

# Healthy Minds

## *A Child & Adolescent Mental Health Research Project*

*“What are the mental health needs of  
Bradford’s Pakistani Muslim children and  
young people and how can they be  
addressed?”*

UNIVERSITY  
OF CENTRAL  
LANCASHIRE



**Centre for Ethnicity & Health**

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# Acknowledgements

The authors gratefully thank all the individuals from the voluntary and statutory sectors who gave their time to be interviewed and all those from the community, especially the children and young people who participated in the focus groups.

Particular thanks also go to everyone who has helped in the development of the work especially, Professor Corinne Wattam, Kusminder Chahal, Professor William Bingley, Yasmin Saloojee, Helen Stevenson, Peter Scholey and Dr Lesley Hewson.

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## 1. INTRODUCTION

This report was commissioned by the City of Bradford Metropolitan District Council (MDC) Directorate of Social Services; the aims and objectives are presented in section two, but simply stated the research seeks to determine the mental health needs of Bradford's Pakistani Muslim children and young people and, based on the findings, recommend ways in which those needs can be addressed.

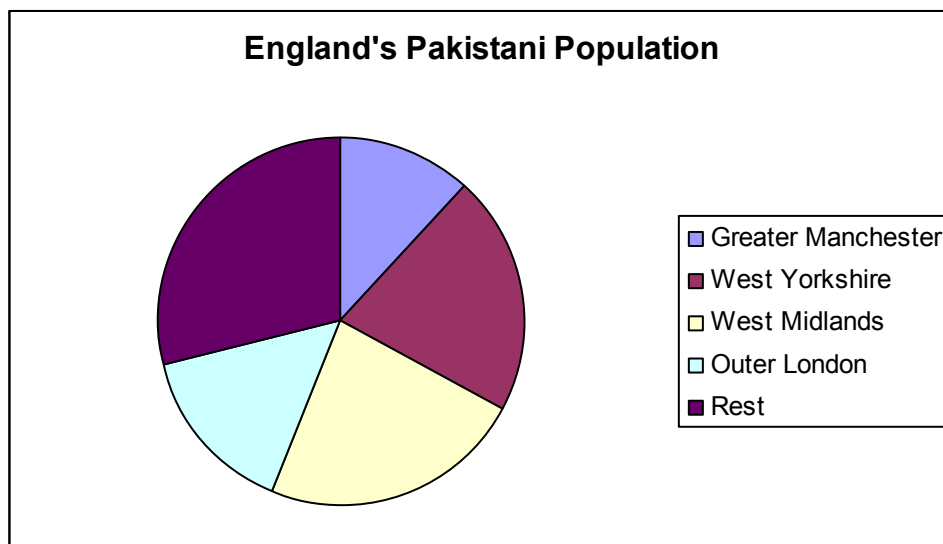
It is important to mention here that the research was commissioned following a Joint Planning Team recommendation that noted a lack of information around the mental health needs of Bradford's 'Asian' population. A population that makes up a sizeable component of Bradford and yet whose children and young people are significantly under represented in Child & Adolescent Mental Health Services (CAMHS). In recognition of the complexity of cultural, religious, language, geographical regions of origin and socio-economic experience encompassed in the term 'Asian' (Patel K, 2000) the decision was taken to concentrate on the Pakistani Muslim community, which is the largest minority ethnic group in Bradford.

This introduction will, therefore, through narrative and through a review of the relevant literature, seek to prepare the ground for the views of the professionals, young people, children, parents, carers and community members that follow this chapter. It will paint a broad demographic picture of the UK's and Bradford's Pakistani Muslim population; bearing in mind the universal environmental, family and child risk factors as identified by the Health Advisory Service (HAS. 1995) identifying those specific to the Pakistani Muslim population in the Bradford Metropolitan District; and discussing the impact of the findings, negative and positive, on the mental health and mental health needs of the children and young people of this population.

### **THE PAKISTANI POPULATION – NATIONAL DEMOGRAPHIC PROFILE**

Recent population estimates show that the Pakistani community is the second largest minority ethnic group in Great Britain, accounting for 1.2% of the total population and 17.4% of the Black and minority ethnic population as a whole (ONS 1999).

Continuing patterns of early settlement when Pakistani men arrived in the UK to take up employment in the industries of the UK's major manufacturing towns and cities, the population still tends to be concentrated in the larger conurbations of, for instance the North West: Manchester, Oldham, Rochdale, Blackburn and Pendle; West Yorkshire: Bradford, Calderdale, Kirklees and Leeds; the West Midlands: Birmingham, Sandwell and Walsall; London: Brent, Ealing, Hounslow, Redbridge, Waltham Forest and Newham; and, the South East: Luton, Slough and Wycombe. Derby, Sheffield and Nottingham also have sizeable Pakistani populations. The largest Pakistani communities, however, are those of Birmingham which, based on figures from the 1991 census, is home to 13.9% of the UK's Pakistani population and Bradford which is home to 9.5%.



## THE LOCAL PICTURE

The South Asian presence in Bradford is extensive and visually prominent, with many well-frequented Asian restaurants or 'curry houses', shops selling South Asian produce, Pakistan-based banking outlets, etc, whilst at the same time it is also contained and exclusive. So that whereas overall, the South Asian community comprises one-fifth of the city of Bradford's population, this is a sharply divided city. In many of its outer regions, whether the leafy suburban and semi-rural middle-class areas, or some of the poorest and most downtrodden working class housing estates which are dotted around its perimeter, there is virtually no well-established pattern of South Asian settlement. By contrast, in Bradford's older inner city, largely characterised by late 19th and early 20th century terraced housing there are neighbourhoods where the South Asian presence is substantial and even dominant.

The extent of these divisions, together with the aggravated levels of social deprivation experienced by Bradford's South Asian communities, is easily summarised by reference to 1991 census data. Of Bradford Metropolitan District's 30 electoral wards, in one-half of these South Asians comprise 1 per cent or less of the population. By contrast, in six electoral wards South Asians amount to 20-30 per cent of the population; in a further two areas South Asians constitute one-half; and in one inner-city area they amount to 70 per cent of local residents. In other words, 85 per cent of Bradford's South Asian population live in less than one-third of its electoral zones.

The Pakistani population is by far the largest of Bradford's South Asian populations. Approximately 80% of the Bradford Pakistani population originates from the rural Miripur district of Azad Kashmir the remaining 20% mainly originating in the Punjab region. Bradford MDC estimates that in 2002 the Pakistani population will total 76,650, that is, 16% of the total population of the district. (Bradford MDC 2001) The Pakistani community can be found in each of Bradford's inner city wards, however they are most concentrated in Toller, Bradford Moor and University.

Settlement patterns within Bradford are very much a clear example of a combination of constraint and choice theories that surround minority ethnic housing patterns, and in particular South Asian housing patterns. That is, that through choice the Pakistani community clustered together on arrival, firstly because they did not view their immigration as permanent and therefore chose cheaper housing nearer their place of work; and secondly, they preferred to live together in order to preserve cultural identity. The constraint exists in discrimination and prejudice toward the newly arrived immigrants in the 1950s and 1960s amongst the host population. Allegations of discriminatory money lending around housing, confined many immigrants including the Pakistani community, to cheaper houses that could be bought outright with small loans from friends and family.

Whilst many of the Sikh and Hindu communities have, over time, moved away from their inner-city first residences, movement within the Pakistani community has been slower and in many instances has been restricted to relocating to better accommodation but still in the inner-city area. (Singh 1994). Lewis confirms this changing geography amongst Bradford's South Asian population citing evidence of suburbanisation amongst all communities, though less so amongst the Pakistani and Bangladeshi communities. She further reports that even within this suburbanisation there still remains some residential clustering which she partly explains by social class and partly by the desire for clustering for social support. She goes on to note that there are parts of the city from which South Asian people are relatively absent, again she contends this is partly social class and past discrimination and perceptions amongst some communities, particularly the Pakistani and Bengali communities, that some social housing is 'white territory' and should be avoided. Through evidence gathered through focus groups with young people she concludes that:

*"The indications are that some (Pakistanis and Bangladeshis) are trapped in poorer areas by their economic circumstances and that social housing away from the inner city is not perceived as a particularly attractive alternative ... clustering on the basis of ethnicity remains important, even for the younger generation of South Asians. It is sustained by positive community links, traditions and a sense of ethnic identity. It is also maintained by a fear of racial harassment."* (Lewis undated)

## AGE PROFILE

In line with national trends the Bradford Pakistani community is characterised by its relative youth; according to figures taken from the 1991 census 64.5% of Bradford's Pakistani population were aged 24 years and under compared to only 32.4% of the white population.

**TABLE 1 – Population of Bradford District 1998 by Age and Ethnic Group. Source Bradford MDC Estimate**

Ethnic Group	Age 0-15	Age 16-17	Age 18-24	Age 25+	Total
African Caribbean	1685	203	573	3751	6212
Bangladeshi	2163	269	858	1901	5191
Indian	3387	504	1430	8106	13427
Pakistani	26166	3043	9426	26999	65634
White	78375	9784	32734	268353	389246
Other	2374	310	845	3162	6691
<b>TOTAL</b>	<b>114150</b>	<b>14113</b>	<b>45866</b>	<b>312272</b>	<b>486401</b>

More recent estimates (table 1) illustrate the age profile of the community, which although showing a slight decline in the numbers of young Pakistani people, still indicate that there is a significant gap - estimating that 58.9% of the Pakistani population and 31.1% of the white population is currently aged 24 years and under.

## **SOCIO ECONOMIC PROFILE**

Social deprivation amongst the UK's Black and minority ethnic communities, relative to the indigenous population, is well documented. The Fourth National Survey of Ethnic Minorities, Diversity & Disadvantage (Modood et al 1997) undertaken in 1994 concludes its chapter on Income and Standards of Living acknowledging that at the outset of the Survey it was known that the Pakistani community was poor, but that the findings of the Survey had been '*startling*' in revealing the extent of that poverty:

*"Name any group whose poverty causes national concern – pensioners, disabled people, one-parent families, the unemployed – Pakistanis and Bangladeshis were poorer."*

The reasons for this poverty are explained by the author as being due to a combination of factors, each of them powerful in their own right: high rates of male unemployment, low rates of female economic activity, low wages for those working, large household sizes comprising more adults per household than whites and more children per family than any other ethnic group. The author contends that **all** of these factors would have to change before there was any substantial change in the poverty level of the Pakistani and Bangladeshi communities.

These national findings are borne out in Bradford where the four wards that are home to the vast majority of the Metropolitan District's Pakistani community are amongst the 2% most deprived wards in the country. (DETR 2000)<sup>1</sup> A local survey, conducted in Bradford in 2000 found that:

*"More than 80 per cent of Muslims (mainly Pakistanis/Kashmiris and Bangladeshis) were living in areas classified as 'struggling' in 2000. These were typically inner city areas."*(Lewis undated)

The local survey also found that 10% of Muslims were present in reasonably well off suburban areas. However, it is not clear from the report whether these 10% were also Pakistani/Kashmiri and Bangladeshi. This raises the interesting point of whether or not poverty amongst Pakistani and Bangladeshi communities in Bradford (and elsewhere) is affected by religion rather than ethnicity and the Fourth National Survey (Modood et al) considers this question and reports that Hindus, Sikhs and Indian/African Asian Muslims are all less likely to live in households with low incomes than Pakistanis and Bangladeshis, although the Indian/African Asian Muslims were significantly more likely to live in households with lower incomes than the Sikh and Hindu sample.

Further explanations for the incidence of poverty amongst the Bradford Pakistani community are often cited as being those surrounding origin, that is the community originates from a rural area, its members are less educated than their city dwelling counterparts and many families send remittances back to Pakistan either to support family (Modood et al 1997) or to invest in land and property.

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<sup>1</sup> The DETR Index of Social Deprivation ranks wards by level of deprivation, taking into account a number of factors such as income, employment, health deprivation and disability, education, skills and training, housing, access to services and child poverty.



## RELIGION AND CULTURE

The lines between religion and culture are often blurred but its joint impact on family life in Bradford cannot be underestimated. Findings from the Fourth National Survey report that 74% of all Muslims rated religion as *very important as to the way they led their lives* with the figure being highest amongst those members of the Pakistani population who had entered the country after the age of 16. Together with the Bangladeshi sample that arrived in the country after the age of 16, this group reported the highest incidence amongst all age groups within the sample for stating that religion was very important to the way they led their lives. (Modood et al 1997). The majority of Bradford's Muslims are Sunni Muslims; there is a smaller number of Shias and smaller groupings of Ahmedya and Wahabi Muslims. Actual figures are notoriously difficult to estimate, data on religion, up until the 2001 census has not been collected nationally and figures from religious denominations tend to be unreliable in their collection methods. However, with over 50 well attended mosques in the Metropolitan District that are seen as taking care of the "community needs, the collective needs, educationally, socially and welfare wise" (Singh 1994) it is understandable that the culture/religion mix is profound:

*"Religion plays a big role in our lives, because in fact Islam teaches you a way of life. It's not just a set rule of doing a certain thing at a certain time. It's a code of life"*  
(Bradford Pakistani Muslim cited in Singh 1994)

In a study by Cinnirella & Loewenthal that looked at the religious and ethnic group influences on beliefs about mental illness, women from a number of Black and minority ethnic groups were interviewed about their perceptions of the effectiveness of religious coping strategies in the face of depressive and schizophrenic illness. Low referrals to agencies for Pakistani Muslims were reported. A number of contributory factors were cited for this low referral rate: social stigma as a result of help-seeking; effectiveness of support within the Muslim community; and cognitive factors (particularly faith and prayer) play an important role in managing depression. (Cinnirella & Loewenthal 1999)

The study further reports that two thirds of the Muslim sample felt that religion could play a *causal* role in depression and schizophrenia, citing lack of faith and failure to pray regularly as contributing factors to depression. This particular group, unsurprisingly perhaps, also reported that faith and prayer would be effective in treating mental illness and also cited faith and prayer as being preferable to seeing a 'Holy person'. However, the sample did report instances where they felt that other people (not themselves, probably members of the older generation and most likely 'uneducated' people) in their community might prefer to see a 'Holy person', possibly because this was common practice 'back home', and possibly because they believed that mental illness is spiritual in origin.

Social stigma as a result of help-seeking and also more specifically around mental illness featured prominently in this study. Help-seeking in general was seen as a sign of weakness and therefore detrimental to one's reputation. In close-knit communities, like Bradford, family reputations within communities appear to be closely guarded and although the study acknowledges the perception that help would be found within the community, it also reports the conflicting perception that fear of community stigma ensures that mental illness is often kept within the family. Two major reasons are cited for this preference for privacy; the difficulties in finding marriage partners for the children, siblings and sufferers of mental illness; and a cultural preference for keeping family problems private. The authors conclude from the evidence:

*“It is clear why the private nature of prayer is particularly valued by participants in this group...”*

## **FAMILY LIFE**

This Islamic code of life, mentioned earlier, leads many commentators to describe Islam as ‘patriarchal’. The practices of arranged marriage, consanguinity, and extended family living, which some have argued arise from Islamic concepts of female protection are practices that appear to be employed not only by devout Muslims but also by non-practising Muslims and have a powerful impact on the everyday lives of Bradford’s Pakistani community. It can, however, be argued that cultural and traditional norms and values actually explain these practices as opposed to religious concepts.

Edmund et al describe marriage in Islam as a contract with the roles of men and women being clearly defined. Comparison is made to Hinduism where marriage is seen as a sacrament. (Edmund et al 2000)

Arranged marriage is still the most common form of union amongst the UK’s Pakistani community. The Fourth National Survey notes that in general the practice is declining within South Asian communities as a whole. Within the Sikh and Hindu communities the practice is affected by socio-economic status, whereas within the Pakistani community arranged marriage is evenly spread across all occupational classes and, although showing a small decline, is still practised by the majority. The Survey also comments on regional variations and notes that two thirds of Pakistanis in the Yorkshire/Humber regions had an arranged marriage compared to three quarters in the North West and less than half in the South East. (Modood et al 1997).

The Fourth National Survey also comments on the preference of the Pakistani community for marrying cousins, noting that around 60% of the Pakistani marriages in Northern England and the West Midlands region are consanguineous. The authors make a number of interesting points; firstly, that the practice was twice as common amongst manual workers than it was amongst other socio economic groups; secondly, that it was not necessarily influenced by religion, as relatively few Bangladeshi and African Asian Muslim marriages were consanguineous; and thirdly, that this practice may well be increasing amongst the Pakistani community as 64% of younger Pakistanis in the sample reported marrying their cousins compared to an overall figure of 54% . Of further relevance to this discussion is the authors’ contention that whilst there is a growing concern that the children of consanguineous marriages are at greater risk of genetically carried illness, there is no hard evidence so far to suggest that this is the case. (Modood et al)

A further factor around marriage that distinguishes the Pakistani community is the preference for intercontinental marriage. This preference is clearly influenced by the practices outlined above and in itself impacts on the way of life for Bradford’s Pakistani Muslim community. Much of the commentary surrounding intercontinental marriages in Bradford focuses on the negative consequences on young women, who are often said to be illiterate in their home language and have little or no spoken English, who leave rural Mirpur for inner city Bradford and have little option other than to make the best of it. Singh notes two predictable consequences of intercontinental marriage; firstly,

*“that it ensures that the home culture and language is likely to remain other than English ... slowing down the whole process of their (the children’s) adjustment to wider society; and secondly, it increases the likelihood of many more unstable and unhappy marriages to continue”* (Singh undated).

The first point will be returned to later, but the second point will be discussed further here as in its reference to the continuance of unhappy and unstable marriages it suggests a degree of power and control in these relationships that may not be as great in non-intercontinental marriages, as well as poor access to support and appropriate services.

Chantler et al identify two interlinking factors as responsible for creating this imbalance of power in intercontinental marriage and placing extraordinary pressure on young women to sustain them. The first is the immigration law’s ‘one year rule’ that does not extend the full rights of a citizen to spouses until a period of one year has passed after entering the country, therefore ensuring that these women would have no recourse to welfare benefits should they leave their partners. Furthermore, this rule would return the spouses to their country of origin if the marriage fails within that year. The second factor is the shame and loss of family honour, honour that under Islam is carried by the woman, which would make her return home as, or possibly more unbearable than the prospect of sustaining her marriage, no matter how abusive.

The report, which describes a qualitative research project into suicide and self-harm amongst South Asian women notes that nationally the suicide rate is high amongst this group and cites: sexual and physical abuse, domestic violence, immigration issues, forced marriages, racism and issues of loss as contributing to attempted suicide and self harm. Importantly the report makes the point that many of these issues are common to all women but that:

*In comparing the experiences of distress of white women and South Asian women, it needs to be understood that even where factors are in common with white women (e.g. domestic violence, sexual abuse) access to services for Asian women is far more difficult. Coupled with racism, isolation is much more acute with correspondingly few options to turn to.*

A further cause for concern could be the issues surrounding male spouses; Kalra notes that *“For most Mirpuri men a government job or marrying abroad are the two main routes to financial security”* (In Lewis) However, the cultural experiences of men and women arriving in Bradford do differ; and the consequences for males whose culture places them in the dominant role but whose reality finds them dependant on the family of their new wife, with little hope of anything but the most lowly paid employment, must be significant in any discussion of family life in the Pakistani community of Bradford.

The role of the extended family, as mentioned earlier, characterises the Pakistani Muslim community. The Fourth National Survey reports that Pakistanis and Bengalis lead the field in the number of large families and also in the number of large complex households. Two conflicting issues often arise in discussion of the extended family, the first is that the large complex household is seen as a source of stress, particularly in relation to financial stress; the second is that the extended family is seen as a source of security, particularly for the older generation and children. Clearly the first issue is evident in the manner in which the Pakistani (and the Bengali) community have remained in poverty suffering disproportionately from over-crowded housing and having to stretch perhaps only one income further than a nuclear family.

The second issue is raised in a wide body of literature that suggests that the affectionate and protective nature of the extended family structure is of great benefit in particular to children and elders.

In a study conducted into the effect of extended family living on the mental health of Muslim and Hindu families the authors replicate a study conducted in 1995 that found that the children in extended families fared better, but their mothers fared worse than Muslim and Hindu nuclear families. The later study looked at three generations and similarly concluded that positive effects of extended family living on mental health was conditional upon generational status, that is, children and grandmothers had fewer mental health problems and mothers had more than their counterparts living in nuclear families. Reasons for mothers' poorer mental health are cited as being those surrounding the increased burden of care; intergenerational conflict; disagreement over child rearing; and feelings of isolation and helplessness in the face of a strong and dominant grandmother. The study also found that mental health problems were more common amongst the Muslim mothers than amongst the Hindu mothers with the explanation offered that the Muslim mothers were younger, less likely to work outside the home and to come from less acculturated families. Of significance is the fact that the study found that the mental health of the children in extended families was better, not only than that of their Hindu and Muslim counterparts in nuclear families, but also than that of their white indigenous counterparts. (Cintirella & Loewenthal 2000)

## **LANGUAGE AND EDUCATION**

One of the consequences of the cultural and religious practices outlined earlier is the effect on language and education. Clearly language is a significant issue, the Fourth National Survey finds that nearly half of all Pakistani women and more than a fifth of Pakistani men *“do not speak or have only limited English”*. This is evident in Bradford where the stress on children and young people around language is reported as follows:

*“In all children are expected to operate efficiently across four languages learned in different ways; English as taught in school, Punjabi at home as an oral tradition, the Qur’an in Arabic taught by rote learning and Urdu within a South Asian Pedagogical style.” (Lewis)*

This expectation around language is clearly a burden for many of Bradford's Pakistani children and is one of the factors attributed to the poor educational achievement of Bradford's Pakistani Muslim population. Reporting on national educational achievement standard targets, Lewis notes:

*“In 1999 Pakistani heritage youngsters reached only 21.8% targets – in the city it was 34% and in the country 46% ... the results are even more disturbing (when disaggregated into male and female) with the figure for boys 16.7% as against 27.8% for girls.” (Lewis)*

Further factors for poor educational achievement as noted by Lewis from a report from the Office of Her Majesty's Chief Inspector of Schools include: extended leave in Pakistan, sudden removal of girls for arranged marriages, tensions between progressives and the 'orthodox' in the mosque, racial tension and poverty.

## CROSSING THE CULTURAL DIVIDE

It is often commented on that young South Asians inhabit two very different worlds, the 'Asian' world of home and the western world of school. In Bradford it would appear that school and home, for most of the Pakistani Muslim young people are both 'Asian', with the majority of Pakistani Muslim children attending schools in the wards in which they live, which are largely dominated by their own communities. The situation has been referred to as *benign apartheid* in education with 19 first schools, 8 middle schools and 3 upper schools all drawing in excess of 90% of their pupils from Muslim communities. (Lewis)

This separation in education could, of course, provide young Pakistani Muslims with a stronger sense of community and kinship which could be beneficial to their mental well-being; it could protect them from the stark contrast between cultures that many young South Asians in less segregated areas are faced with daily and which is often cited as a cause of stress. However, the Fourth National Survey contains an interesting discussion on cultural identity commenting that ethnic identities are:

*"Not pure or static. Rather, they change in new circumstances or by sharing social space with other heritages and influences". (Modood et al)*

In an effort to measure this changing cultural identity amongst South Asian groups the Survey looked at seven potential indicators of South Asian identity: clothes, religion, language, marriage, self description, self identity and school and found that whilst there was a weaker sense of South Asian identity amongst those born in the UK or those who entered the UK before starting primary school than amongst those who entered the UK before starting secondary school and those who entered after the age of 35, amongst the Pakistani and Bangladeshi groups this was far less pronounced than, for instance, the Indian or African Asians. The authors contend that although their data cannot explain this difference the fact that the Pakistani and Bangladeshi sample are more likely to have originated from poorer, rural backgrounds, with linguistic, educational and occupational differences to the other groups is significant, furthermore, they propose:

*"It has been suggested that also relevant are attitudes and practices in relation to gender-roles, marriage and ties of kinship and the sense of 'siege' and 'threat' that some Muslim peoples have historically felt in the context of Western colonialism and cultural domination, and to which rural peoples in particular responded to through a 'defensive traditionalism". (Modood 1990 cited in Modood et al 1997)*

Whether this defensive traditionalism is descriptive of Bradford's Pakistani young people or not is debatable, although clearly from earlier discussion around culture, religion and marriage practices the Pakistani Muslim community is, in each sphere, more traditional than other South Asian communities and the Northern (including Bradford) Pakistani communities appear to be more traditional than their counterparts in the South. Yet, looking at much of the commentary surrounding the Bradford riots last year, which focussed on a backlash against years of racism directed at their community, there was a strong sense of changing identity, not necessarily becoming more western, but certainly moving away from the attitudes of their parents.

The Observer, for instance, spoke of the change in the willingness of the young Pakistani community to put up with further discriminatory treatment, it also focussed on the discernable identity of Pakistani youth and the change it had undergone in this generation:

*“Gripped by poverty and unemployment, pushed into segregated, failing schools and fearful of a police force they see as hostile, many Asians live in the same cities as their white counterparts, but inhabit very different worlds ... Now a new generation is pushing through, throwing off the more subservient attitudes of their elders and demanding radical change.” (The Observer July 15 2001)*

It could be argued, however, that this demand for radical change in the face of racism and discrimination is evidence of high self-esteem amongst these young people. Findings from a recent survey reveal that

*“...’being an object of prejudice does not damage self-esteem’. If anything, the authors contend, the reverse is true and they cite Black Americans as evidence, noting that they enjoy higher self-esteem than their white counterparts.” (JRF 2001)*

This radical change, however, is not only evident in the assertion of rights; it is also evident in the growing levels of crime amongst Pakistani Muslim youth and the use of drugs and alcohol. Since the late 1980s there has been a growing body of evidence linking young South Asians, particularly Pakistani Muslims to illicit drug use. Early studies conducted in Bradford revealed a vibrant trade in heroin (Patel K 1998, Patel & Pearson 1995; Pearson and Patel 1999) and more recent studies of Pakistani, Bangladeshi and Indian communities across the country have revealed an increasing use of Class A drugs including Heroin and Crack cocaine coupled with poor access to services (Patel et al 2000, 2001).

## **2. AIMS & METHODS**

The project arose from a tender specification issued by Bradford District Metropolitan Council in 2000. The aim of the project was:

*“What are the mental health needs of Bradford’s Asian children and young people and how can they be addressed?”*

### **2.1 OBJECTIVES**

The tender specification stated three key objectives:

- i. Carry out a comprehensive assessment of mental health needs of Asian\* children and young people in the Bradford Metropolitan District Area. Include local demography and descriptive epidemiology of mental health problems in children and young people*
- ii. Qualitative research involving children and young people, parents and carers and professionals*
- iii. Assess need against current provision and identify areas for further development and improvement*

*\*In responding to the tender specification the Centre for Ethnicity & Health proposed concentrating the research on the Pakistani Muslim population. This would enable greater specificity as the term ‘Asian’ encompasses a wide range of diverse communities, languages, cultures and religions. The Pakistani Muslim population are also the largest minority ethnic group in the Bradford District area.*

### **2.2 METHODS**

#### **2.2.1 LITERATURE REVIEW**

A literature review was carried out exploring a variety of national and international databases, library searches and internet specialist Child and Adolescent Mental Health list servers. It was not anticipated that the literature search would produce very much as the absence of research in this area was one of the stated reasons for commissioning the work. It was also known that little research took place prior to 1995 (NHS Health Advisory Service Thematic review.1995) so the point of the literature review was to confirm if any substantial and relevant pieces of research had taken place since that time.

#### **2.2.2 DESKTOP RESEARCH**

Desktop research included examining a number of local documents relevant to the planning and delivery of Child & Adolescent Mental Health Services in the Bradford District Area.

### **2.2.3 INTERVIEWS**

A total of thirty-three interviews were conducted with a variety of professionals including school nurses, Health Visitors, CAMHS workers, managers and commissioners of services.

The interviews were conducted using a semi-structured interview schedule, which was formed in conjunction with mental health professionals. The interview data was thematically analysed (see Findings) (A breakdown of the interview respondents is not provided in order to preserve the confidentiality of the respondents).

### **2.2.4 FOCUS GROUPS**

#### **YOUNG PEOPLE**

A total of seven focus groups were undertaken with 50 children and young people aged between 11 and 18 years (22 girls and 28 boys). These young people attended secondary schools in Bradford and Keighley, where the largest concentrations of Pakistani Muslim children and young people are located. Recruitment to the focus groups was undertaken with the help and support of local Youth and Education Services.

#### **COMMUNITY MEMBERS**

A total of five community focus groups were conducted with parents, carers and local residents from the Pakistani Muslim community. There were 61 participants in total, 17 men and 44 women. One focus group was comprised of South Asian woman experiencing mental health problems and currently in receipt of mental health services.

The focus groups and community groups have been analysed using a thematic grid, which identified common areas of interest and concern. These themes are presented in the Findings section.

(A breakdown of the children and young people and community focus group participants can be found in Appendix B)

### **2.2.5 PROJECT MANAGEMENT**

The project was managed by the Centre for Ethnicity & Health and a project management Steering group was established consisting of Professor Kamlesh Patel OBE, Professor Corrine Wattam, Professor Richard Williams, Jon Bashford, Kushminder Chahal, Yasmin Saloojee and Professor William Bingley. In addition representatives of the commissioners of the project were invited to attend and participate in several initial steering group meetings.

***Individual quotes used in the report are not attributed in order to protect the anonymity of the respondents.***



## 3 FINDINGS

### 3.1 PROFESSIONAL VIEWS

This section reflects four main themes arising from the interviews; the level and nature of mental health disorders/problems in Pakistani Muslim children and young people, factors that prevent access and support seeking, Child and Adolescent Mental Health Services and Service development.

#### 3.1.1 Level and nature of mental health disorders/problems in Pakistani Muslim children and young people

##### *Perceptions of how mental disorders, problems and/or distress is expressed*

Very few respondents described clear clinical syndromes or used diagnostic criteria when describing the behaviours they see which they perceive to be related to mental health problems. One respondent used the term 'schizoid events' and many spoke about 'depression' but the vast majority described behaviours in three main ways, withdrawn, attention seeking and aggressive or violent.

*"Screaming, crying, aggressive, lashing out, withdrawal"*

*"Silence, withdrawal, violent and verbal behaviour, attention seeking are how young people manifest problems"*

*"They go silent, seek attention - one girl has been passed around various relatives and is now in foster care, she is very attention seeking, angry and aggressive, she is not being supported by CAMHS."*

*"Unquestioning acceptance – passive behaviour, most of them can't articulate their distress, they do it through withdrawal or aggression, attention seeking"*

*"There is more withdrawal than behaviour problems"*

*"Those that withdraw are of more concern"*

Learning difficulties, which may be undiagnosed were also identified:

*"Moderate learning difficulties, not known or acknowledged by school and family"*

*"There are more South Asian kids with learning difficulties but we don't see them in special units/schools, they are in care, looked after children."*

Problems for mothers were identified either in relation to the child's aggressive behaviour directed toward them, or in terms of their own mental health needs:

*"Huge problems with communication, it's more mother with mental illness impacting on the children, they abuse the mothers, foul language, behavioural problems, attention seeking"*

*"A lot of anger is directed by the kids at the mothers, they are not aware of their own distress"*

*“Mainly the mental health concerns are with mums, she may present with one problem but then more come out “*

*“Among mums there is long term depression, not being allowed to go out, burden of looking after many kids, isolation, feeling drained, giving up, worn out”*

*“Issues in families: Levels of physical and emotional violence, in the majority of cases most of the stuff is dumped on women”*

One respondent felt that there was a ‘*lot of concealed family breakdown*’ and that the impact on children is in behavioural terms:

- *they can be timid or crying and not know how to manage*
- *children replicate the violence they are exposed to in the home*
- *poor eating, poor diet, weight loss, poor co-operation*
- *speech problems – set in a context of poor parental literacy levels*

Some respondents viewed racism as significant:

*“I think racial harassment affects families considerably, especially as they get no support.”*

*“Racism has a large part to play”*

The children and young people are not generally thought to have much awareness of their own behaviour as being a mental health problem, though girls were perceived to have greater awareness than boys:

*“I don’t think kids are very aware, much more engrossed in domestic problems”*

*“Kids are not aware of mental distress then things blow up”*

*“Children are not really aware of mental health problems, girls may be more aware than boys, as they have greater knowledge about services and how to access them”*

## **Carers**

The mental health of young people can be affected by caring for family members with mental health problems. In addition to the added burden of caring for the mental health of others, various impacts for the young people are described, from increased aggression and unmanageable behaviour among young children to concerns about missing school:

*“In my experience of families they are aware of mental health problems, but I’m not sure they are aware of the impact, in the cases I know, where the parents have a mental illness themselves, they are wrapped up in what’s happening for them rather than the kids. Also in these cases the parents don’t speak English.”*

*“One Asian young carer looks after her Mum who won’t allow her to go upstairs because she is afraid there are demons there. She is staying off school to be with her mum and the school are getting concerned. Another has witnessed his mother self-harming and is very distressed by it.”*

*“I don’t think the young people are aware at all of their mental health problems, they just know that they are unhappy for some reason. I think a lot have parents with mental health problems, so they share with nobody.”*

*“Young carers are often bullied, they may smell as they don’t wash or look after themselves”*

*“In one case Mum had mental health problems, which affected the child’s attendance – both parents worried that the child may be hit. In another case the mum was suffering from racial harassment, which made her very protective and over vigilant that the nursery could protect the child from racial harassment”*

*“Kids find themselves in a supportive role, kept away from school”*

*“A lot of Asian young carers are caring for someone with a mental illness, one case who comes here is caring for three family members, she handles all the appointments, organises the bills and money and acts as a translator. She is starting to experience problems at school.”*

Children acting as and being used as interpreters appears to be common, despite good recognition of the problems that this can cause:

*“Use of kids as interpreters is problematic”*

*“Kids get a lot of responsibility put on them, when interpreting they get access to information it may not be good for them to hear”*

### **Parents, family and the cultural context**

One of the most significant areas identified by professionals that have an impact on the mental health of children and young people is how the issues are perceived within the families. There is a strongly held view that many Pakistani Muslim families have a poor understanding of the concept of mental disorder or mental health problems, and that as a consequence they are more likely to view emotional and behavioural problems as ‘naughtiness’ in the child or young person:

*“It is not a priority for parents, they don’t understand mental health needs, what is normal or abnormal”*

*“Mental health as a concept is unknown”*

*“I don’t think it would be seen as a mental health problem, they would be more likely to see it as the child being naughty.”*

*“That’s the way the child is”*

*“Parents see children as problems i.e. if bed wetting, they blame the child, they don’t look at what is causing it”*

*“Parents put it down as bad behaviour”*

*“Parents see it as naughtiness, the kids are bad”*

*“They can’t understand changes in adolescents, poor understanding of this stage of development, the ones from Pakistan who don’t speak English just see it as naughty behaviour”*

*“Parents perceive child as the problem rather than behaviour that can be worked with...”*

*“Little family awareness, families put it down to the environment, ‘youngsters being teenagers’...”*

Some respondents identified other factors that families used to understand behavioural problems:

*“Parents don’t acknowledge emotional distress, they see it as Taveez<sup>2</sup>, Jadu<sup>3</sup> etc”.*

*“They view it as a ‘gift’ or the will of Allah, they don’t look outside for services that might improve the condition”.*

Though this was recognised as a service responsibility:

*“Family do not accept mental health, depression as problems, I do not think they have any knowledge of it and they are not aware of services”*

*“They don’t know its something that can be worked with, because we don’t tell them”*

Also, key generational and educational differences were acknowledged:

*“Younger parents are more aware of issues”*

*“How parents perceive the problem depends on their background and education”*

*“The older women and those who are not educated don’t relate problems to mental health”*

*“Parents put it down to ‘the times’, which they see as very different to their own, the more educated ones put it down to cultural conflict, most pressure comes from aunts and uncles”*

*“Problems are more likely to be high where parents are not literate”*

Some respondents identified wider issues to do with the extended family, cultural patterns and norms:

*“Many will try to contain problems within the extended family, don’t always acknowledge it’s ‘bubbling under the surface’, wait for it to come out”*

*“The root causes are escapism – from family pressures for academic achievement, pressure to conform to parental norms, sibling rivalry”*

*“Mums are powerless as husband and in-laws are the key decision makers”*

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<sup>2</sup> Taveez – an amulet with a prayer inside it – usually used to protect and keep the wearer safe (though there are also taveez’s that are believed to be used in a variety of negative ways)

<sup>3</sup> Jadu - Magic (usually interpreted as “black magic)

*“Living in extended family, conflict with parenting styles”*

*“Parents don’t have much education and are narrow minded, fear of unknown”*

*“Large families is an issue”*

*“Cultural variations in parenting i.e. weaning, leaving kids on their own”*

*“Tensions arise due to conflict in parenting ideas between mothers and older generations”*

*“With adolescent girls the main issues are marriages and runaways”*

*“Day to day structure is different – sleeping, diet etc”*

### **Cultural conflict and identity**

That young people, particularly adolescents were experiencing high levels of cultural conflict and identity problems were a common perception among professionals.

*“They don’t want to reject own culture but want to move on”*

*“They need support re identity issues”*

*“Being generally misplaced”*

*“Issues arise out of wanting to be like friends – English friends – “*

*“They share problems within the peer group but are frightened of being alienated”*

*“Confusion for kids, different expectations”*

Distinct differences between genders were also seen as significant in this regard:

*“Girls not allowed to use make-up or to go to discos, youth groups etc. Boyfriends are an issue, concerns about marriage...”*

*“Distinct gender roles, girls appear to be more intellectually liberated, they tend to do better at school”*

*“Lack of consistent messages”*

Though educational pressures were identified for boys and girls:

*“Kids are struggling with academic pressures, parents don’t understand these pressures”*

*“Cultural conflict issues, boredom, lack of education, employment chances leading to no money, no future”*

Some respondents linked a variety of experiences and pressures and that these were related to the environment, including the degree to which services were responding to these:

*“Dissatisfaction, disinterested, drugs, violence, gangs, apathy, , some of these issues have a cause – are a reaction to the environment and what services provide”*

*“The key issue generally is alcohol, there is peer pressure to drink alcohol”*

*“Violent behaviour is on the increase, they are bored”*

*“Families hide the problem, it is humiliating and embarrassing for the mums, they think the children are just naughty, blame it on the contact with other kids”*

Others also made links with wider factors of poverty and deprivation;

*“It’s the gap between aspirations and reality of opportunities, deprivation as a key factor”*

*“Housing”*

*“Lack of work opportunities, pick up aspirations of parents”*

*“General stress of deprivation, poverty, culture conflict, feeling restricted, confused”*

*“Strain to achieve yet perceptions are that they won’t ever get a job”*

### **3.1.2 FACTORS THAT PREVENT ACCESS AND SUPPORT SEEKING**

Respondents identified a number of factors, which they perceived to be important in preventing access to services, or inhibited young people themselves from seeking support.

#### **Lack of awareness of services**

*“Parents don’t question the GP, don’t know services are there”*

*“Young Asian people are prevented from being open and seeking help because they are not aware what is available”*

*“Service not known about”*

*“Lack of information, advice, access to services and cultural awareness”*

*“Don’t understand the value of support, prefer medicine, professionals feel inadequate if they can’t communicate openly and freely”*

*“There is a reluctance to use services”*

Some thought that therapies and play therapy in particular was not well understood or appreciated by South Asian parents:

*“Asian parents don’t understand the purpose of play therapy, they have a different concept of what learning is, it depends on the parent’s own up-bringing, could be a class thing”*

*“Parents don’t realise the value of play”*

*“Awareness of therapies is poor, Asian families don’t attach much value to these i.e. play therapy”*

Others said that there was very little understanding about any of the services:

*“There is just not enough information out there about where people can go and who they can talk to”*

*“Not being aware of services, you can’t ask for what you don’t know about”*

Children were thought to be harbouring resentments that the parents knew so little:

*“When kids see someone with some problem improving, and families functioning better, kids, other siblings do see a need and perhaps bear resentments for the parents for not having sought support, its not just the one with a disability but also the siblings”*

Other factors related to lack of understanding among parents and families included:

*“If the option is counselling or medication the latter is quicker and easier”*

*“Families would not support counselling for fear of what might be divulged”*

*“No confidence that they will bring about change”*

#### **Lack of trust and fears about repercussions**

*“Parents mistrust what will happen i.e. kids being taken away”*

*“Not wanting to be taken away from families, may be ashamed, don’t want friends to know they are different, afraid of repercussions if people find out”*

*“Families perceive talking services as just ‘nosy’ and not real treatment”*

*“Fears that kids will be taken away, most parents don’t understand services, they have a fear of being shamed in family”*

It is important to recognise that although this research is focused on Pakistani Muslim communities, it is likely that many of these issues would be found within white families. This is known in relation to fears of Social Services removing children and there are strong associations of stigma and mental health across all ethnic groups. There will also be similarities related to class and social exclusion and families living in poverty. It is the mechanisms by which communities interpret issues and compounding factors such as discrimination and racism that can lead to greater significance for many of these issues within Black and minority ethnic communities.

## **Stigma**

Stigma was identified as the largest factor affecting the take up of support services and in preventing help seeking among Pakistani Muslim communities.

*“Fear of labelling”*

*“Don’t access because of stigma, lack of information, no awareness of services”*

*“They are concerned about what the community will see and think, it will reflect on the family”*

*“There are huge stigma issues around special needs, parents don’t ask for services, ‘its Gods will’”*

*“Being known as having mental health problems would affect marriage prospects”*

This was seen to be a factor for children themselves:

*“Those in secondary school with good English do not want parents involved”*

*“Young people may recognise problems but are afraid to approach people for support, would be afraid of going to a clinic or health service due to family laughing”*

*“They wouldn’t discuss with teachers, scared of approaching professionals, awareness is not there”*

Within their communities families are perceived to be closed and secretive, afraid of anyone outside the family knowing what is going on:

*“Problems with trust and secrecy”*

*“The key cultural difference is the privacy aspect – not wanting people to find out”*

*“Things are kept secret, trouble between in-laws. It is a close knit community, word gets around, and services can’t help you anyway so why bother?”*

All these factors are seen to contribute to lack of understanding about problems and services and to prevent debate or exploration of issues:

*“Mental health problems are a taboo subject”*

*“We don’t have an appropriate language or discourse about it”*

*“Self harm is ignored”*

Some respondents identified access problems within service responses, or the perceived lack of them:

*“There are problems for kids in school when they are in temporary accommodation, contact is minimal with school, not aware what input school is having”*

*“We struggle on their behalf to secure services, we tend to treat symptoms not the cause.”*



*“For the groups I work with they may be aware of having mental health problems, but have few people to share with and no access to professionals”*

*“Not much around for parents to get support, mental health is not an issue they address, Home Start etc are not yet well established, they seek support from school staff”*

*“As workers it is hard for us to recognise and isolate mental health problems, we see it as part of being homeless, uprooted, we expect the kids to be dysfunctional”.*

### **Pathways**

A number of issues were related directly to particular care pathways at tier one and there is apparent confusion about which pathways work best. The Health Visitor appears to offer a gateway to services:

*“Our first point of contact would be the Health Visitor”*

*“The pathway at the moment would be through the Health Visitor, who would direct us to appropriate support”*

*“Young people and families would seek support from the Health Visitor or family centre”*

However, one Health Visitor felt that they were often left to manage cases:

*“Onus is on Health Visitor to define the client needs and then multi-disciplinary team decide yes or no re services. If no, then the Health Visitor is left with the case.”*

*“We don’t know if they have a mental health problem until they come to us and we start working with them.”*

*“There is a greater burden on Health Visitors”*

Though there was a view that primary care services are more accessible and appropriate:

*“Primary care is less stigmatising – its where everyone goes”*

There are mixed views about how accessible school nurses are perceived to be:

*“They tend to confide in school nurses more because we see them on a day-to-day basis”*

*“Children relate to those they know, such as the school nurse, it’s about their stage of development, they are not usually so willing to talk to strangers”*

While some tier one workers clearly feel able to manage a level of mental health problems themselves, the options to refer on do not appear straightforward:

*“There is nowhere to go, I’ve rung and rung different agencies and they can’t offer help, you are left with Social Services and Home Start, so far I’ve had no support from either, Social Services say its not their role”*

*“School nurses and counsellors usually refer to Social Services rather than CAMHS, they may see themselves as giving the mental health input, so no need for CAMHS”*

The role of Social Services in particular was seen as problematic:

*“Social workers don’t generally work with others; they wouldn’t refer to a voluntary agency as they don’t have confidence in them”*

*“Social Services go in too quickly; they don’t work with school nurses”*

### **The need for cultural sensitivity**

For some the issues of access are clearly related to the need for more culturally sensitive and specific services:

*“There is low uptake because we’re putting on, imposing someone else’s values onto families to whom it may be alien”*

A variety of cultural factors were listed that may not be appropriately recognised or addressed within agencies such as language barriers, the size of families and centrality of extended families, gender roles, work patterns and cultural norms.

One central aspect in the debate about culturally sensitive services is the employment of South Asian staff. This appears to be a polarised debate as to whether South Asian communities want to be seen by someone from their own culture or if this increases fears about stigma and confidentiality:

*“Wary of getting an Asian worker, fears about confidentiality”*

*“It can be an issue for white professionals to understand where an Asian Muslim father or mother is coming from and not to judge. They still stereotype”*

However, the majority of South Asian respondents did not see the issue as problematic:

*“Some white workers say Asian staff are not wanted due to fears of confidentiality but this is not a problem for Asian workers in post”.*

*“Its to do with the person, the way they present, their code of conduct. It is a trust issue, more to do with building up a relationship.”*

*“They usually welcome an Asian worker, they don’t have to justify or explain their behaviour to you”.*

*“I just don’t accept the arguments about Asian staff breaking confidentiality in the community, interpreters are Asian”*

*“Sometimes people have had bad experience with Asian workers, so tarnish all of them with the same brush. If the Asian worker doesn’t do what they want then they request a change of worker, fears about confidentiality are used as an excuse to try another avenue, boundaries are not understood”*

One respondent recognised that the issue of fears about confidentiality and stigma is generic to mental health services:

*“Mental health carries a stigma with it, there are concerns about confidentiality of services”*

### **3.1.3 CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)**

One aim of the project was to address issues related to the use of CAMHS by Pakistani Muslim children and young people. This was in some part driven by the CAMHS services themselves who recognised they were not being accessed by this community;

The professional respondents were asked about their experiences of Pakistani Muslim young people using these services and what they perceived to be potential barriers to service access and up-take. Respondents identified a variety of issues relating to understanding about services and their perceived relevance or use:

*“Young people may refuse to go because can’t see immediate benefits”*

*“Carers feel it’s not me so why should I need sorting out”*

*“Service not perceived as much use”*

*“Wouldn’t know of CAMHS existence – language barrier”*

*“Fear of statutory services taking kids away”*

#### **Relationship between tiers**

There appear to be a number of more general questions about the relationship between services in different tiers and whether CAMHS services are perceived to be at tier two or three, or even four:

*“It’s a strange relationship between CAMHS and primary care staff, professionals are just not aware of the range of work, perception that CAMHS is at tier four”*

*“Tiers one to three are where the issues are, people just don’t have a grip of this”*

*“I think if you asked the majority of professionals or managers about the use of joint finance funds by CAMHS and how much should be targeted towards primary care, they would want to see those resources on early identification and responses to issues”*

*“There is no relationship at present between CAMHS and frontline staff, this may change with the advent of Connexions which is located in the Youth Service. The role of personal advisors gives an opportunity to develop links”*

*“I would like to know more about CAMHS, what their criteria is for working with families, what the referral system is, like to know how we could all work together to support whole families”*

*“CAMHS should be much more community involved with a simpler referral process”*

*“Relationship with CAMHS is very good, they have visits and invite us to go along, learning and experience for both of us”*

*“We’re so used to referring and being turned down, we are conscious of the fact that children have to be very acute, access criteria is quite high, careful of labelling kids also.”*

*“Only severe cases get to CAMHS”*

*“The referral system has become more cumbersome and time consuming for us. You feel I’m not likely to get much for the time I spend making the referral, which could have been spent with the family. It’s off putting”*

*“When we refer we feel we have put the information on the form but then they ask us to be part of the assessment, whereas I feel they should undertake that assessment independently”*

*“In reality CAMHS only deal with the acute end”*

One respondent identified particular problems accessing psychology services, though access to CAMHS services in general was perceived to be getting harder:

*“Access to CAMHS is being made more difficult, they argue that cases are tier one but we only refer when we can’t cope, the load is just thrown back on to others, its passing the buck”*

*“There is no follow-up – if the person does not attend the case meeting, the case is closed”*

*“From my experience of the service, its really difficult to speak to someone, they are engaged or always in with someone”*

Stigma and the added stigma of specialist mental health services was seen to be a factor in poor uptake:

*“CAMHS can appear stigmatising”*

*“CAMHS implies you have a problem, if we’re serious about the tiered approach then tier 1 & 2 should be part of every day practice and shouldn’t be part of CAMHS”*

*“If you are ill you go into hospital but if you have a mental illness you go somewhere specialised, where it is located, this gives a strong message to users”.*

*“Going somewhere like CAMHS means acknowledging there is actually a problem, work needs to be done to help them understand the value of the service.”*

### ***The requirement for parental consent and presence***

The requirement for parental consent in order to access the services raised a number of strong views, both in favour of this and against:

*“Parental consent is a barrier, particularly for the South Asian community, it has become a block to treatment”*

*“Parental consent is definitely a barrier, even for younger ones. They are not going to speak candidly if the parents are there and they may also be the cause of the problem”*

*“Parental consent is a barrier as young people, especially young men wouldn’t want to talk to their parents about their problems”*

*“Parental consent may be necessary for younger ones, but it is a barrier and a formality”*

*“Parental consent for the adolescent end of the spectrum seems unnecessarily cumbersome, its trickier with younger children, depends on individual child”*

*“Parental consent is a barrier, South Asian girls can get the pill without parental consent so why not a mental health service”*

*“Parental consent is a barrier, will use School Nurse instead as this is more confidential”*

Alternatively, parental consent was an integral part of the service:

*“Parental consent is not a barrier, its one of our principles to work with parents”*

*“I feel that parents have a right to know, parents need to vet the services, could potentially be damaging if the parents don’t know. It is good practice to involve them”*

*“Over 50%of work is with parents, they are part of the assessment., we include them up to sixteen. We would not see a child under sixteen without parents consent. It is not a deterrent; often they turn up with sisters and brothers. It is more likely that we don’t have street appeal”*

It is clear that there are divided opinions about this issue and there are important points to be made on each side. It is not simply a matter of gate keeping or even barriers to service up-take as legal and ethical issues must be considered in the provision of specialist services alongside statutory obligations.

### **Did Not Attend (DNA) on appointment**

There is a high DNA rate for South Asian clients referred to CAMHS and various reasons for this are proposed. A principal factors is perceived to be related to the location and physical resources needed to access the services:

*“CAMHS are not locally accessible, they need to get a bus there, they’re not seen as within the community”*

*“Physical distance, transport, costs”*

*“Physical access to CAMHS service is difficult”*

*“The main reason for DNA is stigma and practicalities in getting there”*

*“Language barriers, stigma, cost, who will take with them”*

*“Poverty affects ability to get to the place”*

*“Practicalities of getting there – issues for women leaving the home”*

*“Difficult to find, families don’t see it as a priority, they have many kids, often all are young so travel not easy”*

Though one respondent felt that attendance was related to the level of concern about the children's behaviour or problems:

*"If really worried about the kids they will go"*

One respondent felt that including other professionals such as Health Visitors in the arrangements and referral process could mitigate the practical difficulties:

*"They will go if they have transport, if re-enforced by Health Visitor i.e. it's useful when a letter is copied to the Health Visitor"*

Others related the high DNA rate to issues of stigma and fear, being faced with an unfamiliar environment and the waiting time:

*"Most families would not go to a place they are not familiar with"*

*"DNA is high due to stigma of the service"*

*"The waiting list is around 16 weeks, by that time circumstances have changed; it's no longer a priority"*

*"Fears – they don't know what the appointment is about"*

*"Time lag between identifying problems and getting CAMHS appointment"*

*"DNA in CAMHS is due to stigma, language problems, not being physically able to get there, mistrust of disclosing information"*

*"Need more information about the service, unclear of their criteria for access, what they do"*

*"Mums don't always read English, physical accessibility of services – can involve 2 buses, it's not always seen as important, not followed up with phone calls"*

Many respondents identified issues related to parents understanding the referral letter, which is written in English and requires a return slip to be completed confirming the appointment:

*"Often the letter is not understood i.e. the need to return the slip if they want the appointment"*

*"Appointments are primarily done by letter, they really need to be followed up"*

*"Letters are not in the right language, but it's not just Asian parents who do not attend its everyone"*

*"Appointment letters in English – the slip is a problem"*

It is important to consider within this context that there are high levels of illiteracy within the South Asian adult community, not just in relation to English. It is unlikely therefore that written communication will be the sole answer to this issue.

One respondent identified similar problems with regard to education services:

*“There are real issues about the DNA rate, we have the same problem with statement meetings, I don’t think the parents always see the real benefit, the quality of provision is poor, not quick outcomes, don’t want to send kids to white euro centric services”.*

### **Perceived cultural sensitivity of CAMHS**

For some the perceived cultural sensitivity and friendliness or familiarity of the CAMHS services was the key factor affecting access:

*“May not see a welcome face when they get there”*

*“They need to visit people’s houses, need more Asian staff who would be sensitive to young people’s needs”*

*“Need more familiar faces i.e. ‘Black’ faces”*

*“Family structure is an issue, we need to accommodate whole families, especially when they are large”*

*“Whole family needs to be worked with or its only treating part of the problem”*

*“Lack of cultural sensitivity, alienating and perceived as racist”*

Issues over the use of interpreters and conflicting views about what families want were also apparent among the respondents. Some views appear to confirm stereotypical views about South Asian communities:

*“If parents need an interpreter they often don’t want a professional one, they prefer a family member or an advocacy worker”*

Others confirmed professional barriers to working with interpreters:

*“They can’t have a therapeutic relationship with an interpreter”*

### **3.1.4 SERVICE DEVELOPMENT**

All the professionals were asked what kind of service developments they would like to see, the responses are grouped as follows:

#### **Employment of Black staff**

*“Services need to employ people from the communities who speak the language and understand the culture, when distressed you want to speak in mother tongue”*

*“Recruitment and training of Asian staff”*

*“Need more Asian nurses in the schools so that Social Services are not brought in too soon and things escalate”*

*“Specialist Asian workers”*

### **More family work**

*“Work with husbands”*

*“More family workers”*

*“Combination of services in package for families”*

*“Whole families need to be worked with, but there is a range of problems to involving the whole family”*

*“Needs of parents and carers need to be addressed”*

Some of this work was directly linked to the need for education and awareness raising about problems and services:

*“More awareness raising with families re what’s available and the impact on family life of mental health problems”*

*“Approach it from work with parents – awareness raising re mental health”*

*“Info re services and how to access them”*

*“There is a definite need to educate families”*

### **Older generations and extended family**

Some identified the need to specifically work with the extended family and older generations i.e. grandparents;

*“We need to work with the older generation”*

*“We should harness the grandparent carers in the community if we want to be a bit creative”*

*“Restructuring of access to include extended families”*

*“Involve the range of generations, parents with problem kids want help instantly”*

*“Targeted support at whole families”*

### **Links with other services**

Improving links between services and across tiers were identified as priorities for development:

*“Demystifying things and at the same time increasing information to allow people to spot signs earlier, particularly in relation to links with Sure Start and their work in helping kids and families earlier”*

*“Children’s services should be providing CAMHS”*

*“School nurses believe their role in respect of children and mental health problems could be big”*



*“Pastoral worker systems”*

*“Maybe CAMHS should link into schools, if school nursing teams had someone with mental health training it would be a great help”*

*“Training for school nurses”*

*“Primary Care Trusts create an opportunity for CAMHS workers to work more closely with primary care teams – integrated work within a locality, focused response to health and social care issues.”*

*“Counselling should be taken out of CAMHS into the community”*

### **Service improvements**

Various recommendations were made to improve existing services such as making them more readily accessible in the community and creating more peer based service programmes:

*“Relocate services to community and be more fluid, not so much a specialist service, a more generic role”*

*“Make services more child accessible, not through schools and parents, but through other sources that they can contact themselves”*

*“Support needs to be at the time it is needed, if you don’t get it at the right point you will go downhill”*

*“Regular meetings to monitor development and progress”*

*“Reduce waiting times”*

*“Quick response team for initial assessment”*

*“More preventative work”*

*“Drop-in services”*

*“To be pro-active”*

*“Going into people’s homes”*

*“Visit the home, involve Asian workers, have an interpreter who understands the therapeutic process”*

*“Whole families should be included”*

*“Peer education schemes”*

*“Social groups where kids come together”*

## SUMMARY

The professionals identified a wide range of factors that they perceived to be influencing the mental health of Pakistani Muslim children and young people. The predominant impression of how Pakistani Muslim children and young people express mental distress or problems is through withdrawal and passive-aggressive behaviours. Withdrawal is also viewed as the behaviour that causes most concern. The factors that are perceived to lie behind these problems can be characterised as follows:

- Family conflict and breakdown
- Cultural context
- Environment
- Poverty and deprivation
- Co-existing family problem

There is a strong perception among the professionals that where children and young people are experiencing mental health problems this is often in response to family conflict and breakdown. Apart from some concerns about domestic violence within the home, this conflict is predominantly characterised as generational i.e. between parents and grandparents over parenting styles. The key issue that is seen to generate the most conflict is that of marriage, though little distinction is made by the professionals between arranged and forced marriages.

There is a strong gender bias in the professionals' perceptions, with women perceived as being the focus of most conflict, whether this is from the children themselves or from other family members. Mothers are portrayed as isolated, often unable to leave the home and denied access to other parents and potential sources of support. Girls were also portrayed as being subject to greater controls that can be a source of conflict, very often in relation to adopting western lifestyles such as using make-up or being allowed to attend discos. It is the degree to which these issues are generating conflict within the home that is identified by the professionals as being a cause of concern. Underlying this are assumptions that traditional cultural patterns and norms are breaking down, resulting in increased levels of distress and problem behaviours among children and young people.

The degree to which culture is identified as a source of problems; or rather the degree of cultural conflict between children and young people and traditional family patterns is a consistent theme among the professionals. Young people are strongly characterised as experiencing issues regarding identity as they are caught between the different worlds of home and the 'outside world' in general. However, as can be seen in the next section, the children and young people felt that they had a strong sense of identity and did not perceive this to be a source of problems.

Also connected to concepts about cultural influences were some suggestions that religion and superstition may influence the way in which mental health problems are addressed.

The concepts of faith healing and certain superstitious belief systems were said to be used by parents in interpreting and dealing with problematic behaviours. This is in turn connected to a view that concepts of mental illness are culturally bound and that there is very little concept of the western idea of mental illness and mental disorder within the Pakistani Muslim communities.

This view was linked to educational attainment among parents and the degree to which they spoke English, with a clear suggestion that the less well educated and older the parents the less likely they were to have a concept of mental health problems.

A consequence of this is that parents are thought to characterise all deviant or abnormal behaviour in children and young people as wilful and 'naughty' rather than symptomatic of other problems. The common example given was that of bed wetting where parents perceived it to be a result of bad behaviour and tended to blame the child.

In addition to family and cultural conflict, environmental factors were also identified as significant, notably alcohol and drug use. It is particularly interesting to note that alcohol was perceived to be a cause of problems given the religious and cultural prohibitions against alcohol. The professionals also saw parents as blaming environmental factors such as contact with other children from non-Muslim backgrounds. The professionals do describe a sense of alienation and disaffection among the young people, which they link, to boredom and increasing levels of violence and gang related conflict. However, this is more symptomatic of the social and environmental conditions rather than having direct relevance in terms of mental health.

Although environmental factors are perceived to be important much greater emphasis is placed on deprivation and poverty. It is known that these communities are largely concentrated in some of the most deprived wards in the area and that there are high levels of unemployment. Family patterns also result in large families, which further exacerbates the economic and social conditions in which they live. Housing in particular was identified as a key factor with overcrowding viewed by many professionals as a detrimental factor for children and young people.

Given the factors of multiple deprivations it is not surprising that the professionals also identified co-existing problems within the family as contributing to the mental health problems of children and young people. While there was recognition of learning difficulties among siblings and a suggestion that much of this is undiagnosed the key area of concern was in relation to the mental health problems of mothers and children and young people acting as carers.

A third of the children and young people accessing the young carers support service were reported as being South Asian, though it was also said that many are prevented from utilising the service because they were girls and were not allowed to attend on their own. The professionals clearly view the presence of co-existing mental illness in the family as significant and that the children and young people are affected in a number of ways including developing their own mental health problems, losing friends and social supports and missing school.

The overriding impression from the professional's perceptions is of a hidden burden of mental health problems compounded by various cultural and socio-economic factors. In particular there is thought to be very little understanding about mental health issues and a degree of conflict between western and Asian concepts about behavioural problems. It is useful to compare and contrast these views with those of the children and young people and parents, carers and community members who were consulted through a number of focus groups.

## 4 CHILDREN AND YOUNG PEOPLE'S VIEWS

Seven focus groups were held in different locations with Pakistani Muslim children and young people, aged between 11 and 18. The children were asked a series of questions that were derived from the analysis of interviews with the professionals. A prompt card was also used to probe differences between the children and young people's views and those of professionals.

### 4.1 What does being 'mentally healthy' mean to you

The children and young people in the focus groups were asked to identify things, which they saw as being 'mentally healthy'. The answers have been grouped to suggest understanding across seven domains; views of others, ability, identity, physical health and attributes, feelings, mental ability and behaviour.

#### **Views of others**

*"No one ever saying you are mental"*

#### **Ability**

*"Able to do anything"*

*"Good at adapting – ability"*

*"Perform normal life tasks"*

#### **Identity**

*"Identification"*

*"Knowing who you are"*

*"Knowing identity and being quite happy with it"*

#### **Physical health and attributes**

*"Being normal, eating well, being active"*

*"Dental health"*

*"Body language"*

#### **Feelings**

*"Feeling good about yourself, calm and relaxed"*

#### **Mental ability**

*"Being brainy at school"*

*"Thinking better"*

*"Not slow"*

#### **Behaviour**

*"Good behaviour"*

*"Being offered drugs and saying no"*

The majority of responses related mental health to physical attributes and mental ability.

## **4.2 What do you think are the mental health problems for young people**

When asked to identify mental health problems for young people the respondents in the focus groups identified six domains: emotional, disability, behavioural, mental, eating disorder and physical.

### **Emotional**

*“Stress, depression”*  
*“Depression – mainly parents issue”*  
*“Stress”*  
*“Not feeling right”*

### **Disability**

*“Disabled”*  
*“Handicapped”*

### **Behavioural**

*“How they behave – aggressive, rude, violent”*  
*“Might beat someone up, go crazy”*  
*“Disturbing other people”*  
*“Bad attitude at home, swearing, family life disturbed”*

### **Mental**

*“Mentally disturbed”*  
*“Mentally disturbed in head”*  
*“Not doing things properly”*  
*“Might do stupid things”*  
*“Putting stupid clothes on, acting stupid, pulling faces”*  
*“Being lost in the head, a bit slow, unable to think for yourself”*  
*“People who believe they are Adolph Hitler”*  
*“Slow in the brain”*  
*“Mentally delayed, disabled”*  
*“Mental health problems equals dumb”*

### **Eating disorder**

*“Anorexia”*  
*“Skinny”*

### **Physical**

*“Might be ill – cancer”*  
*“Health problems”*  
*“Being unhealthy”*  
*“Worn out”*

### **4.3 What do you think causes mental health problems?**

When asked to identify the causes of mental health problems the young people were able to link mental health problems across a wide range of spheres of experience including; family, arranged and forced marriage, racism, relationships, substance misuse, body image, emotions, school and academic pressures, self image, being a carer, cultural/parental conflict, unemployment and peer influence.

#### **Family**

*“Parents being too strict”*

*“Mental health of elders”*

*“Parents mental health – kids have no work, daughters in love drives them mental”*

*“Family and cultural pressures, not being allowed to see a film, but varies from family to family”*

*“Family, marital problems”*

*“Parents do not realise what kids are doing”*

*“Family problems – we care about education and they think about marriage, no communication, we want to go one way and they want to go another”*

*“Having our lives planned for us”*

*“Family, they might chuck you out if you’ve done something bad, you might have a girlfriend they don’t want you to have”*

*“Influence of family – bad influence by not looking after you, neglecting you, if you are disabled or parents always fighting”*

*“Family conflict, domestic violence affects kids and wives”*

*“Single parents”*

#### **Arranged and forced marriage**

*“Arranged marriages can cause it – might not agree, forced marriages, not wanting a woman from Pakistan can cause family problems with in-laws”*

*“Stress from parents about marriage”*

*“Girls pressurised into marrying”*

*“Arranged marriages when you are too young or might already be in a relationship”*

*“Arranged marriages if they don’t like the person and want to marry someone else, some parents insist on their choice, some not”*

*“Parents are backward, marrying in Pakistan, the boys are just looking for a passport, they come here, are left alone and get depressed, isolated”*

*“Arranged marriages”*

#### **Racism**

*“Racism – if you are getting picked on, might go mental”*

*“In school there is bullying, racism by the teachers, brothers will threaten those troubling me, it is a threat culture”*

*“Teachers very racist”*

*“Abusive language”*

*“Racism is very bad, even the teachers are racist, different rules for whites and blacks e.g. if a white person swears at an Asian and the Asian swears back the Asian will be the one in trouble”*

*“Racism goes both ways”*

*“Racism not an issue, its all Asian here”*

*“See it outside school too”*

*“Teachers act like they don’t really want you to be educated”*

### **Relationships**

*“Love-life problems”*  
*“Relationships”*  
*“Girl friends”*

### **Substance Misuse**

*“Drugs”*  
*“Drugs, drinking”*  
*“Drugs, heroin”*

### **Body image**

*“Image”*  
*“Weight loss”*  
*“Weight”*  
*“Image”*  
*“Not eating, puking, losing weight”*

### **Emotions**

*“Related to not feeling happy”*  
*“Feeling down all the time”*  
*“Depression”*

### **School and academic pressures**

*“Worry about teachers, being penalised by them”*  
*“GCSE’s”*  
*“Problems at school, lots of fights with white people, gang fights”*  
*“Problems at school, fights, bullying, gangs”*  
*“Exams”*  
*“Pressure to succeed or be like someone”*

### **Self image and how viewed by others**

*“Rejection”*  
*“Being treated differently”*  
*“Jealousy – “You see someone is better than you and you want to copy them and want them to like you”*  
*“People talking about you at school”*  
*“People talking about your mum, parents”*  
*“Rumours”*

### **Being a Carer**

*“Young carers”*  
*“Being a carer – it affects education, wont get a good job, really important for future”*  
*“We don’t think Asian kids have to care more, we get help from all the family”*  
*“Being a carer is a good thing, looking after the family”*

### **Cultural/parental conflict**

*“Cultural pressures e.g. clothes, going out etc., but if they don’t let us its alright, its for our own good”*

*“Cultural pressures – you want to go to the youth club and your dad wants you to do Namaaz” (Prayers)*

*“Coming in late and your parents not knowing where you have been causes stress”*

*“We live in 2001, everything is so modernised so girls want to wear trousers, talk about boys and parents don’t like it”*

*“Cultural pressures”*

*“Doing something wrong”*

*“Girls have too much responsibility”*

### **Unemployment**

*“Unemployment is a big source of stress”*

*“Being unemployed and need money, doing drugs”*

*“Poverty, aspirations, debts”*

### **Peer influence**

*“Peer pressure friends making you do drugs”*

*“Hanging around bad people”*

*“Peer pressures, everything starts from peer pressures”*

### **Other**

*“Someone passing away”*

*“Superstition”*

### **Identity**

In contrast with the professional views identity was strongly rejected as a cause of mental health problems except possibly for those of dual heritage:

*“Identity is not an issue – ‘I am a Pakistani Muslim male’ – Behave different at school and with Dads”*

*“Identity – people feel alright where there is a large majority of Asians, there’s not isolation then”*

*“Identity is not a problem”*

*“We don’t struggle with identity, we become independent when we marry and settle, white kids are just thrown out”*

*“Half-caste kids not accepted by either background”*

## **4.4 Who would you go to for support?**

When asked who they would go to for support and help if they did have a mental health problem, some of the children and young people were very specific about wanting someone from their own culture and others expressed their concerns about what going to someone for help may mean or what might happen to them:

*“If referred for mental health I would go to Pakistan”*

*“Be scared to go to a service, don’t know what would happen to you, might be taken to a mental hospital”*



*"I would want to speak to someone I don't know"*  
*"Someone from my culture"*  
*"Prefer someone different, I would feel ashamed with someone of my own religion"*  
*"Someone who speaks my language"*

One very specifically would not want to see an Asian worker,

*"I would tell who I trust, not an Asian worker"*

### **Family**

The family were viewed by a significant number as a source of potential support and help, even if only as a last resort:

*"Keep it to yourself and then when worse comes to worse tell friends or family"*  
*"Family would be there if needed, our parents are not strict we find them supportive"*  
*"Aunties, sisters who are the same age"*  
*"Dad, big brother"*  
*"Big brother"*  
*"Mum, sisters"*  
*"Uncle"*  
*"I would go to my Uncle"*

Only two had reservations about going to the family,

*"Mum would be scared and shocked"*  
*"Wouldn't let parents know, they would think we couldn't get married"*

### **Friends**

Friends were the next main source of support,

*"Talk to friends about family problems"*  
*"Friends"*  
*"Friends give advice from someone same age"*  
*"Talk to friends"*  
*"Rely on friends not family"*  
*"My friends"*

### **General Practitioners (GP)**

There were very strong rejections of the GP as someone the children and young people would go to for support, with only one saying the GP as a first choice:

*"Don't trust GP"*  
*"Can't be bothered with doctors or nurses, they just say yes, yes, yes and at the end give you paracetamol tablets"*  
*"By the time you see the doctor something has happened"*  
*"Not GP, probably just give you drugs"*  
*"Only see GP if very unwell"*  
*"GP would be last choice"*  
*"Parents use emergency doctors"*

### **School nurses and Counsellors**

Equally, school nurses and counsellors are not readily seen as accessible or approachable for support:

*“Would not go to counsellors, don’t see them as useful”*

*“We wouldn’t talk to the school nurse, they don’t make sense, they don’t understand what we are saying”*

*“I would talk to the school nurse but I wouldn’t tell her anything about my family, just me”*

*“Wouldn’t go to school nurse”*

*“We don’t even know our school nurse, we never see them”*

*“Never see our school nurse”*

*“When we need them they are not there, when we don’t need them they are there”*

*“School nurse if we get an opportunity to build a relationship with her”*

*“If we talk to the teacher they talk to the school nurse about it in the staff room”*

Only one person said they would go to a teacher.

### **Social Services**

Social services were also viewed as a poor option:

*“Wouldn’t talk to Social Services”*

*“I wouldn’t talk to anyone, they tell Social Services and they come to the house”*

Though said they would talk to a social worker if the person was Asian and another said they would use social services as a last resort.

*“I would talk to an Asian Social worker”*

*“I would risk it and see what happens”*

### **Other services**

Only a few mentioned the Youth Service and one did so with ambivalence:

*“Youth Service”*

*“Not sure if I would use help line or youth service”*

## **4.5 What kind of service would you like to see?**

### **Location**

Location was an important issue for service development, though there were mixed views about whether this should be local or far away:

*“One out of town, you wouldn’t want anyone to see you there”*

*“A building with lots of courses”*

*“Local”*

*“Asian counsellor based locally”*

*“Not local, people might know you, they would stare, laugh at you”*

*“So you could walk to it”*

### **Parental consent**

The issue of needing parental consent to access a service was a concern:

*"I wouldn't go if parents consent was sought, they would worry and tell everyone else"*

### **Culturally sensitive**

The children and young people did identify culturally specific issues, especially language as being important in service developments:

*"Where people can understand you, talk like you and in own language"  
"Where you can talk comfortable and use own language, speak Punjabi at home"  
"Don't mind Asian professionals as long they are nice and I can talk to them"*

### **Help lines**

The largest support was for the development of telephone help lines, which were seen as offering more privacy and confidentiality. Computer and Internet access were also identified as being service developments that the children and young people would like to see:

*"Help lines, not face to face, confidential"  
"Help line"  
"Phone service"  
"Internet, computer access"*

### **Process**

There were particular views about how the processes of receiving help should operate and the range of services that should be on offer:

*"Initial meeting shouldn't be recorded"  
"Appointments not too long"  
"Trust"  
"More information about things we could do"  
"Going out, socialising more"  
"People who have been through it"  
"Somewhere you can just walk in"  
"Support services, natural treatments"*

The children and young people also identified the need for service development that was targeted at their parents:

*"Parents don't know about agencies, they've got it wrong, you should tell them, they should go to their houses and tell them services are available"*

## SUMMARY

The professionals did not perceive Pakistani Muslim children and young people to be very aware of mental health problems or their own distress. This is in direct contrast to the views expressed by the children and young people themselves who articulated a very sophisticated description of what constitutes mental health and how mental health problems may be caused. The children and young people linked mental health across the domains of;

- views of others
- ability
- identity
- physical health and attributes
- feelings
- mental ability
- behaviour

Mental ability was given particular prominence and this is reflected also in concerns about academic performance and aspirations to achieve. Community members raised schooling and academic pressures as being a potential cause of mental health problems. Professionals also highlighted academic pressures and the aspirations of parents against the socio-economic reality of poor employment chances.

Physical health was also given particular prominence by the children and young people and this is interesting given the higher rates of attendance at GP surgery's by Pakistani young people (ONS. 1999). Concerns about weight and dental health were mentioned specifically and the latter in particular is a known factor within this group and obesity has also been identified among older Pakistani women (ONS. 1999). Concerns then with physical health and its connection to mental health may well be rooted in the common health concerns within Pakistani communities as a whole. These issues did not receive prominence among the professionals.

The young people identified family conflict though much more in relation to marital problems between parents or conflict with parents than in terms of generational conflict with grandparents. Parental strictness and discipline were viewed as the main sources of conflict with parents. The young people also identified domestic violence.

The issue of marriage was perceived by the young people as a potential cause of mental health problems if it was forced or if the young person was already involved in a relationship. The children and young people largely saw the issue of marriage affecting girls though there was recognition that the young men coming over from Pakistan to marry were often left isolated and became depressed.

Cultural issues for the children and young people were identified in terms of family conflict arising from wanting to be more westernised such as attending youth clubs, discos etc. However, while these issues clearly involved cultural conflict when asked about identity the children and young people strongly denied that this was an issue. This is in direct contrast to the professional views. Behaving differently at home and with friends in school was not perceived as an issue and the young people proudly asserted their Pakistani Muslim heritage. However, self-image was perceived to be significant especially if someone was the subject of rumours or ridicule. There was a marked concern with rejection and fears about being treated differently within the peer group.

The children and young people were making a clear distinction between identity as part of cultural heritage and identity as image and perception among peers. There was a view that identity issues may be more prominent among those of dual heritage.

Environmental factors did not figure prominently among the children and young people though drugs and alcohol were mentioned. Poverty and deprivation was referred to in terms of unemployment and linked to the academic pressures to perform well at school.

Of far greater concern to the children and young people, and this was not prominent among the professionals, was racism. The experience of racism was common among the children and young people and while it was recognised as being both within and outside schools, there were particular concerns in relation to racism within schools and from teachers in particular. There was a perception that in situations of conflict with white pupils the latter would be favoured and some spoke of living within a culture of confrontation and threat. Given the recent riots in Bradford and the findings of the Ousley report in relation to issues of segregation and division between white and Black communities it is particularly interesting that the children and young people identify racism as a significant factor in mental health problems. The relative lack of concern about these issues among professionals may also be of interest in that it is clear that an ability to work with the realities and experiences of racism is necessary for working with this group of children and young people.

Being a carer was given recognition by the children and young people as an issue, though they also viewed caring roles within the family as a good thing and something that could also be protective. The key negative impact of being a carer was perceived in terms of educational problems and missed schooling rather than leading to mental health problems in the carer. There were no specific references to mental illness among mothers or within the family.

One of the over-riding messages that comes through strongly from the children and young people is that they should be seen as children and young people first and not pigeon holed or stereotyped according to their cultural background. There is a strong sense that they are developing a new culture, which crosses both traditional boundaries of home, family and religious life and more modern 'western' lifestyles and choices as experienced within school and the wider community.

## 5 VIEWS OF PARENTS, CARERS AND COMMUNITY MEMBERS

Five community focus groups were held involving a total of 61 people (see Appendix B). A key difficulty with this set of groups was their struggle to identify concepts of mental health in relation to children and young people.

### 5.1 Types of mental health problems

Some of the community group participants actively denied that children and young people experienced mental health problems:

*“Young people don’t have mental health problems, the government supports them”*

One saw mental health issues in terms of possession or physical illness resulting in confusion:

*“Not mental health issues – possession, ill or confused”*

Others said that they had never heard of eating disorders, self-harm or drug use among their young people and they were shocked by the idea, saying that they must be very ill indeed.

One respondent linked the lack of awareness in their community to an attitude of blame and judgement about young people’s behaviour and feeling threatened by other explanations:

*“Parents see it as a threat to their culture, the influence of this society – being too clever for their own good “*

The type of problems that the groups did identify were largely behavioural:

*“When your brain doesn’t work, when they don’t understand what they are doing”*

*“Change of behaviour, anger, stubborn”*

*“Eating disorders”*

*“Anorexia”*

Others linked mental health problems to declining appearance and truancy from school.

### 5.2 Causes of mental health problems

A variety of views were expressed regarding possible causes of mental health problems, and there was a clear divide in opinion as to the degree that cultural and familial norms may or may not contribute to behavioural problems among children and young people. One respondent said that it was a matter of cultural differences rather than pressures.

## **Family problems**

Some recognised family and generational conflicts as a cause of problems for young people:

*“Marital conflict over the kids marriages”*

*“Pressure from Grandparents creates family tension, leads to poor mental health for women”*

*“Domestic violence is an issue, but for few, isolated cases”*

*“Marriage”*

*“Parents who don’t have time”*

Arranged marriages were not recognised as a cause of problems:

*“Arranged marriages are only an issue for girls, the boys are alright, they get their wives and keep their girl friends”*

*“Only send to Pakistan for marriage when they have no choice”*

*“Arranged marriages are not a problem, it’s when they are forced and both parties don’t agree”*

*“Not arranged marriages”*

*“If they are good at school we will not send them for marriage”*

Others saw the extended family as a positive influence and that the issues resulted from children and young people not listening or obeying their parents:

*“Large families are good, not an issue”*

*“Not listening to parents”*

*“No respect for elders”*

Much of the focus on mental health issues as behavioural became apparent as many group members identified the problems in terms of lack of respect and lack of discipline:

*“They are just naughty”*

*“No laws”*

*“Too much freedom”*

Drugs and alcohol were also mentioned as causes of mental health and behavioural problems.

There was recognition of issues related to the mental health of mothers and possible impact of this on children:

*"If mum is depressed the responsibility falls on the eldest girl"*

*"Girls from 10 – 14 are being diagnosed with the same as their mothers, tension, muscular pains – they don't go to school, not allowed to go to young carers group"*

Despite this children and young people were not recognised as carers by many of the community group respondents, some of whom felt very strongly about this issue:

*"There are no young carers, they don't care, they have their cars, music, playing and they get on with their own stuff"*

*"Not young carers – this is good, large families are good, kids mature earlier"*

*"Being a carer is good, it's a value we instil, we keep our elders at home and look after them"*

### **Environment and employment**

The largest area identified as being a factor in the mental health or behavioural problems of children and young people was the environment in which they lived:

*"The environment ruins the kids and encourages them to lose all values and structure"*

*"This environment encourages it"*

*"Unemployment, poverty"*

*"There is a culture of unemployment"*

*"Unemployment is biggest cause"*

*"In a survey here most of the kids aspired to being a taxi driver"*

The media was also cited several times as having an adverse influence on the behaviour of children and young people.

### **School based problems**

There was recognition of problems at school, in particular academic pressures and bullying:

*"Bullying at school"*

*"Teachers don't have time to listen to problems they just discipline"*

*"Pressure of academic work"*

*"Academic pressure"*



One respondent related problems to the recent riots and the issues of racial segregation in the schools:

*“The schools are segregated this is why there have been riots, there is no opportunity for integration during school age, white people don’t send their kids to the same schools as our kids”*

Racism, particularly in the schools was recognised as a significant issue:

*“Racism is a big issue for young people”*

*“Safer to stay inside”*

*“Problems at school, bullying –racism – the kids feel they are ignored if picked on but punished if they retaliate”*

One participant felt that children and young people should be taught about mental health issues:

*“Kids at 14, 15 are very vulnerable, not aware of mental health, don’t know the importance of it, if they have sex education why not mental health education?”*

#### **5.4 Who would children and young people use for support**

Parents were certainly the preferred option among the community group respondents, even if they were aware that children and young people may not wish to talk to their parents:

*“Should use parents”*

*“Parents would use help if recognised the need”*

*“Parents thinking is different, they want to protect the kids”*

The general attitude about professional and medical services as sources of support was negative:

*“Social Services always make things worse, they always support the kids”*

*“We wouldn’t go to the GP”*

*“School nurse is not accessible”*

Friends were recognised as a source of support and some participants mentioned the use of Pirs (religious/spiritual leader) and Hakims (traditional alternative healer).

#### **5.6 What kind of services would you like to see?**

The groups did not have very many ideas about the type of services they would like to see, though it was suggested that peer based services would be problematic as they *‘will only make each other worse and take drugs’*. The main suggestion for service development was that it should be based around parents and parental advice.

## **SUMMARY**

Among the parents, carers and community members in focus groups concepts of mental health were poorly identified. This in some ways confirms the professional views that there is little awareness and understanding of mental health within the community. When asked to identify mental health problems these were largely behavioural such as conduct problems and eating disorders. However, a number of respondents had no awareness of these phenomena and appeared quite shocked that this might be happening within their communities.

Family conflict was recognised as an issue, including recognition of domestic violence. Generational conflict between parents and grandparents was not mentioned, the extended family was viewed as a positive factor and only a source of conflict when younger people did not respect the elders. A distinction was drawn between arranged and forced marriages and while it was perceived that the latter could cause mental health problems arranged marriages were uniformly viewed as good. Linkages were made between educational attainment and marriage with the suggestion that if a young person was doing well at school they may not be pressurised into marriage.

Where problems are given an external cause this is usually attributed to the environment, particularly in relation to exposure to 'western' influences. Drugs and alcohol use in particular were mentioned in this regard.

Deprivation and poverty were seen to be significant factors, especially in relation to employment and the low aspirations that were generated by the social and economic conditions in which the young people were growing up.

Mental health problems in mothers were recognised but there was a very strong reaction to the notion of young carers with a complete rejection that the young people were burdened with this. The overriding impression was that children and young people were not caring enough, as family responsibility was prized highly within the groups and there was a sense that concern for traditional values was lacking in the younger generations.

Racism was seen to be significant and like the children and young people this was strongly associated with the schools and attitudes of teachers. Bullying and academic pressures were also identified.

## 6. LITERATURE REVIEW

Before making conclusions about the data presented in the previous section it is necessary to explore what has been learnt from the literature review and the national and local policy context.

As was said previously in the methods section, there never were high expectations as to what the literature review may contain. It was known that there has been very little research in this area in the UK, certainly up to 1995 and while research from the USA and other countries can sometimes provide some insights, it is always inherently difficult to translate findings from other countries into the UK context.

The prevalence figure of mental disorders among children and adolescents is thought to be up to 25% with as many as 40% thought to be experiencing mental health problems (Meltzer et al. 1999). The same national survey attempted to include prevalence estimates among Black and minority ethnic children and young people aged 5 to 15 years. Table 1 shows the prevalence rates for Indian, Pakistani and Bangladeshi children and young people compared to all children. It is important to be cautious in approaching this data for the following reasons:

- The sample size of Indian, Pakistani and Bangladeshi children is very small
- In attempting to address Pakistani Muslim children and young people the sample size is even smaller and can not be extracted from the Bangladeshi sample
- Responses to the survey were done on a self completion basis and it is unclear what, if any steps were taken to address the high rates of illiteracy among Pakistani adults, there may therefore be an inbuilt bias within the sample
- There has been very little research on cross-cultural effectiveness of various mental health screening tools and different cultural interpretations of mental health disorders and behaviour may affect the survey responses

What can be seen from the data in table 2 is that while overall prevalence rates for any mental disorders are lower for Pakistani and Bangladeshi children and young people, the rates for emotional disorders are generally higher than other ethnic groups.

**Table 2 Prevalence rates of mental disorders by ethnicity. (Meltzer et al. 1999)**

<b>Ethnicity</b>	<b>Characteristic</b>	<b>%(p) (adj)</b>	<b>Sample size</b>	<b>Confidence interval</b>
White	Emotional disorders	4.31	9529	3.88 – 4.74
	Conduct disorders	5.38		4.85 – 5.90
	Hyperkinetic disorders	1.57		1.31 – 1.83
	Any mental disorder	9.58		8.94 – 10.23
Black	Emotional disorders	3.25	247	1.15 – 5.35
	Conduct disorders	8.56		4.76 – 12.35
	Hyperkinetic disorders	0.38		-0.37 – 1.13
	Any mental disorder	11.99		7.79 – 16.19
Indian	Emotional disorders	2.90	215	0.55 – 5.25
	Conduct disorders	2.11		0.15 – 4.06
	Hyperkinetic disorders	0.00		0.0 – 0.00
	Any mental disorder	4.02		1.30 – 6.74
Pakistani and Bangladeshi	Emotional disorders	5.47	189	1.59 – 9.35
	Conduct disorders	2.99		0.09 – 5.89
	Hyperkinetic disorders	0.00		0.0 – 0.00
	Any mental disorder	7.52		2.51 – 12.52
Other	Emotional disorders	5.63	251	2.67 – 8.59
	Conduct disorders	3.94		1.15 – 6.73
	Hyperkinetic disorders	0.44		-0.40 – 1.27
	Any mental disorder	10.17		6.03 – 14.30

The survey used ICD- 10 diagnostic criteria to determine the presence of mental disorder, that is

*“...a clinically recognisable set of symptoms or behaviour associated in most cases with considerable distress and substantial interference with personal functions.”*  
(ONS. 1999. Chapter 2. 2.2 page 16.)

The sub-categories for emotional disorders include:

**Anxiety disorders**

*Separation anxiety*

*Specific phobia*

*Social phobia*

*Panic*

*Agoraphobia*

*Post Traumatic stress Disorder (PTSD)*

*Obsessive-Compulsive Disorder (OCD)*

*Generalised Anxiety Disorder (GAD)*

*Other anxiety*

**Depression**

*Depressive episode*

*Other depressive episode*

Further breakdown by age and gender shows that the rates for any disorder are lower among all Pakistani and Bangladeshi girls and lower among boys aged 5 – 10. Among Pakistani and Bangladeshi boys aged 11 – 15 the rates for emotional disorders are more than double (Table 3)

The survey report makes no specific comment on these differences, probably due to the very small sample sizes. It is also not possible to extract Pakistani children and young people from the Bangladeshi ones in the sample references. This finding is worthy of further investigation.

**Table 3: Prevalence of mental disorders by ethnicity, age and sex (11 – 15 year olds)**

Age and gender	White	Black	Indian	Pakistani & Bangladeshi	Other	All
<b>Boys 11 – 15 year olds</b>						
	4.9	4.9	5.5	12.4	6.3	5.1
Emotional disorders	8.6	17.8	2.3	4.6	7.2	8.6
Conduct disorders	2.5	1.5				2.3
Hyperkinetic disorders	12.6	22.1	5.8	15.3	13.5	12.8
Any mental disorder						
<b>Base</b>	<b>2077</b>	<b>70</b>	<b>60</b>	<b>51</b>	<b>51</b>	<b>2309</b>
<b>Girls 11 – 15 year olds</b>						
	3.3	4.2	-	1.7	5.0	3.2
Emotional disorders	2.8	3.1	1.9	1.9	2.6	2.7
Conduct disorders	0.5			-	-	0.4
Hyperkinetic disorders	5.9	7.4	1.8	3.6	7.8	5.9
Any mental disorder						
<b>Base</b>	<b>2638</b>	<b>73</b>	<b>60</b>	<b>61</b>	<b>86</b>	<b>2917</b>
<b>All 11 – 15 year olds</b>						
Emotional disorders	5.7	3.6	3.2	9.0	5.2	5.6
Conduct disorders	6.3	12.6	1.3	2.4	4.5	6.2
Hyperkinetic disorders	1.5	0.8	-	-	-	1.4
Any mental disorder	11.3	15.7	3.4	10.7	9.7	11.2
<b>Base</b>	<b>4168</b>	<b>129</b>	<b>103</b>	<b>96</b>	<b>107</b>	<b>4604</b>

(ONS. 1999)

The Health of Minority Ethnic Groups '99' Health Survey for England (Joint Health Surveys Unit. 2001) is one of a series of health surveys about the health of people living in private households. Interviews were obtained with 6,844 adults and 3,415 children from minority ethnic groups.

Commissioned by the Department of Health it is the largest and most extensive survey of the health of minority ethnic groups ever carried out in England. It is also the first national survey to include minority ethnic children as well as adults.

Minority ethnic children were less likely than the general population to report either long-standing or acute illness though Pakistani boys and girls and Indian girls were more likely than the general population to have possible behavioural and emotional difficulties as measured by the Strengths and Difficulties Questionnaire (SDQ).

The Audit Commission undertook a national survey of CAMHS from 1997 – 1999 and published a final report, “Children in Mind: child and adolescent health services”. The audit covered 59 Health Authorities and 147 Trusts, which equates to approximately 60% of the Health Authorities commissioning CAMHS and 90% of the Trusts providing CAMHS at Tiers 2, 3 and 4. Information was collected from CAMHS professionals who reported on details of each child they saw over a four-week period.

In the overall sample of children 12.5% were classified as non-white. The classification was based on the professional’s opinion about ethnic origin. The 1991 census indicates that the population of non-white children under the age of 14 was 9.7%. The Audit Commission report notes:

*“Where local minority populations are high, the CAMHS caseloads reflect this” (Audit Commission. 1999. Ch.1. 20. page 15).*

This conclusion is supplemented by further examination of two trusts where there was a high Black and minority ethnic population, one in Manchester and one in London. The report comments on these Trusts:

*“The non-white component of the CAMHS caseload was 35 per cent in the Manchester trust compared with its non-white child catchment population of 13 per cent, while in the London Trust, just over 50 per cent of the cases were non-white, compared with the local non-white child population of 36 per cent.” (ONS. 1999. Ch.1 20. page 15)*

Unfortunately, the report makes no further comment on these issues, except to suggest that overall, CAMHS services appear to meeting a representative sample of the population. This is particularly unsatisfactory, especially given the fact that in Bradford, where there is a significant Pakistani population, presentation levels from this community are seen as very low. There are also indications from other studies that the apparent over-representation in Manchester differs between minority ethnic groups with the suggestion that only some groups from some parts of Manchester were over-represented in CAMHS (Bhugra and Bahl. 1999).

The report uses the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and while there is no ethnic breakdown of the findings four categories were found to present most frequently (60 – 80 per cent of cases), these were:

- problems with family life and relationships
- problems involving emotional and related symptoms (including eating disorders)
- problems with peer relationships; and
- disruptive, antisocial or aggressive behaviour

These are all areas receiving prominence in the findings from this project.

Studies of Gujarati children in Manchester (Hacket et al 1991; Hacket & Hacket 1993,1994) shed light on certain behavioural patterns and cultural aspects of parenting and understanding of problem behaviours within this community. The studies explored a variety of factors among 100 Gujarati families with a white control group. The areas covered included; the inculcation of physical and social independence, tolerance of disruptive play and temper tantrums, attitudes to violence and lying, disciplinary practices, toilet-training, feeding, sleeping arrangements, attitudes to ownership and possessions, habits and the expectation of obedience.

The central finding of the study was that Gujarati children enjoy greater psychological well-being than their White British counterparts, which is offered as a partial explanation for the under-representation of this group within CAMHS. This finding contrasts with the high representation of non-white children within CAMHS services in Manchester and it is evident that understanding differences between different minority ethnic groups is of paramount importance.

However, while the focus on different minority ethnic groups is important there may be certain similarities between groups that can be of use in understanding particular patterns of behaviour and help seeking. In the Manchester Gujarati sample, there were cultural differences in comparison with the White sample that are also indicated by the findings of this project, notably, higher expectations of obedience and less tolerant behaviour of disruptive play in the home. Also, sleep patterns were notably different in the Gujarati sample and this may be due to common characteristics of South Asian settlement and employment patterns i.e. larger families with several children sharing a bed and later sleeping hours due to working patterns of parents. These factors alone do not indicate more or less behavioural problems but can be problematic in professional understandings about different patterns of family life (Minde. 1976).

Hacket suggests that there are protective factors as a result of family structure within the Gujarati sample such as the greater stability offered by lower rates of parental separation. However, Nazroo, (1997) found that the incidence of adult mental health problems increased for those who migrated to Britain at an early age or were born here. It is very likely that in addition to significant differences between different minority ethnic groups there is also a rapidly changing picture emerging among third and fourth generation South Asian children.

Apart from specific issues related to differential prevalence rates among Black and minority ethnic groups there is a question about equity of service provision. There has been much more attention to this area in reports on adult health, however, Cooper et al (1999) did address whether equity is achieved in health service utilisation by children and young people aged 0 – 19 years.

The authors drew on data from the British General Household Survey 1991 –1994 and examined the influence of ethnicity, along with social class, housing tenure, family structure and employment on parents' use of GP services, outpatient and inpatient services. They conclude that there is an 'ethnic paradox' in that South Asian children have higher rates for utilising GP services yet the use of hospital services for all minority ethnic children is lower relative to the White population. This persists even after controlling for socio-economic and demographic factors. It was also the case that certain minority ethnic groups had more follow-up appointments with the GP in the sample time frame.

In understanding the 'ethnic paradox' the authors contend that it may be at the point of assessment and referral with the GP that the inequity lies, suggesting that children from particular ethnic groups, notably Pakistani and Bangladeshi, may receive a poorer initial consultation. There are two possible hypotheses about the low take up of hospital service by these groups in contrast to the higher rates of GP consultation, either there is an inappropriately low level of GP referrals or there is poor uptake of appointments following referral.

There is insufficient data within the GHS to make confident conclusions about these differential patterns of service utilisation matched to problem identification. However, the authors do posit two further questions in relation to the issue of equity:

1. Whether consulting with a GP more than once in a two week period is part of a pattern of minority ethnic service use and
2. Whether parental place of birth is associated with ethnic differences in the use of GP and hospital services.

The authors suggest that it possible parental place of birth acts as a proxy for linguistic and extra-linguistic factors which affect the expectation and outcome of the GP consultation. In conclusion they argue for more research in this area as:

*"...where the child's mother was not UK-born, utilisation of GP and outpatient services diverged from that of children with UK-born parents of the same ethnic group, whose use of services more closely resembles that of white children with UK-born parents." (Cooper et al. 1999. pp476 – 477).*

Caroline Leahy (1999) explores a variety of factors that may influence particular take up of services among South Asian children accessing the Family Support Unit in East Birmingham. Leahy makes particular reference to the use of standard appointment letters that are in English and the problems this may pose for parents of South Asian origin who may not speak or read English. She goes on to argue that,

*"Bridging the gap between professionals providing services for children and their parents is a vital key to ensuring that children benefit." (Leahy. 1999. p 94).*

In 'Excellence not excuses' Inspection of services for Ethnic Minority Children and Families (O'Neale, V. 2000 a number of organisational issues with regard to Local Authority services are highlighted:

- There is little evidence that anti-racist and equal opportunities policies are being implemented
- Where policies did exist for managing and dealing with racial harassment they did not cover issues of racism relating to children
- Training in anti-discriminatory practice was often ad hoc with little arrangements made to up-date or maintain it.
- Links between authorities and Black voluntary groups were often fragile
- Practice in relation to recruitment and developing Black staff was variable
- Families seeking support often experienced difficulty in accessing services, because they did not understand the role of Social Services, particularly if English was not their first language.
- Workers had varying levels of understanding of the situations of ethnic minority families.
- Assessments were often partial and rarely covered parenting capacity, the child's needs and family and environmental issues



- There was little evidence that care planning took a lifelong view of the situation of ethnic minority looked after children.

The report also concluded that there were gaps in accessing the child and adolescent mental health services, as well as relevant psychological support.

“Listening to children” (Armstrong et al 1999) is a qualitative research study undertaken in Scotland as part of the Bright Futures initiative. The survey was undertaken with 169 young people aged between 12 – 14 and included four focus groups and five individual interviews with 25 children from two minority ethnic groups, Chinese and Pakistani Muslim. Two of the focus groups were undertaken with children from the Pakistani Muslim group.

The project specifically sought to explore qualitative data about young people’s perceptions of mental health on the basis that including the views of young people is important in understanding issues and future service development. It is also in recognition that stigma and fear around mental health issues are factors in inhibiting service use and help seeking (Royal College of Psychiatrists. 1995), so understanding how people perceive mental health issues is important in developing strategies to combat stigma.

In relation to the Pakistani Muslim children, the report notes:

*“As might be expected young people from Pakistani Muslim backgrounds identified the family as particularly important sources of support and friendship especially in times of difficulty. However, the pressure of the family was also identified as causing some young people additional stress especially in terms of academic achievement.” (page 25).*

In general the report identifies very little difference between the two minority ethnic groups and the white sample with all groups identifying feeling happy with one self, not scared and having lots of family defining positive mental health and academic pressures, bereavement and bullying being identified as the most negative influences on mental health.

Goddard, Nick et al (1996) describe a survey of 100 adolescents conducted over a three year period, 64 of whom were White, 28 of whom were Black.

It begins by highlighting the difficulty of quantifying the degree of deliberate self-harm (DSH) amongst adolescents, briefly referring to some of the scant studies on the subject, before stating that there is even less available material on DSH and ethnicity. What there is however, suggests that there is a lower rate of DSH amongst the Black population.

The survey used a structured data collection sheet, which gathered demographic data, as well as recording factors that had previously been shown to be important in cases of DSH.

From these sheets, a ten-item depression scale was developed. There were two main findings obtained from the survey. The first was that the referral rate for Black adolescents was in proportion to community composition. The second was that characteristics of Black and white adolescents referred following DSH were similar for socio-demographic variables, psychiatric symptoms and circumstances of attempt and outcome. There was however, more social stress reported in the Black sample population.

Finally, the researchers point out some of their concerns about the study. They point out that there are limitations in the use of ethnicity as a research variable, and they also state that only ¼ of cases of DSH actually lead to contact with medical services, while not all those cases presenting to casualty are necessarily referred.

While it is known that suicide rates for South Asian women are higher than the national average and up to 60% higher for those aged 25 – 34 (Balarjan & Raleigh 1995), suicide information on ethnic and immigrant groups in England and Wales is limited (Neeleman et. al., 1997).

Neeleman et. al. (1997) conducted a three year survey (1991-1993) of suicides in a multi-ethnic urban area (Lewisham, Lambeth, Southwark and the borough of Greenwich).

In this instance, suicides were classed using clinical as opposed to legal criteria.

*“Cases were imputed to be suicides (n=329) if a suicide verdict was given, a suicide note had been found, the method unambiguously indicated suicide and/or communications of suicidal intent had been recorded” (p463).*

The results of their survey are summarised below:

- ❑ *Drowning and jumping from heights were used by proportionally more by non-White than White. The reverse was true for overdoses.*
- ❑ *Among White deaths, suicide method and country of birth were not associated.*
- ❑ *The odds of a non-suicide verdict were higher in deaths of women compared with men, ethnic minorities compared with Whites and Whites not born in England or Wales compared with those who were born there.*

The researchers also found that African-Caribbean's had relatively low, and young Indian women, relatively high rates of suicide compared to Whites.

In conclusion, the researchers assert that classification of suicide “is biased with respect to ethnicity and national origin.” (p463) The previously existing rate patterns in ethnic minority groups reflected those seen in *attempted* suicides.

With respect to depression in general among the Pakistani population, Husain, Nusrat, et al. (1997) argue that the social origins of depression among Pakistani people in the UK are not fully understood. They may not, it claims, be the same as for the white indigenous population

This hypothesis was investigated through a GP practice in North Manchester, from which 16-64 year old Pakistanis were identified. Those considered eligible for the research were invited to complete a Personal Health Questionnaire (PHQ) in English or Urdu. All high scorers, along with a random sample of low scorers were asked if they could be interviewed at home or in a room at the surgery. In all, 3 people refused to complete the PHQ's and 5 refused to be interviewed.

As well as gaining demographic data, the interviews used a Psychiatric Assessment Schedule (PAS) to confirm detections of depressive illness uncovered by the initial questionnaire. In order to represent the 12 months prior to the research, a Life Event & Difficulty Schedule (LEDS) was administered.

This revealed that all but 5 of those thought to be suffering from depressive illness had chronic (lasting more than year) depression. In total, 44 people with depression and 33 non-depressed people were interviewed.

The findings of the research were as follows:

- *75% of the sample was born in Pakistan.*
- *57% of cases and 33% of non-cases spoke English with difficulty*
- *75% of cases and 36% of non-cases had experienced an independent severe event, and/or major difficulty*
- *The difficulties most readily related to depression were to do with marital, health and housing issues.*
- *Overt racial harassment and discrimination were rare as contributory factors.*

The authors end by acknowledging that this is a preliminary study and that more acceptable forms of social support, as well as help with marital, housing and employment problems will be needed to ease depression in this population.

There has been a particular focus in research on cultural and generational conflict, particularly in relation to young South Asian women (Kurtz 1998, Thompson 1999). The issue of arranged and forced marriages have featured strongly in this debate but there has been very little attention on the mental health implications beyond suicide and self-harm and in particular, the role and appropriateness of specialist mental health services such as CAMHS remains unclear.

The experience of racism and implications for the mental health of children and young people is also an important area for consideration. While discrimination is often cited as a risk factor in the development of mental health problems (Mental Health Foundation. 1999) it is often overlooked within specific studies. Some of this may be related to research methodology and the understanding held by particular researchers about issues such as 'race' ethnicity' and 'culture'. Singh (1997) argues that there needs to be more clarity of meaning in terms which delineate population groups. He asserts that labelling in psychiatry is far too polarised, and that the distinction between 'race' and 'ethnicity' is not often recognised. Few studies define their categories of ethnicity, and fewer still justify them.

A brief history of the use of 'race' terms, covering the Ancient Egyptians and Greeks, is provided along with more recent scientific theories and their bearing on race definitions. Singh concludes that, despite some basic different traits (blood group, etc.), "racial classifications based on traits such as skin colour are scientifically invalid" (p.306).

Singh then discusses the terms 'race', 'culture' and 'ethnicity', stating that they have plural, and often ambiguous, meanings. Hence there is a difficulty in defining ethnicity within psychiatric research. Ethnicity is often defined through appearance and social perceptions (such as discussion with health staff). In recent years, self-definition has become an acceptable mode of defining ethnicity. It is argued that not only does this force individuals to pigeonhole themselves, it relies on the potential outcome of the definition. The example is offered that someone may self-assign the label of 'Black' in a context of racism, 'Asian' when referring to their geographical background and 'Sikh' when constructing a religious identity.

Such arguments may beg the question, “Why measure ethnicity?” (p.306). Singh replies that researchers should avoid colour-blindness, but should also explain their particular need for measuring ethnicity in a way “that allows a valid interpretation of their findings and avoids accusations of bias” (p.307).

Phinney (1990) highlights the importance for professionals working with Black and minority ethnic children to recognise the development of racial identity. Phinney suggests that not understanding the development of racial identity is one of the factors inhibiting the development of services for children from Black and minority ethnic communities.

The main difficulty with much of the research in this area, is that what there is contains very small sample sizes, is often not specific to the minority ethnic group in question, does not fully address mental health needs and does not address the role and function of CAMHS in this context.

This is not entirely unexpected as there has been considerable debate in general terms about the role and function of CAMHS and in particular the definitions of mental disorder, care pathways and gate-keeping functions of specialist child and adolescent mental health services (HAS, 1995; Audit Commission 1999).

## 7. CONCLUSIONS

Across the various data sources there are some areas of consensus and some important differences of opinion. Taken together a rich picture emerges of the key concerns about and attitudes towards mental health problems among Pakistani Muslim children and young people.

In order to make sense of this it is necessary to create a typology that can describe the various factors in relation to particular categories and across different domains. The specific domains we are interested in, are:

- ❑ the universal factors that influence the mental health of all children and young people
- ❑ those factors that are specific to the ethnic group in question
- ❑ the particular interactions that arise

In creating the typology it is necessary to select a category definition structure that will help explain the factors, which influence mental health, in doing this we have chosen to use the concept of predisposing risk factors as outlined in the HAS review (1995) (See table 4).

**Table 4 Predisposing risk factors (HAS. 1995.4:50)**

<p><b>Child risk factors</b></p> <ul style="list-style-type: none"><li>• <i>Genetic influences</i></li><li>• <i>Low IQ and learning disability</i></li><li>• <i>Specific developmental delay</i></li><li>• <i>Communication difficulty</i></li><li>• <i>Difficult temperament</i></li><li>• <i>Physical illness, especially if chronic and or neurological</i></li><li>• <i>Academic failure</i></li><li>• <i>Low self esteem</i></li></ul> <p><b>Family risk factors</b></p> <ul style="list-style-type: none"><li>• <i>Overt parental conflict</i></li><li>• <i>Family breakdown</i></li><li>• <i>Inconsistent or unclear discipline</i></li><li>• <i>Hostile and rejecting relationships</i></li><li>• <i>Failure to adapt to a child's changing developmental needs</i></li><li>• <i>Abuse – physical, sexual and/or emotional</i></li><li>• <i>Parental psychiatric illness</i></li><li>• <i>Parental criminality, alcoholism and personality disorder</i></li><li>• <i>Death and loss – including loss of friendships</i></li></ul> <p><b>Environmental risk factors</b></p> <ul style="list-style-type: none"><li>• <i>Socio-economic disadvantage</i></li><li>• <i>Homelessness</i></li><li>• <i>Disaster</i></li><li>• <i>Discrimination</i></li><li>• <i>Other significant life events</i></li></ul>
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The table of categories describing predisposing risk factors is useful in that it covers the individual child, family and environmental factors, all of which are present in the data within this study. It also supports a structure, which seeks to identify both universal and specific factors that influence the mental health of children and young people from the target group. For instance, overt parental conflict can be said to be a universal risk factor, but the data suggests that there are specific factors to do with the influence of the extended family for Pakistani Muslim children and young people and that there is a complex interchange across three to four generations.

Table 5 uses the predisposing risk factors from the HAS as universal factors and places specific factors from the research about Pakistani Muslim children, young people and communities.

**TABLE 5 UNIVERSAL AND SPECIFIC RISK FACTORS**

***Child risk factors***

<b>Universal</b>	<b>Specific</b>
<i>Genetic influences</i>	Potential impact of consanguineous marriage
<i>Low IQ and learning disability</i>	Intellectual capacity strongly associated with mental health Increased prevalence of learning disability
<i>Specific developmental delay</i>	Young children removed from school for extended periods of time in Pakistan
<i>Communication difficulty</i>	Largely constrained to younger children where English is not the first language spoken in the home Levels of illiteracy among adults
<i>Difficult temperament</i>	Factors affecting parenting i.e. relative isolation of mothers, access to support
<i>Physical illness, especially if chronic and or neurological</i>	High levels of GP appointments despite reports of lower levels of long standing illness Dental health and sense of body image
<i>Academic failure</i>	High aspirations linked to desire to escape poverty Academic failure among boys Pressure on girls in relation to earlier marriage if not doing well in school Perception that teachers do not push for achievement
<i>Low self esteem</i>	Impact of cultural conflict with parents and sense of parental disapproval

***Family risk factors***

<b>Universal</b>	<b>Specific</b>
<i>Overt parental conflict</i>	Parental conflict with extended family
<i>Family breakdown</i>	Stigma and nature of 'close knit' community contributing to hidden nature of family breakdown Difficulties within intercontinental marriages
<i>Inconsistent or unclear discipline</i>	Mixed messages between wider culture and family culture and norms
<i>Hostile and rejecting relationships</i>	Racism Conflict between members of extended family
<i>Failure to adapt to child's changing developmental needs</i>	Educational level and awareness of parents Impact of rural cultural norms Views about discipline and interpretation of difficulties as control issues
<i>Abuse – physical, sexual and/or emotional</i>	Children's experience of domestic violence Impact of stigma and hidden family breakdown Poor access to services
<i>Parental psychiatric illness</i>	Prevalence of mental illness among mothers Poor levels of community awareness and understanding about mental health/illness Impact of religious and faith beliefs Children acting as carers
<i>Parental criminality, alcoholism and personality disorder</i>	Increasing levels of crime and drugs and alcohol use within the community
<i>Death and loss – including loss of friendships</i>	None specific

## Environmental risk factors

Universal	Specific
<i>Socio-economic disadvantage</i>	High concentration of deprivation factors within the community, over crowding, unemployment, poor education, low incomes, late working hours
<i>Homelessness</i>	Family breakdown resulting in more young people living in temporary or transient accommodation Young girls leaving home to avoid marriage Domestic violence
<i>Disaster</i>	Unknown – potential impact of disaster in Pakistan
<i>Discrimination</i>	Racial and religious discrimination
<i>Other significant life events</i>	Riots Arranged or forced marriage

It is clear that there are wide-ranging specific pre-disposing risk factors for mental health problems among Pakistani Muslim children and young people. These are best understood against the background of cultural norms and migration and settlement patterns as outlined in the introduction.

There is a significant interplay between these specific factors and the universal ones that goes beyond the issues of mental health among children and young people to the wider infrastructure and development of these communities within Bradford. The introduction outlined some of the characteristics that distinguish Bradford's Pakistani Muslim community, not only from the indigenous population but also from other minority ethnic, including other South Asian communities. The question is whether or not these distinguishing characteristics offer a sufficient explanation as to why this population is so under represented in CAMHS.

From the typology outlining universal and specific risk factors for the Pakistani Muslim community in Bradford it could be argued that in some ways the children and young people's mental health is at greater risk than that of other ethnic groups, however, a number of factors that could possibly be described as protective have also been raised.

Environmentally they suffer disproportionate socio-economic disadvantage. They live in poor housing, over crowded conditions; their parents have high unemployment rates, low incomes and poor levels of literacy. They also suffer from overt and covert racial and religious discrimination and cope with a very different culture outside the home than that within it. The protective factors arise from living in a close-knit community where reportedly they feel comfortable and have strong networks of friendship and family; and also the affection and security of the extended family, which some commentators argue, attributes to their psychological well-being.

However, the specific family risk factors associated with child and adolescent mental health see the role of extended family living and cultural and religious factors as possibly having a negative impact on the mental health of Pakistani Muslim children and young people. Overt parental conflict, family breakdown, inconsistent or unclear discipline, failure to adapt to a child's changing developmental needs, parental psychiatric illness, parental criminality, alcoholism and personality disorder are all present to some degree amongst the Pakistani Muslim community, sometimes more so than in other communities.



But significantly, this is often hidden within families in attempts to avoid community stigma and the perceived racism or lack of understanding within predominantly 'white' services.

Significantly child risk factors pose a number of specific concerns for this community. There is a potential risk of genetic disorders being emphasised by the practice of consanguinity, communication difficulties imposed by specific language developmental problems, academic failure, particularly the under achievement of boys. Whilst low self-esteem, a causal factor of depression and anxiety, is not associated necessarily with racism it is thought to be affected powerfully by poor parenting, lack of parental approval and parental acceptance which would appear to be evident as a consequence of the widely different life experiences of Pakistani children and their parents.

Given this context what is particularly striking about the views of the Pakistani Muslim children and young people themselves is their sense of identity and high levels of awareness about the pressures they are under. First and foremost they appear to be saying that they are children and young people and that their needs and aspirations are much the same as children and young people in other ethnic groups. They appear to be developing a culture of their own that crosses both the divides of family life and Pakistani Muslim cultural norms with the life of school and the norms of the wider community. Those under the greatest stress in relation to this would seem to be the older Pakistani Muslim community members and to some degree white professionals who tend to pathologise levels of conflict within South Asian families.

This is not to say that the specific risk factors identified above do not apply, as they clearly do, but what is important in developing service responses and addressing the levels of unmet need is that this must take place within the context of the community as a whole and take good cognizance of the views of the children and young people.

The research highlights a number of specific issues in relation to service provision and development. In relation to CAMHS in particular it is clear from the data that there is confusion about the meaning and nature of CAMHS. Some professionals place CAMHS at the level of tier two while others see CAMHS as purely specialist services at the levels of tier three or even four. The picture emerging from health visitors and school nurses in particular is that the gateway to CAMHS is becoming more restrictive and narrow, so that only very severe cases of mental disorder would get through.

As it was not possible to undertake a pathway analysis within the CAMHS this cannot be verified by a case audit, however, that the perception exists, is in its self significant and will undoubtedly have an impact on referral behaviour among tier one professionals. Indeed, this appears to be the case as health visitors reported managing increasing numbers of mental health cases without any input from CAMHS.

There is an increasing view that the notion of specialism within CAMHS needs to be broken down and that they should in fact form part of tier one services, as CAMHS in this respect are seen to be part of 'everyone's business' (NAW. 2001). The impact of this for Pakistani Muslim communities would be to help remove the stigma associated with specialist mental health services that currently acts as a barrier to access. It would also increase the potential for co-operation between different professionals and enable greater diversification in service development i.e. an enhanced role for the voluntary sector and lower threshold services.

It is interesting to note in this context how the young people said they would like to see services developed. They wanted to see very easy, low threshold access including drop-in and they wanted a wide range of services provided including courses and recreational facilities. They were also more interested in telephone services and increased use of the internet than going to see professional counsellors or therapists in a one to one situation. In terms of listening to the voices of young people and developing services that are child centred these are important messages that support the view that CAMHS ought to be part of tier one provision.

## 8. RECOMMENDATIONS

We have deliberately kept the recommendations to a minimum by focusing on the need for key strategic developments that arise from the research. Although concerned with CAMHS, these recommendations need to be considered within a wider context and the underlying community problems within Bradford. Years of under investment and neglect of significant problems have been factors in the recent riots and these recommendations provide an additional dimension to the ongoing debate about what is happening and how things can be improved for Bradford's young South Asian population.

In the local context a great deal of work has been taking place in Bradford to address the issues related to access and use of services and it is important to understand the current planning frameworks in order to draw conclusions from the data in this project and suggestions from the literature review.

The key document concerning the development of CAMHS in Bradford is 'Healthy Minds A Strategy for Improving Children and Young People's Mental Health' (May 1999).

This document outlines a shared view for all the relevant agencies and staff who believe in: "Working together in a variety of ways, with children and young people, parents, carers and the community to enable all children and young people in the District to develop healthy minds and so enhance their life opportunities"

The strategy for planning and delivering services must:

- incorporate comprehensive and integrated approaches
- include a range from health promotion and community empowerment to early identification and interventions to intensive provision for the most troubled children and young people

The strategy is to be based on the following values:

- Putting children and young people's needs first
- Enabling families and communities to meet the needs of children and young people wherever possible
- Ensuring equality of access to service for all children and young people
- Actively involving children and young people and their parents and/or carers in the design, delivery and review of services
- Ensuring that what we do is sustainable by the child, family and community
- Making sure that services provide best value

In addition, services should be underpinned by various principles, services should be:

- local
- making effective and efficient use of resources
- making available information to inform users choices
- non stigmatising
- appropriate to and take account of race, culture, language, religion and sexuality, means of communication, specific abilities/disabilities and other health needs
- valuing of all differences whilst recognising and challenging racism and other oppressions as significant contributing factors to mental ill health
- using an evidence base
- provided according to priority of need

The document also recognises the importance of diversity with workforce planning for the success of the strategy:

*“Service developments will only succeed if they are matched with effective planning to ensure a workforce with the necessary capacity, skills and diversity”.*

It is clear from the above vision, values and principles that meeting the needs of the local Pakistani Muslim population will be of paramount importance in the overall strategy, in particular, ensuring equality of access, the provision of non-stigmatising services that are appropriate to and take account of the child’s or young person’s race, culture, language and religion while valuing difference and challenging racism.

Within the NHS, responding to the needs of a diverse multicultural society is recognised in the NHS Plan. The Department of Health has published a race equality agenda and launched ‘Equalities Framework for the NHS, the Vital Connection’ that includes clear requirements for the NHS to promote race equality involving a package of standards, indicators and monitoring arrangements.

However, the key legislative framework impacting on mental health service provision for Black and minority ethnic communities is the Race Relations (Amendment) Act 2000. This Act came into force in April 2001 and places a general duty on all public authorities to promote race equality with the expectation that public bodies will review their functions and identify steps to be taken to comply with the new provisions. In addition, the Council for Racial Equality (CRE) are producing a series of codes of practice on the formation of equality frameworks and will be responsible for the monitoring and implementation of the new Act.

Tackling institutional racism is at the heart of the Race Relations (Amendment) Act 2000. Actions to achieve this need to be taken at a strategic level in addition to individual service and agency responses. The Act will apply to all public authorities and services they contract, however, without a higher level strategic response to addressing issues of institutional racism there is a risk that a variety of initiatives will take place on an ad hoc, piece meal basis and that individual agencies may duplicate action and fail to learn from each other. The Healthy Minds Joint Planning Team is best placed to provide an over arching strategic framework for addressing racial equality in mental health services.

The approach to race equality is expected to be embedded within the overall modernising government policy arena and as such should be part of a broad organisational culture change. A ‘tick box’ approach will not be acceptable under the monitoring arrangements for the Act. The duty to promote race equality is not the same as the provisions for outlawing discrimination. This is an important distinction as the Amendment Act seeks to drive up standards from which individuals will benefit rather than result in particular outcomes for individuals.

A key concept concerned with the provisions of the Amendment Act is ‘mainstreaming’. This is defined as:

*“...the organisation improvement and evaluation of policy processes, so that ... equality perspective is incorporated in all policies at all levels and at all stages, by the actors normally involved in policy making.” (Council of Europe)*

The administrative guidelines for mainstreaming include:

- **Consultation** with Black and minority ethnic representatives;
- **Assessment** of likely impact of policies on Black and minority ethnic groups;
- **Monitoring** of policy implementation and service delivery; and
- Action to **remedy** any unexpected and unjustifiable outcomes for Black and minority ethnic groups and communities.

This is the framework by which the Healthy Minds strategy needs to address how it is meeting the needs of the local Black and minority ethnic populations.

## RECOMMENDATION 1 – RACE EQUALITY AND CAMHS

The Healthy Minds Joint Planning Team to respond to the key findings within this report and the implications of the Race Relations (Amendment) Act 2000 by the development of a strategic Race Equality Framework. The framework needs to provide clear guidance and steer in the form of short and long-term targets and activities, for all child and adolescent mental health service providers in Bradford.

The Race Equality Framework would need to address a number of key issues in terms of commissioning and developing child and adolescent mental health services that are able to meet the needs of Black and minority ethnic communities, in particular those of the Pakistani Muslim community.

The strategic lead provided by the Joint Planning Team would enable service providers to have direction and guidance with respect to a range of steps for the practical application of the strategy in effecting change at the level of service development and delivery.

Overall, the key organisational features will need to include:

- Workforce monitoring and the steps undertaken to ensure fair treatment of people from Black and minority ethnic groups;
- Assessment of policies and programmes that could affect people from Black and minority ethnic communities and in particular identifying areas that have the potential for adverse differential impact and taking steps to remedy this;
- Ensuring the implementation of policies and procedures is monitored for the extent to which the needs of Black and minority ethnic groups are being met; and
- Having a publicly stated policy on race equality.

Alongside these overall themes, key strategies will need to be developed in relation to the findings contained within this report.

### **Commentary**

*Services need to be culturally sensitive and able to ensure race equality and the promotion of good relations across all their activities. This is also a requirement of the Race Relations (Amendment) Act 2000 which applies to all public authorities and any services that are contracted from public funds.*

*There is a need to ensure that policies and procedures within agencies have been assessed for any differential impact on particular Black and minority ethnic groups and staff groups need to be trained in equality and diversity. There are some very clear areas that a strategic Race Equality Framework for CAMHS would need to address:*

- ❑ *Use of interpreters – the provision of appropriately trained interpreters, training for all staff in the use of interpreters and clear guidelines regarding the use of family members and especially children and young people as interpreters*
- ❑ *Ethnic monitoring systems and training for staff and managers in the collection and analysis of data for use in service planning and delivery*
- ❑ *Exploration of differential care pathways through case audit*
- ❑ *Staff skills and understanding in working with Black and minority ethnic children and young people and the experience of racism*

*The Race Equality Framework would need to address a number of key issues in terms of commissioning and developing child and adolescent mental health services that are able to meet the needs of Black and minority ethnic communities, in particular those of the Pakistani Muslim community.*

*The strategic lead provided by the Healthy Minds Joint Planning Team would enable service providers to have direction and guidance with respect to a range of steps for the practical application of the strategy in effecting change at the level of service development and delivery across the four tiers.*

## **RECOMMENDATION 2 – Community Engagement and education/awareness raising**

**Undertake community engagement programmes that seek to promote greater understanding about mental health and the available sources of support. Such programmes should actively involve community members in the dissemination of information as part of a capacity building process for both communities and individuals.**

**Identify, and/or develop specific media resources for use as part of an awareness raising and education programme on mental health issues and services. This would best be undertaken with the direct involvement of the local community.**

**Recruit and train a number of community inter-actors<sup>4</sup> to deliver the awareness and education training within the local community i.e. taking place within people's homes, local voluntary sector agencies etc. Specific recruitment of mothers for these roles would be beneficial though given the prevalence of mental health problems within this group it may be necessary to do this alongside the development of support services.**

**Mosques should be actively encouraged to participate in the programme and be recognised as significant centres for dissemination and support. In addition, religion and faith need to be recognised as playing an important part in community beliefs and understanding, and all spiritual, faith and alternative health care people who are approached by the community can have an important contribution to make.**

**Develop connections with wider neighbourhood renewal and community regeneration programmes to link the capacity building element of the awareness raising and education programme to wider employment and personal development initiatives targeting Black and minority ethnic communities.**

**Develop mechanisms to ensure there are ongoing links between the development of the Healthy Minds strategy and the local Pakistani Muslim community.**

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<sup>4</sup>The Community Inter-actors model was developed by The University of Central Lancashire in response to the need to encourage greater uptake of further and higher education among South Asian Communities. The model works on the understanding that by contacting and supporting key community members, information can best be disseminated throughout excluded communities.



## **Commentary**

*The specific mental health needs of Pakistani Muslim children and young people cannot be divorced from the needs of the wider community. There are very low levels of awareness about services and issues among older generations and there is little engagement between the communities, notably parents, and helping services. In addition the fears about stigma and how this can inhibit service take-up mean that without an extensive education campaign based on community consultation families will continue to be prevented from coming forward and seeking help. This is especially important in relation to young carers.*

*The advantages of such a model is that the community is directly engaged in the process rather than attempting to filter information through established agencies or community leaders. It is also possible to engage a significant number of people in the community consultation and awareness raising activities so that effective change within communities can be realised.*

*There are additional benefits in that mainstream service providers and commissioners can enhance their contact and understanding with particular communities and the capacity to undertake effective needs assessments is greatly increased. Also, through the individual capacity building programme there is a foundation for development of future mental health service workers from within these communities, which is recognised as a key deficit in recruitment drives. (See appendix C for a more detailed description of community commissioning and how this relates to the development of the race equality framework).*

*Community engagement means much more than representation, it is the direct and active involvement of the community in service planning and delivery. Community Engagement can be broadly defined as the simultaneous and multi faceted engagement of communities and relevant agencies around an issue or set of issues in order to raise awareness, assess need, and achieve the sustainable provision of appropriate services.*

*Hence it's as much about service development as community development. In the first instance, in relation to mental health, this will require a substantial programme of community awareness and education, but this can be part of a wider programme of community engagement if members of the community are recruited to act as educators, or community 'inter-actors'.*

*Inter-actors are individuals whose position in the community gives them unique access to individuals and groups are recruited. These individuals are not necessarily those who would be naturally perceived to be community leaders. The work of the Centre for Ethnicity & Health suggests that often working with designated community leaders can exclude the most marginalised individuals within communities.*

*Community Inter-actors work alongside other workers to develop –*

- *A conduit for the provision of information*
- *Advocacy and support for individual community members*
- *Opportunities for project development*
- *Vital community feedback on project initiatives*

*This will need to be viewed within a medium to long term time frame and may require the development of specific resources such as videos in mother tongue languages. Levels of illiteracy in the adult population make it important to consider alternatives to leaflets and written tools for communication.*

*The stages for an extensive community development programme would involve:*

- *Needs assessment and consultation on resource development*
- *Education and awareness raising*
- *Capacity building – training and development for key individuals selected openly from within the community*
- *Inclusion in strategic development and planning*
- *Increased recruitment pool for employment within services*

*The issue of longer term capacity building and increasing the potential pool of employees from within the community is very important, not least because of the low levels of employment within the community. It is possible that the training and development provided to inter-actors could become part of a staged development programme, linked to other mainstream employment and regeneration initiatives, that enables a level of community based CAMHS 'Linkworker' to be developed.*

### **RECOMMENDATION 3: Widening access to CAMHS within tier 1**

There needs to be much greater emphasis within the Healthy Minds strategy on the role of tier 1 professionals as being part of CAMHS. Within this context there should be a training needs analysis leading to specific professional development programmes aimed at raising skills in working with diverse communities among tier 1 professionals.

Capacity to meet the needs of Pakistani Muslim children and young people at tier 1 should be increased through enhanced voluntary sector involvement with development of low threshold, accessible support services including use of telephone help lines and Internet services.

Specific initiatives are required that address the needs of young South Asian women and girls who are experiencing stress related problems, eating disorders and depression. Although this review is concerned with children and young people, these initiatives will need to be developed on a multi-agency basis involving adult, young peoples services and CAMHS. Specific targeting of parents would be beneficial given that parents are identified in this report both as principal carers and potential inhibitors of access to services. Individuals could be recruited to take part in an initiative that uses resources to raise awareness and promote greater understanding about the stresses and problems experienced by young South Asian women and girls and sources of support. *(Could link to recommendation 2)*

There needs to be greater understanding of the religious and spiritual dimensions of mental illness within South Asian communities. In particular the role of complimentary, alternative and faith healers needs to be understood. There should be a specific needs assessment incorporating healers, and users who access them to determine the potential benefits of greater linkages with mainstream service providers

Related services should be able to identify and respond to mental health issues i.e. Connexions through training on mental health for personal advisors

There should be a review of the use of GPs by Pakistani Muslim children and young people to identify case presentation issues, GP assessment and referral practices and the views of parents on GP consultations for their children.

#### ***Commentary***

*There are significant access issues related to specialist CAMHS that affect the whole population, not just Pakistani Muslim children and young people. Barriers to access such as statutory and legal requirements for parental consent, waiting lists and availability of interpreters exist against a national background of widely differing levels of investment in CAMHS across authorities.*

*However, concentration on access to the specialist elements of CAMHS may in fact be a distraction from where the real level of need lies i.e. within tier 1 provision.*

*The notion that CAMHS is 'everyone's business' is particularly important within the context of considering the needs of minority ethnic groups as the evidence suggests that a wide range of professionals within tier 1 services do have the opportunity to identify and intervene with problems among Black and minority ethnic groups, and South Asian communities in particular. It has already been identified that Pakistani children and young people have more appointments with GPs than other ethnic groups and teachers, school nurses and health visitors have extensive contact with these populations.*

*However, there do appear to be issues related to professional practice and equality and diversity as views among professionals about cultural issues can obscure professional judgement preventing Pakistani Muslim children from being seen as children first i.e. fears about appearing racist, stereotypical assumptions and lack of sensitivity. These issues can be further compounded by community concerns about stigma, confidentiality and perceptions of services as being predominantly provided by and for white people. Of particular concern are the views of children and young people about poor responses among teachers and school nurses.*

*Specific service development that seeks to meet the needs of Pakistani Muslim children and young people needs to address all of these issues, taking account of professional skills and training needs while enhancing the capacity within the system to increase access to levels of support through the kind of service development that the children and young people themselves have identified.*

*Employment and educational prospects are very significant areas of concern among the children and young people and there is scope to address this through developments such as Connexions, ensuring that mentors and personal advisors are able to identify and work with mental health issues.*

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## APPENDIX A

### INTERVIEW QUESTIONNAIRE

#### BRADFORD HEALTHY MINDS - RESEARCH & DEVELOPMENT PROJECT

Name of Interviewee:

Organisation:

Contact Address:

Contact Tel:

Interview conducted by:

Date:

Time commenced:

Length:

Confidentiality statement

1. What is your particular role in respect of services for children and adolescents with mental health problems?
2. In your experience of having worked with Pakistani Muslim children and families in Bradford what information do you have about the level and nature of problems experienced by this group?
3. Are there issues common to Pakistani Muslim children and adolescents?
4. To what extent are children aware of their own mental health problems and who might they be sharing these with?
5. To what extent are families aware of their children's mental health problem and whom would they be sharing this with/seeking support from?
6. What do you think would prevent children and young people from being open about their distress and seeking out support services?
7. *What do you see as the key cultural and inter-generational issues impacting on the mental health of Pakistani Muslim kids?*
8. How (in what terms) do children understand and articulate/explain their distress?
9. How do parents understand/perceive their children's distress or behavioural problems?

10. Why do you think the levels of DNA among this group are so high for CAMHS services
11. Following support for individuals in the school setting if you feel there is a need for further treatment and support what would be the pathway to getting that. Could you take me through the process?
12. Could you describe the characteristics of the inter-action between children and professionals that in your view makes for a more constructive/positive outcome?
13. Is the issue of parental consent a barrier or a useful and necessary tool in accessing CAMHS services?
14. Why do you think counselling uptake is low for this group? How do South Asian parents perceive the role of talking therapies in improving mental health? What might they see as the most useful method? Should this be delivered via an interpreter?
15. In your view would access to services by individuals or whole families be more useful?
16. How would you like to see the access criteria to CAMHS services and the way they are organised be improved?
17. What kind of relationship do primary care workers in the Borough have with CAMHS services? How would you like to see this changed/improved? Do they provide and training?
18. What kind of strategies/ interventions would you deploy in order to improve the mental health of Pakistani Muslim children?

Interviewer's notes

## APPENDIX B

### Focus groups

#### Young people

Group	Gender	Age range	School/College
1	5 boys	14 – 17	Nabwood Secondary. Bradford College Rhodesworth
2	4 girls	15 – 18	Belle Vue Girls School
3	6 boys	15 – 17	Belle Vue Girls School Nabwood Secondary
4	7 girls	12 – 17	Belle Vue Girls School Nabwood
5	8 boys	11 - 14	Belle Vue Boys School Nabwood Broadway Girlington
6	9 boys	13 - 16	Greenhead High School, Keighley
7	11 Girls	12 - 17	Greenhead High School Holly Family Keighley College

#### Community Groups

Group	Gender	Age range	Location
1	Men	40 - 60	Karmand Centre
2	Women	16 - 60	Barkerend
3	Women	20 - 60	Millan Centre
4	Women	17 - 50	Roshni Ghar

## APPENDIX C

### COMMUNITY COMMISSIONING AND THE RACE EQUALITY FRAMEWORK

The Race Equality Framework is designed to ensure an organisation, with the involvement of key local external stakeholders, identifies and implements a strategic implementation plan for organisational change with consequent impacts on service planning and delivery. In keeping with the National Service Framework for Mental Health requirement for the inclusion of service users, carers and local communities in planning and implementation of services the success of the framework rests upon a model of community commissioning.

This model has been developed by the Ethnicity & Health Unit and has a successful track record of achievement within a national project focusing on needs assessments among Black and minority ethnic communities involving 47 community groups across the English regions representing 25 different Black and minority ethnic groups. (Department of Health/Ethnicity & Health Unit. *Black and minority ethnic community drugs misuse needs assessments*. 2001).

The Community Commissioning model is designed to create a structured, long-term development process that provides a sustainable infrastructure for working in concert with Black and minority ethnic communities.

It has the following outputs:

- Direct access to 'hard to reach' communities
- Meaningful participation of communities in mainstream planning and service delivery
- Awareness raising of services and issues
- An increase in the pool of potential Black and minority ethnic workers
- Improvements in effectiveness and appropriateness of services to Black and minority ethnic communities
- Enabling public authorities to meet the general and specific duties under the Race Relations (Amendment) Act 2000, particularly promoting good local race relations.

A number of people are identified to act as local inter-actors within a newly formed Community Panel. They are recruited through a strategic local media campaign involving a high degree of pre-application support and advice. In this way community commissioning is not reliant on established community group representatives but rather goes directly to the ordinary community members drawing on the local demographics to ensure a truly representative mix in the recruitment process.

The Community Panel are not passive recipients of information, nor are they solely recruited to act as consultees but are invited to become direct participants in a process of community involvement and interaction.

Alongside these activities the Community Panel are provided with a discreet training and development programme that will increase their skills and knowledge base in such a way that meets the local human resources planning needs for greater employment of Black and minority ethnic individuals.

Working directly with local commissioners and providers the team of Community Panel Inter-actors undertake local community contact and engagement work within their communities.

This work is undertaken as part of the mainstream planning and development agenda and can be targeted to answer specific commissioning, service and practice issues that can feed directly into the local health improvement and NSF implementation plans.

The community commissioning model is designed to give much more than consultation as it provides the means to achieve long-term bench marking of issues affecting Black and minority ethnic communities including access to and up-take of services. In addition the model delivers a capacity building process that will have a direct impact on the local work force planning targets.

The role of the Ethnicity & Health Unit in community commissioning is to act as the facilitator undertaking the recruitment and selection of local participants, providing training and other capacity building functions such as mentoring and advice and ensuring the appropriate and robust analysis and evaluation of data drawn from the community contact and engagement process.

As the model is directly concerned with developing the capacity of local individuals who largely come from deprived and underdeveloped neighbourhoods there is scope to attract additional funding for the implementation of the model from the National Neighbourhood Renewal and European Social Funds.

Any investment undertaken by commissioners and providers in the model can be used as match funding in securing additional investment. This ensures that activities undertaken through the model are in keeping with the ethos of cross-sectoral working. It will also enhance the development of Local Strategic Partnerships.

The Community Commissioning model is a separate but integrated part of implementing the Race Equality Framework. It ensures that organisational development is based on a broad community involvement process and that specific long-term goals are addressed from the outset of the change process.

The model can be undertaken on a small or large scale depending on the degree of local interest and commitment.