How do we understand the underrepresentation of Black children and families accessing Child and Adolescent Mental Health Services (CAMHS)?

A mixed methods qualitative research with professionals and service users

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I would like to thank my husband for his unconditional love and unwavering support, both, practically and emotionally. To my children, for their patience and humour.

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It is by faith and my trust in the Lord that I have completed this race.

Commit to the Lord whatever you do, and He will establish your plans
Proverbs 16:3

ABSTRACT

This research explores how professionals and service users make sense of the underrepresentation of Black children and families engaging with mental health services. A recent audit of referrals received in an inner London Children and Adolescent Mental Health Services (CAMHS) confirmed the underrepresentation.

Using a Qualitative, Reflexive Thematic Analysis, audio recorded and transcribed, semi-structured interviews in focus groups explored the lived experiences of four Black mothers of African-Caribbean descent who accessed CAMHS; and four professionals who shared their experiences of working with Black families in need of mental health support.

The findings revealed that difference, mistrust, fear, and disjointed thinking within the professional network affected access and engagement. Families described feeling isolated in their attempts to navigate the service and access support, and service satisfaction was variable depending on the stage of access. However, the children progressed when a good therapeutic alliance developed between service users and professionals. The findings were analysed, and the implications for the Black community, the practice of Child and Adolescent Psychotherapy and the NHS were considered using psychoanalytic concepts.

Keywords: Black African-Caribbean; CAMHS; Health Inequalities; Child and Adolescent Psychotherapy; Reflexive Thematic Analysis; Focus Groups

INTRODUCTION

I am a newly qualified Child and Adolescent Psychoanalytic Psychotherapist approaching the end of a Professional Doctoral Programme with the Tavistock and Portman Training School and Essex University. My research project will investigate the Under-representation of Black Children and Families Accessing Child and Adolescent Mental Health Services (CAMHS), a National Health Service (NHS) funded statutory service in the United Kingdom.

CAMHS assesses and treats children and young people with behavioural, emotional, and mental health difficulties (Young Minds, 2017). Multi-disciplinary teams are made up of clinicians offering treatments to children, young people, and families, including medication and psychological therapies, cognitive behavioural therapy, counselling, art therapy, and child and adolescent psychotherapy.

The term Black for this research will be used to describe children and families with African ancestry, including African-Caribbean or dual heritage individuals with one biological parent of African descent. The government (gov.uk 2021) uses the following ethnicity categories: Black, African, Caribbean, or Black British - Africa, Caribbean, Any other Black, African, or Caribbean background. Throughout the research, Black will be written using a capital B since I am referring to people of the African and Caribbean diaspora and not the colour black (Adamson, 2022). There have been long debates about this. Adamson (2022) brings our attention to the long history of Black people being dehumanised and the use of offensive language such as 'Slave boy' or 'Negro' and the lack of willingness to use appropriate titles such as Mr., Miss, Mrs., Dr or Professor. In June 2020, approximately one month after the murder of George Floyd, the Associated Press (AP)[1] updated its style guide to include the capitalised B when referring to Black people in the racial, ethnic, or cultural sense. Since the purpose of the study is not to raise up one group or community over another but to strive for equality and recognise the need for equity, I have also chosen to use a capital W when referring to White people in this study, contrary to AP's current position.

Campbell-Stephens, (2020) introduced the term Global Majority (GM)[2] rather than terms such as BME, BAME or 'people of colour', a term often used in the USA. These terms can offend as they suggest that all non-white people are the same and have the same lived experiences as Black people. These terms also allude to 'otherness' and a 'less than' position to their White counterparts. GM include Black, Asian, dual-heritage individuals, indigenous to the global south, and anyone who has been racialised as an "ethnic minority". Campbell-Stephens (2020) highlights that these groups represent approximately 80% of the world's population; therefore, they are not minority groups, as other terms suggest.

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[1] https://apnews.com/article/archive-race-and-ethnicity-9105661462
[2] https://www.leedsbeckett.ac.uk/-/media/files/schools/school-of-education/final-leeds-beckett-1102-global-majority.pdf

Aims

This research explores how professionals and service users make sense of the underrepresentation of Black children and families engaging with mental health services. What are the dynamics between families and professionals during the early identification of mental health challenges? I seek to understand how psychotherapy as a discipline can engage more fully with these matters. In this study, I summarise a recent audit of referrals received in an inner London CAMHS. In the study's second phase, in focus groups, service users and professionals shared their experiences of referring Black families and accessing the service.

Background to my Interests

Long before "*Our world became under siege by anti-Blackness and COVID-19—pandemics restricting the capacity to breathe for indigenous, immigrant, poor, and Black people...."* (Gaztambide, 2021, p.177), I developed an interest in gaining an understanding of the experience of families accessing CAMHS. While working in the education sector, before embarking on clinical training, I often heard professionals say, "*we can call [CAMHS] for advice, but 'it' [the mental health concern] won't meet threshold*!" Colleagues had expressed their lack of confidence that the referrals they made would be accepted.

I began gathering information during a Literature Search and Precis of papers in the summer of 2019 at the end of my first year of training. The more I read about the disparities in mental health care provisions for marginalised groups, the more I began to reflect on my experience supporting children and families in education, social care, and the housing sector; primarily from culturally diverse and deprived geographical locations with complex social and emotional needs over the last twenty years.

My professional experience triggered my curiosity about the accessibility of CAMHS for young people. Despite reports indicating that young Black boys were the largest population in the borough to become victims of knife crime and the LONDON ASSEMBLY 2022[3] recent report highlighting similar concerns; I was not aware of any referrals from schools, youth offending services, GPs, or directly from families who were worried about their child's emotional well-being following the direct or indirect impact of such traumatic events. Children were experiencing physical and emotional harm through violence, and others were affected by County Lines.[4] Families were suffering, but these matters never featured in team meetings or made their way onto agendas. This ignited my interest in understanding service access, pathways, and the mental health needs of the Black community.

Questions

As a Black mother, I had many questions!

- What did referrers understand about therapy, the mental health needs of children, and their internal world?
- What were the experiences of service users trying to engage with primary services?

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[3] https://www.london.gov.uk/press-releases/assembly/commission-on-knife-crime-in-black-community

[4] County Lines: County lines is a form of criminal exploitation. It is when criminals befriend children, online or offline, and then manipulate them into drug dealing. The 'lines' refer to mobile phones that are used to control a young person who is delivering drugs, often to towns outside their home county (Children's Society).

- How could we work towards understanding the over-representation of Black people in psychiatric wards and what were the reasons for the under-representation of the same community receiving early therapeutic support?
- Why is there an underrepresentation of GM therapeutic staff and psychiatric doctors in the mental health profession?
- Finally, how can the pathway for sustained specialist CAMHS treatment be better support for Black children and families?

Initially, I was apprehensive about researching such a topic. I worried that my interest would be criticised or rejected. I thought a study looking at the challenges faced by various ethnic groups from marginalised communities would be more acceptable. While there were no overt objections from the training school, there were many obstacles and challenges that I had to overcome before I gained ethical approval and could begin collecting my data. I also found colleagues in my training placement somewhat resistant and sometimes even defensive when invited to engage with the subject matter. Fakhry Davids (2020) stated that Black African-Caribbean professionals attempting to bring complex matters to light run the risk of their research being marginalised. However, the more the whole world was being invited to consider the impact of 2020 on the mental health needs of children and families and how services could become more inclusive; the more I became confident that in the current climate, research of this kind would add value to NHS, CAMHS and the discipline of Psychotherapy.

The Thesis Plan

In the following section, I share the rationale behind the focus of my thesis, followed by a series of publications and reports highlighting the disparities in service provisions. Finally, in the Literature Review, I describe the process followed to conduct a literature search for empirical evidence to support the investigation of the research question:

> **'How do we understand the Underrepresentation of Black Children and Families Accessing Children and Adolescent Mental Health Services?'**

The review considers articles and contributions to the debate about mental health provisions and service use. The history and role of Psychotherapy in relation to race, class, and culture; the chapter also introduces theoretical ideas underpinning psychoanalytical thinking and work conducted to meet the needs of the Black community.

In the Methodology Chapter, I detail the design of the research project, the method, and ethical considerations. I also highlight the main themes extracted from the data and discuss the study's limitations. Finally, in the Findings and Discussion Chapter, I draw on theoretical ideas developed by Freud (1926), Klein (1946) and Bion (1962) and a range of other theorists to support my findings before I summarise, reflect and conclude the study.

Why focus on the Black Community?

It was not until I was openly challenged in a team meeting by a senior staff member in my placement about why I was only looking at Black families that I became clear about *my* 'why'! I was familiar with my own lived experiences, but I was yet to articulate my interest in a public forum. While I am aware of the underrepresentation of other ethnic groups accessing CAMHS, the findings detailed below were the main drivers behind my commitment to the research. They became the foundation of my rationale, allowing me to articulate this confidently to others who would later express curiosity.

MBRRACE (2020) found that Black women in the UK were four times more likely to die during pregnancy and childbirth. Black Caribbean pupils are five times more likely to be excluded from school (The Guardian 2021). Children in the Black community are also more likely to experience Adultification.[5] The bias that sees Black children treated as adults and not considered vulnerable or afforded the same compassion as other children which is likely to affect the care and treatment they receive. A recent study[6] revealed that Black boys were more likely to be stripped searched than other groups. A study conducted and reported by the Guardian (2020) highlighted that young Black men between 18-24 years were nineteen times more likely to be stopped and searched. While a report published by the Detentions under the Mental Health Act in June 2022 revealed that Black people were almost five times more likely to be detained under the Mental Health Act. Black people are also four times more likely to experience racial harassment.[7] A disproportionate number of Black families live in some of the

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[5] Originally a psychology term first mentioned in a study by Georgetown Law Centre on Poverty and Law (2017)
[6] Children's Commissioner of England published in August 2022
[7] Commission for Racial Equality 2006

poorest inner-city areas and are least likely to own the property they live in[8]. Up to 57,000 Commonwealth migrants (15,000 of whom were Jamaican)[9] were likely to be affected by the Windrush Scandal (2018)[10] Moreover, many were threatened with deportation creating further anxiety and instability in this community.

Bowlby's (1988) concept of parenting suggests that a secure base provided by both parents is critical for children and adolescents to explore the world outside the family. Unfortunately, based on the concept, traumatic life events and the experiences outlined above will mean that a 'secure base' may not always be available, nor is the outside world likely to feel safe for many children and families from the Black community. This is concerning, as research reviewed later in this chapter suggests this community is among those least likely to access CAMHS, therefore, even less likely to access Psychotherapy.

How can we make CAMHS accessible for all? As a Child and Adolescent Psychotherapist with knowledge of organisational dynamics, I plan to explore the barriers to accessing support for this marginalised community highlighting blind spots and unconscious bias which may affect sustained engagement. I look forward to creating a document that will open up thinking and begin a dialogue about how services can become more inclusive. By increasing the understanding of the needs and best practice approach when working with this community, from the point of

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[8] Department for Communities and Local Government 2008

[9] https://migrationobservatory.ox.ac.uk/resources/commentaries/commonwealth-citizens-arriving-before-1971/

[10] The Joint Council’s Welfare for immigrants published a review on the Windrush Scandal in 2020

referral to successful assessments, I hope to see more Black families entering consulting rooms should they require support services and treatment.

Publications and Reports regarding Racial Disparities

Dame Rachel de Souza published a report in 2022[11] on the findings from a project she commissioned entitled The Big Ask, following the Serious Case Review of Child Q, a 15-year-old Black girl strip-searched at school.[12] The children reported the barriers they faced which prevented their achievement; a sample can be seen below:

"Racism and discrimination because it makes me feel like an outsider [and] police brutality, especially towards black people" – Girl, aged 15.

"…when it comes to policing, well, the statistics show black people are 9x more likely to be stopped and searched than their white counterparts! Why is this happening? We all know why; it's because of racism… So that's the first thing that's stopping me, being perceived as a criminal."– Girl, aged 15.

"In certain areas, there is heavy youth crime, where I live there's youth violence happening every single day, what stops young people in England from achieving is because the government don't put enough money into dangerous areas like ours. The government need to invest heavily to stop knife crime and gun crime from the root of the problem, stop and search simply won't work well for starters we need more youth clubs where kids can go instead of going to the streets." – Boy, aged 15.

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[11] The Children's Commissioner for England published a report analysing the number of children strip searched by the Metropolitan police service between 2018 – 2020

[12] Local Child Safeguarding Practice Review Child Q March 2022

The Child Q independent review also included a report of the searches within the same London borough in 2020-21. A total of 25 children under 18 were subjected to 'further searches'. Nineteen were male, and 18 were handcuffed during the process. The reasons for the search primarily related to suspicions about drugs (20), followed by weapons (4) and stolen property (1). 22 (88%) of the searches were negative, with an outcome of no further action recorded. Regarding ethnicity (per the codes used by the police), 15 (60%) of the children searched were Black, 6 Asian, 2 Arab or North African, and 2 were White.

The Children's commissioners study revealed that 650 children between the ages of 10 and 17 experienced intrusive and traumatic searches, 23% of these searches were without an appropriate adult present, and 58% of all the boys searched were Black. This report also highlights that no further action was taken on 53% of all the searches. It raises concerns about the lack of commitment to safeguard children and consider their emotional well-being prior to the search. The report suggests that the findings are a systemic child protection matter that requires attention.

Dr Tosin Bowen-Wright (2020)[13], a Clinical Psychologist, expressed her view in an interview with Paul Jenkins, chief executive of the Tavistock and Portman Foundation Trust*: "There is a need for more people in the criminal justice system that understand what it means to be Black '[…]' with more Black men and women in powerful senior positions making decisions, there would be more positive outcomes for Black boys in particular."* In the same year, the Trust celebrated 100 years of clinical practice. During

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[13] https://tavistockandportman.nhs.uk/about-us/news/stories/change-needs-happen-real-systemic-level/

this time, they recognised the work of Frank Lowe[14], a Black Psychoanalytic Psychotherapist born in Grenada. At 16, he joined his father in the UK and enrolled in the sixth form at a school in Wembley to take his 'A' levels. He found he was the only Black boy studying A' levels, even though approximately 20 per cent of the pupils in the school were Black.

In 2014, Lowe highlighted the importance of professionals reviewing their practices while working with patients from different racial and cultural backgrounds by exploring the meaning of responses and reactions. Davids (2020) challenged the institutional and unconscious racism inherent in the psychoanalytic community and encouraged both members of society and professionals to search 'themselves', arguing that most racism is unconscious. The NSPCC produced a Safeguarding document (updated 2022) to understand the challenges of marginalised communities. In order to encourage professionals to build trusting relationships by taking appropriate action to help keep children safe by removing bias and stereotypes, anti-discriminatory practices and communication and language barriers.

Dr Andrews (2022) interviewed Dr Aggrey Burke.[15], NHS's first Black, Consultant Psychiatrist. The article details how Dr Burke arrived in the UK at 16 years old from Jamaica and was the only Black child in his class; he completed his professional qualifications in Trinidad and Tobago before returning to the UK, where he was appointed the first Black forensic psychiatrist in London, working at St George's

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[14] https://100years.tavistockandportman.nhs.uk/key-figures/

[15] Dr Kehinde Andrews writing for the Guardian – 13 January 2022

hospital. Dr Burke's publications in 1984 and 2018 describes how he fought tirelessly against racism and discrimination in healthcare and medical school training. He stated: "*Unfortunately, my colleagues in psychiatry tended to see the Caribbean person through tinted glasses. The first thing that comes to the observer's eye is 'this is a dangerous one; watch out!"*

In an interview John Lawlor (2022), Chair of the Tavistock and Portman NHS Trust, expressed his desire for clinical and educational services to be genuinely tailored to the needs of the people the Trust serves. Thanda Mhlanga[16], expressed his view on inclusion and diversity in leadership:

> *Without diversity, we risk creating echo chambers with blind spots, and this has significant consequences at policy level. There are certain things that people won't see simply because they are too close to them. For instance, in the NHS, the board room is still very much a white space. Often, there is a gap between policies that we design to shape the realities of multicultural or diverse societies from monocultural decision-making tables and the actual experiences of the people, particularly groups that are underrepresented and misunderstood.*

Kline (2014)[17]investigated this matter in his study exploring the underrepresentation of Black and GM people in more senior roles within the NHS. I was flabbergasted to learn that the first Black clinician Laverne Antrobus[18] was only recruited at the

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[16] https://tavistockandportman.nhs.uk/about-us/news/stories/black-leaders-awareness-day-in-conversation-with-john-lawlor-and-thanda-mhlanga-on-diversity-and-inclusion/

[17] The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England.

[18] https://100years.tavistockandportman.nhs.uk/timeline/laverne-antrobus-becomes-the-first-black-clinician-at-the-tavistock-and-portman/

Tavistock in 2000. Antrobus continues to be a key member of the Trust, supporting children and families.

Dr Bowen-Wright, who arrived in the UK from Nigeria as a child, spoke of her experience of being the only Black person on her Doctoral course in early 2000 and having to manage negative remarks that she now describes as microaggressions from peers and qualified professionals. However, she said those who believed in her and dared to be curious about what it means to be Black were most helpful while she was training.

When I embarked on the Child and Adolescent Doctoral programme in 2018, I was speechless to find that when we gathered at the end of the term for a whole course event, I was the only Black person in the room of almost 100 students and teaching staff. While the course has become more diverse in recent years, this is only the beginning of a move to a more inclusive approach to what has been a primarily White middle-class profession.

According to Suslovic (2020), being the only person of colour in any setting surrounded by 'whiteness' evokes ambivalence, grief, or rage in 'not belonging'. Furthermore, the American author states that to be alone is a loss of a community of colleagues and a loss of the potential for shared identity or understanding; this loss, she says, is grieveable and melancholic. Sulslovic encourages all psychoanalytic practitioners to begin personal work to understand the experiences of 'people of colour.'

Brickman (2017) stated that 'people of colour' have been dehumanised and harmed at the hands of Psychoanalysis and encourages clinicians to consider the impact of racial loneliness on our transference (Freud, 1905) and countertransference (Freud, 1910). Suslovic states that without awareness of such challenges, practitioners face the risk of enacting (Jacobs, 1986) in the consulting room.

Mullally (2005)[19] reflects on experiences shared with her, when Black African-Caribbean nurses experienced racial prejudice from patients and staff. Mullally concluded that although she valued diversity, she often made assumptions rather than attempts to understand what the world was like for someone else. Mullally stated that cultural competence and a willingness to understand are critical if we are to offer an inclusive service to our communities.

Mosse (2019, p.2) describes the aims of the clinic as fourfold: to offer *treatment,* partly as a means of *research* into possible social means of *preventi*ng such difficulties, and then to *teach* their emerging skills to other professionals. When considering the unconscious at work, Mosse argued that anyone engaging with an organisation is engaging with a social system. Like individuals, institutions develop defences against difficult emotions that are too threatening or painful to acknowledge. Therefore, one becomes at risk of being caught up in the systemic culture of the organisation and loses the ability to question or challenge.

Suslovic suggests that the paranoid-schizoid position (Klein, 1946) is activated in isolated settings. Where whiteness is seen as good, individuals split off the bad parts of the self and project this into the Black clinician. Anything or anyone falling outside the norm of whiteness is quietly rejected, leaving the clinician of colour feeling like an outsider. Even when (the author says) they are surrounded by friendly White

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[19] https://www.makingconnectionswork.com/wp-content/uploads/MARY-SEACOLE-215th-Anniversary-Celebration_1805_2020.pdf

colleagues and supervisors. In a PEP-Web video entitled Black Psychoanalyst Speak (Winograd, 2014), the author describes the unique isolation that trainees and practitioners of GM experience. During the video, Kathleen White asked the Analysts whether they thought it was possible for Black trainees to 'survive' in *this* world [of psychotherapy] and hold onto their sense of identity in an over 90% White field.

Workforce Race Equality Data (2020) revealed inequalities in pay and career progression opportunities and experiences of discrimination and bullying in the NHS. The study found that doctors, nurses, and managers from 'ethnic minority groups' were not earning as much as their counterparts or living in similar conditions.

Thanda (2022) encouraged those in a position of influence in the Trust to consider the history of the service, built on 74 years of NHS history and over 100 years of Tavistock legacy. He suggests that engaging with the history and understanding the context will provide a springboard to begin decolonising policies, processes, and systems. Thanda expressed the need to understand the needs of the patients and students studying at the Trust's training school; he describes:

> *Being epistemologically black is a mindset; it means having a black consciousness…understanding that blackness isn't a weakness; it is beauty, resilience, power….*
>
> *It's about understanding that this particular race, faces considerable challenges in education, the workplace, in healthcare and in society in general to this day. Why is it that when we say, 'Black Lives Matter', some people may respond angrily, 'But white lives matter too' or 'All lives matter'! They're missing the point; they don't understand what Black Lives Matter means. Is there not enough evidence that some lives are more at risk than others? Risk in terms of being*

> *manhandled or shot at by the police who are meant to be protecting you and so on. People are not asking for preferential treatment but appealing for support as their lives are in danger. If you are epistemologically black you get that, and you are not defensive, you engage with that reality and use it in a positive way to address inequality and become an advocate or ally.*

Altman (2000) describes whiteness[20] as complacency automatically experienced by White people who fail to reflect on the meaning of their ethnocultural position with little empathy for the position of other categories of people or the ability to imagine what it can be like. Altman suggests that whiteness can become a countertransference blind spot, particularly if neither the therapist-in-training nor the training therapist express any interest or feel equipped to explore the issue.

During his interview with Dr Andrews (2022), Dr Burke shared his experiences in the 70s of Jamaican psychiatric patients who had been deported from the UK. Dr Burke recalled, *"The idea among my colleagues was that by sending them home to live 'under the coconut or a banana tree', they would get better."* However, while on tour in Jamaica, Dr Burke said he saw the consequences of this medical decision to return people who had come to the UK to raise money for their families. Burke stated, *"They were broken and far from recovering in the heart of their communities. Many patients were rejected because of the stigma attached to coming home mentally ill and penniless."* Dr Burke, also reflected on the research of the Windrush scandal of 2018[21],

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[20] white*ness* refers to the construction of the white race, white culture, and the system of privileges and advantages afforded to white people in the U.S. (and across the globe) through government policies, media portrayal, and decision-making power within our corporations, schools, and judicial systems.

[21] The Joint Council's Welfare for immigrants published a review on the Windrush Scandal in 2020

which revealed that hundreds of Commonwealth citizens were wrongly detained, deported and denied legal rights. The 'Windrush' generation arrived in the UK from Caribbean countries between 1948 and 1973 and took on jobs in the NHS and other sectors affected by Britain's post-war labour shortage. Since the Caribbean was a part of the British Commonwealth, those who arrived were deemed British and entitled to live and work permanently in the UK. The review found that many Black Britons' lives were devastated by what was described as Britain's deeply flawed and discriminatory immigration system. The review argued that decades of immigration legislation explicitly aimed at reducing non-white immigration from the Commonwealth destroyed the lives of many Black and minority ethnic British people.

Dr Burke stated that the policies, then [in the 70s] and now, create feelings of rejection and instability and send a message to Black people that they do not truly belong. He also stated that the figures which suggest that Black people are almost five times more likely to be detained under the Mental Health Act hide the scale of the problem. Individuals identifying as "Black other" are more than 11 times more likely to be sectioned. Burke believes this group is likely to include a significant proportion of descendants of Caribbean migrants who no longer feel a strong bond to the region after their arrival in the UK as children.

McIntyre, J. C. et al. (2021) investigated the relationship between ingroup identity and paranoid ideation among people from African-Caribbean backgrounds. He found that people from these backgrounds experience high rates of paranoia, which may stem from social causes such as a lack of belonging and negative social experiences. Among people from African backgrounds living in the UK, British identification is associated with lower paranoia when people's social experiences with White British people are positive and higher paranoia when their social experiences with White British people are negative. Social interventions designed to reduce paranoia in vulnerable groups are recommended to foster positive social contact and community belonging, which should enhance feelings of personal control. Understanding the complex interplay between social identity and social contact in the development of paranoia may help therapists and researchers better understand the phenomenology and risk factors of paranoid symptomology.

Dr Burke contends that the assumption that Black people have “much more mental illness” remains prevalent in psychiatry and feels that the biases in diagnosis can be seen in how psychosis has been treated over the years. He states that before the 1960s, psychosis and conditions such as schizophrenia affected highly intelligent, artistic White people, whose creative minds had led them to lose touch with reality. However, he argues, when the civil rights era brought Black anger and protest onto the streets, psychosis became associated with violence and danger and became a label disproportionately placed on Black bodies. Metzl (2009) describes how psychiatrists genuinely theorised that the delusional dreams of racial equality brought a "protest psychosis". In conclusion, Dr Burke believes that the cause of overrepresentation in in-patient wards is rooted in fear of the 'violent, disordered, rebellious Black body'.

Lawrence V. et al. (2021) reported consistent evidence that members of the Black Caribbean population in the UK are more likely to have coercive relationships with mental health services, typified by high levels of police involvement and compulsory treatment.

Any adult who may have first-hand or even an eyewitness account of this would be sceptical about engaging with mental health services for their children. With this in mind, my passion for understanding the experience of children and families accessing mental health services was sparked further.

LITERATURE REVIEW

This study is a small-scale qualitative Child and Adolescent Psychotherapy, Doctoral project designed to understand the accessibility of child and adolescent mental health services for a specific group. The study intends to produce a document to support professionals in developing their thinking and approach when supporting diverse community groups who require interventions and services but are considered less likely to engage.

Psychoanalysis through the eyes of Black Professionals

In this section, I will review the history of Psychotherapy; Mhlanga (2022) suggests that looking back into the history will provide us with a greater understanding to move forward toward a more inclusive service.

Fanon (1959) began studying phenomenology, psychoanalytic theory, and psychiatry in 1951 at Saint Alban Hospital. By 1953, in his attempt to understand how racism develops in the mind, he put community psychoanalysis into practice at a hospital in Algeria. Fanon noted his unconscious reactions to patients and found a need to restructure staffing relationships with patients. He observed that patient conflicts evoked "acute problems" among staff, who "adopted certain habits in which a repressive attitude was prevalent". Fanon provided supervision to help staff work through countertransference and resolve these enactments.

Gaztambide (2021) describes that Psychoanalysis for Fanon was a "science of the collective" (p. 219), shedding light on the relationship between self and the world. When the self cannot find its place in a relationship, it reacts with compensatory feelings of superiority or inferiority. Gaztambide questions, '*can psychoanalysis make room for the Black anger and pain without premature attempts at repair that restrict the capacity to breathe? What would it mean to teach Fanon in core courses alongside Freud, Ferenczi, and Lacan instead of relegating this literature to a "diversity" course? To teach his descendants, from Paulo Freire to Lewis Gordon and David Marriot, as core readings in psychoanalytic training? To see anti-Blackness not as a "special issue" in our journals in the aftermath of Black death but as the bedrock for psychoanalytic reflection and action? To create space where Black and other candidates of colour can be allowed to breathe? To restore psychoanalysis as a revolutionary and communal practice.* *(*Gaztambide 2021, p.177)

Dalal (2002) suggests that the theoretical inadequacy of psychoanalysis handicaps its engagement with racism and highlights the defensiveness of the clinician. According to Blackwell (2014, pp. 305), various psychodynamic mechanisms and defences such as projection (Klein, 1946), projective identification (Klein, 1952), denial (Anna Freud, 1936), disavowal (Freud, 1927) along with Oedipal issues (Freud, 1899) and anxieties about castration (Freud, 1909) are prevalent in scenarios of racism.

Green et al. (2004) reported that one in ten young people in the UK suffer from a diagnosable mental health disorder. Alongside conduct disorders, anxiety, depression, and attention deficit hyperactivity disorder (ADHD) are the most prevalent issues in the UK. Failure to address such problems in childhood can lead to increased risks of self-harm, suicide, substance misuse and contact with the criminal justice system, and lower educational, employment, and financial achievements (Richards et al., 2009). These findings highlight the importance of early unbiased intervention and prevention.

Gaztambide (2021) helps us think about the troubled child who does not know what to do when the individual they rely on, teacher or parent, becomes vulnerable and begins to fall apart. When the child becomes terrified and begins to act out in response, fleeing from the room, running aimlessly around the school, or retreating to their bedrooms and slamming the door. The response often results in a sanction as the despairing adult attempts to 'correct' the 'bad' behaviour.

Consequently, when the therapist meets face to face with a child who is the descendent of colonised parents, bearing all the emotional scars that come with the experience, it takes some time before the child can begin to settle and trust that the professional can be open to sitting with the 'mistrust' and await the opportunity to explore what it means to grow up in environments where your community has little representation of positive figures in authority or positions that you might aspire to, or to be considered less able academically or feared and seen as challenging or dangerous before you have even spoken. These children need a compassionate individual who will take the time to break down the walls built up for protection and survival from pain, hurt and abuse. Someone who can recognise that for generations, these very walls also become a prison, shutting out those who might come along to offer love, help, and support. These families need time and space to heal before we can see them operate as the best versions of themselves.

In the following excerpt, Gaztambide (2021, p.181) writes with references to the adult patient in an inpatient ward. Since this research project is exploring the experiences of the Black child and family, I will include the [child] and [parent or teacher] in the commentary from here on so that readers might begin to consider the voice and the mind of the child or adolescent in their care:

> *“Who am I? Why am I this way? Who has power?*
>
> *The patient [child] who “does not know” the unconscious reason for their rage and the therapist, [parent or teacher] who is “supposed to know” descend into madness. When the madman therapist [teacher or parent] who “knows” collides with the madman [child] who “does not know,” the confusion of tongues ends with the patient [child] being forcibly restrained in an isolation unit, rejected, cast out (rejected from mainstream school, excluded, and placed in a pupil referral unit, out of the home and into the streets or foster care as professionals attempt to make sense of the madness). In this sense, the patient's [child’s] aggression “tests the institution’s degree of resistance, simultaneously probes its plasticity and solidity.”*

In the next section, I outline the process of conducting a literature search to establish the view of researchers with an interest in the subject matter of Black mental health.

Method of conducting the literature search

The PsycINFO database was used via EBSCOhost to conduct the literature review. It is regarded as the most comprehensive database for psychology-related disciplines, providing full-text links to many journals and eBooks.

My initial literature search in 2019 focussed on access to psychotherapy as a treatment. I wanted to investigate three main points; Who referred children to this specialist service? Who was accessing the service? Most importantly, who was not referred or accessing the service and why? I was keen to find research that would be relevant to CAMHS in London.

I noted all the keywords that would be relevant and related to my research topic. The first concepts included **Therapy, Analysis, and Psychotherapy**. I used the Boolean operator 'OR' to ensure that the papers included will have at least one of these three words, rather than using 'AND' as this would only bring up papers with both words in the document. The symbol * includes variations of each word, such as 'Therapy and Therapist,' as displayed below in Figure 1.

Figure 1: Initial Literature Search

	Concept	
S7	school* OR communit* OR organis*	Search modes - Boolean/Phrase
S6	depress* OR anxi* OR worr*	Search modes - Boolean/Phrase
S5	London OR UK OR British	Search modes - Boolean/Phrase
S4	refer* OR interven* OR support* OR access*	Search modes - Boolean/Phrase

S3	race OR ethnic OR cultur*	Search modes - Boolean/Phrase
S2	Child* OR teen* OR adoles*	Search modes - Boolean/Phrase
S1	therap* OR analys* OR psych*	Search modes - Boolean/Phrase

The search (see Appendix A), which includes only S1, S2, S3, and S4, produced 35,099 papers. The searches were combined using AND to indicate that the research papers should include at least one of the concepts from each concept group searched. I also used limiters which produced the following results: Linked to Full Text = 13,552 papers, Methodology - Empirical = 9,787 papers. Finally, I added the following Subject Major Headings: Racial and ethnic differences = 694 papers and Mental health services = 43 papers.

All 43 papers were saved to the database folder. Of these, only six were deemed relevant and selected to be read in detail. However, most of the literature focussed on work conducted in the United States. Therefore, I decided to alter the search to look at access to CAMHS rather than specifically searching for access to psychotherapy with a direct link to referrals and schools.

I also found that during the pandemic and the Black Lives Matter campaigns[22], more research became available for review in 2020. As a result, new search concepts were created as detailed in the figure below:

Figure 2. Second Literature Search

	Concept	
S4	Brit* or England or UK or London or Scotland or Wales	Search modes - Boolean/Phrase
S3	Access* or Representation or Referral or Allocation or Pathway	Search modes - Boolean/Phrase
S2	Black or African or Caribbean or Black British or Mixed Race or Afro-Caribbean	Search modes - Boolean/Phrase

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[22] https://blacklivesmatter.com/

S1	CAMHS or Mental Health Service, or Mental Health Stigma, or Mental Health Disorder, or Social Perception or Mental Health or Stereotyped Attitudes or Mental Illness	Search modes - Boolean/Phrase

Appendix B displays my final search, including S1, S2, S3, and S6, producing 557 papers. Again, I used limiters to produce the following results: Open Access = 87 papers. Linked to Full Text = 74 papers.

Of the 74 papers, 22 were saved to the database folder and read in detail. Based on relevance and full-text accessibility, nine papers were critically analysed and will be discussed in the following section.

Studies and Statistics – Meeting the Needs of Diverse Communities

According to the Detentions under the Mental Health Act Published June 2022, in the year to March 2021, Black people were almost five times more likely than White people to be detained under the Mental Health Act – 344 detentions per 100,000 people, compared with 75 per 100,000 people. Black African people had the highest detention rate out of all ethnic groups (excluding groups labelled 'Other'). The data measures rates of detention under the Mental Health Act 1983. The data includes people detained (commonly known as 'sectioned') in hospitals for assessment or treatment under the Act.

Research conducted by Richardson (2020) reported that Black African-Caribbean pupils face three times as many exclusions as their peers in some areas of England. With schools being amongst the lead referrers into CAMHS, I planned to include the experiences of educationalists with knowledge of safeguarding and inclusion in the study.

Cooper et al. (2013) found that school-based counselling has positive outcomes in pilot randomised trials. However, the researchers indicate a need to improve access for young people from Black and Minority Ethnic (BME) backgrounds to and ensure that services are equipped to meet the needs of young people from vulnerable groups, such as looked after children (DfE, 2016). The researchers also found a difference in the demographic profile of young people supported in Voluntary Community Services (VCS) compared to those supported in CAMHS and school-based counselling services. The VCS was accessed by significantly older young people (mean age of 20 years), with 31% of clients from BME backgrounds accessing the service compared to 18% in CAMHS (Wolpert et al., 2016) and 30% in schools (Cooper, 2009). The results suggest that VCS services may play an essential role in meeting the needs of BME groups, who are often under-represented in talking therapies (Mind, 2013). Importantly, this suggests that such services may be more accessible and be perceived as less stigmatising than CAMHS. McKeague, L. et al. (2018) conducted a study exploring the feasibility and acceptability of a school-based self-referral intervention for emotional difficulties in older adolescents. The researchers also contend that providing psychological support in the schools makes it more accessible for 'hard-to-reach' groups, such as BME students.

Edbrooke-Childs et al. (2019) conducted a study to examine the referral routes to CAMHS. They reported that ‘‘ethnic minority’’ groups were less likely to make self-referrals or be referred via primary care services such as the GP or school than White British youth. The researchers conducted a study using a large sample of 21,586 pseudonymised clinical data extracted from one of Europe's most prominent mental healthcare providers covering a geographical catchment of 1.3 million residents from 4 boroughs of South-East London (Lambeth Southwark, Lewisham, and Croydon). The sample included patients diagnosed with anxiety or non-psychotic depressive disorder registered between the 1st of January 2008 to the 31st of December 2016. The study found inequalities in referral sources and care pathway routes. For example, patients aged 12 to 15 referred by the GP were mainly White British females living with their parents and referred to outpatient services. Other researchers also interested in accessibility found that the inequalities in referral destinations may be perpetuated by inequalities generated at the point of access (Chui et al., 2021).

In contrast, the researchers state that those aged 16 to 17 have the most significant proportion of 'ethnic minorities' and referrals from social criminal justice services. I found this section of the report somewhat misleading as later, the authors state that only 4% of all recorded referrals came from social care or criminal justice services, which suggests a much smaller figure than I previously thought. The study also revealed that Black Caribbean patients were twice as likely to be referred to patient wards compared to their White counterparts. The current study also investigated the responses from Black African, Black Caribbean and Black British participants, indicating that the researchers recognise that the lived experiences of each group within the Black community are likely to differ (e.g., differing migration status).

The authors suggest that data should be collected with sensitivity. They also highlight the need for clinicians to undergo regular implicit bias training to consider policies and processes that may unintentionally lead to oppression or inequality when behaviours indicate early signs of mental health distress unnoticed.

Finally, the study revealed that Black African patients, in particular, were less likely to remain in treatment. Adopting a culturally sensitive approach which considers the community's needs, such as how they think and manage health-related matters, particularly during the transition phase from CAMHS to adult care, will better support longer term engagement. While the findings are insightful, it is important to note that a quarter of the information indicating who the referring professionals were, was missing from the data. This was disappointing, considering establishing the referral route into CAMHS was the study's main purpose.

Newbigging K.et al. (2013) studied the effectiveness of advocacy and found that mainstream mental health advocacy services are often poor at providing appropriate services for the Black community. In contrast, services developed by the Black Community and voluntary sector are grounded in different conceptualisations and therefore have a better understanding of the needs of African and Caribbean men.

The study design included a systematic literature review on focus groups in a national advocacy practice survey and qualitative interviews. The researchers thoroughly investigated the subject matter of advocacy for Black men suffering from mental health difficulties. The study suggests that services can improve accessibility and engagement and highlights the lack of such services to meet the needs of this community. The researchers encourage commissioners to consider funding for the sustainability of such provisions. Though the findings are in relation to support for Black men, Black children and families accessing CAMHS would also benefit from the support that culturally competent advocacy offers to aid successful referrals and support engagement in services.

Codjoe L. et al. (2021) also recognised the advantage of using appropriate community networks to increase mental health awareness and reduce stigma. This systematic review aimed to highlight the effectiveness of mental health and other health stigma interventions implemented in Black faith settings. The authors used mental health and wider health stigma literature to inform the design of the ON TRAC, a collaborative partnership between Kings College London, South London and Maudsley (SLaM) NHS Foundation Trust and the Black faith community groups in Southwark and Lambeth. In addition, the review aimed to explore the Church's role in Black African-Caribbean communities in relation to seeking help, advice and support when experiencing mental distress. Due to a limited number of UK-based quantitative and qualitative studies and no direct public engagement or service user involvement, it was complex for the authors to ascertain the effectiveness of the mental health stigma interventions within this community. However, the review draws attention to the importance of co-production and partnership working to ensure that acceptable and accessible interventions are agreed upon. They believe that using bottom-up approaches and mental health champions to gain 'buy-in' from the community and faith leaders can be applied to future work with Black African-Caribbean communities.

Dr Bowen-Wright (2020) talked about working from a Eurocentric perspective and Black families needing to be 'socialised' to this model to get the most out of services.

The psychologist says that parents, mainly from African and other ethnic groups, do not have the Eurocentric language to describe their difficulties or to explain how they are dealing with them. This model focuses on the individual and decontextualises the problems without adequately considering a bio-psych-social model approach.

Mantovani et al. (2017) explored the relationship between stigma and help-seeking for mental illness in African-descended faith communities in the UK. The researchers highlight that ‘One-size-fits-all’ approaches cannot effectively meet the needs of diverse populations. Semi-structured interviews and Thematic Analysis were used to analyse the qualitative data. The interviews were conducted in Faith-Based organisations (FBO), a familiar environment to the participants and, therefore, a safe space to explore sensitive experiences. While the study explored the impact of stigma on service use, the sample of 26 men and women involved were members of an FBO rather than individuals living with mental health difficulties or other non-faith-based individuals to compare their views on stigma and help-seeking. Based on the data gathered, the FBO members would unlikely come into contact with the client group in question as the researchers describe individuals being hit by 'triple jeopardy' – rejected by their families, alienated from their communities, and internalised 'self-stigma'. Therefore, their views are only speculative, with perhaps little knowledge about the process of seeking help and support or the daily challenges faced by individuals living with mental health difficulties.

Gillard S. et al. (2021) examined the 'Experiences of living with mental health problems during the covid-19 pandemic in the UK’. An earlier study conducted by Mind (2020) found that members of the Black community were most likely to report that financial worries, housing, and employment matters were negatively impacting their mental health during the pandemic. The researchers kept cultural context and health inequalities at the forefront of the project. They used a co-production approach to their study, allowing community-based researchers to use their lived experiences to shape the research process. The study found that new remote ways to access mental health care, including digital solutions, provided continuity of care for some but presented substantial barriers for others. In my own therapeutic experience, many families did not have access to a suitable device, or they did not have a suitable confidential space in the home where they could receive therapeutic support. In addition, the researchers found that people from Black and 'ethnic minority' communities experienced heightened anxiety, stigma, and racism associated with the pandemic, further impacting their mental health. The researchers concluded that there is a need for evidence-based solutions to achieve accessible and effective mental health care in response to the pandemic. Particular attention is paid to understanding inequalities of the impact on mental health, especially for people from Black and other non-white communities.

Jensen et al. (2021) designed a qualitative study using semi-structured interviews with 22 African-Caribbean service users with psychosis and their nominated family member to determine the acceptability of Culturally - adaptive Family Intervention (CaFI) as an appropriate intervention. The researchers highlight the disparities in mental healthcare for this community and suggest that the low uptake of services usually stems from distrust and fear. Morgan et al. (2004) suggest that an expectation of discrimination caused a delay in seeking help and negative attitudes towards health services. Keating and Robertson (2004) argue that the lack of culturally compatible services leads to subsequent disengagement. The interviews took place once the families had completed the Cognitive Behavioural Therapy sessions. Service users and their families were invited to share their views regarding the acceptability and accessibility of psychological therapy. The study's limitations include the small sample of participants, which affects the generalisability of the findings and the lack of participation of male family members.

Nevertheless, in their pursuit to explore interventions that would improve access and engagement, a study such as this gives voice to a community that they say is often overlooked and marginalised. Participants stated that the CaFI should be made available to all service users irrespective of ethnicity and cultural background, indicating that the intervention was well received. In addition, the study is well referenced throughout, highlighting extensive research to understand the lack of engagement of African-Caribbean families accessing mental health services.

The Independent Review of the Mental Health Act (2018), commissioned by the UK government, highlighted the disparities in compulsory admissions for Black African-Caribbean patients. Studies have shown that, compared with White British patients, Black African patients were four to five times, and Black Caribbean patients were approximately two times more likely to be compulsorily admitted to hospital at first presentation for psychosis.

Sashidharan, S. P. and Gul, M. (2020) researched ethnicity and mental health and stated that despite much discussion on race and mental health, and more promises of change, there is no parity between Black and minority ethnic communities and the White majority in access, experience, or outcomes of mental health care. They report that these communities do not do as well as the white majority in any aspect of mental health care, and they generally fare much worse. Rudi Page (2020) stated in his reflections on 'How RCN Connect made the real change?' *“The past 20 years have taught us that we still need to pursue inclusion, fairness, well-being, and psychological safety to maintain staff and public trust in local systems."*

Oduola S. et al. (2019) analysed data from two First Episode Psychosis (FEP) studies conducted in the same geographical area in South London 15 years apart. The study found that 266 patients with FEP, aged 18–64, presented to mental health services in South London in 1997–1999, and 446 presented FEP in 2010–2012. The key strength of this study is the large sample size and the comparison of two data sets in the same catchment area at different points in time. When the two samples were compared, ethnic differences in compulsory admission remained the same for Black African patients, i.e., three times higher than White British patients in both samples. The researchers recognise that higher compulsory admission rates among Black and 'minority ethnic' groups remain a major concern for patients, mental healthcare providers, and policymakers. They also make a concerted effort to explore the noteworthy changes in wider society that may have affected the data, such as an increased number of fewer community-based services available during the first study, which may have affected compulsory admission rates. In addition, the researchers highlight immigration status as a factor to be considered, as a lack of security can impact one's mental health. In addition, the study highlights a difference between the Black African and the Black Caribbean admission rates, recognising that there may be different contributing factors that need to be considered in relation to service provision and access.

The summarised research papers suggest that there is much work to do to ensure mental health services are equally accessible to all members of society irrespective of their race, class, and culture. In the next section, I consider the work of individuals and community organisations working to improve accessibility.

The role of race, class, and culture in relation to service use

Culture, conscious and unconscious stereotypical ideologies belonging to the patient and the professional are likely to impact service engagement. Therefore, equipping trainee clinicians to enter the world of psychoanalysis with a clear plan of how to better engage Black families by offering support to those who struggle to see how they might be understood and their needs taken seriously is key to eliminating barriers to engagement.

In 2002, Frank Lowe created the forum Thinking Space to think about race, culture, and diversity in psychotherapy at the Tavistock Clinic in London to improve access to psychotherapy for Black African, Caribbean, and young GM communities. He sought to understand how we can openly consider race, class, and culture more personally as professionals. He also recognised that the GM communities have a different attitude toward mental health services:

> *Many members of the Black community are not confident that mental health services will understand them. As a result, over time, racism, cultural insensitivity, high rates of over-representation (under sectioning or compulsory admission), and more likely to be given medication than psychotherapy which has led to a lack of trust and a tendency to only make contact at crisis point.*

Frank Lowe (2020)

In May 2021, MindinMind,[23] an organisation that hosts online events and streams digital discussions with some of the world's leading clinicians working in child mental health, organised an event entitled 'Rethinking the Mental health of Black, Asian & minority ethnic children'. Details of findings from various professionals present at the event are documented below:

Rethink Mental Illness (2021) reported that Black women are more likely to experience common mental illnesses such as anxiety disorder or depression, and older South Asian women are an at-risk group for suicide. Rethink suggests that mental illnesses develop in families from these backgrounds due to inequalities in wealth and living standards, bias, discrimination, racism, and stigma about mental health.

Shivani Lamba (2021) informed delegates that adverse childhood events such as community, youth violence, and police brutality could cause stress to the body and brain, which moves to constant high alert. Furthermore, these traumatic experiences affect mood and ability to learn, causing long-term behavioural difficulties in children from the Black community.

Partisan, an organisation that works with communities to understand local challenges, highlighted that mental health support is not accessible for many children, young people, families, and communities, leaving families vulnerable to unmet needs. Jay Perkins, the founder, says that current services are staffed by professionals with a limited understanding of cultural contexts. The systems need to be more flexible to meet marginalised and stigmatised communities' specific and complex needs. He

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[23] https://mindinmind.org.uk

believes these communities often have complicated relationships with help and negative experiences with the current systems, leaving them feeling judged, uncomfortable, and unsure whom they can trust, leading to disengagement and loss of resources.

In addition to Frank Lowe’s extensive work at the Tavistock and Portman NHS Trust, he developed an empowerment service within the adolescent department, which supported Black parents and adolescents at risk of exclusion from Camden schools. Working with Onel Brooks and Maxine Dennis, he also developed the Young Black People Consultation Service. The service was based on the young people's consultation service model, which aimed to make psychotherapy more accessible to young Black people.[24]

Following the 2011 London riots.[25] The Thinking Space was made available to the public and taken to Tottenham. The Haringey Thinking Space was developed in 2013 and was seen as a radical approach to community mental health. Two independent evaluations (UEL 2015 and LSE 2018) found that Thinking Spaces in Haringey helped reduce isolation, improve self-understanding and personal functioning, and increase resident cooperation. In 2015 Lowe was awarded The Psychoanalysis and Diversity Award by the British Psychoanalytic Council for establishing 'Tottenham Thinking Space.’ “*Thinking Spaces (therapeutic spaces) in the community are needed and can improve lives*" (Lowe, 2020).

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[24] https://100years.tavistockandportman.nhs.uk/key-figures/

[25] https://www.lse.ac.uk/Research/Assets/impact-pdf/causes-2011-riots-reform-police-stop-and-search.pdf

A study conducted by Haringey Clinical Commissioning Group in 2017[26] identified an under-representation of Black African, Caribbean, Asian, and Minority Ethnic children and young people in CAMHS. Highlighting that there was yet more work to do, and as a result, the borough continues to aim to improve access and tackle mental health stigma within its local communities.

The Racial Disparities in Mental Health Literature and Evidence Review (2019) also highlighted the complexities around the services received by Black African-Caribbean and ‘ethnic minorities’ groups. The review also identified overrepresentation in detained settings, experiences of psychosis in African Caribbean men, and the experiences of poor care across Black African, Caribbean and ‘minority ethnic’ communities. In addition, the review highlighted other barriers affecting these communities accessing primary health, which include language barriers, lack of interpreters, awareness, service information, and discrimination.

Conclusion

The Black community are considered less likely to engage with services. The literature reviewed in this chapter illuminates the undeniable urgency for professionals to engage with networks and collaborate with community groups and families to eliminate the barriers to accessing specialist CAMHS interventions. Drawing on the studies in this chapter, I intend to use psychoanalytic thinking to explore how the experiences of professionals and service users may aid our understanding and make sense of the underrepresentation of Black children and families accessing CAMHS. This study intends to produce a document to support professionals in developing their thinking

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[26] Minutes.haringey.gov.uk

and approach to supporting Black communities. The process of collating and analysing the data from the participants in the study will be described in the next chapter.

METHODOLOGY

Introduction

This chapter reintroduces the research rationale and the methodological approach to answer the research question. I outline the research design, ethical considerations, and the participant recruitment process. The epistemology, how we know what we know, will be considered alongside the ontology: what are the emerging research concepts and categories, and how each relates to the other?

In my capacity as an Appropriate Adult for young people facing criminal proceedings or my role as a mentor supporting a Black student who had become a victim of crime, I do not recall any therapeutic intervention being offered to these families. As described in Chapter 1, there were reports of increased knife crime across London's capital. I became curious about the lack of referrals to CAMHS for mental health support for the children and families affected by this crisis, predominately affecting Black families.

With this in mind, I initially planned to interview staff in eight schools across London boroughs to establish their view of the mental health needs of children and the referral process. As the research progressed, it was redesigned to include service users and a range of professionals, offering a richer insight into the process of referral and engagement in CAMHS interventions and treatments. Unfortunately, I was advised in the early exploratory stages of the study that ethical processes for interviewing children in a small-scale study would be too complex and unlikely to be approved.

Therefore, I agreed that I would interview the parents to gain their perspective on the service.

Lester and Glasby (2006) highlight the widespread recognition that service users are experts with an in-depth knowledge of mental health services and the impact of living with mental health difficulties. These experiences, they say, can help improve individual care and services more generally. In addition, Sayce et al. (1999) state that service user involvement may encourage greater social inclusion.

Initial literature searches in 2019 and early 2020 revealed a paucity of research studies on access to psychotherapy, CAMHS interventions and marginalised groups (see Appendix A, B). However, this changed following the pandemic in March 2020 and the murder of George Floyd when I found further literature became available. I was keen to know more about the challenges faced by the Black community. In addition, I was keen to establish the contributing factors that prevented these families from accessing mental health support.

The Research Design

This study is a small-scale qualitative research project designed to answer the following research question:

> **How do we understand the Underrepresentation of Black Children and Families Accessing Children and Adolescent Mental Health Services?**

I chose a qualitative research method as it does *not* assume there is only one correct version of reality or knowledge. Instead, it allows the researcher to collect data and encourages the exploration of alternative perspectives (Braun & Clarke, 2006).

The study includes two separate data sources. According to Patton (1999), using multiple methods of data sources in qualitative research aids the development of a comprehensive understanding of phenomena and provides studies with validity.

Data Source One

Phase one of the study includes a summary of the audit of referrals received in a London-based CAMHS between 2019-2022 (see Appendix C-F).

Data Source Two

Phase two of the study includes the data collected from the Focus Group interviews with professionals and service users. Focus groups capitalise on communication between research participants to generate data in a group interview setting. Focus groups were used in this study to explore the service user's experiences and to establish their needs and attitude (Kitzinger, 2000, p.20) toward accessing CAMHS.

At the same time, I considered the professional's experience working with this group in a particular context and the meaning of these experiences.

The common themes and patterns which emerged from the audit, the focus groups, and any correlation between the outcomes and the proposed question; are detailed in the findings and discussion section of the report.

A Thematic Analysis (TA) methodology was selected as it is flexible, straightforward, and easily accessible (McLeod, 2011). This method is commonly used by counselling and psychotherapy researchers to explore the experiences and views of specific groups of clients and therapists (Mortl & Gelo, 2015). Braun and Clarke (2006) also describe it as the most user-friendly method of analysis for those new to qualitative research and ideal for small-scale student-led projects. I used the method to identify patterns and themes within the data in relation to the research question. TA helped me develop an understanding of the participant's experience and brought clarity to the meaning they made of their experiences.

Thematic Analysis was first developed as an approach by Gerald Holton in 1970 (Merton, 1975). However, Braun and Clarke gave the method a distinctive set of procedures for the social sciences in 2006. Unlike other qualitative analytic methods, TA only provides a method for data analysis. It does not prescribe data collection methods, theoretical positions, or epistemological or ontological frameworks. One of the main strengths of TA is its flexibility; this method can answer any research question and analyse almost any large or small dataset. The flexibility of this method allowed me to adapt the working title as the research developed, allowing the question to emerge from the acquired data, which ensured the question remained relevant.

Reflexive Thematic Analysis

This method adopts an experiential approach to focus on the participants' perspectives while considering how they experience and make sense of the world. The inductive approach allowed me to identify, analyse, and report patterns and themes across the dataset. In contrast, I explored the thought processes of professionals and the family's experiences of interacting with services. In addition, by adopting a latent approach, I was able to consider the underlying ideas and assumptions that shaped the data. The approach allows the codes to emerge through the analysis process instead of trying to fit the data into my pre-existing conceptions about the subject matter. Finally, the realist, essentialist approach supports the creation of a more accurate narrative about the lived experiences and needs of the Black community, which the research suggests is complex and multi-faceted.

Considerations of the Research Design

The semi-structured interview allowed me to present predetermined questions (see Appendix G) and include spontaneous exploration of topics and themes relevant to each group (Hill et al., 2005; Hill et al., 1997). Interviews are deemed reliable, easy to analyse and encourage two-way communication; thus, the rapport between participants and the facilitator allows sensitive issues to be discussed (Shuy, 2003). Knox & Burchard (2009) state that the method has been established to understand the experience of others and the meaning they make of that experience. In addition, Carr & Worth (2001) state that facial expressions, gestures, and other paraverbal communications enrich the meaning of spoken words. This method provided rich data that assisted me in uncovering unconscious thoughts and ideas. The use of transference and countertransference (Freud, 1905, 1910) allows researchers to bring any prejudices about race, gender, and class, which can influence the research process at the interview stage and data analysis into awareness. This allows these ideas to support the research rather than compromise it, says Holloway (2006). Consequently, the aims of this study, which included exploration of the conscious and unconscious decisions made by professionals supporting Black children and families with mental health needs, were undertaken using semi-structured interviews. In addition, the observational skills acquired during my psychoanalytic training supported the process of bringing unspoken and nonverbal data into consciousness (Hiller & DiLuzio, 2004).

Careful observation of the responses and interactions during the interview process allowed me to offer clarification and support to aid understanding and encourage an open exchange within the group. While following up on potentially ambiguous questions, I avoided assuming that all the questions meant the same thing to me as they did to each participant. Kuhn (1962) highlights the paradigm, which refers to the beliefs, assumptions, values, and practices shared by a research community. He says it provides the framework for research, which is seen as a strength rather than a weakness since this is a subjective method; inevitably, I bring my views, perspectives, and frameworks for making sense of the world, including my political view and passion for the research process. As a Black researcher, the second generation born in the UK and descendant of my father and grandparents who were born in the Caribbean, it was essential to remain mindful of what was evoked in me as I conducted the focus group interviews. How might my Christian faith, my culture, and beliefs impact my responses to what may arise during the sessions? I was required to consider how my unconscious bias could impact the interviews. I took advice from experienced researchers (Braun & Clarke, 2013) to journal my thoughts. I used personal analysis to reflect and process my feelings as they arose during the research process, marking them for my attention later during the research analysis and discussion phase. The interview allowed me to listen to a) what the participant wished to say, b) what the participants did not wish to say, and c) to identify what the participants could not say without help (Mayo, 1930). It was important that each participant felt that their thoughts and contributions were essential to the overall discussion; therefore, I summarised each response, attempting not to add to or distort the content. Additionally, I transcribed the interviews as soon as possible after each conversation to avoid losing unspoken communications and the overall feeling in the room. (Brinkmann 2014).

Limitations of the Research Design

According to Braun and Clarke (2013, p.180), some qualitative researchers suggest that TA lacks the substance of other 'branded' and theoretically driven approaches like IPA and Grounded Theory and suggests a lack of concrete guidance for higher-level, more interpretative analysis. Critics also believe researchers using TA will only find what they are already looking for and question the objectivity of the method—arguing that preconceived ideas and historical information should be discarded to see new data afresh. However, in 2013 Braun and Clarke (pp.36-37) reminded researchers that subjectivity and reflexivity are positively valued in the qualitative paradigm as it invites participants to share their experiences and encourages the researcher to consider their own experiences while reflecting on the research process.

To mitigate some of the perceived challenges of the research, I conducted a pilot study before recruiting the research participants. Four experienced professionals from my network, established in education, social care, and mental health services, were invited to participate. The process allowed me to receive feedback on how my interview questions and technique came across. I revised the question structure where necessary and familiarised myself with the technology I would use to audio record the interview to avoid unconscious data elimination. The pilot highlighted the importance of maintaining consistency when posing questions to reduce bias, imposing views, or unnecessary probing. I was also able to note the transference and countertransference at play. At the same time, I monitored the pace of the interview and established whether the proposed hour and thirty minutes were sufficient. The process provided insight into my effectiveness as a focus group facilitator and confirmed that the interview schedule would remain unseen to eliminate participants pre-planning and rehearsing responses, which they may consider socially acceptable.

Ethical considerations

I was required to apply to the Tavistock Research Ethics Committee (TREC) for permission to begin the study. Due to the service user element, I was required to complete a Full Data Protection Impact Assessment (DPIA). The technicality of the assessment required me to develop new skills outside of the psychoanalytic domain, which was long and arduous. I was required to confirm that personal details such as names, email addresses and telephone numbers would only be recorded at the point of consent and that minimum personal details would be used during the focus group interviews. Copies of the recruitment posters for professionals and service users, information sheets, and consent forms were also required for the DPIA. In addition to completing a Data Flow Mapping exercise, I conducted a risk assessment of the data collection process to evaluate potential risks to participants (see Appendix H-M). Confirmation of completed information governance training was also a prerequisite for ethical approval. The application for ethical approval was made in March 2021; this was provisionally granted by TREC in July and then finalised in October 2021 once I had completed all the requirements set out by the local Trust (see Appendix N).

Confidentiality, Anonymity, and Safeguarding

Stringent steps were taken throughout the research process to maintain the confidentiality of everyone involved. The details of organisations and locations were disguised, while job roles and titles replaced the names of individuals.

The anonymity of the data collected was preserved in line with the Trust's and training school's data protection policy, ensuring transcripts were anonymised. Only data relevant to the study was collected and stored securely in a locked cabinet or on a password-protected device, with access only permitted to the researcher and restricted access to the research supervisor for discussion and supervision purposes.

Participants were notified that the transcribed data would be kept for the duration of the study, and personal data collected on the participant consent forms would be kept for two years before being destroyed securely. In addition, participants were notified that a debrief to provide the project outcomes would be available on request. Participating in the research offered a space for professionals and service users to reflect on real-life, lived experiences. Goss & Leinbach (1996) regard the Focus Group experience as empowering as participants are given the opportunity to collaborate with researchers and contribute to how we think about the community's mental health needs and access to support.

Interviewing professionals and service users about personal experiences of interacting with others when there are concerns around mental health and emotional well-being may cause some emotional distress. Therefore, participants were reminded that they could withdraw from the interview at any time without any further explanation. Service users were also informed that withdrawal would not impact their access to mental health services. Keeping the emotional well-being of all participants in mind, they were encouraged only to share what they felt comfortable sharing in the group setting and to use supervision or service user support via assigned clinicians should they become distressed during the process. In addition, the participants were encouraged to take some time out of the interview or withdraw from the meeting if necessary. Finally, they were advised that any safeguarding concerns or disclosures would be shared with the Trust’s safeguarding team and other relevant professionals on a need-to-know basis.

Participants

Participants were invited to get involved on a non-obligatory voluntary basis. Professionals were recruited via email advertisement sent to CAMHS clinicians, social workers, and local schools. The parents and carers were approached via assigned clinicians. Eligible participants who declined the invitation were reassured that this would have no impact on ongoing or future CAMHS intervention and support. The participants' demographics were collected, including their ethnicity, age range, employment, and marital status. However, as a small-scale study, the data was insufficient to conduct a meaningful comparative analysis.

Potential participants were given the opportunity to discuss the requirements and were made aware of the purpose of the study prior to consent. All information was clearly described in the participant information sheet, including their right to withdraw from the study at any time, without reason. In addition, the reassurance that any unprocessed data would be removed.

Recruited participants were invited to join one of the focus groups for an interview lasting no longer than 1hr 30mins. All interviews were conducted remotely using Microsoft Teams, an online video-call conferencing platform. I opted for this method due to the pandemic and tier restrictions which affected the number of individuals that could safely gather in a room. In addition, opting for a remote meeting eliminated the need for masks which may have affected the audio quality of the interview recording.

Inclusion criteria

In keeping with the psychotherapy concept of work discussion groups, where varied levels of professionals learn from each other while exploring significant events in the workplace, I sought to capture the experience of professionals who have significant experience engaging with children and families from the Black community. Therefore, only professionals with a minimum of 5 years of experience (inclusive of a pre-qualification and training period) working with families and some knowledge of referring to CAMHS were recruited.

Black parents and carers of service users with the mental capacity to give consent to participate in the research were invited to share their thoughts and experiences of accessing CAMHS.

Exclusion criteria

The client group focus for this research was Black service users. Therefore, parents from other ethnic groups were not recruited for the study. In addition, service users with chronic mental health difficulties, chronic health issues, or learning disabilities that would impact engagement in the interview were also not considered suitable to join the study.

Recruitment

A social worker, a senior teacher, and two CAMHS clinicians were recruited. The groups consisted of four professionals and four service users who were parents of children referred to CAMHS. The recruitment of each group is detailed below.

Recruitment of Professionals

Initially, I had hoped to recruit eight professionals: 2 Social workers, 2 Teachers, 2 CAMHS clinicians, and 2 GPs. However, I was deterred by colleagues who said that GPs were not easily accessible. Furthermore, it was thought that they would have even less availability to participate, in the aftermath of the pandemic. Unfortunately, without attempt, I gave up on the idea of contacting the 'too busy' elitist group of professionals. Later I considered the possible parallel for the Black community. Did professionals quickly become discouraged from approaching and engaging these families as I did the GP based on an assumption?

I created an email outlining my new requirements for two educationalists, four CAMHS clinicians, and two social workers. In addition, I approached schools that already had a working relationship with CAMHS. Simultaneously I sent out an email to our multi-discipline CAMHS team requesting four CAMHS clinicians. Out of the sixty-plus staff members, two clinicians agreed to take part. Though some expressed an interest in the study, it was unclear why there was minimal interest in participating in the research. I was left speculating whether it was due to the clinic's work demands, low staff morale, high staff turnover, or the nature of the subject matter that often saw staff meetings brought to a silent halt whenever there was an invitation to discuss matters arising in the community, such as the Child Q case.[27] Lester and Glasby (2006, p.200) conclude that there is a danger that staff from a particular group may be perceived as the 'expert', e.g., Black staff members as experts on ethnicity. They say not only does this deskill and exploit these staff members, but it also takes the responsibility away from other workers for making services more responsive to the needs of service users from particular backgrounds. While Morgan (2008) highlights the defences involved in professional thinking and argues that, in issues of racial exclusion, therapists open themselves up to shame, guilt, envy, denial, defiance, and the fear of exposing oneself or saying something unforgivable. The 'silence' in the profession on these matters, Fleming (2020) says, serves to defend against several intolerable feelings.

I contacted a senior social worker asking whether they could disseminate the recruitment poster for professionals (Appendix I) among colleagues. Four social workers responded, expressing their interest; however, I was contacted by a more senior member of the team, who instructed me to ‘withdraw’ until we had spoken. The manager questioned who would monitor what participants shared; there was also reference to the email reaching locum staff, implying that non-permanent staff were

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[27] Local Child Safeguarding Practice Review Child Q March 2022

likely candidates for disloyalty and mistrust. As I attempted to reassure and elevate the manager's concern, inclusion and exclusion came to mind. I confirmed that the interview focus was not on their service provision but on staff experiences interacting with the Black community in need of mental health support. The manager reluctantly agreed but insisted that direct managerial permission would be required for the individuals. The stipulation felt like an attack on intellectual freedom. It highlighted the fear in the system about what might be ‘exposed', which initiated what felt like an oppressive proceduralised selection process of only ‘trustworthy and loyal staff’ to be granted access to the study. Due to a lack of trust, spontaneity was denied as the service defended against the unknown. I wondered about the organisational structure and dynamics. What were the unconscious processes at play? (Mosse, 2019, p.7)
I worried that the social worker, who happened to be Black, would be disciplined by the more senior White colleague, and I was left feeling responsible. Something was suffocating about the restriction on the freedom to explore and be interested.

Once recruitment resumed, I learned that some social workers who expressed interest were advised that I had all participants needed. However, others failed to respond following my request for the newly stipulated managerial consent. In the end, only one social worker was successfully recruited. I found myself thinking about the missed opportunity for staff and the parallel process for members of the Black community and their experiences accessing CAMHS.

Recruitment of Service users

Clinicians were invited to identify suitable families to participate in the focus group. Initially, I had hoped to have two small groups of 4-6 participants to capture everyone’s view and encourage equal participation. However, I found recruiting service users even more challenging than recruiting professionals. Recruitment was contingent on the efforts of other professionals, and outside of my control, responses from colleagues were slow. As with the professionals, I wondered about the parallel between my limited access to the client group and the notion that the said client group had ‘limited’ access to CAMHS. I continued to send out email requests and made announcements in team meetings; however, this made little difference. Finally, it was agreed that I could access the database of Black families referred to the service and make direct contact with clinicians assigned to provide more context to see whether they were happy to contact the families to discuss participation. Most clinicians appeared supportive. However, I had to chase responses, and often promises to approach families never materialised.

Some queried the inclusion criteria and wondered if mixed-heritage children could be included. While others said, the families on their caseloads had their own challenges or required interpreters and were excluded before contact could be made. A Black senior clinician stated that she would not approach families as they did not want to re-traumatise those who had had difficult and negative experiences with the service. They felt that requesting their input would add 'insult to injury’, as it were.

One mother, whom I had worked with directly in the past, confirmed this notion and said she was unwilling to offer CAMHS *anything* since she felt let down and said the service had failed her child. I became less hopeful but felt that something crucial was being communicated that I needed to understand.

My supervisor suggested advertising the focus group in the clinic waiting area.
The admin team agreed to print and display the poster; however, they were not in colour as I had hoped and were rather poorly positioned on the noticeboard, making it hard to see. With no promised volunteers, my supervisor encouraged me to ask the administrators to signpost families who came for appointments. Unfortunately, this avenue also proved unsuccessful.

I returned to my supervisor feeling disheartened by what felt like an impossible task; in response, she brought her caseload up on the screen. Despite consciously displaying her commitment to supporting the recruitment of participants, she had overlooked several Black families and openly expressed her curiosity about why she had not put them forward. Even once families had been identified, blind spots (Mosse, 2019, p.135) and suspected unconscious bias would continue to see families labelled as unsuitable for the study for reasons such as lack of childcare.
A Black colleague who had worked directly with some of the families aided a helpful discussion with my supervisor to assist in reconsidering these families as viable options.

This moment felt like a breakthrough in the research process. My supervisor's acknowledgement of her oversight of families seemed to galvanise other clinicians within the psychotherapy team to approach families on their caseload. The families selected were a combination of those being seen by clinicians in our team as either the child's therapist or the parent worker. One parent whom I had worked with historically was keen to participate. I discussed the impact of our pre-existing therapeutic relationship and their need for an interpreter with my supervisor. We considered the additional time required to meet this need and the impact on the group dynamics when other participants were fluent English speakers. In order to include this mother, it was agreed that I would have a separate interview with her and the interpreter, asking the same questions as those in the focus group.

It took two months to identify five potential participants. Later I considered the missed opportunity to think with participants about what triggered their interest in getting involved. Was it due to the recent events affecting society, such as the effects of Covid-19, Black Lives Matter campaigns, the murder of George Floyd and the ongoing effects of the Windrush scandal? A total of four mothers of three boys and one girl, were interviewed, the youngest child to access the service was three years old at point of referral and the oldest at the time of the interviews was sixteen years old.

Setting up the focus groups

The Professional Focus Group

The participants were sent the information sheets and consent forms to read and sign, ahead of the group. Although keen to get involved, a professional sent a list of questions asking whether there was a need to conduct research before the meeting, whether they could have the questions in advance, or were spontaneous responses part of the process. I thought the enquiries indicated a desire to arrive at the group 'well equipped' to answer this 'emotive' question. However, there seemed to be a worry about not knowing. There was also a request to clarify the exclusion criteria.

While the participants had agreed to meet at the clinic in person, as the date drew near, a petrol crisis hit London's capital, with all travel heavily impacted. I had also considered in discussion with my supervisor the limited number of rooms large enough on site that we could use safely in line with the covid-19 regulations. Therefore, we agreed to meet online using Microsoft Teams which the participants were familiar with since remote working had become commonplace during the pandemic.

The Service Users Focus Group

The service users were less responsive via email. Text message follow-ups, reminders, and support from the assigned clinicians to read and sign the consent forms were required. The fifth participant did not respond to any follow-up requests to participate; therefore, no further contact was made. Following the success of the online professional focus group, we agreed that the service user group would also take place online. The meeting was arranged during the day when I thought the children would be at school and the home quieter to increase the chance of engagement.

Data analysis

Once both focus groups were complete, I used the Braun and Clarke (2006) six-phase model of analysis outlined below:

The process

I began by transcribing the professional focus group. The process was lengthy and time-consuming as I manually typed the data from the audio recording, as the dictation function was not as effective as I had hoped. I added my countertransference in a different colour to note the feeling in the virtual room to avoid losing essential information, which I would require later for the analysis. I also anonymised the data by changing identifying personal details such as names and places to protect the identity of the participants without losing the essence of what they said.

I was surprised to learn how much I had forgotten, reminding me that reliance on one's memory would be unreliable and insufficient for this kind of work. This exercise was repeated for the service user focus group and the individual interview I conducted with the participant who required an interpreter. I left some time and space between this initial phase of analysis before I reacquainted myself with the data checking for any errors in the transcription.

I noticed that I was reluctant to engage with the next stage in the analysis. Instead, I focused on other parts of the project and training school requirements. Despite working through this process before on a smaller project on the training course, I felt uncertain about how to approach the task at hand. I recall a sense of fear and paralysis; something stopped me, and the task seemed too difficult to approach. I wondered whether, unconsciously, I feared what I might uncover. I liaised with colleagues in my research workshop about what I had noticed, and helpful discussions jump-started my engagement with the material again.

In June 2022, I was invited to share a poster presentation of my research at the National Association for Child and Adolescent Psychotherapy; the process helped me reconnect with why I was researching this particular subject matter and why this data needed to be analysed and the findings communicated, to consider the matters concerning mental health inequalities.

Braun and Clarke (2006) encourage researchers to consider how participants make sense of their experiences. Why might they make sense of their experiences in *this* way? What *different* ways do they make sense of the topic discussed? How would I feel if I was in that situation? (Is this different from or similar to how the participant feels, and why might that be?) What assumptions do they make in talking about the world? What kind of world is 'revealed' through their account? They also encourage visual thematic maps (see Appendix O) as a valuable aid in exploring the relationships between codes, themes, and subthemes (Braun & Clarke, 2013). A thematic map allows visual exploration and refines the connections between these elements. By reading and re-reading the data, new words were added and extended, and anything that did not fit or occurred infrequently was discarded. These new words became the codes and were highlighted throughout the data each time they occurred. The codes were then combined and assigned to a representative word which became a theme. The themes were reviewed to ensure that they were accurate and informative in relation to the purpose of the study. Extracts from the data were used to illustrate my interpretation of the findings in relation to that found in the literature review. All participants were given pseudonyms, and any other identifying features were removed or replaced with words in square brackets, which were added to improve readability and clarity in relation to the context of the dialogue. Where verbatim quotations have been cut to 'clean' up the data, ellipsis in square brackets '[...]' were used (Braun & Clarke, 2013). The ethnicity of the participants was also included as it was relevant to the emerging themes and the overall research question.

Figure 3: Themes for the professional focus group

Theme	**Sub Themes**
Difference and Sameness **The impact of language, class, and culture**	Working to understand and meet patient's needs Referral pathways – who is referred and who is not? Difference causing worry and concern
The benefits of a good therapeutic alliance	Restoring hope in families Creating a safe environment for intervention
Mistrust and fear affect access and engagement	Fear of failure and rejection
Disjointed thinking within the professional network	Fancy service names – not meeting needs Battles between agencies Hierarchical responses

Figure 4: Themes and sub-themes for the parent participants

Theme	**Sub Themes**
Seeking help can feel isolating and lonely	Feeling discouraged by the community and professionals Overwhelmed and anxious Feeling frustrated and misunderstood Misguided information
The challenges of managing a child with complex needs	Multiple complex needs Struggling to relate Trauma separation and loss
All children made progress after treatment	Committed to getting help Proactive and determined
Variable service satisfaction depending on stage of access	Struggling to navigate and understand the system Successful referral Long waiting times Difficulties denied Feeling criticised and judged

Limitations of the study

Limitations of the study include the small sample size of eight participants.

In addition, all the parents who participated were from the same service, and three out of four mothers were supported by clinicians from the same team. As a result, critics may question how representative their experiences were of CAMHS across London or within the UK. There were also no male participants in the service user group. On reflection, I also noted that I had never worked with a Black father during the four-year psychoanalytic training placement. It is vital to explore this absence further and the need to gain the Black male's perspective on children with mental health difficulties in need of support and accessing services. Other limitations include the absence of the voice of the children as the primary service users. Further considerations of the study can be found in the conclusion of the findings and discussion section of the report.

Concluding thoughts

Despite the challenges I faced in gaining ethical approval and during the recruitment process of the participants, I realised that my ownership of the project developed during the process. My interest in the subject increased rather than becoming curtailed by the obstacles I faced, and as a result, I began to claim the project as my own. I was determined to work to understand the unconscious institutional reservation that seemed to cause professionals to ‘turn away’ rather than 'look' beneath the surface of the underrepresentation of Black families accessing CAMHS.

FINDINGS AND DISCUSSION

In this chapter, I present the findings from the Thematic Analysis of two focus groups conducted remotely using an online video conferencing calling platform. I analysed the data in relation to the following research question:

> **How do we understand the Underrepresentation of Black Children and Families Accessing Children and Adolescent Mental Health Services?**

Reflexive qualitative research does not take data at face value. Therefore, the results and discussion sections were combined to explore the findings in detail. This method of analysing the data takes an interrogative stance on the meanings expressed in the data. I unpack the ideas and concepts from the data and tie the findings to thinking around race and racism within psychoanalytic psychotherapy and mental health discussions identified in the literature review (Braun Clarke 2013, pp.308-311, 329). Finally, I reflect upon associations and my countertransference (Holloway, 2006) as the group facilitator and researcher while considering the implications for clinical practice, mental health services, and society as a whole.

In the first phase of the study, the data collected from the audit of referrals into a London-based CAMHS service between 2019 – 2022 will be summarised (see Appendix C-F), followed by findings from the study's second phase – Thematic Analysis of the focus group interviews.

The pilot study conducted with a consultant Clinical Psychologist, a Senior Social Worker, a Senior Teacher, and a Trainee Psychotherapist early on in the research project will not be analysed; however, it is important to note that the group found it difficult to identify positive examples of Black children accessing CAMHS or any other positive outcomes of therapeutic support in other settings. This finding was surprising considering the number of years of professional experience between them, which spanned across multi-disciplinary teams in London boroughs. The group consisted of three Black women and one White male; their views and concerns were similar to those raised by the participants within the main study (see Appendix P)

In the main study, participants joined an online focus group, where they were invited to respond to the unseen semi-structured interview questions (see Appendix G). The four main themes and sub-themes are displayed below (see Figures 3 and 4). The selected extracts illustrate the individual responses and demonstrate how patterns of meaning cut across the datasets of both groups.

It would be important to note that while remote working aids accessibility and most individuals have become accustomed to this method, and we have learnt how to use our observation and interpretative skills online, there is an undeniable distance that this method of meeting creates. For example, members can avoid being seen; there is also the loss of subtle non-verbal communication between group members and the effect on the natural flow of a conversation and interchanges that occur when people meet together in a room.

Phase 1: Summary of the audit of referrals into a CAMHS in London

According to The Census 2021, there are over 200,000 residents in the borough where the research was conducted; approximately 43,000 of those residents are recorded as Black or of Mixed African-Caribbean heritage. The data from CAMHS (see Appendix C) shows that the total number of referrals to the service between 2019-2022 was 4267. Of this number, 16% were recorded as Black or Black British, 10% were of mixed heritage, 7% were recorded as 'other' ethnicity, and 4% were Asian, compared to 31% of referrals for White children. Interestingly this category was not labelled as White British or Other in the same way that the Asian and Black groups were. Lewis (2000, 2007) argues that whiteness becomes ‘de-ethnicised': it is stripped of 'ethnicity' in fantasy, setting it up as a category representing normality and neutrality.

Finally, 28% of ethnicities were categorised as not known and 3% as not stated (1% any other group). This information was not captured or recorded at the point of referral. I wondered whether this group consisted of individuals who lacked a sense of belonging (Dr Burke, 2022) to an ethnic group or society. The audit indicated that 63% of the referrals for Black children were for anxiety, 27% for assessments and 10% were for ‘other’ (not stated). Of all the referrals received for Black children, 29% were not offered or did not attend any appointments. 25% attended 1-3 appointments, 14% attended 4-6, and 32% attended seven or more appointments. While there is no indication of the type of treatment received, the data does tell us that 35% of all referrals to the clinic were received via the GP. The second-highest referral route came via the Local Education Authority (LEA). The data is again unclear as there are two education categories.

Another essential entry missing from the audit is the age of the children at the point of referral. Children accepted into the service at a young age are likely to present with attachment concerns, emotional dysregulation, long-standing difficulties in the parent and child dynamic or peculiar behaviour that is hard to explain. How these difficulties manifest and present in latency and adolescence are likely to change as the difficulties become more entrenched. It is important to note that during 2021-2022 I worked with thirteen children under the age of 5 years old. Only three of those children were Black, indicating that further work may be required to engage this group.

Though the audit provided some information, the data was limited. Therefore, I was unable to establish, for example, how many families rejected involvement, either at the assessment stage or during treatment which resulted in discharge.

The professional focus group also highlighted experiences of poor data collection practices from referrals received to the service. One group member stated: "*I am quite shocked by how little urm… information is captured from referrers regarding background. In '[…]', those sorts of things would be on the referrals, and they would be clear. I think here [London], because everyone seems to come from somewhere else, I am really surprised that it does not seem to be captured in a way I would have expected it. '[...]' they have been put down as the wrong background as well. It is almost as though that has been guessed rather than actively asked.*"

The extract suggests that capturing data on ethnicity feels easier when there is less diversity in the community group. It is possible that the importance of recording demographic data has been underestimated or overlooked. There is also a possibility that professionals lack the confidence to enquire about race and culture. Perhaps there is a feeling that one should ‘know’ or a fear of offending, as suggested by a colleague during the recruitment of participants to the study. While training, I found that ethnicity and culture were essential to Social Work family assessments. In my experience, during clinical practice as a trainee psychotherapist, ethnicity often felt like an afterthought, similar to the voice of fathers, whose contact details were also often missing from referral forms for various reasons.

To improve service provision and accessibility, organisations must implement more robust data collection systems. While initial assessments may capture further information, this is not centralised or easily accessible. Culturally sensitive care planning can be initiated by capturing all relevant data about the child and family. The reach and gaps in the service provision can also be easily identified.

Phase 2: Findings from the focus groups

The participants of the professional focus group included: A Black Social Worker (Monica), a White Teacher (Martin), a Black CAMHS Clinician (Martha) and a White CAMHS Clinician (Mary). The service user group comprised of four Black mothers: Alison, Amy, Amanda, and Angela. The groups will be referred to as the 'Professional' and 'Parent' groups. All participants have been given pseudonyms, and any other identifying features have been removed or replaced within square brackets. In addition, the ethnicity of each clinician has been included as it holds meaning in relation to the emerging themes and the overall research question. Extracts directly from the focus group discussions will be inserted into green boxes. Where verbatim quotations have been cut to 'clean' up the data (Braun & Clarke, 2013), ellipsis in square brackets ‘[...]’ are used. In some instances, words in square brackets have been added to improve readability.

As each interview progressed, the participants resembled a working group (Bion, 1961) that generally did not resort to basic assumptions but instead appeared to strive to offer support to each other in relation to sharing their experiences in an attempt to understand the needs of members of the Black community. Bion defines the working group as one that is able to be open to new ideas:

> *This is the foundation of the state of mind of the individual who can retain his knowledge and experience and yet be prepared to reconstruct past experiences in a manner that enables him to be receptive of a new idea.*
>
> *Bion, (1984)*

In the next section, I use the extracts from the Professional group to illustrate how each theme emerged.

Findings From the Professional Focus Group

Figure 3: Themes and subthemes for the professional focus group

Theme	**Sub Themes**
Difference and Sameness **The impact of language, class, and culture**	Working to understand and meet patient's needs Referral pathways – who is referred and who is not? Difference causing worry and concern
The benefits of good therapeutic alliance	Restoring hope in families Creating a safe environment for intervention
Mistrust and fear affect access and engagement	Fear of failure and rejection
Disjointed thinking within the professional network	Fancy service names but not meeting needs Battles between agencies Policy does not reflect reality

Difference and Sameness - The impact of language, class, and culture

This theme emerged from clinicians repeatedly commenting on the impact of difference and similarities between them and the families they support. They commented on their ability to relate to the families and how hard they worked to understand and meet their needs. Others spoke from a place of despair and frustration as they described multiple challenges due to 'different' ways of being. There was an appreciation of insight into alternative views and the consideration of systemic challenges that needed to be understood.

Attempting to understand and meet needs

In the extract below, Martha shares her experience meeting with a Black family for an initial assessment.

> *There was a lot of hostility from mum initially it's in every report it's literally listed that mum is hostile and aggressive '[...]' the language barrier and stuff it just seemed to alleviate*
>
> *initially, she was speaking in her best English when she entered the room '[...]' once I spoke '[...]' then she was speaking in patois, and then she's able to really vocalise her frustrations and really vocalise how she feels mistreated by the system, and obviously there was an unspoken language there I'm Black '[…]' so I can understand her body language and how she is expressing herself… and in that instant err again I was able to empathise on a different level and sort of hear the mother's cry.*
>
> Martha (Black CAMHS Clinician)

Immediately I was impacted by the strong emotive labels 'hostile and aggressive' assigned to this mother by professionals in multiple case files and thought about how such entries can affect the possibility of more positive interactions. However, while Martha did initially experience hostility, she remained curious.

Moylan (2019, p.21) states that *"the fundamental part of the training of psychoanalytic psychotherapists is to learn to attend to the material that patients bring, including attending to the feelings it evokes in the clinician".* The author describes how clinicians can become uncomfortable when unable to connect with a family immediately, and the rise of feelings of inadequacy, fear of criticism, and even doubt can lead to the selffulfilling prophecy that this family or group cannot be helped. Fortunately, Martha could contain this mother’s distress, and I was relieved that she was not cast aside or ‘written off’ as ‘hard to reach’.

In a seminar discussion, Navaratnem (2022) stated that people feel more reassured when people look like them as there is confidence in an unspoken language. However, the extract suggests that this mother did not assume that their shared ethnicity automatically made the clinician an ally or that her plight would be immediately understood. Instead, the identified 'hostility' subsided when she felt safe enough to be herself. Her language was no longer a barrier as she felt able to speak in a dialect where she did not have to carefully select her words and alter her tone.

Referral pathways – who is referred and who is not?

The social worker Monica and Mary, a CAMHS clinician, shared their experience of referrals, support and working with other agencies in the extracts below.

> *…the police were called and [Black children] are more likely to get excluded from school before something happens. You can see the difference ‘[...]’ middle-class White family ‘[...]’ child is in hospital and then probably be working with CAMHS for a long time, and they're not refer to us [social care]. ‘[...]’ referring [Black children] to the police or criminalising ‘[…]’ rather than looking at it as a mental health problem.*
>
> Monica (Black Social Worker)

I think it is so sad when I get asked to do a mental health assessment and it is a young Black male often in handcuffs, in A&E or police cells, less so in the police cells now since the rules changed but that's terrifying, horrible.

Mary (White CAMHS Clinician)

Monica's and Mary's observations support the research findings by Edbrooke-Childs et al. (2019) that people of Global Majority (GM)[28] are less likely to be referred via primary care services such as the GP or schools and more likely to be referred by criminal justice services to CAMHS.

The extracts also support the research into Adultification[29] and the outcomes from the LCSP Review 2022[30] of a Black girl who was strip searched at school. Adultification bias is the form of racial prejudice where Black children are treated with significantly less compassion than their peers, with some professionals finding it hard to consider the age or stages of development in relation to the child's behaviour. The review found that Child Q's ethnicity and socio-economic background were considered the basis for criminal justice rather than child protection. Adultification was identified as one of the major contributing factors in the case. The review reports: *"the lack of action after the strip search shows Child Q was primarily seen as 'the risk' instead of being 'at risk'.*

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[28] https://www.leedsbeckett.ac.uk/-/media/files/schools/school-of-education/final-leeds-beckett-1102-global-majority.pdf

[29] Originally a psychology term first mentioned in a study by Georgetown Law Centre on Poverty and Law (2017).

[30] Local Child Safeguarding Practice Review Child Q March 2022

Because of this, little thought was given as to whether a referral to external agencies might be required."

Mary's observation described in the extract below is similar to that of Dr Burke (2022). The Black psychiatrist reports experiences of colleagues '*seeing him through different glasses'* and considering him as *'dangerous.'*

> *…easier to see him [Black boy] as having a mental illness as opposed to the trauma and maybe even to judge the stabbing as something related to gang-related violence, '[…]' so, I think, I think we got different glasses on sometimes.*
>
> Mary (White CAMHS Clinician)

Klein (1946) describes how individuals and organisations gain relief from internal conflicts by splitting. The painful conflict between admiration and hate, for the Black community, in this instance, can be relieved by splitting the community or individual into good and bad. Mosse (2019, p2) describes how projections (Klein, 1946) often accompany splitting and involve locating feelings of aggression and hatred in others rather than oneself.

It is my view that if Black professionals trained to support families feel they are feared and criminalised by their colleagues, and the vulnerability and needs of Black children are met with exclusions from school and society, we are in desperate need of reform. Having said this, first, we must gain a better understanding of these responses and experiences.

Dr Hilary Robertson-Hickling (2008) brings our attention to the impact of migration on resilience. She says that the effect of colonisation on third-generation migrants was considered as researchers recognised a lower rate of psychosis in the Caribbean. The study highlighted that the Caribbean community are not contending with societal challenges such as structural and cultural violence, educational exclusions or the dehumanisation of Black people. The researchers state that microaggression impacts resilience as one is impacted daily at school, work and in the community, which can affect daily functioning. In addition, Arnold (2011) suggests that where racism is blatant and persistent, this can have long-term adverse effects on one's self-esteem and mental health.

The CAMHS clinicians discuss the Black families they have worked with in the following extracts. Martha, who mostly saw families with children who did not have a diagnosis, reported working with very few Black families only 2 out of approximately 48. While Mary, a White medical clinician, shared that 80% of her caseload were Black or GM communities off the 55 families she saw with multiple complexities and severe learning needs that were often on medication only 2 of these were White middle-class families.

> *I'm used to working with lots and lots of translators North African '[…]' families; I see an awful lot in my field because of the genetic predisposition to Autism.*
>
> Mary, White CAMHS Clinician

> *In three months, I have only worked with two Black families* ‘[...]’ [I see] four [families] per week.
>
> Martha, Black CAMHS Clinician

The extracts indicate a difference in the referral pathways for Black families who are likely to access CAMHS for diagnosis and medical treatment rather than talking therapies. It would be important to establish why this is so. I wondered about the impact of presumptions and the geographical grouping together and misrepresentations similar to that made by Mary and the impact that this line of thought can have on referral pathways and treatments for members of the Black community.

Frank Lowe, a Black Psychotherapist, shared a similar view in 2020, prior to the pandemic and describes his experience of members of the Black community being more likely to be given medication than psychotherapy which he says has led to a lack of trust and a tendency for families to only make contact in crisis points.

Difference, causing worry and concern

Martin, a White school teacher, shared his experience working with Black parents of children in his school and, in particular, an encounter with a Black father following a fire in the family home.

> *I have had to tread carefully really and try to discuss and debunk a few comments and opinions surrounding some of my families, whether that is linked to any cultural or religious beliefs that they may have, or maybe not beliefs but just assumptions that they have surrounding things…*
>
> *…It was a really interesting clash that I hadn't had before, and I don't know whether that would have perhaps been in a family where the perception of the cultural male head of the household would be or not. We just wanted to help, and the dad was absolutely adamant he was [Caribbean] and was, was adamant he would not have any second-hand clothing… …interesting to be faced with that level of adversity and still have that urm I don't want to call it stubbornness but that mindset you know, it would be hard to offer support because of that.*
>
> Martin (White Teacher)

The differing views about second-hand clothes show us how meaning and belief can drive one's behaviour. For this reason, Arnold (2011) encourages professionals to be conscious of their attitudes and differing belief systems from those of other ethnic groups.

It seemed Martin felt helpless and ill-equipped to know how to respond to the crisis and engage the father who appeared to be 'in need', but unable to accept help. Help-seeking for some members of the community seems to come at an emotional price, and the stigma attached is associated with weakness, which can put families at risk of poor health and mental health outcomes, e.g. higher suicide rates for men[31].

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[31] https://media.samaritans.org/documents/Suicide_Stats_England_2021.pdf

Monica describes her understanding of the thought process of some members of the Black community. It would be important for families to begin recognising the difference between ‘coping’ and understanding trauma so that they might begin working towards healing from adverse experiences.

> *…in the Black community, there is this thing about you just don’t talk your business, you DON’T talk about what’s going on in your house. You don’t put it out there, you get on with it! Black people are used to just getting on with it and coping ‘[...]’ it’s felt like a weakness to reach out, urm, and it’s just not the done thing to sit there, and you know.*
>
> Monica, Black Social Worker

When faced with misunderstanding, it would be helpful for professionals to consider where they find themselves on the ‘scale’ of projections and defences as we work to support families. Dr Kirkland Vaughans (2021) stated that the Black community see accepting assistance as a sign of inadequacy. While the White community sees it as entitlement, so they welcome assistance. This demonstrates the need for clinicians to understand the mindsets of the communities they are attempting to engage.

Martin believed he was offering something good, but this father could not be certain. The mention of ‘insecurity’, albeit directed at his son, seemed to act as a trigger for layers of current and likely historical intergenerational trauma and distress as described by Dr Arnold (2011, pp.91-99).

Though it was clear that Martin was attempting to be helpful and supportive, something felt dismissive and ‘othering’ in his description of events in the following extract.

> *…all I said literally the words I, I said well I think this child is showing some signs of insecurity “[…]." I was going to elaborate ‘[...]’ but were not given chance because the father who is (dip in tone) [Caribbean] exploded. I was a bit blown away and ended up making a phone call and doing a home visit with the family to [say] look; this is who I am.*
>
> Martin (White School Teacher)

Roberts (2019, pp.133–5) describes how professionals inevitably and repeatedly encounter failure in their work with damaged and deprived clients. This can arouse intolerable guilt and anxiety in the professional, who may retreat to primitive defences to maintain precarious self-esteem and defend against the anticipated retaliation for failing to heal. Lewis (2000) suggests that an encounter with ‘difference’ can set up an us-them dynamic where ‘they’ (the clients) become the sick or mad or needy ones, and ‘we’ (the staff) are the well, sane, strong, helping ones. These defences maintain the sense of a benign self (Morgan, 2008) and a feeling that one’s own culture is both good and normal (Fleming, 2020).

As the interview progressed, the group began to consider what gets lost in translation between the professional and families from the Black community.

> *[I am] relatively used to working with interpreters now but recognising that you've got your, your voice that you might share within your own community compared to voice that you might share with professional people that, that's fascinating.*
>
> Mary (White CAMHS Clinician)

> *"I have learnt words from some Jamaican people that I've had to look up in the dictionary. They are more clever than they think they are, they use words in different contexts, and they know what they want to say, but urm because of trust and anger, their articulation is just not great."*
>
> Monica (Black Social Worker)

The group explored whether professionals account for dialect and non-verbal communication and what it means to have a 'third' person in the room when working with interpreters. It became apparent that intergenerational trauma and disappointment can also act as a language barrier until one feels safe enough to be their true authentic self, particularly during moments of distress. Navaratnem (2022) states that clinicians become culturally competent when they understand themselves and are committed to learning while being culturally sensitive. Dr Fredrick Hickling (2004), who initiated Culture Therapy in the Caribbean, advocated for a more collaborative approach, stating that communities and families are the experts. However, due to fear, many professionals do not explore or show any curiosity about faith-based or cultural practices and end up making inaccurate assessments of the child and family.

Martin shares his experiences of attempting to relate to families while feeling far removed from their experiences based on gender, ethnicity, class, and culture.

> *I don't believe that I am the best person because I'm not only am I White, I mean not only am I male, but I'm also White. I didn't grow up in here; I don't, I don't know what it's like to be a single mother of three children in a one-bedroom apartment with a child where, where one of the children is severely autistic and causing some challenges and difficulties, so I really have to be quite tactical about how, how to support.*
>
> Martin (White, school teacher)

According to Moylan (2009, p.21), even if English is a shared language, if the clinician is so far removed, there is no common language and the patient and professional resort to the primitive unconscious language of projective identification (Klein 1946, 1955). Understanding this communication can help the clinician feel less overwhelmed and elicit an understanding between the two so that the intervention does not break down. Furthermore, this approach helps the clinician stay in touch with their feelings rather than avoid them.

Mistrust and fear effects access and engagement

The Department of Health (2000a p.28) stated, *"patients are the most important people in the health service. However, too many patients feel talked at, rather than listened to."* When families feel they have not been consulted and the referral is presented as compulsory rather than voluntary, suspicion immediately arises, making it challenging for the family to imagine that anything good or positive could come from the encounter.

Fear of failure and rejection

The group suggested that a lack of trust affected families engaging with professionals; however, one professional had an alternative view and provided further insight into her theory as each member shared examples of interacting with families displaying resistance to accessing support.

> *'[...]' I think, for me it goes deeper than trust. I think it is a genuine fear for me trust feels like we are coming in at a bit of a zero and were sort of building on that. But I think we are literally coming in at a big minus and then we've got to get to that trust bit and then build from there. It's just those micro communications, those interactions of just building and understanding. It's not actually trust it is actually fear deeply embedded in a lot of layers.*
>
> Martha, Black CAMHS Clinician

Fear can create multiple layers of tension and a disconnect between Black families and professionals assigned to offer support. In the following extract, Mary considers the impact of adverse histories on the Black community being subjected to historical harmful, unethical healthcare research and medical trials. She thinks about the impact of such experiences, which illustrates why some members of the Black community would find themselves in the paranoid, schizoid position (Klein, 1946) as they defend against the threat of harm and anticipated malpractice.

> *Many people from that background, particularly from African-Caribbean backgrounds, may have actually been experimented on you know, and that's urm think that's a degree of, fearful… I would be scared if I had those stories in my background.*
>
> Mary, White CAMHS Clinician

The Caribbean community, in particular, may also be less likely to trust professionals due to other historical, social, and political injustices, such as the invitation to come to the UK to help rebuild the country following WW2, only to find that society was less welcoming than anticipated. Having worked hard against the odds, it is likely they felt more aggrieved by injustices and ill-treatment. Monica describes in the extract below her experiences of suspicion and scepticism from some of the Black families she has attempted to engage.

> *Working with Black families and being a Black female has been extremely difficult at times, '[...]' you're seen as working for the system '[...]' you know not thinking I'm going to be empathising with them or there to help them I'm just working for the White man or the system, and it is really difficult to try to get them to trust or even open up. [There is a] lack of trust of authority, and lots of times, I have to go with a prepared speech…*
>
> Monica, Black Social Worker

> *….I found that Black African families would trust a White person more than they would trust me [Black Caribbean] to be quite honest... and I think that urm, I don't know whether it is back to slavery, I don’t know.*
>
> Monica, Black Social Worker

> *Sometimes I have said the absolute right thing, and I have no idea how or why I’ve said it, but (laughs) you don’t know if the family is going to be more responsive if you are White or not White. If you’ve got that shared heritage so…*
>
> *Martin, White School Teacher*

Martin and Monica shared similar experiences of feeling that their race created a barrier to making a connection with families. It is possible that while professionals search for a 'connection' via their commonalities, families may have noticed a lack of confident curiosity about the differences, causing further distance between the family and the professional.

Barnes (2012) encourages us to consider how the Black community suffered from the dislocation and enforced submission to lifestyles imposed on them by others which would require survival techniques and defences that we still see present even within the third generation in the UK today. Carrying defences from then into the present day creates a challenge. Arnold (2012) describes how, despite being the third and fourth generation of people from African-Caribbean origins, many of whom, identify as British they are still treated as though they were immigrants. Others describe themselves as feeling they do not belong in Britain but are unable to identify with their birthplaces in the Caribbean and therefore feel a sense of detachment. If people cannot easily relate to their environment, a feeling of unease and unbelonging can affect their emotional health.

I have seen how my mum has had to navigate through the systems over time […] the teacher rang my mum and said that your son was misbehaving today, my mum will unpack that, and she wants to know how the day has gone, what has happened and how the teacher came to that result. Whereas I have seen with my African counterparts the parents have been like "OK thank you for telling me and I will deal with that accordingly".

Martha, Black CAMHS Clinician

We just engage with services different. '[...]' there is a lot more resilience with Black African family in terms of, you know, 'if can't beat 'em, join 'em' kinda culture just play the game and get in. Whereas with the Caribbean, we've had the struggle for so long no there's a lot more resistance no we've done our bit so we deserve better and if not we're not going to engage with the service.
So, a bit more like a rebellion towards the system.

Martha, Black CAMHS Clinician

Martha spoke emotively about her experience of the differences within the Black community. Terms such as '*join them and play the game'* imply silent compliance that feels safe, avoiding conflicts and confrontation. While '*resistance and rebellion'* create an image of speaking out and having a voice that usually has negative connotations and is often linked with the term *‘hard to reach’*. A term commonly rejected by marginalised communities as it puts the onus on the individual to *‘get involved’* or engage’ rather than the organisation ensuring that services are accessible to all members of the community it proposes to serve. Either way, the individuals from these communities have the same objective of trying to survive the threat of a potentially hostile and unpredictable society.

Even with the best intentions, errors happen, mistrust and a fear of failure can ignite suspicion within communities. These barriers can be minimised by maintaining a flexible and curious posture with a willingness to learn, which will make a difference when building a therapeutic alliance with the families we work with.

The benefits of a good therapeutic alliance

Lester and Glasby (2006, pp 177–178) maintain that we know that different groups of people do not all start from a level playing field and by treating everyone the same, there is a risk of perpetuating existing inequality while failing to challenge the divided and unequal society that we work and live in. Treating people differently means that professionals can provide more support for those who need it most to pursue true equality. The authors state that it is not appropriate to provide a standard level of service to everyone as different groups may need greater support due to the discrimination they have faced.

Restoring hope in families

Martha describes her interpretation of the experiences of Black families journeying through various systems. She explains how these experiences can be passed on to the next generation, like case notes between professionals stirring up anxiety or the erection of defences in anticipation of a negative experience.

> *… the journey doesn't start with the CAMHS clinician, psychiatrist, the school teacher; the journey starts as early as mums experience during pregnancy with the health care system, going to GP, vocalising your challenges there, going to housing, vocalising your challenges there having repeated conversations and not being heard and that is intrinsic for the parent that these systems don't operate for us they operate against us. Our voices are not heard, that is embedded in the parenting and then becomes embedded in the family's core values, and it trickles on especially with Black African Caribbean families.*
>
> *"[...]" like now since the Black Lives Matter and this term BAME and it's got a whole new meaning but really you are again, just clustering everyone together and as we have said there is a massive differentiation between the Black African and the Black Caribbean experience in the UK alone. As clinicians and '[...]' organisations, there has to be more training you know, we are putting everyone in the same basket so to speak and saying BAME, all Black, all non-Whites basically fall in the same category.*
>
> Martha, Black CAMHS Clinician

According to Morgan (2021), White professionals do not have the resilience of their Black colleagues, whom she says have had no choice but to face issues of racism from an early age. Gibbs (2009) stresses the need for therapists to effectively examine their racial and cultural understandings, prejudices, and fantasies in their personal analysis to attend to the patient’s particular needs. However, it is unlikely that the professionals (excluding therapists) working with these families would have undergone personal analysis and therapy or attended a group relations conference to begin recognising unconscious bias and blind spots at play (Sedlak, 2019).

With support, the group were able to share examples of how the families they have worked with benefited from demonstrations of care following long periods of mistrust and scepticism. The group described going the *‘extra mile’*, ‘*over and above*’ and ‘*holding cases for that bit longer*’. This level of support has proven to be a viable route to being seen as a benign helpful figure. Martha's contribution invited professionals to think about the positive experiences that could influence community members to begin accessing services.

> *…that’s a mother that has had a positive experience and seen the benefit of it. And it is also a mother that will go back into her community and vocalise that this ‘[...]’ service [is] available and it worked for me, and this is what it provided, and then in the community, you’ve got representation.*
>
> Martha, Black CAMHS Clinician

> *Working beyond my strict role ‘[...]’ I’m doing all sorts of things like housing letters and things like that. With some of the families over the lockdown, I was ‘[...]’ [doing home visits,] I think I think urm if they actually see you behaving in a way that is responsive that is incredibly helpful.*
>
> Mary, White CAMHS Clinician

That relationship between CAMHS and school and the parent '[...]' was the core of the successful the success in his development and he has progressed enormously and he is a massive success story… I think communication and relationships is the key to success in many ways.

Martin, White School Teacher

…it was just an amazing piece of work '[…]' this man was so anti-establishment, to actually say goodbye 'sis' urm, was amazing, it was amazing, '[…]' it was a bit late, I was leaving his house at half past seven at night, but it really brought a tear to my eye urm, instead of working with child I was actually working with the dad.

Monica, Black Social Worker

Disjointed thinking within the professional network

The group found it possible to consider the differences between them more effectively than I have observed in other settings where professionals find it easier to locate the differences outside the group in the 'other,' e.g. the families or organisations.

Managing frustrations

The frustration between agencies and a lack of understanding of the service they offer can lead to system failures and children and families falling through the gap in service provisions. In the following extract, Monica shares her frustration with organisational dynamics, differing views and assumptions.

> *One of the things that managers or people ask is well have they got a diagnosis and if they haven't got a diagnosis then there is nothing wrong - kind of attitude and I also find that interesting. Urm not everyone is gonna have a diagnosis*
>
> Monica, Black Social Worker

Martin shared his view of the hierarchical imbalance between agencies in the extract below. This can stir feelings of inferiority in both the professional and service users. However, Halton (2019, p.17) suggests that if such projections can be re-owned, integration and cooperation within professional groups and the communities they serve will cause a shift from the paranoid-schizoid to the depressive position.

In the extract below, we see the CAMHS professionals suddenly becoming the 'all-powerful and knowing' members of the group.

> *…start giving a bit more, a bit more weight to other professionals, and I have asked, I had to write and the same goes with funding I have written to CAMHS professionals '[...]' to say can you please write a report to you know to identify the needs we have discussed in our meeting because I need to apply for funding and need backing from you guys because you guys have extra weight….and it is frustrating.*
>
> Martin, *White, School Teacher*

Throughout the interview, Martin appeared cautious and seemed to fear saying something unforgivable (Morgan, 2008). I recalled his keenness to see the questions in advance to prepare for the interview. Was this his way of protecting against a harsh or critical eye? The insecurities attributed to the boy and [his father] in his early accounts could be felt in the virtual space. There was a sense of feeling outnumbered by ethnicity, gender, and professional authority. This can be seen also in the extract below where I seem to lose my identity as the facilitator and became part of the ‘all Black group’ and then the ‘all female’ group of participants.

> *‘[...]’ even though myself and Mary are both the only two White participants of this meeting, you know, certainly our backgrounds would have been different as, as, as all four of you are female, and I’m assuming, urm, here I am assuming but five years ago I would have said that without any problem and now I am wanting to say, you know urm that I do not want to assume how you ladies, you people identify. Urm it is about continuously evolving and learning and urm but realising that it is OK it’s OK not to have all the answers and so much layers.*
>
> Martin, White, School Teacher

If any progress is to be made, staff must have a safe space to reflect without repercussion. Cohn (2019) describes that when staff were offered informal spaces to think, individual spaces for more personal matters and group spaces to consider group dynamics were developed. However, this was only possible after trust had been built. The author argues that organisations must be willing to invest in such a resource to allow staff to get in touch with difficult and disturbing feelings that they may hold towards themselves in relation to internal figures and the very people they have been assigned to serve.

Beckhard (2019, p.194) encourages professionals to create safe environments that consider the following: There's your stuff, there's my stuff, and there's our stuff. *He states, "good managers take the time to figure out whose is which! It takes time to get there but working in the light – even if it's dim at first – is usually more productive than living and working amongst un-named shadows."*

Monica brings the group's attention to the importance of making links for families to prevent them from feeling like they have to keep retelling their stories, which can cause them to feel unheard and insignificant.

> *You can get somebody that will open up and say it, but then you have to repeat again to another professional and another professional and that's just not…if you've said it once, everybody works for the same kinda place, I told that person already, I ain't telling you again! You get that shut, block-ness there.*
>
> Monica, Black Social Worker

Moylan (2009, p.19) encourages professionals to listen carefully to the individual's story, in order to discover what is wrong, and emphasises that it is not enough to rely on the content to give you information but to also consider how the story is presented and conveyed.

Martin shares his view regarding heavy workloads and how staff are under enormous pressure. The Department of Health (1998 c, p.3) consider the impact of this, particularly on individuals with complex needs spanning health and social care. They say that good quality services are sacrificed for sterile arguments about boundaries. "*When this happens, people most vulnerable in our society and those who care for* *them find themselves in ‘no man’s land’ between health and social services. This places the needs of the organisation above the needs of the people they are there to serve. It is poor organisation, poor practice, poor use of taxpayers’ money – it is unacceptable.*”

> *Perhaps better training and education, for you know, those earlier services it, could help elevate the pressures on all of us because I don't know, have never worked with a professional that is not overworked.*
>
> Martin, White School Teacher

In 2000 the Sainsbury Centre for Mental Health encouraged partnership working to minimise bureaucracy and duplication and to maximise integration for service users and staff. They say this prevents the service user from experiencing fragmented services, a lack of continuity and conflicting information in situations where local agencies fail to collaborate effectively.

The focus group could be described as a well-functioning working group (Bion, 1961), turn-taking and operating in the depressive position (Klein, 1935), showing concern for others, tolerating, exploring, and valuing difference. Although, I wondered whether they would have continued to interact in this 'socially acceptable' way over time if they, with their different cultures, beliefs, and organisational standpoints, continued to meet.

Findings from The Parent Focus Group

One participant required an interpreter, my supervisor and I considered the impact on the group dynamics, and I agreed to conduct a separate interview with this mother. Although all the questions were the same, the absence of other participants may have affected her responses; nevertheless, I decided to report the findings from the parent group and individual interview together due to the similarities in the emerging themes.

Participating mothers included: Alison, Amy, Amanda, and Angela (interviewed separately), each responded based on their experiences accessing CAMHS with their children. The mothers answered questions based on the experiences of three boys and one girl, who, in total, were supported for eleven years within the service.

In the next section, I will use the extracts from the Parent focus group to illustrate how each theme emerged. During the process of summarising the data analysis the increased subthemes in comparison to the professional group highlighted the complexity of the parent's experiences which saw selected extracts cutting across multiple subthemes. Therefore, to avoid duplication, repetition, or a loss of the essence and quality of examples I decided not to group the extracts under any one subtheme heading in the same way I did for the Professional focus group. Instead, I opted to provide a series of examples from the participants and explain in depth how each extract related to the theme and its relevance to findings from earlier studies and responses from professionals.

Figure 4: Themes and sub-themes for the parent participants

Theme	**Sub Themes**
Seeking help can feel isolating and lonely	Feeling discouraged by the community and professionals Overwhelmed and anxious Feeling frustrated and misunderstood Misguided information
The challenges of managing my child's complex needs	Multiple complex needs Struggling to relate Trauma separation and loss
All children made progress after treatment	Committed to getting help Proactive and determined
Variable service satisfaction depending on stage of access	Struggling to navigate and understand the system Successful referral Long waiting times Difficulties denied Feeling criticised and judged

Seeking help can feel isolating and lonely

The mothers seemed to welcome a space to reflect on their journey into CAMHS.

They spoke of the stigma they experienced while seeking help but were clear; they were not afraid to let people know they were striving to access support. One member said that the referral reason seemed to determine the stigma attached, e.g. receiving mental health support following a bereavement was deemed acceptable. Thornicroft et al. (2007) state that stigma refers to a lack of knowledge (ignorance), attitudes (prejudice) and behaviour (discriminatory).

> *When I first accessed CAMHS, things were really bad and I didn't know how things would go over time. I was really suffering at that time I was really, really suffering […] I thought I was going mad. I was being told most of the time that there wasn't anything wrong, there was no real identification of what the issue was although I knew something was wrong.*
>
> *Angela (parent*)

Moylan (2019, p.19) states that sometimes it is impossible for people in distress to put into words those aspects of their experience for which they want help. They do not know consciously what is troubling them; they only know they are suffering. Angela described knowing that her son was experiencing difficulties but being uncertain of the nature of his troubles caused the parent, child, and the school staff great anxiety.

> *[I was told] they are not going to help you because you're Black, as far as I am concerned, Black, White whatever colour I am here to get support for my child, so I am going to continue to come. A lot of the Black parents the people think that you are not going to be helped because of the colour of your skin but that does not interest me at all. But there is that tendency in the Black community to think that because your child is Black that you are not going to get the support the same level of support as a non-Black child.*
>
> *People were saying why are you bothering why are you wasting your time. They are not helping you. I was determined to get something done, but people kept telling me that there is no point '[...]' your child isn't White erm and, I really suffered in that period, my children too suffered at school. But I preserved, I continued, I was persistent but erm I was not encouraged.*
>
> Angela (Parent)

Although each mother remained composed throughout the interviews as they described the challenges they experienced, I felt an overwhelming sense of grief and loss. I admired their tenacity to continue advocating on their child's behalf, d not well advised or supported, and despite feeling re-traumatised by events when their difficulties were denied, they had managed to internalise something good and kept a positive internal figure.[32] in mind when things became challenging.

In light of the challenges described earlier in this section, members of the Black community need someone willing to listen, take in and contain (Bion, 1967) all the aspects of their story and the different feelings and emotions they have in relation to the event by processing the detail rather than withdrawing because it is too painful. When it feels safe enough, individuals can begin to make progress. However, the progress is likely to be slow due to fear of maltreatment within service structures and systems, as described in the professional's focus group.

In the extract below, Amanda explains her experiences with the British education system.

> *The school don't understand her. They call her attention seeker. I get told that she is acting up for you; it is only you that she is doing it for init. She is attention seeking, is what I get told. CAMHS admitted it, but other professionals outside don't want to accept that she has struggles.*
>
> *…because she was being quiet and she scratched her head, to get at her the teacher made a comment based on her afro and said all you people do is think about your hair.*
>
> *…They left her with broken foot and when I called them and ask them where's the accident form they told me mum she is lying, and she is manipulating you and I took her to A &E and they put her in cast, A&E were like oh my gosh her foot was swollen, I was like oh my gosh, no one is helping her.*
>
> Amanda (Parent)

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[32] The New Dictionary of Kleinian Thought pp.40-62

Jane O'Rourke (2021) states that racism is a known barrier to accessing learning or therapeutic support. O'Rourke impressed upon professionals to ensure we clarify prejudice and racism if we are to understand the plight of the Black community. Prejudice can be the act of hostility towards someone because of the colour of their skin or their beliefs, while racism is a belief that another race is inferior, coupled with the power to negatively affect the lives of those perceived to be inferior (DeGruy, 2005, pp.21-25).

In the extract below Amy's confirms Monica the social workers' view that *'Black people don't talk their business'.*

> *Erm, yes (laughs) I guess I did face that [stigma] with family when I said that he was going to see CAMHS they said oh what's the point of that? He will grow out of it; he just probably misses his dad because I am a single parent '[...]' Typical Black boy who's just acting up '[...]' I had to overcome that and ignore the voices around me and just go for it because I still believe that people don't believe in seeing someone and speaking to someone… it's quite difficult.*
>
> Amy (Parent)

Did Amy's laugh represent embarrassment and shame about the community's response to difficulties and her disappointment with a view that left her and the other mothers feeling unsupported? They describe their concerns being minimised and denied by professionals. They were advised that their children's difficulties would dimmish over time and were discouraged from seeking professional help.

The extracts support Mantovani et al. (2017) theory of ‘triple jeopardy’. The researchers describe patients being rejected by their families, alienated from their communities, and faced with internalised 'self-stigma'. According to the study, stigma reduction has become a public health priority, and challenging stigma is a fundamental strategy to achieve social justice and equity.

> *…a few times when professionals [at school] have got frustrated with her because she is very quiet and, in her shell, and then inappropriate comments, and when I have complained, I am told […]that I shouldn’t complain and that they are always trying to help and I am never satisfied...because she does not have a diagnosis or nothing, ‘[...]’ basically she just left to erm, right, basically just left to erm…*
>
> Amanda (Parent)

Amanda’s comment about children without a diagnosis also matches the view shared by Monica’s experience of a diagnosis having a significant impact on views about levels of support.

Amy describes feeling as though her son was misunderstood and negatively labelled until the family came into contact with a Black therapist. It is possible that the same ethnicity and other commonalities granted the pair the freedom to acknowledge when things went wrong and therefore allowed for the creation of a safe environment which developed into a trusting relationship.

I felt like that was always a problem with my son because he was always loud and screaming and shouting, and they just saw him as he's violent, angry Black boy. But he just needed someone who understood him, and that's all it was. That was all it took. I think if he was being seen by someone else from another minority, he would have been kicked out of CAMHS long time ago.

Amy (Parent)

Establishing a good enough alliance for feelings to be acknowledged is essential, but how much space is allowed for the negative transference (Freud, 1912b) in our work with children and families? I thought about the harshness of the language Amy used; she thought her son would have been '*kicked out of CAMHS'* if it was not for this Black therapist. The brutal rejection that this mother anticipated felt hard to digest.

Sainsbury Centre for Mental Health (1999) found that many patients from marginalised communities were not receiving culturally sensitive care (Warner et al., 2000b). *Chui et al. (2021)* describes the current system for accessing appropriate mental health treatment as inflexible and rigid. The researchers state that it requires young people to fit into services instead of services responding to their needs, causing some to fall through the gaps. They also advocate for collaboration with community organisations and service providers to be universal across boroughs, particularly in ethnically diverse areas, to reduce the inequality and injustices experienced by Black people in mental health services.

Clarke (1966) and Massiah (1982) argue that it is common in Caribbean families of lower socio-economic positioning for the home to be female-headed. The extracts highlight that there may be a lack of understanding of the traumatic impact of loss on small children. All four children lived without their fathers (one father had passed away). While I had no direct contact with any Black fathers during the study or my four-year placement at CAMHS, the voice of Black men did find its way into the study via Martin and Monica, who provided some insight into the challenges faced from a male perspective.

Lamba (2021) advised that adverse childhood events can cause stress to the body and brain, creating a state of constant high alert. The stress affects the child's mood and ability to learn, causing long-term behavioural difficulties in children from the Black community. Chui et al. (2021) advocate for implicit bias training to ensure that clinicians and professionals do not overlook or misinterpret certain behaviours in some ethnic groups, which may be the hallmark of mental health problems. Such findings may be the foundation for increased exclusions from educational establishments.

The challenges of managing a child with complex needs

Angela and Alison re-engaged their children in education following successful treatment. Amy’s son remained out of education and has not accessed any learning for more than two years. While Amanda’s daughter accessed a home-schooling programme set up by a community of Black mothers ‘*feeling let down by the system.’*

> *[my son] would cry quite a lot, and he wasn’t sleeping, and even now, the only way that he is able to sleep now is that he is given sleeping aids, he would wake and say he was afraid.*
>
> *Angela (parent)*

She started to have separation anxiety, urm biting her lip. Urm, she doesn't like big groups she does not like noise. I feel like there is not much support outside for mental health. I think there's not enough support outside, '[...]' kind of left to do our own thing. They don't support our mental health outside.

Amanda (parent)

He has not been to school since for the whole of the pandemic and feel like there is no support with home-schooling. I have to figure it out myself. He's had loads of struggles. He's never been in school for the full time. He's struggled with relationships, it's just that no one gets him. He just unravelled his behaviour was so bad it was so hard to go to the meetings and see someone cause he was screaming the whole time, so it took about three years for him to adjust to someone to get some form of help and to get a diagnosis which was urm Autism and then '[…]' was diagnosed with ADHD.

Amy (parent)

My son was suffering from low mood and anxiety and all these, you know, and he started school, refusal…

Alison (parent)

Amanda comments on the positive experience of the community home-school group. Cooper et al. (2013) suggest that Voluntary Community Services (VCS) may fill a gap in statutory and educational service provisions. Mind (2013) argue that VCS play an essential role in meeting client groups' needs, often under-represented in talking therapies. Chui et al. (2021) also promote healthcare professionals utilising culturally appropriate community networks to increase mental health awareness and develop partnerships. Despite lengthy waiting times, these mothers' persistent and proactive nature saw them successfully access talking therapies. Three of the four accessed long-term psychotherapy, and one had a shorter group therapy experience.

Children made progress after treatment

The mothers in this study demonstrated their commitment to getting help; they were determined to ensure their children’s needs were met. Barnes (2011) who wrote the foreword, stated that Dr Arnold’s book encapsulated the resilience of the Black community surviving against terrible odds. The author highlights the importance of attachment and commitment of family members to one another for good mental health and a sense of identity.

I mean, the last two years has been a brilliant transformation, he is coping, he hasn’t got low mood now, he is going out now, he’s going out, he’s going to [school].

Alison (parent)

Urm, but over time, the help, and the support that I have received from CAMHS has been really positive, and I am really pleased with where things are at right now. It's been, the outcome has been very positive, so going from where, the starting point of really suffering and being in situation where things were really confusing and challenging, erm, I've come to the point where all the support that I have had from CAMHS '[...]' I am very pleased…

….The turning point for me has been working with '[...]' It's from THAT point onwards that I have seen clear progress, erm, as opposed to when I was going to '[...]'; there's been an improvement; I hope and am confident that things will continue to improve with '[…]'. And it is clearly since '[...]' intervened, the outcome altogether has been very positive.

Angela (parent)

The counselling has been helping her like she is able to process things quicker. '[...]' she trusts CAMHS, and she has a good relationship with her psychotherapist. So, I think that is a positive because she trusts and likes CAMHS.

Amanda (parent)

While the families acknowledged that their children still required support, it was encouraging to hear that they were assigned to clinicians who were able to make positive connections. Having said this, the successful interactions were not always consistent, and the families reported variable satisfaction with the service.

Variable service satisfaction depending on stage of access

Alison initially had a positive experience with easy entry into CAMHS; however, on their return, accessing support and navigating the service was difficult and mirrored the description of the other mothers who also found accessing CAMHS arduous. The families share a series of both positive and negative experiences in the extracts below.

> *I felt like she more understood him cause there was a point where when her manager was saying that I don't think you can see him anymore, because he was lashing out at her as well, and they did not want him to hurt her or anyone else and they were telling her to you won't be able to see him anymore. '[...]' she said I'm not going to give up on this boy, because he needs someone, he needs help so that's why I felt like she understood him, and she wanted to help him. So, she just continued, and it took years for him to get even… it was so hard for all three of us to do this, but we continued, so, yea.*
>
> *Amy (parent)*

This therapist attended patiently to the family's emotional needs while making sense of the boy's communications. Amy was grateful that the service agreed to continue supporting her son, even though they had a lengthy and challenging start. As a result, the 'triple jeopardy' (Mantovani et al., 2017) that families often face was replaced by a positive three-way partnership between parent, child, and therapist. Codjoe et al. (2021) highlight the importance of co-production and partnership working to ensure that interventions are acceptable and accessible.

The child's behaviour and responses to therapy are an important method of communication. Moylan (2009, p.20) invites us to consider that if the therapist feels frightened and threatened in the room, it is likely that the individual feels frightened and intimidated by peers, a sibling, a partner, professionals, or society.

Painful interactions with a family, including defences such as projected aggression and hatred, can cause the therapist and an organisation to lose the capacity to think. Though the experience in the room may feel unbearable at times, the patient's ability to recreate the difficulties seen in the external world in the consulting room allows the therapist to analyse the depth of the child's worries in order to begin working towards progress.

In the extract below, Amanda describes the drastic action she took to educate her daughter at home following a long period of feeling unheard and misunderstood. She describes feeling that up until this point, her concerns about her daughter were not taken seriously.

> *I think with my daughter, everyone started to take it seriously when I said that I was pulling her out of school. '[...]' that's* <u>when</u> *everyone had a meeting. She has been struggling for years, and professionals never had a meeting. But as soon as I pulled her out of school, a meeting has been arranged without me, a professional's meeting.*
>
> *Amanda (parent)*

Equipping professionals to enter the world of psychoanalysis with a fresh outlook on how to better engage Black families by offering support to those who struggle to see how their needs could be taken seriously or how they might be supported and understood is essential to seeing more families engaging with services. Professionals in the focus group spoke of daring to be flexible and open to changing the setting and altering boundaries to meet the child's needs.

Alison describes her initial experience of accessing support from CAMHS, which she says was positive.

> *…first referred because it was a bereavement; he was seen quite quickly. I thought she was excellent, there were two Black women, again (laughs) and one particular was really good, '[...]' really engaging, I felt, yea, I felt really understanding of the group of what they had been through, what they were going through. It was really good, actually. My memory of that course was very good. So that mixture of different ages… ….and I think that they were all Black that was really good that multi-generational thing as well where yeah so that was quite comforting and quite reassuring, felt like you were with your community and different ages within the community, enabled to talk and share sort of free-er you know what I mean, so that felt good and maybe because it was all Black.*
>
> *Alison (parent)*

Jensen, E. *et al.* (2021) argue that interventions considering the needs of ethnic and cultural groups can potentially improve the mental health care and experiences of service users and their families. The researchers concluded that adapting interventions to be more culturally sensitive makes it possible to enhance the care of those who typically have poor engagement with mental health services.

> *She finds it a safe place, basically, she finds it a nice place where she can say what she feels [“…”] without being judged.*
>
> *Amanda (parent)*

> *[I] think that some clinicians need training to understand other ethnicities. When I am calm, ‘[...]’ they say that is my White side, but when I get annoyed, they say oh, it’s your Black side coming out ‘[...]’ if I am emotional.*
>
> *Amanda (parent)*

> *I think navigating CAMHS is really difficult because you're sent off on one path, and you're with a team, and you know, and you get some intervention, ‘[...]’ if something comes up, you get you navigated somewhere else. He needs his treatment around his ADD to go forward. You know that is quite frustrating because that is taking some time.*
>
> *Alison (parent)*

Chui. et al. (2020) suggest that adolescents risk getting lost in the service provision gap between child and adult mental health services. They highlight language barriers, the social stigma of mental illness, the imbalance of power and authority between service users and providers, and insensitivity and discrimination towards the needs of 'ethnic minority' service users as major risk factors.

> *I harassed CAMHS for about two weeks straight […] basically I harassed the social services, CAMHS and said you're not ignoring, no one is ignoring her this time […] she needs to get help before it becomes, before it gets a lot worse.*
>
> *Amanda (parent)*

> *[second referral] it was completely the wrong thing, in terms of I was told I had to do '[...]' before I could get him assessed, but that wasn't the case. So, there was errors, so it's just delayed.*
>
> *Alison (parent)*

During the interviews, I witnessed expressions of helplessness and despair from professionals and service users as they shared their stories. I offered sympathetic nods following painful descriptions of the lived experiences and silently rejoiced when positive connections were made. However, later I considered the individual who may be less able to withstand such adverse experiences while seeking help. The process of getting help for professionals and service users suggests that both groups require a degree of containment (Bion, 1962) in their pursuit to aid and receive support.

SUMMARY OF FINDINGS

Main findings

The findings of this study must be considered via a systemic lens. The study confirmed an underrepresentation of Black children and families accessing CAMHS and suggests that a contributing factor to the lack of early intervention is rooted in a failure to identify needs and then refer families to services due to unconscious bias, misunderstanding communications of distress and cultural needs. These missed opportunities may be the cause of the overrepresentation of Black people accessing services at crisis point and involuntary stages of mental health support.

The Thematic Reflexive Analysis revealed that despite experiences of great distress and difficulties in accessing the service and receiving treatment, the mothers expressed their determination to get help, regardless of how long it took, which challenges the notion that suggests members of the Black community do not seek help or engage with services. These mothers made a personal commitment and invested in their child’s well-being by committing to the therapeutic treatment.

This research makes a significant contribution to ongoing discussions about mental health disparities. While there is a national agenda to consider outcomes with significant research on Black mental health focused on referral data and access, which became more widely available post the murder of George Floyd and the Covid-19 pandemic, this study fills a gap in modern research by considering the barriers to accessing mental health services from the outset by creating a space for professionals to share their lived experience of working with members of the Black community.

The literature search highlighted the paucity of studies exploring the views of professionals, however, this research draws attention to the possible enactments (Fanon, 1959; Jacobs, 1986) that take place when interacting with Black children and families. Often professionals are seen as ‘the expert’ leaving the detail of their interactions, thought process and what they bring to the dynamic, overlooked, unresearched and not considered with the same level of importance. By considering their perspective of working with this community and the impact of adverse lived experiences on the mental health of service users and professionals this research demonstrates that professionals are not exempt from the impact of systemic racism and disjointed structures, irrespective of their race and level of professionalism and expertise.

Systemic Racism

The research evidenced that systemic challenges cannot be overcome by well-meaningness. The stark differences in the referral pathways for children and families exposes the illusion of inclusivity and highlights how racism which is deeply embedded in systemic structures must be taken seriously. It is harmful; and though unconscious, at times, it cannot be excused. By holding these points in mind when supporting members of the Black community we can begin working towards eliminating mistrust and fear and aiding successful service engagement.

> *To support families, we must develop a willingness to acknowledge the realities of privilege, prejudice, discrimination, and internal racism (Davids, 2011).*

As the interviews proceeded the impact of prejudice and discrimination became more apparent as parents reported their distress. The cries of the mother and child could not be heard, struggles denied followed by reports of a lack of compassion and failure to recognise both physical and mental health needs. The reoccurring narrative that families should be ‘satisfied and grateful’ with the ‘*offer*’ without complaint can be experienced as an attack on one’s dignity. The painful reality of approaching professionals and making calls multiple times a day in an attempt to access support can leave parents feeling hopeless and powerless and as a result the parents in this study attested to the cultural insensitivity described by Lowe (2020).

The young people in Dame de Souza’s survey (2022) reported racism as a barrier to their achievement. Black children who are stopped and searched in the community or excluded from the school community will experience this as rejection and a lack of a sense of belonging. Three out of the four children in this study began to refuse education, it is possible that the outside world had begun to feel unsafe.

Implicit racism and subtle assumptions can operate unconsciously, highlighting these racist connotations and microaggressions are likely to be painfully exposing and will require a sensitive approach (Davids, 2011). One of the mother’s described her son’s presentation at the start of therapy – this was his way of communicating his distress. However, his emotional well-being became secondary and the ‘safety’ of his therapist was presented as a reason to withdraw services. The mother reported how grateful she was that her son’s Black therapist did not ‘give up’ on her child.

During the analysis of the findings it transpired that fear of the unknown often caused the professional to reject the child and family and at times families to reject the professional. However, once the families and professional became known to one another, progress was made. Though the families described experiences of discrimination and racism that were blatant and persistent in some cases; which is likely to significantly affect one's mental health (Arnold, 2011), the reported positive outcomes suggest that the families benefited from continuity and containment that long-term individual psychotherapy, group and parent work offers. This suggests that psychoanalytic psychotherapy as a mode of treatment should be more widely considered with this client group.

In 2020 NHS England launched its first ever pilot anti-racism framework: The Patient and Carer Race Equality Framework (PCREF)[33]. The ground-breaking mandatory framework was designed to support Trusts and providers on their journey to becoming actively anti-racist, by ensuring that they are responsible for co-producing and implementing concrete actions to reduce racial inequalities within services.

By examining the experiences of service users and professionals, this study aligns with the framework which aims to ensure that individuals and communities are at the heart of the design and implementation of the services they need.

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[33] NHS England » Patient and carer race equality framework

Using Psychoanalytic concepts to summarise the findings

The following concepts were selected based on the profound reoccurrence in every aspect of the entire research process.

Resistance (Freud, 1926): the intensity of resistance, that was highlighted was palpable in the virtual interviewing room and mirrored much of my own research journey; from the initial proposal, to ethics, to securing professional and service user participation, through to final consent and engagement. The professionals shared the resistance they experienced when attempting to collaborate between services, combatted by the resistance they experienced from the parents they attempted to engage. Similarly, the service users spoke of the resistance they experienced from professionals and members of their own communities who verbalised their reluctance to support their pursuit of therapeutic support.

Splitting and Projective Identification (Klein, 1946, 1955): this defence has the ability to close down thinking, causing professionals to deny what they bring to the dynamic, hold onto the title of a ‘considerate carer’ while risking the oversimplification of highly complex matters. It is important that we do not underestimate how challenging understanding ‘difference’ can be. The intensity of interactions can be so overwhelming that professionals split off the painful aspects of themselves and project them into the 'other', the ‘stubborn’ father who would not accept assistance from the school or the mother who was reported as ‘aggressive’ on every file and could not be helped. While professionals keep themselves ‘good’ and leave the families to bear all the pain and distress, it can be hard to offer, or be open to receive help and support when ongoing unconscious processes remain unaddressed.

Services can mitigate against settings becoming unsafe and detrimental to the health of Black service users, by creating safe spaces for staff to continuously assess their approach and reflect on decision making and outcomes.

Containment (Bion, 1967): is essential for the positive well-being and functionality of individuals at all levels. The study revealed, real living examples of families feeling isolated and lonely while attempting to manage their child's complex needs and seek help. With many experiences too painful to digest; rather than 'take in' and ‘giveback’ to families an understanding of their worries in a digestible way, what is stirred by the child or parent’s presentation, is at risk of being evacuated. The network loses the ability to think, make and maintain links to contain the family and they become at risk of rejection or disengagement.

The study however did reveal that when professionals felt safe and contained by the system a good therapeutic alliance was formed and they were better able to facilitate a more effective approach and service users began to feel seen, heard and better able to engage and access the service. Likewise, when I was supported and contained by my supervisors and colleagues I felt better able to continue with the research process despite the challenges I faced.

RESEARCH REFLECTIONS

Limitations of the study

According to Iflaifel (2023) distrust of services and research can contribute to a lack of diversity amongst participants, which threatens the generalisability of knowledge and findings.

The small-scale qualitative study conducted with eight participants all working with the same service included parents, (service user participants) identified by clinicians who also worked in the same team, therefore they were already filtered through the lens of ‘another’ from a particular discipline, this recruitment process of a (semi) self-selected group of participants meant that I had no access to those who had less positive outcomes, disengaged or chose not to engage with the service from the outset.

Phase 1 of the study revealed the need for more robust data collection and control processes. Missing information from systems could only be noted and highlighted as an area for development within the service, making it hard to complete a comprehensive analysis of service user referrals and engagement with support.

While the already established working relationships I had at all levels seemed to support the recruitment, I believe the varying degrees of familiarity I had with the participants is likely to have had an impact on the interview experience. However, without having a control group it would be hard to predict the impact but certainly is noteworthy. I had worked directly with one parent and one professional; two professionals knew ‘of’ me, while the final professional and three other parents were completely unknown. The limited access to potential participants made it difficult to control the familiarity variable, widen access and be selective about who to accept if I was going to recruit a viable number for the study.

The absence of male service user participants and the direct participation of the children who accessed the therapy are also in my opinion limitations to a greater depth of understanding of the lived experience of accessing support for the Black community.

Conducting qualitative research is time consuming with limited reach, which can have an impact on how the findings can be perceived in terms of policy shaping in comparison to quantitative research that is driven by statistical data.

Critics may question how representative can the experiences of this small group be of Children and Adolescent Mental Health Services across London and the UK. However it is my view that despite the above limitations the findings are valid and reliable, as a significant number of interview responses were substantiated by participants in the alternative parent or professional group and further supported by findings from previous research studies referenced in the literature review.

Implication for further research and recommendations to be considered:

The system is responsible to provide better care. The NHS long-term plan[34] aims to reduce health inequalities, create a comprehensive mental health offer for children and young people from birth to age 25, and plans to redesign core community mental health services by 2023/24.

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[34] https://www.england.nhs.uk/long-term-plan/

Can the system reimagine what it would mean to eliminate inequality and foster equity by levelling the playing field? How can we create an accessible and sustainable service for all?

1. **Through commitment**: by creating a workforce that remains curious we are likely to offer improved care and outcomes beyond tokenism and through the development of culturally competent and sensitive staff members irrespective of their backgrounds through regular reflective practice. To conflict and mistrust where the system becomes defensive, this practice must be integrated into teaching, training and supervision of all professionals working to support children and families.
2. **Through representation**: I am often cast into a nurse or social worker role in network meetings. There is an overrepresentation of Black women in these professions. The mental health profession would benefit from an increase in the number of Black and GM people in senior practitioner roles, particularly in Psychotherapy and front-line roles receiving and assessing referrals in CAMHS.
3. Further recommendations for improvement by the focus group participants in this study can be found in Appendix Q.

In anticipation of a larger group of researchers and budget, the study could be improved by:

- An increased sample size of parents to further explore the cultural differences within the Black community

- An attempt to consider the role an absent father plays in the mental health difficulties of children of African descent. To include fathers where possible to hear their view on parenting a child with additional needs and seeking professional support.
- To create an opportunity to think with the mothers about what it means to raise their children and ‘battle’ the system alone. I would be interested to know more about their own experiences of being parented and attachments.
- An increased sample size of professionals (particularly men), GPs, and faith/community group leaders
- To extend the interview questions for professionals to consider bias or unconscious organisational dynamics at play that may have impacted their approach to supporting families
- Directly obtaining the child’s view on accessing CAMHS.
- Exploring the impact of the pandemic on mental health. What effect did it have on their care and support? Were *these* Black families more adversely affected? (Mind 2020)
- To interview families where referrals have been rejected, or the family have declined the offer of support. To establish whether the reasons behind the lack of engagement corroborate with suggestions made by other researchers and those highlighted by professionals and parents within this study.
- To consider interviewing other communities, such as Asian and White families, to compare their experiences accessing CAMHS.

- Conduct a follow-up session with participants to consider the impact of the focus group on their practice, approach, or view of the service and think with them about what motivated their initial participation in the study.

CONCLUSION

I felt privileged to provide a safe space and a voice to the self-selected group of experts by experience. The focus group provided a reflective space and a shared learning experience, with a therapeutic quality as participants valued being listened to. While we acknowledge areas for improvement, it is also important to hold on to positive experiences described by the professionals and parents during this study. Particularly during more challenging moments as we strive to make services more inclusive.

I returned to research for the first time since my undergraduate studies almost 20 years prior to the time of writing this thesis. It was daunting; there were moments of confident spurts of enthusiasm to write, but many more periods of disengagement where I chose to focus on the clinical work that now felt more familiar. I soon became aware that the researcher role demanded different knowledge and skills to the work of my day job within CAMHS or even my role as a student. The time came when I would move away from dutifully reading the course material and I would begin to actively research my subject of interest. I could not rely on historical reading to ‘do the job’, nor could I assume I already knew all there was to know.

I had already adopted a habit of reading a book a week; although this was for pleasure and personal growth, the year-long habit had increased my appetite to learn and digest new information. By re-reading papers from much earlier in the course, I now better understand clinical concepts. Reading, The Unconscious at Work (2019) excited me as I considered how I would work with my newfound awareness of the self in relation to organisational dynamics. However, there were still moments when fear or anxiety about completing my thesis created writing paralysis (Braun & Clarke, 2013). I was relieved to read literature that could help me understand my experience in these moments of despair.

Sharing my Podcast style Poster Presentation in a team meeting allowed me to let my organisation know that I had transitioned from practitioner to practitioner–researcher (Taylor & Hicks, 2009). The promotion of my research within my service and at the ACP conference in 2022 was designed to evoke thought and initiate discussions around race, class, and culture in relation to mental health services, which I recognise can often feel like a no-go area. Some received the presentation well, with one Black professional enquiring about gaining access to watch it again to better digest all the information. Another colleague commented on how professional it was visually and audibly. Most attendees appeared visibly uncomfortable on the screen. I wondered whether it felt safer to compliment my creativity, rather than make direct contact with the subject matter?

In conclusion, I believe that very few individuals would be committed to persevering to overcome the barriers these mothers faced to access support. Due to historical traumas and negative experiences, most families from the Black community work hard to avoid the internal and external judge of their difficulties. Therefore, they are likely to disengage at the first barrier, which can be erected by the self, internally or by others externally. Many families are also unlikely to be aware of services available, the self-referral options or have access to private mental health care. Therefore, they are reliant on a professional to recognise their need and make a referral in the hope of accessing a service in a safe and conducive environment, in order to progress.

Through culturally sensitive, competence training, community group collaborations and repeated positive experiences from the point of referral to treatment; I hope this study encourages more people to get involved in research to better understand the lived experience of Black children and families and the professionals who work with them. As a result, I hope to see more Black children and families entering consulting rooms and accessing the help and support they need.

A message of hope
Speak up for those who cannot speak for themselves, for the rights of all who are destitute
Proverbs 31:8

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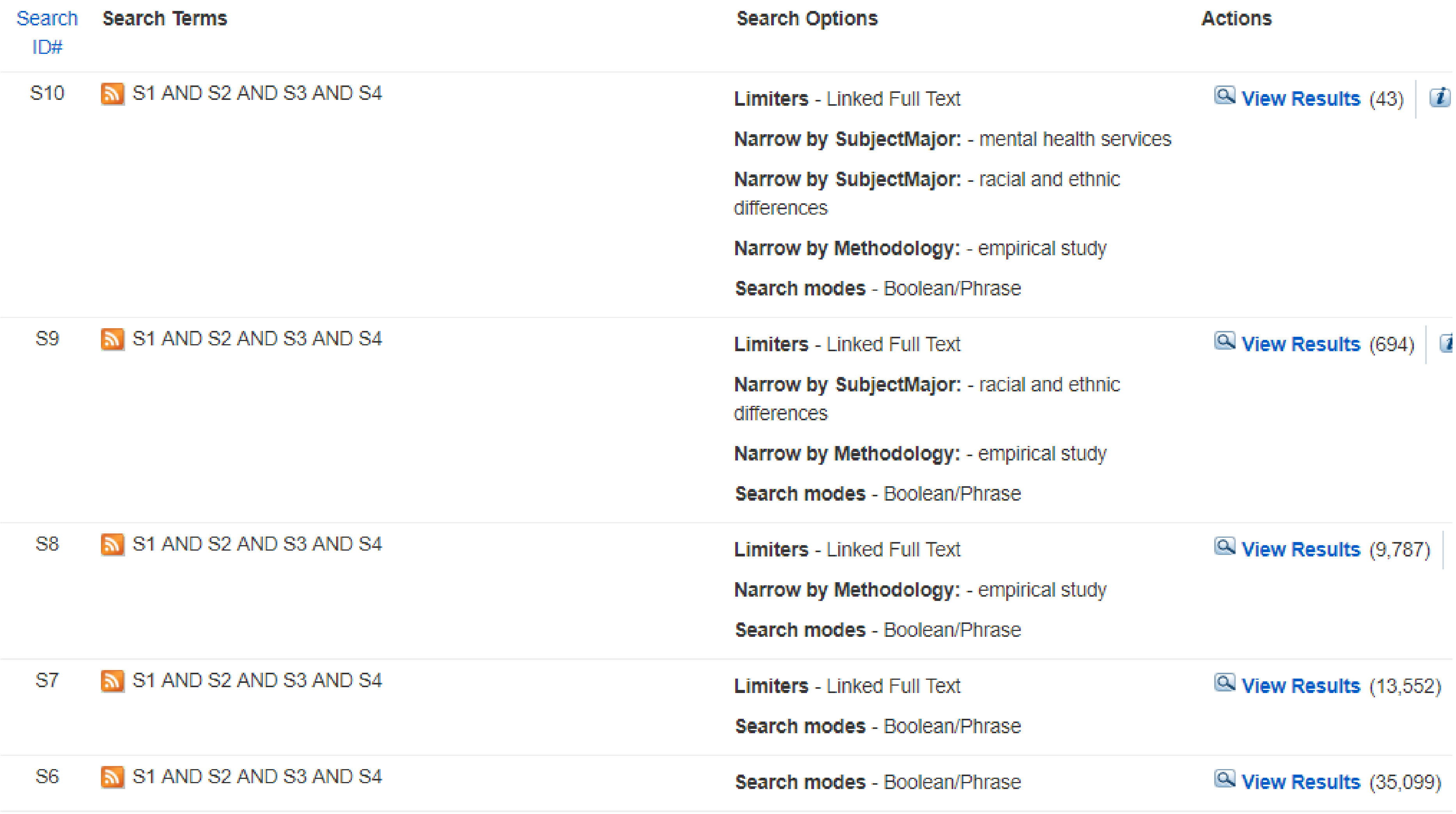
APPENDICES

LIST OF FIGURES

APPENDIX LIST

Appendix A



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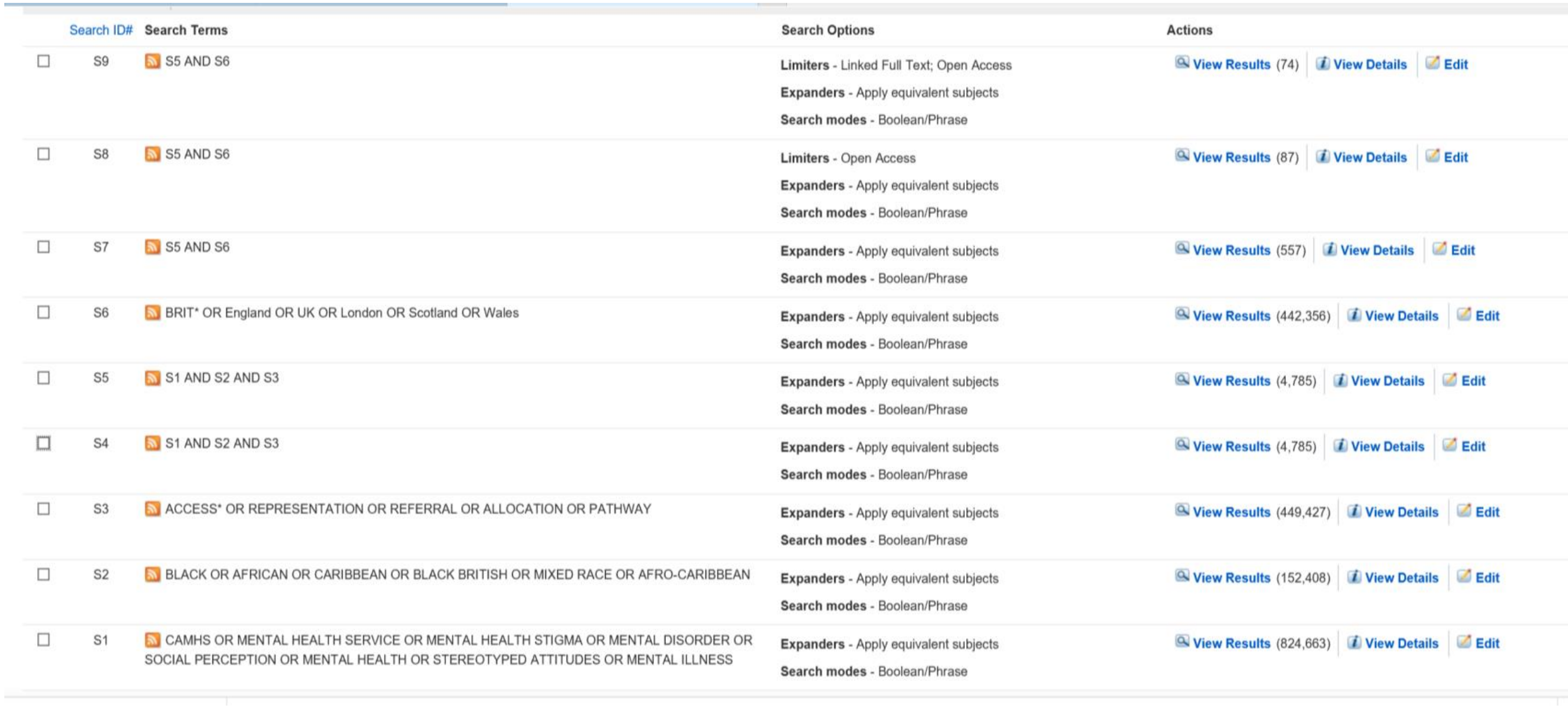
S10	S1 AND S2 AND S3 AND S4	**Limiters** - Linked Full Text **Narrow by SubjectMajor:** - mental health services **Narrow by SubjectMajor:** - racial and ethnic differences **Narrow by Methodology:** - empirical study **Search modes** - Boolean/Phrase	**View Results** (43)
S9	S1 AND S2 AND S3 AND S4	**Limiters** - Linked Full Text **Narrow by SubjectMajor:** - racial and ethnic differences **Narrow by Methodology:** - empirical study **Search modes** - Boolean/Phrase	**View Results** (694)
S8	S1 AND S2 AND S3 AND S4	**Limiters** - Linked Full Text **Narrow by Methodology:** - empirical study **Search modes** - Boolean/Phrase	**View Results** (9,787)
S7	S1 AND S2 AND S3 AND S4	**Limiters** - Linked Full Text **Search modes** - Boolean/Phrase	**View Results** (13,552)
S6	S1 AND S2 AND S3 AND S4	**Search modes** - Boolean/Phrase	**View Results** (35,099)

Appendix B



	Search ID#	Search Terms	Search Options	Actions
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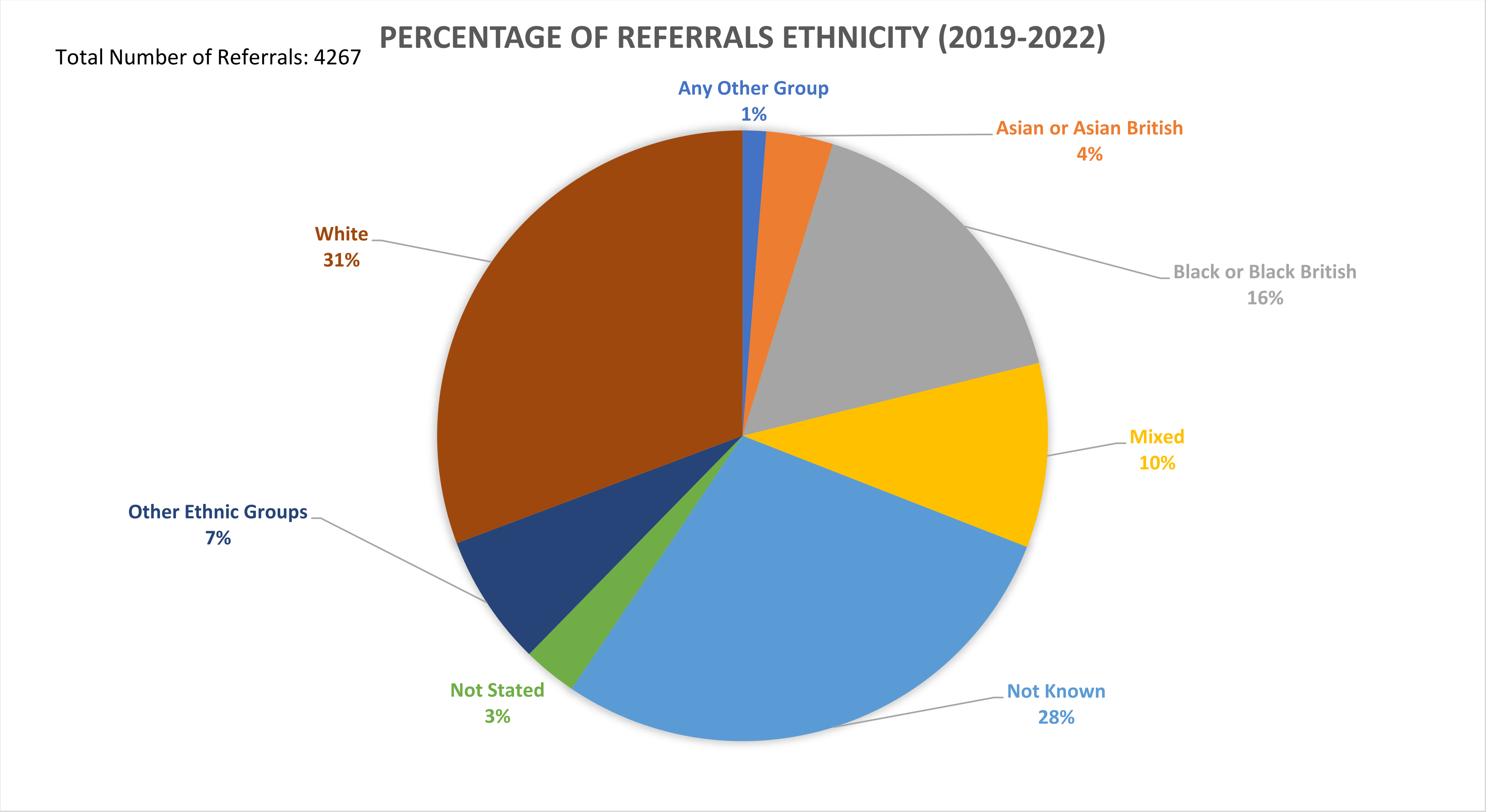
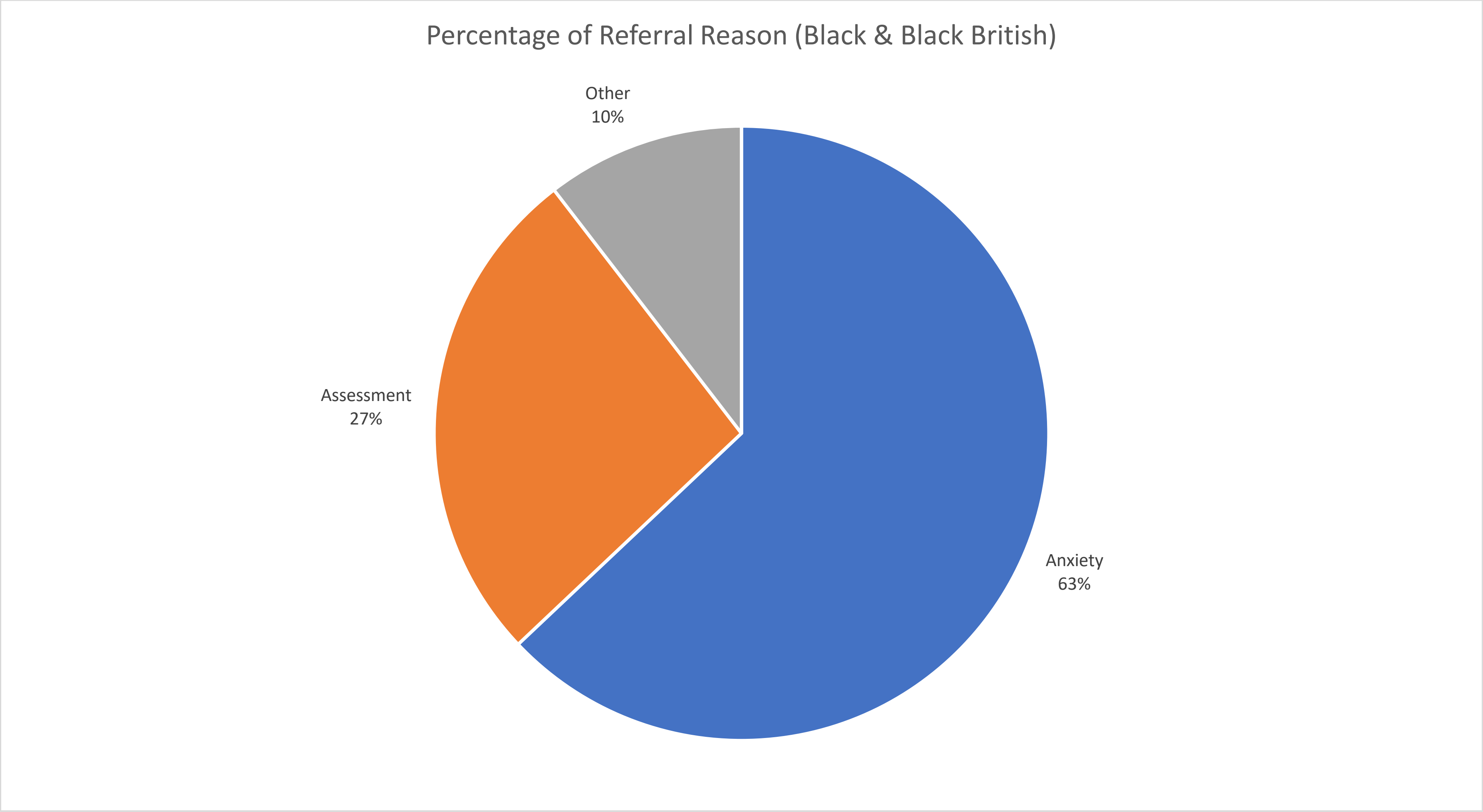
☐	S8	S5 AND S6	**Limiters** - Open Access **Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (87) | View Details | Edit
☐	S7	S5 AND S6	**Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (557) | View Details | Edit
☐	S6	BRIT* OR England OR UK OR London OR Scotland OR Wales	**Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (442,356) | View Details | Edit
☐	S5	S1 AND S2 AND S3	**Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (4,785) | View Details | Edit
☐	S4	S1 AND S2 AND S3	**Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (4,785) | View Details | Edit
☐	S3	ACCESS* OR REPRESENTATION OR REFERRAL OR ALLOCATION OR PATHWAY	**Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (449,427) | View Details | Edit
☐	S2	BLACK OR AFRICAN OR CARIBBEAN OR BLACK BRITISH OR MIXED RACE OR AFRO-CARIBBEAN	**Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (152,408) | View Details | Edit
☐	S1	CAMHS OR MENTAL HEALTH SERVICE OR MENTAL HEALTH STIGMA OR MENTAL DISORDER OR SOCIAL PERCEPTION OR MENTAL HEALTH OR STEREOTYPED ATTITUDES OR MENTAL ILLNESS	**Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (824,663) | View Details | Edit

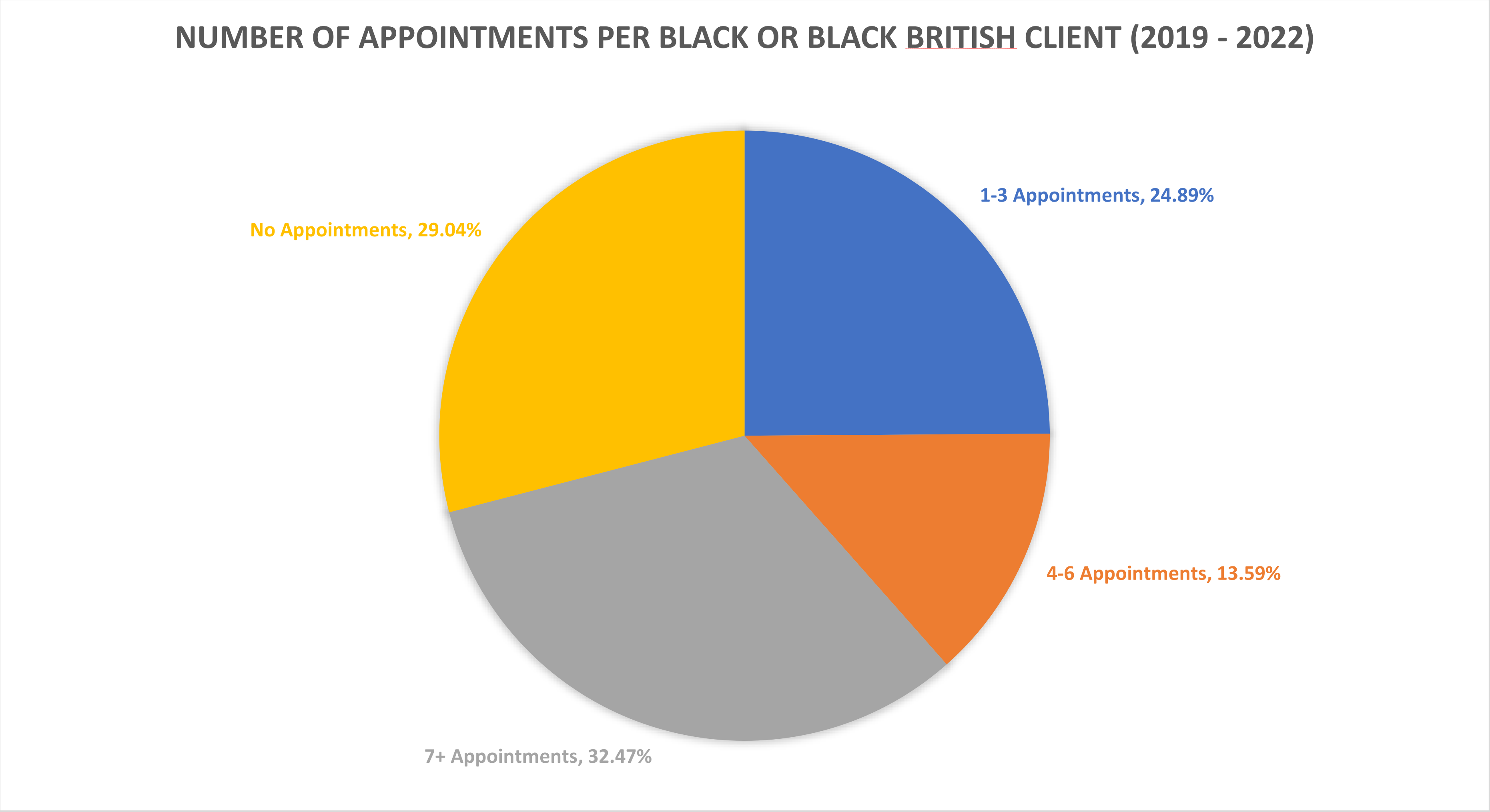
Appendix C


PERCENTAGE OF REFERRALS ETHNICITY (2019-2022)
Total Number of Referrals: 4267
Any Other Group
1%
Asian or Asian British
4%
Black or Black British
16%
Mixed
10%
Not Known
28%
Not Stated
3%
Other Ethnic Groups
7%
White
31%

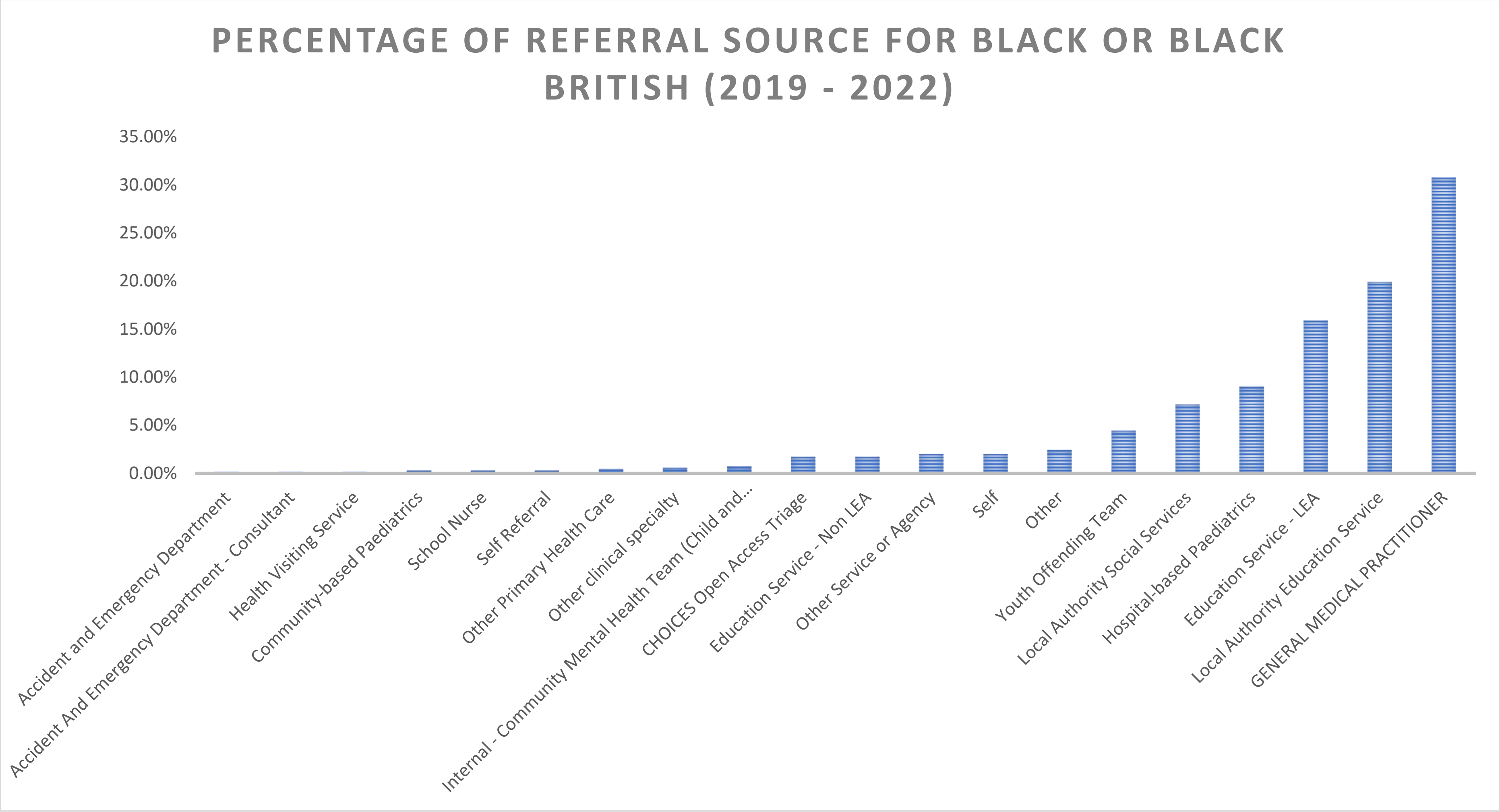
Appendix D


Percentage of Referral Reason (Black & Black British)
Other
10%
Assessment
27%
Anxiety
63%

Appendix E


NUMBER OF APPOINTMENTS PER BLACK OR BLACK BRITISH CLIENT (2019 - 2022)
1-3 Appointments, 24.89%
No Appointments, 29.04%
4-6 Appointments, 13.59%
7+ Appointments, 32.47%

Appendix F


PERCENTAGE OF REFERRAL SOURCE FOR BLACK OR BLACK BRITISH (2019 - 2022)
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Accident and Emergency Department
Accident And Emergency Department - Consultant
Health Visiting Service
Community-based Paediatrics
School Nurse
Self Referral
Other Primary Health Care
Other clinical specialty
Internal - Community Mental Health Team (Child and...
CHOICES Open Access Triage
Education Service - Non LEA
Other Service or Agency
Self
Other
Youth Offending Team
Local Authority Social Services
Hospital-based Paediatrics
Education Service - LEA
Local Authority Education Service
GENERAL MEDICAL PRACTITIONER

APPENDIX G

The Tavistock and Portman
NHS Foundation Trust

Research title:

How do we understand the underrepresentation of Black African / Caribbean children and families in CAMHS? A qualitative research with professionals and service users.

Interview schedule for Professionals:

Below is the schedule for the professional and service user focus groups. There will be three main questions followed by prompts where necessary to help develop responses and the interaction in each group.

The interview:

Thank participants for agreeing to take part in the focus group, remind participants about the length of the interview and to only share what they feel comfortable in sharing. Explain that each group will maintain the confidentiality of all matters discussed unless there are safeguarding concerns.

The notion:

Research shows that there is an underrepresentation of Black children and families accessing Children and Adolescent Mental Health Services. What are your thoughts about this?

Questions for Professionals

1) In the context of mental health needs, to what extent do you think that there is a difference between how the behaviour of Black children is understood in comparison to White or other ethnic group children?

2) Members of the Black community are often referred to as 'hard to reach.'

   In your experience do you think that there are any particular difficulties for Black families when it comes to engaging with additional support offered by Social Care, Education and CAMHS?

3) Based on your own experience or personal opinion, how do you think we can improve engagement of Black families in longer term interventions (e.g. psychotherapy?)

   Prompt questions:
   - Are you aware of families who have been referred talking therapies

- Can you share any success stories of Black families engaging with CAMHS

Research title:

How do we understand the underrepresentation of Black African / Caribbean children and families in CAMHS? A qualitative research with professionals and service users.

Interview schedule for Service Users:

Below is the schedule for the service user focus groups. There will be three main questions followed by prompts where necessary to help develop responses and the interaction in each group.

The interview:

- Thank you for agreeing to take part in the interview
- The interview will last 1 hour and 30 minutes
- Only share what you feel comfortable in sharing
- The group will maintain the confidentiality of all matters discussed unless there are safeguarding concerns.
- The audio will be recorded and then transcribed for the research and then deleted as soon as possible
- Consent confirmed

The notion:

Research shows that there is an underrepresentation of Black children and families accessing Children and Adolescent Mental Health Services. What are your thoughts about this?

Questions:

1) Can you tell me about your experience of accessing and engaging with CAMHS

   Prompt questions:
   - What led you to CAMHS?
   - How long have you been accessing CAMHS?
   - Have you or a family member received a diagnosis of any kind following a CAMHS assessment?
   - Have you or a family member been prescribed medication following an assessment?
   - Did you or your family member receive a talking therapy intervention of any kind?
   - What did you find most difficult or challenging?
   - What did you find most helpful?

2) In your opinion is there a stigma within the Black community attached to seeking professional help for yourself or your children?

3) How could CAMHS staff and the service increase the number of Black families accessing mental health services?

Appendix H

Data Protection Impact Assessment (DPIA) Questionnaire

Introduction

It is a requirement of the General Data Protection Regulations (GDPR) that all systems and Projects requiring use of personal identifiable data have a DPIA conducted. A DPIA is required for any processing that is **likely to result in a high risk** to individuals.
This will also include any Project or systems of data processing that may not require use of identifiable data but includes the involvement and use of Business / Corporate sensitive information.

Completion of a **full** DPIA may not apply in all cases, but it is **mandatory** that the screening questions are completed to identify why a full DPIA may not be required.

If you are assessing or using a system and it does not have a DPIA, including one that identifies that a full DPIA is not required, please complete the relevant section of this questionnaire.

The questionnaire will be reviewed by the stakeholders and the Trust Information Governance Manager, recommendation from the questionnaire will be notified to the relevant Director who is the Information Asset Owner.

The questionnaire will be signed off by the relevant delegated Lead.

Document revision history

Date	Version	Revision	Comment	Author
2019	1	Final Template	Template	IG Lead /DPO
July 2020	2.0		Document review and update with GDPR components.	IG Manager / DPO

Document Approval

Date	**Version**	**Revision**	**Role of approver**	**Approver**
2019	1	Final Template	Information Governance Group (IGG)	IGG
August 2020	2	Document review and update with GDPR components	Information Governance Group (IGG)	IGG

Project / Stakeholders Information

Project / Initiative Manager Details	
Project Manager Name	KENISHA JACKSON
Job Title	CHILD AND ADOLESCENT PSYCHOTHERAPIST IN DOCTORAL TRAINING
Location	xxxxxx
Telephone number	xxxxxx
Email address	Kenisha.jackson@xxxxx
Team Name	Xxxxxx xxxxxxx
Directorate	CHILDREN AND FAMILIES
Information Asset Owner (Director / Head of department)	xxxxx Service Manager

Other Stakeholders details	
Name	xxxxx
Organisation	TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
Contact detail	Head of Academic Governance and Quality Assurance academicquality@tavi-port.nhs.uk

About the Project / Initiative	
Project or Initiative Name	**How do we understand the underrepresentation of Black African/Caribbean Children and Families accessing CAMHS**
In brief, what is the purpose of the project / initiative.	**I will conduct two focus groups with professionals and service users to evaluate the above**
How is the processing of information necessary to that work?	**In terms of audio recording some names may be mentioned. However, I intend to transcribe the recordings as anonymised information and the recording will then be destroyed.**
What is the expected outcome?	**To better understand experiences of service users**

Timeframe for Project / Initiative			
When is it due to begin? If it's time limited, please note the expected end/review date.	**Summer 2021 – Summer 2022**		
Nature of Information (Please indicate Yes or NO) *Anonymous information is data or information relating to an individual which has been rendered anonymous in such a manner that the data subject cannot be identified.*			
Will all of the information be truly anonymised information? Anonymised data must meet the ICO code of practice. (page17)		NO	
Will the information be new information as opposed to using existing information in a different way? (please explain)	NO		

Key Contacts Details	
Who are the key stakeholders?	xxxxxxx Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

Date	**21.7.2021**

DPIA - Screening Questions (answer Yes or No)

Will the project involve collecting of information about individuals?	YES
Does the project or initiative introduce new or additional information technologies that can significantly reveal business sensitive information? That can have specific high impact on the business, whether within a single function or across the whole business?	NO
Will information about individuals involve using information in a way it is not currently used.	YES
Will the project compel individuals to provide information about themselves?	NO
Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	NO
Are you using **personal or special category (sensitive) data** about individuals for a new purpose or in a new way that it is not currently used (is it different from existing use)?	YES
Does the project involve you using new technology which might be Perceived as being privacy intrusive? For example the use of or for biometrics or facial recognition or to make an automated decision about care.	NO
Will the project result in you making decisions or taking actions about individuals in ways which may have a significant impact on them? For example Service planning or Commissioning of new services.	NO
Will you be contacting individuals in a way that they might find intrusive?	NO
Are the individuals concerned vulnerable?	NO (REFERRED TO RESEARCH FROM CURRENT CASEHOLDERS - PARENTS OF PATIENTS – MITIGATION PLAN IN PLACE FOR APPROPRIATE SUPPORT)
Is the information about individuals of a kind, particularly likely to raise Privacy concerns or expectations? For example, health records, criminal records or other information that people would consider to be particularly sensitive.	NO

Will the project result in you making decisions about individuals in ways which may have a significant impact on identifiable individuals? I.e. does the project change the delivery of direct care? **N.B.** If the project is using anonymised/pseudonymised data **only**, the response to this question is "**No**".	NO
Does the project involve multiple organisations, whether they are public sector agencies accessing **personal data/special category data** i.e. joined up government initiatives or private sector organisations e.g. outsourced service providers or business partners?	NO
Does the project involve new or significantly changed handling of a considerable amount of **personal data/special category data** about each individual?	NO
Will the project involve new or significantly changed consolidation, inter-linking, cross referencing or matching of personal data/special category data from multiple sources?	NO

If any of the above questions end up with a "Yes" response, you must proceed with completions of the **full** a Data Protection Impact Assessment (DPIA) Questionnaire on the following pages.

If the response to **all** the questions are **"NO" you do not** need to complete the full DPIA. Please return the document to the Information Governance Team.

Email the completed DPIA document is all cases to XXXXXinformation.governance@XXXXX

Data Protection Impact Assessment (DPIA)

- **Complete if any of the screening questions were answered "yes"**
- **Attach any project documentation, where relevant and forward to the Data Protection Officer via** XXXXXXinformation.governance@XXXXX

1. Identify the need for a DPIA

Explain broadly what the project aims to achieve and what type of processing it involves. You may find it helpful to refer or link to other documents, such as the project proposal. Summarise why you identified the need for a DPIA.
In this study I will summarise a recent audit of referrals into our London based CAMHS clinic to establish the number of referrals received for Black African / Caribbean children and families. The audit will determine of the total number, how many attend initial appointments for assessments and engage in treatment. In comparison to how many families reject involvement, either at assessment stage or during treatment - resulting in discharge. In the second phase of the study I plan to develop an understanding of the experience of professionals referring and engaging Black African / Caribbean children and families in Children and Adolescent Mental Health Services. In keeping with the popular psychotherapy concept of work discussion groups, where varied levels of professionals learn from each other whilst exploring significant events in the workplace. I plan to set up two focus groups to include four professionals: two CAMHS clinicians, one Social Care Worker and one Teacher. Two further focus groups will meet with two times four service users referred to CAMHS from the Black African / Caribbean community.

2. Consultation Process

Consider how to consult with relevant stakeholders: describe when and how you will seek individuals' views – or justify why it's not appropriate to do so. Who else do you need to involve within your organisations? Do you need to ask your processors to assist? Do you plan to consult information security experts, or any other experts?
Two small focus groups will facilitate and encourage participation in a way that one large group may not. Participants will be recruited by approaching current service users via assigned clinicians, including those referred to the service within the last 5 years. Participants will be invited to get involved on a no obligation voluntary basis. Eligible participants who decline the invitation to get involved will be reassured that this will have no impact on ongoing or future CAMHS intervention and support. Professionals will be recruited following an email advertisement internally for CAMHS clinicians, Social Care teams in the borough and local primary and secondary schools already making referrals and engaging with our services. Interested participants will be selected using the Purposive Sampling method based on responses.

3. Identify the Controllers and Processors

Are multiple organisations involved in processing the data? *If yes, list below and clearly identify their role.*		No
Name of Organisation	Controller or Processor?	Completed and compliant with the DSP Toolkit[35]
		Yes/No
XXXXXX	XXXXX	YES

Controller' means alone or jointly with others, the organisation that determines the purposes and means of the processing of personal data – for example, this is the case where an organisation is obliged by law to carry out a specific function– for example, the Trust is always a Controller.

'Processor' means alone or jointly with others, the organisation is processing personal data under the instruction of a Controller and **does not** determine the purposes and means of the processing of personal data

The Data Security and Protection Toolkit is a self-assessment tool provided by NHS Digital to assess compliance to the 10 National Data Guardian Security Standards.

Has a data flow mapping exercise been undertaken? *If yes, please provide a copy, if no, please ensure this is completed – speak to the IG Team for guidance* Flow Chart .docx		YES

Is Mandatory Staff Training in place for the following?	Yes/No	Dates
• Data Collection:	YES	13.08.2021
• Use of the System or Service:	No	
• Collecting Consent:	No	
• Information Governance:	No	

4. Description of the processing and Information (Data)

Describe the scope of the processing	
What is the nature of the data?	As detailed above
Does it include special category or criminal offence data? How often will this be?	No
How long will you keep it for?	1-2 years (Consent forms Transcribed data)
How many individuals are affected?	Up to 8 service users and 4 staff

What geographical area does it cover?	London

Use of personal information				
Why would it not be possible to do without personal data?	All data will be anonymised. I will need personal contact details to begin with to contact families and staff.			
Please confirm that you will be using only the minimum amount of personal data that is necessary.	I confirm that personal details will be recorded only at point of consent and minimum personal details will be used.			
Would it be possible for the Controller/s to use pseudonymised data for any element of the processing?	YES	☒	NO	☐
If Yes, please specify the element(s) and describe the pseudonymisation technique(s) that you are proposing to use and how you will prevent any re-identification of individuals.	Steps will be taken throughout the research to maintain confidentiality, eliminating all identifying details of individuals, organisations and locations. The data collection will be altered to preserve anonymity in line with my employer, training school and place of work's data protection policy.			

Description of data: National and local data flows containing personal and identifiable personal information. What are the required personal data items?			
Personal Data	**Please tick all that apply**	**Special Category Data**	**Please tick all that apply**
Name	☒	Racial / ethnic origin	☒
Addess (home or business)	☒	Political opinions	☐
Postcode	☒	Religious beliefs	☐
NHS No	☐	Trade union membership	☐
Email address	☒	Physical or mental health	☐
Date of birth	☐	Sexual life	☐
Payroll number	☐	Criminal offences	☐
Driving Licence [shows date of birth and first part of surname]	☐	Biometrics; DNA profile, fingerprints	☐
Please supply a dummy sample, e.g. blank forms or an itemised list of the data items.		Bank, financial or credit card details	☐
		Mother's maiden name	☐
		National Insurance number	☐
		Tax, benefit or pension Records	☐
		Health, adoption, employment, school, Social Services, housing records	☐
		Child Protection	☐
		Safeguarding Adults	☐
Additional data types (if relevant)			

Describe the nature of the processing:	
How will you collect, use, store and delete data?	Data will be collected using voice recordings. Names and contacts details will be provided by case-holding clinicians via NHSmail. Data will be kept for 1-2 years only. Arrangements for a debrief to provide final outcomes of the project should participants request it. No personal data will be recorded in the form of audio recordings. All electronic data will undergo secure disposal.
What is the source of the data?	Name and contact details, ethnic origin from RIO for service users.
Will you be sharing data with anyone?	Only anonymised data will be shared. (see previous data flow diagram.)

You might find it useful to refer to a flow diagram or other way of describing data flows. (Please attach a flow diagram).	
Are there any processing identified as likely high risk involved?	NO

Describe the context of the processing	
What is the organisations relationship with the individuals?	Patients / colleagues
How much control will they have? Would they expect you to use their data in this way?	All participants will consent to participate in the study and may withdraw at anytime.
Do they include children or other vulnerable groups? (Please state).	No
Are there prior concerns over this type of processing or security flaws? Is it novel in any way?	No
What is the current state of technology in this area?	
Are there any current issues of public concern that you should factor in?	No
Are you signed up to any approved code of conduct or certification scheme (once any have been approved)?	**Tavistock and Portman Trust Research Ethics Committee (TREC)**

5. Lawfulness of processing

See Appendix 1: for Legal Basis to apply for processing under GDPR and Data Protection Legislation

GDPR **"Lawfulness of processing"** Processing shall be lawful only if and to the extent that at least one or two lawful basis is applied from **Article 6 or 9:** Special category / Sensitive information processing will require a second lawful basis from Article 9.	
Article 6 **Sets out the conditions that must be satisfied for the processing of personal data to be lawful**	**Article 9** **Special category / Sensitive Data** Processing of personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation shall be prohibited.

Conditions for processing for special categories: to be identified as whether they apply				
Condition	**Please tick all that apply**			
Explicit consent unless or allowed by other legal route	Explicit consent	☒	Other legal route	☐
Processing is required by law				☐
Processing is required to protect the vital interests of the person				☐
Processing is necessary for the performance of a contract				☐
Processing is necessary to perform a task in the public interest				☐
Processing is necessary for a legitimate interest or the legitimate interests of a third party				☐
Is any processing going to be by a not for profit organisation, e.g. a Charity				☐
Would any processing use data already in the public domain?				☐
Could the data being processed be required for the defence of a legal claim?				☐
Would the data be made available publicly, subject to ensuring no-one can be identified from the data?				☒
Is the processing for a medical purpose?				☐
Would the data be made available publicly, for public health reasons?				☐
Will any of the data being processed be made available for research purposes?				☒

The answers provided above will not specifically identify the legality of the data flow.

You need to identify the specific legal basis below using GDPR article 6 (for personal data) and article 9 (for special category data) as referenced in Chapter 2, section 8 and 10 of the Data Protection Act 2018.

The IG Team is available to help you identify the legal route for processing data.

Answer all the questions below for the processing of Personal Confidential Data	
What is the legal basis for the processing of identifiable data? Please identify the conditions under GDPR lawful basis and Data Protection Act 2018 or the Section 251 approval under the NHS Act 2006 – please include the approval reference number. Where applicable, please include a copy of your consent form and identify when and how this will be obtained and recorded.	Article 6: (a) The data subject has given **consent** to the processing of his or her personal data for one or more specific purposes; Article 9: (a) The data subject has given **explicit consent** to the processing of those personal data for one or more specified purposes
Where and how will this data be stored?	Name, address and ethnicity details will be stored on secure file server.
Who will be able to access identifiable data?	Kenisha Jackson only
How will you ensure the accuracy of the personal data (including their rectification or erasure where necessary)?	Details provided by the clinicians will be clarified with the service user when contacted. If details need to be updated I will refer the new information back to clinicians.
How will you monitor and maintain the quality of the personal data?	As above
Will the data be linked with any other data collections?	No
How will this linkage be achieved?	N/A
Is there a legal basis for these linkages? i.e. is the Controller/s responsible for the data expected to co-operate/link data to carry out their legal obligations.	**N/A**

Answer all the questions below for the processing of Personal Confidential Data	
How have you ensured that the right to data portability can be respected? i.e. Data relating to particular people can be extracted for transfer to another Controller, at the request of the person to which it relates, subject to: • Receipt of written instructions from the person to which the data relates. • Including data used for any automated processing, And The transfer of the data has been made technically feasible. **N.B.** Transferable data does not include any data that is in the public domain at the time of the request. No data that may affect the rights of someone other than the person making the request can be included.	N/A
What security measures will be used when the data is in transit?	Secure NHSmail

What confidentiality and security measures will be used to store the data?	Secure file server	
How long will the data be retained in identifiable form? And how will it be de-identified or destroyed?	For the duration of the study.	
What governance measures are in place to oversee the confidentiality, security and appropriate use of the data and manage disclosures of data extracts to third parties to ensure identifiable data is not disclosed or is only disclosed with consent or another legal basis?	No identifiable data will be shared with third parties.	
Please confirm you have a System Level Security Policy (SLSP) for the project/service.	SLSP Policy	

This policy needs to identify the technical controls that enable you to demonstrate that you have ensured privacy by design has been addressed by ensuring you have information on the controls required to protect the data.	Yes
If holding personal i.e. identifiable data, are procedures in place to provide access to records under the subject access provisions of the DPA? Is there functionality to respect objections/ withdrawals of consent?	Yes Participants will also be informed of their right to withdraw from the study at any time without reason and withdraw any unprocessed data previously supplied.
Are there any plans to allow the information to be used elsewhere either in the wider NHS or by a third party?	NO
Will the privacy notices in relation to this data be updated and ensure it includes: • ID of controller • Legal basis for the processing • Categories of personal data • Recipients, sources or categories of recipients of the data: any sharing or transfers of the data (including to other countries) • Any automated decision making • Retention period for the personal data • Existence of data subject rights, including access to their data and/or withdrawal of consent and data portability	Recruitment poster service users.docx INFORMATION SHEET .docx Recruitment poster .docx PARTICIPANT CONSENT FORM.doc
Where consent is the legal basis or there is automated processing. The data must be able to be easily separated from other datasets to enable data portability (see previous questions), audit of data relating to specific organisations and to facilitate any requirements for service transitions.	No identifiable data will be included in the research findings. Should people require personal details these can be sent as requested via NHSmail

Please describe how you will meet this requirement.	

6. Access and reporting

What access controls will you have in place to ensure there is only authorised access to the location the data is stored? Please include your procedure for enabling, monitoring access and identifying any inappropriate access.	
All files will be stored in secured file server with restricted access.	
Are there any new or additional reporting requirements from the system/software being used for this project/service? **If "No" move to section below: Business Continuity planning**	Yes/No No
What roles will be able to run reports? E.g. service activity reports, reports on individual people.	
KENISHA JACKSON only	
What roles will receive the report or where will it be published?	
Anonymised data only. **Results of the research may be reported and disseminated in the following ways:** ▪ Peer reviewed journal ▪ Non-peer reviewed journal ▪ Peer reviewed books ▪ Publication in media, social media or website (including Podcasts and online videos) ▪ Conference presentation ▪ Internal report ▪ Promotional report and materials ▪ Reports compiled for or on behalf of external organisations ▪ Dissertation/Thesis ▪ Other publication ▪ Written feedback to research participants ▪ Presentation to participants or relevant community groups	
Will the reports be in person-identifiable, pseudonymised or anonymised format?	
Anonymised only	

Will the reports be in sensitive or redacted format (removing anything which is sensitive) format?	
Anonymised data only	
If this new/revised function should stop, are there plans in place for how the information will be retained / archived/ transferred or disposed of?	Yes/No YES
What plans are in place in relation to the internal reporting of a personal data breach? (NB Unless the personal data breach is unlikely to result in a risk to the rights and freedoms of the individual(s), it will normally need to be reported to the ICO within 72 hours.)	
Any personal data breeches should be reported on the Ulysses system.	
What plans are in place in relation to the notification of data subjects should there be a personal data breach? (NB Where a personal data breach is likely to result in a high risk to the rights and freedoms of the individual(s), they should be notified as soon as reasonably feasible and provided with any recommendations to mitigate potential adverse effects.)	
As per Trust policy.	

7. Business continuity planning

How will the personal data be restored in a timely manner in the event of a physical or technical incident?	If RIO and NHSmail is in-operative - wait until system is functional before receiving personal details.

8. Direct marketing

Will any personal data be processed for direct marketing purposes?	Yes/No	No
If Yes, please describe how the proposed direct marketing will take place:		

9. Automated processing

Will the processing result in a decision being made about the data subject solely because of automated processing (including rofiling)?	Yes/No	No
If Yes, is the decision: • necessary for entering into, or performance of, a contract between the data subject and a data controller • authorised by law • Based on the data subject’s explicit consent?		
Please describe the logic involved in any automated decision-making.		

10. Risk Management, Mitigation and Action Plan

The risk identified is dependent on the Information or Data that is processed and the risk involved, which will determine the level of authorisation needed for any DPIA.

Risk scored at medium or upper range of high risk will require Data Protection Officer review and approval.

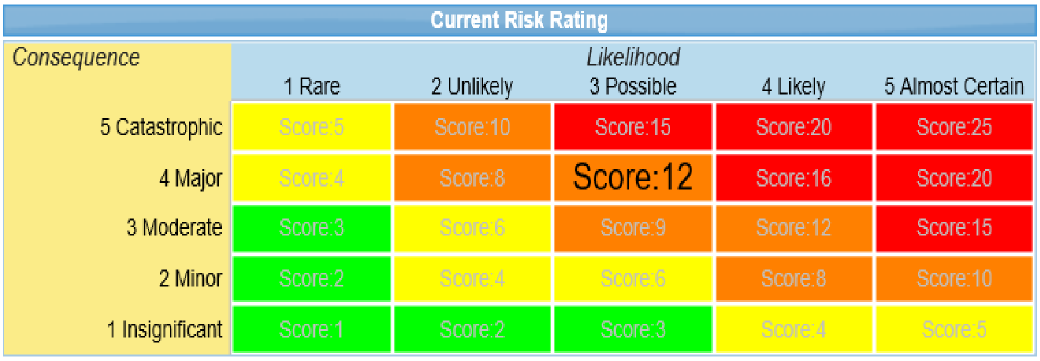
A higher risk score will require escalation to NHS England and approval from the Information Commissioner’s Office (ICO) before any processing can commence.

The escalation process review is to enable the risk to be lowered to within tolerance, if possible.

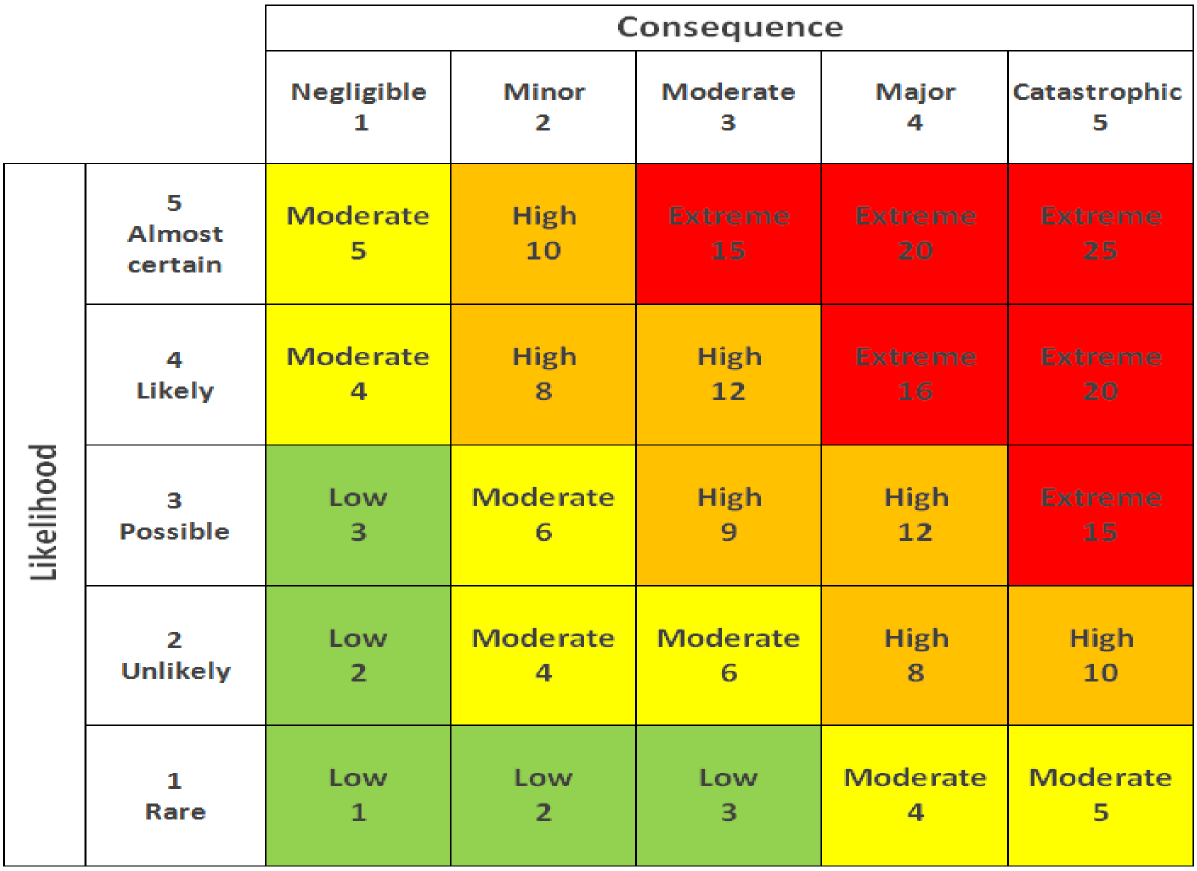
Use embedded Information Risk Assessment rating Tool below for Risk Scoring.

Where the dependency of the initiative / project is strongly linked to a Clinical Service or a particular service, with its own risk scoring tool, such service risk assessment matrix will be used to assess the risk, alongside the information risk tool where possible.

Risk Scoring Matrix



Current Risk Rating					
Consequence	*Likelihood* 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	Score:5	Score:10	Score:15	Score:20	Score:25
4 Major	Score:4	Score:8	Score:12	Score:16	Score:20
3 Moderate	Score:3	Score:6	Score:9	Score:12	Score:15
2 Minor	Score:2	Score:4	Score:6	Score:8	Score:10
1 Insignificant	Score:1	Score:2	Score:3	Score:4	Score:5



		Consequence				
		Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Likelihood	5 Almost certain	Moderate 5	High 10	Extreme 15	Extreme 20	Extreme 25
	4 Likely	Moderate 4	High 8	High 12	Extreme 16	Extreme 20
	3 Possible	Low 3	Moderate 6	High 9	High 12	Extreme 15
	2 Unlikely	Low 2	Moderate 4	Moderate 6	High 8	High 10
	1 Rare	Low 1	Low 2	Low 3	Moderate 4	Moderate 5

Risk Level	Score

Low Risk	1 to 7
Medium	8 to 12
High	13 to 25

Data Protection Risks

Describe any identified or potential risk to Data Protection and Personal Information that may be associated to this project, the source of the risk and nature of potential impact to individuals, including associated compliance and corporate risk.

Identified Risks must be included on the project risk register

Risk Description (Individuals, or wider Compliance)	Likelihood of harm	Impact (severity of harm)	Overall Risk score	Mitigation Plan (Proposed Risk Solution)
Unauthorised access to personal data	3	4	12	Minimal personal data to be recorded on audio devices which would make it extremely difficult to identify individuals.
Inaccurate personal data	1	3	3	All personal details to be checked and clarified at point of consent.

Residual risk (Low, Medium or High)	Effect of mitigation plan / solution on Risk (Is the risk reduced, transferred or accepted?)	Evaluation – what will be the likely final impact on individuals after implementing the proposed risk solution to the aim of the project? Please select. (Justified, Compliant or Proportionate)
Low (1x4)	All audio recordings to be conducted on premises and will be transcribed onto secured server Reduced	Proportionate
Low (1x3)	Accepted	Compliant

10 Risk Approval

IG Team / Information Security			
Risk Description	Approved solution / Mitigation Plan	Approved by	Approval date

11 Further Actions / Outcome

Actions		
Required actions	Action Owner	Date completed

12 Further Consultations requirements and Conclusions

Apart from those listed above (in Stakeholder’s details) - Provide or list any other groups or individuals with whom consultation should take place with regards this project / Initiative.(Where a lead Commissioner / Controller has been identified, that organisations must consult with, capture actions from and gain approval from all collaborating partners). *It is the project / service leads responsibility to ensure consultations take place. IG will advise and provide guidance on any outcome from such consultations.*

Further Information / Attachments Provide any additional / further information that you feel will support this DPIA	

13 Comments / Advice / Query

IG Team comments
IT Security Comments

14 IG review / Approval

IG staff name:

Signature:

Date:

Please email entire completed document to: xxxxinformation.governance@xxxxxx

The Information Asset Owner identified as co-ordinating projects/services involving multiple partners must present the completed DPIA to the management group with oversight of the project/service to obtain their approval before signing on behalf of the partners.

Information Asset Owner (IAO) approval (for low to medium risk processing)

IAO name:

Signature:

Date:

The SIRO is responsible for ensuring all collaborating partner SIROs have approved the DPIA before signing on their behalf (if needed) below. If in doubt, the procurement or project manager must consult with the SIRO from each collaborating partner. Consultations that relate to risk mitigation must be reflected in the action planning section and capture actions and related approvals from all stakeholders, to capture the collaborative view of risks and issues before signing the DPIA below.

SIRO approval (for high risk processing)

SIRO name:

Signature:

Date:

Data Protection Officer (DPO) approval (for high risk processing)

DPO name:

Signature:

Date:

Following acceptance of this DPIA by Information Governance a determination will be made regarding the Data Protection impact and how the impact will be handled. This will fall into three categories:

1. No action is required by IG excepting the logging of the Screening Questions for recording purposes.

2. The questionnaire shows use of personal information but in ways that do not need direct IG involvement – IG may ask to be kept updated at key project milestones.

3. The questionnaire shows significant use of personal information or high risks to information, requiring IG involvement via a report and/or involvement in the project to ensure compliance.

It is the intended that IG will advise and guide those projects that require it but at all times will endeavour to ensure that the project moves forward and that IG is not a barrier unless significant risks come to light which cannot be addressed as part of the project development.

Appendix 1 – Legal Basis for processing under GDPR and Data Protection Legislation

GDPR **"Lawfulness of processing"** Processing shall be lawful only if and to the extent that at least **one** or **two** lawful basis is applied from **Article 6 or 9:** Special category / Sensitive information processing will require a second lawful basis from Article 9.	
Article 6	**Article 9** **Special category / Sensitive Data** Processing of personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation shall be prohibited.
(a) The data subject has given **consent** to the processing of his or her personal data for one or more specific purposes;	(a) The data subject has given **explicit consent** to the processing of those personal data for one or more specified purposes,
(b) Processing is necessary for the performance of a **contract** to which the data subject is party or in order to take steps at the request of the data subject prior to entering into a contract;	(b) Processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the controller or of the data subject **(Legal Obligation)** in the field of employment and social security and social protection law in so far as it is authorised by Union or Member State law or a collective agreement pursuant to Member State law providing for appropriate safeguards for the fundamental rights and the interests of the data subject
(c) Processing is necessary for **compliance with a legal obligation** to which the controller is subject;	(c) Processing is necessary to protect the **vital interests** of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent
(d) Processing is necessary in order to protect the **vital interests** of the data subject or of another natural person;	(d) Processing is carried out in the course of its **legitimate activities with appropriate safeguards by a foundation, association or any other not-for-profit body** with a political, philosophical, religious or trade union aim and on condition that the processing relates solely to the members or to former members of the body or to persons who have regular contact with it in connection with its purposes and that the personal data are not disclosed outside that body without the consent of the data subjects;
(e) Processing is necessary for the performance of a **task** carried out in the **public interest** or in the exercise of official authority vested in the controller; **(Public Task)**	(e) Processing relates to personal data which are **manifestly made public by the data subject;**
(f) Processing is necessary for the purposes of the **legitimate interests** pursued by the controller or by a third party, except where such interests are overridden by the interests or fundamental rights and freedoms of the data subject which require	(f) Processing is necessary for the establishment, exercise or defence of **legal claims** or whenever courts are acting in their judicial capacity;

protection of personal data, in particular where the data subject is a child. **(Does not apply to the Trust in its capacity as a Public Authority - Cannot be used)**	
	(g) processing **is necessary for reasons of substantial public interest**, on the basis of Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject;
	(h) processing is necessary for the purposes of **preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services** on the basis of Union or Member State law or **pursuant to contract** with a health professional and subject to the conditions and safeguards
	(i) processing is necessary for reasons of **public interest** in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices, on the basis of Union or Member State law which provides for suitable and specific measures to safeguard the rights and freedoms of the data subject, in particular professional secrecy;
	(j) processing is necessary for **archiving purposes** in the public interest, scientific or historical **research purposes or statistical purposes** in accordance with Article 89(1) based on Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject.

APPENDIX I

NHS
The Tavistock and Portman
NHS Foundation Trust

I am conducting research to know more about the experiences of professionals working with the Black community to meet their educational, emotional and social needs.

- Have you worked professionally with children and families for more than five years with a 'good' understanding of the needs of families and vulnerable groups?
- Would you be interested in talking to me about your experiences and how we might understand more about the underrepresentation of Black African / Caribbean children and families accessing Children and Adolescent Mental Health Services?

Prior to my training as a Child and Adolescent Psychotherapist I supported children and families in both the education and private sectors across many London Boroughs. As part of my current training I am conducting the following research entitled:

How do we understand the underrepresentation of Black children and families in CAMHS?

A qualitative research with professionals and service users.

Taking part in the study will involve meeting with a small focus group of four professionals for no longer than 1hr 30 minutes. The focus group will help me to understand more about working with and engaging the Black community in the use of local services.

If you would be interested in taking part or would like to know more, please find attached the Participant Information Sheet which will give you more details about my research project.

***please note participation is voluntary, and professionals are under no obligation to participate in the study.**

Thank you,

Kenisha Jackson

Appendix J

NHS
The Tavistock and Portman
NHS Foundation Trust

Would you be interested in taking part in a research project to think about your experience of CAMHS as a member of the Black African / Caribbean community?

I am conducting research to know more about the service user experience and accessing CAMHS.

- Have you been referred to CAMHS in the last 5 years?
- Would you be interested in talking to me about your experiences and how we might understand more about the underrepresentation of Black African / Caribbean children and families accessing Children and Adolescent Mental Health Services?

Taking part in the study will involve joining a small group of other services users to discuss your experiences and help me understand how members of the Black community engage with local services. The meeting will last no longer than 1hr 30 minutes.

If you would be interested in taking part or would like to know more, please speak to reception or contact me on: xxxxxxxxxx

***please note participation is voluntary and service users are under no obligation to participate in the study.**

Thank you,

Kenisha Jackson

Appendix K

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RESEARCH INFORMATION SHEET

Research title: How do we understand the underrepresentation of Black African/ Caribbean children and families in CAMHS? A qualitative research with professionals and service users.

Dear perspective participants,

This research aims to explore how professionals and service users understand and make sense of the underrepresentation of Black children and families in CAMHS. What are the dynamics between families and professionals during early identification of mental health needs? How can ones culture and stereotypical ideologies impact engagement in support programmes and emotional well-being interventions?

My interest in this area developed following 20 years of experience of working in diverse communities supporting children and families in a number of private and public sectors settings; primarily from culturally diverse and deprived geographical locations, with complex social and emotional needs. While I am aware that there may be other ethnic groups underrepresented in the CAMHS, children in the Black community are three times more likely to be excluded from school and Black adults four times more likely to be detained on a mental health ward. Through observations of the number of Black families experiencing the trauma of knife crime across London’s capital and the almost non-existent referrals received and accepted into the service for support of this kind caused further appetite to explore the barriers to accessing CAMHS in the Black community.

I plan to explore, how can this group positively engage with primary services, firstly prior to referral to meet emotional and social needs; and secondly how they can move to longer term support following assessment and referral to specialist CAMHS treatment pathways.

I plan to recruit professional participants with experience of making referrals to CAMHS and experience of demonstrating a ‘good’ understanding of the needs of vulnerable groups via multi-discipline meetings and discussions from the following sectors: Social Care, Education and internal CAMHS clinicians based in my service. A focus group of between four to eight service users who are already registered with the Trust in this capacity will also be recruited to make a contribution to the research.

Potential participants will have the opportunity to discuss the interview requirements and will be made aware of the purpose of the study prior to consent. In addition all information will be clearly described in the participant information sheet. Participants will also be informed of their right to withdraw from the study at any time without reason and withdraw any unprocessed data previously supplied.

Inclusion Criteria

Each focus group consisting of four participants will meet via an online platform to discuss the predetermined questions and explore their experiences of engaging with Black children and families in their professional capacities. A further group of four to eight service users who identify as Black, Black British, African or Caribbean or (Mixed) Black Heritage will also be invited to share their thoughts and experiences in relation the questions.

Exclusion Criteria

I seek to capture the experience of professionals who have significant, wide spread experience of engaging with children and families from the Black community. Therefore professionals with less than 5 years of experience working with families and some knowledge of referring to CAMHS will not be recruited (this includes pre and post qualification period of professional training).

Since the research will seek to explore the underrepresentation of Black children and families accessing CAMHS services, services users from other ethnic groups will not be recruited for the study.

Service users with serve mental health difficulties, chronic health issues or learning disabilities which will impact engagement in the interview will not be included in the study. I am also aware that those without access to suitable devices or a private and confidential personal space to take part in the interview may be excluded from the study and will consider how the Trust can support the engagement for all interested participants.

Steps will be taken throughout the research to maintain confidentiality, eliminating all identifying details of individuals, organisations and locations. The data collection will be altered to preserve anonymity in line with my employer, training school and place of work's data protection policy. Only data relevant to the study will be collected and stored securely requiring a document password and access only permitted by the researcher and research supervisor for discussion and supervision purposes. I will also discuss, agree and indicate the duration data will be kept and consider arrangements for a debrief to provide final outcomes of the project should participants request it.

Data Protection Privacy Notice

xxxxx, xxxxx and xxxxx xxxxxxx NHS Trust will be the data controller.

Why I am collecting your personal data.

I need your name and contact details to get in touch with you. Your personal details will not be shared with anyone else.

Legal basis for processing your personal data

I will only use your information with your consent [see consent form]

Data Protection Act 1998: Article 6 (1) (a) – The processing has been given explicit consent (i.e. for personal data).

Retention period for your personal data

In line with the 5th principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary for that purpose or those purposes for which it was collected; I will only keep your name and contact details for the duration of the project: 1-2 years.

Storing your personal information

Your personal information will be stored on a secure file server and only I will have access.

Withdrawing Consent
If at any time you wish to change information you have shared with me, or wish to discuss withdrawing your consent to share any information you have the right to do this.

Your Rights
Your right of access - You have the right to ask for copies of your personal information.
Your right to rectification - You have the right to ask to rectify information you think is inaccurate. You also have the right to ask me to complete information you think is incomplete.
Your right to erasure - You have the right to ask for erase of your personal information in certain circumstances.
Your right to restriction of processing - You have the right to ask me to restrict the processing of your information in certain circumstances.
Your right to object to processing - You have the right to object to the processing of your personal data in certain circumstances.
Your right to data portability - You have the right to ask for the transfer of information you gave me to another organisation, or to you, in certain circumstances.

You are not required to pay any charge for exercising your rights. If you make a request, the Trust has one month to respond to you.

How to Complain
If you have any complaints about our use of your personal information, you can make a complaint to us at

The Information Governance Manager
xxxxxxxxx
xxxxxxxx
xxxx
xxx xxx

Tel: xxxx xxxxxxxx
Email: Email: xxxxxx@nhs.net

You can also complain to the xxxxxxxxxxxx if you are unhappy with how we have used your data.

Address:
Xxxxxxx xxxxxxx
Xxxxxx xxxxxx
Xxxxxx
xxxxxx
xxxxxx
xxxx xxx
Helpline number: xxxxxxxxxx
website: xxxxxxxxx

Kind regards

Kenisha Jackson

Child and Adolescent Psychotherapist in Doctoral Training
xxxxxxxxxxxxx
Kenisha.Jackson@ xxxxxxxx

Appendix L

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The Tavistock and Portman
NHS Foundation Trust

PARTICIPANT CONSENT FORM

RESEARCH STUDY:

Should you agree to participate in this study, please sign this consent form to provide your consent to participate and to confirm that you have read this document and the participant information sheet.

Please confirm your response by ticking each of the following statements:

☐ I……………………………………… voluntarily agree to participate in this research study titled

Research title: How do we understand the underrepresentation of Black African / Caribbean children and families in CAMHS? A qualitative research with professionals and service users.

☐ I have had the purpose, nature, location and likely duration of the study explained to me in writing and I have had the opportunity to ask questions about the study and have received clarification about the participant expectations.

☐ I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind and in particular there will be no impact in relation to service use or support.

☐ I understand that I can withdraw from the study at any time without reason and withdraw any unprocessed data previously supplied from my interview within two weeks after the interview, in which case the material will be deleted.

☐ I understand that participation involves attending a one-off research focus group for 1 ½ hours one either face to face or via an online platform with a small group other participants and the named researcher to discuss proposed questions.

☐ I understand that there will be no monetary benefit from participating in this research.

☐ I agree to my interview being audio-recorded and to the recording being transcribed for the purpose of this research.

☐ I understand that all information I provide for this study will be treated confidentially in accordance with the Data Protection Act of 1998.

☐ I understand that in any report on the results of this research my identity will remain anonymous. This will be done by changing my name and disguising any details of my interview which may reveal my identity or the identity of people I speak about. I understand that since this is a small scale study this may have some implications for confidentiality / anonymity.

☐ I understand that participation in the research will have no impact on future assessment / treatment / service-use, partnership working or support.

☐ I understand that disguised extracts from my interview may be quoted in the following ways*: research thesis, conference presentation, published papers etc*.

☐ I confirm that I have read and understood the above and consent to participate in this study. I have been given adequate time to consider my participation and agree to comply with the above guidance in accordance to the needs of the study.

☐ I understand that if I inform the researcher that I or someone else is at risk of harm this information will be shared with responsible safeguarding leads - they will discuss this with me first but may be required to report with or without my permission.

☐ I understand that signed consent forms and original audio will be retained under a secure password and only accessible by the researcher and research supervisor until the exam board confirms the results of their dissertation in accordance to the universities data protection policy.

☐ I understand that a transcript of my interview in which all identifying information has been removed will be retained for two years from the date of the exam board in accordance to the universities data protection policy.

☐ I understand that under freedom of information legalisation I am entitled to access the information I have provided at any time while it is in storage as specified above.

☐ I understand that I am free to contact any of the people involved in the research to seek further clarification and information.

☐ This research project has received formal approval from TREC. I understand that if I have any concerns about the conduct of the researcher or any other aspect of this research project, I should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

Please keep your copy of the consent form and the information sheet together.

Participant's Name (Printed): ____

Participant's Signature: ____ Date: ___________

Email: ____

Telephone: ____

Researcher’s Name (Printed): ____

Researcher’s Signature: ____ Date: ___________

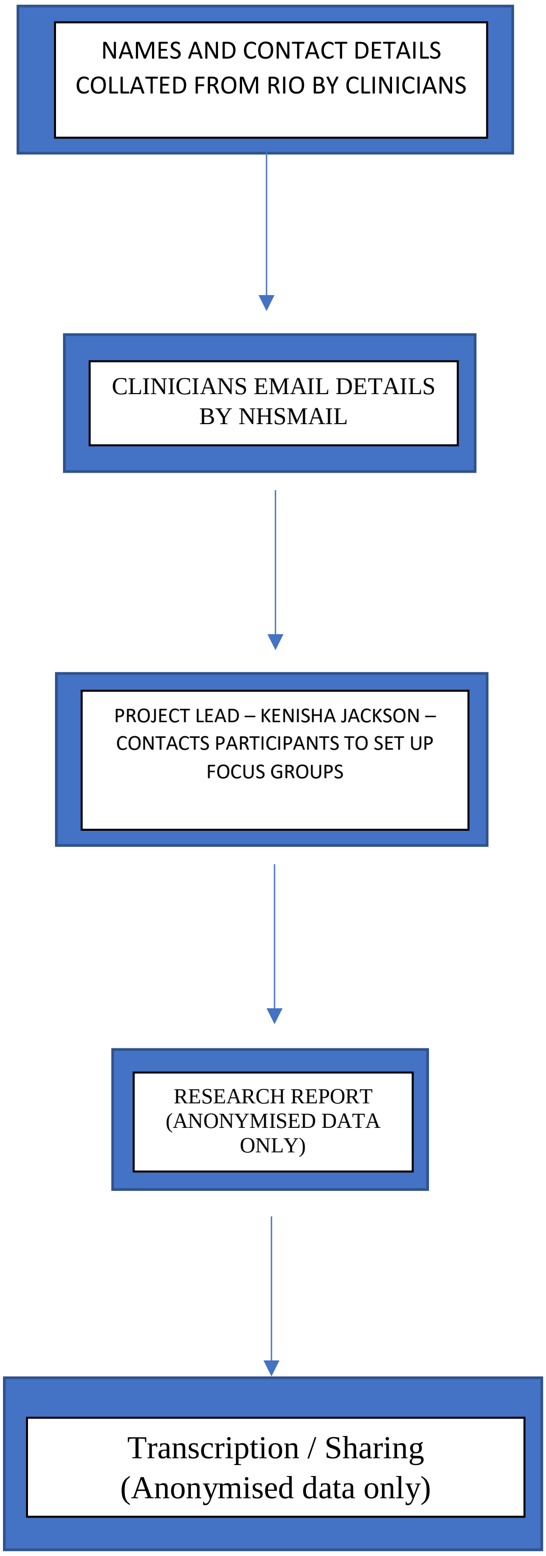
Email: ____

Telephone: ____

Address: ____

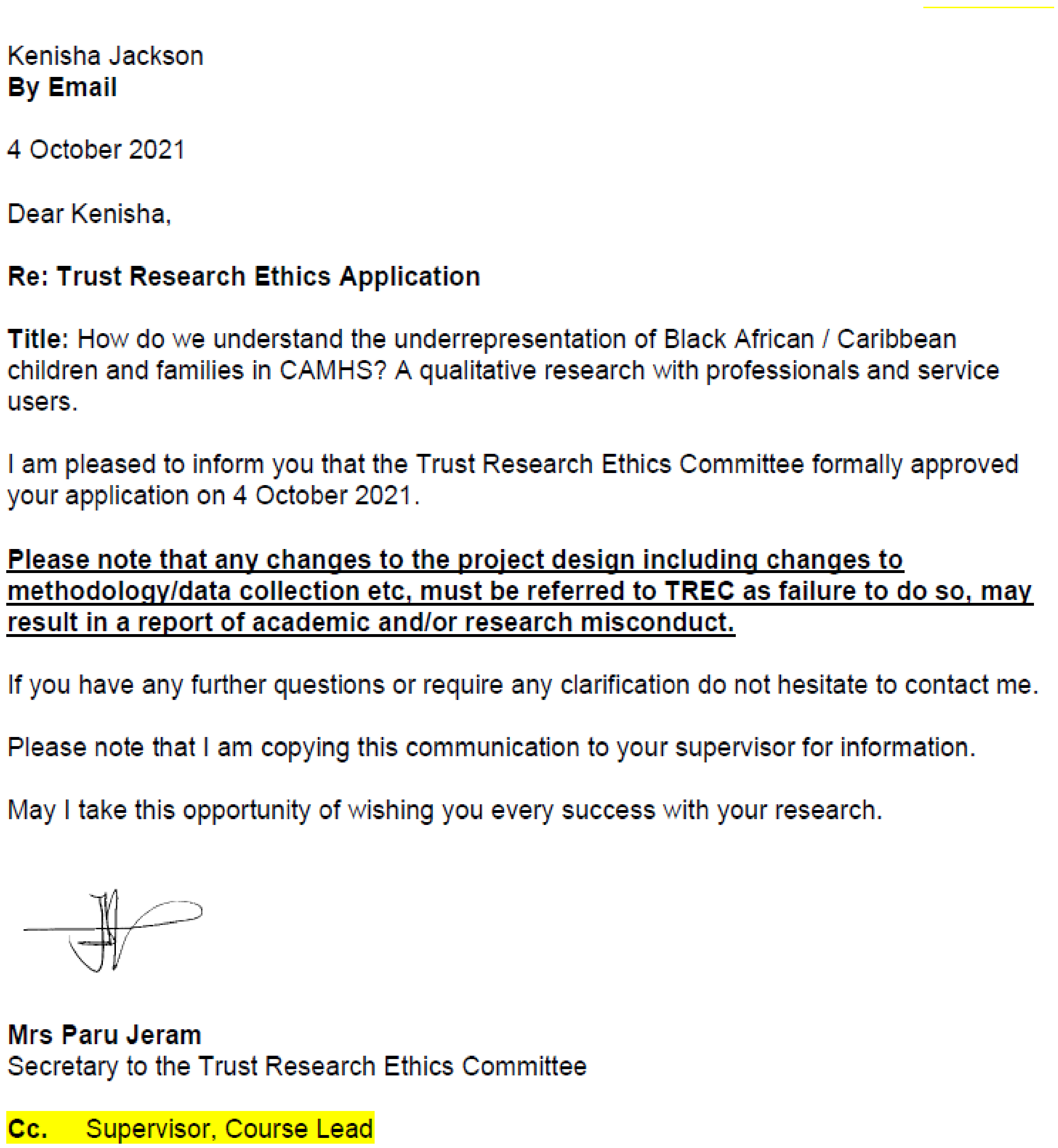
Appendix M

DATA FLOW MAP



Appendix N

Ethical Approval



Kenisha Jackson
By Email

4 October 2021

Dear Kenisha,

Re: Trust Research Ethics Application

Title: How do we understand the underrepresentation of Black African / Caribbean children and families in CAMHS? A qualitative research with professionals and service users.

I am pleased to inform you that the Trust Research Ethics Committee formally approved your application on 4 October 2021.

Please note that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

Please note that I am copying this communication to your supervisor for information.

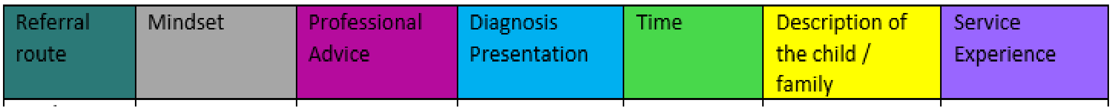
May I take this opportunity of wishing you every success with your research.

Mrs Paru Jeram
Secretary to the Trust Research Ethics Committee

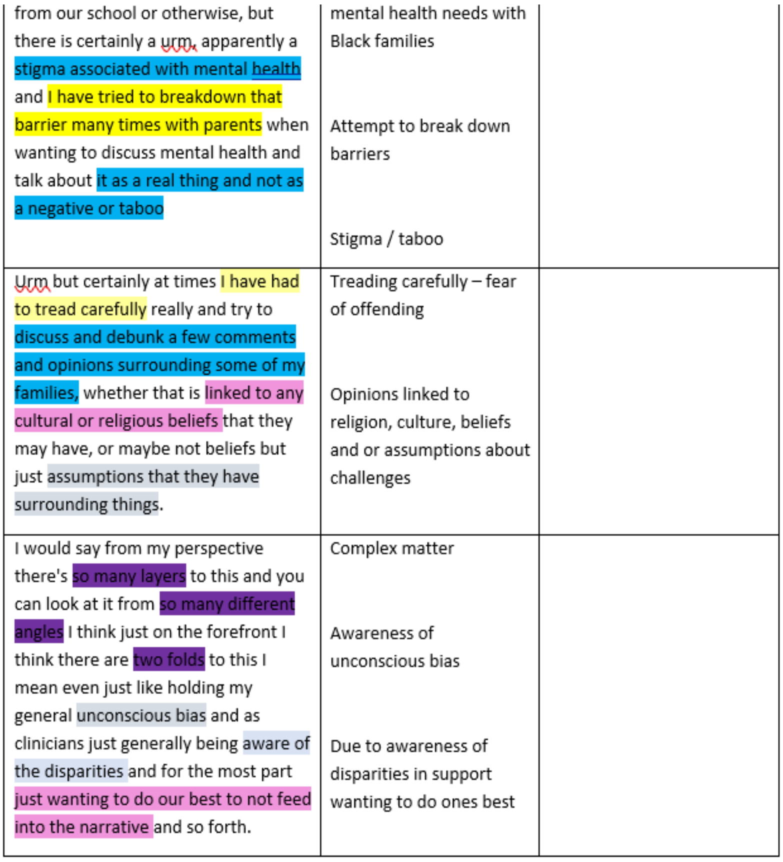
Cc. Supervisor, Course Lead

Appendix O

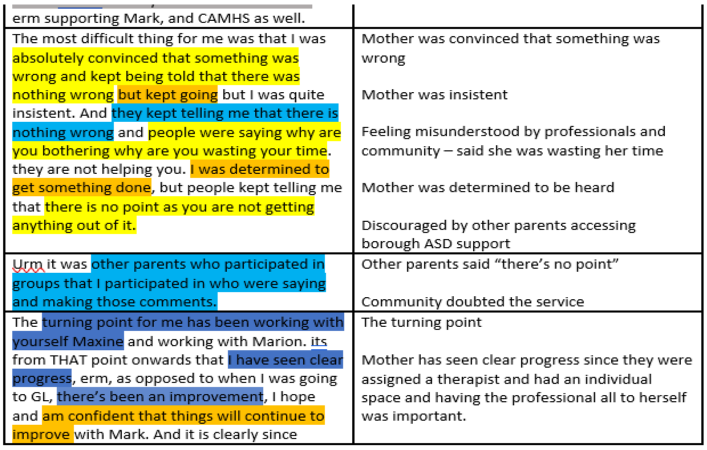
Creating Codes and Themes



Referral route	Mindset	Professional Advice	Diagnosis Presentation	Time	Description of the child / family	Service Experience



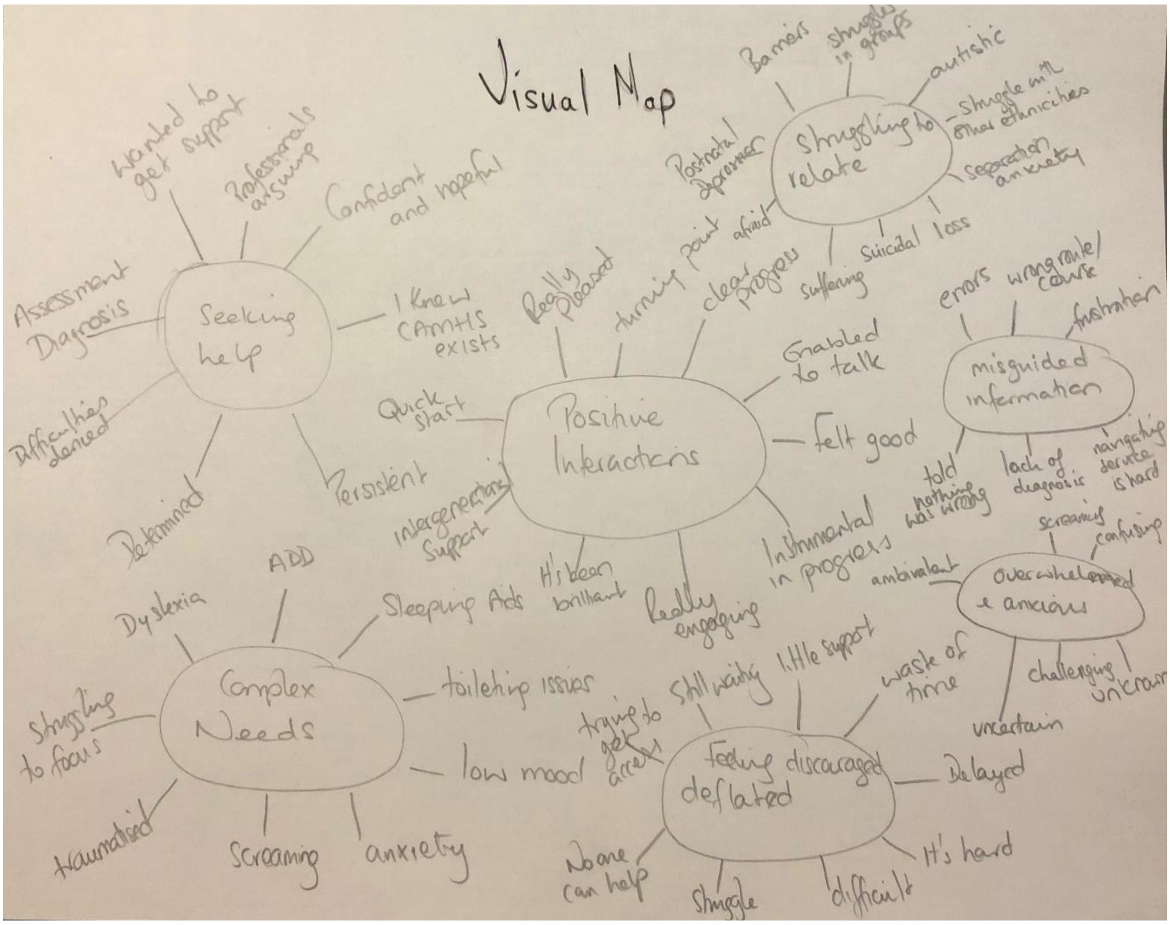
from our school or otherwise, but there is certainly a urm, apparently a stigma associated with mental health and I have tried to breakdown that barrier many times with parents when wanting to discuss mental health and talk about it as a real thing and not as a negative or taboo	mental health needs with Black families Attempt to break down barriers Stigma / taboo	
Urm but certainly at times I have had to tread carefully really and try to discuss and debunk a few comments and opinions surrounding some of my families, whether that is linked to any cultural or religious beliefs that they may have, or maybe not beliefs but just assumptions that they have surrounding things.	Treading carefully – fear of offending Opinions linked to religion, culture, beliefs and or assumptions about challenges	
I would say from my perspective there's so many layers to this and you can look at it from so many different angles I think just on the forefront I think there are two folds to this I mean even just like holding my general unconscious bias and as clinicians just generally being aware of the disparities and for the most part just wanting to do our best to not feed into the narrative and so forth.	Complex matter Awareness of unconscious bias Due to awareness of disparities in support wanting to do ones best	



erm supporting Mark, and CAMHS as well.	
The most difficult thing for me was that I was absolutely convinced that something was wrong and kept being told that there was nothing wrong but kept going but I was quite insistent. And they kept telling me that there is nothing wrong and people were saying why are you bothering why are you wasting your time. they are not helping you. I was determined to get something done, but people kept telling me that there is no point as you are not getting anything out of it.	Mother was convinced that something was wrong Mother was insistent Feeling misunderstood by professionals and community – said she was wasting her time Mother was determined to be heard Discouraged by other parents accessing borough ASD support
Urm it was other parents who participated in groups that I participated in who were saying and making those comments.	Other parents said “there’s no point” Community doubted the service
The turning point for me has been working with yourself Maxine and working with Marion. its from THAT point onwards that I have seen clear progress, erm, as opposed to when I was going to GL, there’s been an improvement, I hope and am confident that things will continue to improve with Mark. And it is clearly since	The turning point Mother has seen clear progress since they were assigned a therapist and had an individual space and having the professional all to herself was important.

Difference and Sameness	**Perceived mistrust and fear affecting access and engagement**	**Good alliance with children and parents resulted in positive outcomes**
Making sense of Language, culture, and beliefs	**Meeting complex needs**	**Restoring Hope in Families**
Relatable Attempting to understand able to vocalise frustration expressive safety in the room confident in role celebrating different cultures shared understanding can't beat 'em, join 'em – African acknowledge unconscious bias Willing to learn OK to not have all the answers Attempting to restore hope Going extra mile Feasibility of approach	Little language Severe Learning disabilities Working hard to understand Multiple complex needs Working with translators Culture / belief / Housing poverty Poverty barrier Making appointments a priority Complex layers – lack of trust Cultural tension Fear of being judged Complexity Beliefs about disturbance	Understand unspoken language Able to empathise Cultural / relatability Something in common Change in language / body language Said the right thing Be open to ask questions Build a rapport Open and flexible When children and families feel like they belong Regular contact between services Professionals learning from each other Improved well-being of whole family Massive success Ongoing contact through transition phase Relevance

Feeling discouraged and deflated	**Trauma Separation and Loss**	**Feeling Frustrated and Misunderstood**
Discouraged and deflated I knew something was wrong I was convinced Why are you bothering You're wasting your time There's no point I was not encouraged Delayed years Just delayed Still waiting Trying to get access Difficult Waiting and not knowing I don't even know where I am right now, to be honest It was hard To a whole year Took 3 years to settle There wasn't much support He'll grow out of it	**DV** **Suicidal** Suffering Lost relatives Thought I was going mad Crying a lot Wasn't sleeping – afraid of being alone Trauma – what he'd been through Bereavement Single parent Husband passed away Premature – in hospital for a year Rough start as a baby Its been rocky postnatal severe generational trauma - under CAMHS as a kid myself for learning difficulties signs of abuse separation anxiety biting lip until it bleeds	There were errors Sent on wrong route Waiting frustrating because that is taking some time they just saw it as he's violent angry Black boy the social worker said that I was mad I annoyed everyone Presents like an older child Attention seeking No diagnosis **Misguided Information** Not going to help because you're black Different level of support for black children Wrong advice – wrong course


Visual Map
Seeking help
Wanted to get support
Professionals arguing
Confident and hopeful
I knew CAMHS exists
Assessment Diagnosis
Difficulties denied
Determined
Persistent
Positive Interactions
Really pleased
turning point
clear progress
Enabled to talk
felt good
Quick start
intergenerational Support
It's been brilliant
Really engaging
Instrumental in progress
Struggling to relate
Barriers
struggles in groups
autistic
Struggle with other ethnicities
Separation anxiety
Postnatal Depression
afraid
suffering
Suicidal
loss
misguided information
errors
wrong route/course
frustration
told nothing was wrong
lack of diagnosis
navigating service is hard
Overwhelmed & anxious
screaming
confusing
ambivalent
challenging
unknow
uncertain
Complex Needs
Dyslexia
ADD
Sleeping Aids
toileting issues
low mood
anxiety
Screaming
traumatised
struggling to focus
Feeling discouraged deflated
Still waiting
little support
waste of time
trying to get access
Delayed
It's hard
difficult
Struggle
No one can help

Appendix P

Pilot Study Responses

Experiences for Black families	Challenges in Engaging
Narrative – seen as challenging What happens in the classroom Children and families feeling unheard - that no one understands lack of representation in services lack of trust hard to reach how can we become more inclusive system not acceptable trauma relating to identity triggers around fear untold stress stigma trust doubting that professionals can meet their needs Afro Caribbean children are difficult to turn around CAMHS – high dropout rates black children lost in the teenage years	Stigma places a burden on the community Support for CAMHS clinicians supervision and safe environments Bias in schools Language needed to build relationships include parents in planning Empower parents to make solutions Referral process is unpleasant Children are rejected by school Process is affected by professionals Lack of compassion Social care mostly received their referrals from school Take up of services as less frequent Services not meeting criteria family is not meeting criteria Professional difficulties creates barriers Racism lack of understanding from therapist creates a breakdown in work loss families and schools are a breaking point how to support schools before crisis in the early stages comes is seen as an elite service harder to engage children becoming number in services parents were unable to demand services they are entitled to

How can we improve	
Structure of offer Targeted promotion would be effective - currently relying on professional to refer Share success stories – make mental health services visible in school like dental health is Options and interventions to steer the partnership Parents know their rights Initial assessment joined up working Link CAMHS with adult services Social content is important – must be considered Adjust the eurocentric training changes in services implementation	Consider holistic and cultural influences Consider the context this is not always understood Behaviour is not the issue it's likely to be PTSD parents responses are concerning Parent own trauma to be considered and addressed Psychotherapy not offered signposted to psychiatry / medication gender is a factor mostly Black boys early interventions are required but these families are not meeting thresholds in services promoting working together parenting intervention to consider who's offered what

Appendix R

Suggested Recommendations for Improvement: Focus Group Participants

How to improve services and practices:	
Best practitioners are currently working at the top need to be on the ground delivering interventions. More Black professionals Allow more time to get to know families and understand their needs Develop joined-up thinking between professionals More psycho and culturally competent education to encourage curiosity Create positive experiences at every opportunity when engaging Black families Take ownership of errors	Know the demographics and the need Develop a sense of community and relatable services Positive promotion of services meeting the needs of Black people Regular contact between services Noting the importance of timely responses Early intervention Make use of community-based services /leaders Co-location of services