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Chapter 14

Ethnic Minority Children and Families and Mental Health

Preventive approaches

Philip Messent

Ethnic minority children and families tend to be under-represented among referrals to child and adolescent mental health services (Hillier *et al.* 1994; Stern, Cottrell and Holmes 1990). It could be argued that this is a measure of a lack of such problems among such communities, and there is a certain amount of evidence that some particular minorities are indeed more psychologically healthy. Meltzer *et al.* (2000) found that Indian children have a lower prevalence rate of mental disorder than any other group. However, there is also evidence to suggest that the reasons why such families are not referred or when they are referred do not attend such agencies is more to do with a lack of knowledge about such services among some migrant communities (e.g. Messent and Murrell 2003), and a belief among ethnic minority communities that statutory mental health services are stigmatising, and are largely run by the white majority community, following Western norms about how children should be understood and families should be organised (Fatimilehin and Coleman 1998). Referrers meanwhile may not see some minority communities as benefiting from the sort of psychological help on offer. Bal and Cochrane in an unpublished study in Birmingham in the 1980s describe how more Asian than white UK patients came to GPs there with somatic complaints, but the doctors were more likely to refer their white UK patients for psychological help. Some communities may receive help only when they reach a level of seriousness that necessitates the most

'heavy end' of interventions – medication and inpatient care (Messent and Murrell 2003).

Elsewhere (Messent and Murrell 2003) the author has argued that if services are to avoid allegations of institutional racism, there is a need for them to examine the take-up of help by different ethnic minority communities, and explore ways of offering services to ensure that they can be accessed by such communities. The National Service Framework emerging findings document (Department of Health 2003) urges services to ensure that they are equally accessible to all children and young people.

One way in which services can make themselves more accessible to members of ethnic minority communities who are not accessing services is to develop outreach and preventive ways of delivering services. Rather than waiting for problems to develop to such an extent that such children have to receive help only in a crisis, services could be offered to young people who are at a less serious stage of difficulty in ordinary settings such as schools that they are routinely attending.

The emerging findings of the Children's National Service Framework for Child and Adolescent Mental Health (Department of Health 2003) require services to be contributing to both universal child health programmes and preventive services aimed at particularly vulnerable groups. This chapter will focus in some detail on some particular initiatives in the London Borough of Tower Hamlets, a particularly ethnically diverse area familiar to the author. These are described not as a model to be followed indiscriminately elsewhere (the whole point of such initiatives is that they should be designed to meet the circumstances of particular ethnic communities), but as examples of the kind of preventive approach which can reach out more proactively to ethnic minority communities.

The Multi-Agency Preventative (MAP) Project

In Tower Hamlets the Bangladeshi community has been growing such that by 1997 they represented a majority (54%) of the school-age population (London Borough of Tower Hamlets 1999). However, as a proportion of the children and young people referred to clinics they represented only 19 per cent (Messent and Murrell 2003). In a multi-agency review of local child and adolescent mental health services carried out in 1997, many local schools requested that services should be offered within schools. They saw many Bangladeshi young people, boys in particular, as at risk of becoming alienated and losing interest in their education, but felt that they were not going to be able to persuade the parents of such boys of the relevance of the sort of child and adolescent mental health services being offered in outpatient clinics.

Funding was obtained using this finding to argue for the need to develop a preventive service aimed at this particular group of young people in three local secondary schools. A multidisciplinary team of youth workers, child clinical psychologists and social workers was formed, which developed over the course of two years a model of work which included as important elements:

- initial individual support offered to boys referred within school
- developing relationships with the boys' families through home visits to ensure that they understood and supported the sort of help being offered and to undertake an assessment of family needs
- group work with young people in schools, run on brief solution focused therapy (De Shazer 1988; George, Iveson and Ratner 1990) lines, encouraging a sense of competency and increasing the boys' self-confidence
- courses, outings, residential weekends and events offered outside of school hours to increase a sense of group cohesion and connection with workers
- psychologists in the team seeing young people with the more severe difficulties and facilitating a referral where appropriate to mainstream outpatient services
- group work with mothers
- a video on the project's work being developed and used for community education.

During its first two and a half years the project has worked with a total of 108 young people, aged between 11 and 15, offering the sorts of interventions described above. The outcome of the work has been independently assessed by a team from the Royal Holloway College (Barn, Lee and Loewenthal 2001) and has been found to be well received by young people, families and teachers, and to have had an impact on attendance levels at school and boys' self-esteem. Professionals have found themselves working in new and unusual settings, which have in turn helped them to develop new ways of working, for example using brief solution

focused therapy ideas to develop a style of running short-term groups in schools that is sustainable and effective in raising self-esteem, resulting in significantly increased scores on a self-image profile (Barn *et al.* 2001) Youth workers have commented on how their involvement in the project has led to their being able to provide mental health advice in other work settings; a psychologist has spoken about the very different kind of relationship it is possible to develop with a young person of Bangladeshi origin with whom you have been out canoeing, as opposed to the more usual forms of professional contact. A number of Bangladeshi social workers and youth workers have been recruited who have developed an expertise in the area of child mental health. This project is mentioned in the green paper *Every Child Matters* (Department for Education and Skills 2003) as an exemplar of how a multi-agency team can offer effective early intervention.

Case Example: The boy who hated dirt

Jamal, a 14-year-old Bangladeshi boy, was referred to the MAP project due to concerns about his increasing rebelliousness and worsening attendance. He lived at home with his mother, older brother (aged 19) and two younger siblings. His brother had met with the head of year and agreed to a referral to MAP; he complained about Jamal's behaviour at home – refusing to get up, being aggressive and showing a lack of interest in his religion.

After two unsuccessful attempts to meet Jamal in school, the clinical psychologist was introduced to Jamal by the school 'link worker' in an empty classroom. Jamal had his cap on, his hood up and was slumped on his desk. When alone, the psychologist gave an explanation of the project, who she was and his right to choose whether to meet. She acknowledged some of the differences (for example in gender and ethnicity) between her and Jamal and raised some of the possible affordances or constraints of these in building a relationship. Using ideas from narrative therapy (White 1989) she led the discussion on to his interests and plans for the future rather than focusing on 'problem-saturated' stories. By the end of the session Jamal was making eye contact and his hood was down. Further meetings took place in school and a relationship of trust began to form as Jamal responded to externalising questions (White 1989) about what was getting in the way of him fulfilling his life plans (which included succeeding in his GCSEs). Jamal described wanting to have friends and not to be seen as a 'boffin', wanting to develop his own relationship to Islam, and finding school a dirty, unpleasant place.

It was agreed between them that in order to help him to achieve these life plans, he would need to instruct school staff in how they could best help him. Two meetings were held in school which included a learning mentor, Jamal's head of year and his big brother, in which a solution-focused (De Shazer 1988) approach was used, focusing on the times when Jamal was in school and what helped him to learn best. These meetings had the effect of reducing mutual blame between home and school, and increasing the level of practical support offered to Jamal, and the head of year spoke appreciatively about the accessibility of the MAP project.

Jamal had spoken about how at home he felt his point of view was heard only when he was angry and agreed with some reluctance for the psychologist to visit with a Bengali-speaking social worker from the project. These visits allowed discussions with Jamal's mother about dilemmas she faced in raising her son in an unfamiliar cultural and social environment and her difficulties in knowing who to turn to. The social worker introduced her to some local community resources, which she reported helped her to feel she was being a more effective parent. Discussions with her and her eldest son about their hopes and expectations of Jamal, and how he could have his ideas heard while respecting cultural beliefs about showing respect to his elders, seemed to allow them to feel their good intentions were appreciated and to consider what they could do differently to help Jamal to achieve his potential.

During school holidays Jamal was invited to attend a four-day residential trip, where project youth workers observed Jamal having difficulties in making relationships with other young people and participating in some of the activities. In a later individual session, the psychologist raised these observations, which allowed

Jamal to open up about intrusive, obsessive thoughts about dirt which were making it difficult for him to attend school. A detailed exploration of 'exceptions' followed, times when Jamal got the better of these thoughts, and over time Jamal built a resource folder including a list of 'ideas for overcoming intrusive thoughts' and helpful music.

Seeing Jamal in school initially allowed for the development of a relationship of trust between him and the psychologist. This opened the door to the social worker becoming involved who could connect with the family, helping them towards a new perspective, and identifying resources in the community available to them. It also allowed Jamal to be involved in activity programmes where youth workers were able to encourage Jamal to find more examples of success in new activities, reinforcing his stories of success. Feedback from Jamal and his family revealed that individual family members felt that the MAP project had provided an accessible service for all involved, and an appreciation of the different contributions of the team.

The African Families Project

Anane-Agyei, Lobatto and Messent (2001) describe the African Families Project, another local initiative aimed at a particularly vulnerable community. African families represent 3.36 per cent (2001 census) of the local population in the London Borough of Tower Hamlets, the area the project serves. While children and young people referred to formal CAMHS from this community are not under-represented, there is some evidence to suggest that they tend to come to the service only in an acutely ill condition, such that the service they receive is skewed towards relatively heavy end interventions, seeing psychiatrists as opposed to other members of the multidisciplinary team, being seen over a more extended period of time, and more likely to receive medication and/or periods of in-service treatment. (Messent and Murrell 2003). Goodman and Richards (1995) also found a high rate of more serious diagnoses (autism and schizophrenia) among children of African Caribbean origin attending child psychiatric clinics. One possible hypothesis about the sequence of interaction here is that African families do not approach psychiatric services until they are forced by circumstances to do so because they fear stigmatisation, a lack of understanding and being trapped into their children receiving the sort of heavy end interventions described above. But by avoiding having any such contact until problems have become acute and severe, they render the sort of response from services that they fear rather more likely to occur. Or from another point of view, largely white services are more likely to understand the problems presented by African children and young people as warranting a certain style of intervention, and this tendency is reinforced and exaggerated by the way in which such families tend to find their way to such services, out of a fear that they are going to be seen in such a light.

In order that such an endlessly reinforcing negative cycle can be interrupted, there is a need for the development of services which are more user-friendly to members of this community. Anane-Agyei *et al.* (2002) describe attempts to develop such a service including the following key elements:

1. Workers of African origin from services working in the community – tiers one and two, in terms of the model of service development described in *Together We Stand* (Department of Health 1995) – co-working with white workers from within mainstream CAMHS to help to ensure that service users have the feeling that their perspective is being understood.
2. Services being offered in a way that honours African parents' sense of themselves as having authority to decide about interventions offered to their children and families, meeting with them for example first to obtain their permission before engaging in work with their children.
3. Services being sensitive to issues arising from the disruption in many African families' lives arising out of the process of migration.
4. Services making use of 'Afrocentric' tools and ways of understanding, for example using 'ecomaps' (Department of Health 1988) rather than family trees as an initial tool for understanding webs of important relationships which may go well beyond the nuclear family.
5. Services needing to confront and challenge African parents about using forms of punishment which are not acceptable in the UK, but doing this from a position of respect for

parents' good intentions for their children, and without taking away their sense of empowerment to remain in a position of authority and responsibility in their families.

6. Services needing to address negative views towards African families of other agencies, intervening in negative cycles of interaction which maintain problems in children and young people.

Case Example: The boy who loved his grandmother's dog

An 11-year-old Nigerian boy, Anthony, was referred to the Social Services Department for a child protection investigation as he had told teachers at school that he was being locked in the toilet for extended periods at home when he was naughty. He had a history of having been reunited with his birth parents in the UK two years previously after being raised until that time in Nigeria with extended family members. He presented with behavioural problems in school such that he was always in trouble there, although his parents felt that he was no more difficult than other pupils and that he was 'picked on' by teachers because of his reputation. He had been wetting his bed and was seen by teachers (though not his parents) as needing 'counselling'.

An African social worker commenced an investigation, working as a part of an African Families Project partnership with a white CAMHS social worker in order to ensure that Anthony's mental health needs were addressed. In the course of her investigation she got Anthony to draw an ecomap of the people or things that he felt closest to, and was struck by his positioning of his grandmother's dog, his neighbour's dog and his Sega Megadrive game as most important to him. The importance of the dogs seemed to stem from a previous close relationship with the dog of informal foster carers who had looked after Anthony when he had first arrived in the UK.

Sharing this finding with his parents acted as a powerful intervention in itself, helping them to begin to think differently about Anthony's need for more of a sense of relationship with them. When the parents came with their African social worker to meet with the white CAMHS worker they were already speaking more positively about Anthony, seeing him as communicating more with them and now having stopped bedwetting. When Anthony did his ecomap again it was noticeable that now it was his immediate family members who featured as his most important relationship. Problems remained at school, however, where he was continuing to get into trouble with teachers.

The two African Families Project workers undertook a visit to Anthony's school, meeting with his teacher and his headmistress, and finding Anthony in trouble again, sitting outside the headmistress's office. The school had made strenuous efforts to better meet Anthony's needs, to the extent of recruiting a black male teacher for his class; however, the headmistress felt that this had had little effect. In fact when the black teacher was interviewed separately, he felt that Anthony had made some improvements but these hadn't been noticed by the headmistress or anyone else in a position of real power in the school, despite his efforts to draw their attention to these changes. The workers suggested to the headmistress that she institute a new system whereby instead of Anthony coming to her only when he was in trouble, he should be sent by his teacher to see her on a regular daily basis to report on things that had gone well for him. This intervention was based on narrative ideas (White 1995) about the need to mark and call attention to change among significant audiences in order that these changes should become consolidated and long-lasting.

Anthony's daily visits to his headmistress with his messages of hope and success seemed to have the desired effect in altering her and other teachers' views about him, which in turn improved their relationship with his parents, enabling more of a sense of partnership and working together between home and school. This will have in turn contributed to Anthony feeling more contained by the sense of parents and teachers working together and in accord, and established a positive cycle of interaction in which change leads to more change.

Parents reported in feedback interviews a sense of being heard and understood, particularly by their African social worker, and that their love and good intentions for their children were being appreciated in a way that had not been the case in their previous dealings with white workers.

Building links with the community

Messent and Murrell (2003) asked groups of the Bangladeshi parents of service users about what sense they made of the comparatively low level of referrals to the local CAMHS of families from their community (30% as against 55% among the school-age population in 1997), and in particular the fact that there were practically no self-referrals by parents or families. This was not, they felt, due to any sense of stigma about attending such services, but was due to a lack of knowledge about such services among the community. They recommended that the service should be more proactive about advertising its service on posters, in newspapers and on local radio.

Since then service representatives have held meetings with representatives of the largest of the local mosques, building a sense of a shared understanding of problems and towards a collaboration in the form of a shared conference on fate and disability. This idea followed upon a successful conference organised by the local Social Services Department on the subject of forced marriages, attended by 85 imams and out of which a shared agreement had been reached about how this problem should be addressed both in the mosques and by the local authority. In the course of such discussions many mutual prejudices can be checked out and dissolved, making the prospect of CAMHS professionals working alongside imams and mosque officials in preventive initiatives a practical possibility.

Similarly following the Victoria Climbié inquiry (Department of Health and Home Office 2003) there is an onus on statutory services such as social services and CAMHS to establish connections and working relationships with African and African Caribbean churches. As a first step towards establishing such links the local authority sent out a letter to churches they had found operating within the borough, inviting representatives to attend a meeting. This attempt at making connections was not successful, so a worker was employed from one of the churches to go out and visit as many of the church groups as she could manage to contact, talking with church leaders and representatives about why, following the Climbié inquiry, it was in everyone's interest for the churches and the local authority to find a common understanding regarding child abuse and ways of communicating and working together on cases that present themselves.

For CAMHS to participate in preventive approaches to the problems of ethnic minority young people it is going to be necessary for services to develop similarly proactive ways of establishing connections with different communities, and a willingness to offer services in innovative ways in a variety of locations – schools, community centres, youth clubs and doctors' surgeries. Dwivedi (2002) has written about developing such links in Northampton, networking with local Pakistani, Bangladeshi, Sikh, African and Gujarati groups, stressing that such efforts need to be undertaken with continued mainstream funding rather than relying on temporary initiatives. Other requirements laid out in the National Service Framework emerging findings (Department of Health 2003) to contribute towards preventive services, to map need, to ensure that the needs of particularly vulnerable groups such as ethnic minority groups are met sensitively, and to offer outreach services in a variety of settings all provide opportunities for service planners to increase mainstream initiatives in this area of work.

Child and adolescent mental health services will also need to find ways of recruiting ethnic minority staff. Hillier *et al.* (1994) found that Bangladeshi service users in Tower Hamlets wanted most of all a CAMHS in which they were receiving help from Bangladeshi professionals. While some Bangladeshi social workers have been recruited to the service (and ethnic minorities in general are comparatively well represented among social workers and nurses) the training of Bangladeshi and other ethnic minorities for the other main CAMHS professional groups (psychiatry, psychology, family therapy and child psychotherapy) has lagged behind. As proactive ways to encourage such recruitment, services can arrange to visit schools and colleges to speak about opportunities in such professions (Mahtani and Marks 1994), give preference to ethnic minority students seeking placements, and create entry-level training posts for members of local communities such as the bilingual co-worker posts developed in the London Borough of Newham CAMHS in recent years and emulated in 2003 in Tower Hamlets.

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Chapter 15

The Mental Health Europe Projects and the Greek Perspective

G. Kolaitis and John Tsiantis

Introduction

Mental health promotion and prevention of mental disorders in early life has increasingly been of immense interest among professionals, researchers and also policy makers. Mental health problems in young children and adolescents are common, ranging from 7 per cent for children to 22 per cent for teenagers (European Commission 2003). They affect the functioning of the young person and are frequently associated with school failure, impaired peer relationships, work and interpersonal difficulties and may also lead to increased involvement with police, legal, mental health and social services in adulthood (Angold and Costello 1995; Robins and Rutter 1990; Rutter and Smith 1995). They are often accompanied by emotional pain and suffering, increased physical problems, mortality, poor quality of life, social stigma and discrimination with subsequent social, financial and political consequences (Lavikainen, Lahtinen and Lehtinen 2000; World Health Organization 2002b).

Moreover, it has been estimated that only 10–15 per cent of children with mental health problems reach the existing child mental health services (Cox 1993; Offord 1987) and of the childhood mental disorders which spontaneously remit, approximately 50 per cent still persist later in life (Cohen, Cohen and Brook 1993). It has also been estimated that approximately two-thirds of 3-year-olds with emotional disorders have mental health problems when followed-up as 8–12-year-olds (Campbell 1995).