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Service innovations: developing a service for the mental health needs of South-Asian children and adolescents

Over recent years there has been concern regarding health service accessibility for minority ethnic groups and this was reflected in the introduction of mandatory recordings of patient ethnicity upon hospital admission (Giu & Johnson, 1995).

British community-based epidemiological studies indicate a 7% prevalence of emotional and behavioural problems for pre-school children which rises to 20% in adolescence (Rutter, 1975, 1989; Meltzer *et al*, 2000). Some epidemiological studies suggest different rates of disturbance for South-Asian and White children. Cochrane (1979) compared rates of psychological disturbance in Indian, Pakistani, West Indian and White English children and found less morbidity in the two Asian groups. Hackett *et al* (1991) found lower rates of psychiatric disturbance in Gujarati-speaking than White children. Stansfeld *et al* (2004) found that Bangladeshi pupils had lower rates of psychological distress.

In contrast, Newth & Corbett (1993) found similar rates of behavioural problems in South-Asian and White children, which was possibly explained by the inclusion of those with mild difficulties. Bhugra *et al* (2003) found no ethnic differences in adolescents presenting with self-harm. Dosanjh (1972) reported more psychiatric disturbance in Punjabi-speaking immigrants compared with the indigenous White sample.

Parental perceptions of normal and deviant child behaviour may vary with culture, which would affect studies using parental reports. Bussing *et al* (2003) found White families more likely to seek help for hyperkinetic symptoms. This possible difference in parental perceptions has implications for service use. Hackett & Hackett (1993) explored this using a semi-structured interview and found that Gujarati-speaking parents had higher expectations and tolerated fewer behavioural difficulties. Their children displayed fewer behaviour problems.

Recent studies have examined referral patterns to child and adolescent mental health services (CAMHS). Kramer *et al* (2000) found similar expected and actual referral rates for ethnic groups based on predicted rates from the 1991 census. Fewer South-Asian children had psychiatric disorders. Stern *et al* (1990) found that referrals of South-Asian children to CAMHS were lower than predicted by local education authority figures. No significant differences were noted between South-Asian and other children on a range of clinical dimensions, including presenting problem.

Daryanani *et al* (2001) reported an over-referral of White children and adolescents by general practitioners (GPs). Black and South-Asian children and adolescents tended to be referred by specialist doctors. The finding that South-Asian children were more likely to be referred through medical wards was reproduced by Roberts & Cawthorpe (1995).

Background to the project

Ensuring equal service access for all is an important part of provision and planning. In 2000 the Manchester Health Authority commissioned health, social services and the voluntary sector to develop a CAMHS strategy. This addressed service provision for families from minority ethnic groups and made a number of recommendations, including the establishment of a South-Asian child and adolescent mental health practitioner post to implement this strategy. Manchester Health Authority agreed to fund a 2-year post; this was later changed to 3 years.

In this report the term South-Asian refers to first-, second- and third-generation Pakistani, Indian and Bangladeshi people and encompasses the beliefs, customs and practices of various religions and cultures from the Indian subcontinent.

Recruitment and training

J.P. started work as a South-Asian child mental health practitioner in 2001, bringing experience of working with children and families in the UK and abroad, and knowledge of the cultures and religion of South-Asian people. Her duties included 3.5 days of direct clinical work, 1 day of service development and 0.5 days undertaking needs assessment with L.H.

J.P. received training equivalent to other departmental clinicians. This included undertaking emergency assessments, a certificate in family therapy, brief solution-focused therapy, cognitive–behavioural therapy and Webster-Stratton parent group training. Consultant psychiatrists supervised her clinical work.

Needs assessment

The needs assessment incorporated different strands. The first involved a review of South-Asian CAMHS in six British cities. Clinicians were identified as struggling to understand issues of culture, ethnicity and religion, and this was affecting the therapeutic process. Training in these three areas has addressed this lack of understanding. In addition, organisational and structural changes have been found to reinforce training and enhance awareness in these teams. Setting up such services requires extensive resources and commitment. Difficulties occur when clinicians do not share the vision

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of improving access, or when individual workers are pressured to become the Asian culture 'expert'.

The second strand involved two studies in Manchester. First, a retrospective study of referrals accepted by a clinical psychology department (1999–2000): 85% were White and 5% South-Asian (6.3% of the North Manchester population are South-Asian). Significant differences were noted in age distribution and presenting problems. No other significant differences were noted, including route of referral, gender, engagement, sessions attended and length of involvement. The second study reviewed Tier 2/3 psychiatry referrals in 1999–2000: 73.2% (74% of the whole population) were White, 11.5% (8.5%) Black, 7.8% (12.2%) South-Asian and 6.7% mixed race (not reported in the Registrar General's population estimate for mid-2000). There was no significant difference among ethnic groups in presenting complaint, age, gender, reason for closure or therapy outcome. Antisocial behaviour was the most common problem for the White, Black and mixed race groups and autistic traits for the South-Asian group.

The third strand involved consultation with local statutory and voluntary organisations through collating the results of a questionnaire and two development days in 2001 and 2002 with group discussion on services. Local GPs and a group of South-Asian parents and adolescents were also consulted.

Issues raised

Issues raised at the consultation session and first development day included suicide, alcohol misuse, undiagnosed learning difficulties, inter-generational problems and cultural conflict. Barriers to accessing CAMHS included lack of information regarding the service and mental health problems, and an unwillingness to discuss family circumstances with GPs. A lack of culturally appropriate services with sensitivity to language, culture and religion was also identified. Suggestions for involving the community in service delivery included liaising with community leaders, clinicians maintaining contact with community groups, service provision within the community, increasing knowledge about mental health and ensuring families understood the purpose of meetings.

Recommendations

Recommendations included raising awareness, establishing closer links with other relevant services and advertising services within the community. It was stressed that service delivery should take account of individuals needs, allowing treatment choice and recognising and respecting different cultural and religious beliefs. The importance of link workers and the necessity of training such workers and those they work with was reiterated.

At the second development day, progress was reported and further suggestions gathered. These included evaluating the skills of the practitioner and developing services for other minority ethnic communities.

General practitioners believed that the barriers to accessing services were stigma, communication problems, lack of transport and a tendency to present with physical and not emotional symptoms. Suggestions for service development included raising awareness among GPs, meeting community leaders and educating through outreach work.

In consultation with a group of parents, case scenarios that are typical of Tier 2/3 CAMHS referrals were examined. Parents suggested that accessibility would be increased by more such sessions, providing an understanding of child mental health problems and what CAMHS could offer. Advice on their children's behavioural difficulties was also requested.

Focus groups were used for consultation with adolescent Asian girls. These reported cultural and religious pressures, lack of money and school difficulties. Isolation, anxiety and sadness were identified as consequences. The group examined case scenarios and identified pressures resulting in young people experiencing thoughts of self-harm. They believed that families can find attending services stigmatising and try to resolve difficulties at home. They wanted a service with experienced empathic staff, an inviting base, confidentiality and home visits. All participants felt it was difficult for young people with mental health problems to establish where to get help and that fear may prevent them. They reported a lack of understanding of mental health services in their communities and recommended addressing this through advertising.

Outcome

The Tier 2/3 referral audit was repeated after the service was established (2002) and revealed a significant increase in South-Asian referrals (from 7.8% to 17%). The referral rate for the African–Caribbeans stayed the same. A user satisfaction survey of South-Asian families undertaken by an independent assistant showed significant user satisfaction with this project.

The dedicated mental health practitioner (J.P.) played an important role in developing cultural sensitivity in the service. Formal avenues included the fortnightly education forum within the department. She presented two clinical cases a year and took an active part in the discussion of other case presentations and journal reviews. She made full use of team meetings, both for discussion of her own case-load and for informing other clinicians. J.P. fostered a culture of accessibility and was frequently consulted by her colleagues. She also took part in the development days.

However, she reported a feeling of professional isolation and felt that she was perceived solely as the South-Asian worker, which at times made it hard to engage in generic CAMHS work. She also found that patients from the South-Asian community at times expected her to be accessible in a way that is not normally a part of CAMHS work. J.P. recommended that

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two workers should be recruited to future posts to share responsibility and prevent clinician burnout. However, she reported supportive and effective supervision and management.

Discussion

The strategy document (Hackett, 2000) that assisted the development of the South-Asian CAMHS project is the foundation for this report. Section 2.30 of *Every Child Matters* (Department of Education and Skills, 2003) reports that it is 'essential to develop high quality commissioning of mental health services that takes into account the needs of the group for whom there is currently poor or no provision'. Consultation of users is advised, and formed a key part of this project.

Evaluation of our new service revealed a significant increase in referral rate and that users were satisfied with the service provided. The establishment of the dedicated mental health practitioner post has enhanced service provision to the South-Asian community in Manchester, but we now need to consider service provision for other minority groups with difficulties in accessing CAMHS. The project report was well received and commissioners have agreed to fund a full-time senior Black and minority ethnic worker to serve all minority ethnic populations. The post is concerned with service provision (50%) and service development (50%) alongside other statutory and non-statutory agencies.

Declaration of interest

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