Social, Emotional and Mental Health Needs Assessment: Children and young people from Black, Asian and Ethnic Minority Communities in Leeds

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Executive Summary

1. Introduction

Mental health inequalities for adult Black, Asian and Minority Ethnic (BAME) groups are well known, but there is less clear evidence regarding children and young people. This report takes a 'comparative need' approach to explore differences in Social, Emotional and Mental Health (SEMH) need between White British and BAME school aged children in Leeds. It provides a broad overview of the needs and experiences of children and young people from BAME groups, rather than a detailed exploration of cultural issues faced by different groups. Research challenges include using broad ethnicity categories and the applicability of mental illness assessment and conceptualisation across cultures.

2. Demographics

School Census data from 2018 shows the proportion of the Leeds school population from Black and Minority Ethnic (BME) backgrounds has nearly doubled since 2005 (from 17.4% to 33.8%). The "White British" category has decreased both numerically and proportionally throughout this time (81.5% to 64.7%).

- The greatest numerical change can be seen among those children identifying as Black, closely followed by White Other.
- The greatest proportional change continues to be in "White Other" with over three times the number of children and young people identifying with this group in 2018 compared to 2005.
- Between 2010 and 2015, the numbers of White Eastern European more than tripled from 872 in 2010 to 2,609 in 2015. This has now more than quadrupled by 2018 to 3,845. The number of young people identifying as White Eastern European continues to account for the majority of the large increase in the main White Other category over this time period. There were also two and a half times more White Roma pupils since 2010; and more than double the number of White Western Europeans in January 2018 compared to January 2010.
- Children identifying as Black or Mixed have also seen a substantial increase since 2005. The number of pupils identifying as Black African has more than quadrupled, and the number of pupils identifying as Mixed has more than doubled; although the year on year increase for both of these groups has been steadier than White Other.

3. Epidemiology

3.1 Prevalence

A variety of research including the national prevalence survey, the Millennium Cohort study and a systematic review consistently show that people from BAME communities have similar or lower rates of mental health problems than White British young people. Young people with Mixed Heritage are an emerging group in terms of mental health need.

The use of broad ethnicity groupings and the cross-cultural validity of assessment tools (such as the SDQ) means that caution must be taken when interpreting these findings. Nevertheless it raises interesting questions regarding resilience and community assets within BAME communities that may contribute to these lower prevalence levels.

3.2 Equity of service access

Nationally children and young people from BAME communities appear to be under-represented in CAMHS, with stronger evidence for this within South Asian families.

BAME children are more likely to be referred to CAMHS through education, social, and other services than primary care, compared to White British children. Socioeconomic status plays an important role but does not account for all the inter ethnicity differences.

There are ethnic differences in SEN data, with Black Caribbean and Mixed White and Black Caribbean pupils twice as likely to be identified with SEMH needs as White British pupils, controlling for age, sex and socio-economic deprivation. Traveller Irish category is also over-represented. These groups (plus Gypsy/Roma) are also more likely to be excluded from school.

Black, Mixed and Other categories are all over-represented in the youth justice system, with Asian and White categories under-represented compared with the population as a whole. BAME children appear to be slightly over-represented in the looked after children population, in particular children of Mixed and Black ethnicity. It is well-known that these systems have adverse impacts on mental health.

3.3 Factors that influence SEMH of BAME groups

The following factors have been identified as impacting on SEMH difficulties and barriers to accessing getting support:

- Exposure to risk factors for mental health problems
- Emotional distress may be interpreted as behavioural problems

- Interface with primary care
- Lack of awareness of service provision
- Stigma
- Distrust of authority services/ fear of racism
- Cultural appropriateness of services
- Perceptions of mental Illness
- Language problems

4. Health Needs Assessment: Quantitative Research

4.1 Epidemiology: Local modelling of prevalence rates

Prevalence estimates from the survey 'Mental Health of Children and Young People in England, 2017' by NHS Digital have been applied to the Leeds population to estimate the number of children and young people likely to have a mental disorder in each ethnic group:

707 Asian/ Chinese young people
436 Black young people
1179 Mixed/ other young people
216 White other young people
10,549 White British Young People

This doesn't represent all SEMH need as it only includes those who fit the criteria applied in the study of 'mental disorder'.

Using these figures, the proportions of the total population of children and young people in Leeds expected to have a mental disorder are as follows:

5.4% - Asian/ Asian British
3.3% - Black/ Black British
9% - Mixed
1.7% - White other
80.6% - White British

4.2 Analysis of Pupil Perception survey

Analysis of My Health My School (a pupil perception survey carried out in many schools) by ethnicity showed some significant differences including:

- Mixed and White secondary aged girls reported significantly higher rates of f eeling sad/upset than Asian secondary females.

- Chinese secondary boys report significantly higher rates of feeling sad/upset than Asian boys, Black boys or White boys.
- Chinese, Mixed, and White British females report significantly higher self-reported self-harm than other groups.
- Chinese males report significantly higher self-harm than all other groups (apart from ‘’Other’). White British boys have significantly higher self-reported self-harm than Asian boys.
- In general White groups reported higher bullying levels (apart from Chinese boys)

White British, Mixed and Chinese groups report the poorest mental health. The sample size of the Chinese group is very small so findings must be interpreted with caution, however despite this some differences were statistically significant.

Differences were less apparent amongst primary age children.

These findings echo the national data that suggest BAME groups have similar or better mental health than White British young people.

4.3 Analysis of local service use

This has been summarised in two ways – firstly at service level and secondly by ethnic group.

Service level:

Compared to the population, BAME groups under-represented in:

- MindMate SPA
- CAMHS
- Beeston, Cottingley and Middleton Cluster emotional support
- The Market Place
- Kooth
- Self-harm admissions to A&E

BAME groups are represented in line with population in the SILC cluster emotional support

The following BAME groups over-represented in terms of being identified for SEMH in SEN data from schools: Traveller Gypsy/Roma, Mixed White & African, Mixed White & Caribbean, Other Mixed, Black Caribbean, Black other groups.

When the controls were included to account for confounding factors, Black Caribbean and Mixed White & Caribbean remained significantly over represented:

Following groups over-represented in the care system: Black (by a small amount), Mixed, Other. Within the Therapeutic Social Work team (who support this cohort), the Mixed group were represented in line with the population proportions.

Within Leeds Youth Offending Service, Black population and the Mixed population are over-represented (the latter is statistically significant).

Within school exclusions data the following groups are over represented: Gypsy, Roma, Traveller, White Irish Traveller, Mixed Black and Caribbean and Black Caribbean pupils.

By ethnic group:

Asian population is highly under-represented in SEMH support services.

Black population is highly under-represented in SEMH support services. Also over-represented in SEMH SEN data. Slightly over-represented in care system and Leeds YOS. Over-represented in exclusions data.

Mixed population is underrepresented in SEHM support services, but is much closer to the population proportion in most cases. Also highly over-represented in care system and in Leeds YOS. Over-represented in exclusions data.

White Other population is under-represented in SEMH support services, but not by as larger proportions as Asian or Black groups. Gypsy, Roma and Traveller data is subsumed within the group which is an issue due to research suggesting poor mental health outcomes for these groups. SEN data shows GRT groups over-represented in SEMH rates. Also over-represented in exclusions data.

Other population is under-represented in SEMH support services.

5. Health Needs Assessment: Qualitative Research

5.1 Young People focus groups

Pakistani girls focus groups (10 girls):

- Some understanding of mental health but majority struggled to express ideas around concept. View that discussing mental state might bring shame on family
- Protective factors included loving self, talking to others who were trustworthy, social and creative activities.
- Risk factors focussed on social media and celebrity culture. Also homework load and pressure to achieve high grades.
- Circles of support – mixed response re family – some can talk but others felt parents can't relate and they needed to mask struggles. Friends were strong source of support. Mixed response re schools – some positives but most focused on challenges including worries about confidentiality.

- Awareness of services – little knowledge – 2 mentioned ChildLine. Feedback that Asian families view external support at negative – risk of people finding out leading to isolation and negative implications for families.

Bangladeshi girls focus group (5 girls):

- Good understanding of mental health concept
- Protective factors – surrounding self with trustworthy people, activities, exercise, prayer and social media all discussed
- Risk factors – pressure from family to do well in education/careers to get respect. Also huge stigma in community, especially older generations, about acknowledging mental health difficulties. Some young people isolated due to strict parents.
- Circles of support – Close friends differentiated from wider friends as key support. Parents identified but some felt they don't understand. Teachers mentioned.
- Support services – felt they would access GP who would refer to counsellor if needed support. Mentioned helplines. Attitude that schools are not helpful and would break confidentiality.

African Caribbean/ Mixed Caribbean/White boys focus group (6 boys):

- Very negative connotations of mental health and sense it didn't apply to them
- Protective factors – didn't engage with idea they can look after emotional health. Talked about spots, computer games and chilling/not being bored.
- Risk factors – very negative attitudes about school – compared to prison. Belief teachers treat boys unfairly
- Circles of support – focus on 'spending time on own' or resting to help feel better. Social media also mentioned. Do not talk to friends about emotions.
- Support services – low awareness of services and lack of trust – feeling that they might be spied on or treated badly. Also sense people don't' keep promises.

Chinese focus group (5 boys and 5 girls):

- Good conceptualisation of mental health
- Protective factors – goal setting, socialising and talking to friends, not being told what to do, creative arts.
- Risk factors – social media mainly seen as negative and described as addictive plus pressure to fit in. Culture of parents working long hours and boredom for children. Pressure to achieve. Social stigma to discussing mental state and tarnishing family name.

- Circles of support – some felt parents being supportive but others less so. Friends mentioned though not always loyal. Using creative hobbies and computer games to relieve stress.
- Awareness of support services – limited awareness though did know about ChildLine. Enthusiasm of online support especially from boys. One school had anonymous therapist. Trust discussed as barrier and fact that professional is unfamiliar with Chinese culture.

5.2 Parent/Carer questionnaire

- 42 people completed the survey with a broad range of ethnicities.
- 80% Female, 20% Male
- 4 participants had accessed support for their child's emotional health. The biggest barrier was waiting times.
- 38 participants had not accessed support. When asked how to get support the most common answers were to go to GP, support in family or talk to school.
- When asked if anything would stop them, waiting times were identified most followed by not knowing how to get support, lack of trust in services and lack of culturally appropriate services. Worries about gossip or what others would think was not a key barrier for most.
- Most prominent theme regarding helping children and young people have good mental health was a stable supportive family. Communication and peer support also key.
- Regarding issues that cause problems – difficult family life, issues with peers, no one to talk to or trust, social media, pressure from adults and school and lack of positive role models.
- 10 participants also raised issues specifically relevant to issues in this report, including BAME young people being treated unfairly, professionals disregarding family values and taking euro-centric approach, constant discrimination in society, feeling excluded/ not understood, lack of understanding of history and feeling out of place.

5.3 Feedback from stakeholders

Stakeholders mentioned racism and discrimination, with BAME young people not having the same access to support and not achieving full potential due to low expectations. Commonly held attitudes included a view that talking doesn't help or that they wouldn't seek help outside their community. Also that professionals stereotype, particularly the police. A sense that there needs to be clearer pathways and more 'safe spaces' with more funds for community projects.

A mental health professional from BAME background fed back that parents felt she would understand better than a White British worker, even when they were from a

different community. Also that the Eurocentric approach of mental health services doesn't always fit.

(**Note** – only four stakeholders contributed so small sample).

6. Conclusions

- National research and local self-reported data suggest children and young people from BAME groups have similar or better mental health than children from White British populations. However, the tools for assessing mental health may be culturally skewed towards White British populations, meaning this finding is not conclusive. It must also be appraised within the context of the entrenched mental health inequalities experienced by adults from BAME communities.

- Prevalence findings raise questions about community assets and resilience, which must not be ignored in favour of focussing solely on BAME children and young people as a vulnerable group in need of support.

- Children and young people from BAME groups are under-represented in the majority of services to support SEMH in Leeds, when compared to the proportions in the population.

- Although a small sample, under-representation was particularly apparent in the early intervention mainstream cluster service. This echoes the pattern with adults accessing services at crisis point. More analysis of cluster services is required.

- Nationally Kooth online counselling has over-representation from BAME groups. This is not the case in Leeds but they do show one of the highest proportion of BAME groups of all the local services so their national success should be capitalised upon locally.

- Robust national research shows that BAME children and young people are less likely to be referred to CAMHS by a GP, and more likely to be referred from Education or Social Care. Local data showed White British young people slightly more likely to be referred from a GP however the difference was not significant.

- African Caribbean and Mixed White/Caribbean young people are over-represented in SEMH SEN data locally, yet this is not reflected in terms of access to SEMH support services. Cultural biases may result in emotional

distress being interpreted as behavioural problems in these communities. In the focus group, the young men conveyed a very negative experience of school and felt unfairly treated.

Children and young people from Mixed heritage stand out as having high SEMH needs within Leeds, including:

- Under-represented in many support services
- Higher likelihood of receiving SEMH identification within SEN data
- Self-report poor SEMH within Pupil Perception survey
- Over-represented in Youth Justice Service
- Over-represented in Children in Care

- This is a growing population as the number of pupils identifying as Mixed has more doubled in Leeds since 2005.

- Chinese young people report poor emotional health in SEMH questions analysed from the Pupil Perception Survey. Although this is a small sample many of the findings are significant. The focus groups showed high anxiety about performing well academically and struggled with parents working long hours.

- Asian young people report the best emotional health in the SEMH questions that were analysed from the Pupil Perception survey. Young women from Pakistani and Bangladeshi communities felt there was high stigma and shame attached to accessing support for mental health and parents struggled to relate to them.

- SEMH needs of Gypsy and Travellers are explored in a report from 2017 (see Appendix 1). Inequitable pathways to services are due to a complex range of factors including discrimination from services and societal racism, high levels of elective home education/school exclusions and perceptions/knowledge of mental health support. Bereavement is a key issue.

- Data collection is challenging for this group, with many services combining ‘Gypsy/Roma’ despite being distinct groups. Gypsy/Roma is over-represented in SEMH SEN data and exclusions data. In some services these ethnicities are subsumed under ‘White Other’.

- The fasted growing ethnic group in Leeds is ‘White Other’ however there is variation in how this group is recorded in monitoring data, resulting in lack of clarity about the needs of this group.

- Trust came out as a key theme in all focus groups. Young people felt lack of trust in some services, in particular they felt that schools could not be relied on to keep confidentiality or keep promises. Trustworthy friends are key support. Parents/carers also identified having someone trustworthy to talk to as important.

- Parents/Carers perceive long waiting lists as the major barrier followed by not knowing how to get help and having a lack of trust in services. The risk of people gossiping was not a key barrier to accessing support suggesting stigma was not as high as presumed.

- Discrimination and racism was raised by stakeholders and some parents/carers as impacting on children's SEMH. A feeling of being excluded or treated differently to their White British peers, especially by authority figures/organisations, resulting in lack of access or poorer outcomes.

- MindMate SPA has particularly high 'null' ethnicity recording. Teen Connect does not currently collect ethnicity data. Cluster based emotional support services do not collect as a rule. Overall there is some inconsistency in categories.

In summary, these findings should be considered as part of a life-course approach. BAME children and young people are under-represented in SEMH support services, but over represented in crisis services as adults, suggesting a lack of early intervention may be contributing.

Patrick Vernon, The CEO of The Afiya Trust summarises the challenge by stating that we must make sure that young people today '*do not become part of the conveyor belt of over representation and misery in the mental health system which for the past 30 years has failed to effectively tackle issues around racial inequality*'.

1. Introduction

The 2018 Annual Refresh of Future in Mind: Leeds Local Transformation Plan, included a commitment to better understand the needs of Black, Asian and Minority Ethnic (BAME) groups and identify gaps in local provision.

The purpose of this Health Needs Assessment (HNA) is to systematically review the Social, Emotional and Mental Health (SEMH) needs and issues facing BAME children and young people in Leeds, in order to inform future service development and commissioning.

1.1 Background

"Profound inequalities" exist for adults from ethnic minority communities in accessing mental health treatment, their experience of care and their mental health outcomes[1]. However, there is less clear evidence or local research into the needs and support for children and young people from BAME groups. The Chief Medical Officer report [2] stated:

'there is a need for better research evidence on the prevalence of child mental health problems in minority ethnic groups as well as looking at service utilisation and whether particular groups experience barriers to receiving a service, in addition to understanding why some groups and communities may be more resilient.'

1.2 Scope & Interfaces

This report focusses on children and young people from age 4 upwards. A pragmatic approach was taken in terms of the age range reviewed depending on the data available:

- The best demographic data available regarding ethnicity is from the School Census which includes reception to year 11 (4 – 16 year olds).
- The prevalence data was drawn from national survey which included 5 to 19 year olds.
- My Health My School (local pupil perception survey) includes young people aged 7 to 16.
- Service data was collected from the broad range of local services supporting young people that have different age cut offs, varying from 16, 18 and in some

[1] Department of Health and Social Care, 2018, *Modernising the Mental Health Act – final report from the independent review*

[2] Murphy and Fonagy, 2012, Mental health problems in children and young people. Chapter in Annual Report of the Chief Medical Officer 2012 'Our Children Deserve Better: Prevention Pays'

cases for young people with additional needs, 25. Although this can be seen as a weakness in the report as it is not comparing exact age groups.

Future in Mind Leeds[3] is a broad strategy that straddles health, education and social care, so where possible, data has been gathered from across sectors to reflect this.

Interfaces include the Future in Mind Health Needs Assessment 2016 [4] and the Leeds in Mind 16 to 24 year old Health Needs Assessment[5].

Due to wide variety of ethnic groups, it is not possible to look in depth at the issues facing each group. Therefore this report is a broad overview of the needs and experiences of children and young people from BAME groups in Leeds, rather than a detailed exploration of cultural issues faced by different groups. Likewise it does not explore the particular issues related to seeking asylum or becoming a refugee in any detail. The report does not focus specifically on issues facing Gypsy and Travellers as a previous report was produced in 2017 focusing on this (see Appendix 1)

The rationale for choosing particular ethnic groups for the focus groups is explained at the start of that section.

1.3 Methodology and Sources of Data

A methodological approach of 'comparative need' has been applied, as the report considers matches (or mismatches) between levels of health and availability of health services between population groups[6]. It explores the health status and services available to BAME groups in comparison to the majority White British population.

It will assess the national evidence base and local data and intelligence, including service data. This will be combined with qualitative research with families and stakeholders, resulting in a better understanding of the needs faced by BAME groups and how, in Leeds, this need is being met.

[3] Future in Mind: Leeds. A strategy to improve the social, emotional, mental health and wellbeing of children and young people aged 0–25 years 2016–2020. https://www.leedsccg.nhs.uk/content/uploads/2018/05/Future-in-Mind-Leeds-Strategy-FULL-VERSION.pdf

[4] Cudmore et al., (2016) Future in Mind Leeds: Health Needs Assessment https://www.mindmate.org.uk/mwg-internal/de5fs23hu73ds/progress?id=oMfEKJGsbSX03qN3GWZe_lw6vl8gi7cctBt0ziYFxuk

[5] Hanson and Erskine, (2018) Leeds in Mind Young People 16 - 24 years. Accessed on 10th October 2019 https://observatory.leeds.gov.uk/wp-content/uploads/2018/10/Leeds-in-Mind-Young-People-16-24-years.pdf

[6] Marosszeky, N., Rix, M., and Owen, A. (2006) Knowing what you need to know about needs assessment. https://ro.uow.edu.au/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1088&context=gsbpapers

1.4 National & Local Policy Context

National Policy documents have focussed on mental health needs of BAME communities but they haven't given sufficient focus to children and young people[7]. For example, the plan to improve the mental health of BME communities 'Delivering Race Equality in Mental Health Care, the government's five year action plan (2005-2010)' was unclear in terms of implementation across CAMHS leading to a suggestion that little significant change occurred[8].

The current all age strategy 'No Health Without Mental Health (2011) does not mention children and young people in the section on 'race' and therefore does not explore the application of issues such as culturally appropriate IAPT services in relation to children and young people. Similarly, Future in Mind (2015) does not identify BAME children and young people as a target group though briefly mentions training to deliver services in a non-discriminatory way with respect to ethnicity and developing a workforce strategy including an audit of ethnic mix.

1.5 Ethnicity Concept

Ethnicity is a fluid concept as it develops and changes over time. It tends to be categorised based on a person or family's country of origin, however this does not give a full indication of someone's ethnic identity, as many other factors play an important part, such as religious beliefs, language and specific country of origin within the continent[9].

Ethnicity is much broader than the concept of race which tends to be associated with physical or biological difference[10]It is unhelpful to view ethnic minorities as 'non-White' as this suggests ethnicity is just linked to skin colour and also leads to some ethnic groups being missed.

This report applies the definition set out by the Department of Health [11] which focuses on disadvantage by defining the term 'Black and minority ethnic' (BME) as referring to "*all people of minority ethnic status in England. It does not only refer to skin colour but to people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, those of Mediterranean origin and East European migrants".*

[7] Malek, M. (2011) *Enjoy, Achieve and Be Healthy: The mental health of Black and minority ethnic children and young people*. Internet publication, The Afiya Trust
[8] Ibid 7
[9] Malek, M., and Joughin, C., (2004) Mental Health Services for Minority Ethnic Children and Adolescents. Jessica Kingsley Publisher
[10] Ibid 9
[11] Department of Health (2005) Delivering race equality in mental health care An action plan for reform inside and outside services and The Government's response to the independent inquiry into the death of David Bennett

1.6 Research challenges

Researching mental health amongst BAME communities is challenging due to the complex nature of the ethnicity concept and the cross-cultural issues related the concept of mental health. This can impact on the generalisability of research[12]. Challenges include:

- Broad ethnicity groupings, such as 'Asian', can result in groups being seen as homogenous, which assumes a uniformity of experience rather than keeping a focus on the diversity between individuals and within cultures[13].

- Using the category of 'White' can result in some disadvantaged minority groups such as eastern European migrants being missed so less is known about the mental health of these communities[14]

- People from mixed heritages do not necessarily fit into these broad categories and may have specific challenges [15]

- Smaller communities such as Chinese or Vietnamese may be missed and have less known about their mental health [16]

- There is an issue in terms of applicability of diagnoses of mental illness across cultures, for example words used to describe symptoms may have different meanings or indicate different levels of distress in some cultures[17].

- Measures used to assess mental health differences may not have cross-cultural validly, as they are likely to have been developed from Euro-centric populations and not re-developed involving other ethnic groups [18]

- Many service providers still do not collect ethnicity data

- Many studies borrow from adult findings and apply to children and young people

[12] Murphy and Fonagy, 2012, Mental health problems in children and young people. Chapter in Annual Report of the Chief Medical Officer 2012 'Our Children Deserve Better: Prevention Pays'
[13] Ibid 9
[14] Goodman, A., Patel, V. and Leon, D. (2008) *Child mental health differences amongst ethnic groups in Britain: a systematic review*. BMC Public Health 2008, 8:258
[15] Lavis, P. (2014) The importance of promoting mental health in children and young people from black and minority ethnic communities. A Race Equality Foundation Briefing Paper
[16] Ibid 15
[17] Ibid 9
[18] Ibid 9

1.7 Summary

There are clear mental health inequalities for adult BAME groups, but less clear evidence regarding children and young people. This needs assessment takes a ‘comparative need’ approach to explore differences between how SEMH needs are being met between White British and BAME populations of school aged children in Leeds. It provides a broad overview of the needs and experiences of children and young people from BAME groups in Leeds, rather than a detailed exploration of cultural issues faced by different groups. Research challenges included comparing ethnicities using broad groupings and applicability of mental illness assessment and conceptualisation across cultures.

2. Demographics

The proxy indicator for the population used in this report is the School Census data, which is a statutory requirement for all maintained schools, academies, and specialist inclusive learning centres. This has been chosen as it has detailed ethnicity data available.

Caveats regarding this data source include:

- This includes children from reception (aged 4/5) up to year 11 (aged 15/16) so does not include young people aged 17 or 18.

- It does not include students at private schools or home educated students

2.1 Ethnic breakdown of School Aged Population

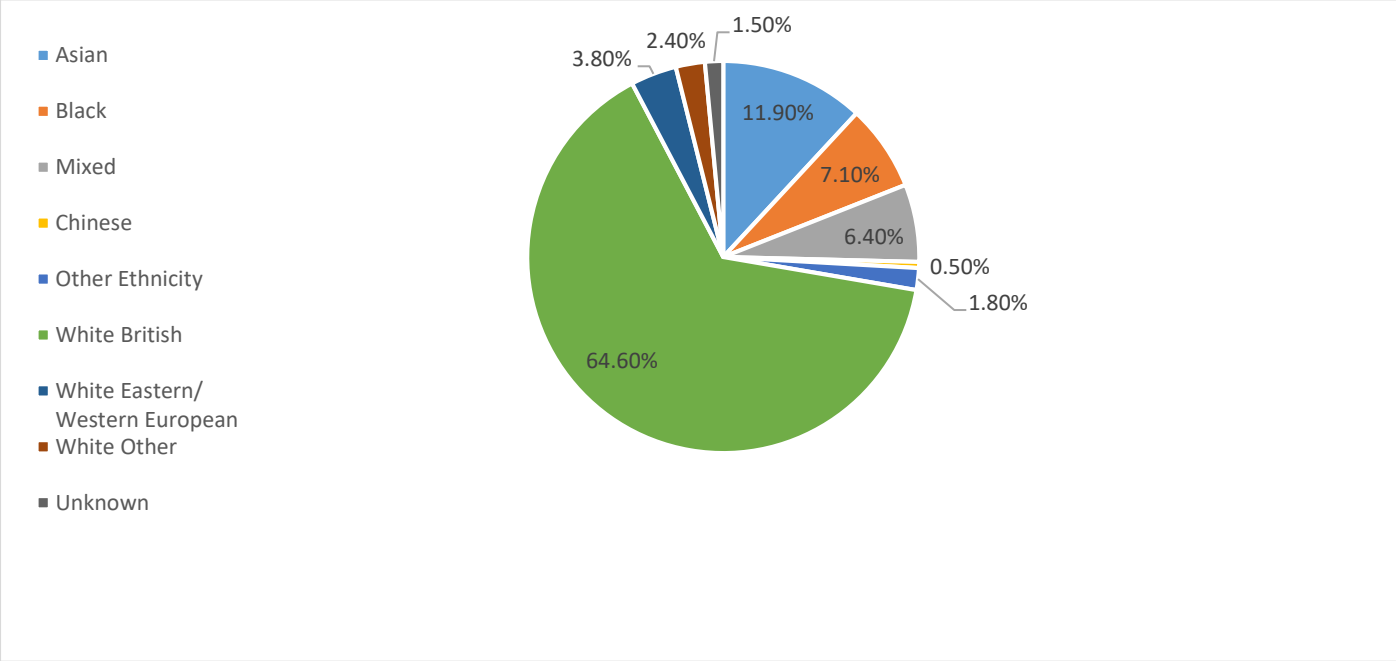
There were 109,582 children of statutory school age attending schools in Leeds at January Census 2018. Of this total, there were 69,039 primary age children and 40,543 of secondary age. Figure 1 shows the breakdown by ethnic group and Figure 2 shows the proportions of the population by ethnic group.

Figure 1: School age population by ethnic group

	Asian	Black	Mixed	Chinese	Other Ethnicity	White British	White Eastern/ Western European	White Other	Unknown
Total	13000	7784	7014	599	1957	70802	4129	2601	1696
Primary	8093	5046	4654	414	1487	43781	2943	1616	517
Secondary	4800	2638	2292	180	455	26249	1152	973	1138
Special	107	100	68	5	15	772	34	12	41

Source: 2018 January School Census

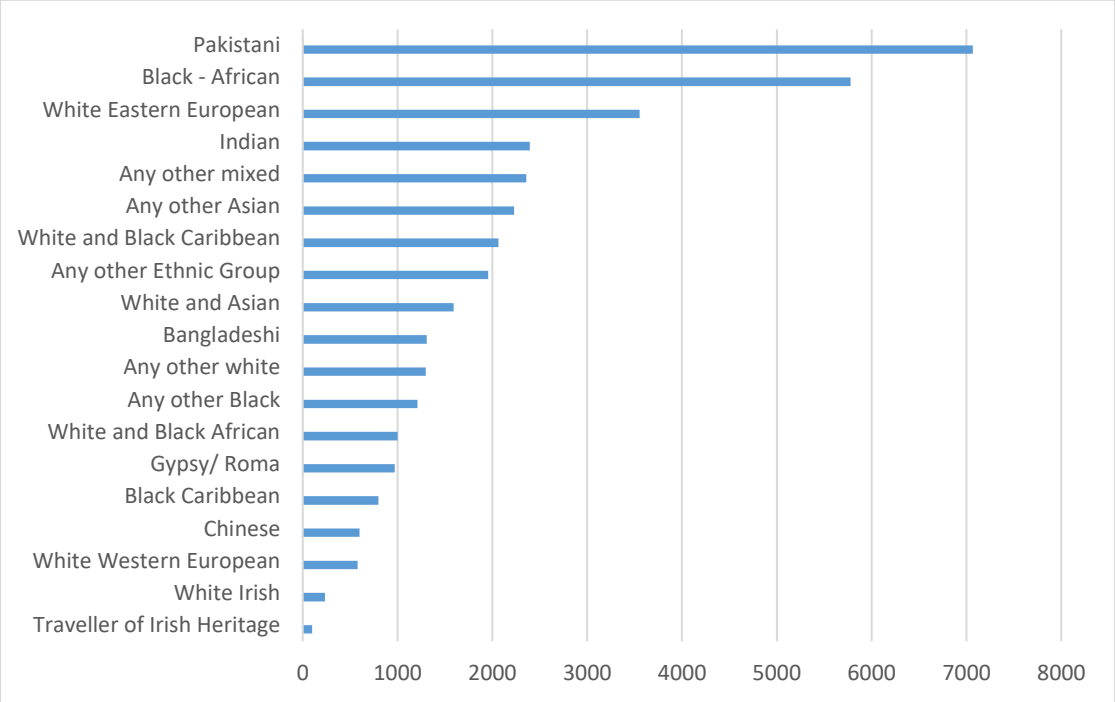
Figure 2: Proportions of school age population by ethnic group



Source: 2018 January School Census

The following graph breaks down the broad groupings into the granulated groups, and is set out in in order of size of population. The categories 'White British' and 'unknown' have been removed.

Figure 3: BAME groups by size order



Source: 2018 January School Census

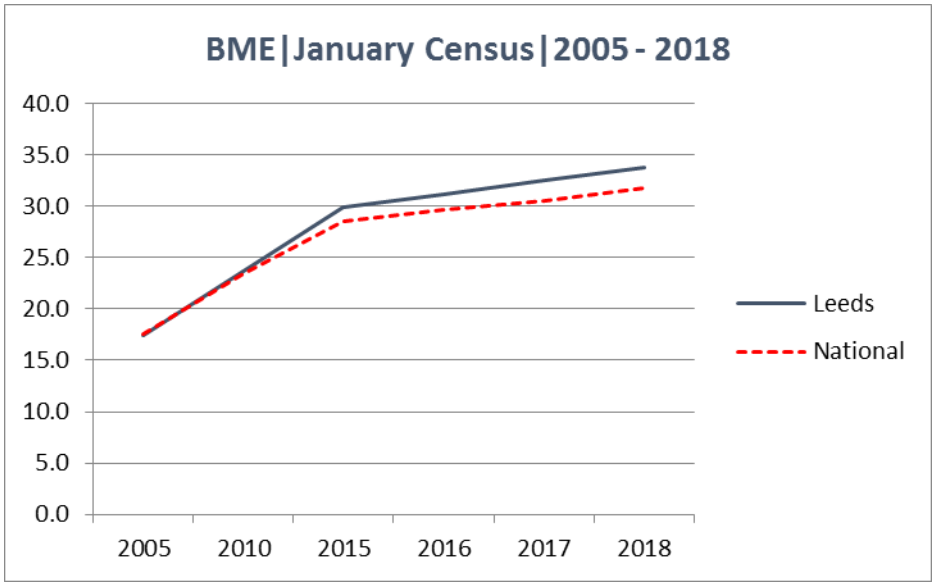
2.2 Analysis of ethnicity trend data

The following analysis of ethnicity trends is taken directly from the report '*City-wide analysis of School Census (January 2018)*' prepared by Nev Smith and Tom Ellis from Leeds City Council.

The proportion of Black and Minority Ethnic (BME) groups in Leeds has more than doubled since 2005 (an increase of 113%). In 2005, 19,447 (17.9%) children and young people in maintained schools identified with a BME group and by 2018, this has increased to 41,432 (33.8%), as **chart 4.1** illustrates. This pattern is relatively consistent with national trends, albeit Leeds has diverged very slightly. There remains a higher proportion of BME pupils in primary school (35.49%) compared to secondary schools (31.07%). The proportion of BME pupils in the Secondary phase has increased this year; although the proportion in the Primary phase has actually dropped.

Note: there have been significant changes to some categories, in particular White Other, and also to the definition of BME, during the period of this analysis. For that reason, some caution should be used with some of the following comparisons.

Chart 4.1: Percentage of BME groups, Leeds v National, 2005, 2010, and 2015 - 2018.



Source: January school census 2018

White British continues to be the majority ethnic group in Leeds, although numbers have been decreasing over time. In 2005, 81.5% of children and young people in Leeds maintained schools identified as White British, compared to 64.7% in 2017. While the proportion of pupils identifying as White British has decreased since 2005; the proportion in BME groups have continued to rise.

Table 4.1 shows in greater detail the changes in ethnicity since 2005. The greatest proportional change from 2005 to 2018 has been in "White Other" with over three times the number of pupils identifying as White Other in 2018. The largest increase was observed between 2010 and 2015 with an average annual change of 18.5%; compared to 11.5% in the previous five years. The annual change shows some signs of slowing down over the latest 3 years; from 11.8% (2015/2016) to 9.0% (2017/2018).

Prior to 2010, it's difficult to attribute the large change to any specific group within "White Other", as additional categories "White Western European" and "White Eastern European" were introduced to the census at that point. Previously, people identifying as either of these ethnicities would have been categorised as "White other".

Between 2010 and 2015, the numbers of "White Eastern European" pupils more than tripled from 872 in 2010 to 2,609 in 2015 and this accounts for the majority of the large increase in the main "White Other" category during this time period. It isn't possible however, to say whether or not these would have made up the bulk of the change between 2005 and 2010. The number of pupils identifying as "Gypsy/Roma" has increased by over five times when compared to 2005, and there were also double the number of "White Western European" pupils in 2015 compared to 2010. Whilst the increase in pupils identifying as "White Eastern European" continues to be high, those identifying as "Gypsy/Roma" actually saw the biggest percentage increase in the "White Other" category since 2017, with a 16.8% increase.

Those pupils identifying within "Black" or "Mixed" ethnicities have also seen a substantial increase over the time period. The number of children and young people identifying as "Black African" has more than tripled between 2005 and 2018. Those identifying as "White and Black African" has doubled; although the increase for both of these groups has been more steady over the ten year period. "Black" and "Mixed" continue to see the second and third greatest increases respectively.

The main changes between the 2017 and 2018 census include an increase across all main ethnicities with the exception of "White British". A lower increase than previous years can be observed for all other ethinicites. Table 4.1 describes these changes in greater depth.

Table 4.1: number of pupils by extended ethnicity, and change over time – see other page

Table 4.1: number of pupils by extended ethnicity, and change over time

Sour

		Number of CYP						Total % change		Average annual change		Annual Change		
		2005	2010	2015	2016	2017	2018	2005-2018	2010-2018	2005-2010	2010-2015	2015-2016	2016-2017	2017 - 2018
	Bangladeshi	962	1250	1439	1450	1476	1487	54.6%	19.0%	6.0%	3.0%	0.8%	1.8%	0.7%
	Indian	2243	2286	2567	2613	2702	2764	23.2%	20.9%	0.4%	2.5%	1.8%	3.4%	2.3%
	Kashmiri other	97	132	140	141	137	133	37.1%	0.8%	7.2%	1.2%	0.7%	-2.8%	-2.9%
	Kashmiri Pakistani	1665	2177	2512	2568	2395	2340	40.5%	7.5%	6.2%	3.1%	2.2%	-6.7%	-2.3%
	Other Pakistani	3850	4316	5079	5187	5591	5805	50.8%	34.5%	2.4%	3.5%	2.1%	7.8%	3.8%
	Other Asian	640	1424	2007	2158	2242	2388	273.1%	67.7%	24.5%	8.2%	7.5%	3.9%	6.5%
Asian		**9457**	**11585**	**13744**	**14117**	**14543**	**14917**	**57.7%**	**28.8%**	**4.5%**	**3.7%**	**2.7%**	**3.0%**	**2.6%**
	Black African	1334	3022	4885	5347	5897	6091	356.6%	101.6%	25.3%	12.3%	9.5%	10.3%	3.3%
	Black Caribbean	1349	1115	946	924	891	870	-35.5%	-22.0%	-3.5%	-3.0%	-2.3%	-3.6%	-2.4%
	Any other Black background	660	747	1027	1052	1204	1685	155.3%	125.6%	2.6%	7.5%	2.4%	14.4%	40.0%
Black		**3343**	**4884**	**6858**	**7323**	**7992**	**8646**	**158.6%**	**77.0%**	**9.2%**	**8.1%**	**6.8%**	**9.1%**	**8.2%**
	Chinese	496	534	648	670	689	680	37.1%	27.3%	1.5%	4.3%	3.4%	2.8%	-1.3%
	Any other ethnic group	925	1259	1625	1745	2049	2219	139.9%	76.3%	7.2%	5.8%	7.4%	17.4%	8.3%
Other		**1421**	**1793**	**2273**	**2415**	**2738**	**2899**	**104.0%**	**61.7%**	**5.2%**	**5.4%**	**6.2%**	**13.4%**	**5.9%**
	White and Asian	679	971	1390	1522	1642	1753	158.2%	80.5%	8.6%	8.6%	9.5%	7.9%	6.8%
	White and Black African	320	432	795	902	1005	1073	235.3%	148.4%	7.0%	16.8%	13.5%	11.4%	6.8%
	White and Black Caribbean	1507	1703	2038	2101	2201	2261	50.0%	32.8%	2.6%	3.9%	3.1%	4.8%	2.7%
	Any other mixed background	917	1489	2006	2191	2383	2591	182.6%	74.0%	12.5%	6.9%	9.2%	8.8%	8.7%
Mixed		**3423**	**4595**	**6229**	**6716**	**7231**	**7678**	**124.3%**	**67.1%**	**6.9%**	**7.1%**	**7.8%**	**7.7%**	**6.2%**
White British		**90865**	**81756**	**79165**	**78991**	**79867**	**79400**	**-12.6%**	**-2.9%**	**-2.0%**	**-0.6%**	**-0.2%**	**1.1%**	**-0.6%**
	White Eastern European	-	872	2609	3105	3503	3845	-	340.9%	-	39.8%	19.0%	12.8%	9.8%
	White Irish	413	310	270	264	271	254	-38.5%	-18.1%	-5.0%	-2.6%	-2.2%	2.7%	-6.3%
	Traveller of Irish heritage	103	105	103	107	106	105	1.9%	0.0%	0.4%	-0.4%	3.9%	-0.9%	-0.9%
	Any other white background	1140	975	1200	1241	1339	1446	26.8%	48.3%	-2.9%	4.6%	3.4%	7.9%	8.0%
	Gypsy / Roma	147	312	763	835	868	1007	585.0%	222.8%	22.4%	28.9%	9.4%	4.0%	16.0%
	White Western European	-	263	520	558	603	635	-	141.4%	-	19.5%	7.3%	8.1%	5.3%
White other		**1803**	**2837**	**5465**	**6109**	**6690**	**7292**	**304.4%**	**157.0%**	**11.5%**	**18.5%**	**11.8%**	**9.5%**	**9.0%**
Unknown		**1206**	**1091**	**1780**	**2172**	**1416**	**1918**	**59.0%**	**75.8%**	**-1.9%**	**12.6%**	**22.0%**	**-34.8%**	**35.5%**
All		**111518**	**108541**	**115514**	**117843**	**120477**	**122750**	**10.1%**	**13.1%**	**-0.5%**	**1.3%**	**2.0%**	**2.2%**	**1.9%**

ce: January school census 2018

Charts 4.2 and **4.3** order Leeds clusters by number and percentage of children identifying as BME in the January School Census 2018. This year contains the same top six most ethnically diverse, albeit with higher numbers than last year. Proportionally though it is clear that there is a difference. Despite this, the top six most ethnically diverse clusters remain the same in both charts.

Chart 4.2: Number of BME pupils by cluster

Source: January school census 2018

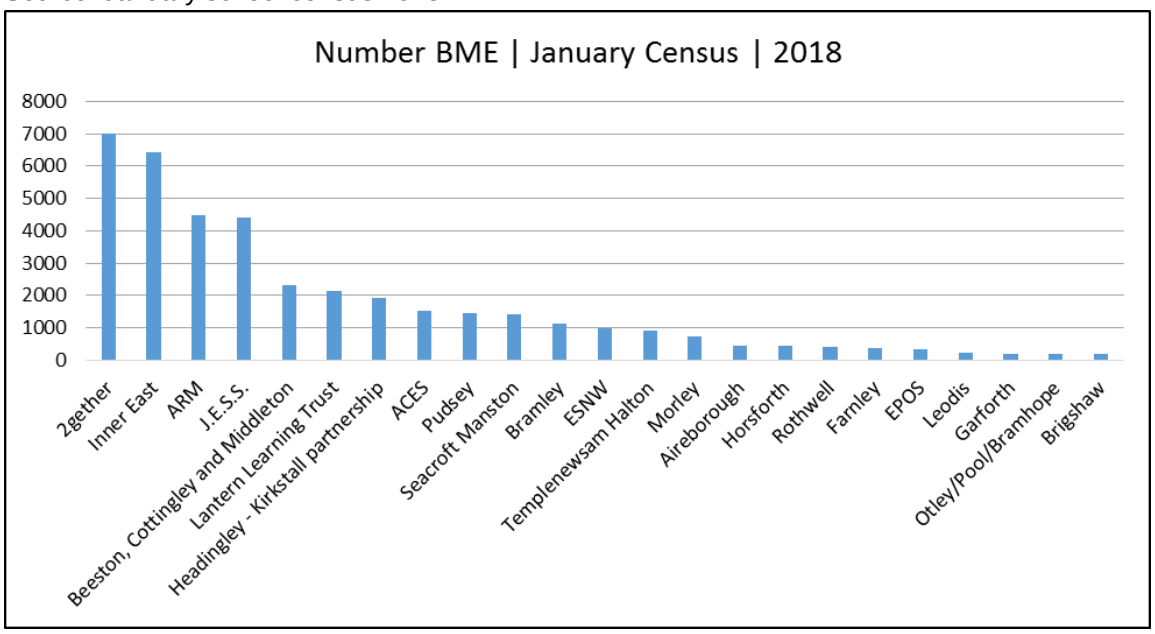
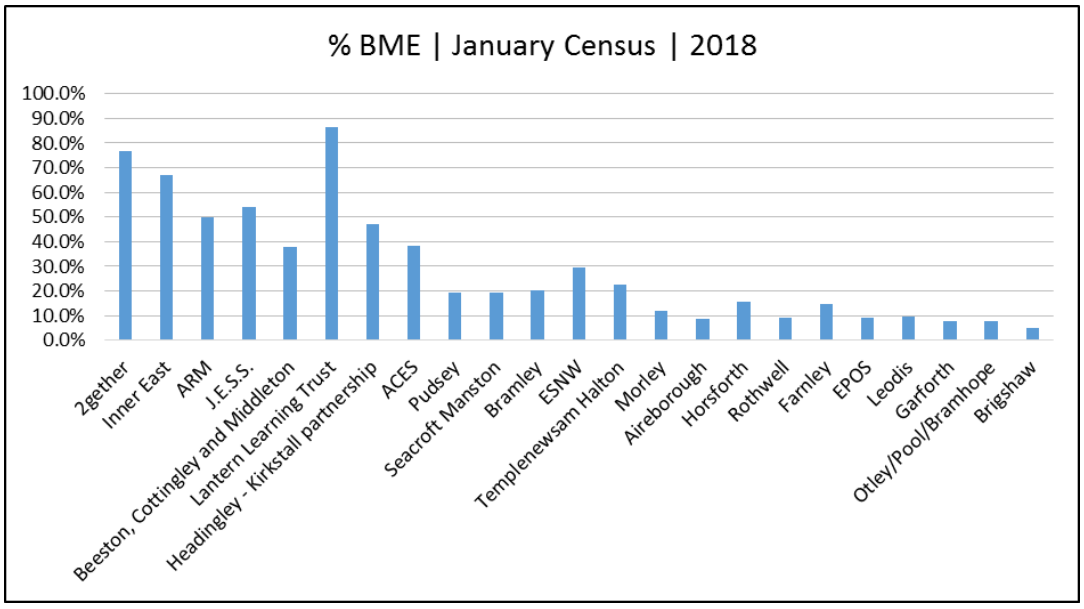
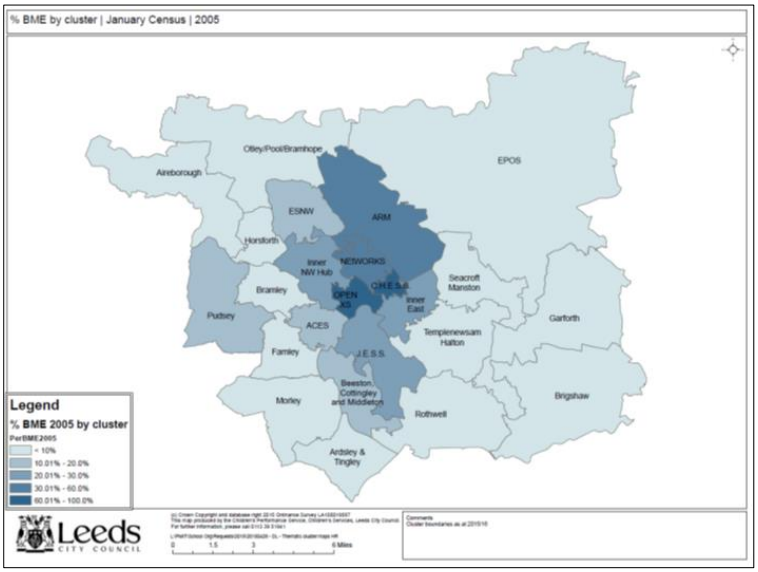


Chart 4.3: Percentage of BME pupils by cluster (January Census 2018)

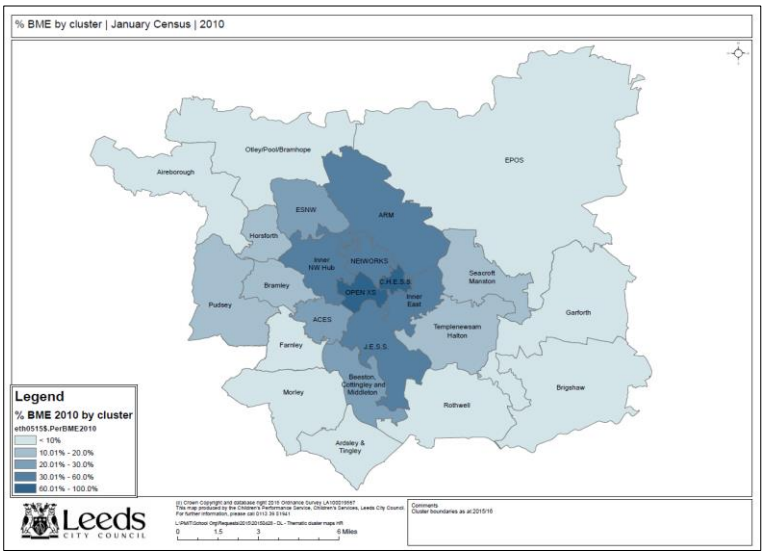
Source: January school census 2018



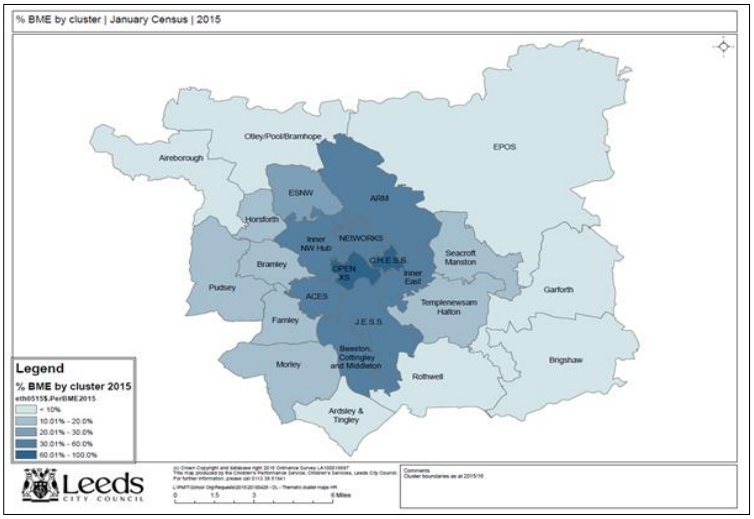
Map 4.1: Number of BME pupils by cluster, January 2005



Map 4.2: Number of BME pupils by cluster, January 2010



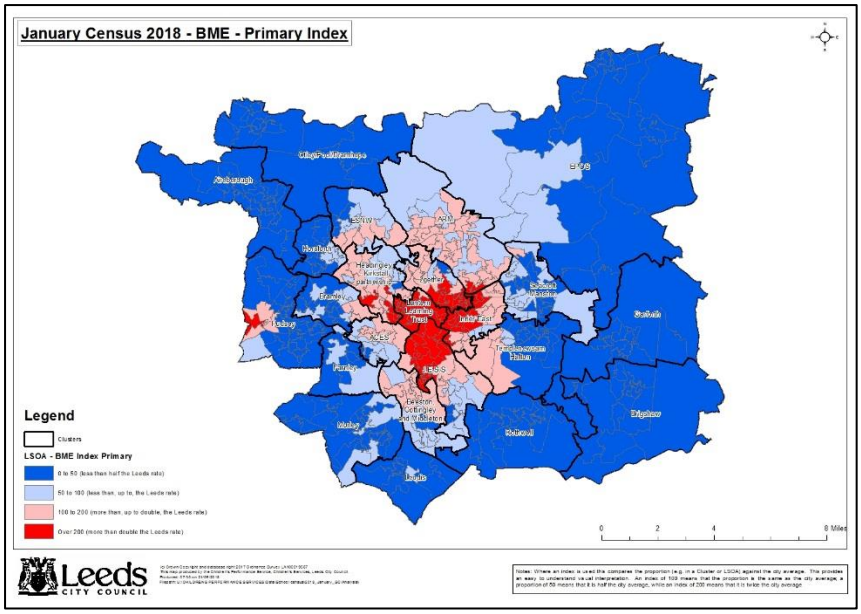
Map 4.3: Number of BME pupils by cluster, January 2015



Ethnicity changes by cluster between 2005 and 2015

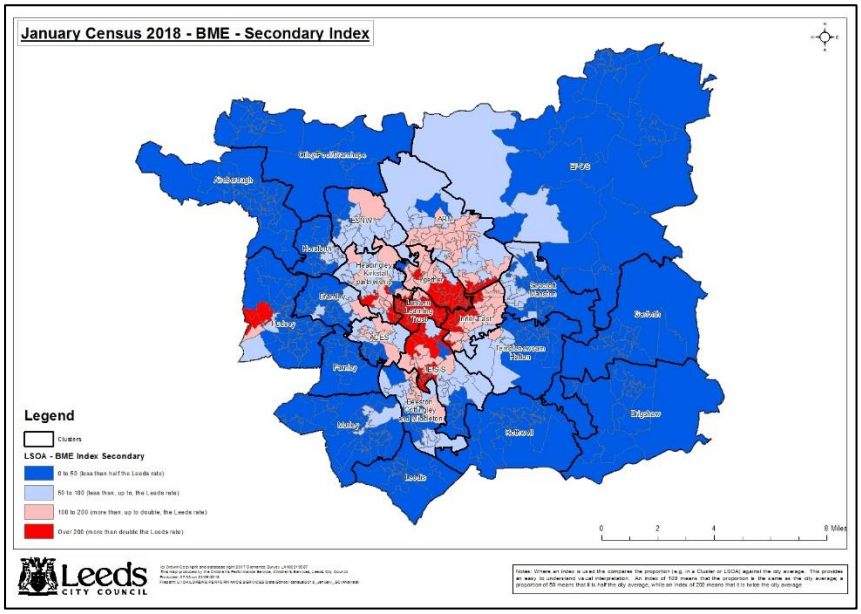
These maps display the number of BME pupils by cluster. Since 2005, the number of clusters with a large proportion of BME groups has increased and spread south of ARM with seven clusters in total having a BME population of between 30% and 60% compared to two in 2005. Open XS and CHESS remain the most ethnically diverse clusters with between 80% and 100% children and young people identifying as BME. This is followed by ARM, NEtWORKS, Inner NW Hub, Inner East, J.E.S.S, Beeston, Cottingley and Middleton and ACES who all have above average proportions of BME. Across Leeds, Garforth and Brigshaw were the least ethnically diverse in 2015

Map 4.4: Primary phase BME Index by LSOA



Source: January school census 2018

Map 4.5: Secondary phase BME Index by LSOA



Maps 4.4 & 4.5 illustrate further detail on BME by LSOA using an index system. The index compares the proportion in the LSOA against the city-wide average; so that an index of 100 is the same as the city rate, 200 is double (dark red), while 50 is half the city rate (dark blue).

For primary aged pupils in Leeds, LSOAs with at least double the city average of BME pupils are mostly centred within the inner city LSOAs of Lantern Learning Trust, Jess, Inner East and 2gether, with further clusters in the West of Pudsey, Headingley - Kirkstall Partnership and ARM. There is a similar pattern for secondary aged pupils, though the inner clustering spreads outwards covering a wider range of inner LSOAs and a greater number of LSOAs in ARM and Headingley - Kirkstall Partnership.

Language

- English as an additional language (EAL) has further increased to 20.0% in the 2018 census. EAL was 18.8% at the January Census 2017, which in turn was a 1% increase on the 2016 census.
- EAL remains higher in primary aged pupils (22.1%), than in secondary (16.5%). Within both phases, EAL has been increasing year on year.
- Within both Primary and Seconday School phases, Urdu was the most common spoken language (after English). In Primary Schools this is followed by Polish and in Secondary it is Panjabi.
- Romanian has seen the greatest increase across both Primary and Secondary phases.

End of extract from report '*City-wide analysis of School Census (January 2018)*'

2.3 Summary

The proportion of the Leeds school population from Black and Minority Ethnic (BME) backgrounds has nearly doubled since 2005 (from 17.4% to 33.8%). The "White British" category has decreased both numerically and proportionally throughout this time (81.5% to 64.7%).

- The greatest numerical change can be seen among those children identifying as Black, closely followed by White Other.
- The greatest proportional change continues to be in "White Other" with over three times the number of children and young people identifying with this group in 2018 compared to 2005.
- Between 2010 and 2015, the numbers of White Eastern European more than tripled from 872 in 2010 to 2,609 in 2015. This has now more than quadrupled by 2018 to 3,845. The number of young people identifying as White Eastern European continues to account for the majority of the large increase in the main White Other category over this time period. There were also two and a half times more White Roma pupils since 2010; and more than double the number of White Western Europeans in January 2018 compared to January 2010.
- Children identifying as Black or Mixed have also seen a substantial increase since 2005. The number of pupils identifying as Black African has more than quadrupled, and the number of pupils identifying as Mixed has more doubled; although the year on year increase for both of these groups has been steadier than White Other.

3. Epidemiology

Epidemiology is *"the study of the distribution and determinants of health-related states or events (including disease), and the application of this study to the control of diseases and other health problems"*[19]. When applied to this area it concerns ***whether*** children and young people from different BAME groups have higher or lower rates of mental health problems from majority White British, and if so, ***why*** this is the case [20]

This section will explore the differences between groups, drawing on prevalence survey data and then reviewing population based studies. It will then explore equity of service access. The underlying reasons will be explored later in this chapter.

3.1 Research regarding SEMH needs

3.1.1 National Survey

Large population based research carried out in 1999, 2004 and in 2017 by the Health and Social Care Information Centre have all shown that children and young people from BAME groups have **lower rates of mental health disorders** than children and young people from White British groups.

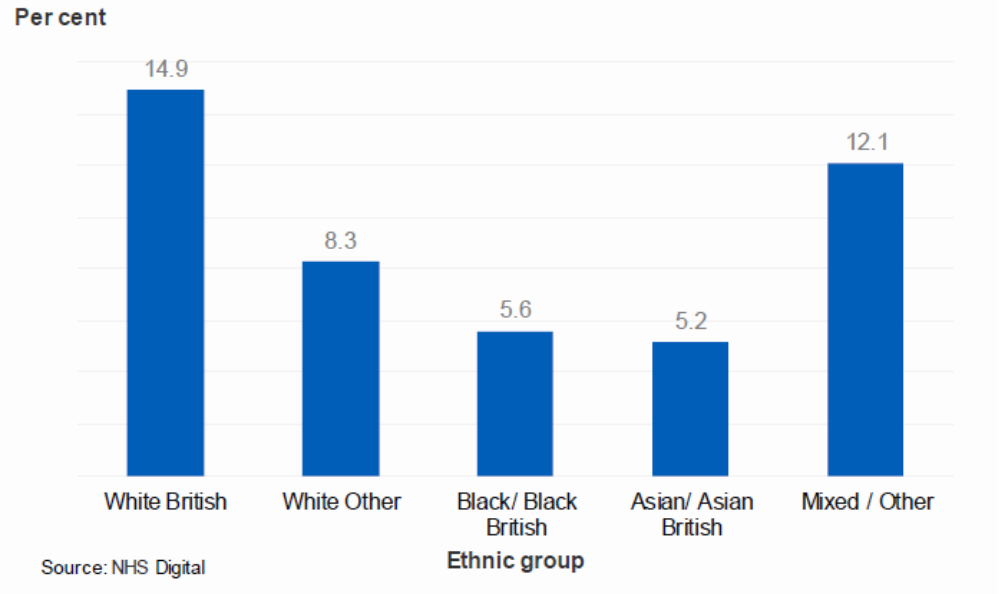
The 2017 survey[21] (showed that rates of mental disorder were highest among those in the White British group (14.9%) and lowest among those in the Black / Black British (5.6%) and Asian / Asian British (5.2%) groups. This pattern of association was similar for boys and girls.

While many surveys use brief tools to screen for nonspecific psychiatric distress or dissatisfaction, this series applied rigorous, detailed and consistent methods to assess for a range of different types of disorder according to International Classification of Disease (ICD-10) diagnostic criteria. All cases were reviewed by clinically-trained raters.

[19] World Health Organisation (2019) Epidemiology. https://www.who.int/topics/epidemiology/en/
[20] Ramchandani, P (204) Ibid 9
[21] Health and Social Care Information Centre (2018) Mental Health of Children and Young People in England, 2017
Trends and characteristics. Health and Social Care Information Centre.
https://files.digital.nhs.uk/A0/273EE3/MHCYP%202017%20Trends%20Characteristics.pdf

It should be noted that the sample included only English speakers and was underpowered to examine variation by ethnicity in detail. Even given this, the survey identified a lower rate of mental disorder for Asian/Asian British, as well as Black/Black British, children. More information about the survey design and methods is available here – https://files.digital.nhs.uk/22/793517/MHCYP%202017%20Survey%20Design%20and%20Methods.pdf

Figure 4: Any mental disorder by ethnic group, 2018



A request was submitted to receive the ethnicity data broken down by age in order to explore if there were differences in prevalence between primary and secondary age, however the sample size was not large enough to perform this analysis.

3.1.2 Population studies

A systematic review was carried out in 2008 of population based studies exploring child mental health differences amongst ethnic groups in Britain[22]. Similarly to the prevalence survey, the systematic review found that children in the main minority groups have **similar** or **better** mental health than White British children for common disorders:

- Population-based studies suggest that Black African and Indian children may experience **better** mental health than White British children, while the mental health of Mixed race, Black Caribbean, Pakistani and Bangladeshi children is **similar**.

- Within the common mental disorders, Indian children seem to display relatively more emotional and/or fewer behavioural problems.

- The converse may be true of Black Caribbean and Mixed White/Black Caribbean children – i.e. relatively more behavioural and/or fewer emotional problems.

- Eating disorders: there is some evidence of problematic eating attitudes in South Asian girls.

Some studies adjusted for confounding factors, but this had little effect on observed advantages.

A 2017 study of 2000 adolescents in England (age 13-18) completed the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS). Differences between lifetime history of self-harm was statistically significant between participants with a White background (16.3%) and those with an Asian background (6.8%)[23].

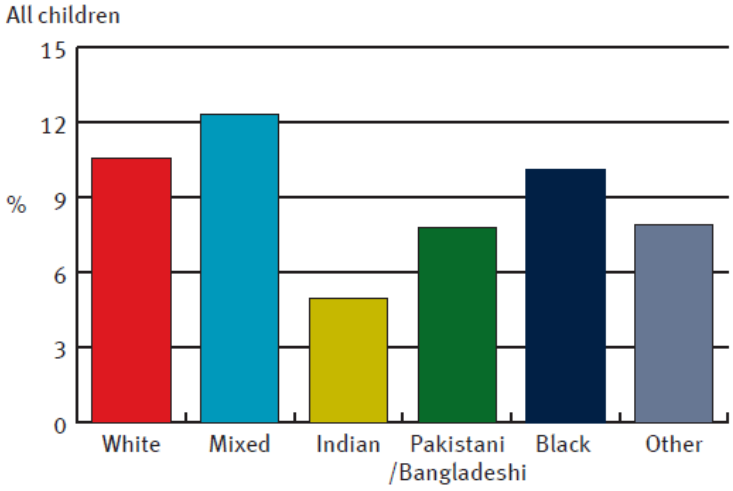
[22] Goodman, A., Patel, V. and Leon, D. (2008) *Child mental health differences amongst ethnic groups in Britain: a systematic review*. BMC Public Health 2008, 8:258

[23] Morey, Y., Mellon, D., Dailami, N., Verne, J. and Trapp, A. (2017) Adolescent self-harm in the community: an update on prevalence using a self-report survey of adolescents aged 13-18 in England. Journal of Public Health, V29 (1) PP. 55-64

3.1.3 Mental health findings from the Millennium Cohort Study

A recent, large scale study using the data from the Millennium Cohort Study [24] explored the difference in the proportions of 11-year-old children with severe mental health problems according to a range of socio-demographic factors including ethnicity. All the findings are based on SDQ scores provided by parents.

Figure 5: Percentages of 11-year-old children with severe mental health problems (total difficulties) by ethnicity: parent ratings, UK, 2012



This shows that, among all children, prevalence is highest in the Mixed group, followed by those classified as White. In all the other four ethnic groups for which information is given, the prevalence of severe problems is below the national average and is particularly low among children of Indian origin. These differences are not, however, at a level which reaches statistical significance.

Figures 6 and 7 show this split by gender.

[24] Gutman LM, Joshi H, Parsonage M, Schoon I. (2015) *Children of the new century: mental health findings from the Millennium Cohort Study, Centre for Mental Health*.. http://cdn.basw.co.uk/upload/basw_120221-1.pdf

Figure 6: Percentages of 11-year-old boys with severe mental health problems (total difficulties) by ethnicity: parent ratings, UK, 2012

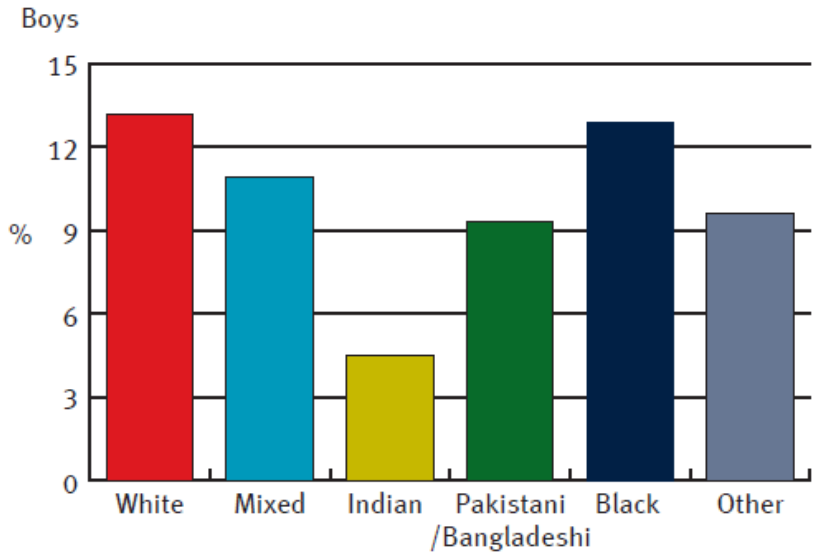
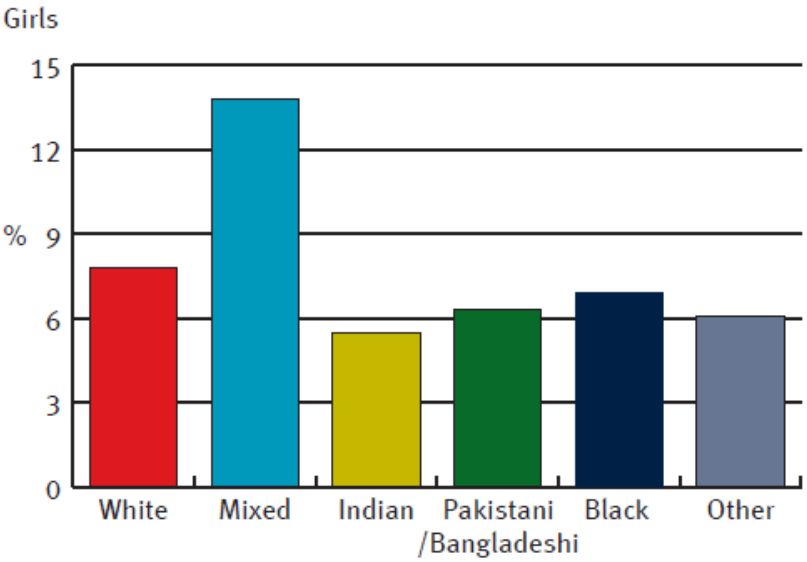


Figure 7: Percentages of 11-year-old girls with severe mental health problems (total difficulties) by ethnicity: parent ratings, UK, 2012



Patterns for boys and girls within ethnic groups are broadly similar but with some exceptions. In particular, the prevalence of severe problems among boys in the Mixed group is below rather than above the national average, meaning that the high overall prevalence of severe problems in this group is fully explained by an extremely high level of problems among girls.

Severe mental health problems are most common among White boys, closely followed by those classified as Black. Among both boys and girls, prevalence is lowest in Indians, with the rate for boys being particularly low.

More detailed analysis showed the following features of note:

- very low levels of conduct problems - but not hyperactivity/inattention - among Indian children;
- high levels of emotional problems among children in the Mixed group, particularly girls;
- exceptionally low levels of conduct problems among girls in the Black and Other groups
- very high levels of peer problems among boys in the small and heterogeneous Other group

The pattern of severe problems across ethnic groups just described contrasts with earlier waves of the survey, where Indians and Mixed had similar total difficulties scores to Whites, while Pakistanis and Bangladeshis, particularly the former, had significantly higher levels of problems[25]. The earlier surveys show a contrast between a high level of problems among Black Caribbean people and a particularly low one for Black Africans.

3.1.4 Summary

A variety of research including the national prevalence survey, the Millennium Cohort study and a systematic review consistently show that people from BAME communities have similar or lower rates of mental health problems than White British young people. Young people with Mixed Heritage are an emerging group in terms of mental health need.

The use of broad ethnicity groupings and the cross-cultural validity of assessment tools (such as the SDQ) means that caution must be taken when interpreting these findings. Nevertheless it raises interesting questions regarding resilience and community assets within BAME communities that may contribute to these lower prevalence levels.

[25] George, A., Hansen, K., Schoon, I. (2006). Child Development. In: S. Dex & H. Joshi (Eds.). Millennium Cohort Study Second Survey. Descriptive Report. London: Centre for Longitudinal Studies. Cited in Ibid 25

3.2 Equity of service access

Alongside understanding prevalence estimates, it is necessary to explore whether the needs of those people that do have mental health difficulties are being met in an equitable way, by reviewing access to support for SEMH issues. This section reviews national research regarding access to mental health services, plus data from education, youth justice and the care system as these systems are known to impact on and be interrelated with mental health difficulties.

3.2.1 Mental Health Services

The systematic review[26] reviewed studies about service access and found the following:

- Consistent evidence of underrepresentation of Indian, Pakistani, Bangladeshi and 'South Asian' children (10 out of 13 studies)

- Sparse evidence re Black and Black African, Black Caribbean underrepresentation however the methodology is too poor to draw conclusions.

- One clinic study showed overrepresentation of in-patients with psychosis (mostly refugees from Africa)

The Department for Children, Schools and Families carried out an independent review of CAMHS[27]. In their review of the literature relating to BME groups they concluded it was inconsistent in terms of accessing CAMHS, however as part of the review they visited and reviewed 9 areas in the country and stated that BME children and young people were underrepresented.

In contrast, an online counselling and support service, 'Kooth' has recently reported an over-representation of BAME young people using the service, in comparison to the population[28]. In certain regions, the difference was particularly stark. Twenty-one per cent of Kooth clients in Hertfordshire were from a BAME background, compared to 12 per cent of the Hertfordshire population, while in Lewisham, 67 per cent were BAME, compared with 46 per cent of the population.

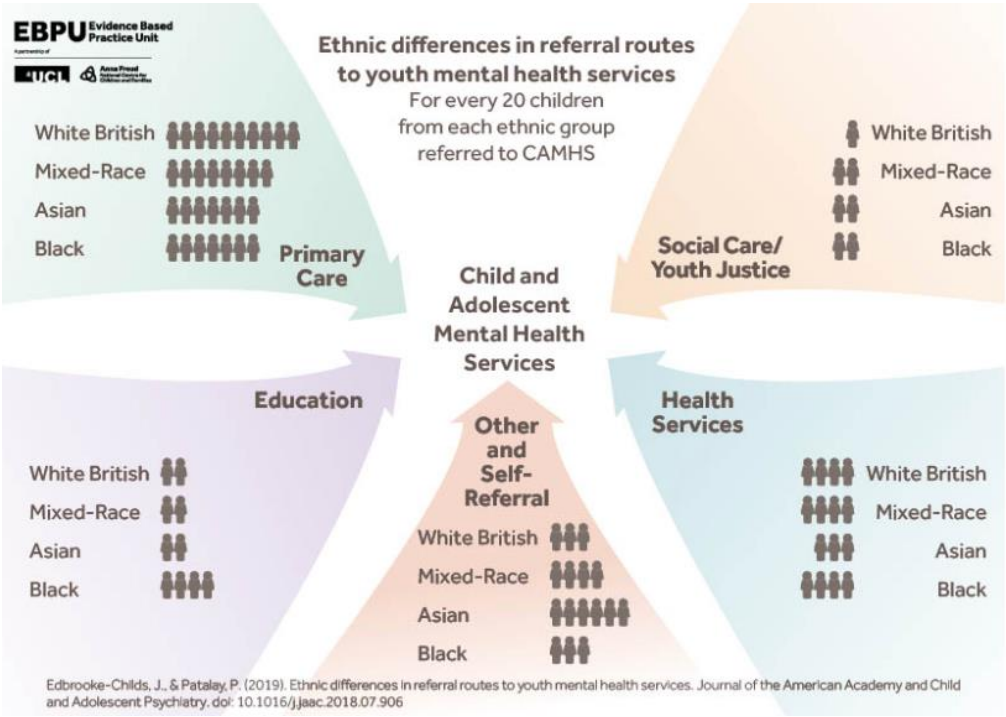
[26] Goodman, A., Patel, V. and Leon, D. (2008) *Child mental health differences amongst ethnic groups in Britain: a systematic review*. BMC Public Health 2008, 8:258
[27] Department for Children, Schools and Families (2008) *Children and young people in mind: the final report of the National CAMHS Review*. London: Department of for Children, Schools and Families
[28] Education Policy Institute (2017) Online mental health support for young people. https://epi.org.uk/publications-and-research/online-mental-health-support-young-people/

3.2.2 Referral Route to CAMHS

Research has consistently demonstrated a difference in referral route to CAMHS depending on ethnicity. A recent study[29] used multinomial logistic regressions to show that BAME children were more likely to be referred to CAMHS through education, social, and other services than primary care, compared to White British children. It found:

- Among white British young people, one in 20 are referred to CAMHS from social care or youth justice routes.
- The proportion doubles to two in every 20 among mixed-race, Asian and black young people.
- Ten in every 20 referrals for white British young people are through a primary healthcare professional such as a GP
- The proportion falls to eight for every 20 among referrals of mixed-race children and seven in every 20 children of Asian and black heritage who are referred to CAMHS.

Figure 8: Ethnic differences in referral routes to youth mental health services



Source: Edbrooke-Childs and Patalay 2019

[29] Edbrooke-Childs and Patalay, (2019) Ethnic Differences in Referral Routes to Youth Mental Health Services Journal of the American Academy of Child and Adolescent Psychiatry Volume 58, Issue 3, Pages 368–375.e1.

A sensitivity analysis examined whether ethnic differences in referral route were attenuated when also accounting for service area deprivation, and the above effects were only partially attenuated. This suggests socioeconomic status plays an important role but does not account for all the inter ethnicity differences[30].

3.2.3 CAMHS Treatment termination

There is inconsistent evidence about how BAME children and young people terminate treatment with CAMHS with some findings suggesting BAME children were more likely to terminate treatment prematurely. A recent large scale study[31] showed that compared to White British children, BAME children were *less likely* to have their case closed because child and family stopped attending (i.e. dropped out) than mutual agreement to end treatment (i.e. planned end). Asian children were also more likely to have their case closed because of referral to another service and were less likely to have their case closed because of other reasons than mutual agreement to end treatment, compared to White British children. This would suggest that once BAME children attend CAMHS they are less likely to drop out than White British children, however the findings are inconclusive.

3.2.4 SEMH Special Educational Needs (SEN) data

The term Social, Emotional and Mental Health needs (SEMH) replaced the term 'behaviour difficulties' in the SEN code of practice (2014). The reforms sought to empower families in decision-making about the services they use, and to speed up and simplify access to support[32]

Statutory Guidance [33] states that SEMH may manifest itself in a variety of ways including '*becoming withdrawn or isolated, as well as displaying challenging, disruptive or disturbing behaviour.*"

It acknowledges that '*these behaviours may reflect underlying mental health difficulties such as anxiety or depression, self-harming, substance misuse, eating disorders or physical symptoms that are medically unexplained. Other children and young people may have disorders such as attention deficit disorder, attention deficit hyperactive disorder or attachment disorder."*

[30] Edbrooke-Childs and Patalay, (2019) Ethnic Differences in Referral Routes to Youth Mental Health Services Journal of the American Academy of Child and Adolescent Psychiatry Volume 58, Issue 3, Pages 368–375.e1.
[31] Edbrooke-Childs, J., Newman, R., Fleming, I., Deighton, J., and Wolpert, M. (2016) The association between ethnicity and care pathway for children with emotional problems in routinely collected child and adolescent mental health services data. European Child and Adolescent Psychiatry, Vol 25 (5) pp 539-546
[32] Ibid 3
[33] Department of Health, 2015, Special educational needs and disability code of practice: 0 to 25 years Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities

A recent report[34] analysing data from the National Pupil Database from 2005-2016 in England, shows Black Caribbean and Mixed White and Black Caribbean pupils are twice as likely to be identified with SEMH needs as White British pupils, controlling for age, sex and socio-economic deprivation. 84 LAs show over-representation of Black Caribbean/ Mixed White/Black Caribbean for SEMH, none show under-representation.

3.2.5 Exclusions from education

Analysis of national exclusions data [35] for 2016/17 in England shows:

- pupils from the Traveller of Irish Heritage and Gypsy/Roma ethnic groups had the highest rates of both temporary ('fixed period') and permanent exclusions
- pupils from the Chinese and Indian ethnic groups had the lowest temporary exclusion rates
- Black Caribbean pupils were permanently excluded at nearly 3 times the rate of White British pupils
- across the broad ethnic groups, Black and Mixed ethnicity pupils had the highest rates of both temporary and permanent exclusions

Exclusion rates would seem to be a proxy for the presence of diagnosable level of conduct disorder[36].

3.2.6 Youth Justice Service

The overall picture for England and Wales shows that Black, Mixed and Other categories are all over-represented in the youth justice system, with Asian and White categories under-represented compared with the population as a whole

Looking at the rate of arrests for other ethnicities compared to the rate for White children in 2017/18 in England and Wales, Black children are over four times as likely as White children to be arrested. Children from Mixed and Chinese or Other

[34] Strand, S. & Lindorff, A. (2018). Ethnic disproportionality in the identification of Special Educational Needs (SEN) in England: Extent, causes and consequences. http://www.education.ox.ac.uk/wp-content/uploads/2018/08/Executive-Summary_2018-12-20.pdf

[35] Department for Education, 2018, Exclusions. https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/absence-and-exclusions/pupil-exclusions/latest

[36] Department for Education (2016) Special educational needs in England: January 2016. National tables SFR29/2016. Table 6. [Online]
Available at: https://www.gov.uk/ government/statistics/special-educational-needs-in-england-january-2016 .
Cited in Ibid 52

ethnicities were around twice as likely to be arrested than White children, while Asian children had a similar chance to their White counterparts of being arrested[37].

3.2.7 Looked After Children

Analysis of ethnicity breakdown of the looked after children population in 2017 in England [38] shows:

- 75% of looked after children at 31 March 2017 were white, 9% were of mixed ethnicity, 7% were black or Black British, 5% were Asian or Asian British and 3% were other ethnic groups.

- Non-white children appear to be slightly over-represented in the looked after children population, in particular children of mixed and black ethnicity. Children of Asian ethnicity are slightly under represented.

- Over the last five years there have been small increases in the proportions of looked after children of non-white ethnicity which is likely to reflect the increase in the number of unaccompanied asylum seeking children.

Note that the Department for Education report used the term 'white' rather than White British, and also used terminology 'non-white' to describe BAME groups. This is not the approach taken in this report as explained in the Ethnicity Concept chapter.

[37] Youth Justice Board, Statistics Bulletin 2019
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774866/youth_justice_statistics_bulletin_2017_2018.pdf
[38] A Department for Education document 'Children looked after in England (including adoption), year ending 31 March 2017'
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664995/SFR50_2017-Children_looked_after_in_England.pdf

3.2.8 Summary

Children and young people from BAME communities appear to be under-represented in CAMHS[39], with stronger evidence for this applying to children and young people from South Asian families[40].

BAME children are more likely to be referred to CAMHS through education, social, and other services than primary care, compared to White British children. Socioeconomic status plays an important role but does not account for all the inter ethnicity differences[41].

There are ethnic differences in identification of SEMH with SEN data, with Black Caribbean and Mixed White and Black Caribbean pupils twice as likely to be identified with SEMH needs as White British pupils, controlling for age, sex and socio-economic deprivation. Traveller Irish category is also over-represented. These groups (plus Gypsy/Roma) are also more likely to be excluded..

Black, Mixed and Other categories are all over-represented in the youth justice system, with Asian and White categories under-represented compared with the population as a whole[42]. BAME children appear to be slightly over-represented in the looked after children population, in particular children of mixed and black ethnicity. It is well-known that these systems have adverse impacts on young people, particularly in terms of mental health.

[39] Ibid 9

[40] Goodman, A., Patel, V. and Leon, D. (2008) *Child mental health differences amongst ethnic groups in Britain: a systematic review*. BMC Public Health 2008, 8:258

[41] Edbrooke-Childs and Patalay, (2019) Ethnic Differences in Referral Routes to Youth Mental Health Services Journal of the American Academy of Child and Adolescent Psychiatry Volume 58, Issue 3, Pages 368–375.e1.

[42] Ibid 37

3.3 Factors that impact on SEMH of BAME groups

The second element of epidemiology is to explore *why* differences are apparent. This section explores the issues that may impact on SEMH of BAME groups, including prevalence and access to services/ support.

3.3.1 Exposure to risk factors

Likelihood of developing mental health problems increases with exposure over time to a complex interplay of individual predispositions to ill health and environmental risk factors[43].The more risk factors that someone experiences, the more likely that they will experience mental health problems.

Children living in poverty in the UK are four times more likely to have mental health problems than children from high-income families[44]. The recent analysis of data from British Millennium Cohort Study showed that both persistent levels of poverty and transitions into poverty are strongly associated with levels of and transitions into childhood mental health problems.

Children from BAME backgrounds are more likely to be living in poverty than are White British children[45]. In England in 2016, 14% of White British pupils are eligible for a Free School Meal (FSM) but this doubles to 25% of Black African, 28% of Black Caribbean and 29% of Mixed White and Black Caribbean pupils[46].

A stable and supportive family life can be a protective factor against mental health problems, with children from single parent families experiencing increased risk factors[47]. Children from Black and mixed heritage backgrounds are more likely to live in lone parent families compared to those from other minority ethnic and White backgrounds[48]. It may be that that other factors associated with being a single parent such as poverty, parental mental health problems and stress play a role, rather than being a single parent per se.

[43] Khan, L., Saini, G., Augustine, A., Palmer, K., Johnson, M. and Donald, R. (2017) Against the Odds, Evaluation of the Mind Birmingham Up My Street programme. Centre for Mental Health https://www.centreformentalhealth.org.uk/against-the-odds

[44] Gutman LM, Joshi H, Parsonage M, Schoon I. (2015) *Children of the new century: mental health findings from the Millennium Cohort Study, Centre for Mental Health*.. http://cdn.basw.co.uk/upload/basw_120221-1.pdf

[45] Pople L, Rees G. Good Childhood Report 2017. August, 2017. The Children's Society. https://www.childrenssociety.org.uk/what-we-do/resources-andpublications/ the-good-childhood-report-2017

[46] Strand, S. & Lindorff, A. (2018). Ethnic disproportionality in the identification of Special Educational Needs (SEN) in England: Extent, causes and consequences.

[47] Ibid 15

[48] Holms, J and Kiernan, K (2010) Fragile Families in the UK: Evidence from the Millennium Cohort Study. Cited in Ibid 15

A good education is a protective factor, however children from some BAME groups face a range of barriers to accessing a good quality education resulting in attainment gaps.

BAME families are more likely to be affected by homelessness, a further risk factor for mental health problems, with ethnic minorities accounting for 40% of homeless households in England in 2016, despite representing 15% of the total population[49]. Living in unsafe neighbourhoods is a further risk factor.

Khan et al (2017)[50] set out growing evidence that for certain young people and at certain critical time periods, cannabis can have a detrimental and in some cases long-lasting effect on mental health. They state there is contradictory evidence on whether African Caribbean boys (the ethnic minority group their paper focuses on) are more likely to be cannabis uses than others. It is concluded that although it is an environmental risk factor that can contribute to triggering schizophrenia in at-risk populations if consumed during high risk adolescent periods, it does not fully explain the over-representation of schizophrenic type illnesses in young African Caribbean men.

There is a strong relationships between exposure to racial discrimination and mental health problems, wellbeing, and behavioural problems[51]. In some studies the experiences of racism/perceived racism had an independent effect even after being adjusted for deprivation and other confounding factors. The negative impact was weakened in the presence of positive factors including having strong family support , the act of celebrating and exploring one's ethnicity and having contact with a range of ethnic groups. Having high self-esteem also affected the extent to which racial discrimination impacted a person's self-worth and how much they felt supported influenced the extent to which they developed severe behavioural difficulties. Positive nurturing parenting, strong social support, performing well academically and ethnic attachment seemed effective in reducing negative effects of racial discrimination on mental health (including behaviour)[52].

Khan et al (2017) also set out the research regarding the incremental 'wear and tear' on the immune system following prolonged exposure to environmental adversity including everyday experiences of racism. Chronic stress impacts on physical and mental wellbeing and is particularly detrimental during childhood; this is known as a person's 'allostatic load'. Studies demonstrate a link between prolonged day to day racism – often referred to as 'micro-aggressions' - and stress responses.

[49] Ibid 43
[50] Ibid 43
[51] Priest, N. et al. (2013) A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people. Social Science & Medicine, Volume 95, pp. 115-127.; cited in Ibid 43
[52] Ibid 43

Interestingly the difference in allostatic load scores between White and Black communities is very small in late teens, but widen with age.

Collective historical trauma, such as holocaust survivors or those with histories of slavery, can have an impact across multiple generation, demonstrated by heightened trauma symptoms[53]. Suggested explanations include higher parental stress; traumatised mothers transmitting stress hormones to foetus affected genes; reminders of original trauma through family and community narratives. These can be 're-ignited' by continuing experiences of injustices such as exposure to racism or poverty. However it may also contribute to building resilience and a sense of thriving 'against the odds'[54].

3.3.2 Emotional distress may be interpreted as behavioural problems

The higher rates of exclusion and SEMH categorisation of children from Black Caribbean heritage would suggest higher rates of diagnosable conduct disorder amongst this group, but the prevalence data (including the recent Millennium Cohort data) does not support this.

A hypothesis for this disparity is that emotional distress amongst some groups is interpreted as behavioural issues. SEMH is socially constructed when compared to other forms of Special Educational Needs, such as profound learning difficulties which have a clear biological basis. Identifying SEMH needs relies on professional interpreting pupils' behaviour in line with expected norms[55]. Therefore the higher rates of Black pupils with SEMH within education settings is often explained as an inappropriate interpretation of ethnic and cultural differences including teacher racism, low expectations and a failure of schools to provide quality instruction or effective classroom management[56].

3.3.3 Interface with Primary Care

Compared to White British peers, young people from ethnic minorities are less likely to enter the mental health system through referral by primary care. The different referral routes by ethnicity are important as a primary care referral implies voluntary help-seeking, social care or youth justice represents a more compulsory admission.

[53] Mohatt, N., Thompson, A., Thai, N. & Tebes, J. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. Social Science & Medicine, Volume 106, pp. 128-136. Cited in Ibid 43

[54] Jones, R. L. (2004) Black psychology. 4th ed. New York: Cobb & Henry. Cited in Ibid 43

[55] Strand, S. & Lindorff, A. (2018). Ethnic disproportionality in the identification of Special Educational Needs (SEN) in England: Extent, causes and consequences.

[56] e.g. Artiles, A. J., Kozleski, E. B., Trent, S. C., Osher, D., & Ortiz, A. (2010). Justifying and Explaining Disproportionality, 1968-2008: A Critique of Underlying Views of Culture. Exceptional Children, 76(3), 279-299. cited in Ibid 35

The difference in referral routes may in some cases be appropriate, as they may be actual differences in morbidity which lead to presentation to different referrers. However if inappropriate then the reasons could include parental perceptions, preferences or knowledge about help seeking (explored below), or it may also relate to professional inherent biases. Interestingly lower referrals to CAMHS for South Asian (mostly Pakistani) families in Glasgow compared to White British young people were apparent even when the GP was South Asian themselves[57].

3.3.4 Lack of awareness of service provision

In one study[58] African Caribbean parents had little awareness of clinical psychology services and how to access. In another study[59] Bangladeshi parents of children attending a CAMHS service suggested that people did not know about the service and were unfamiliar with this kind of support as it is not typical in the area of Bangladesh where most had migrated from.

3.3.5 Stigma

Research with young people from BAME groups[60] showed high levels of stigma and fear in terms of accessing services. Focus groups with British Asian families in Glasgow who were using the CAMHS service[61] identified the stigma of mental illness and the fear of gossip as strong disincentives to use CAMHS. Families who had been in contact with CAMHS sought to minimize the stigma they suffered by emphasizing that mental illness was not madness and could be cured. Fear of gossip about children's 'madness' constituted a major barrier to service use for Asian families in this city.

This issue was suggested as a cause for the higher rates of BAME young people accessing Kooth nationally, due to the anonymity of the service.

[57] Ibid 9
[58] Fatemilehin, I. and Coleman, P. (1999) 'You've got to have a Chinese chef to cook Chinese food!! Issues of power and control in the provision of mental health services' Journal of Community and Applied Social Psychology 9. Cited in Ibid 9
[59] Messent and Murrell (2003) research leading to action: A study of accessibility of A CAMH Service to ethnic minority families. Child and Adolescent Mental Health 8, 3, 118-124
[60] Street, C., Stapelkamp, C., Taylor, E.,Malek, M. and Kurtz, Z. *(2005)* Minority Voices *Research into the access and acceptability of services for the mental health of young people from Black and minority ethnic groups. Internet publication, Young Minds.*
[61] Bradby, H., Varyani, M., Oglethorpe, R., Raine, W., White, I. and Minnis, H. (2007) British Asian families and the use of child and adolescent mental health services: a qualitative study of a hard to reach group. Social Science and Medicine, Vol 65, Issue 12

3.3.6 Distrust of authority/ fear of racism

Communities may have negative attitudes about mental health services, related to the higher rates of compulsory detentions for adults from BAME groups. This may lead to lack of trust in services, with a knock on effect in terms of accessing support for children and young people. Asian families in Glasgow whose children had complex emotional and behavioural problems said that discrimination by health, education and social care professionals exacerbated their child's difficulties[62].

3.3.7 Cultural appropriateness of services

In one study[63] some African parents felt that mental health services represent White culture and lack understanding about the values and child-raising approaches in other cultures. Another study[64] found wariness, with some parents requesting Black psychologists who can practise from a non-Eurocentric knowledge base. There may also be cultural differences in symptom expression which clash with the understanding of euro-centric services or even lead to misdiagnosis[65].

An "underrepresentation" of specific ethnic minority backgrounds within the mental health workforce was identified in a recent review [66] (focussing on adults) as another issues contributing to the poor experiences of ethnic minority groups in mental health services. Particularly true of people of Black African and Caribbean origin, the review found poor workforce diversity left service users feeling they "were not understood" by those meant to deliver therapy.

3.3.8 Perceptions of Mental Illness

Individual perceptions about mental health impact on the ability to recognise contributing factors. If the client or the professional does not recognise factors that play a part then the assessment and treatment of issues is likely to be minimised[67]. Clients may also find it difficult to express certain concepts to professionals if they speak a different language, and likewise professionals may not recognise and expression of distress if it does not fit their cultural context[68].

[62] Bradby, H., Varyani, M., Oglethorpe, R., Raine, W., White, I. and Minnis, H. (2007) British Asian families and the use of child and adolescent mental health services: a qualitative study of a hard to reach group. Social Science and Medicine, Vol 65, Issue 12
[63] Ibid 9
[64] Ibid 58
[65] Edbrooke-Childs and Patalay, (2019) Ethnic Differences in Referral Routes to Youth Mental Health Services Journal of the American Academy of Child and Adolescent Psychiatry Volume 58, Issue 3, Pages 368–375.e1.
[66] Department of Health and Social Care, 2018, Modernising the Mental Health Act – final report from the independent review
[67] Ibid 9
[68] Ibid 9

It has often been said that South Asians have a tendency to 'somatise; mental distress by focusing on physical manifestation of distress, however more recently it has been shown that South Asians are not more likely to somatise than other ethnic groups (either majority or minority)[69].

The language and understanding of mental distress differs across ethnic groups[70]. In the Yoruba and, to a lesser extent, in the Bangladeshi culture, magic has a role in causation and cure for mental distress[71]. One study in 2005[72] amongst Muslims in Britain, showed a widespread belief in jinn (spirit) possession. These ideas are ususally alien to most professionals working in the mental health sphere. It is therefore crucial that mental health issues are addressed with cultural sensitivity and an understanding of different cultural models.

3.3.9 Language problems

Cohen[73] interviewed recent migrants with poor English, who found it harder to access primary care (often gate-keepers of mental health services) and who 'dreaded' using child health services as frustrated about communication issues.

3.3.10 Summary

The following factors have been identified as impacting on the development of SEMH difficulties and the barriers in terms of getting support if required:

- Exposure to risk factors for mental health problems
- Emotional distress may be interpreted as behavioural problems
- Interface with primary care
- Lack of awareness of service provision
- Stigma
- Distrust of authority services/ fear of racism
- Cultural appropriateness of services
- Perceptions of mental Illness
- Language problems

[69] Patel, N (ed) (2000) Clinical Psychology: 'Race' and culture: A training Manual. Cited in Ibid 9

[70] Mallinson, S. and Popay, J. (2007) Describing depression: ethnicity and the use of somatic imagery in accounts of mental distress. Sociology of Health and Illness. https://onlinelibrary.wiley.com/doi/full/10.1111/j.1467-9566.2007.01048.x

[71] Lavender, H., Khondoker, A. and Jones, R.(2006) Understandings of depression: an interview study of Yoruba, Bangladeshi and White British people. Family Practice 23(6):651-8.

[72] Khalifa and Hardie (2005) Jinn and psychiatry: comparison of beliefs among Muslims in Dhaka and Leicester. Royal College of Psychiatrists

[73] Ibid 9

4. Health Needs Assessment – Quantitative Research

Chapter 4 assesses the SEMH needs of the Leeds population of children and young people from BAME communities by analysing available data from a variety of sources. This includes:

- estimating mental health prevalence across ethnic groups
- analysing the self-reported pupil perception survey to explore if there are any statistically significant differences by ethnic group
- assessing representativeness of service data compared to the population and predicted prevalence by ethnic groups

As the methodological approach is a comparative needs assessment, where possible, this has been considered in terms of a comparison to the mental health needs of the majority White British group.

4.1 Epidemiology: Local modelling of prevalence rates

Figure 9: predicted rates of mental disorder for each ethnic group, based on the prevalence data provided from the survey Mental Health of Children and Young People in England in 2017.

Ethnic group (categories in national survey)	**Prevalence rates of 'any mental disorder' 5-19 year olds by ethnic group % MD All age**	**Ethnic Group (categories in school census)**	**Total Leeds population School Census January 2018 4 – 16 year olds**	**Number of young people in Leeds estimated to have mental disorder**
Asian / Asian British Indian Pakistani Bangladeshi Chinese Any other Asian background	5.2	Asian Chinese	13,599	707 Asian/ Chinese young people
Black/Black British African Caribbean Any other Black/African/Caribbean background	5.6	Black	7784	436 Black young people
Mixed / Other White and Black Caribbean White and Black African White and Asian Any other Mixed/Multiple ethnic background, **Arab** **Any other ethnic group**, please describe	12.1	Mixed Other Ethnicity	9741	1179 Mixed/ other young people
White other	8.3	White Eastern/ Western European	**2601**	216 White other young people
White British English/Welsh/Scottish/ Northern Irish/British	14.9	White British	**70802**	10,549 White British Young People

Source 1: Mental Health of Children and Young People in England in 2017.
Source 2: 2018 January School Census

The term used within the NHS Digital survey is ‘mental disorder’ therefore this has been applied here, despite it not being a term that is utilised within Leeds due to negative connotations.

The ethnicity categories used in the survey did not exactly match the categories used in the school census so in some cases groups have been combined.

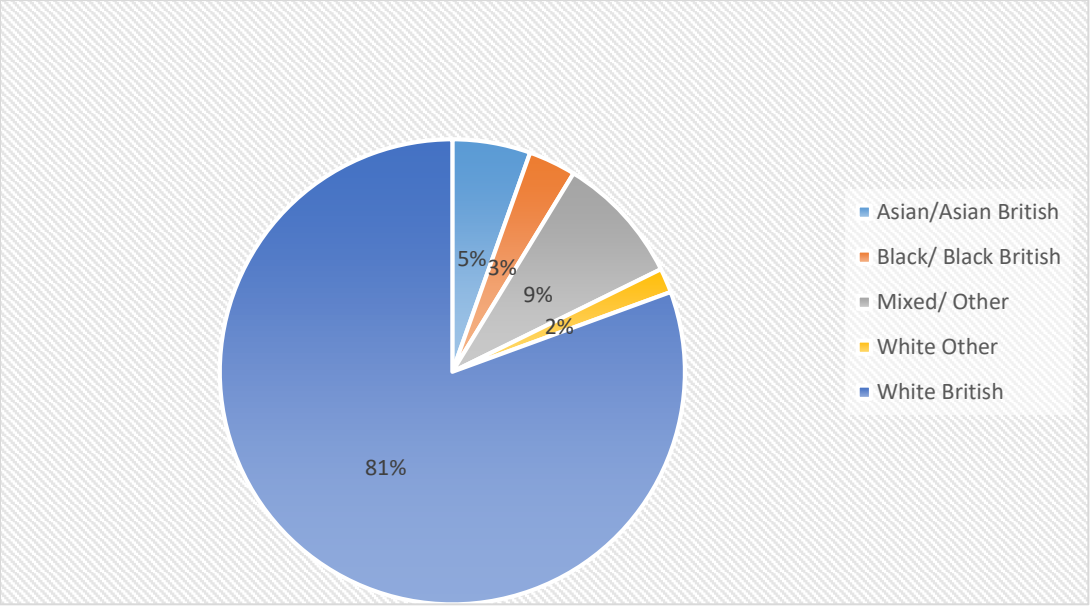
The numbers of young people estimated to have a mental disorder in Leeds do not fully represent the children and young people in each group that have an SEMH need, as it only covers those that fit the criteria employed within the survey, i.e. those that fit a diagnosis within International Classification of Disease (ICD-10) diagnostic criteria. In line with an early intervention approach, there will be a lot more young people who do not fit this criteria but still need support regarding SEMH issues.

Therefore further analysis was carried out to use these prevalence rates to work out what *proportion* of the population of children and young people with mental disorders would be expected to be from each ethnic group.

If the total predicted numbers of children in each group are combined then percentages worked out, we would expect the following breakdown:

Asian/ Asian British – 5.4%
Black/ Black British – 3.3%
Mixed – 9%
White British – 80.6%
White other – 1.7%

Figure 10: Total population of CYP with predicted mental disorder by ethnic group



4.1.1 Summary

Number of young people in Leeds estimated to have mental disorder using the prevalence estimates in the survey ‘Mental Health of Children and Young People in England, 2017’ by NHS Digital:

707 Asian/ Chinese young people
436 Black young people
1179 Mixed/ other young people
216 White other young people
10,549 White British Young People

This doesn’t represent all SEMH need as it only includes those who fit the criteria of ‘mental disorder’ within the study.

If the total predicted numbers of children in each group are combined then percentages worked out, we would expect the following breakdown:

5.4% - Asian/ Asian British
3.3% - Black/ Black British
9% - Mixed
1.7% - White other
80.6% - White British

4.2 Pupil Perception Survey

My Health My School is a pupil perception survey is carried out in many schools across Leeds. It asks children and young people in years 3, 4, 5, 6, 7, 9 & 11 (spanning age 7 to 16) a number of questions in order to generate vital information on the health and wellbeing of these individuals. Answers are anonymous and completed online.

Three years of data (2015-16, 2016-17 and 2017-18) has been combined to provide a larger sample size.

Figure 11: Sample size

	Asian	Black	Chinese	Mixed	Other	Unknown	White	**Total:**
Primary	2755	1277	90	1195	300	1684	13208	**20509**
Secondary	2129	798	52	915	174	623	11902	**16593**

Young people are asked to select their ethnicity from the list below.

Figure 12: Ethnicity question from My Health My School

Which of these describes you?	Tick
White (British, Irish, Traveller or Irish Heritage, Gypsy, Roma and any other White background)	
Asian (Asian British, Indian, Pakistani, Bangladeshi, Chinese and any other Asian background)	
Black (Black British, Black Caribbean, Black African and any other Black background)	
Mixed (White and Black Caribbean, White and Black African, White and Asian and any other Mixed background)	
Other Ethnic Group	
Don't know / Prefer not to say	

Source: My Health My School Survey

There is no open text facility on the survey so children are not able to provide their own responses regarding their ethnicity.

The Chinese category was a separate group for the first 2 years of data but was subsumed into the broader 'Asian' category for the third years' worth of data.

The survey uses a broad category of 'White' rather than 'White British' and 'White Other', subsuming minority groups such as Gypsy, Roma and traveller.

As always with self-reported surveys there are issues relating to validity, however as this questionnaire is anonymous and has a very large sample size it is a good source of data regarding how children and young people in Leeds understand and report their own health and wellbeing.

This section presents the findings from analysis of some of the SEMH focussed questions, comparing the responses from different ethnic groups.

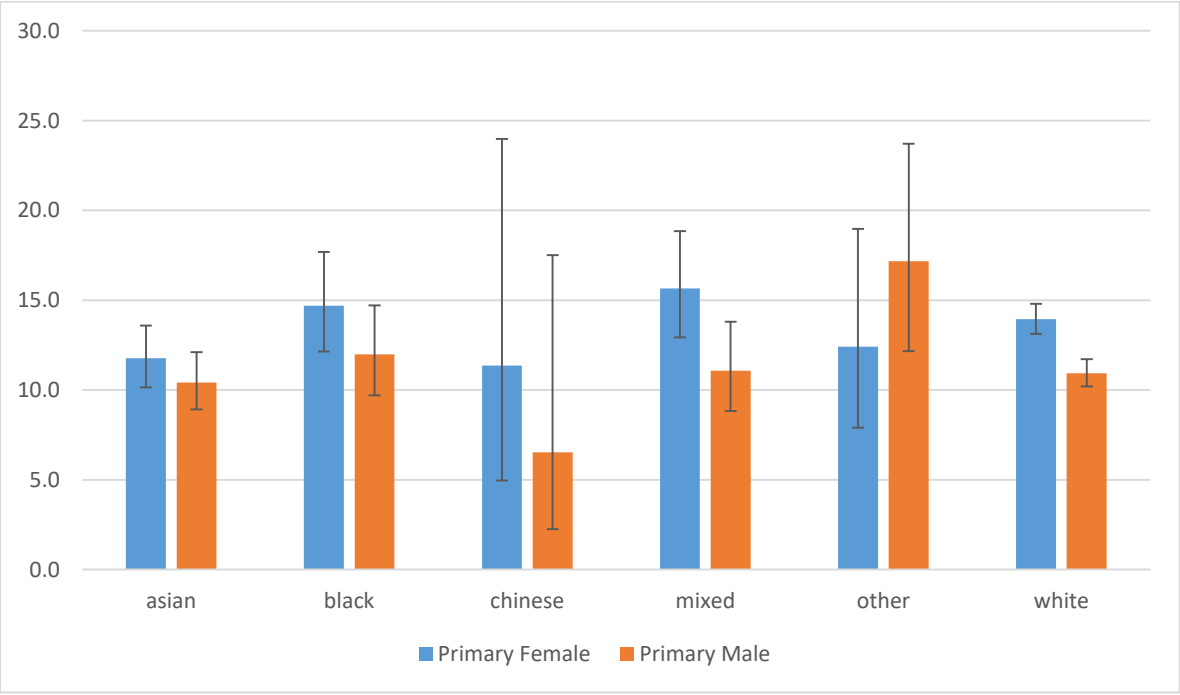
Question: How often do you feel the sad or upset?

Response options: Every day/ most days/ some days/ hardly ever/ never.

Figure 13: Percentage of primary age children (year 3/ age 7 upwards) who selected either 'most days' or 'all days' by ethnic group

Sad/Upset		Asian	Black	Chinese	Mixed	Other	White
Primary	Female	11.8%	14.7%	11.4%	15.7%	12.4%	13.9%
	Male	10.4%	12.0%	6.5%	11.1%	17.2%	10.9%

Figure 14: Percentage of primary age children (year 3/ age 7 upwards) who selected feeling sad/upset either 'most days' or 'all days' by ethnic group, with confidence intervals



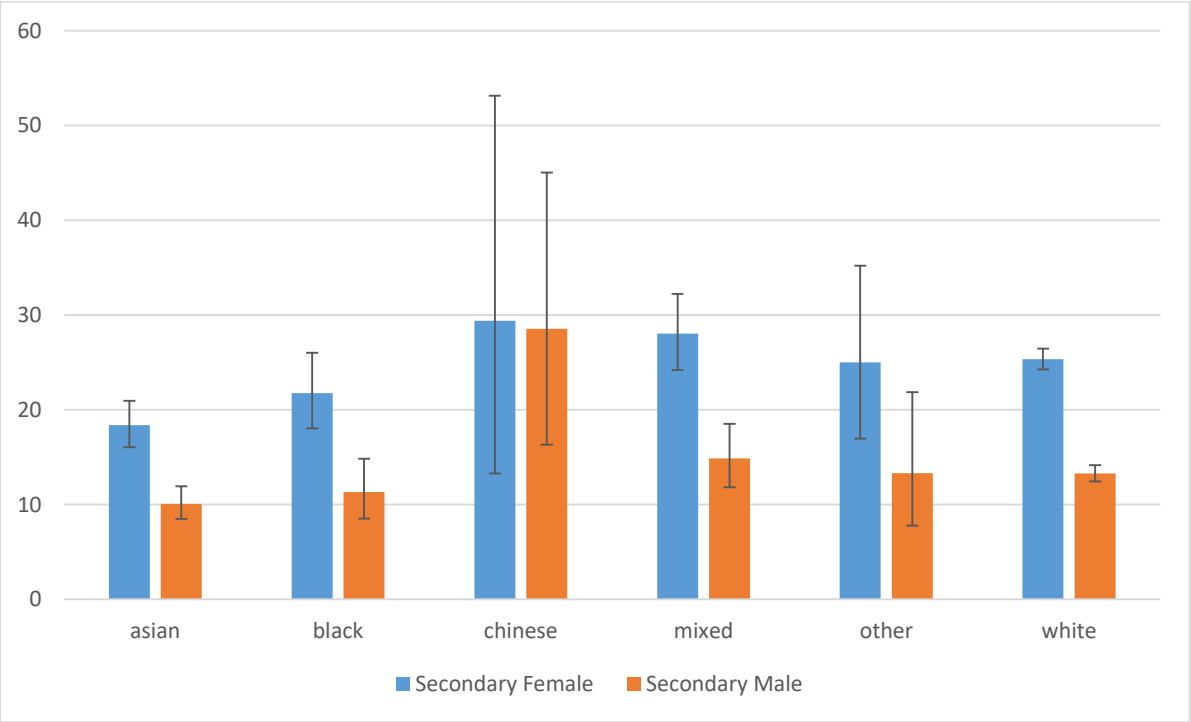
There are no significant differences between ethnicities in Females in Primary School.

Primary boys from ‘Other’ group report significantly worse rates of feeling sad/upset than White boys, though the difference is very small. No other significant differences between ethnic groups within primary boys.

Figure 15: Percentage of secondary age children who selected feeling sad/upset either ‘most days’ or ‘all days’, by ethnic group

Secondary Sad/Upset	Asian	Black	Chinese	Mixed	Other	White
Females	18.4%	21.8%	29.4%	28.0%	25.0%	25.3%
Males	10.1%	11.3%	28.6%	14.9%	13.3%	13.3%

Figure 16: Percentage of secondary age children who selected feeling sad/upset either ‘most days’ or ‘all days’, by ethnic group with confidence intervals



Mixed or White secondary aged girls report significantly higher rates of feeling sad/upset than Asian secondary females. No other significant differences were found between ethnicities.

Chinese boys report significantly higher rates of feeling sad/upset than Asian boys, Black boys or White boys.

White secondary boys report significantly higher rates of feeling sad/upset than Asian boys.

Question: "Have you ever hurt yourself on purpose? (Often referred to as self-harm)"

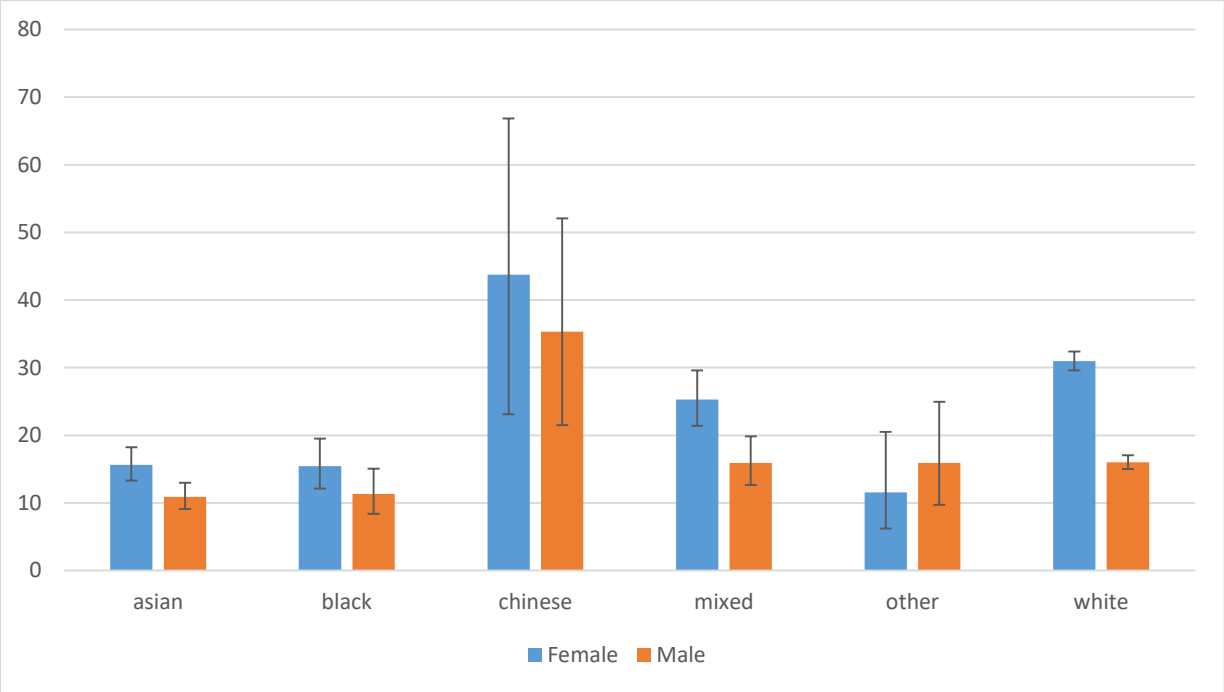
Response options: Yes, No

This question is just asked to secondary aged pupils.

Figure 17: Percentage of secondary age pupils who answered 'yes', by ethnic group

Self harm	Asian	Black	Chinese	Mixed	Other	White
Female	15.6%	15.4%	43.8%	25.3%	11.5%	23.6%
Male	10.9%	11.3%	35.3%	15.9%	15.9%	16.0%

Figure 17: Percentage of secondary age pupils who reported they had ever hurt themselves on purpose, by ethnic group with confidence intervals



Chinese, Mixed, and White British females report significantly higher self-harm rates than Other, Black and Asian groups.

Chinese males report significantly higher self-reported self-harm than all other groups (apart from ''other')

White British boys report significantly higher self-reported self-harm than Asian boys

Question: In the last 12 months, how often (if at all) have you been bullied in or around school?

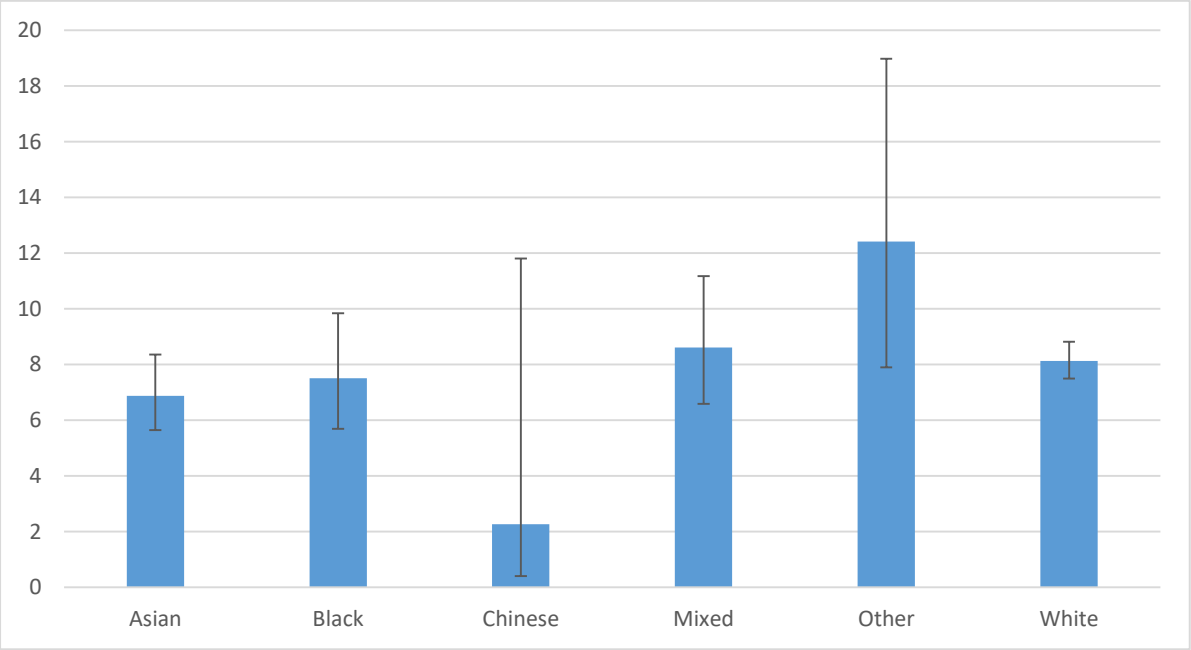
Response options: Not at all/ a few times this year/ every month/ every week/ most days/ every day

Those who selected either 'every day', 'most days', 'every week' or 'every month' have been grouped together to constitute 'regular bullying'

Figure 18: Percentage of primary aged pupils (year 3/age 7 upwards) who reported 'regular bullying', by ethnic group

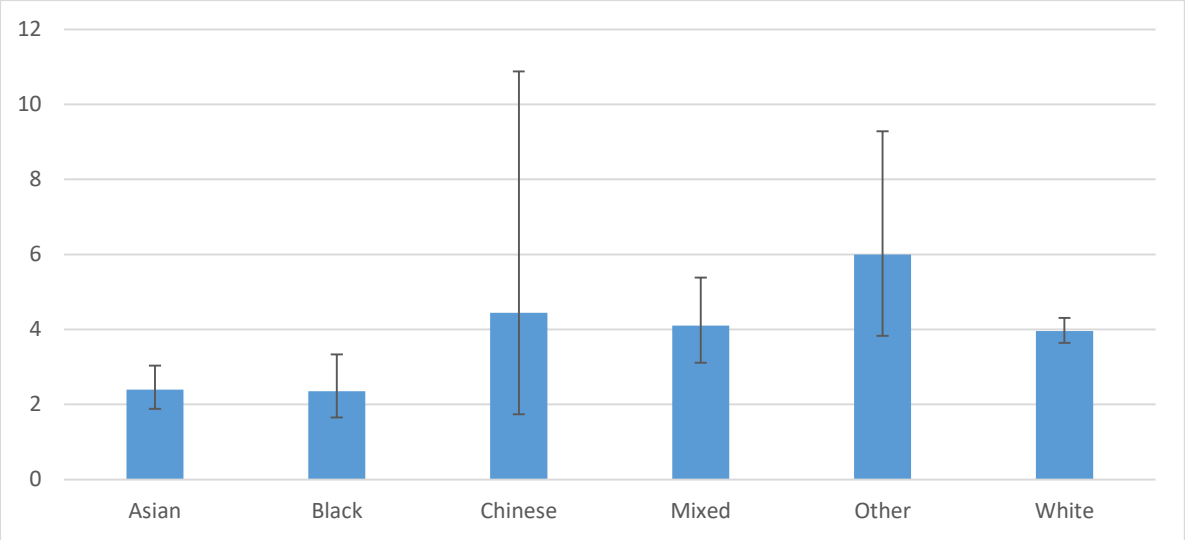
Reported bullying		Asian	Black	Chinese	Mixed	Other	White
Primary	Female	6.88	7.51	2.2	8.6	12.4	8.13
	Male	2.4	2.35	4.44	4.1	6	4

Figure 19: Percentage of primary aged girls (year 3 upwards) who reported 'regular bullying', by ethnic group with confidence intervals



There are no significant differences between ethnicities.

Figure 20: Percentage of primary aged boys (year 3/ age 7 upwards) who reported ‘regular bullying’, by ethnic group with confidence intervals

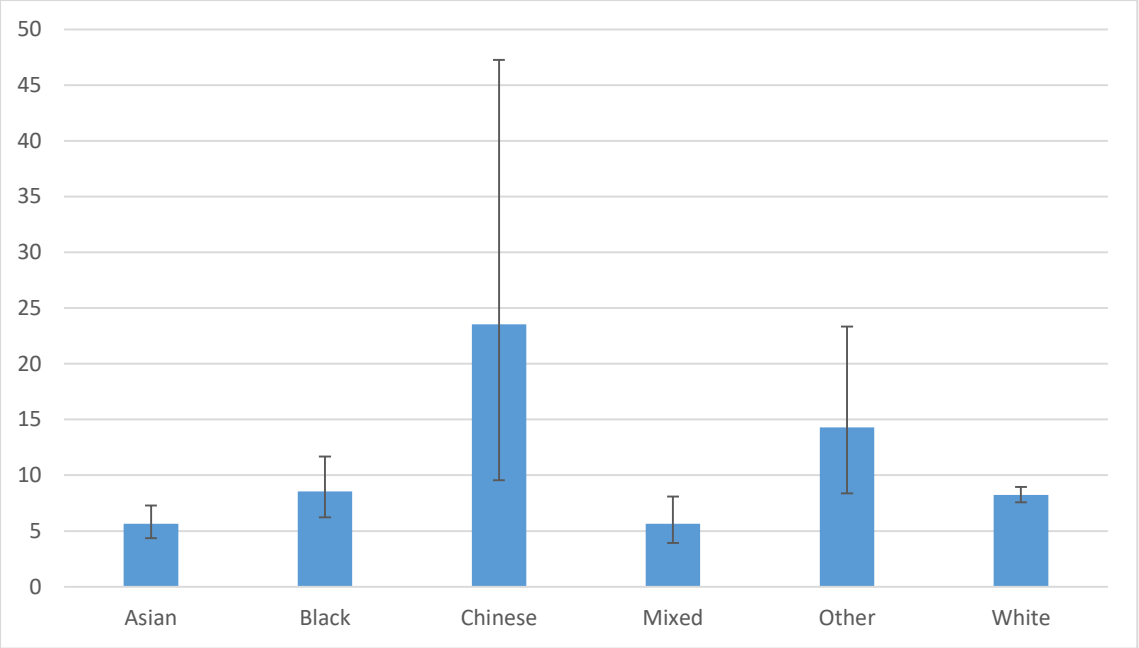


White primary boys report significantly higher rates of bullying than Black and Asian boys, though the difference is small.

Figure 21: Percentage of secondary aged pupils who reported ‘regular bullying’, by ethnic group

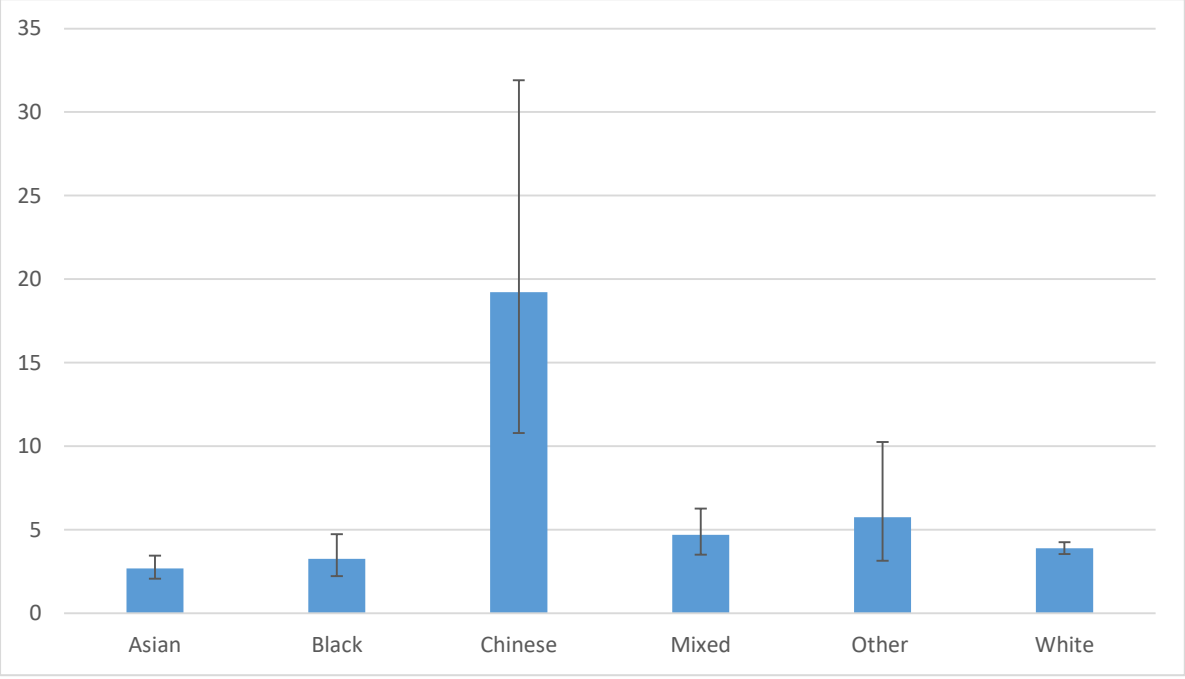
Reported bullying		Asian	Black	Chinese	Mixed	Other	White
Secondary	Female	5.64	8.56	23.52	5.64	14.29	8.34
	Male	2.68	3.26	19.23	4.7	5.75	3.9

Figure 22: Percentage of secondary aged girls who reported ‘regular bullying’, by ethnic group with confidence intervals



Slightly higher rates of bullying reported by White British girls than by Asian girls- this is significant but very small difference.

Figure 23: Percentage of secondary aged boys who reported ‘regular bullying’, by ethnic group with confidence intervals



Chinese secondary boys report significantly higher rates of bullying than rest of the groups.

White British boys have significantly higher rates that Asian boys however the difference is very small.

The responses to a variety of other questions relevant to SEMH were also assessed. These showed the same patterns (BAME groups with similar or better mental health than White British) however analysis was not carried out to assess statistical significance, so the findings have not been included in this report.

3.2.1 Summary

Analysis of My Health My School (a pupil perception survey carried out in many schools) by ethnicity showed some significant differences including:

- Mixed and White secondary aged girls reported significantly higher rates of feeling sad/upset than Asian secondary females.
- Chinese secondary boys report significantly higher rates of feeling sad/upset than Asian boys, Black boys or White boys.
- Chinese, Mixed, and White British females report significantly higher self-reported self-harm than other groups.
- Chinese males report significantly higher self-reported self-harm than all other groups (apart from ‘’other’). White British boys have significantly higher self-reported self-harm than Asian boys.
- In general White groups reported higher bullying levels (apart from Chinese boys)

White British, Mixed and Chinese groups report the poorest well-being. The sample size of the Chinese group is very small so findings must be interpreted with caution, however despite this some differences were statistically significant.

Differences were less apparent amongst primary age children.

These findings echo the national data that suggest BAME groups have similar or better mental health than White British young people.

4.3 Analysis of local service use

This chapter includes analysis of the main services supporting SEMH of children and young people in Leeds by ethnicity. This includes:

- MindMate Single Point of Access (a triage service to ensure children and young people access the most appropriate SEMH service)
- The Market Place (a Third sector service offering a broad range of support including 1-to-1 support, counselling and drop ins)
- Kooth (an online counselling service)
- Child and Adolescent Mental Health Service (CAMHS)
- Two examples of cluster based emotional health support –Beeston, Cottingely and Middleton Cluster cluster and SILC cluster (In Leeds every school belongs to an area of the city called a 'cluster' which provide services that help with additional needs, including emotional and mental health support)

Alongside this service data, the following is also analysed:

- SEMH identification within SEN in education settings
- Analysis of self-harm hospital admission data by ethnicity.

Analysis of ethnic proportions of children and young people within the care systems (and the Therapeutic Social Work team that supports SEMH for this cohort), school exclusions and Leeds Youth Justice Service is also explored. The rationale for this is that these broad systems have impact on mental health and we also know from national data that there is ethnic inequality in these areas.

Finally some detailed analysis of CAMHS data is included, for example, referral route into CAMHS by ethnicity.

4.3.1 Method

Each service provided data regarding service users by ethnicity which was then analysed to find out the proportions from each ethnicity. In order to asses whether ethnic groups are under-respresented or over-represented, these proportions are compared to the ethnic proporrtions in the population (using the school census data). Alongside this, the proportions are also compared to the predicted prevalence for each ethnicity, using the modelling in section 4.1.

The key SEMH services have been presented in a table with percentages, however SEMH identification of SEN is not presented in the service table as it has been analysed externally and presented as odds ratios rather than population proportions, so it is not comparable to the other service data.

4.3.2 Caveats

The following issues regarding reporting ethnicity data were identified:

- Percentage of 'null' (i.e. no ethnicity recorded) is high in some services in particular the MindMate SPA (31% null) followed by CAMHS.

- Teen Connect, the telephone crisis helpline service, was not able to provide ethnicity data.

- Cluster based emotional health services do not report centrally on ethnicity so they are not required to collect it. Some clusters do collect and two of these provided data for this report.

- Services use a different list of ethnicities to record (see Appendix 2 which sets out the differences) therefore in some cases it was necessary to group categories together in order to compare in a meaningful way against the population data.

Other caveats regarding data quality are:

- There will be some double counting as referrals to SPA will also be counted in referrals in the specific services (as the SPA acts as a triage service).

- Different services provided data for different time periods, for example, the smaller services provided data across a longer period to make analysis more meaningful. Kooth (online counselling) is a new service so just had 3 Quarters of data available.

- Services work with different age groups so they are not comparable like for like.

4.3.3 MindMate Single Point of Access

Figure 24: Referrals to SPA during 1st July 2018 - 30th June 2019, by broad ethnic group

Ethnic group	Number	Percentage	Percentage of school population
Asian	104	3.06	12.4
Black	51	2.05	7.1
Mixed	197	5.69	6.4
Other	13	0.49	1.8
White Other	66	1.82	6.2
White British	1932	55.84	64.6
NULL	1075	31.1	-
Total BAME	**431**	**13.11**	**33.9**

All BAME groups are under-represented in the SPA, although the 'Mixed' group is closer to the population. However, there is a particularly high 'Null' group making conclusions from this data impossible.

4.3.4 Cluster based emotional health support

Beeston, Cottingley and Middleton Cluster

Figure 25: Referrals to emotional health services within Beeston, Cottingley and Middleton Cluster during 2017/18 and 2018/19.

Ethnicity	Number	Percentage	Percentage of school population
Asian	17	3.24	12.4
Black	21	2.7	7.1
Mixed	30	4.78	6.4
Other	0	0	1.8
White other	10	1.59	6.2
White British	547	87.1	64.6
Unknown	3	0.48	-
Total BAME	78	12.31	33.9

All BAME groups are under-represented against the Leeds population. It is also worth noting that this cluster has a higher than average BAME population so this under-representation is even more significant.

Overall the numbers accessing the service are small making it difficult to draw firm conclusions, but it suggests there is an issue in terms of access for BAME groups.

SILC Cluster

This Cluster is made up of Springwell Leeds Academy, East SILC – John Jamieson School, Broomfield The South SILC, West Oaks School, North West SILC and West SILC.

Figure 26: referrals to emotional health services within SILC cluster during 2017/18

Ethnicity	Number referred	Percentage	**Percentage of school population**
Asian	21	11.17	12.4
Black	18	9.57	7.1
Mixed	12	6.38	6.4
Other	3	1.6	1.8
White British	125	66.49	64.6
White other	8	4.26	6.2
Unknown	1	0.53	-
Total BAME	62	33	33.9

The proportions are much more in line with population figures within the SILC cluster, with 33% of referrals from BAME groups which is almost the same as the population. There is an over-representation of Black referrals.

This has not been compared to the SILC cluster total population, so it would be interesting to do a more in depth analysis of this.

4.3.5 Kooth

Figure 27: Kooth new registrations during September 2018 and Aug 2019 by ethnic group

Ethnicity	Number	Percentage	**Percentage of school population**
Asian	177	8.42	12.4
Black	70	3.33	7.1
Mixed	122	5.8	6.4
Other	7	0.33	1.8
White Other	96	4.57	6.2
White British	1599	76.11	64.6
Not stated	27	1.29	-
Total	2101	100	
Total BAME	472	22.47	33.9

Figure 28: Kooth new registrations during September 2018 and Aug 2019 by ethnic group, split by quarter

	Q4 18/19	Q1 19/20	Q2 19/20
Total new registrations	598	971	540
Number of BAME new registrations	97	213	104
% of BAME new registrations	16.22%	21.94%	19.26%

This shows that all BAME groups are under-represented in Kooth locally, however the proportions of Mixed and White Other are closer to the population proportions.

The percentage of Asian people accessing the service is higher than many other services, although still below the population proportion.

Nationally we know that Kooth is particularly well used by BAME groups, so it will be interesting to monitor this as the service becomes more established in Leeds.

4.3.6 The Market Place

Figure 29: The Market Place Service user data for January – December 2018

Ethnicity	Number	Percentage	Percentage of school population
Asian	55	6.3	12.4
Black	27	3.07	7.1
Mixed Heritage	55	6.26	6.4
Other	2	0.22	1.8
White Other	35	3.98	6.2
White British	605	68.8	64.6
NULL	100	11.37	-
Total	879	100	100
Total BAME	152	17	33.9

The Market Place also has under-representation of young people from BAME groups, apart from the Mixed group which is the same as the population total. The

White Other group is also worth noting as it closer to the population proportion than other groups.

4.3.7 Child and Adolescent Mental Health (CAMHS)

Figure 30: CAMHS referrals for January – December 2018 by ethnic group

Ethnicity Group	Number	Percentage	Percentage of school population
Asian or Asian British	95	5.3	12.4
Black or Black British	45	2.51	7.1
Mixed Background	110	6.13	6.4
Other ethnic group	32	1.8	1.8
Any other white background	71	4	6.2
White - British	1156	64.47	64.6
Not known (Patient refused)	4	15.8	-
Not Stated	4		
NULL (No ethnicity recorded)	276		
Total	1793	100	100
Total BAME	353	18.5	33.9

BAME groups, apart from Mixed and Other groups, are under-represented in CAMHS. White Other is under-represented but as it closer to the population proportion than Black and Asian groups.

18.5% is recorded as Null, which impacts on the findings, though the overall numbers to the service are high.

4.3.8 Self-harm hospital admission

The following data is for admissions to the Emergency Department for self-harm therefore it does not represent all people who self-harm as the majority do not access hospital. It is ten years of data for people aged 0-19 years old.

Figure 31: Self-harm admissions data age 0-19 years old for 2007/8 to 2017/18 by ethnic group

Ethnicity	Count	Percentage	Percentage of School population
Asian	146	2.88	12.4
Black	84	1.66	7.1
Mixed	101	1.99	6.4
Other	58	1.14	1.8
White other	33	0.65	6.2
White British	4273	84.39	64.6
Null	368	7.27	-
Total	5063	100	100
Total BAME	422	8.33	33.9

Figure 32: Self-harm admissions data for 0-19 year olds 2007/8 to 2017/18 by ethnic group and sex

Ethnicity	Female Count	Percentage	Male count	Percentage
Asian	106	2.7	40	3.7
Black	78	2	6	0.6
Mixed	82	2	19	1.8
Other	50	1.3	8	0.7
White other	24	0.6	9	0.8
White British	3368	84.5	905	83.9
Null	276	6.9	92	8.5
Total	3984	100	1079	100
Total BAME	340	8.5	82	7.6

This shows that White British groups (both male and female) are over-represented compared to the population. The ‘other’ group is close to the population proportion. All other BAME groups are under-represented. This could suggest lower levels of self-harming behaviour, or may be related to BAME groups not attending A&E.

Figure 33 below summarises the service data presented so far in this chapter.

Figure 33: percentage of service users for variety of services by ethnic group

Ethnic Group	School population	Prevalence estimate	MindMate SPA[74]	CAMHS	The Market Place	B. C. & M Cluster[75]	SILC Cluster	Kooth	Self-harm Admissions 0 - 19 year olds
Asian	12.4	5.4	3.06	5.3	6.3	3.24	11.17	8.42	2.7
Black	7.1	3	2.05	2.51	3.07	2.7	9.57	3.33	2
Mixed	6.4	9	5.69	6.13	6.26	4.78	6.38	5.8	2
Other	1.8	-	0.49	1.8	0.22	0.33	1.6	0.33	1.3
White Other	6.2	1.7	1.82	4	3.98	1.59	4.26	4.56	0.6
Total BAME	33.9	19.4	13.11	18.5	19.83	12.31	33	22.17	8.5
White British	64.6	80.6	55.84	64.47	68.8	87.1	66.49	76.11	84.5
NULL	-	-	31.1	15.8	11.37	0.48	0.53	1.21	6.9

[74] SPA = Single Point of Access
[75] B, C & M = Beeston, Cottingley and Middleton

The second approach set out in figure 33 is to compare the service usage to the predicted prevalence proportions (instead of the population propotions).

Taking this approach would suggest that services are better meeting the needs of BAME children and young people, as the proportions accessing services are generally in line with the predicted prevalence. However, this must be interpreted with caution due to the methodological issues set out previously regarding how these prevalence rates were produced.

4.3.9 Identification of SEMH within SEN

Local Authority (LA) feedback reports provide information on ethnic disproportionality in Special Educational Needs (SEN) identification within each LA[76]. The underlying data on which results are based include information on pupils in Year 1 to Year 11 (ages 5-16) at the time of the 2016 January School Census.

Disproportionality exists when pupils from an ethnic minority group are more (or less) likely to be identified with SEN than pupils in the majority group (in England, White British pupils). We say an ethnic minority group is *over-represented* when pupils in that group are *more* likely to be identified, and we say an ethnic minority group is *under-represented* when pupils from that group are *less* likely to be identified, than those in the majority ethnic group.

The report includes *unadjusted Odds Ratios (ORs)* that take into account only pupils' ethnic group membership and type of SEN, and *adjusted ORs* that account for other aspects of pupils' backgrounds and contexts (age, sex and socio-economic deprivation) that may be associated with SEN identification.

The report considered ORs according to the following cut-off values:
<= 0.67 "substantially under-represented":
<= 0.75 "under-represented":
>= 1.33 "over-represented":
>= 1.50 "substantially over-represented":

For adjusted ORs, additional controls were included to account for other individual pupil background characteristics that might be expected to be associated with the odds of SEN identification. Control variables included:

- Entitlement to a Free School Meal (FSM) (with not entitled to FSM as the reference group)

[76] Department of Education (2019) *Ethnic disproportionality in the identification of Special Educational Needs (SEN): Leeds Local Authority Feedback Pack*. http://www.education.ox.ac.uk/wp-content/uploads/2019/01/Leeds-LA-pack.pdf

- Gender (with Girl as the reference group)
- Birth season (Autumn, Spring or Summer; with Autumn as the reference group)
- Year group (with Y1 as the reference group)
- Indicators of Deprivation Affecting Children Index (IDACI) score for each pupil's home neighbourhood (normalised; a continuous measure)

Figure 34: Leeds and national Unadjusted SEMH Odds-Ratios by ethnic group (Yr1-11) 2016

Ethnic Group	Leeds	National
White Irish	-	0.92
Traveller Irish	-	**2.86***
Traveller Gypsy/Roma	**1.74***	**1.64***
White other groups	0.75*	0.57*
Mixed White & African	1.38	**1.18***
Mixed White & Caribbean	**2.50***	**1.94***
Mixed White & Asian	0.95	0.72*
Other Mixed	**1.61***	**1.07***
Indian	0.15*	0.24*
Pakistani	0.63*	0.50*
Bangladeshi	1.00	0.46*
Any other Asian	0.35*	0.31*
Black African	0.93	0.83*
Black Caribbean	**3.48***	**2.29***
Black other groups	1.33	1.31*
Chinese	-	0.20
Any other group	0.36	0.61
Unclassified/Refused	**1.01**	**1.11***

- = significant at the p<0.05 level

Source: Department of Education (2019) Ethnic disproportionality in the identification of Special Educational Needs (SEN): Leeds Local Authority Feedback Pack.

Figure 35: Leeds and National SEMH Adjusted Odds Ratios by ethnic group (Yr1-11) 2016

Ethnic Group	Leeds	National
White Irish	-	0.85*
Traveller Irish	-	**1.53***
Traveller Gypsy/Roma	1.08	1.17*
White other groups	0.65*	0.53*
Mixed White & African	1.02	0.92*
Mixed White & Caribbean	**1.76***	**1.38***
Mixed White & Asian	0.78	0.67*
Other Mixed	1.28*	0.88*
Indian	0.19*	0.23*
Pakistani	0.47*	0.36*
Bangladeshi	0.51*	0.26*
Any other Asian	0.26*	0.27*
Black African	0.56*	0.52*
Black Caribbean	**2.14***	1.43*
Black other groups	0.82	0.84*
Chinese	-	0.21*
Any other group	0.27	0.40*
Unclassified/Refused	0.83	0.95*

*=significant at the p<0.05 level.

Source: Department of Education (2019) Ethnic disproportionality in the identification of Special Educational Needs (SEN): Leeds Local Authority Feedback Pack.

Figure 36: Leeds SEMH frequency count – Yr 1 -11 (2016)

Ethnic Group	Leeds
White Irish	3
Traveller Irish	6
Traveller Gypsy/Roma	34
White other groups	90
Mixed White & African	29
Mixed White & Caribbean	121
Mixed White & Asian	35
Other Mixed	84
Indian	10
Pakistani	117
Bangladeshi	36
Any other Asian	20
Black African	122
Black Caribbean	71
Black other groups	34
Chinese	X
Any other group	16
Unclassified/Refused	24
White British	1909

Source: Department of Education (2019) Ethnic disproportionality in the identification of Special Educational Needs (SEN): Leeds Local Authority Feedback Pack.

In summary, the following categories have higher likelihood of being identified with SEMH within SEN data in Leeds: Traveller Gypsy/Roma, Mixed White & African, Mixed White & Caribbean, Other Mixed, Black Caribbean, Black other groups.

When the controls were included to account for confounding factors, Black Caribbean and Mixed White & Caribbean remained significantly over represented:

Note that ‘Traveller Irish’ category has significantly higher odds of SEMH in the national data but this does not translate to the local data – this may be due to the small numbers of young people in this group locally,

4.3.10 School Exclusions

Analysis of Leeds exclusion statistics from 2016/17 by ethnicity showed over representation from Gypsy, Roma, Traveller, White Irish Traveller, Mixed Black and Caribbean and Black Caribbean pupils[77].

4.3.11 Children in care

Figure 37: All children who have been in care for any point during the 3 years 01/04/2016 – 31/03/2019. Note - it only count's each child once no matter how many times they've been in care)

	Number	Percentage	Percentage of school population
Asian	97	4	12.4
Black	209	8.4	7.1
Mixed	334	13.8	6.4
Other	67	2.8	1.8
White other	112	4.6	6.2
White British	1604	66.1	64.6
Null	2	0.1	-
Total BAME	819	33.6	33.9

Source: Intelligence & Policy Service, Leeds City Council

Black, Other and Mixed groups are over-represented compared to the populaiton, with a particulary high proportion of children and young people from Mixed heretage.

4.3.12 Therapeutic Social Work Service

The Therapeutic Social Work Team (TSWT) is Leeds Children's Services' innovative response to promote the emotional well-being of children and young people who are looked after, living in kinship care), subject to child protection plans or subject to a supervision order. The team works with children and young people up to the age of 18, or to 25 if the young person is a care leaver.

Although this client group is broader than 'children in care', the proportions of this group have been included below to help consider the representation within this service against this population.

[77] DfE statistical first release: fixed term and permanent exclusions, 2017

Figure 38: Service data from three years - 2016/17, 2017/18 and 2018/19

Ethnicity	Number:	Percentage	Percentage of school population	Percentage of LAC population
Asian	40	4.8	12.4	4
Black	39	4.68	7.1	8.4
Mixed	54	6.47	6.4	13.8
Other	50	6	1.8	2.8
White Other	-	-	6.2	4.6
White British	651	78.06	64.6	66.1
Total BAME	819	21.95	33.9	33.6

Source: Therapeutic Social Work team

This would suggest that Asian young people accessing support through TSW service are roughly proprotionate to the proptions of Asian young people who are Looked After. Black, Mixed and White Other are under-represented. The ‘other’ group is higher but this may be related to ethnicity recording issues.

Note – this is crude analysis and would require further detailed analysis to draw defintie conclusions.

4.3.13 Leeds Youth Justice Service

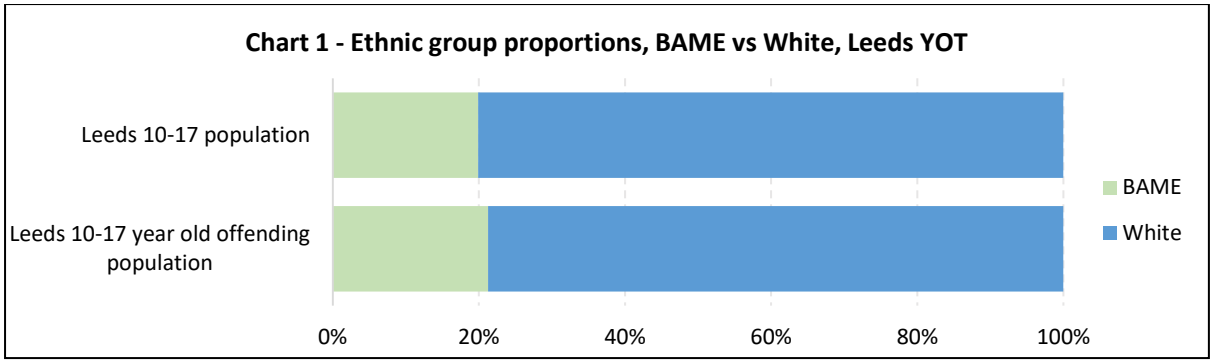
The following extract is taken directly from the report 'Ethnic Disproportionality' produced by Leeds Youth Justice Service, using figures from the Youth Justice Board.

Ethnic disproportionality

The following table shows the proportion of young people who received a youth caution or court sentence in Leeds over the last six years, broken down by ethnicity. The data was published by the YJB in June 2019.

Share of total	2013	2014	2015	2016	2017	2018	2011 mid year 10-17 population by ethnic group
Asian	5%	4%	5%	4%	5%	5%	8%
Black	6%	6%	8%	5%	5%	6%	3%
Mixed	5%	8%	5%	6%	8%	10%	6%
Other	0%	1%	3%	2%	2%	1%	1%
BAME	16%	20%	21%	18%	19%	21%	17%
White	84%	80%	79%	82%	81%	79%	81%

The biggest change in the year from 2017 to 2018 is in the Mixed ethnic category, which has increased by 2 percentage points, and in the White category which decreased by 2 percentage points. The proportion of young people from the Mixed ethnic category has doubled in the years since 2013 to 2018, from 5% to 10%. Although the demographics have changed since the 2011 census in which Mixed young people made up 6% of the total 10-17 population, the 2018 secondary school census in Leeds shows the Mixed population to be 6%, which suggests this group may be over-represented in the youth justice system in Leeds.
The chart below shows a comparison of the ethnic composition of the young people known to Leeds YOT compared with the overall 10-17 population (2011 census).

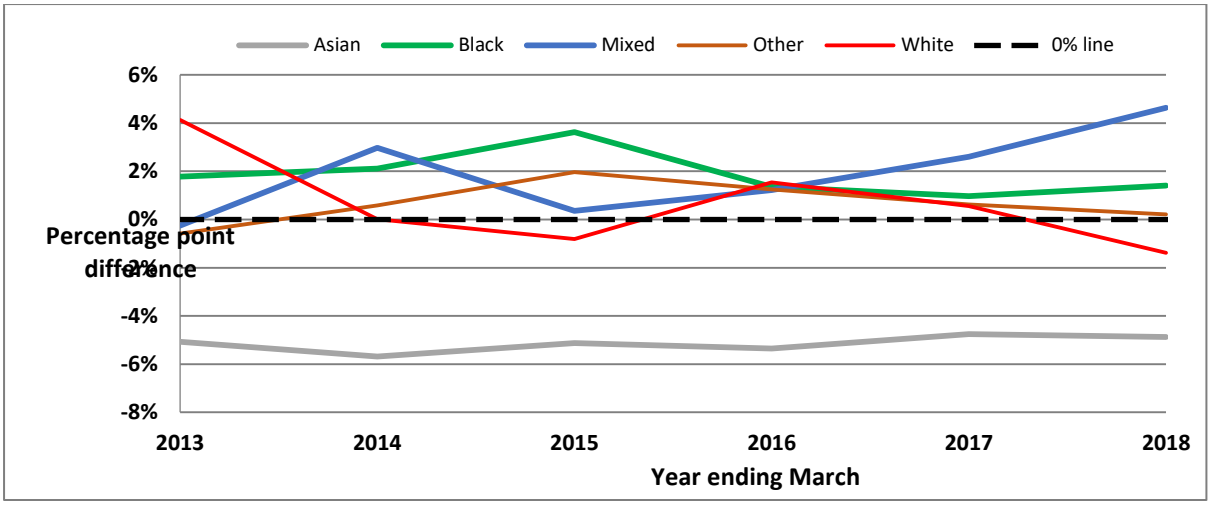


The following table shows that the Mixed population are over-represented in the Leeds YOT and that this is statistically significant.

Ethnic group	Offending Population	Share of total [1]	2011 mid year 10-17 population by ethnic group	Share of total [2]	% Point Difference	Statistically significant	Over-represented and Significant cohort size
Asian	18	5%	6,522	10%	-5%	Yes	No
Black	20	6%	2,728	4%	1%	No	No
Mixed	35	10%	3,335	5%	5%	Yes	Yes
Other	4	1%	595	1%	0%	No	No
BAME	77	21%	13,180	20%	1%	No	No
White	285	79%	53,066	80%	-1%	No	No

The overall picture for England and Wales shows that Black, Mixed and Other categories are all over-represented in the youth justice system, with Asian and White categories under-represented compared with the population as a whole.

The following graph shows the percentage point difference between the ethnic groups in the Leeds YOT cohort compared with the 10-17 population as a whole. A positive difference shows where a cohort makes up a greater proportion of the offending cohort than the population as a whole. The difference has been steadily growing for the Mixed ethnic cohort since 2015, rising to 5 percentage points in 2018. Young people in the Black ethnic category have always been over-represented, although the difference is smaller at 1 percentage point in 2018.



End of extract from Ethnic Disproportionality Report, produced by Leeds Youth Justice service.

4.3.14 Detailed analysis of CAMHS data

Further analysis was carried out regarding CAMHs data.

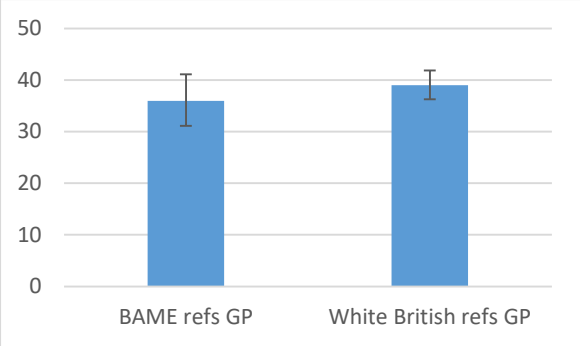
Referral route

Figure 39: Referral route to CAMHS for referrals January to December 2018

	Number BAME	Number White British	Percentage of total BAME referrals	Percentage of total White British referrals
A&E Ref	26	78	7.36	6.75
Acute Trust (not A&E)	59	184	16.7	15.91
Community Health	12	61	3.4	5.28
Community Paediatrician	22	55	6.23	4.77
Education	16	53	4.5	4.58
General Medical Practitioner	127	451	35.97	39.01
Health Visitor	21	65	5.95	5.6
Other	10	28	2.83	2.42
Local Authority	5	26	1.42	2.24
Self referral	5	21	1.42	1.82
Trust outside Leeds	6	27	1.7	2.34
Youth Offending Team	19	40	5.38	3.46
Social services	5	13	1.41	1.12

Figure 39 shows that there are very similar proportions of referrals from most referring categories, with some small differences. The most apparent difference is with GPs, as 39.01% of all referrals for White British population come from the GP compared to 35.97% of the total BAME referrals. However, figure 34 below shows that this difference is not significant.

Figure 40: Percentage of referrals from GP for BAME and White populations, with confidence intervals



There is also a higher proportion of referrals from Leeds Youth Justice Service ('Youth Offending Team') for BAME groups.

Although the differences are not significant it does reflect findings from national research that White British young people are more likely to be referred by a GP. Although we cannot draw this conclusion locally it is worth considering whether the lack of significance is due to the small sample size and whether analysis of a larger chunk of data would show a significant difference.

Referral reasons

Figure 41: Primary referral reason for referrals to CAMHS for referrals January to December 2018

Primary referral reason	Percentage of total White British patients	Percentage of total BAME patients
Neurodevelopmental Conditions	27.94	32
Self-Harm	27.25	25.79
Anxiety	11.76	8.5
Attachment/Bonding	8.47	8.5
Depression/Low Mood	7.69	8.22
Eating Problems	4.5	3.97
Conduct Problems	3.11	3.12
Non Specific Behaviour Problem	2.77	0
In Crisis	1.12	1.42
Obsessive Compulsive Disorder	1.04	0.85
Adjustment to Health Issues	0.17	0
First Episode Psychosis(Suspected)	0.17	0
Gender Discomfort Issues	0.3	
Organic Brain Disorder	0	0.28
Post-Traumatic Stress Disorder	0.6	0.28
Psychosis (Ongoing/Recurrent)	0	0.57
Self-Care Issues	0.17	0
Unexplained Physical Symptoms	0.09	0
Phobias	0.35	0.28
Family Relationship Problems	0.43	0.28
Not Known	2.08	4.25
Total numbers of people	1156	353

This shows that of those accessing CAMHS, the primary referral reasons for White British and BAME young people follow the same pattern i.e. both have the highest proportion of referrals for Neurodevelopmental conditions, followed by self-harm, anxiety and depression.

The following small differences can be seen:

- Higher percentage of BAME children presenting with Neurodevelopmental conditions (32%) compared to 27.94% White British
- Self-harm is slightly higher amongst White British (27.25%) compared to 25.79 for BAME
- The percentage of BAME with anxiety is 8.5% compared to 11.76% for White British (136 young people)

- If ‘Conduct problems’ and ‘non-specific behaviour problems’ are combined into one group then it is higher for White British (5.88%) than for BAME (3.12)
- BAME have a higher rate of ‘not known’, as this is 4% compared to 2.08 for White British, however this only represents 6 young people (24 for White British category)

These differences have not been analysed for statistical significance, however as the differences are small it is unlikely they would be significant with this sample size.

Level of Risk

Figure 42: risk categories for referrals split by BAME and White British

	NULL (No risk assessment)	No Risk Identified	Low	Medium	High
BAME	26.05	20.73	34.17	18.49	0.56
White British	16.35	21.8	42.39	18.33	1.21

Figure 43: risk categories for referrals split by BAME and White British displayed as graph

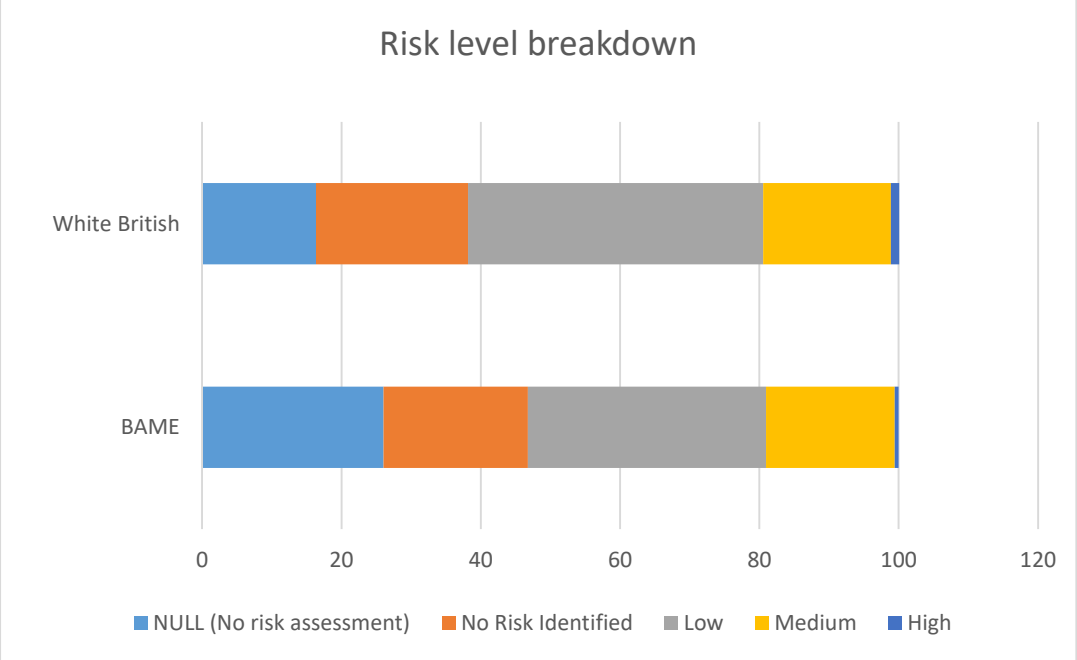


Figure 43 show that there is much higher proportion of ‘null no risk assessment’ for BAME groups. There is a higher proportion of White British with low risk, whereas the numbers with medium and high risk are similar.

This has not been assessed for statistical significance.

4.4 Summary

This has been summarised in two ways – firstly at service level and secondly by ethnic group.

Service level:

Compared to the population, BAME groups under-represented in:

- MindMate SPA
- CAMHS
- Beeston, Cottingley and Middleton Cluster emotional support
- The Market Place
- Kooth
- Self-harm admissions to A&E

BAME groups are represented in line with population in the SILC cluster emotional support

The following BAME groups over-represented in terms of being identified for SEMH in SEN data from schools: Traveller Gypsy/Roma, Mixed White & African, Mixed White & Caribbean, Other Mixed, Black Caribbean, Black other groups.

When the controls were included to account for confounding factors, Black Caribbean and Mixed White & Caribbean remained significantly over represented:

Following groups over-represented in the care system: Black (by a small amount), Mixed, Other. Within the Therapeutic Social Work team (who support this cohort), the Mixed group were represented in line with the population proportions.

Within Leeds Youth Offending Service, the Black population and the Mixed population are over-represented (the latter is statistically significant).

Within school exclusions data the following groups are over represented: Gypsy, Roma, Traveller, White Irish Traveller, Mixed Black and Caribbean and Black Caribbean pupils.

By ethnic group:

Asian population is highly under-represented in SEMH support services.

Black is highly under-represented in SEMH support services. Also over-represented in SEMH SEN data. Slightly over-represented in care system. Over-represented in exclusions data.

Mixed population is underrepresented in SEHM support services, but is much closer to the population proportion in most cases. Also highly over-represented in care system and in Leeds YOS. Over-represented in exclusions data.

White Other population is under-represented in SEMH support services, but not by as larger proportions as Asian or Black groups. Gypsy, Roma and Traveller data is subsumed within the group which is an issue due to research suggesting poor mental health outcomes for these groups. SEN data shows GRT groups over-represented in SEMH rates. Also over-represented in exclusions data.

Other population is under-represented in SEMH support services.

5: Health Needs Assessment Part 2: Qualitative Research

This chapter includes:

- Young People focus groups
- Parent/Carer questionnaire
- Feedback from stakeholders

5.1 Young People Focus Groups

The focus group analysis has been structured using the following headings:

- Conceptualising mental health
- Protective factors
- Risk factors
- Circles of support
- Awareness of services

5.1.1 Pakistani Girls

Rationale: research literature and anecdotal feedback locally both suggested high levels of stigma within South Asian girls/ young women.

Group 1 – 5 girls took part (ages 13, 14, 14, 14, 18)
Group 2 – 5 girls took part (ages 13, 12, 16, 14, 13)

1. **Conceptualising mental health**

There was some understanding of mental health, but this was limited to two individuals who used phrases depression, anxiety, state of mind - your wellbeing, weaknesses and strengths, fixed mind sets and one's ability to do well in stressful situations, to demonstrate their understanding. When prompted to consider mental health and how it may have been presented through school settings or through the media, the majority struggled to express ideas or thoughts around the concept of mental health. This could suggest the concept of mental health may not feature in their vocabulary, however this is an inconspicuous area as later in the discussion one girl talked about not wanting to bring shame on the family by discussing their state of mental health with others.

They felt is someone is experiencing mental health difficulties they may put on a happy face, but suffering internally. Some people went to great lengths to have an increased presence in social situations to cover up their insecurities. Conversely, some people become withdrawn 'you don't see them around' and isolate themselves.

2. Protective factors

Learning to love oneself, treating yourself and not getting caught up in self-blame when things went wrong was discussed. The idea that talking to others for advice and support if one was anxious or stressed was important; parents were cited as the first place to go. Social activities that didn't involve social media including being outdoors, engaging in physical activity and being with friends was also key for the promotion of good mental health, and for some it offered a distraction from troublesome situations. Craft, art based activities and writing were also tools for escapism. Maintaining a distance from friends who were disloyal and created negativity was considered key for achieving good mental health.

3. Risk factors

Social media was considered the biggest risk factor for poor mental health. There was a sense that communication via online chat rooms was quite common but destructive and discussed as 'cyber bullying' by one. Celebrity endorsed videos and blogs appeared to play a big role in how young people judged themselves. There was a strong association between self-image and good mental health. There was an awareness of eating disorders and this behaviour appeared to be exacerbated by the world of celebrities. People acknowledged that whilst someone could look good on the outside it didn't always draw a parallel with their mental state. Body confidence was a significant issue and would at times result in bullying, especially amongst children who were overweight. Pressure from peers to conform to unrealistic ideals of beauty prompted feelings of inferiority which was troublesome for the girls. Homework load and failure to achieve high academic grades at school were contributory factors for low mood in Pakistani children. Seeing others doing well had the potential to bring about low self-esteem and confidence. One individual talked about an unstable home life including domestic abuse and parents divorcing as risk factors for mental health difficulties.

4. Circles of support

Family - Parents played the most important role in providing emotional, physical and responsive support to children in this group. They serve an important purpose because 'parents know you best'; young people were seeking familiarity, a safe place where they could seek reassurance and sound trusted advice. Although it was a small number of people, some didn't feel comfortable going to their parents because they 'can't relate to me'. Siblings were also a 'go to' place for support but this was only useful if there was a match in gender. As an older child, opportunities for support were limited as there was pressure to be a role model and live up to other people's standards; academia was the most prominent factor here with every family's desire for

their children to be in the top sets. Kids masked their struggles, and talked about not wanting other people to find out.

Friends - Friends were also a strong source of support and people connected over their shared interests, ease in communication and mutual respect, but most importantly they were drawn to their peers because their experiences largely mirrored their own. Most importantly they were able to offer advice that was trusted; 'friends get you and you can trust them … and know your situation'.

Community members - One individual shared her experience of being able to confide in a trusted member of the community who taught sports to children in a local community venue. Enabling factors for effective communication included impartiality and good listening skills.

Schools - There was a mixed response when discussing the role of schools and the promotion of good mental health. Near to exam time some schools delivered advice on strategies for achieving good mental health and how to achieve a good routine for revision. They delivered lifestyle advice and highlighted the benefits of achieving a good sleeping pattern and a healthy diet. Where there was a dedicated member of staff who children could approach the experience was more positive. Senior staff members [head of year] were more approachable than regular classroom teachers and appeared to make themselves available and regularly checked in with children. Some individuals talked about schools being the least significant source of support. In cases of bullying, schools intervened and dealt with 'effects' but seldom delved into 'causes'; they 'don't support wellbeing'. Excessive attention given to disruptive children which meant other children who are experiencing issues are missed. Others talked about 'nobody to go to in school setting'. There was a general consensus that there was a lack of investment in the promotion of positive mental in schools but rather a preoccupancy in educating children about drugs and homosexuality.

Online- Social media platforms offered anonymity, and with an exclusive focus on the situation, this detracts from any judgment which was beneficial. Celebrities were considered to be inspirational, through the use of lyrics in music and drama/videos. YouTube videos give advice from one peer to another; shared experiences have a positive impact.

Diary - A safe place to express emotions, providing a release - there is no judgement.

Prayer - Prayer is important, feeling nearer to God helps with communication and feeling positive. One individual talked about the importance of self-awareness. An ability to reflect, assess the choices available and seeking your own solutions was considered the key to achieving good mental health.

5. **Awareness of services**

Limited knowledge of where to go; 2 people mentioned ChildLine.
When asked about whether they would consider accessing a service, there was a huge disinclination with this idea. Some explained that it would be hard to discuss their issues with a stranger, it would be awkward and unproductive as the professional 'doesn't [don't] know you'. With some prompting, it was confirmed that Asian families viewed external support as a negative thing. People would be discouraged from accessing services. However, one girl explained this was dependent on your family background and relationships within the family circle; if it was a strict family you would not be allowed out. Admitting to parents that you were experiencing problems with your mental health would be overtaken by a feeling of embarrassment. There was the idea that seeking external support and people finding out that you were experiencing poor mental health would lead to isolation and have negative implications for the family. People would refer to you with derogatory language.
Children did not find school based support appealing and would not access this due to concerns around confidentiality. They don't trust school and trust is very important.

5.1.2 Bangladeshi girls

Rationale: research literature and anecdotal feedback locally both suggested high levels of stigma within South Asian girls/ young women.

5 girls took part in the focus group.

1. **Conceptualisation of mental health**

The girls had a good understanding of the concept of mental health '*it's linked to mental wellbeing and thought processes…it's thoughts and emotions and how you control them'*

They talked about feeling content, happy with oneself and not having many insecurities as signifying being mentally healthy.

There was a suggestion that you don't always know if someone is struggling '*you can smile and put a brave face on'* though you may realise if someone stopped taking part in activities or stopped looking after their appearance '*some people just give up'*

The link between mental and physical health was mentioned with the example of anorexia.

2. Protective factors

The girls talked about surrounding themselves with people who '*make you feel happy and that you can trust'*

Activities such as shopping, trips to parks/seaside etc, pampering were all mentioned. Exercise was mentioned by many of the girls in terms of releasing hormones and physically looking after yourself. One girl mentioned taking social media breaks.

When asked if religion could be supportive many of the group agreed *'it gives you something to have hope in and follow cos you want to please god'* and *'You can pray – it's like peace when you pray – can distract yourself'* They stated that they pray at home as women don't go to the mosque.

Social media came up as a positive and a negative – it was suggested that taking a social media break could be helpful for maintaining good mental health. However, they also suggested that people find you-tubers who share about their own mental helpful, as well as using social media to find out about support.

3. Risk factors

Pressure

The group talked about pressure and expectations from others, particularly in terms of family pressure to do well in education and follow particular career paths and have plenty of money. They identified that this is a particular a stereotype in Asian families.
This can lead to trying to make yourself into something to please other people but they felt that having lots of money doesn't always make you happy - '*cos society has made this image that if you become 'this' you'll be respected and have a good name – but that's not always the case because people have different characteristics'*

Stigma within community

The group talked about high levels of stigma regarding talking openly about mental health difficulties 'mental health is unheard of in our community.
They said that they are mostly third generation, so they feel things are changing, however they discussed how parents/ family born in Bangladesh don't understand mental health as in their childhood it was 'unheard of'. They stated that mental health was something 'quite new'.

The group stated that ‘the majority of Punjabi women gossip a lot’ and this would be a reason to not tell anyone if they were feeling anxious etc, as they would worry that it would be talked about and exaggerated.
‘Even if someone does have mental health issue they try to hide it as reputation and name and honour is something they want to maintain’ – this was seen to particularly important if they are from a ‘known family’.
They stated that there are words within their language but older generations don’t always accept it

The girls felt that older generations may think it’s a phase that they should just ‘get over’ or they may blame it on other people (including hanging around with people from different cultures) or from factors such as going out too much. *‘They don’t realise it’s your own thoughts that can trigger you to feel a certain way’.* There was a real sense that the young women in the group had a very different understanding of mental health than older generations and that could cause frustration as they felt that they were being misunderstood.

The group discussed how this might change when they left home to get married. It was discussed that this might help ‘It’s until you’re married out of that family and you can make your own decisions for yourself; but others felt it could make it worse when you move into your in-laws family.
They identified that the attitudes and stigma resulted in girls being so close to their friends

‘That’s why most Asian Bengali girls like to confide in their friends cos they know they won’t be judged like that as they can be honest and not be worried’

Isolation

The group discussed how some young people in Asian communities have really strict parents, and they are not allowed to have a phone or go on social media. They said that these young people are only allowed to go to school but otherwise they do not go out to socialise. This can also lead to young people not feeling they can talk to their parents
‘Some parents are strict so they don’t feel like they can speak to them – they have to follow their rules and guidelines’
There was a sense they were feeding back about their peers rather than talking about specific personal experience.

Celebrities

The group briefly discussed how celebrities don’t’ set a good example for young people in terms of body image.

4. Circles of support

Friends

Close friends were seen as a main source of support and were differentiated from wider friends. *'Even though you don't have friends you have levels of friends. Some you tell everything and others you wouldn't trust.'* Others agreed that some friends could still judge them.

Most of the girls talked about close or best friends being key '*We have deep conversations and tell each other everything'.* They said they can connect and related as they have grown up together and share experiences. Most felt that it's easier to talk to friends than parents.

Parents

All the girls talked about their parents as a source of a support but two of the girls said that they felt their parents were their top support 'I can tell them everything' and 'they know you more than anyone else'. Others felt that parents were supportive but not as much as their friends 'Parents understand but to a certain extent as they grow up in different time'. Other family including siblings were also mentioned including aunties and siblings

Teachers

3 of the girls mentioned teachers at the edge of their circle of support (see next section for discussion).

5. Awareness of support services

When asked where they would go for support if needed the main response was to go to their GP. They suggested a GP could refer to a counsellor. When promoted if there were any other areas of the NHS they would access they said that they felt others were 'harder to get to unless you're referred by a GP'. The group felt that GPs keep confidentiality and also felt they would rather see a GP from the same sex as they may be able to emphasise more. All the group said they haven't been independently and go with their parents.

A couple of people mentioned helplines including ChildLine and the Samaritan's. One girl said that she knew there were helpline details on her collage lanyard.
The group were asked about online support and they referred to chatrooms and finding things through social media but there wasn't a sense that they found support via this medium themselves.

There was a broad discussion about schools not being helpful in terms of accessing support – the group talked about how they are not equipped and they try to not get involved. If they do find out about issues the group thought they would call their parents. They felt that people would not talk openly at school due to confidentiality worries. A couple of people identified that there is someone at school (who they could talk to) but they felt they would prefer to talk to a trusted teacher rather whom they had a relationship with. One girl stated that teachers sometimes talk to each other which would make me feel more insecure.
In a wider discussion about schools the girls felt that teaching about mental health sometimes felt a bit 'tick-box' so they would do an assembly on mental health rather than really thinking about how to address issues within their school. However they girls fed back about a variety of things from schools including lots of assemblies on the topic, posters in toilets, a special week with presentations. They felt personal stories was a good medium to use, especially if it was someone they could relate to and showed how they had overcome issues.

There was a further discussion about how schools can impact negatively on mental health, with an example given of a boy with mental health difficulties '*but instead of helping him they though he was the problem and isolated him from the rest of the school. It doesn't give them the confidence back.'* Others agreed that there were multiple areas where they isolate people. They also felt that people were transferred or taken out of school if they have mental health problems which wasn't fair and affects their future.

5.1.3 Chinese boys and girls

Rationale: The My Health My School survey showed high levels of self-reported SEMH need amongst Chinese young people, some of which was statistically significant despite the small cohort. It was decided an additional focus groups should be added with this group to explore the issues further.

5 girls 5 boys took part in the focus group

1. **Conceptualising mental health**

The group was relatively comfortable with conceptualising mental health and associated this with behaviours, low self-esteem, emotions and feelings. Some explained that mental health is often perceived as a negative state and linked to stress, but recognised that stress can be healthy for people and helps one to deal with things better.

2. Protective factors

Goal setting was seen as a process that helps bring purpose to one's life, with the potential to create 'happiness and give direction for future'. There was strong feeling that conversing and socialising with friends and family encouraged good mental health; conversely being isolated was seen to comprise one's mental health and brought about low confidence. 'Doing what we love, enjoy and not being controlled or being told what to do' was a significant protective factor. Some individuals were engaging with creative arts and talked about reading and art, and how these mediums could help people 'improve and maintain good mental health and manage changes in your life'.

3. Risk Factors

Social media

There was a mixed response to this but largely perceived as a negative influence. On an emotional level people talked about being alone and feeling like 'you don't have a purpose'. Addictive behaviour and anxiety were the common phrases used to describe the effects of social media and it was not considered to be a tangible way of engaging with others. Unrealistic ideals of beauty and body image were being perpetuated via social media platforms, which was placing pressure on individuals to look and behave a certain way in order to be accepted in their social circles. There was also a fear of losing their 'audience' on social media. Examples shared were kids being embroiled in drugs and alcohol motivated by wanting to fit in and appear cool; one explained as a young person it was very important to feel wanted and included. If you didn't conform you didn't feel like you belonged. However, girls were equally vocal about the importance of retaining one's core values, being comfortable with who you were and not trying to aspire to look like a supermodel as it was an unrealistic standard posed by society. Overuse of technology was associated with bullying.

Parents and Culture

Due to the dynamics surrounding the working lives of Chinese people, often those working in the restaurant trade, there were minimal opportunities to share things with parents due to long working hours. Also, children were not wanting to disturb the equilibrium as they were often reminded by parents that their hard labour would build a better future for the family. However, most of the children recognised it was important to 'get it [things] out'. There was also pressure on children to help them at work, often against the child's will

Poor mental health was exacerbated by a boring lifestyle in the UK for Chinese children; nowhere to go, nothing to do.

The perceived notion that there were better economic and educational opportunities in the UK was often the key motivator for parents to migrate with their children from China to the UK. However, in reality this has not been the experience within the British education system, which is relaxed and far from the strict regime parents want for their

children. Acculturative processes and young people's readiness to adapt and adopt British lifestyles was further exacerbating the tension between the generations. A couple of children explained that there was a reluctance to communicate concerns to their parents as they were 'not on the same level'.
Social stigma prevents people from discussing their mental state within the Chinese culture, as it would tarnish a family's name and reputation in the community if people found out; you are 'looked down on in society' and marginalised if you have poor mental health.

Self-harm
Four young people in the group were aware of peers who had self-harmed and contributing factors included pressures borne from poor educational achievement, family issues, bullying, hurtful comments and racism. When prompted about suicide, they attributed high suicide rates in their native country China, to educational pressures imposed by family members. Parents' aspirations for their children to achieve well academically in Chinese culture can compromise mental health. Some children experience physical abuse; smacking was a way of punishment when a child achieved lower than expected grades at school.

How would you notice if somebody had poor mental health?
The characteristics that would be at play included ignoring people and not talking; fake gestures such as smiling; looking sad; isolating yourself and withdrawing from social situations.

4. Circles of support

Those who appeared to have a good relationship with their parents (n=5) talked about family being a stable factor in their life, and a source of support they could rely on to help sort things out.
Friends offered something different; they were accessible and there was an element of trust. But this was not shared by the whole group. Trust was very important to these young people and friends were not always loyal (based on the experience of three people).
Hobbies such as art, literature, music, singing and physical activity were being used as vehicles for expression, promoting confidence and self-esteem for a number of young people in the group. Being able to express your emotions using drawings, singing, writing it down or movement were invaluable ways of relieving stress, negative energy and lowering anxiety levels. There was a recognition that reading books to learn new strategies for coping could potentially help people better manage their mental health. Parents were proactively encouraging children to engage with activities that have been proven to help improve wellbeing and to 'keep them busy and stop them getting bored'.

One person talked about retail therapy helping them to release stress. Another talked about meeting new people and the potential it has for acquiring new knowledge.

One individual talked about using computer gaming as a stress reliever. He explained that with a game you were able to get a second chance, compared to real life where you only got one chance. When prompted for clarity he compared this to GCSE exams. There was a profound silence amongst the group and sadness in the eyes of this individual. This really exemplifies the acute pressure being placed on young Chinese people to excel in academia and the subsequent impact on their wellbeing.
Consuming a nutritious diet was deemed conducive to good mental health.
50% of the group talked about school's promoting positive mental wellbeing and offered different forms of talking therapy and pastoral care which was being delivered and received effectively.
Smiling and laughing was good therapy.
Petting and playing with pets was having a positive impact on people's stress levels.
Prayer was a source of comfort for people in challenging and stressful situations and a way of coping; there was a sense of being heard, connecting with something greater than self and a safe space to share worries and seek guidance.

5. Awareness of support services

There was limited awareness of NHS based services, as they were largely perceived as a secondary care service with no association with mental health.
There was an understanding that ChildLine could help children of all ages, and as it was external to the school it reduced the element of embarrassment and people could potentially express themselves better.

When prompted about awareness of online support, there was no knowledge but would welcome more information. There was a genuine enthusiasm for access to this type of support, especially amongst boys, as 'it was good to talk and it keeps you healthy'.
In China people refrain from talking about mental health but in the UK there is open discussion about the promotion of good mental health through settings such as school. At one particular school, children could request appointments with a therapist anonymously; access to support that was outside the sphere of teaching staff was an enabling factor. Children refrained from talking to teachers, school nurse and GPs as they were deemed untrustworthy based on experiences of trust being betrayed.
When prompted to consider access to counselling, young people talked about a lack of trust and not being taken seriously as the main barriers. There was the notion that a professional's unfamiliarity with Chinese culture and potential mismatch in background would not serve the individual well. Cost was also an obstacle, with a reluctance to ask parents to pay for a service. There was reference to the Chinese custom of secrecy and silence and not involving 'others' in your family affairs.

5.1.4 African Caribbean & Mixed White/Caribbean Boys

Rationale: Boys/ young men from these populations have a higher likelihood of being identified with SEMH need in SEN data, as well as a high level of exclusions. They are under-represented within the more traditional NHS funded SEMH support services.

6 boys took part in the focus group (aged 12, 14, 13, 14, 14, 17)

1. **Conceptualising mental health**

The phrase 'mental health' elicited very negative connotations like crazy, depression, self-harm. Phrases included '*There's something wrong with your head'* and *'someone who's crazy literally'*.

Only one person (who was slightly older and had some personal experience of health issues) said the word '*mindset'* – this was the only example of an understanding that mental health as a concept was wider than mental illness

When asked if mental health was something that they had personally, the answers were negative again reinforcing the view that it refers to problems. The older participant mentioned above said *'no not any more, I used to [have mental health] I used to get bullied in primary school'*

2. **Protective factors**

The participants didn't engage with the idea that there were things that they could do that could help keep them mentally well, presumably linked to their lack of understanding that mental health was a wider concept than mental illness. When pushed for examples of things that make them feel good they mentioned sport, playing computer games, 'chilling' and 'not being bored'.

During an exercise to identify 'circles of support', Sport was mentioned by 4 of the 6 boys and 4 mentioned listening to music.

3. **Risk Factors**

School:

Throughout the focus group, school was repeatedly raised as a negative place.

> *"My school they have radios where they talk to each other"*

"Same as mine"
"Yeah they do that – it's like the police officers"

The participants felt that they were treated unfairly, though the reference was in comparison to girls rather than related to ethnicity.

"Probably sound sexist but I feel like the girls get a better opportunity than boys do – like the teachers treat the girls different to the boys."
"Has anyone else had that experience?"
"Yeah" [all agree]
"I think everyone has to be honest"

When asked why they think they are treated unfairly the response was that all the boys can be talking but the teacher just tends to pick on one person and tell them off.

The participants talked about getting angry and walking out of lessons because the teacher annoyed them.

Exams were briefly raised with on boy talking about '*dreading them'*. Again this discussion came back to how they were treated for their behaviour:

"[During exams] *you can't even yawn if you're tired. If you yawn you get sent out…it's just pathetic how you can't yawn"*

Other risk factors:

The participants were asked if the 'perfect' images they see on social media make them feel pressure to live up to this, the group did not feel this was the case.

When asked what makes them feel down or bad one boy answered *'I hate being bored'*

4. **Circles of support**

Spending time alone:

There was a sense throughout the session that a way to deal with having a bad day or feeling low was to spend time alone for example:

'If you were having a bad day where would you turn?'
'I'd just stay in my bedroom'

This was also given as the advice that they would say to friends who were feeling down and it came up again in a discussion about accessing support if they were struggling: "*I'd stay in my bedroom"* and "*Just go rest"*

Social media

Social media was given as an example of a support – with 3 of the 6 boys citing it in the Circles of Support exercise. When asked who they would got to try to make themselves better if feeling low, one boy responded '*Go on your snapchat'.*

Family

Parents and family was not discussed much throughout the session. During the 'Circles of Support' exercise, 2 of the 6 boys mentioned family support.

When asked directly about their family it elicited responses including:
'I'm not close to any of my parents' and '*Some parents don't have the time for you'*

Friends

The boys did not suggest that they talk to friends about their feelings. When were asked how they would feel about a friend telling them they felt down, they reacted in a way that suggested this doesn't happen much and they wouldn't want it to.

One boy did state the following: *'Depends if it was one of my close boys'* suggesting they would feel slightly more comfortable talking about these issues with close friends.

5. **Awareness of support services**

Low awareness of services

When asked where they would go for support there was not much awareness of the variety of services available. Two boys said that they had heard of MindMate (in school assemblies) but would not use it. One boy suggested going to the school nurse but others did not agree.

Lack of trust in services

Lack of trust in services came out strongly from the group, for example, when asked if they would use the MindMate website to access support if they needed it the boys said no, with one boy stating "*they're probably spying on you"* – others in the group then agreed with this statement.

Other examples of mistrust with services included an example of someone dying when operation went wrong;

"*Some people who work at hospital are different. Some are good and some are bad. They could do anything and put bleach in you"*

There was also a sense that hospitals (within discussion about general support) were just for physical health issues with one boy stating:

"if you're upset the hospital not going to give you a cast for upset-ness"

Most participants said wouldn't talk to teacher; "*They [teachers] say 'deal with it - it's your fault".* They did not feel like the teachers would keep their promises:

"What do you think a teacher would do if you said you were feeling really down?"
"They'd say come after then wouldn't even be there. They'd have gone home"

A couple of the boys said there was one teacher they liked despite the overall view that teachers were not to be trusted:

"I only like one teacher in that school as she tried to free me from isolation"

Talking about emotions

In line with their responses about 'not having mental health' the boys gave the impression that it was not the done thing to talk about feelings and that it was boring.

One participant identified that '*people don't get help they just hide it away'* but mostly there was a sense that help was not necessary and people could deal with their problems by taking time on their own.

When encouraged to think about what advice they would give their friends, this mainly focussed on telling their friend to rest, sleep or go home. Just one boy said they would tell their friend to '*go to the medical'*. The others were asked if they would suggest this but the general response was that it would not help and they should just rest.

Note – it must be acknowledged that the issues discussed around stigma may have impacted on the boys comments, as they were taking part in a focus groups with their peers. It's possible some of the boys may have provided some different answers if they had been interviewed individually.

5.2 Parent Questionnaires

Recruitment:

Participants were recruited via the Engaging Voices project, part of Voluntary Action Leeds which works strengthen and enhance existing engagement activities and ensure that easily ignored groups within society are heard in engagements on a range of health issues.

Participants:

42 parent questionnaires were completed. Participants were asked to select the ethnicity of their child/children which were as follows (some people selected more than one ethnicity based on different children being different ethnicities):

- 5 Asian
- 9 Black Caribbean
- 13 Mixed White and Caribbean
- 6 Black African
- 2 Mixed White and African
- 7 Arab
- 1 Mixed White and Asian
- 1 any other ethnicity/multiple ethnicities - 'Moor'
- 1 x Mixed Indian, Black Caribbean & UK White
- 1 x Black British / Caribbean background, Indian, Chinese

1 person said that they were a refugee/asylum seeker.

80% Female, 20% Male
18% (9 families) had used services for child. 81% had not.

Those that selected that they had accessed support (4 people) were asked the following:

Did anything get in the way or stop you from receiving support for your child? (Please select as many answers as you wish)

- 3 people selected waiting times,
- 2 people selected 'I was worried about how my child would react'
- 2 selected 'I didn't believe that services would help'.
- In the free text one participant wrote *'School thinks he is fine but not understanding behind every smile there could be a hidden worry in a child'*

What was positive about the support your child relieved from services?

No answers completed.

What could be improved?

- **‘**coming together as a family’
- ‘understanding of situation’

The next section of questions were asked to those who had not accessed emotional health support for their child/children:

Where or how would you get support? Please select as many answers as you wish:

Out of a total of 38 participants:

- 23 said they would go to their GP
- 21 said they would talk to teacher/school
- 20 said they would support them in the family and not access external services (however, many people who selected this *also* selected that they would use other routes such as GP, suggesting they did not fully read the question)
- 19 said they would look online
- 3 said they would get advice from religious leaders
- One participant also said they would get help from Girl Guiding service.

Would anything stop you getting support for your child? Please select as many answers as you wish:

Out of a total of 38 participants:

- Waiting times too long – 16
- Not knowing how to get support – 10
- Lack of trust in service – 9
- Don’t think services would be culturally appropriate – 7
- Worried conversations wouldn’t be kept private – 7
- Worries about how the child would react – 6
- Worried people might gossip – 2
- Language issues – 2
- Don’t believe it would help – 1
- Worried what others think – 1
- Other – ‘*There is no excuse for not getting support if it is needed’*

All 42 participants were asked the final three questions:

What do you think helps children and young people have good emotional health?

The most prominent theme were:

- Stable, supportive family and feeling loved.

Other issues raised included:

- Communication and being able to talk to someone about problems
- Peer support and activities with friends/after school including outdoors
- Positive role models
- Financial stability
- Being involved in community
- A fair society that doesn't discriminate
- Educating others about background

What do you think causes problems for children/young people's emotional wellbeing?

The following themes were raised:

- Difficult family life including families arguing, lack of support, financial issues
- Issues with peer groups including peer pressure, bullying,
- No one to talk to and distrust
- Social media
- Pressure from adults/schools
- Lack of positive role models

Some issues were raised that were particularly pertinent to BAME groups so the direct quotes have been included below, as they are particularly relevant for this report:

> *"When professionals do not take into consideration cultural values that a child comes from and become quite imposing or disregarding of the family values e.g spirituality etc"*

> *"White supremacy, and their need to isolate and bash certain groups by constantly incorrectly singling them out. Children are sharp and notice all discriminatory and unfair subtle jibes and actions they are faced with. Such things are hugely detrimental to their emotional wellbeing and have long term ramifications on their mental health which leads to knock on effects in all aspects of life. Children can see when certain actions are considered acceptable and labelled softly when related to a Caucasian, but the same act*

related to a BME or Muslim individual is immediately judged terribly and labelled using very negative language and amplified and used to incorrectly to misjudge ALL people of that faith or ethnicity."

"Torn between two different identities/cultures"

"Feeling excluded or different to other groups, not being listened to or understood, not enough opportunities to use their voice and enhance their confidence."

"Keeping their cultural heritage while they are in British country."

"Racism – Intuitional/ Individual"

"What they see in the media/Live up to in the Media"

"Problems are caused by the lack of understanding our history and background. We're introduced to being slaves, rebels and too hyperactive, especially if you are a boy. History should present the diversity in our background of inventions and discovery. Black teachers and more male figures."

"Feeling out of place not part or anything ie - family, community, school."

"Lack of understanding to presented emotional state (euro - centric)"

5.3 Stakeholder feedback

Summary of verbal feedback from CAMHS practitioner who is passionate about making service more culturally appropriate:

- Involved in organisational work to try to create a more diverse workforce. Personal feedback is that parents feel relieved that she is from a BAME background even if it's from a different ethnic group. Receives comments such as 'you would understand', 'our people', 'White people don't understand'. This builds relationship and results in better quality assessment.
- Has witnessed many examples of where Eurocentric approach of mental health/ social work services doesn't fit with a families' cultural beliefs
- Aware families have a difficulties filling in SDQs
- Sees a difference in referral routes/ reasons for boys as young as 6 years old
- LCH now offering 'unconscious bias training' for all leaders and new recruits
- Keen to be involved in ongoing work if capacity in the service

A questionnaire was sent out widely to community groups, BME network and other partners. Three responses were received (full text from surveys included):

Feedback from colleague at Damasq (works with refugees, many from Arabic speaking countries)

- **Protective factors** - Love and care from parents, community support, food from home, contact friends and family back home.
- **Risk factors** - Belonging and identity confusion, racism, not able to achieve full potential, low expectations (teachers and tutor ...they can communicate in English now), family and parents pressure, some parents don't give enough support due to lack of knowledge.
- **Common attitude** - Talking doesn't help ....prefer practical solution
- **What needs to change?** - Easy access at school and colleges. Change the name and call it something else to fit with their language the word MENTAL isn't popular or used in different concept among youth.

Feedback from colleague at First Base music organisation (runs sessions in Archway for predominantly BAME young people)

- **Protective factors** - Our young people respond well to tutors from the same ethnic background this leads to both tutors and leaners having a good understanding of each other's needs this creates a harmonious sharing environment
- **Risk factors -** Racism has a big impact on our kids generally speaking also our young people can feel excluded from society and feel they don't have the same access to some of the facilities available to young White folk who come from the same economic background
- **Common attitudes -** We feel that the medical and police profession don't always understand what we need or how to help they may be fearful and hold stereo typical beliefs and are very quick to misdiagnose a problem that can lead to devastating consequences for our young people this is more the case for the police than medical profession.
- **What needs to change?** - More safe places for young people to use, more access to arts music sports facilities, More funds made available for projects such as ours so we can offer more support as we have a very limited time that we can operate which means we are always treating the symptom and not getting to the cause of the problems that our young people are facing.

Feedback from a colleague at Leeds Gypsy and Traveller Exchange

- **Protective factors -** Children and young people feel supported and well looked after in the Gypsy and Traveller community. Everyone watches out for

each other's children. The community is very good at looking out for each other and will rally round if someone is suffering low mental health. Children and young people that have access to their cultural heritage is important to their overall wellbeing.

- **Risk factors -** Racism and discrimination have a huge impact on children and young people's mental health and wellbeing. Gypsies and Travellers have such inequitable pathways to services that their general outcomes are poor. High levels of bereavement with little to no access/lack of awareness of counselling impacts negatively on young people's mental health and wellbeing
- **Common attitudes/behaviours** - Generally speaking, Gypsies and Travellers don't seek help for their mental health outside of the community. There is a sense of looking after their own. This is starting to change and people are speaking to services such as Leeds GATE to get support for their mental health and wellbeing.
- **What needs to change?** Less discrimination and clear pathways to services. More support around referrals and more services visiting Gypsies and Travellers onsite. Services not being frightened to support Gypsies and Travellers and treat them as they would any other community.

5.4 Summary

Pakistani focus groups (girls)

- Some understanding of mental health but majority struggled to express ideas around concept. View that discussing mental state might bring shame on family
- Protective factors included loving self, talking to others who were trustworthy, social and creative activities.
- Risk factors focussed on social media and celebrity culture. Also homework load and pressure to achieve high grades.
- Circles of support – mixed response re family – some can talk but others felt parents can't relate and they needed to mask struggles. Friends were strong source of support. Mixed response re schools – some positives but most focused on challenges including worries about confidentiality.
- Awareness of services – little knowledge – 2 mentioned ChildLine. Feedback that Asian families view external support at negative – risk of people finding out leading to isolation and negative implications for families.

Bangladeshi focus group (girls)

- Good understanding of mental health concept
- Protective factors – surrounding self with trustworthy people, activities, exercise, prayer and social media all discussed

- Risk factors – pressure from family to do well in education/careers to get respect. Also huge stigma in community, especially older generations, about acknowledging mental health difficulties. Some young people isolated due to strict parents.
- Circles of support – Close friends differentiated from wider friends as key support. Parents identified but some felt they don't understand. Teachers mentioned.
- Support services – felt they would access GP who would refer to counsellor if needed support. Mentioned helplines. Attitude that schools are not helpful and would break confidentiality.

Chinese focus group (mixed boys and girls)

- Good conceptualisation of mental health
- Protective factors – goal setting, socialising and talking to friends, not being told what to do, creative arts.
- Risk factors – social media mainly seen as negative and described as addictive plus pressure to fit in. Culture of parents working long hours and boredom for children. Pressure to achieve. Social stigma to discussing mental state and tarnishing family name.
- Circles of support – some felt parents being supportive but others less so. Friends mentioned though not always loyal. Using creative hobbies or computer games to relieve stress.
- Awareness of support services – limited awareness though did know about ChildLine. Enthusiasm of online support especially from boys. One school had anonymous therapist. Trust discussed as barrier and fact that professional is unfamiliar with Chinese culture.

African Caribbean/ Mixed Caribbean/White group (boys)

- Very negative connotations of mental health and sense it didn't apply to them
- Protective factors – didn't engage with idea they can look after emotional health. Talked about spots, computer games and chilling/not being bored.
- Risk factors – very negative attitudes about school – compared to prison. Belief teachers treat boys unfairly
- Circles of support – focus on 'spending time on own' or resting to help feel better. Social media also mentioned. Do not talk to friends about emotions. Familty/parents not mentioned much.
- Support services – low awareness of services and lack of trust – feeling that they might be spied on or treated badly. Also sense people don't' keep promises.

Parent Questionnaire Summary

- 42 people completed the survey with a broad range of ethnicities.
- 80% Female, 20% Male
- 4 participants had accessed support for their child's emotional health. The biggest barrier was waiting times.
- 38 participants had not accessed support. When asked how to get support the most common answers were to go to GP, support in family or talk to school.
- When asked if anything would stop them, waiting times were identified most followed by not knowing how to get support, lack of trust in services and lack of culturally appropriate services. Worries about gossip or what others would think was *not* a key barrier for most.
- Most prominent theme regarding helping children and young people have good mental health was a stable supportive family. Communication and peer support also key.
- Regarding issues that cause problems – difficult family life, issues with peers, no one to talk to or trust, social media, pressure from adults and school and lack of positive role models.
- 10 participants also raised issues specifically relevant to issues in this report, including BAME young people being treated unfairly, professionals disregarding family values and taking euro-centric approach, constant discrimination in society, feeling excluded/ not understood, lack of understanding of history and feeling out of place.

Stakeholder Feedback

Stakeholders mentioned racism and discrimination, with BAME young people not having the same access to support and not achieving full potential due to low expectations. Commonly held attitudes included a view that talking doesn't help or that they wouldn't seek help outside their community. Also that professionals stereotype, particularly the police. A sense that there needs to be clearer pathways and more 'safe spaces' with more funds for community projects.

A mental health professional from BAME background fed back that parents felt she would understand better than a White British worker, even when they were from a different community. Also that the Eurocentric approach of mental health services doesn't always fit.

(Note – only four stakeholders contributed so small sample).

6. Conclusions

National research and local self-reported data suggest children and young people from BAME groups have similar or better mental health than children from White British populations. However, the tools for assessing mental health may be culturally skewed towards White British populations, meaning this finding is not conclusive. It must also be appraised within the context of the entrenched mental health inequalities experienced by adults from BAME communities.

Prevalence findings raise questions about community assets and resilience, which must not be ignored in favour of focussing solely on BAME children and young people as a vulnerable group in need of support.

Children and young people from BAME groups are under-represented in the majority of services to support SEMH in Leeds, when compared to the proportions in the population.

Although a small sample, under-representation was particularly apparent in the early intervention mainstream cluster service. This echoes the pattern with adults accessing services at crisis point. More analysis of cluster services is required.

Nationally Kooth online counselling has over-representation from BAME groups. This is not the case in Leeds but they do show one of the highest proportion of BAME groups of all the local services so their national success should be capitalised upon locally.

Robust national research shows that BAME children and young people are less likely to be referred to CAMHS by a GP, and more likely to be referred from Education or Social Care. Local data showed White British young people slightly more likely to be referred from a GP however the difference was not significant.

African Caribbean and Mixed White/Caribbean young people are over-represented in SEMH SEN data locally, yet this is not reflected in terms of access to SEMH support services. Cultural biases may result in emotional distress being interpreted as behavioural problems in these communities. In the focus group, the young men conveyed a very negative experience of school and felt unfairly treated.

Children and young people from Mixed heritage stand out as having high SEMH needs within Leeds, including:

- Under-represented in many support services
- Higher likelihood of receiving SEMH identification within SEN data
- Self-report poor SEMH within Pupil Perception survey

- Over-represented in Youth Justice Service
- Over-represented in Children in Care

This is a growing population as the number of pupils identifying as Mixed has more doubled in Leeds since 2005.

Chinese young people report poor emotional health in SEMH questions analysed from the Pupil Perception Survey. Although this is a small sample many of the findings are significant. The focus groups showed high anxiety about performing well academically and struggled with parents working long hours.

Asian young people report the best emotional health in the SEMH questions that were analysed from the Pupil Perception survey. Young women from Pakistani and Bangladeshi communities felt there was high stigma and shame attached to accessing support for mental health and parents struggled to relate to them.

SEMH needs of Gypsy and Travellers are explored in a report from 2017 (see Appendix 1). Inequitable pathways to services are due to a complex range of factors including discrimination from services and societal racism, high levels of elective home education/school exclusions and perceptions/knowledge of mental health support. Bereavement is a key issue.

Data collection is challenging for this group, with many services combining ‘Gypsy/Roma’ despite being distinct groups. Gypsy/Roma is over-represented in SEMH SEN data and exclusions data. In some services these ethnicities are subsumed under ‘White Other’.

The fasted growing ethnic group in Leeds is ‘White Other’ however there is variation in how this group is recorded in monitoring data, resulting in lack of clarity about the needs of this group.

Trust came out as a key theme in all focus groups. Young people felt lack of trust in some services, in particular they felt that schools could not be relied on to keep confidentiality or keep promises. Trustworthy friends are key support. Parents/carers also identified having someone trustworthy to talk to as important.

Parents/Carers perceive long waiting lists as the major barrier followed by not knowing how to get help and having a lack of trust in services. The risk of people gossiping was not a key barrier to accessing support suggesting stigma was not as high as presumed.

Discrimination and racism was raised by stakeholders and some parents/carers as impacting on children’s SEMH. A feeling of being excluded or treated differently to

their White British peers, especially by authority figures/organisations, resulting in lack of access or poorer outcomes.
MindMate SPA has particularly high ‘null’ ethnicity recording. Teen Connect does not currently collect ethnicity data. Cluster based emotional support services do not collect as a rule. Overall there is lack of consistency in categories.

In summary, these findings should be considered as part of a life-course approach. BAME children and young people are under-represented in SEMH support services, but over represented in crisis services as adults, suggesting a lack of early intervention may be contributing.

Patrick Vernon, The CEO of The Afiya Trust summarises the challenge by stating that we must make sure that young people today ‘*do not become part of the conveyor belt of over representation and misery in the mental health system which for the past 30 years has failed to effectively tackle issues around racial inequality*’.

Appendix 1: Gypsy and Traveller Children and Young People SEMH report

This report was completed in 2017 by Charlotte Hanson and Samantha Pease, Leeds City Council.

Following a review of the Mental Health Needs Assessment and the Future in Mind (FiM) action plan, Gypsy, Roma and Traveller (GRT) children and young people were identified as a vulnerable group with additional SEMH needs, yet no work specifically targeting these communities was included in the FiM work.

This is a brief scoping report which highlights key issues, but does not aim to capture all the complexities regarding SEMH needs of these groups.

Stakeholder engagement

The following stakeholders have been consulted and their comments have informed this report:

- George Bright, Youth Improvement Officer, Inclusion Team (which focusses on GRT children and young people), Leeds City Council Children's Services
- Sue Pennycook, Change Manager, Youth Offer Leeds City
- Elizabeth Keat , Outreach Nurse, Gypsy and Traveller Community. Works for Leeds Community Healthcare but seconded to West CCG. Project funded until January 2018.
- Ella Montgomery-Smith, Youth Inclusion Worker, Leeds GATE. Post commissioned by Children's Services.
- Ellie Rogers, Partnerships Manager, Leeds GATE
- Barbara Temple, Children missing out on education and exclusions monitoring lead, Children and Families, Leeds City Council

Children, young people and parents from GRT communities were not consulted as part of this report due to capacity. It was also felt that the issues to discuss are very broad and it may be more beneficial to consult on the next steps of the project with members of the community rather than this initial scoping report.

Ethnicity

Gypsy, Roma and Traveller or GRT is often used as shorthand; however it is not one community and contains different distinct ethnic identities and many different experiences.
The terms can be confusing and often inappropriately used. The correct use of these terms is essential to giving person-centred support and building relationships. The below defines the ethnicities as described by UK law.

Romany Gypsies: Gypsies have been settling in the UK since the 16th century. Many people within this population define themselves as Romany Gypsy, this is not to be confused with the Roma population.

Irish Travellers: Irish Travellers, whilst having much in common in terms of lifestyle and to some extent shared history with Romany Gypsy and Scottish Gypsy Traveller people, have different ethnic roots. Irish Travellers are recognised as a distinct group in UK law as above.

Roma: The term Roma describes European *'Gypsies'.* The number of Roma people in the UK has increased over the last 50 years, particularly from Eastern Europe.

Roma young people are largely **recent migrants** from Eastern European countries and often face different challenges to Gypsy and Traveller young people such as language, unstable and exploitative accommodation, poverty and migration.

Full explanation available https://leedsgate.co.uk/sites/default/files/media/Ethnicity-Briefing.pdf

Scope of report

Summary of communities that stakeholders work with:

- Leeds GATE works predominantly with Gypsy and Traveller communities.
- Liz Keat is funded just to work with Gypsy and Traveller communities.
- The Inclusion team within Children's services works across Gypsy, Traveller *and* Roma communities.

Ellie Rogers, Partnership Manager at Leeds Gate states: *"I would advise that any work separates Gypsy Traveller young people (largely Romany Gypsies and Irish Travellers - who are UK or Irish born and have similar lifestyles, accommodation type and service access barriers but distinct cultures) and Roma young people."*

This report will therefore focus on Gypsy and Traveller communities in recognition of the different needs, and will not address the issues specific to Roma communities.

What do we know about SEMH issues facing Gypsy and Traveller CYP?

At present there is a lack of both national and local data regarding the health status of the Gypsy and Traveller community in the UK, however the few studies that have been carried out tend to reveal similar messages. Findings from the studies show that the Gypsy and Traveller community have significantly poorer health outcomes than both the general population and populations in social deprived areas [78] [79]

The most robust report to date was completed by the University of Sheffield in 2004 with a research group made up of 293 Gypsies and Travellers. The study showed that this community have the lowest life expectancy of all ethnic groups and an infant mortality rate three times higher than the national average[80]. Specifically in relation to social, emotional and mental health issues, the study found that members from the Gypsy and Traveller community were almost three times as likely to suffer from anxiety than the general population and twice as likely to be depressed[81]. Similar findings were noted by Cumbria NHS, Surrey NHS and NHS Luton through health needs assessments.

Although there is little or no data describing the social, emotional and mental health needs of the younger members of the populations, the prevalence in the adult population suggests that many young people are experiencing similar problems or will face them at some-point in their lives[82].

Several reports have highlighted similar causative factors to social, emotional and mental health difficulties in the Gypsy and Traveller community and barriers to addressing these issues. The Leeds GATE Youth Work Strategy (2015)[83] identified Elective Home Education as a key issue locally with bullying and racial abuse being prime push factors away from schools and towards home education. Elective Home Education reduces opportunities for young people, for example- reduction in alternate provisions and no access to cluster provisions and TAHMS (NB – this was at time of writing the report).

Another identified factor was isolation from society as a product of sites such as Cottingley Springs being far out of the city centre with poor bus routes. This reduces the ability of young people from the Gypsy and Traveller community to access

[78] Leeds GATE. 2013. *Leeds Gypsy and Traveller Community Health Needs Assessment.* http://leedsgate.co.uk/sites/default/files/media/Leeds-Gypsy-and-Traveller-HNA-June-2013.pdf
[79] Parry, G; Cleemput, P; Peters, J; Moore, J; Walters, S; Thomas, K and Cooper, C. 2004. *The Health Status of Gypsies and Travellers in England.* University of Sheffield.
[80] Ibid 79
[81] Ibid 79
[82] Ibid 78
[83] Leeds GATE. 2015. *Leeds GATE: Strategy for Working with Gypsy and Traveller Young People.*

services that are located in other areas of the city and enhances their feelings of isolation from the rest of society[84].

A review by Leeds City Council Children Services cited similar reasons as above as to why young people from the Gypsy and Traveller community find accessing services difficult. Examples included- rural isolation, lack of transport, unease and unfamiliarity with systems, literacy and communication barriers and prioritisation of cultural traditions and norms.

Stakeholder feedback:
All stakeholders consulted agreed that there is unmet need in terms of SEMH with children and young people in these communities. Discussion took place regarding the rates of adult mental health problems and a lack of understanding about the impact this can have on children.

Liz Keat (LCH/CCG Outreach Nurse**)** stated that mental health is being highlighted in her project as a key area.

Barbara Temple fed back about the number of young people who have elective home education. In a snapshot taken from the Children Services review it showed that Gypsy & Irish Traveller children that live on sites are less likely than those in housing to attend school. Currently, around 20% of electively home educated children are of Gypsy & Irish Traveller ethnicity, half of whom are based on the Cottingley Springs site; an obvious over-representation.

Ellie (partnership manager from Leeds GATE) highlighted the following specific issues:

- Bereavement - Health outcomes being very poor in the community (average life expectancy of 50 compared to 78 for settled population, Leeds REC 2004) young people are much more likely to have experienced the death of a sibling or the early death of a parent or grandparent. The close knit nature of communities means their networks are wide and close, this coupled with independence in providing care for loved ones means deaths of relatives can have a huge impact on young people.
- There is also increasing evidence of a suicide epidemic amongst GT communities, with young men being most at risk. The All Ireland Traveller Health Study found Irish Traveller men to be x7 times more likely to die from suicide with 11% of deaths due to suicide, those most at risk were male age 15-25. We have no hard evidence for what the figure might be in Leeds but we do know that we regularly hear of families affected by suicides of young men.

[84] Ibid 83

SWOT analysis

Internal Weaknesses – Why doesn't the SEMH provision in the city meet the needs of these groups?

Barriers for Gypsy and Traveller young people accessing appropriate SEMH support were discussed and included compounding inequalities:

- **Not being part of established systems** (e.g. Not accessing schools and children's centres). Elective Home Education (EHE) is a big barrier to young people accessing support which is delivered through schools clusters, resulting in these young people missing out on these services.

- **Confusion regarding eligibility for cluster based emotional support** – some stakeholders fed back that children in EHE are not eligible for cluster based emotional health support (or any wider support from the cluster).

  Liz Keat stated that they ARE eligible for cluster support even if home schooled however many people working in this area are unaware of this, including the clusters themselves. (see for case study below demonstrating confusion)

- Early help plan may be in place but **targeted services often don't work in partnership** with specialist services focussing on supporting GT communities which is a missed opportunity

- **Access to a local GP -** Difficult to register with a GP if you are from the Cottingley site, most Gypsy Travellers are registered with GP's in South East CCG boundary (many at Morley Health Centre and Middleton surgery)

- Lack of cultural understanding by services of the needs of these communities.

External Threats - Why doesn't the SEMH provision in the city meet the needs of these groups?

- **Discrimination** – 9 out of 10 GT kids report being bullied or physically attacked due to their ethnicity. Also *perceived* discrimination can lead to defensiveness, perpetuating stereotype e.g., the Cottingley community rarely use the bus as their experiences are bad, also reports of buses not stopping, and taxis refusing, then they "stop trying" and behaviour becomes more extreme.

- **Perceptions of self / own SEMH needs** – discussions regarding the stigma of mental health problems

- **Perception of value of education –** limited number of GT young people who have completed school but perception is that they have not gained anything.

- **Cultural differences and social norms** including a heightened concept of "shame" in relation to cultural expectations e.g., gender roles and expectations is key and related home responsibilities (caring for siblings/relatives etc) often comes before education as a priority. Also associated social difficulties in own communities if behaviour is contra to these e.g., a young person in these communities who is LGBTQ

- **Opportunity / ability to engage with support outside own community -** fear of services due to current or historic negative experiences,.

- **Isolation and 'ghettoization' of Cottingley Springs** – 40 families – highly stressed community – own rules, e.g. cannabis use very open

- **Limited Mobility -** travel into, and identification with the city centre where much of the SEMH support is located, is limited

- Other common barriers are experiences of, bullying and physical violence, lack of address or postal service, literacy, and rapid eviction.

Strengths – the things that have come together to make it possible / timely to focus on improving SEMH support for GRT young people.

- Leeds is unique as it has a dedicated Inclusion Team within Children's Services that focusses on GRT children and young people. It used to be part of "Travellers Education" and there was a separate "Travellers Play" service, now they have come together into the GRT Team Managed by Georgina Bright.

- Inclusion team is part of wider Youth Offer, therefore linked into work led by Sue Pennycook to review and improve links with Future in Mind.

- Children's Services currently commission Leeds GATE to deliver services to young people. Much of the work GATE deliver is in partnership with the Youth Offer, either the Youth Service (Stephen Harper is the team leader) or the GRT Inclusion & Outreach team (George Bright is the team leader) so if you have further questions please contact either of them or Victoria Fuggles, Youth Offer Quality Assurance Lead in CS.

- Liz Keat's project focusses specifically on supporting health services to better meet the needs of these communities. Her role is funded until January 2018.

Opportunities – the following initial ideas were identified as possible opportunities and have been set out next to the relevant FiM Priority:

All of these opportunities have an added value of simply bringing groups together to talk about feelings etc – as per the FIM Leeds vision.

Priority 1 - Develop a strong programme of prevention that recognises how the first 1001 days of life impacts on mental health and wellbeing from childhood through to adulthood	Explore if the Best Start plan includes any work specifically targeting this group.
Priority 2 - Work with young people, families and schools to build knowledge and skills in emotional resilience and to support self-help	Youth Offer MindMate Self Assessment is being developed by Sue Pennycook – this will include the Inclusion team working with GRT (managed by Georgina Bright) Work with GRT young people to co-deliver anti-stigma/mental health awareness campaign. Led by Space2 but in partnership with GATE (if capacity agreed) Explore MindMate Families course at Cottingley Springs. Pilot evaluated well and provider has experience working with wide variety of communities, however unsure how acceptable/popular group work is with GT communities. Make use of positive role models – noted that there is a feeling that even the small number who have completed secondary education may have struggled to get work and then the perceived value of education is reduced “what’s the point?”
Priority 3 - Continue to work across health, education and social care to deliver local early help services for children and young people with emotional and mental health needs who require additional support	Many children not in education – stats available via Barbara Temple. The Youth Offer as a “bridge to universal services” and as an “in between“ on the scale form early help to CAHMS The Youth Offer has the potential to support SEMH with young people missing / not attending education who fall outside of the cluster based support. GATE, GRT Inclusion Team have case studies of when they have successfully worked with schools that others could build on.
Priority 4 - Commit to ensuring there is a clear Leeds Offer of the support and services available and guidance on how to access these	Clarify issue regarding eligibility for Cluster based emotional health support for people who are EHE. Share with key partners working with GT communities.
Priority 5 - Deliver a Single Point of Access (SPA) to include assessment and an initial response for referrals that works with the whole Leeds system of mental health services to	Are the staff at SPA aware of particular issues? Culturally aware?

enable children and young people to receive the support they need, as soon as possible	
Priority 6 - Using an integrated approach to ensure vulnerable children and young people receive the support and services they need	In order to effectively address the complex issues facing GT (and Roma?) children and young people that impact on SEMH, it would benefit from a working group to take forward, if capacity available. Suggested membership Liz Keat, Ellie Rodgers, Georgina Bright and Sue Pennycock. Also need to ensure effective links/influence into FiM work streams. Sue sits on Primary Prevention group. Consultation on this plan – GATE offered to facilitate consultation with the GRT communities of Leeds and there was discussion about what incentives would help this (so that feedback is not restricted only to the GRT community members who are often called on to consult / speak)
Priority 7 - Ensure there is a coherent citywide response to children and young people in mental health crisis	Follow up on Ellie's suggestion that suicide is higher amongst this community. Link into suicide audit work via Catherine Ward (public health) to see if any local data to support this or not. Consider how to develop suicide prevention work (safetalk, crisis card etc) with these communities.
Priority 8 - Invest in transformation of our specialist education settings to create world class provision.	Ongoing complex issue regarding how to support GT families to feel able/want to keep young people in mainstream education. Outside of scope of this report.
Priority 9 - Work with children and young people who have mental health needs as they grow up and to support their transition into adult support and services	The main issue identified regarding transitions is relating to transition between primary and secondary school as this is a key time that children are moved to EHE.
Priority 10 - Establish a city-wide Community Eating Disorder Service in line with national standards and access targets	This was not discussed so not known if this is an issue
Priority 11 - Improve the quality of our support and services across the partnership through evidence based interventions, increased CYP participation and shared methods of evidencing outcomes	Review if commissioned services collect ethnicity effectively.

Case study 1: Professionals feedback

I was working with a family with a young person who was 12. He had attended Primary school. He attended High school only for a few months, family reported several difficulties; Did not settle at School, felt staff did not understand G/T culture, bullying that was not resolved. Young person acting in an impulsive and volatile way, daily exclusions. Mum has mental health problem and struggled with managing. Some attempt at early help plan however school did not include the Gypsy Roma traveller education team or Leeds Gate youth worker. Removed from School for home schooling.

Reports from Mum of young person with uncontained behaviour, poor sleep. no awareness of danger, highly emotive, reports of hyperactivity, poor attention, risk taking. GP had referred CAHMS who refused referral, didn't refer anywhere else. I spoke to cluster who did not think they could take referral as not in school. I referred to CAHMS with more info and weight to the referral. Passed by CAHMS to cluster. Long delay in contacting family. (Family no not read and post man not visiting site, this info was included in referral) I had to follow up twice. Then delay as needed joint visit as cluster not familiar with sending staff to Cottingley springs.

Case study 2 - Example of a GT young person's route to support
This is an example to illustrate barriers to the right educational support that group members are aware of, and have observed with GT young people they work with (nb: this is representative of many, not a storey of an individual).

A young people who identify as GT experience compounding inequalities in accessing a specialist SEMH support. Looking at access to school places from the start point of a young person who is GT arriving in Leeds now, this example demonstrates barriers that are common:

1. Young person arrives in Leeds in August
2. Fair access panel meets monthly, next one is in September / October, school place allocated
3. Young person starts school late in October / November, missing all the transition work, young people's friendship groups already established without them. This is possibly in addition to other barriers that make integration more difficult in the first place e.g.,
    a. May not speak the language
    b. May have had limited experience of school so don't understand the social norms and behaviour can be misunderstood as naughty (example of a 15yr old arriving in Leeds who had never been to school)
    c. Possible embarrassment if they can't keep up with peers e.g., cannot read / write

4. Mixed bag of experience in terms of school's experience and capacity to offer the necessary support to GRT young people (e.g., home visits cited as valuable but only knew of one secondary visit)
5. Along the way SEMH needs become apparent, EHC Plan assessment initiated
6. ENH Plan process over a number of weeks (16weeks?)
7. Young person experiences a long period of time without the necessary SEMH support and has a poor experience and attendance is reduced / stops, SEMH needs increase

Appendix 2: Ethnicity categories

The table overleaf shows the categories used by the services included in this report. The majority of services use the same core list with the following differences:

- The school census has added 'White Western European' and 'White Eastern European' (added in 2010 – would previously been in 'White other' group)
- The school census, MindMate SPA and Children in care also have Gypsy/Roma and Traveller of Irish Heritage
- All services include Chinese but some group this with Asian and some group it with 'Other'.
- CAMHS has 'other Black' and 'other Caribbean' which no other services record.

The Therapeutic Social Work team does not include all categories in the same way as the other services, for example, 'Black British' and 'Black Africa Caribbean' but not 'Black African'. Also includes 'European'

None of the services have the category 'Arab'. This is included as one of the options under 'any other group' in the prevalence survey. It was also written by some of the parents who completed the parent/carer questionnaire under 'any other group'.

School census	CAMHS	SPA & Children in Care	The Market Place	Kooth	TSW	Self harm admissions
Bangladeshi	Asian or Asian British- Bangladeshi	Bangladeshi	Asian – Bangladeshi	Bangladeshi		Bangladeshi (Asian or Asian British
Indian	Asian or Asian British - Indian	Indian	Asian - Indian	Indian	Asian British	Indian (Asian or Asian British)
Pakistani	Asian or Asian British - Pakistani	Pakistani	Asian - Pakistani	Pakistani		Pakistani (Asian or Asian British)
Any other Asian	Asian or Asian British- Any other Asian background	Any Other Asian Background	Asian - Any other background Asian - British	Any other Asian background		Any other Asian background
Black African	Black or Black British - African	Black - African	Black - African	African	Black British	African (Black or Black British)
Any other Black background	Black or Black British - Any other black background	Any Other Black Background	Black - British	Any other Black background		Any other Black background
Black Caribbean	Black or Black British - Caribbean	Black Caribbean	Black - Caribbean	Caribbean	Black African Caribbean	Caribbean (Black or Black British)
Any other Mixed background	Mixed - Any other mixed Background	Any Other Mixed Background	Mixed - Any other mixed ethnicity	Any other Mixed background		Any other Mixed background
White and Asian	Mixed - White and Asian	White and Asian	Mixed - Asian/White	White and Asian	White Asian	White and Asian (Mixed)
White and Black African	Mixed - White and Black African	White and Black African	Mixed - Black African/White	White and Black African	Black / White British	White and Black African (Mixed)
White and Black Caribbean	Mixed - White and Black Caribbean	White and Black Caribbean	Mixed - Black Caribbean/White	White and Black Caribbean	White/Black African Caribbean	White and Black Caribbean (Mixed)
	Other Black Origin					
	Other Caribbean					
Any other ethnic group	Other ethnic group - Any other ethnic group	Any Other Ethnic Group		Any other	Other	Any other ethnic group
Chinese	Other ethnic group - Chinese	Chinese	Chinese	Chinese	Chinese	Chinese (other ethnic group)
Any other white background	White - Any other white background	Any Other White Background	White - Any other background	Any other White background		Any other White background
White - British	White - British	White - British	White - British	White British	White/British	British (White)

White- Irish	White- Irish	White - Irish	White - Irish	White Irish		Irish (White)
Gypsy / Roma		Gypsy / Roma				
Traveller of Irish Heritage		Traveller of Irish Heritage				
White Western European					European	
White Eastern European						