issue is often left unaddressed. The crucial role played by the voluntary sector in supporting these young people is also recognised.

- It is widely appreciated that many young people from Black and minority ethnic groups only access support at a point of crisis and that different ways of working are needed to promote the identification of difficulties and the offering of help at an earlier stage. For many services operating at full capacity, this issue is difficult to address.

- There are particular difficulties meeting the needs of young refugees and asylum seekers including difficulties dealing with their legal status, many and significant past traumatic experiences and their general lack of understanding of how UK health and welfare services work.

- Inter-agency working is thought to be improving in many areas but is being impeded by competition for resources, a lack of information about existing services and different agendas between agencies.

- The value of having staff in CAMHS from different Black and minority ethnic groups is widely recognised but shortages of such staff, and difficulties with recruitment, are widespread. Recruitment has also been affected by funding shortages.

- Many staff want more training in race equality and cultural competence. Greater professional understanding of family concepts and structures within Black and minority ethnic communities is needed if CAMHS are to work effectively with these clients. It is also important that this training is ‘mainstreamed’ and is not left to individual initiatives or restricted to certain groups of staff.

- A lack of interpreters and the availability of counselling in languages other than English affects many services.

- The collection - and crucially the use - of ethnic monitoring data lacks consistency, with little evidence of its systematic use in informing the development of mental health services for children and young people.

Information was gathered from 41 members of staff working in services located in the four sample areas. Additional information was also collected from three staff in non-sample areas, who assisted with the organisation and running of the additional two focus groups.

The professional backgrounds/agencies of those interviewed included:

- CAMHS staff, including four consultant psychiatrists, one family therapist, three clinical psychologists, one community link worker, two occupational therapists, one specialist worker for substance misuse, one Director of CAMHS and two community psychiatric nurses.

- Primary Care Trust staff - two commissioners for children’s services.

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* Ten staff returned their information via a postal questionnaire rather than a face to face interview.
• Education staff, including the co-ordinator of a Behaviour Improvement Programme (BIP) and a headteacher of a specialist education centre working with children in transit including young refugees and asylum seekers and young people excluded from school.

• Social services staff - three team managers.

• Voluntary sector staff - from a wide range of different agencies and projects working with young people including drop-in counselling services; a youth advice service; several housing associations or projects offering supported accommodation; a specialist mental health association for Chinese people, a voluntary sector project for young Somali boys and a drop-in project for young unaccompanied refugees.

The importance of targeted promotion of services

"The thrust of the service is to gate-keep referrals so it is inappropriate to promote a service if clients then find they have to go on a waiting list." (CAMHS respondent)

Amongst the staff interviewed for the Minority Voices study there was widespread recognition of the importance of the targeted promotion of services if intended clients are to be aware of them - an important dimension to facilitating service uptake. However, whilst some services were targeting Black and minority ethnic communities using outreach work, work in schools, networking with local services, community groups and voluntary sector networks, 'word of mouth', leaflets, the radio and internet to do this, many mentioned that they were not targeting for the following reasons:

• CAMH service already running at full capacity and with a waiting list, thus new referrals were not being encouraged and new work was being limited to try and manage existing demand.

• Lack of finances for such activities.

• Targeted promotion not seen as appropriate since the service did not take self-referrals.

• Funding of service unstable and not sure how long the service would be available.

• Specifically with regard to Black and minority ethnic communities, not being able to offer support in languages other than English made targeting problematic.

"The service cannot offer counselling in languages other than English so it’s not appropriate to promote the service to minority ethnic groups and then exclude those who don’t speak English." (CAMHS respondent)

"Further promotion of the service is not feasible because it is currently working to full capacity. The capacity for one project (aimed at young people) is 40 clients and currently there are 120 on the list." (Voluntary sector respondent)

Where targeting of specific Black and minority ethnic groups was reported, a number of staff mentioned initiatives such as Community Link Workers working alongside Tier 1 to explain and provide information about specialist CAMHS. However this targeting largely takes place after a referral has been received. Even where targeting was taking place, some respondents noted concerns about access by people from Black and minority ethnic groups who are smaller in number, illustrated by the following:

"There is a tendency to focus on the majority ethnic group (Pakistani). It is unclear if White minority ethnic groups are adequately represented. The Bangladeshi community does not access the service very much, more needs to be done with this and other minority ethnic groups who appear not to be accessing this service." (CAMHS respondent)

The lack of targeted promotion of CAMH services may be an important contributory factor to two other areas of concern reported by staff interviewees:
• High DNA (Did Not Attend) rates for initial assessments were reported for some groups of young people from Black and ethnic minority communities and these are thought to be partly due to young people and/or parents not understanding what CAMH services are and what they offer, as well as concerns about the stigma attached to mental health.

• The tendency for young people from Black and minority ethnic communities to only reach CAMHS when they have reached crisis point may also reflect this lack of understanding or distrust of what these services offer.

**Inter-agency working**

There was a general consensus about the need for different agencies to work in partnership and to forge effective working links if they are to provide services that can meet the diverse needs presented by young people and which avoid the problems of young people either being ‘passed around’ or being lost in the gaps between different sectors. Positively, a number of respondents indicated improvements in this area. For example, several commented that, whereas before often it was down to one or two individuals to take the initiative, now many more people accept responsibility for this.

Some key factors, however, were noted by respondents to be impeding inter-agency working:

• The overload on statutory services, leading to difficulties in other agencies making referrals and the gate-keeping approach by CAMHS mentioned previously.

• Waiting lists.

• Some CAMHS only taking referrals from health professionals (typically the GP) and whilst CAMHS can refer directly to voluntary sector agencies, they will not accept direct referrals from them.

• A lack of information at the local level about what services there are - with a number of references to the continually changing pattern of services and the closure of voluntary sector provision.

• Different approaches to working, and differing levels of understanding and ability to relate to approaches that are different from traditional (Western) mental health interventions, with the following illustrating concerns specific to Black and minority ethnic groups.

"More multi-agency working to address the needs of minority ethnic groups needs to be developed. This needs to ensure that there is consistency across agencies so that interventions provided by different agencies are not contradictory, replicated or otherwise inconsistent.”

(CAMHS respondent)

**The contribution of voluntary sector services**

The valuable contribution of projects in this sector in supporting young people from Black and minority ethnic communities was a prominent theme in many of the interviews with staff. A number highlighted the discrepancy evident in some parts of the country in terms of the numbers of young people being worked with in specialist CAMHS versus the greater numbers often being supported by much smaller voluntary sector projects. Some of the suggested reasons for this imbalance included:

• The overwhelming preponderance of White British staff in CAMHS.

• The less ‘open’ style of working in CAMHS, especially the requirement for referral in via a GP.

• The more informal venues used by many voluntary sector projects and their support across different areas or social activities - resulting in them being less obviously mental health focused (and thus not such a problem for young people worried about stigma or their family or community becoming aware of their difficulties).
The way that some voluntary sector projects ‘networked’ at the community level, sharing information about what they offered through avenues used by young people such as local clubs, was also thought to be important in giving young people the confidence to use them.

**Staff skills, training and confidence to deliver services to young people from Black and minority ethnic groups**

There were mixed views with regard to whether staff had sufficient knowledge and skills to address the mental health needs of young people from Black and minority ethnic groups. Some services, where they had managed to attract staff from different ethnic backgrounds and where they were able to offer support in a range of different languages, felt reasonably confident but highlighted that:

"Individual teams are at different stages in their capacity to meet the needs of minority ethnic groups.” (CAMHS respondent)

This imbalance could make referring young people on to other services or teams problematic.

Where staff did not feel that they had adequate skills, limitations in existing training were noted, in particular that professional mental health training remains very Eurocentric and does not sufficiently address cross-cultural contexts. What little that is offered was described as ‘very basic’ and was not offered on a regular basis. Other staff said they had received no training specific to the needs of Black and minority ethnic groups and one reason for this was a lack of relevant organisations with the appropriate knowledge that could provide training. It was also pointed out that attending conferences and workshops is:

"not the same as being immersed in a culture. The more distant the client’s culture from the clinician’s the more difficult it becomes to understand the client’s needs and provide effective interventions. This is why it is so important to have minority ethnic group staff...” (CAMHS respondent)

A common theme in the responses to questions exploring what training staff had received was that they had learnt ‘on the job’ or were ‘doing their best’ in an area that is not given priority or sufficient time. A number described acquiring their knowledge through their own initiative, by talking to colleagues or staff in other services:

"Most learning comes from this informal route, by discussing with other colleagues in the same situation and sharing ideas and concerns...” (CAMHS respondent)

Another important point raised by a number of respondents was that it is difficult to benchmark what is ‘sufficient’ in terms of skills and training. There is also a danger in staff assuming they have become ‘experts’ in an area where there needs to be ongoing learning in developing relevant knowledge and skills, including in understanding the subtleties of cross-cultural communication and inter-generational variations in views towards mental health. It was also emphasised that staff attitudes and approach to working with young people from Black and minority ethnic groups are at least as important as acquiring relevant knowledge and skills and that there is a difficult balance between acquiring the latter while refraining from creating or applying stereotypes.

**Training needs of staff in voluntary sector projects**

Alongside the many comments about deficits in CAMH staff skills and training in understanding cultural and religious diversity, another important area of concern emerged in the data gathered. This related to the knowledge and understanding of mental health amongst staff working in voluntary sector projects with young people. A number of respondents from this sector highlighted that they needed more training so that they would be able to identify mental health difficulties in the young people they were working with, and thus would be able to support them appropriately, including where necessary, referring them on to specialist CAMHS.

**Staff support in working with young people from Black and minority ethnic groups**

Again, there were mixed views about this issue that highlighted the different levels of capacity for working with this client group amongst CAMHS across the country. Some staff stated that
they felt sufficiently supported and that they enjoyed good access to interpreters, bilingual linkworkers, open discussion and support from their team colleagues, regular supervision from management and that the service they worked in regularly reviewed its provision to ensure that it was relevant to its local client base. Others quite clearly lack all of these things and support came about only through their own efforts.

■ ‘Structural’ problems impeding effective support to young people from Black and minority ethnic communities

A variety of problems were identified by staff respondents, of which probably the one causing the greatest concern was the lack of staff from Black and minority ethnic backgrounds within CAMHS and serious difficulties with recruitment. Not only is the inability to provide a diverse staff group recognised to be a problem, in terms of helping CAMHS to better reflect the communities they are serving and to enhance understanding of cultural diversity, this deficit can mean that services struggle to provide support in different minority languages. This, in turn, fuels the worry that to promote or target the service is inappropriate.

Other problems identified by staff included:

- **A lack of interpreters** including a lack of funds for such support, but also, the need for both training for interpreters in mental health (strictly ‘technical’ interpreting seen as unhelpful in understanding the subtleties of mental health problems and adequately communicating them to the clinician) and training of mental health staff in working with interpreters. Several respondents had experienced interpreting services at what they described as an ‘unsatisfactory’ standard, and some also noted the lack of continuity that results when different interpreters are used for sessions with the same family.

- **A lack of space in CAMHS venues** which can make it difficult to accommodate members of the extended family at appointments, also the lack of different venues and flexibility in hours of operation, in order to provide a range that better matches the different needs of young people (for example, that addresses worries about visibility of services located too near to a young person’s community or allows attendance at times that do not interfere with education).

- **Restricted referral pathways, notably the need to be referred to CAMHS via their GP or another health professional,** was recognised as a significant barrier for some young people. Some staff indicated that they thought there was a big gap between asking for help from a GP and then coming to CAMHS and that this exacerbates the tendency for young people to use the voluntary sector as a first port of call - who in turn may end up ‘holding’ cases due to an inability to refer on or a lack of knowledge of local services.

- **The limited availability of translated materials** especially in the languages of smaller minority groups and service ansaphones being only in English. Even where services could offer a good range of translated information, some had encountered problems reaching family members who are illiterate.

- **A lack of involvement of young people in the planning of services** was widely reported, including only very limited gathering of feedback data. Where young people had been involved or consulted, several respondents indicated that there had been no consideration of issues specific to Black and minority ethnic groups.
Specific areas of unmet need identified by staff

In addition to the concerns described previously about many services not engaging with young people from Black and minority ethnic groups, and being aware of many only approaching them when their difficulties had reached crisis point, some staff raised some concerns about specific groups of young people.

■ Young refugees and asylum seekers
A number of staff were clearly concerned about the ability of their service to address the needs presented by young refugees and asylum seekers. They suggested that a major difficulty is that often mental health concerns are ‘sidestepped’ until other more practical matters such as their housing and benefits are sorted out. This may have serious consequences in terms of a young person’s mental well-being. Some respondents noted that many staff feel overwhelmed by the multitude of problems presented by these young people, their experiences of extreme trauma, grief and loss and that staff needs, for support for themselves in dealing with these issues, are often unaddressed.

■ Young people from Asian communities
Several respondents singled out young Asian women as one group whose needs may be poorly addressed due to marked difficulties in engaging with them. School staff highlighted concerns about the support needs of young Asian women that they cannot meet and that culturally specific services are needed to address the following issues:

- Pressures at home, including many caring responsibilities, being forced to get married and to achieve highly in school - a form of ‘dual existence’ between home and school that can result in alienation and feelings of extreme isolation at home and at school.
- Experience of racism at school.
- Young women escaping to dangerous environments or becoming involved in prostitution and sexual exploitation.
- Rising numbers using heroin or other substances.
- Young women being coerced into having sex with boys.
- Becoming pregnant as teenagers.
- Young women neglecting their physical and sexual health and often developing problems with eating disorders and low self-esteem.

Staff also noted practical difficulties in sharing information with these young women - for example, mail sent to the home may be opened by the senior male in the household. In addition, GPs are not viewed as good sources of support since they often know the family and may even be related.

■ Young men as heads of households
The relatively higher rate of physical problems such as coronary heart disease and diabetes amongst some Black and minority ethnic groups is resulting in the early death of a significant number of fathers. The knock-on effect of this is the expectation that the eldest son will become the head of the household. Some services have reported young men presenting for counselling due to anxieties about taking on this role. It is quite likely that many more are struggling on unsupported due to their lack of understanding of CAMHS and other services - and of many professionals working with young people not being aware of the need to address this issue.
Table 4: Areas of unmet need/deficits in provision identified by staff

- Support at an early stage rather than when young people have reached crisis point
- Provision for minority ethnic groups that are smaller in number (where service may be addressing needs of the majority ethnic group)
- Counselling in languages other than English
- Interpreter support - patchy availability, limited understanding of mental health and problems with continuity
- Services able to engage with and address many varying needs (young Asian women, young refugees and asylum seekers, inter-generational issues)

Arising from:

- Limited numbers of staff from Black and minority ethnic groups and difficulties in recruitment
- A lack of training, pitched at the right level, available to all staff on a regular ongoing basis
- Variations in management support to staff and prioritisation of work in this area (including allocation of resources)
- Ethos of ‘gate-keeping’ and inflexibility of provision, reflecting the general overload in many CAMHS

Suggestions for improving access to and the delivery of services for the mental health of young people from Black and minority ethnic groups

■ Style of service delivery

Staff made a variety of suggestions including:

- A greater range of settings should be available, including drop-in or walk-in resources, since these have been identified to be used by young Asian women for whom using their local GP may be difficult. More provision, including counsellors, should be based in schools since for many this is a ‘safe’ place to access support.

- Hours of operation should be more flexible, including some provision in the evenings and at weekends. Support should also be available via the telephone. Being aware of different religious days and festivals and avoiding appointments at these times was also suggested.

- When young people need to be referred on, support from the referring professional should be available if required (for example, accompanying them to the first appointment).

- More services should offer to visit young people at home or in other settings they feel comfortable in such as schools or local clubs/voluntary sector projects.

- Clients from Black and minority ethnic groups should have a choice about the ethnicity of the professional they wish to be seen by. Gender issues should also be considered. There should not be an assumption that clients from Black and minority ethnic groups want to be seen by a professional who is also from a minority ethnic group.

- Looking for ways to involve young people in service delivery and collecting feedback information from them on a regular, systematic basis and acting upon this.
• Exploring avenues for empowering parents and communities to understand mental health.

Staff suggested that inter-agency working could be improved by:

• More robust multi-agency work at Tier 1 since this tier influences access to appropriate services.
• Development of formal arrangements for joint working, including more joint training and the scheduling of regular case discussions for staff from the different agencies involved.
• Developing relationships and information sharing between statutory and voluntary sector agencies, including the involvement of both in wider policy, planning and commissioning of services.
• Ensuring referral criteria/pathways are clear - with non-health professionals and voluntary sector agencies able to make direct referrals to CAMHS.
• All agencies being culturally competent - otherwise referral on from one agency to another can be difficult (or may not happen due to staff perceptions that the service is not appropriate for young people from Black and minority ethnic communities).

Information sharing, monitoring and service promotion and targeting

Staff suggested the use of a wider range of places for disseminating information materials, both in English and other languages, and by both written and verbal means. Routes for this included:

• Outreach work in a variety of settings including the town centre and using voluntary sector networks.
• Work in schools including drop-in sessions and peer support training.
• ‘Non-traditional’ routes such as the internet, email, local radio stations, venues used by local community and faith groups and posters/leaflets in local music and sports venues.

"Literature needs to be accessible as well as available. For example, where one or both parents don’t read English or are not literate, then available literature will not be of any use.” (CAMHS respondent)

In terms of promoting services more effectively staff suggested the following would be helpful:

• More awareness raising of mental health issues (as a precursor to promoting actual services).
• Promotion through frontline professionals.
• The use of audio visual materials for those unable to read.
• Changing referral structures to allow self-referrals and increasing service capacity so that new referrals can be seen more quickly.
• Information for parents, wider family and at the community level.
• The holding of ‘open days’, possibly linked into local community initiatives.

“There is a need to look at ways of promoting the service to older people such as parents and grandparents. Young people sometimes don’t want parents to know that they are accessing support from the service and it is not always possible to accommodate this. So it is important to work with parents in order to support access by young people.” (CAMHS respondent)

The limitations in current monitoring data suggest that much that is collected is often not used in a meaningful way that is useful to practitioners. Staff therefore suggested the following:
• The breakdown of whether some Black and minority ethnic groups are over or under represented for conditions such as ADHD.

• The collection of data based on more specific categories rather than the ‘catch all’ census groupings.

• To gather data broken down by ethnicity, take up of CAMHS, type of intervention offered and attendance rates.

• To design more young person friendly forms for the gathering of feedback data.

• A more consistent approach to data gathering across agencies, to support inter-agency and partnership working.

• Greater attention to process, rather than the current focus on inputs and outcomes (which reflects what funders generally want).

A key theme here was that it is not the collection of data that is the problem but understanding it and then using it to develop and refine service provision.

■ Interpreting support

The main suggestions here were for interpreting support to be more widely available, for interpreters to receive training about mental health and also, wherever possible, for services to work with the same interpreters to facilitate continuity of approach to the family/young person.

It was also suggested that options for undertaking simultaneous translations and interpreting should be explored on the basis that often the current approach is not conducive to therapy because there are frequent delays between the client speaking, the interpreter translating, the therapist responding and this being translated back to the client.

■ Staff recruitment, training and support

Whilst acknowledging the difficulties of recruiting greater numbers of staff from Black and minority ethnic groups, a prominent theme in the interviews with staff is that this issue needs to be prioritised if any improvement is to be made.

Staff also emphasised that improvements to existing training and the provision of regular, experienced management support would help to improve staff confidence in this area, not least by removing the sense many staff have of it being ‘up to them’ to find the help and advice they need.

Identified training needs included:

• Cross-cultural communication of distress.

• Engagement skills.

• Challenging personal views, impressions and attitudes.

• Information about how therapeutic models, theories and approaches can be adapted to meet the needs of clients from Black and minority ethnic groups more effectively.

• Information about client contexts such as religious needs and youth culture.

• Information about local services.

It was also noted that training should not be restricted to certain groups of staff but available to all, with time release accordingly. Scheduling training more flexibly - for example holding some courses in the early evening or at weekends - was also proposed in order to make it easier for some staff to attend.
Table 5: Factors that enable services to reflect a multi-ethnic context

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having a diverse staff group able to communicate in a range of languages</td>
</tr>
<tr>
<td>Neutral décor or reflecting local community through signs, posters and displays in different languages</td>
</tr>
<tr>
<td>Interpreter support</td>
</tr>
<tr>
<td>Reception staff from Black and minority ethnic groups</td>
</tr>
<tr>
<td>Celebrating religious and other cultural events</td>
</tr>
<tr>
<td>Space to accommodate extended family members</td>
</tr>
<tr>
<td>Translated materials in different languages (and ideally ansaphone not only available in English)</td>
</tr>
</tbody>
</table>
8. CONCLUSIONS AND RECOMMENDATIONS

The overall picture

The findings of the Minority Voices study paint a very mixed picture of progress in developing services that are accessible and acceptable to young people from Black and minority ethnic groups, and whilst clearly there are pockets of targeted, innovative practice, as evidenced by the findings of the mapping, these are few and far between. Furthermore, developments in this area appear to have been badly hampered by funding instability, competing agendas, the general overload on many CAMHS (which is adversely impacting on inter-agency and partnership working) and priorities for service development lying elsewhere.

The areas of unmet need identified by both young people and staff, were wide-ranging but in particular, as a starting point, highlight a need to more effectively disseminate information about what is meant by ‘mental health’ and what statutory mental health services do, since without this information young people’s fears and limited awareness of the help that is available - and that of their parents - will persist. However, as the staff interviews revealed, this is by no means straightforward since many CAMHS and, increasingly it seems, some voluntary sector projects, are not promoting or targeting their provision due to feeling that this is inappropriate since they cannot accept self or new referrals.

The barriers facing young people

In addition to the capacity issue just mentioned, which is encouraging ‘gate-keeping’ in CAMHS and other services struggling to meet demand, the findings from the mapping and the in-depth fieldwork data suggest that some of the key barriers facing young people from Black and minority ethnic groups are as follows:

- The patchy geographic spread of services, meaning that in some parts of England and Wales there is only limited local provision. The need to travel some distance may pose particular problems for those unable to speak English, including young refugees and asylum seekers unfamiliar with the UK and the transport system.

- The lack of staff from Black and minority ethnic groups - and the predominantly White British staff groups - in many CAMHS, and the lack of staff able to speak different languages and with awareness of different cultural and religious needs.

- The lack of, or limited availability of, interpreter support.

Other barriers, which have been widely recognised to apply to all young people, were also noted including long waiting times, a lack of staff continuity, a lack of age-appropriate resources (especially for the 16-18 age group) and services only being available at times that were difficult for them (for example, clashing with school or college times).

The implications for ‘good practice’ in working with young people from Black and minority ethnic groups

The data gathered reveal a complicated range of issues that need to be addressed if services for the mental health of young people from Black and minority ethnic groups are to be both accessible and acceptable - two key dimensions identified in the analysis of good quality in service provision, set out by Maxwell.93

Despite some important geographic variations, and some issues that are specific to young refugees and asylum seekers, a striking feature of the information gathered has been the consistency between young people’s perspectives and those of staff in a number of key areas. These provide a good starting point for considering how practice might be developed and include:
• The need for awareness raising about mental health - this is agreed to be an essential first step towards young people having the understanding and confidence to approach services.

• The importance of information sharing - of more detailed information about CAMHS and other services able to support young people - and the greater use of non-traditional routes for dissemination.

• The need for services to explore and develop more flexible ways of more promptly delivering mental health services - including attention to using different venues, opening times, support through other routes such as the telephone and email and the removal of restricted referral pathways, which both young people and staff alike recognise as a significant barrier to service uptake.

• The value of having diverse staff groups in CAMHS able to speak different languages and with good levels of understanding of different religious and cultural needs - and crucially, attitudes and approaches that are empathetic to the needs of young people from Black and minority ethnic groups which are not based on assumptions about so-called ‘typical’ young people, but treat young people as individuals with individual circumstances, experiences and needs.

• The key role played by the voluntary sector and the need for continuing efforts in developing multi-agency and partnership approaches and work through different communities. Alongside this the importance of service networks so that young people do not get ‘passed around’ but are able to have their needs addressed in a coherent fashion.

• The need to bear in mind information sharing with parents and other family members, and for services to develop skills in working with inter-generational issues and pressures.

Learning from the study

Minority Voices participants had many suggestions for how CAMHS could be improved and also how information about services could be made more ‘young person friendly’ and effectively disseminated. Already, YoungMinds has taken up some of these suggestions in the range of leaflets produced for young people and it is to be hoped that other organisations in this field will also take an interest in developing other similar materials.

The accompanying guide to ‘good practice’ has been written with practitioners in mind and draws on the data gathered from the research study. Many of the services presented as case studies in this publication are extremely well used by young people from Black and minority ethnic groups and it is to be hoped that other services will be able to take from this document ideas and approaches that can help them develop their work in this area.

Recommendations

The recommendations from the Minority Voices study derive from the key issues raised from the interviews and focus groups, namely: information about mental health services, staff awareness and training and the style of service delivery offered by specialist CAMHS.

From the mapping of provision across the country and also the views of many young people who participated in the study, the crucial role of the voluntary sector in providing flexible, accessible and acceptable forms of support to young people from minority ethnic communities was clearly shown and forms the basis of a further recommendation. The need for training and awareness-raising for frontline voluntary sector staff in recognising emotional difficulties and referring on where appropriate, links to this.
The study recommendations are:

- The lack of awareness and understanding and the poor perception of services that promote mental health, amongst many young people from minority ethnic groups and their parents, must be addressed. New sources of information about CAMHS need to be disseminated more widely, including through ‘non-traditional’ routes that young people may be more interested in using such as the internet, media/radio and through local social and faith groups. It will be important to ensure that this information is available in a variety of languages, addresses the information needs of parents and is accompanied by education and training at the primary care level to improve the early recognition of mental health difficulties and the appropriate referral on to CAMHS.

- **Within CAMHS, understanding of different cultural and religious needs is still variable and requires attention.** The provision of training to address CAMHS staff limitations in these areas is needed, including developing the knowledge base on culturally competent practice and methods for evaluating this.

- **The important role of the voluntary sector needs to be recognised and developed.** This includes: building effective partnerships between CAMHS/health service providers and voluntary sector providers; involving the voluntary sector in the commissioning of services; sharing good practice and crucially, attention being given to providing more sustainable funding of voluntary sector projects.

- **CAMH services need to explore options for developing more flexible and proactive approaches to their delivery.** Whilst many CAMHS are struggling with increasing demand around the country there are examples of innovative practice that indicate there is scope for improvement and greater flexibility despite these pressures. The importance of timing, of young people being able to build up trust in the staff member they are seeing, and providing continuity of care, are other issues requiring attention.
APPENDIX: GLOSSARY OF KEY DOCUMENTS

Government reports and policy documents


Report detailing the findings of the Social Exclusion Unit’s investigation into how to tackle the cycle of deprivation that is linked to mental health, including poor employment and inclusion prospects. The document outlines the scale of the problem amongst the adult population and the progress made so far, also the areas of continuing concern including tackling stigma and discrimination. Separate chapters discuss the role of health and social care services in tackling social exclusion, community participation and social support. The final chapter sets out the government’s ‘action plan’ for addressing this issue.


Report produced as one part of the Department of Health’s response to the Mental Health National Service Framework (MHNSF). The document sets out a range of proposals for reforming the service experiences and outcomes of people from Black and minority ethnic groups in contact with or using mental health services. It sets out the disparities in this area, the seven national standards from the MHNSF and the policy and legal context for driving forward change to eliminate ethnic inequalities in mental health.


Building on the results of the consultation on Inside Outside, this document sets out a draft framework for service planners, commissioners and providers in mental health services for improving services for users and carers/relatives from Black and minority ethnic communities. Outlines information and monitoring requirements and explains the evidence for more appropriate and responsive services and for increased community engagement.


Describes the qualitative element of a study that was conducted alongside a survey of the adult population in Great Britain, looking at ethnic and cultural differences in mental health. Two sections of the report discuss in detail coping mechanisms and use of services, including referral pathways.


Provides a detailed overview of the work of local authorities with this client group. This includes analysis of progress in services implementing the recommendations of the Macpherson report; management activities and strategies for developing a race equality strategy and tackling racial harassment and the collection and use of monitoring data. Outcomes for service users are discussed and examples of good practice are presented. Whilst focused on social work practice, many of the issues discussed - for example referrals, assessments and anti-racist work - are clearly relevant to other professional groups working with young people.

Understanding ethnicity and cultural diversity and the provision of mental health services

Wide-ranging review of the issues concerning ethnicity and its definition, including: ethnicity and identity; families and households; income, housing, education, physical and mental health. Also specific chapters on youth justice, racism and young people, the provision of social services and young refugees and asylum seekers.


Provides an overview of racism and cultural diversity and how these have been addressed over time, including initiatives in mental health service provision and changes in psychiatric and psychological training. One specific section explores changing practice and options for the future, including discussion of how to strengthen the Black voluntary sector and promote access to services.


Draws together current research on mental health services for children from minority ethnic backgrounds, with an aim of highlighting the key issues that need to be considered if mental health practitioners are to be able to make informed decisions about ethnicity, minority ethnic groups and the development of culturally competent approaches. Part two of the book describes the findings from a small survey of service commissioners and child and adolescent mental health service managers. This explored their understanding and approaches to developing services for children and young people from Black and minority ethnic groups.


Presents the findings of a large-scale qualitative inquiry into the provision of mental health services for Black people and explains why there is a need to review the treatment and care offered to those with mental health problems. The report examines the pathways to services, the experiences of this section of the population and the impediments to change, including at the primary care level and the availability of community-based crisis care. Examples of positive practice are identified, and recommendations are set out aimed at supporting the Black community, improving access, creating sensitive services, workforce development and capacity building.

- **Young Asian women**


A handbook that aims to raise awareness and provide information about young Asian women and self-harm. Aimed at practitioners, the handbook is divided into a number of short sections that explore what is meant by self-harm and how to provide accessible responses; the particular issues facing young Asian women that may make them particularly vulnerable to self-harm, and the fears, stereotypes and myths that surround Asian culture. Later sections of the document provide case study exercises and examples.


Research report exploring self-harm and the services available for young women with this difficulty, including analysis of young women’s awareness and understanding of mental health and of mental health services and their existing and preferred pathways to receiving care and support.
**Young refugees and asylum seekers**

Save the Children (2003). *Young refugees. Providing emotional support to young separated refugees in the UK.* Save the Children.

Provides a short, accessible summary of young refugees’ experiences and ‘10 Top Tips’ on providing emotional support.


Provides an overview of the support offered to families with children and unaccompanied children and young people under the Immigration and Asylum Act 1999. The report sets out their rights to services including health, education and social services and explains the applicability of the Children Act 1989 to these groups of children and young people.
REFERENCES


Ibid.


This research report presents the findings from an eighteen month study, *Minority Voices*, carried out by YoungMinds, into the access to, and acceptability of, services for the mental health of young people from Black and minority ethnic groups in England and Wales. The report describes the rationale for the study in terms of national policy and findings from previous research in the field and the methodology, which focused on obtaining the views of young people themselves about their experiences of using mental health services and their suggestions for how these could be improved. The views of staff who work with these young people contribute to a description of the mental health needs and unmet needs of Black and minority ethnic young people and of ways in which services could be developed better to meet these needs.

*Minority Voices: a guide to good practice in planning and providing services for the mental health of Black and minority ethnic young people* complements this research, with the guide drawing on the research findings about what facilitates young people’s access to mental health support.

To obtain either the *Minority Voices* research report or the guide to good practice, contact YoungMinds.