Mental Health and Wellbeing of Black and Minority Ethnic Children and Young People in Glasgow

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Introduction

The Community Mental Health and Wellbeing Supports and Services Framework requires local authorities to provide and enhance services for children and young people, ensuring that marginalised groups are not left behind. [1] Glasgow City has an increasingly ethnically diverse population. Inequalities in mental health and wellbeing of people from ethnic minority backgrounds have been well documented for a number of decades, with many research papers investigating cultural issues within communities and system issues in services, as well as examples of good practice. Much, though not all, of this looks at the adult Black and Minority Ethnic (BME)[2] population and while some themes are cross-cutting, it is important to consider what will be different for children and young people. With the current focus on children and young people's mental health and wellbeing, there are opportunities to consider what assets already exist in Glasgow to support both culturally-specific interventions, and culturally aware universal services that meet the needs of these population groups. There is also much learning to be taken from research and work in other parts of the UK and beyond.

Methodology

A literature search was undertaken by the NHSGGC Library Network, seeking both published and grey literature on the mental health of BME children and young people, including support for family members. The search included challenges and barriers, the needs of different groups, and evidence of approaches that work. An internet search revealed further literature including some very recent reports highlighting inequalities in mental health, as well as a number of organisation and projects currently being undertaken on this topic in different parts of the UK. Where possible, contact was made with these and learning has been incorporated into this report. In addition the author spoke with staff from a number of organisations working with BME children and young people or families, either specifically on mental health and wellbeing or more generally, to sense-check the literature findings and also gain a more local perspective. A list of organisations consulted is included in Appendix I.

Background – recent and local context

The Covid-19 pandemic has highlighted many areas of inequality in UK society, with people from BME communities more likely to become infected with the virus and more likely to have poorer outcomes. This, and the increasing attention paid to the Black Lives Matter movement following the murder of George Floyd in 2020, has prompted discussion across Scotland and within Glasgow about ethnic inequality and the differential experiences of BME children and young people in schools, the health service and society as a whole. This report aims to bring together some of the knowledge that exists about the impact of ethnic and racial inequality, and to make recommendations to improve BME children and young people's experiences.

[1] Community Mental Health and Wellbeing Supports and Services Framework (www.gov.scot)

[2] This paper will refer primarily to BME as this term is most commonly used in Scotland at the time of writing. BPoC (Black and People of Colour) is a preferred term of some organisations, however the scope of this paper extends to white minority groups including Travellers and Eastern European groups.

A 2019 report by Glasgow Centre for Population Health[3] looks at Glasgow's changing demographics with a particular focus on the non-White ethnic minority population (excluding, for example, White Polish, White Irish and White Gypsy/Traveller communities). Using forecasts from this report, Glasgow's Black and Minority Ethnic population is estimated to make up around 17% of the total population in 2021. Forecasts suggests that by 2031 around a quarter of children in Glasgow will be from a non-White ethnic minority group. This figure can be expected to be higher once the above-mentioned White minority groups are included.

While we can learn from examples of interventions around the UK, it is worth noting that Scotland has its own, unique BME population profile, as does Glasgow. In the 2011 census, 33% of Glasgow's non-White population identified as Pakistani, 21% as African, Caribbean or Black (a group that experiences high levels of deprivation and unemployment), and 14% as Indian or Bangladeshi. It is important to note that

- Each of these ethnic groups has its own unique set of experiences and issues;
- Within any ethnic group there may be people whose families have been in Glasgow for three or more generations; young people who have spent most or all of their lives here who may have different experiences than their parents; and people who have much more recently immigrated;
- Within each of these categories there will be different experiences of the immigration process and associated trauma; funding and service availability; understanding of British culture and health care systems; relationship with traditional community and faith leaders within the diaspora community; feelings about identity and belonging, English language capability and so on.
- There are also sub groups with different dialects and traditions, for example the Roma community in Glasgow is made up of four distinct groups.

One youth worker specialising in mental health support to BME young people in Glasgow described this situation as having "layers and layers of complexity" and the gaining of cultural competence as a continuous, never-ending process.

What are the issues affecting BME Mental Health and Wellbeing?

This report draws on national and international studies on specific mental health issues with specific groups of children, young people and families, as well as the literature on adults. The literature review revealed that there is a wealth of research into Black and Minority Ethnic mental health, so much so that BME groups are considered to be over-represented in research terms, but despite this still under-represented in terms of successful mental health prevention and intervention. There is some evidence to suggest a greater or lesser prevalence of some mental health problems among different ethnic groups, however a 2016 study found many flaws and limitations in the data presented and concluded that there are only suggestions of differences and only for some conditions[4]. What we do know for certain is that experiences of migration, refugee and asylum seeker status, racism, service discrimination and lack of cultural competence, and stigma around mental health within some BME communities in the UK, mean that some groups are more likely to

[3] Walsh, D., Buchanan, D., Douglas, A. *et al.* **Increasingly Diverse: the Changing Ethnic Profiles of Scotland and Glasgow and the Implications for Population Health**. *Appl. Spatial Analysis* **12,** 983–1009 (2019). https://doi.org/10.1007/s12061-018-9281-7

[4] Rees, R. et al (2016) **Prevalence of mental health disorders in minority ethnic populations** UCL/Institute of Education

experience associated mental health problems, challenges in accessing services, and differential treatment within those services.

While there are fewer studies on children and young people from BME groups, the experiences of BME adults, and in particular women, are still hugely influential in terms of the context in which children and young people live, experience mental health, and access or do not access support. Parent/carer attitudes towards mental health, previous experience of services, and ability or willingness to access help will impact greatly children and young people's outcomes.

Kalathil (2011) points to the importance of socio-cultural context (experiences of racism, sexism and other forms of discrimination), personal and familial context (role within the household, experiences of abuse, spirituality and faith), and biomedical context (acceptance of psychiatric diagnoses and treatments)[5] in determining mental health outcomes of BME women. These should be taken into consideration when working with children, young people and their families. A 2013 small-scale study of ethnic majority and minority mothers in the Netherlands similarly points to the importance of working with mothers and understanding the barriers and facilitators they experience, in encouraging help-seeking for children's mental health issues.[6]

There is a number of studies on specific mental health issues for children and young people belonging to specific ethnic groups, as well as studies on mental health services and their success or otherwise in serving BME children, young people and their families. In terms of good practice in the UK, the Changemakers programme with the Centre for Mental Health and UK Youth is currently working to give young people from BME communities the opportunity to reimagine the mental health care system, and will be reporting in 2022[7]. Wandsworth Community Empowerment Network (WCEN)[8] has been a leader in addressing BME mental health needs. As well as establishing a number of projects and for a addressing the issue across the age ranges, in 2018 WCEN also founded the Black Minds Matter which aims to improve mental health awareness, access and action for BME young people and their communities.[9]

Key themes

A number of recent reports that feature in this report have identified a similar set of key themes in terms of BME Mental Health. The Ethnicity in Mental Health Improvement Project (EMHIP)[10] Key Interventions report (2020)[11] defined nine key themes in relation to ethnic disparities in Mental Health as shown:

[5] Kalathil, J. et al (2011) **Recovery and Resilience: African, African Caribbean and South Asian Women's Stories of Recovering from Mental Distress** Mental Health Foundation and Survivor Research

[6] Flink I.J., et al (2013) **The role of maternal perceptions and ethnic background in the mental health help-seeking pathway of adolescent girls.** *Journal of immigrant and minority health / Center for Minority Public Health,* 15(2), pp. 292-299.

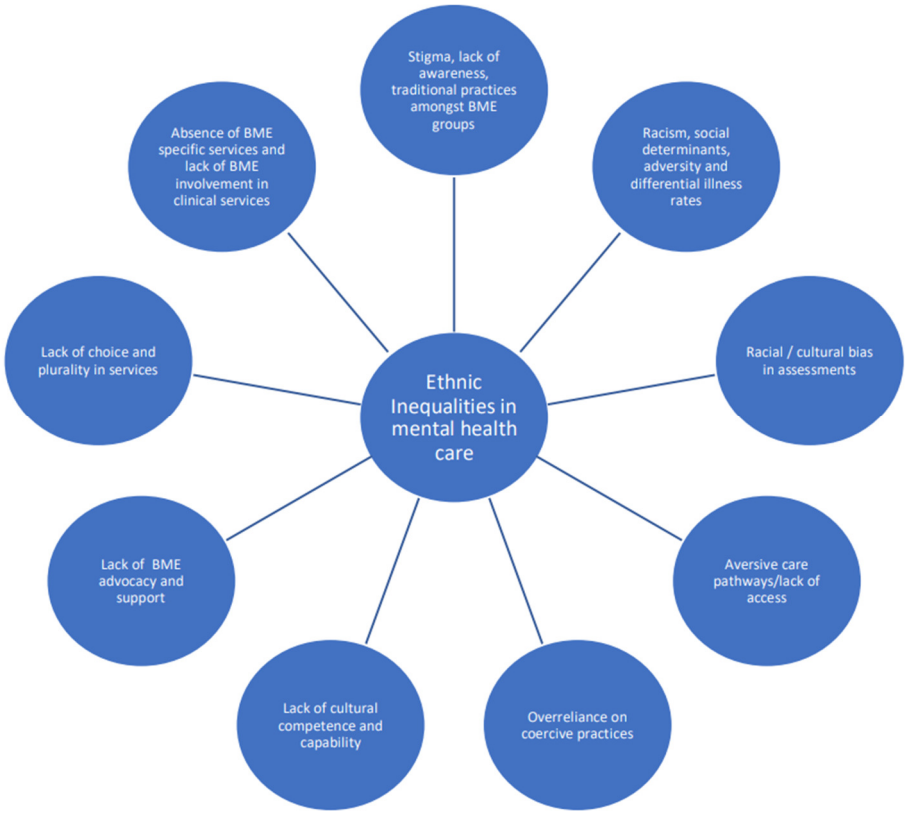
[7] https://www.centreformentalhealth.org.uk/news/working-together-ensure-young-people-racialised-communities-can-access-appropriate-mental-health-support [accessed Dec 20210

[8] https://wcen.co.uk/mental-health/ [accessed Jan 2022]

[9] https://blackmindsmatter.co.uk/ [accessed Dec 2021]

[10] EMHIP is a joint project of South West London & St George's Mental Health NHS Trust and Wandsworth Community Empowerment Network. More information here: https://emhip.co.uk/

[11] https://wcen.co.uk/wp-content/uploads/2020/05/EMHIP-Intervention-Final-1.pdf [accessed Jan 2022]



Taking these as a starting point, this report looks at four broader themes for consideration in Glasgow:

- **cultural issues** within specific BME communities that make it more difficult to talk about, and access help for, mental health;
- **the impact of experiences** like immigration, refugee and asylum seeker status, racism and discrimination;
- **practical and logistical issues** like language, immigration status and understanding of the system; and
- **service and system issues** such as racism, lack of cultural competence and ways of working that may lead to differences in experience with services as well as outcomes.

Cultural issues within communities

This section considers cultural understandings and attitudes that may act as barriers (and sometimes facilitators) to good mental health, that are more prevalent within many BME communities in the UK and other countries, for a variety of reasons.

Stigma and cultural understandings of mental health

Combatting stigma around mental health has long been an area of concern within public health and mental health. Understanding different cultural iterations of stigma is important in understanding why people from some communities may be less likely to feel able to talk about mental health, either within their own communities or to health professionals.

The Race Equality Foundation (2020) literature review highlights studies on African-descended faith communities from Christian based organisations, and on minority ethnic women, both of which

observed cultural beliefs about mental illness; practices within faith communities; family/kinship relations and a preference for non-disclosure and therefore 'suffering in shame'.

> *Participants in the study spoke of mental illness in terms of being a 'curse', 'insanity' 'possession of the devil' and associated it with violence and danger. There was some form of moral failing or a weakness in those who were mentally ill, which was contrary to beliefs of being 'spiritually strong'. Denial and not 'talking about it' or avoiding contact with the individual or their family because of 'social stigma', contributed to the reluctance to seek help… [there was] a belief that mental illness was 'hereditary madness' that needs to be hidden from others.* [12]

"Bad blood" is also discussed in Bradby et al's 2007 research into use of CAMHS by Asian families in a Scottish city. Women talked of how mental illness in the family is often blamed on the woman and her line; one woman described how families are at pains to keep any aspersions of 'madness' a secret because of how closely families monitor each other's health with a view to identifying suitable marriage partners. The fear of gossip was therefore a barrier to engaging with services.[13] This was echoed in conversations with Glasgow organisations who spoke of the stigma of having a family member with a mental illness. This in turn can prevent early treatment and lead to rejection by the community, compounding the isolation of patients and carers, and leading to more severe presentations. Some turn to religious practices and faith leaders rather than conventional medicine (which can be helpful or not – see the role of faith and religion, p8).

The Race Equality Foundation also recognises stigma as a major barrier in the Gypsy, Roma, and Traveller communities with concerns among adults about the perception of being "proper mental, that you're cracking up"; and about social services removing children from their care. Young travellers aged 15 to 21 also talked about a negative perception of, and lack of understanding about, mental health, and of the role of traditional hyper masculine roles in preventing traveller men from interacting with mental health services, with most saying they would "suffer in silence" with a mental health condition.[14]

Au (2017)[15] discusses how East Asian American immigrants' mental health is influenced by a number of factors, including the Confucianist principles that govern family life. These encourage emotional maturity, evidenced by an individual's ability to suppress difficult emotions. They also provide a strong protective factor in terms of collective family responsibility. For second-generation immigrant children the pressure to perform well academically and to have high levels of self-control, in order for the family to gain social status, coupled with sometimes poorer language skills, social isolation and deprivation which make this harder to achieve, can cause stress. Au presents studies showing this group is more likely to internalise mental health problems and to experience social anxiety, depression and suicide. Again, stigma and the idea that mental health disorders are a curse on the family, make members of this group less likely to seek help early.

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[12] Mantovani et al (2016) and Kalathil (2011) cited in Bignall T. et al (2020) **Racial disparities in mental health: Literature and evidence review.** London. Race Equality Foundation. https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf

[13] Bradby, H. et al (2007) **British Asian families and the use of child and adolescent mental health services: A qualitative study of a hard to reach group**, Social Science & Medicine, 65(12): pp2413-2424 ISSN 0277-9536 https://doi.org/10.1016/j.socscimed.2007.07.025.

[14] Thompson (2013), Psarros (2018) and Yin-Hur and Ridge (2011) cited in Bignall T. et al (2020) **Racial disparities in mental health: Literature and evidence review.** London. Race Equality Foundation.

[15] Au, A. (2017) **Low mental health treatment participation and Confucianist familial norms among East Asian immigrants: a critical review.** International Journal of Mental Health, 46 (1) pp. 1-17. ISSN 0020-7411

A discussion with a Glasgow carers support service, whose services include providing support, information and training to families of children with autism, revealed a particular group of East Asian families that struggled to accept the long-term nature of the condition, partly in relation to a strong focus on academic attainment. Conversations with parents sometimes referred to "in the future when they're normal", or ask for information on "something that will make them stop it". The service also observed beliefs about bad luck; a desire to hide the condition; and worries about being ostracised by the community. There are concerns within the service that reluctance to accept the diagnosis may hamper a constructive response and lead to further difficulties and distress.

A quote from a 2006 report into challenges for CAMHS working with BME young people further highlights the need for professionals to understand different cultural and family dynamics in order to help young people:

> *"Asian parents don't understand eating disorders. So white professionals need to be aware of this and the fact that young Asians can't always talk to their parents in the same way that white young people might be able to…."* [16]

Finally, for some, the concept of thinking about and caring for one's own mental health can be alien, as feedback from the work of a BME women's mental health organisation shows:

> *"Many women were unaware of trauma and general mental health issues as the concept of looking after themselves are often non-existent in their communities. Many BAME women are unaware that they are in domestic violence/abusive situation[s], [and] FGM and Forced Marriage and their side effects are often normalised."* [17]

Organisations specialising in the mental health of BME groups have found effective ways of addressing stigma such as considering the language used to describe mental health; offering mental health support without badging it as such (for example alongside homework clubs); offering training and support to faith leaders and networks, and training community members as mental health ambassadors. Edinburgh-based Passion for Fusion, a youth organisation working predominantly with BME young people and their families, have produced storytelling-based resources to help young people talk about mental health in culturally-familiar and -appropriate ways. [18]

Examples in Glasgow include:

- Saheliya's Champions of Wellbeing programme (2017-2019) which trained approximately 20 women per year in mental health awareness, encouraging talking and help-seeking. The groups have continued post-funding on a smaller basis and the women continue to help others in their community with signposting and information sharing.
- Similarly, the African Women's Network trained 20 women in basic mental health awareness in 2020.
- Glasgow East End Carers, at the time of writing, are piloting some bespoke work with Chinese parents of children diagnosed with autism to try to address the many additional barriers this group faces.

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[16] Kurtz, Z. and Street, C. (2006), **Mental health services for young people from black and minority ethnic backgrounds: the current challenge**, *Journal of Children's Services,* Vol. 1 No. 3, pp. 40-49. https://doi.org/10.1108/17466660200600022

[17] Information provided by Saheliya on its Champions from Wellbeing programme, personal communication.

[18] https://www.youthlinkscotland.org/resources/heids-together-a-wellbeing-youth-work-resource/passion-4-fusion/

In addition to community-based anti-stigma work, the Mental Welfare Commission for Scotland recommends that national anti-stigma campaigns be more representative of non-White people and take account of cultural factors.[19]

The role of faith and religion

The 2021 *Hidden Survivors* report on young Muslims' mental health points strongly to faith as both a protective and a risk factor. [20] It demonstrates that young Muslims experiencing mental health problems are highly likely to turn to their faith for support, although they are less likely than older Muslims to describe mental health struggles in language with spiritual connotations (such as references to black magic). The report highlights that young Muslims face the dual issue of navigating their own communities and wider society. Unhelpful aspects within Muslim communities may include the belief that people who practise their faith are less likely to experience mental health problems, or that mental health problems can always be addressed though prayer; while in terms of wider society there are clear links between experiences of islamophobia and mental health problems. It recommends:

- better understanding of the faith, as well as cultural, backgrounds of patients;
- the use of Muslim counsellors and therapists as an option where possible;
- the use of community assets such as mosques as venues for therapeutic services and prevention work;
- that all therapists, regardless of religious belief, should support a conversation with patients about possible fears in order to provide reassurance of professionalism and a non-judgemental approach.

A 2011 US study with 14-21 year old Muslims found that traditional beliefs (for example that prayer, or Koran recitation, can heal depression) were associated with a lower likelihood of accepting a physician's diagnosis and treatment of depression. It also found that strong, caring family relationships made help-seeking from a physician more likely. [21]

Many other reports recommend understanding the importance of faith, faith leaders and faith communities in working with families to support children and young people's mental health needs. A small-scale US study found that Black parents were more likely than White parents to seek help from religious leaders for their children's mental health. [22] However, the Race Equality Foundation discusses the potential pitfalls of engaging with religion to cope rather than using mental health services: "some participants did not feel religious practices addressed the issue but showed the pastor's lack of understanding about mental illness, instead of facilitating individual's engagement with mental health services". [23]

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[19] *Racial Inequality and Mental Health in Scotland: A call to action September 2021* Racial-Inequality-Scotland_Report_Sep2021.pdf (mwcscot.org.uk) [accessed October 2021]

[20] *Hidden Survivors: Uncovering the Mental Health Struggles of Young British Muslims* - Better Community Business Network 2021 http://bcbn.org.uk/Hidden_Survivors_Synopsis.pdf

[21] Haroun, Z. et al (2011). ***Attitudes toward depression among a sample of Muslim adolescents in the Midwestern United States.*** *International journal of adolescent medicine and health.* 23. 293-301. 10.1515/ijamh.2011.058.

[22] Thurston, I.B. et al (2018). **Black and white parents' willingness to seek help for children's internalizing and externalizing symptoms.** *Journal of Clinical Psychology,* 74, 161-177. https://doi.org/10.1002/jclp.22495

[23] Mantovani et al (2016) cited in Bignall T. et al (2020) *Racial disparities in mental health: Literature and evidence review.* London. Race Equality Foundation.

Yamada's study of East Asian American Christian clergy showed that the likelihood of referral of congregants to mental health supports varied according to a number of intersecting factors including the age, ethnicity and education level of the clergy. The study points again to the importance of supporting faith leaders with mental health training and awareness of services, as for many immigrants they are the first point of contact for mental health problems, and can provide a means of doing so without fear of shame.[24]

In Glasgow the Central Mosque works with many Muslim young people from a range of backgrounds including new asylum seekers and refugees as well as third generation UK citizens. Echoing the recommendations of *Hidden Survivors*, a staff member reported that many young people seek help at the Mosque for mental health issues, and indicated willingness to offer space for therapeutic services to operate.

Help-seeking and service under-utilisation

The evidence around prevalence of mental illness within different ethnic groups is inconclusive with a few specific exceptions. However the impact of experiences of trauma, discrimination and racism, and immigration experiences mean there is often a greater need within some BME groups for mental health support. This greater need does not translate into greater service use (although this should also be treated with caution as equalities information is still not routinely collected by all statutory services). The cultural understandings of mental health, stereotypes about being strong, and a tendency to turn to sources of support internal to one's own community described above, provide some explanation as to why BME groups may under-use mental health supports and services. In turn, service under-utilisation contributes to the lack of awareness of cultural issues, and knowledge of prevalence, by mainstream services.

While strong community support networks can be a protective factor, they can also prevent help-seeking. A 2015 systematic review by Kapadia et al into mental health service use by British Pakistani women revealed that the women had high levels of social support primarily through family and friends, but that, as with other communities discussed in this report, these networks held high levels of mental health stigma, leaving women feeling they had to deal with mental illness alone and less likely to use specialist mental health services than white women. They also experienced the dual dilemma of wanting to access practitioners from their own cultural background whilst also fearing opening up because of the risk of disclosure in the community. [25] Other research with South Asian British young people revealed strong feelings that they would not want to access a support clinic and to discuss their problems with "strangers". [26]

This dual issue was raised repeatedly in both the research and conversations with Glasgow organisations. It applies both to young people and adults seeking help for themselves and to parents seeking help for their children. Solutions, discussed later in this report, will need to address both sides of this issue. A useful exercise could be to carry out consultation with BME young people in Glasgow to determine what *would* be the most preferred ways to access mental health support.

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[24] Yamada, A.M. et al (in press). **Community Mental Health Allies: Referral Behavior among Asian American Immigrant Christian Clergy.** *Community Mental Health Journal.* DOI: 10.1007/s10597-011-9386-9.

[25] Kapadia, D., et al (2017). **Pakistani women's use of mental health services and the role of social networks: a systematic review of quantitative and qualitative research.** *Health and Social Care in the Community* 25(4), 1304–1317. https://doi.org/10.1111/hsc.12305

[26] Randhawa, G. and Stein, S. (2007) **An exploratory study examining attitudes toward mental health and mental health services among young South Asians in the United Kingdom**, *Journal of Muslim Mental Health*, 2 (1)pp.21-37

A final barrier to mental health help seeking identified in the research was the model minority myth, an American term used to describe the stereotype of Asian Americans as an exemplary ethnic minority group, whose members work hard, are successful, and contribute positively to society. Kim and Lee (2014) found Asian American college students who had a strong internalised model minority myth (stating that they believed they should have a strong work ethic and inner drive, and be emotionally restrained) were less likely to seek professional help (although perhaps more likely to seek help for family members). [27] This study includes implications for policy and practice including designing programmes that are sensitive to the value of "self-control". While this research refers to a specific American minority group there may be learning for groups in the UK such as British Indians who are perceived as being successful and as not experiencing systemic racism, but who nevertheless experience the impact of both stereotyping and of culturally-informed attitudes to mental health. The issues of "self-control" and a focus on academic achievement were discussed earlier in this report, and are also relevant to internalised expectations of girls from a variety of backgrounds.

Adverse life experiences

The impact of life experiences on mental health is an important factor to consider. While there will be a variety of protective factors for all groups, people from marginalised groups are more likely to experience a range of potentially negative influences on their mental health.

Poverty and deprivation

The association between poverty and deprivation, and poor mental health, has been closely examined in recent years and is widely accepted to work both ways: at its simplest, a decline in mental health may reduce ability to manage financial affairs and affect employment status; while job loss, debt and other financial worries can contribute to stress, anxiety and depression.[28] For children and young people, anxieties resulting from parental financial stress, the impact of poverty on educational and social opportunities, and experiences of bullying may affect mental wellbeing. Therefore, analysis of the factors contributing to mental health difficulties should take account of the likelihood of experiencing poverty and deprivation.

People belonging to many of the ethnic minority groups in the UK are more likely than the White British population to experience deprivation (although it should be noted that there are exceptions where a small number of BME groups fare better than White groups). For example, according to the Equality and Human Rights Commission,

- in Scotland in 2018 people from ethnic (excluding White) minority backgrounds were more likely than White British people to live in poverty (39.6% compared with 17.6%) [29]
- in 2016/17 in the UK Black people (41.5%) were the most likely to be employed in low-pay occupations;
- 3 in 10 children in the UK were living in poverty (2015/16) but this figure rises to 1 in 2 for Pakistani, Bangladeshi and Black African children;

[27] Kim, P. Y. & Lee, D. (2014). **Internalized model minority myth, Asian values, and help-seeking attitudes among Asian American students.** Cultural Diversity and Ethnic Minority Psychology, 20, 98-106. http://dx.doi.org/10.1037/a0033351

[28] For example, a detailed analysis of the relationship is found in Holkar, M. &, Mackenzie, P. (2016) **Money on your mind** Money and Mental Health Policy Institute

[29] https://www.equalityhumanrights.com/sites/default/files/is_scotland_fairer_accessible.pdf [Accessed August 2021]

- Over a 10 year period people from ethnic minorities made up 14% of the population of England and Wales, but 28% of all homeless households in England [30]

Additionally, the 2021 *Hidden Survivors* report details how British Muslims are more likely than the general population, and than other religious groups, to be unemployed, to be economically inactive due to caring responsibilities (for women), to receive a lower hourly pay rate, and, for Pakistani and Bangladeshi young people, to be NEET (Not in Employment, Education and Training)[31].

Racism, Islamophobia and other forms of discrimination

There are many sources showing the links between racism and discrimination, and poorer mental health. A 2018 US study found that police shootings of unarmed Black Americans have adverse effects on the mental health of Black American adults generally. [32] Tynes et al [33] extended this research to investigate the impact African American and Latinx youth of viewing viral online images of both police killings and immigrants locked in cages, showing a significant association with PTSD and depression. The *Changemakers* programme currently underway with young BAME people in the UK has produced a short film where young BAME people talk of their personal experiences of the impact of learning of racist killings in other parts of the world, as well as other experiences of racism and lack of support generally. [34]

The *Hidden Survivors* report discusses racism and islamophobia experienced by young British Muslims and describes an "increasingly hostile environment in Britain in which being a Muslim is becoming steadily more difficult" (p45). A Glasgow youth provider reinforced this, describing a recent rise in hostility with around 75% of the young people he worked with reporting experiencing islamophobia on a daily basis. *Hidden Survivors* recommends a recognition of the underlying factors of structural racism and discrimination on mental health outcomes.

There has been a recent acknowledgement of the extent of racism in Scotland with a Freedom of Information request in January 2021 revealing over 2,200 incidents in schools over a three-year period; in Glasgow 230 incidents were reported in 2019/20. This has been described as the 'tip of the iceberg' since racist incidents tend to be underreported.[35]

As well as experiences of outright racism, the Mental Wellbeing Commission for Scotland describes the cumulative negative effect on mental health of "micro aggressions" experienced by people from diverse ethnic communities on a daily basis, and of racism as a barrier to gaining employment appropriate to level of education. [36]

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[30] https://www.equalityhumanrights.com/sites/default/files/is-britain-fairer-accessible.pdf [Accessed August 2021]

[31] *Hidden Survivors: Uncovering the Mental Health Struggles of Young British Muslims* - Better Community Business Network 2021 http://bcbn.org.uk/Hidden_Survivors_Synopsis.pdf pp41-42

[32] Bor J, Venkataramani AS, Williams DR, Tsai AC**. (**2018) **Police killings and their spillover effects on the mental health of black Americans: a population-based, quasi-experimental study.** *Lancet*. 2018 Jul 28;392(10144):302-310. doi: 10.1016/S0140-6736(18)31130-9.

[33] Tynes, B.M., Hamilton, M.W., Stewart, A.M. & Willis, H. A. (2019) **Race-Related Traumatic Events Online and Mental Health Among Adolescents of Color** *Journal of Adolescent Health* 65:3 371-377 June 10, 2019 DOI: https://doi.org/10.1016/j.jadohealth.2019.03.006

[34] https://www.ukyouth.org/2021/05/working-together-to-ensure-young-people-from-racialised-communities-can-access-appropriate-mental-health-support/ [Accessed August 2021]

[35] https://www.theredcard.org/news/2251-racist-incidents-recorded-in-scotlands-schools [Accessed August 2021]

[36] https://www.mwcscot.org.uk/sites/default/files/2021-09/Racial-Inequality-Scotland_Report_Sep2021.pdf [Accessed September 2021]

Young people interviewed for the *Hidden Survivors* report[20] (pp84-87) talked about minimisation by practitioners of their experiences of racism and the effect this had on their mental health and their relationship with therapists. This is echoed in the Race Equality Foundation report[37] where practitioners were perceived as finding it difficult to understand the minority ethnic experience, and unwilling to engage with or hear about racism its mental health impact. For this reason, some patients wanted to be matched with someone from their own background as they believed there would be cultural understanding which would be beneficial to their engagement and treatment plan. Practitioners at all levels therefore need to acknowledge the impact of what can sometimes be toxic stress caused by these experiences on children and young people's wellbeing.

It also stands to reason that people who have experienced personal and structural racism may be less likely to expect fair treatment from services and may therefore be less likely to seek help for themselves or their children. This indicates a need to build trust between clinicians/services and communities. Religious/faith leaders and the voluntary sector have been found to be effective at bridging this trust gap. Families often feel more confident approaching religious leaders in the first instance. The Race Equality Foundation report showed the contribution of religious leaders was highly rated and could overcome fears about discrimination, lack of understanding by professionals and lack of trust, and that they were good at providing culturally appropriate support. [38] Conversations with faith-based organisations in Glasgow proved that there was an awareness of mental health problems facing young people and families, and a desire to help, but a lack of basic training, awareness and capacity to provide support. Some would welcome the opportunity to provide a local, safe space for services to operate.

Immigration

Refugees and Asylum Seekers are a group of particular concern as regards trauma relating both to past experiences and to the immigration process. This was highlighted by several of the Glasgow organisations that were consulted. Issues identified below refer to children, older young people and/or to adults, but given the role of parental involvement in supporting their children's mental health, all are relevant:

- Pre-immigration trauma from the situation in the home country. Workers described how this trauma often comes to the surface once people arrive in the UK to relative safety, and is complicated by feelings of anxiety and guilt for having escaped leaving loved ones behind.
- Trauma arising from experiences of migration, trafficking and associated abuse, loss and bereavement.
- The immigration process itself: both unaccompanied young people and refugee/asylum seeker parents experience delays, anxiety and stress, having to re-tell their traumatic story, not being believed, and the complexity of the application process. A worker described the paranoia of someone who was convinced there was a camera in his room to monitor him. Primary care services and counsellors were described as not understanding the impact of this traumatic process, and this lack of understanding itself becoming a barrier to accessing support.
- Practical issues like language barriers and access to services, or knowledge of the system and what services are accessible, free or charged for.

[37] Bignall T. et al (2020) *Racial disparities in mental health: Literature and evidence review.* London. Race Equality Foundation.
[38] Ibid p46

- Depression arising from a mismatch of expectations. Many people arriving in this country expect that now they are safe, things will get better. However they then experience poverty, unemployment, racism and discrimination. Workers spoke of parents who were shocked that they were now unable to provide nice things for their children or to take them places by car. They were also shocked by the restrictions they faced, for example not being allowed to work: "Everywhere you turn to they say that is the law".
- Isolation: asylum seekers may be placed in areas where they have no resources or community to turn to. Previous sources of family and community support are no longer there. Language barriers, fear, lack of cultural understanding and discrimination act as barriers to integration. Gaining refugee status, while on the whole positive, can also mean another move to a new area which can be traumatic for children and young people who may have built up a social network at school.
- Unaccompanied young asylum seekers are of particular concern in terms of trauma. There is a comprehensive package of support around most of these young people in Glasgow in terms of good quality accommodation, access to therapy, and an allocated social worker. However there are gaps including young people who arrive above the age of 18, and those who arrive unaccompanied under the age of 18 but are later reunited with their parents, and who consequently lose a large part of their support package.
- Children of refugees and asylum seekers. In comparison to the group above, these children and young people have very little in the way of support and often live in poverty (as asylum seekers on Asylum Seeker Support and in basic accommodation), with parents who may be dealing with many of the issues described above. Many asylum seekers are wary of how much information they provide to authorities, and children also become wary of coming forward for help because of this tendency in the family to mistrust authorities. Children may therefore be living with their own or their parents' mental health problems that are not being acknowledged or addressed. They may also act as interpreters in a variety of situations which can expose them to difficult, confusing or traumatic experiences.

The Mental Welfare Commission for Scotland has recommended that Primary Care staff should all be trained in trauma-informed practice and in understanding the impact of the asylum process. [19]

Identity

Young people belonging to ethnic and religious minority groups in the UK can also experience inner turmoil relating to their sense of identity. There can be conflict between the expectations of the family and community, and the need or pressure to fit in with their peers and assimilate to the local culture and norms. A worker from a Glasgow organisation spoke of third and fourth generation children and young people still suffering from this kind of identity crisis; many considered themselves primarily Scottish but would still be asked the question by others, presumably because they are visibly "different". Discrimination, prejudice and inequality of opportunity can also weaken a sense of belonging, as described in the *Hidden Survivors* report. [39] These issues around identity can have an adverse effect on psychological wellbeing.

Gender violence, FGM and other harmful cultural practices

Harmful cultural practices including Female Genital Mutilation, Forced Marriage, and so-called 'honour'-based violence are still prevalent within some BME communities in Glasgow. According to a

[39] *Hidden Survivors: Uncovering the Mental Health Struggles of Young British Muslims* - Better Community Business Network 2021 http://bcbn.org.uk/Hidden_Survivors_Synopsis.pdf p38

third sector organisation specialising in supporting BME women and girls, many of the people they work with still do not know that FGM is illegal, and there continues to be a reluctance among some to get involved in efforts to end the practice. During the COVID-19 pandemic there has been little opportunity to travel abroad for the purposes of FGM or forced marriage, but specialist services continue to be vigilant for girls being taken south, for example to Birmingham where FGM is rumoured to be carried out. The traumatic impact of FGM has been well documented; the local service spoke of work on human rights issues with women affected by FGM, which can cause mental health issues to surface. For girls and young women at school, learning about human rights issues may have a similar impact, and services should be aware of this and be prepared to offer support.

Beliefs in some communities about family honour and shame mean that the burden is primarily on women and girls to be seen to behave in culturally acceptable ways. A worker spoke of girls being monitored in school by their brothers – including younger brothers – and having no freedom either inside or outside of the home. However, as mentioned above, there is also pressure to assimilate and to fit in with peers, as well as the threat of discrimination and prejudice for being "different". This can leave girls in particular with very few options if they need support, and points to the need for both specialist services with an understanding of the cultural complexities faced by these young people; and also for universal services to develop their own understanding of the reasons why some young people may need support, and how to provide it.

Beliefs about witchcraft have been mentioned earlier in this report. This came up in conversation with workers, one of whom expressed concerns about religious forms of "treatment" for mental illness which they likened to exorcism. However no-one spoken to was able to provide an estimate or evidence of whether and to what extent this happens in Glasgow.

Practical & Logistical issues

Language barriers

Language barriers are a recurring theme in terms of BME groups' access to and use of services in general. Ability to both explain problems and to understand a professional are hampered by difficulties with everyday English as well as with medical and clinical terms. Also, as discussed previously, mental health is understood and talked about differently within different cultural contexts. Discussing mental health without cultural sensitivity can lead to associations with "madness", witchcraft, sprits, curses and black magic, which can prevent engagement with services.

Interpreting carries its own issues. For many BME communities, their minority status means that community members tend to know each other, which can lead to fears of gossip and implications for status in the community, as was raised within a number of the research papers as well as in conversations. The use of male interpreters was highlighted as a particular barrier for women talking about issues related to gender based violence, and examples were given of men discouraging women from seeking help.

Systemic issues were also raised around availability and reliability of interpreters, and there were claims that interpreters did not always relay accurate information. Others said that some interpreters interpret word for word which is not helpful to someone who does not understand the system and needs more detailed explanations. Some women attempted to bring a trusted female friend or family member to appointments for interpreting, with mixed success in terms of this being accepted by services that may have concerns about accuracy and coercion.

One possible solution has been the use of technology to make use of services outside of the immediate community. A community development trust in Glasgow has been exploring outsourcing their counselling service to UK- and foreign-based Romanian speaking organisations. This could also be achieved for interpreting services. However there could be concerns about quality assurance and governance. Another recent example is the effort by Scottish Refugee Council in partnership with Public Health Scotland to produce Covid-19 information videos in other languages. In Glasgow and other health boards as well as nationally there are many examples of health awareness videos produced in a range of languages. Achieving this for mental health could help to at least begin conversations and improve awareness of services.

Awareness of services, understanding of the system

Awareness of the range of services that are available was raised many times in conversations with community organisations. Issues for recent immigrants to Scotland included needing to have a basic understanding of the health system: from knowing how GP appointments work (an example was given of new patients trying to "tell their life story" within a 10 minute appointment) to knowing which services are free and which are not, or how to get to the appropriate hospital. It was also clear from conversations with various groups that even second and third generation immigrants sometimes did not know the range of services available to them or where they could go for help with mental health. NHS Inform has provided fact sheets and videos[40] in a range of languages explaining how the system works, but work clearly needs to be done to ensure this information reaches people.

Mental health charity Mind recommend raising awareness of psychological therapies widely, including through faith and community networks[41]; this recommendation can be extended to the full range of mental health and wellbeing supports and services.

Local "champions" such as Saheliya's Champions for Wellbeing have also been successful in improving knowledge of services by sharing information, including mental health issues, rights, where to get help and how the system works, and encouraging other women to get help/support.

School-based services are also recognised as a universal service that may mitigate against the effects of parental lack of understanding or knowledge of the health care system, especially where these are part of a greater "package" or whole-school approach that includes mental health awareness and stigma reduction. School-based counselling and group work therapy are now available to all children and young people in Glasgow from P6-S6. However it should be noted that the ability of younger BME children to access services may still be heavily influenced by parents and carers, and that of older young people may be limited by many of the cultural and discrimination-based barriers already discussed.

There may also be a need to promote better awareness among BME groups of mental health prevention and early intervention resources and strategies. A wide range of online materials is available across the UK, some of which is particularly aimed at BME young people. In Glasgow there are groups that promote physical and outdoor activity specifically to BME groups that would otherwise face barriers to engaging:

- Boots and Beards is a charity that encourages people from all communities (but focussing on under-represented groups) to engage with nature and the outdoors. They organise hillwalking trips which are attended mainly by Asian families and which participants say have

[40] https://www.nhsinform.scot/care-support-and-rights/health-rights [accessed Jan 2022]
[41] https://www.mind.org.uk/media-a/4426/we-still-need-to-talk_report.pdf [accessed October 2021]

helped them improve their physical and mental health, to engage with the environment and to spend quality time with family and friends. They also provide male and female badminton sessions, and deliver the Duke of Edinburgh award scheme. [42]

- Active Life Club is based in Govanhill and offers a range of physical activity to children and young people from under-represented groups. Founded in response to a lack of inclusive mainstream provision, the project specialise in providing culturally-informed activities that break down barriers, for example encouraging BME women and girls to participate. They also provide a youth employability service. [43]
- There is also a range of community growing projects such as Urban Roots[44] which support mental wellbeing through using greenspaces and food to bring people together, and which are successful at engaging with BME groups.

Immigration status

Whilst free primary and emergency healthcare is available at point of access to almost everyone, not everyone is aware of their rights (as evidenced by the discussion above). There are also barriers, for example, for those with No Recourse to Public Funds.[45] Victims of domestic abuse can be coerced into staying in abusive relationships, and prevented from seeking help, by family members with better knowledge of the system. Asylum seeking families can be cautious about sharing personal and sensitive information with statutory services for fear of this being passed on to immigration services and perhaps damaging an asylum claim (this is not the case but continues to affect help-seeking). Families that have not applied for settlement status in the wake of Brexit may also face charges in future for some services.

System issues

Universality of services

Efforts are often made to include marginalised groups within mainstream provision. However, several third sector providers mentioned the need for work with BME groups to move at a very different pace than would normally happen in mainstream provision. This is partly to allow for interpreting needs, and also for the much deeper discussion required for participants to understand the issues and how they are affected by them. An example given was parenting: cultural norms vary greatly around the world and some BME parents, even when comfortable with the language, are uncomfortable talking about some of the traditional practices they themselves grew up with. In order for universal services to work well with marginalised groups, providers need to understand the barriers, stigma and discrimination people face, and must be able to shape their services accordingly. There is also a need to recognise the benefits of specialist services that can bridge the gaps in trust and understanding, and address some of the additional barriers, in order for some groups to benefit from universal services rather than being left behind by them. A recent example is the Boloh helpline set up by Barnardo's during the COVID-19 pandemic, which puts children and young people aged 11+ and their families in touch with culturally-informed therapists from a range of cultural backgrounds and available in a range of languages. [46]

[42] https://www.bootsandbeards.co.uk/ [accessed Jan 2022]
[43] http://www.activelifeclub.org/ [accessed Jan 2022]
[44] https://www.urbanroots.org.uk/ [accessed Jan 2022]
[45] For example, women and children living with domestic abuse who have arrived in the UK on a spousal visa
[46] https://helpline.barnardos.org.uk/ [accessed Jan 2022]

Unconscious or implicit bias within services and in referrers to services

Unconscious bias can affect the way professionals respond to people in a number of ways, including their perception of presenting issues and underlying causes. It can also contribute another layer to the equalities issues facing under-represented groups. A 2012 study[47] found that clinicians' implicit race bias was associated, particularly amongst Black patients with:

- Poor ratings by patients of care received
- More clinician verbal dominance; less patient centred dialogue
- Less patient liking of clinician
- Lower trust and confidence in, and perception of respect from, clinician

In Glasgow, as in other places, BME groups are under-represented in prevention and early intervention mental health care. The 2019 Quarter 1 report supplied by the provider of the Glasgow Schools Counselling Contract states that 90% of clients seen identified as 'white'[48]. According to the demographics mentioned earlier in this report, this suggests an under-representation of other ethnic groups. The first quarterly report by the provider of the new secondary schools counselling contract beginning in the summer of 2021 shows an improvement and it is to be hoped this will continue. It is not known how much of this arises from referral rates (by, usually, white professionals) and how much from engagement by pupils following referral.

Saheliya have identified that many girls and young women experience mental health issues that are not recognised by statutory services. This may be due to a combination of factors including family and community unwillingness to talk about mental health or about the underlying problems that may cause mental health problems; and the emphasis on academic attainment and emotional repression leading girls from some ethnic groups to internalise rather than externalise problems. As discussed earlier, FGM, forced marriage and honour-based familial expectations are factors that make girls from some groups more likely to experience a range of mental health problems; that make these problems to be less likely to be picked up by professionals and to lead to referrals; and that make some groups less likely to self-refer.

This tendency has been noted in US studies on referrals to school based mental health (SBMH) services. Bear et al (2014)[49] show that SBMH can reduce racial disparities in care found in specialist mental health services by eliminating or reducing logistic barriers to access (e.g., clinic hours, transportation, insurance), decreasing stigma associated with mental health care, improving the chances of detecting mental health problems, and providing education and outreach. However, they also noted disparities in referrals across ethnic minority groups based on cultural stereotypes as well as culturally-influenced presentations of mental health problems: Asian American students tend to be higher achievers academically and are under-represented in referrals to SBMH, compared with Latino youth, suggesting that school staff may overlook emotional or behavioural problems in the former group and observe them more readily in the latter. Implications from this study include the need to better understand the relationship between high academic achievement, internalisation of problems and low referral rates, and conversely between poorer academic achievement,

[47] Cooper, L.A. et al. **The Associations of Clinicians' Implicit Attitudes About Race With Medical Visit Communication and Patient Ratings of Interpersonal Care**, *American Journal of Public Health* 102, no. 5 (May 1, 2012): pp. 979-987. https://doi.org/10.2105/AJPH.2011.300558

[48] Youth Mental Health Improvement: Progress Report: 1st January To 31st March 2019

[49] Bear, L., et al, 2014. **Building the gateway to success: an appraisal of progress in reaching underserved families and reducing racial disparities in school-based mental health.** *Psychological Services*, 11(4), pp. 388-397

externalising problems and higher referral rates. It warns of an unmet need in particular groups and suggests referring staff could receive targeted training to identify mental health needs in groups that are under-represented in referrals.

Structural racism

Mind UK's website lists a number of issues, and corresponding evidence, relating to racism within UK mental health services. [50] These include unequal access to services; inequality in diagnosis; unequal treatment under the Mental Health Act; and inequality in outcomes.

The Mental Welfare Commission for Scotland reported in September 2021 on mental health detention figures for Scotland. [19] While data on restraint is not available by Health Board, concerns were raised that, in Scotland:

- People of colour were more likely to be detained through a less preferred route, and detentions were less likely to have Mental Health Officer consent;
- There were differential perceptions of risk, with Black people more likely to be deemed at risk to themselves than other ethnic groups; Black and Mixed ethnic groups were more likely to be considered a risk to themselves and others than to themselves only; and Black women significantly more likely to be considered a risk than White women;
- Detentions among some ethnic groups are skewed towards younger age groups, which is not seen in White Scottish and other British groups. This is particularly the case for males from the African, Caribbean or Black, and Mixed, ethnic groups, up to the age of 24.

Reasons behind these inequalities include many of the barriers and issues around stigma and access to early treatment that have already been discussed in this report. However, racism by professionals also plays a part in determining which people are more likely to be deemed angry, violent or a risk to themselves and others. This issue applies to children at all stages and within all services. There is evidence that Black boys in early years settings are more likely to be regarded as "challenging"[51], and more likely to experience school exclusions and youth justice. [52] In order to redress the inequalities illustrated above, racism needs to be addressed across society.

Recognising the role of religion, faith & spirituality

A 2014 report for Mind UK and others highlighted the importance of faith and spirituality and noted that talking therapists often did not take account of how therapy interacted with religion and spirituality. It recommends good engagement with local black and minority ethnic communities to ascertain their needs around various treatments, including talking treatments; and the commissioning of services that can demonstrate sufficient diversity and cultural appropriateness. [53] The Race Equality Foundation also suggests that "commissioners should establish effective partnership with community and faith groups to communicate, inform and influence appropriate help seeking behaviour for a more holistic approach." [54]

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[50] https://www.mind.org.uk/about-us/our-strategy/becoming-a-truly-anti-racist-organisation/facts-and-figures/

[51] https://news.yale.edu/2016/09/27/implicit-bias-may-explain-high-preschool-expulsion-rates-black-children

[52] In Scotland in 2018/19, the Black Carribean, African and Roma pupils were the most likely groups to be excluded from school: https://www.gov.scot/publications/school-exclusion-statistics/

[53] *Ethnic Inequalities in Mental Health: Promoting Lasting Positive Change* Lankelly Chase Foundation, Mind, The Afiya Trust and Centre for Mental Health (2014) Ethnic-Inequality-in-Mental-Health-Confluence-Full-Report-March2014.pdf (lankellychase.org.uk)

[54] Bignall T. et al (2020) *Racial disparities in mental health: Literature and evidence review.* London. Race Equality Foundation. pp29-30

Cultural competence and diverse workforce

Cultural competence (the ability to reflect on one's own culture in order to engage effectively with people from other cultures) is discussed in much of the literature on BME mental health and is important for engaging effectively with children, young people and parents/carers. Having a workforce that reflects the demographics of the communities we work with is another important factor in breaking down barriers and encouraging help-seeking. Research into the effect of increased cultural competence in an HIV/AIDS clinic[55], of ethnicity of doctors caring for newborns[56], and of ethnic match between doctors and male patients[57], has shown that these are factors in improved patient/clinician relationships, uptake of screening and therapies, and likelihood of the patient talking about other health issues, and could help reduce racial disparities in quality of care and patient outcomes.

This is echoed in the research by Kurtz and Street. [58] While many of the issues raised by BME young people in the research were consistent with findings for young people in general, a clear need was also identified for understanding the specific cultural dimensions that compound issues about waiting lists, accessibility, young-person-friendliness and stigma. Staff in the research reported the need for specific training to understand these cultural dimensions. Conversations with Glasgow youth workers specialising in BME mental health back this up and point out that cultural competence cannot be achieved by a one-off training course but is a constant, ongoing process. Kurtz and Street's recommendations include mental health services working closely with 3rd sector BME organisations and schools to develop mutual understanding of mental health and cultural issues.

Embracing different ways of working

All of the issues described so far contribute to a lack of accessibility of, and trust in, statutory services and providers. The Mental Welfare Commission for Scotland recommends that services should take themselves into communities rather than waiting for so-called "hard to reach" communities to come to them, and to work with third sector organisations, to build trust and understanding. [59] A 2020 study [60] into the demographic profile of users of community and voluntary sector counselling services showed these services were more likely than statutory and school based services to be accessed by marginalised groups including BME groups.

There are also examples within the literature showing that when statutory services make a concerted effort to engage better with marginalised communities, these barriers can be overcome.

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[55] Saha, S., Korthuis, P.T., Cohn, J.A. *et al.* **Primary Care Provider Cultural Competence and Racial Disparities in HIV Care and Outcomes.** *Journal of general internal medicine*, vol. 28, no. 5, pp. 622-629. https://doi.org/10.1007/s11606-012-2298-8

[56] Brad N. Greenwood, Rachel R. Hardeman, Laura Huang, Aaron Sojourner **Physician–patient racial concordance and disparities in birthing mortality for newborns** *Proceedings of the National Academy of Sciences* Sep 2020, 117 (35) 21194-21200; DOI: 10.1073/pnas.1913405117

[57] Alsan, Marcella, Owen Garrick, and Grant Graziani. 2019. **Does Diversity Matter for Health? Experimental Evidence from Oakland** *American Economic Review*, 109 (12): 4071-4111.DOI: 10.1257/aer.20181446

[58] Kurtz, Z. and Street, C. (2006), **Mental health services for young people from black and minority ethnic backgrounds: the current challenge**, *Journal of Children's Services,* Vol. 1 No. 3, pp. 40-49. https://doi.org/10.1108/17466660200600022

[60] DUNCAN, C., et al, 2020. **Counselling for young people and young adults in the voluntary and community sector: An overview of the demographic profile of clients and outcomes.** *Psychology & Psychotherapy: Theory, Research & Practice,* 93(1), pp. 36-53.

The Building Bridges programme in Liverpool [61] recognised the under-representation of BME children and families in preventative and early intervention services, and their over-representation in interventions like mental health detention, criminal justice and school exclusion. The programme was a collaboration between the NHS trust and community based organisations to transform services into more accessible and culturally competent ones. Principles that were implemented included:

- Holistic services that worked with the whole family on a variety of issues;
- Recognising the importance of parent/carer mental health by allowing adult referrals;
- A Community Participation Group that was paired with and fed into the programme's steering group; and children's participation through consultations;
- Self-referrals and referrals from community organisations;
- Capacity building work that included joint training sessions with statutory and community organisations on a range of specialist topics on issues for working with BME families;
- Solution-focused counselling, adapted to work better with BME families and with therapists trained in advocacy;
- Staff from a variety of BME backgrounds.

Challenges cited include issues with data collection and difficulties filling staff vacancies with all the desired linguistic abilities. The programme ultimately suffered from a lack of sustainable funding. However there were many benefits, some of which continue (Liverpool CAMHS continue to allow self-referral as a legacy of the project) and the principles of working in and with communities could be applied more widely to other marginalised groups.

The CAMHS team serving the Tower Hamlets area of London has also carried out work to improve its outreach to the under-served Bangladeshi community, using a process of enquiry followed by a commitment to respond to what was learned. Although anxieties were raised about increasing referrals from this community at a time when referrals generally were becoming unmanageable, the service as a whole changed its way of thinking. One major change was the creation of specific Bangladeshi co-worker posts within the service. [62] The report is clear that, rather than a model to be replicated, this project is an example of how services can learn more about ethnic inequalities in service access, and respond in ways that are informed by the communities they serve.

The Mental Health Foundation is currently undertaking work with a large staff group from multidisciplinary services in Edinburgh exploring reflective practice around inequalities in young people's mental health. A process of task-sharing, based on a model developed in New York[63], is being supported in Dundee. Reverse commissioning is a similar model that has been developed by the NHS BME network in England.[64] This could be an area for Glasgow's services to learn from and potentially collaborate.

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[61] Fatimilehin, Iyabo. (2007). **Building Bridges in Liverpool: Delivering CAMHS to Black and Minority Ethnic Children and their Families.** *Journal of Integrated Care.* 15. 7-16. 10.1108/14769018200700017.

[62] Messent, P. and Murrell, M. (2003) **Research Leading to Action: A Study of Accessibility of a CAMH Service to Ethnic Minority Families.** *Child and Adolescent Mental Health,* 8: 118-124. https://doi.org/10.1111/1475-3588.00057

[63] https://www.rand.org/pubs/tools/TL317.html

[64] For examples, see https://www.youtube.com/watch?v=TjnpGQiG4ts or https://www.mentalhealthtoday.co.uk/engaging-bme-communities-about-mental-health

Limitations

There are many more groups and individuals across Glasgow and Scotland that are working with BME groups, mental health and/or young people, and that have insights, however it was not possible to speak to all of them. Some did not respond to requests; others were too busy and some said they did not feel they had the expertise to comment. There are also gaps in the literature, particularly around Gypsy/Roma, Polish and other European minority groups, and Chinese groups in the UK. Moreover, intersectionality, for example LGBT+ and BME, needs to be taken into account.

It should also be noted that some of the US-based literature is influenced by inequality of access to free healthcare, which is less pertinent in the UK although not irrelevant given that some resort to private counselling and access will also be hampered by lack of transport, related to poverty.

The voices of BME children and young people, and their families, are not featured in this report. However a 2021 report by Intercultural Youth Scotland does include youth voice and covers very similar themes.[65]

Finally, as mentioned, there is growing recognition among mainstream services in Scotland of the extent and impact of racism. Services and individual staff must be competent in recognising this impact; recognising unconscious or implicit bias, and responding to the impact it can have on BME children and young people's mental health and service access.

Discussion

Clearly there are many nuances around the specific, overlapping barriers faced by different groups; and none of these groups is static but rather the issues will change with time and within groups. However, the discussions showed that it is not necessarily essential, or useful, to try to understand every issue for every specific group at this point. More useful would be to:

Develop culturally competent and reflexive ways of working that ensure services and practitioners are sensitive and responsive to the needs of diverse communities, whatever their background.

"Reflexivity refers to the ability to engage with and understand how one's social locations have shaped their understanding of their world […] it instills a consciousness that trains practitioners to appreciate layered meanings and multiple potential explanations for the emergence of a mental health issue […]; when health care practitioners are capable of doing so individually, treatment also becomes more efficient by ruling out the need to rely on continual consultation with others and preserving the potential for self-organization." Au (2017)[66]

Develop structured and effective working relationships between statutory and community-based specialist services that can help to share tasks and build bridges with those communities. This report has discussed the need for specialist services, and the role of the 3rd sector both in providing these and in bridging the "trust gap" between statutory providers and marginalised communities. The

[65] *Speaking Our Mind: The Impact of Racism and Race on Young Black people and young People of Colour in Scotlands Mental Health Needs* Intercultural Youth Scotland June 2021 https://www.interculturalyouthscotland.org/reports [accessed Jan 2022]

[66] Au, A. (2017) ***Low mental health treatment participation and Confucianist familial norms among East Asian immigrants: a critical review.*** *International Journal of Mental Health,* 46 (1). pp. 1-17. ISSN 0020-7411 p9

examples discussed on pp20-21 of this report provide evidence and good practice on which to build a framework to utilise and develop effective partnerships.

Considerations and Recommendations

Mental Health Providers including schools counselling services and other school-based supports:

- Schools service: Most up to date data suggests a demographic improvement in uptake of school based counselling. Can equalities monitoring be extended to outcomes to give an indication of success across different ethnic groups? HSCP services: interrogate data to explore both uptake and outcomes demographics.
- Cultural competence training or similar reflective practice activity should be mandatory for staff of provider organisations
- Providers should work to increase staff diversity with better representation from BME groups
- Referring staff should have opportunities to reflect on cultural, religious and other issues that might impact on presentations and referrals
- Consider any language (including cultural language) barriers and possible solutions, in promotion and delivery of services
- Consider young Travellers and whether/how they access services
- Consider pilot/test of change opportunities taking learning from approaches to collaborative working with community based organisations, to support task-sharing, bridging the "trust gap" and ensuring therapies, supports and services are accessible and culturally appropriate

Public health

Working in communities

- Work collaboratively with community groups to address mental health stigma in culturally appropriate and representative ways, taking account of language used to describe mental health
- Identify and develop relationships with community assets like faith settings where there is willingness to engage and support mental wellbeing. Investigate how faith and other community leaders can support this agenda (consider targeting faith organisations for basic training, and basing therapeutic services within faith settings)
- Consider how else we might reach BME groups in the community, for example through greenspace and outdoor initiatives engaged in social prescribing, or through homework clubs and other educational activities
- Anti-stigma programmes should consider the additional stigma in BME communities and seek to address this specifically
- Learn from specialist BME organisations like Saheliya and Community Info Source how to effectively engage with marginalised communities
- Consider how well our research and data monitoring engages with marginalised communities, and whether action is needed to improve representation.

Mental health training provision

- Provide targeted training to BME community organisations and faith settings. Consider offering training to private sector providers used by BME young people, eg. hair salons and gyms.
- Work with community and faith groups to ensure mental health training meets the needs of BME communities and those that work with them

Across all services

- Establish a reference group that can advise on whether our prevention/early intervention programmes and therapies are culturally appropriate, eg. should there be alternative 'healing' therapies like yoga, meditation? When is interpreting appropriate or not? How to make commissioning processes more inclusive, both in terms of the profile of commissioned organisations and requirements of organisations to engage with marginalised communities. [67]
- Consider whether/how much people from BME backgrounds are involved in patient & public involvement initiatives
- Address language and communication barriers – consider recruiting staff who speak a variety of languages as an additional option, while maintaining the offer of using interpreters
- Staff at all levels should have training or opportunities to reflect on how racism and discrimination can affect mental health as well as trust, help-seeking/service usage, presentation. They should also all have opportunities to learn about/reflect on how their own cultural and faith background can affect their interactions with patients, and on how culture and faith influence beliefs and behaviours around mental health.

Next steps

It is suggested that all services allocate time and resources to the considerations above so that issues like language, training, staff recruitment and data monitoring can start to be addressed quickly. Longer term, partnership working between statutory providers and community based organisations should be developed using the task sharing, or reverse commissioning models described here. Through these partnerships, issues like staff anti-racist and cultural competence training can be addressed; statutory providers can be supported to build a presence in communities; communities can be supported to talk about mental health and overcome stigma; and specialist 3rd sector organisations can build capacity and capability to respond to mental health needs. The voices of children and young people from BME backgrounds should form part of this response and should be supported through such partnerships.

[67] For more on commissioning, see Bignall T. et al (2020) *Racial disparities in mental health: Literature and evidence review.* London. Race Equality Foundation. p48

Appendix I

Organisations whose staff contributed to this report:

Active Life
African Women's Network
Anyiso
Boots and Beards
Centre for Mental Health (UK)
Community Info Source
Glasgow Central Mosque
Glasgow City Council BME Task Force
Glasgow East End Carers
Glasgow HSCP Health Improvement Team South
Glasgow Social Work Services: Young Asylum Seekers and Roma Team
Govanhill Housing Association
Intercultural Youth Scotland
Mental Health Foundation
Saheliya
Scottish Refugee Council
St Mungo's Academy mental health peer support group
Youth Community Support Agency