# Are adolescent boys from African and Caribbean heritage underrepresented in CAMHS referrals, and what are clinicians' experiences working with this group?

S.C. Komakech

A thesis submitted for the degree of

Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy

Tavistock and Portman NHS Foundation Trust

University of Essex

September 2023

## Acknowledgements

I want to thank my Supervisor, Dr Rachel Abedi, who has guided me through all the stages of my research with patience, invaluable advice and encouragement. With your time and support, this work has been possible.

I want to give special thanks to my family and friends for understanding the journey I have been on all these years, for offering continuous support, and for believing in me. Thank you for your prayers and blessings, which have helped me get to this stage.

Finally, I would like to thank God for his strength and guidance and for getting me through all the difficulties I have experienced through this journey.

# Abstract

Research on Black boys and young men in the UK has been limited. At 11, Black and White boys have the same chance of being diagnosed with a mental health disorder, but when they reach adulthood, Black men are many times more likely to have severe mental health disorders. Therefore, this study was interested in what happens during adolescence, whether they are referred to mental health services, and, if so, what it is like working with them. This study completed an audit to understand the representation of Black adolescent boys (BABs) aged 11-15 in referrals to an inner-city Child and Adolescent Mental Health Service (CAMHS) in 2019. Semi-structured interviews were conducted thereafter with four CAMHS clinicians to understand their experience working with this patient group. Using local population data, the audit found that BABs were underrepresented in referrals to CAMHS. CAMHS received more than expected referrals for adolescent boys who identified as 'White', Mixed', and 'Other'. These results are limited due to the lack of specific data on ethnicity for adolescents 11-15. However, these results indicated discrepancies in referrals to CAMHS based on ethnicity. Interviews analysed using a Reflective Thematic Analysis method highlighted the need for professionals to be curious about the behaviours of BABs to understand their needs and for intersectionality to be part of clinical thinking and practice. The findings highlight the importance of supervision for clinicians to reflect on their unconscious biases and the significance of working flexibly within one's therapeutic frame when working with differences. Building trust was found necessary when working with BABs

and their families to increase engagement and accessibility. The study recommends areas for further research and highlights the responsibility of services to BABs and their families and the community.

**Contents**


**Introduction** p. 1

**Literature Review** p. 6
*Literature search* p. 6
Psychoanalysis and Race p. 7
*Idealisation of Psychoanalysis* p. 10
Black, Asian, and Ethnic Minorities and Mental Health p. 15
Psychoanalysis and Adolescence p. 18
*The Adolescent Process* p. 19
Black Boys, Mental Health, and the System p. 22
*Black Boys and the System* p. 24
*Black Boys and Mental Health Research* p. 26
*The Adultification of Black Boys* p. 28
Inequality and Accessibility to Services p. 30
*Health Services* p. 30
*Education Services* p. 33
*Criminal Justice Services* p. 37
*Social Services* p. 40
*Conclusion* p. 41

**Methodology** p. 43
*Aims of study* p. 43
*Research design* p. 44
*Recruitment* p. 45
*Interviews* p. 48
*Ethical Considerations* p. 50
Data Analysis p. 52
*Audit* p. 52
*Interviews* p. 55

**Findings** p. 58
Audit p. 58
*Age* p. 61
*Gender* p. 62
*Ethnicity Categories* p. 62
Summary p. 64
Reflexive Thematic Analysis p. 65
*Invisibility of Black Adolescent Boys (BABs)* p. 66

*Responsibility of Clinicians and Services* p. 76
*Building trust* p. 87

**Limitation** p. 97

**Researcher's Reflections** p. 101

**Discussion** p. 108
Visibility of Black Adolescent Boys p. 108
*Problematisation of behavior or curiosity* p. 112
*Diversity in CAMHS* p. 116
Clinicians and Services:
Cultural Responsivity and Reflective Practice p. 119
*Approaches to working with Black Adolescent Boys* p. 119
*Use of supervision* p. 122
*Prioritising Equality, Diversity and Inclusion* p. 125
Community: Focus on Building Trust p. 127
*Parental engagement* p. 130
**Conclusions, Further Research, and Recommendations** p. 133
*Clinical recommendations* p. 135
*Research recommendations* p. 137
**References** p. 139

**Appendix A** – Public-facing documents p. 155

**Appendix B** – Local population data p. 161

**Appendix C** – Interview schedule p. 164

**Appendix D** – Interview transcript example p. 165

**Appendix E** – Theme coding and development examples p. 166

# Are adolescent boys from African and Caribbean heritage underrepresented in CAMHS referrals, and what are clinicians' experiences working with this group?

## Introduction

Black, Asian, and Minority Ethnic (BAME) groups are documented to face inequalities when it comes to their experiences with mental health services (Fernando, 2017). They are often overrepresented or disproportionately diagnosed with certain mental health conditions and are less likely to access and utilise mental health services (Bignall, Jeraj, Helsby & Butt, 2019). Research that has been carried out to understand the barriers that the BAME community face highlights discrimination in relation to the stigmas associated with mental illness, the insensitivities towards BAME service users' needs, and the impact of imbalances of power and authority between providers and service users (Chui et al., 2021; Ayo, Morley & Steven, 2020; Memon et al., 2016; Broussard, Goulding, Talley & Compton, 2012).

However, the available literature on ethnic minority groups and mental health offers limited insight into any specific ethnic minority group, as the research tends

to group all under the BAME acronym or not focus on the intersectionality of participants. Intersectionality is a term that helps to understand how aspects of a person's identity shape and influence their experiences with the world and how this impacts how they interact with others (Crenshaw, 1989). For example, in the current study, three different aspects of identity are being thought about, gender (boys), race (Black) and age (adolescence) and how they intersect. Intersectionality helps us understand that BABs may experience sexism, ageism and racism collectively or individually at different times and in different environments. It has been argued that the term 'BAME' is problematic as it allows organisations and services to overlook certain issues, such as hiding the lack of representation and inequalities of specific groups (Malik et al., 2021). This has been kept in mind in the present project and the use of the term has thus been carefully weighed and considered, choosing to specify ethnicity where possible. This allows for greater insight into the issues facing specific groups. There are still ongoing debates about what terms should be used and when. For example, the currently popular term 'global majority' (GM) refers to all non-White people in the world. Regardless of which label is used, research into BAME communities has helped prove that they are at a comparatively higher risk of mental health difficulties and are more impacted by social detriments.

In 2020, the Black Lives Matter (BLM) protests sparked much thinking about the inequalities, discrimination and stigmas experienced by Black people, particularly Black men. Many organisations and services released statements in support of BLM, showcasing their commitment to fighting racism and inequalities. At the same time, some went a step further by recognising their failings towards Black people within their institutions and promising to do more to promote anti-racism. As a Black female clinician working within the NHS, I was disappointed that the NHS's statement of support used the collective term 'BAME' when the BLM movement highlighted specifically Black experiences. There was a sense of this term generalising the experiences of Black people to include other groups, some of which have privileges that Black people do not have. The expression 'Black experience' is used to acknowledge that Black people have experiences that are different from those of other ethnic minority groups, e.g., disproportionate maternal mortality and school exclusion rates. Some ethnic minority groups profit more than others, so services and companies can sometimes tick the box of inclusion for all when only one group sees a benefit. This stirred my interest in the experience of Black patients within the NHS. I noticed that the children and adolescents my colleagues and I often worked with were less likely to be Black and male and more likely to be White and female, and I began to wonder why this was so. If Black families are more likely to face inequalities which impact mental health, then they should surely be accessing mental health services more often.

Research on Black boys and young men in the UK has been limited. One study found that at 11, Black and White boys have the same chance of being diagnosed with a mental health disorder, but when they reach adulthood, Black men are many times more likely to have severe mental health disorders (Khan, 2017). This suggests that this group's mental health may be neglected during adolescence and that later when their mental health has deteriorated, it is picked up by mental health services. Chui et al. (2021) found that 18-29-year-old Black African and Caribbean men were more likely to be referred to inpatient services than outpatient services in comparison to Black females and White adults. Is it possible that by the time some of these BABs reach adulthood with their mental health untreated and are unable to seek help, they hit a crisis point where help needs to be enforced? Or are they misdiagnosed with severe mental health disorders due to the cultural distance between Western psychiatry and Black men, leading to mental health services being out of touch with the reality of this community's experiences (King, 2019)? This all suggests negative pathways to the care of Black children across adolescent and adult service provisions. Therefore, the research wanted to understand whether BAB's needs are being met in the earlier stages of life to give them a chance of better mental health in adulthood.

The researcher wanted to understand whether education and healthcare professionals are not signposting or making appropriate referrals. Or are these boys and their families referred to services but are not engaging or getting the

right support? The researcher wanted to answer these separate but related questions to help understand why BABs may not be accessing mental health services. By first investigating the representation of referrals to CAMHS of BABs, we can get a picture of whether referrals are being made in the first place for them to access treatment. In understanding whether BABs are referred to services or not, the researcher wanted to further understand those referred, what treatments they are offered, and how they respond to clinicians and therapy. Therefore, the second research question aims to examine clinicians' experience of working with BABs so we can have a bigger picture of whether there are further barriers that may impact BABs' accessibility to therapy, e.g. how clinicians understand and respond to BABs mental health presentations, whether clinicians are culturally responsive and how are families helped to engage in treatments. In this research, BABs refer to adolescents identified as Black British or have an African and/or Caribbean heritage. This includes adolescents of mixed heritage: research has found that people of mixed heritage with a Black parent tend to internally identify as Black and/or be identified by others as Black (Khanna, 2010).

To investigate this, a literature review was completed to understand existing research available on Black boys, their accessibility to mental health services and their experience of treatment.

# Literature Review

## *Literature search*

To identify literature in the areas pertaining to my research, I undertook a narrative literature search using traditional scholarly methods, including database searches, articles found via workshops, reading lists from my course of study, and colleagues' recommendations. Since the study is informed by psychoanalytic thought, I have used some key texts from this field to frame the perspective. One of my searches was carried out on the PsycINFO database using keywords related to the specific study area. I chose this database as it is the most comprehensive database for the psychology disciplines. I initially searched for two concepts from my study to enable a wide yield of results. I used a variety of main search concepts. For example, I searched for "Black" and "mental health" using the Boolean operator "AND". I did not complete a search on "adolescents" because I intended to use the database limiters to specify the age range. I looked through the results to find articles directly related to my topic and gathered articles by looking at the bibliographies of the most relevant articles generated by my searches. Not much research was done in the UK, so the literature review includes research from other countries, such as the US, where Black people are also a minority and are likely to experience inequalities in mental health.

This study will be thought about through a psychoanalytic lens since my training is in Child and Adolescent Psychotherapy (CAPT), which is underpinned by psychoanalytic thought. Therefore, the literature review will initially focus on psychoanalysis and race and how it can help us think about working with people from the Black, Asian, and ethnic minority communities (BAME). Following this will be a review of the psychoanalytic understanding of adolescence to help illustrate the turmoil and difficulties that arise during this stage of a person's life, which will then be followed by literature on Black adolescent boys (BABs) and their mental health. To really understand the experiences of BABs, it will be important to discuss the psychosocial aspects and put things into context. This will help integrate the understanding of BABs' psychic internal worlds with their external realities, such as inaccessibility to services, inequalities, and their place in society.

**Psychoanalysis and Race**

Psychoanalysis can be defined as therapeutic frameworks and psychological theories that stem from Sigmund Freud's work. Psychoanalysis presents the belief that people have unconscious thoughts, desires, feelings, and memories, some of which are believed to form the root cause of psychological problems, e.g. in the form of repressed trauma and/or unresolved developmental issues. Freud believed that making these unconscious motivations and thoughts conscious would help the patient deal with the repressed conflict, promote healing, and alleviate

symptoms. In the early 1990s, psychoanalysis was explicitly assumed to be 'colour blind', as it penetrates deeper than social norms (Thomas, 1992). The problem with this assumption is that not seeing someone's race and what it can represent to them and others is not to see that person and their experiences. The idea that psychoanalysis—and, by extension, the psychoanalyst—is colour-blind amounts to a denial of a part of the patient's identity and its relevance to the patient–analyst relationship, which can make it difficult for patients to share issues related to race or discrimination of any sort (Thomas, 1992)

The psychoanalyst would present themselves as a 'blank screen' when working with patients, meaning that they would present themselves as 'neutral' by removing their personality from the space with the patient so that unconscious processes such as transference[1] and projection[2] could be easily accessed and free from any influence from the analyst. This is suggested to be helpful for the analyst–patient relationship, enabling understanding and interpretation of the unconscious material. This neutrality would also promote free association without any unconscious desire to please or fear of disappointing the analyst. The analysts not sharing themselves—in terms of their cultural, political, or moral values—would allow the patient to discover their own. However, it is not possible

[1] "Originally conceived by Sigmund Freud, transference is believed to be a central component in the therapeutic relationship between therapist and patient, and although there may be real aspects in the relationship, transference represents a distortion or cognitive-affective bias. In psychodynamic and psychoanalytic therapies, the tracking and/or analysis of the transference is believed to be important in the treatment" (Levy & Scala, 2020, p. 5564).

[2] "A type of defence mechanism in psychoanalytic theory, whereby unacceptable feelings and self-attributes within an individual are disavowed and attributed to someone else" (Rohleder, 2014, p. 1520).

to be or to present as ‘neutral’ or a ‘blank screen’. Personal aspects of the therapist’s identity are always available to the patient, as accents, gender, race, class, disability, or sexuality may be evident upon meeting. In the 2020 paper Psychoanalysis and Black Lives, Davids shows that powerful racist projections can result from being Black in a White-majority world. These projections can build up over time and be traumatising for Black people. The psychoanalyst’s neutrality can thus be experienced as defensive, in that a therapist can use it to avoid thinking about uncomfortable things, such as differences, which may feel exposing when confronting important interpersonal conflicts that may occur in the room.

In the last two decades, psychoanalysis has attempted to think about the relationships between inner and outer worlds in understanding race (Dalal, 2006; Bonovitz, 2009). Davids (2020) proposes that there is an in- and out-group system whereby two poles (Blackness and Whiteness) become an ‘us’ and a ‘them’. Davids suggests that, like processes such as the Oedipus complex, these systems exist in everybody, regardless of race. Davids (2011) believes that everyone has an ‘internal racist’ system that becomes more active under certain conditions and that we all have racist ways of being. Therapists should, therefore, be able to engage with these system dynamics, and it is important for the therapist to be in touch with their own internal racism (Davids, 2011).

***Idealisation of psychoanalysis***

Clinicians can sometimes find it difficult to be flexible within the therapeutic frame that they are using in their work with patients. For example, when working with differences, there can be a tendency to idealise the frame and not leave room for adaptation, perhaps due to possible unconscious fears of trying something different that may evoke feelings of discomfort, feeling out of control, and not knowing. Clinically, idealisation has been used to label a defence or projection—a normal part of early development and functionally useful in positive adult relationships. Klein (1946) spoke about idealisation in babies, which, when they feel frustrations and anxiety, impels them to seek protection and comfort from the 'good object' (Klein,1932). When these feelings are overwhelming, the object becomes idealised and excessively sought, impacting ego development and the capacity to relate to others. This suggests that clinicians need to be aware of how they process their feelings and reactions to the patients they work with, as they are at risk of feeling persecuted, particularly when working with areas they may not be used to, such as differences.

Psychoanalysis can have its own tendency to idealise, which may hamper the development of the therapeutic relationship. Lanyado & Horne (2006) suggest that idealisation can be dangerous because it creates a reluctance for one to be critical and question the ideas of their framework, and work on the assumption that their techniques, principles, and ideas are right and 'how it should be'.

Brooks (2014) further supports this when raising the issue of how idealisation can interrupt thinking and how this can be "violent and can contribute to violence towards the other" (p. 37). Fleming's (2020) paper on CAPT's fantasies of working with cultural differences found that difference was seen as 'dangerous' and a 'threat' to the psychoanalytic frame and profession. There is also an idea that difference is located in the other, whilst the therapist stays neutral (Fleming, 2020). Brooks (2014) brings up "the argument that our (psychoanalytic psychotherapists) attachment to our theories, our group, and our image of ourselves as thoughtful clinicians may make it difficult for us to be able to think about any issue, including race" (p. 45). At present, there is more engagement with issues pertaining to culture and difference in the child psychotherapy discipline; however, as Fleming (2020) found, there is some catching up to do in practice. This area of thinking has been neglected in child psychotherapy training (Fleming, 2020), teaching (Lowe, 2014), and supervision (Dalal, 2021).

Yi (1998) raised her concern that psychoanalytically-trained therapists working with a racial difference were not leaving space for a developmental view when making interpretations of projective identification[3]. Gibbs (2009) stated that reliance on concepts such as projective identification can lead the therapist to assume that their own negative reactions to the patient are caused by the patient's

[3] "Projective identification is an unconscious phantasy in which aspects of the self or an internal object are split off and attributed to an external object… Phantasies of projective identification are sometimes felt to have 'acquisitive' as well as 'attributive' properties, meaning that the phantasy involves not only getting rid of aspects of one's own psyche but also of entering the mind of the other in order to acquire desired aspects of his psyche" (Melanie Klein Trust, n.d,, para 1-3).

own destructive impulses and may not leave room to think about their own. Understanding notions of defence, projection, and transference is important, but only when we acknowledge that we are just as likely to project, discriminate against the other, and idealise ideas.

Money-Kyrle (1956) highlighted the need for therapists to have personal analysis in order to be able to attend to what the patient is bringing and their needs rather than to confuse them with their own. However, this does not mean that patients will be fully understood, as there will always be times when the therapist is not attuned to the patient, and the therapist thus needs to reconnect. When reconnecting, the therapist will have to work through their own defences that have led to the misunderstanding of the patient and be in touch with how their own feelings spill into the room. This highlights the vulnerability of the therapeutic position, which may be helpful for thinking about race. Holmes (2006) states that, for therapists to work in the area of race and ethnicity, it is not enough to have supervision and training and that "only the therapist's own treatment attuned to racial meanings… can help a therapist master his or her own racially related issues" (in Bradley, 2014, p. 88).

Psychanalysts of colour (e.g., Holmes, 1999) have spoken about their experiences of working with White liberal patients and how the thinking and speech of these patients can unravel when issues of race come up or the unconscious communication of the patient's fear of exposing their racist thoughts or feelings

that is evidenced when speaking with an analyst of colour. This can be described as the paranoid-schizoid position, where there is a fear of exposing something bad in the self whilst also experiencing the other as threatening for simply holding a mirror to their internal process (Rankine & Loffreda, 2016). In response, the patient may try to hide these parts of themselves and feel wronged when they are noticed. Alternatively, the other may be idealised in a defensive way in the hope that it will be reflected in turn. However, this is not helpful as it leads to miscommunication and a lack of emotional intimacy grounded in splitting and suspicion. Lowe (2014) suggests these dynamics can also be found in White therapists' work with patients of colour.

More importantly, when working with people from different racial backgrounds, therapists are working with their minds; this cannot be effective unless they face and understand what is to be found in their minds. The capacity to reflect and communicate about race in an open way is a step forward. It is important to highlight that this is not reparative, but effective outcomes are not possible without it (Lowe, 2014). For example, Dolev et al. (2018) have found that in psychoanalytic therapy with Black men, the development of trust is thought to be jeopardised if unconscious and conscious cultural elements are not brought to awareness. The study found that the treatment had a good outcome when cultural aspects were addressed, leading to the resolution of ruptures that occurred in the therapy. This is felt to be very important in psychotherapy because when ruptures

and cultural aspects are not addressed, there is a poor outcome of treatment. However, this study was limited, as it was based on the in-depth analysis of just two Black men.

In a world where mental health interventions and literature are dominated by Western views and bias, research suggests that there is a need for flexibility considering cultural differences. This is the case not only for psychoanalysis but for other forms of psychotherapy as well. Pieterse, Todd, Neville, & Carter (2012) argued that, for psychotherapy to be successful, it is crucial that it adapts to minorities. Without adaptation of a rigid way of working, it would be hard to form a good alliance with a minority client, which Cordaro, Tubman, Wagner & Morris (2012) stressed was important for better outcomes and higher rates of treatment engagement. Flexibility in interventions such as psychotherapy would include addressing sameness and difference in the work. A lower degree of alliance was found in treatments where patients perceived micro-aggressions (subtle forms of racism) (Sue et al., 2007). This supports the view that it is important to explore and discuss cultural aspects of treatment and attend to the therapeutic relationship. Race-based stereotypes may be present in treatment where there is a racial difference between the patient and clinician. Yi (1998) found that Black patients would sometimes be perceived as impulsive, aggressive, and lacking insight. There would also be feelings of superiority and hostility towards Black patients. It is suggested that if these issues remain

unaddressed, the treatment might be affected. It is thus important to evaluate the research concerning mental health within these communities if we are to understand their needs and the current practice.

**Black, Asian, and Ethnic Minorities and Mental Health**

The rate of mental health problems is reportedly high for BAME groups. For example, South-Asian women are an at-risk group for self-harm (Husain, Waheed & Husain, 2016), while Black men are more likely to be diagnosed with a psychotic disorder and be detained under the mental health act than their White counterparts (NHS Digital, 2021). In addition, asylum seekers are more likely than the general population to experience anxiety and depression and have a diagnosis of post-traumatic stress disorder (PTSD) (Knipscheer, Sleijpen, Mooren, Ter Herde & Van Der Aa, 2015). However, this may not be a true reflection of the mental issues among BAME groups due to the lack of available data and reduced likelihood of reporting in these communities.

Different communities understand and talk about mental health in different ways. Worries of stigma and feelings of shame relating to mental health are prevalent in BAME communities. Mantovani, Pizzolati & Edge (2016) found that in faith communities such as Christianity, seeking help was affected by stigma, as ill mental health would be interpreted as a ‘curse’ or ‘possession of the devil’, or it was preferred to ‘suffer in shame’ rather than to disclose mental health

difficulties. These are essential factors that impact people from these communities getting the help and support that they need. Mantovani et al. (2016) speak of a 'triple stigma', highlighting the depths of shame in these communities, concerning fear of rejection from both family and society, in addition to an internalised self-stigma. However, it can be said that although there is a lot of shame attached to mental illness in some faith communities, people see their communities as a protective factor and would rather turn to religion to cope than use mental health services (Mantovani et al., 2016). However, some do access mental health services. For example, Stein (2018) found that a third of Black men would disclose their mental health issues, but they would wait for two or more years to do so. It was found that they were either too embarrassed to take time off work or were more likely to attend to their physical than their mental needs.

The literature stresses the importance of addressing race-related content and building trust when working with ethnic minorities. Research shows that BAME groups have a lack of trust in services, which tends to stem from experiences of racism, discrimination, and socio-economic inequalities (Memon, 2016). However, interventions such as psychotherapy, where trust is very important, have been found to be more efficacious for minority men than medication (Barber Barret, Gallop, Rynn & Rickles, 2012). If people from minority groups do not trust mental health services, then they will likely not get access to the right support. Once interventions such as therapy are accessed, Chang & Berk (2009)

found it to be important for clinicians to raise racial issues when working with minority patients. It is suggested that doing so helps to build trust and confidence in the work. Altman (1995) describes how the shame that minority patients can feel in therapy holds them back from bringing racial content when working with therapists, particularly those of a different race.

Language has also been flagged as an important factor when offering mental health services to minority patients, particularly men. The use of the words ‘depressed’ and ‘mental’ is viewed negatively and seen as highlighting their struggle to cope. There is a preference for more colloquially acceptable language such as ‘feeling down’ or ‘lonely’ or ‘being worried’ (Bignall et al., 2019). The use of such less clinical terms has been found to be more effective and more engaging when speaking to men about mental health. Bignall et al. (2019) have found that, in general, young men are more accepting of interventions when such language is used. However, Stein (2018) argues that how and by whom the intervention is delivered is just as important.

Research has shown that people from BAME groups are at higher risk of mental health issues than their White peers, but the therapies they are offered do not always meet their needs. It has particularly highlighted the importance of thinking about cultural issues and race. However, the available research is based on the experience of adults, while the focus of the present research project is on

adolescents. Research reports that boys begin to disengage and disconnect from healthcare services during adolescence (Rice, 2018). This is due to barriers such as how they present differently to services, experiences of poorly attuned clinical responses, and the impact and need to overcome negative societal attitudes and self-stigma to access services (Rice, 2018). Below, I will illustrate the psychoanalytic ideas about adolescence and mental health before thinking about BABs specifically.

## Psychoanalysis and Adolescence

In adolescence, a number of changes take place in the body and mind. There is a strong move towards independence and separation from the parents in terms of forming outside relationships whilst trying to figure out one's identity. This is evident across cultures where they have rites of passage and age celebrations to mark changes from childhood to adulthood and recognise the increased sense of responsibility that comes with this change (Ngwenya, Chikwari, Seeley & Ferrand, 2023). Waddell (2002) states that the bodily changes that occur in early adolescence can trigger psychological upheaval since they tend to occur before the emotional changes begin to happen.

### *The adolescent process*

Adolescence is a vulnerable time in a person's life, where emotional, physical, and social changes occur. Those exposed to adversities such as poverty, violence,

or abuse are more vulnerable to mental health issues. For adolescents to have positive mental health outcomes, they need to be protected from these experiences through environments that offer socio-emotional learning and psychological well-being and ensure access to mental health care, particularly during their transition to adulthood.

Adolescence is a process where painful thoughts and feelings are stirred up, and these must be worked through. However, adolescents tend to expel rather than contain the pain; for example, instead of thinking, they may try to reduce their internal conflict by acting out. If poorly understood, this approach to difficulties can cause problems.

Projection and re-introjection are essential tools for developing a sense of self at any age. These processes enable exploration of the self and allow recognition of parts of the self, which can then be taken up by the other. However, some adolescents struggle to be curious and experiment, which is important in the face of confusion and mental pain. These adolescents tend to feel depressed, lonely, stuck, and different. Research shows that one in six school-aged children have a mental health problem, which is very concerning considering it was one in nine in 2017 (NHS Digital, 2020). Adolescents are reportedly commonly diagnosed with emotional disorders, with anxiety disorders being the most prevalent, and more so in older adolescents than younger ones (Gutman, Joshi, Parsonage &

Schoon, 2015). Depression and anxiety are increasing among adolescents over 16. Between 1993 and 2015, the rate of these mental health issues increased by 4% (McManus, Bebbington, Jenkins & Brugha, 2016). This highlights the growing needs of young people living in the UK, especially when studies have found that young people with depression are more at risk of self-harm and suicide (Weissman et al., 1999).

These young people may be referred to treatments such as psychotherapy, particularly those who have complex presentations such as intergenerational difficulties, parental mental health difficulties, or problems arising from early trauma and disrupted patterns of development. Midgely et al. (2015) stated that a therapist being able to work with these strong emotions is important because an adolescent with depression would be feeling angry with themselves and those around them, which would lead to feelings of guilt for having these feelings and therapy allows a space for the unthinkable to become thinkable.

Adolescents, particularly those with a history of trauma, are notoriously harder to engage in therapy. At an already vulnerable stage of their lives, their awareness of their vulnerability and feeling small is heightened when they begin to engage in therapy, which increases their resistance to thinking about their thoughts and feelings (Lemma & Young, 2021). If these mental health conditions are not addressed during adolescence, there is a risk of their mental and physical health

being impaired in adulthood, possibly limiting their opportunities to lead fulfilling adult lives. Western ideas refer to adolescence as a time to find and establish one's own mind rooted in but separate from models of identification evident in the community, wider school setting, and family. Not only are they separating from their parents and family, but they are also leaving school and home to be independent. So, for some adolescents, it is a time of hope and expectation, while for others, it is one of distress and sadness. Some adolescents are successful in this challenge, whilst others fail.

Psychoanalytic theory about adolescence has been developed in Western settings based on explicit assumptions and observations of the lives and development of adolescents in a specific context. The implication of just looking at Western views is that the lived realities of adolescents from other cultures are largely ignored. Although the present study is based in the UK, the UK is a Western multicultural setting. Therefore, it is important to note that some adolescents are moving towards independence during this transitional period, but others from, e.g. African and Asian cultures, may be moving towards interdependence where the emphasis is on the group and collective rather than the individual (Wang, Qu & Din, 2020). This is important to think about when considering BABs in this research and their experience of adolescence, where there might be a push and pull between the cultural values and norms of the family that may differ from Western ideas and norms about growing up in the UK.

**Black Boys, Mental Health and the System**

When we think about the mental health of children and adolescents, it is important to think about the social context within which they live. Child development research pays insufficient attention to the social context. Sociologists suggest that an individual is perpetuated by culture. When thinking about Black boys and their mental health, we must, therefore, also think about the factors that impact Black families in Britain, such as imperialism.

The British Empire, which had already begun to take shape in the 15th Century, had affected the rule over large parts of Africa, Asia, the Caribbean, the Mediterranean, and the Pacific. British laws and customs were imposed on these colonies, effectively removing their self-government. In many cases, e.g. Kenya, Jamaica, and India, the populations were oppressed. This meant that religions, traditions, languages, and ways of living were changed to fall in line with British systems, beliefs, and traditions, e.g. the English language, Christianity, and education systems. The decline and end of the British Empire took place over the course of the 1900s. After the World Wars, Britain could no longer afford to maintain its empire. Independence movements were growing in many colonies, and having an empire was beginning to be seen as morally wrong, and that enforcement of rules on other states was unethical. Decolonisation began, and many colonies were given independence.

After World War II, many Caribbean people, commonly referred to as the 'Windrush generation', migrated to the United Kingdom between 1947 and 1971. Due to the impact of the war (losses), the British government needed help from former colonies to fill shortages in the labour market and mass immigration to England was encouraged. The Windrush generation were promised a 'safe haven' and were told they would have access to jobs, accommodation, and freedom. However, they were met with signs of 'No Irish, No dogs, No Blacks'. During this time, the 'colour bar' meant that a person could be legally banned from housing, employment, and public places because of the colour of their skin. This was to protect White people's access to certain jobs. For example, Caribbean people who had had highly skilled jobs back in their countries would not be able to acquire the same jobs when arriving in Britain despite having a British education. The Black children and adolescents living in Britain today have thus grown up with parents and/or grandparents who experienced traumatising levels of racism and discrimination, which would have had an influence on their quality of life. The maternal and paternal functioning of some of these parents may have been impacted due to the history of slavery and migration, leading to deficits in the care and control of their children (Fletchman-Smith, 2011). Therefore, Black families accessing mental health services may be presenting with complexities related to intergenerational trauma, some of which stem from the trauma left

behind from slavery. With which thinking about can be “still defended against in order to maintain psychic integration” (Fletchman-Smith, 2011, p. 16)

***Black boys and the system***

Current research reports that African and Caribbean families have a greater risk of being exposed to long-term poverty, daily inequalities, and routine experiences of racism and discrimination in Britain (Institute of Race Relations, 2023). According to writing from Barbara Fletchman-Smith, although slavery and colonisation ended, the cycle of trauma continued for Black people. Some migrants and their children have been able to move towards a more depressive position and start a new life. In contrast, others are stuck in a paranoid-schizoid position, worried about what may be awaiting them as the external world continues to inflict cruelty through institutional racism. For example, they are likely to be followed around a shop on suspicion of theft, be stopped and searched by police, and be exposed to negative media representation. These experiences are likely to have an impact on the emotional well-being of Black children and adolescents.

In an evaluation carried out by Khan (2017), young Black men shared their experience of being flooded, over time, with negative images of themselves, which reportedly undermined their self-belief. For example, Mark Duggan, who died in 2011 in a killing that sparked the London riots, was described by police

as a ‘known gangster’ so as not to evoke empathy from the public, in comparison to young White men in similar circumstances. It has been found that media would often refer to a Black victim in a criminalising way, mentioning past indiscretions in headlines, while a White perpetrator might be referred to as a ‘son’, with headlines mentioning academic achievements and/or mental health difficulties (Wing, 2017). In 2011, Cushion, Moore & Jewell found that nearly 70% of British media news coverage about Black boys and men would be associated with criminality. Only about 5% of news reports concerning Black boys and men were positive stories about achievements, the positive roles of Black boys and men in the community, or about local activities, school events, club activities, or charity work. This further adds to the ongoing distorted understandings and attitudes towards Black boys and men that can lead to negative real-world consequences for them.

These issues have been known for a long time, and several large reviews of local authorities and national services have recommended that changes be made and/or implemented. For example, there are several targeted schemes and funding for groups such as Black boys and other disadvantaged groups (HM Inspectorate of Probation, 2021). However, it is felt that action is lacking and never sustained; things become stuck and then get worse. For example, after the London riots in 2011, there was a recommendation for councils to invest in youth services to

prevent future riots, but by 2021, at least 110 London youth centres had closed down (Francis & Welsh, 2021).

***Black boys and mental health research***

In the US, Williams's (2022) study into Black boys' and other ethnicities' perceptions of mental health found that Black boys have a high degree of knowledge about mental health. However, their understanding does not relate to their own experiences of mental health issues, such as depression. When explored further, these boys reported that if they had mental health needs, they were likely to try and address them on their own rather than seek help. However, DuPont-Reyes (2020) found that Black adolescent boys had less knowledge of mental illness and less of a positive attitude towards others with mental illness than Black and White girls. Black boys also reported greater discomfort and avoidance and wanted more social separation from peers with mental illness. This may explain their own struggles with seeking help.

Williams (2022) sees this self-reliance as a barrier to accessing mental health services. However, those Black boys who were aware that the stigma presented a barrier were able to use school mental health resources when these were promoted and made easier to access. Williams suggests that the independence of Black boys with depressive symptoms is important, so they need to keep this intact. To do this, Williams suggests that they first try to work on their mental health on their

own so as to have control over whom they seek help from and how much they share. Having mental health resources in schools and communities that can recognise these barriers and needs can thus make a difference in these boys' lives.

The need to be self-reliant and independent may stem from the dominant culture among young men's expectation to be strong, invulnerable, and unemotional (Fortunato, 2005). However, when they have experienced trauma or are struggling emotionally, this way of being makes it harder for them to be open to the process of healing, which would include seeking help and disclosing their experiences. This is, therefore, a risk factor since this will then increase the likelihood of depression, suicide, and unhelpful coping strategies, such as addictions, as compared to their female peers. An Australian study found that conforming to some masculine norms may be harmful to the mental health of young boys and increases the risk of suicidal ideations (King et al., 2020). Cwik (2021) found that Black boys and girls younger than 13 are two times more likely to commit suicide than their White peers, and in America, death by suicide is increasing rapidly amongst Black youth as compared to other ethnic groups. Fortunato (2005) suggests that narrative therapy techniques should be incorporated alongside the current treatment paradigms for trauma when young men do seek help because it won't just focus on the trauma symptoms but also help them redefine their identities and give their own meaning to their experience.

It is important to offer young boys alternatives and multiple ways of being ‘male’ to encourage help-seeking rather than self-reliance (King et al., 2020).

***The adultification of Black boys***

Thinking about the intersectionality of Black boys, while they are expected to be independent and unemotional as men, they are criminalised and institutionally discriminated against as a race and are therefore at risk of adultification. Adultification is a form of racial prejudice where minority-group children are treated as more mature than they are by a reasonable social standard of development (Davies & Marsh, 2020). This was evidenced in a UK evaluation study of the youth offending services, where staff felt that other professionals often perceived Black and mixed-heritage boys to be older than they were (HM Inspectorate of Probation, 2021). When a young person is seen as older, their vulnerabilities are less likely to be seen. This is another layer that can impact engagement with services because when the young person doesn’t want to engage and is seen as older, there is a perception that they are capable of informed choices and are deemed to be ‘choosing not to engage’. What professionals may need to think about is how adolescents can sometimes present as pseudo-adults as a defence without this having been integrated into their personality yet. This is a common adolescent defence against learning from experience—the ‘know-it-all’ period—but they do not, in fact, know it all; they need guidance (Waddell, 2002). Being an adolescent, it is common for there to be anxieties and difficulties

engaging, which might not be thought about due to unconscious biases that may be occurring within the professionals whom they are in the care of. In the above evaluation, Black adolescents shared that a lot of the time, they did not know they needed help, and if they did, they did not know what that looked like until they had received the help (HM Inspectorate of Probation, 2021). Further exploration and understanding seems very important when working with this group of young people.

Adultification puts Black children at risk because when a Black child is in trouble, they will be more likely to be primarily seen as a threat rather than a child who needs support (Davis & March, 2020). Bernard & Harris (2018) reported that practitioners were found to perceive Black boys who were involved in gangs and missing from care as able to protect themselves from harm. This would lead to the practitioner not acting to protect these boys from child sexual exploitation, serious youth violence and drug and alcohol misuse. These professionals may be acting out on their unconscious biases but may also be responding to the omnipotence that adolescents express in their thinking, feelings, and behaviour. This omnipotence is protective and helps them to manage the developmental tasks of adolescence. It also helps them to turn towards the external world and away from familiar childhood family and school. It is important for the adolescent to feel like they are in charge and to feel powerful, even if, in reality, they cannot always be. This feeling is what helps them function independently in the world

(Lemma & Young, 2021). This needs to be understood so their vulnerabilities are recognised and responded to with empathy and appropriate safeguarding. In order for this to happen, these adolescents need to have access to services to help meet their needs.

## Inequality and Accessibility to Services

### *Health services*

There is evidence that mental health services are underused by young people, despite their vulnerabilities, and that in both the UK and the US, ethnic minority groups such as Black children have the greatest unmet need (Chui et al., 2021: Bignall et al., 2019). Arogundad, Shibib, Melton & Younis reported that in Sheffield, children and young people from Black and Asian backgrounds were underrepresented in referrals to CAMHS (2023), and those living in deprived areas were more likely to experience barriers to access mental health services. This is a cause for concern because children from Black communities are underrepresented in CAMHS but overrepresented in adult mental health inpatient services (Malek & Joughin, 2004). There is a need to understand why this is the case, as it is evident that many of these adults would have already been in a mental health crisis in adolescence. In London, it has been found that some Black adolescents have been offered mental health support, although via more adverse pathways than their White peers, particularly at ages 16–17, just before they transition into adulthood (Chui et al., 2021). These pathways would often be

presented via the criminal justice system and are less likely to be voluntary. There is limited UK research investigating referrals to outpatient and inpatient services among the BAME community, especially for adolescents approaching adulthood who are at risk of falling through the gap between child and adult mental health services (Chui et al., 2021). A systemic review examining the mental health of Black males between ages 12 and 29 reports a lack of research specific to this group and that there is poor representation of this group in selected studies (Lindsey, 2018). This is a cause for worry also because English (2014) found that Black adolescent males are more susceptible to depressive symptoms as a result of experiencing racial discrimination than their female counterparts.

More recently, research into Black males, their sense of mental health, and their support system found that the 10 young men interviewed referred to formal mental health services as "unkind", "unapproachable", "unfamiliar", and "discriminatory" (Meechan, John & Hanna, 2021). For these young people, it seemed that speaking to family and friends was more accessible. However, the conception of mental health issues in their minds and within their communities provided further silencing on using this support. There is thus an understanding that Black males are at high risk of mental health difficulties due to recurrent racism and discrimination; however, it is important to highlight that this can sometimes be experienced through the systems that are meant to help them. The underutilisation of mental health services is therefore understandable, as there is

a fear of what may be experienced. One study looked at 1600 patients accessing talking therapies for two years and found that only 20 of them were BAME (Bignall et al., 2019). There may be many factors for why this is the case, but it is evident that services need to do more to engage these communities.

A study completed in South London in 2015 focused on the use of secondary and tertiary clinical services for obsessive-compulsive disorder (OCD) and depression for ethnic minorities (Fernandez de la Cruz, Llrens, Jassi & Krebs, 2015). It found that African and Caribbean patients were underrepresented in the use of community/national and specialist services in comparison to White patients, particularly for OCD. It was suggested that OCD can present differently in ethnic minority patients, therefore perhaps impacting the detection of symptoms and misdiagnosis (Fernandez de la Cruz et al., 2015). These findings were supported by Adams et al.'s (2015) study, which found that in North America and England, doctors had difficulties diagnosing depression in African and Caribbean patients, it being often confused with more physical conditions such as diabetes. This study was carried out to determine whether race impacted a doctor's decision-making about depression. It found that although recommendations for interventions for depression did not differ between White and Black patients, it was evident that there was greater uncertainty regarding emotional problems and depression in African and Caribbean patients. The research thus highlights that even when Black patients do manage to seek help,

they may face clinicians and doctors who struggle to detect and diagnose their mental health issues. Caldwell (2014) proposes that clinicians working with Black patients need to think about their own racial biases, stereotypes, attitudes, and behaviours. Doing so will allow more room for understanding cultural impositions and limitations of traditional interventions and be more culturally responsive to the needs of the patients.

***Education services***

When thinking about Black children and their mental health, it is important to think about access to education. School education is very important because it leads to better opportunities in life and helps develop a child's skills, whether they are academic or creative. It also creates opportunities for children to develop their social skills, such as building and maintaining friendships. However, in the UK, Black children are disproportionately excluded from school and nearly four times more likely to be educated in pupil referral units (Gil, Quilter-Pinner & Swift, 2017). The Department for Education (2019) reported that exclusion is a risk factor for substance abuse, youth crime, mental health problems, and homelessness. This means that Black children are less likely to have better life outcomes if they are excluded, which helps understand the 'School to prison pipeline'[4] that highlights the link between school exclusion and prison.

[4] "This pipeline is used to identify the process through which students are pushed out of schools into alternative education provisions and then into prisons" (We are Breakthrough, 2022, para 2).

Exclusions typically occur in secondary school during the period of adolescence, which Waddell (2002) refers to as “compliant or rebellious” (p. 45), adding that it is a process and not a state. In 2018, according to NHS Digital, teachers (48.5%) were the most commonly cited source to have contact with children with mental health problems in comparison to mental health specialists (25.2%). Therefore, the school setting is the best place for early recognition of emotional difficulties and help these young people access the relevant services.

In some areas of the UK, the exclusion rate for Black Caribbean children and adolescents is six times higher than that of their White peers (McIntyre, Parveen & Thomas, 2021). Repeated policing of hairstyles (afro hair), greetings, and mannerisms associated with Black culture has become normal practice in school, creating a hostile environment. This is essentially a monitoring of inherent Blackness, which leads to the criminalisation of race and key cultural elements (We are Breakthrough, 2022). These experiences are bound to impact how these young people see themselves, especially since schools are major components of secondary socialisation. Office for National Statistics (2020) noted that a third of Black children were likely to come from low-income households and be eligible for free school meals (FSM). Students entitled to free school meals (FSM) are more likely to be excluded from school than those not entitled to FSM. Therefore, these children are at risk of not having their needs met at home, e.g. regarding the

provision of food and heating. This can then lead to non-attendance or even bullying for not having certain things, which can lead to challenging behaviour at school (We are Breakthrough, 2022). According to Gutman et al. (2015), children from poorer households are more likely to have serious mental health difficulties by 11 years of age. It is not clear whether mental health is thought about before exclusions are actioned and whether referrals are made to mental health services to think about their emotionality alongside their behaviours. Lowe (2014) stated that this "failure to understand or be interested in the meaning of the behaviour or the message behind the antisocial act can lead to more severe disaffection and more serious antisocial behaviour" (p. 15). As mentioned, wider societal factors affect some of these children's well-being and capacity to manage in school, such as rising poverty and increasing needs for input from social services. This highlights how important schools are in making referrals to external services in order to think about the child in a holistic way. The NICE guidelines state that professionals and caregivers often fail to view externalised behaviour from boys—such as aggression or antisocial behaviour—and internalised behaviour in girls—such as somatic problems—as a dynamic of depression, and they, therefore, do not take the steps needed to get them help (2019).

In 2017, the charity Against the Odds interviewed young Black men who shared that they felt school could be better at promoting mental health support and giving

them positive messages about their identity, potential for achievement, heritage, and well-being (Khan et al., 2017). They voiced a need for male role models, the impact of the reduction of youth services, and the lack of funding and support for community-based initiatives, which, for some, may have been the only context through which they could be exposed to a wider range of male role models (Rafai, 2019). This highlights the need for services to engage communities at risk of poverty, exclusion, and discrimination so that they can have better life outcomes. For example, in London, the 'S.M.I.L.E (Send Me Inspiring Loving Energy)-ing Boys' project was created to address the well-being of Black boys in London through workshops, mentorships, and exhibitions (Rafai, 2019). This research-led project aimed to empower this demographic to develop tangible coping strategies using photography, poetry, and immersive art to engage with their mental health. The main image to represent this project was multiple portraits of Black boys smiling, which can be inspiring to other Black boys, who are less likely to see positive images of themselves in society. This project was based in a school and local arts centre that engaged 52 young people, 20 of whom accessed long-term workshops. It was reported that self-worth increased by 22%, 17% felt less isolated, and 28% of the young people reported overall happiness. This demonstrates how engaging the community can help these young people access support and education to enhance their well-being if we are creative and flexible in how we do this.

***Criminal justice system***

The SMILE-ing boys project was a response to rising youth violence and murders in the UK. It is, therefore, important to think about the criminal justice system and understand more about the school-to-prison pathway. The Ministry of Justice (2020) reported that Black and ethnic adults make up nearly 30% of the prison population despite making up only 14% of the UK population. Some of these adults have been involved in the justice system from a young age. Lammy's (2017) report discusses the increasing disproportionality within the youth justice system and argues that its causes lie outside the criminal justice system. Lammy suggests that in the UK, factors such as poverty, lone-parent families, risk of exclusions from school and of being arrested affect Black children more than children from a White background.

Khan (2017) presents evidence that families of Black and mixed-heritage boys are marginalised and do not get the same level of service care and support as their peers before encountering the youth justice system. HM Inspectorate of Probation (2021) found that youth-offending workers shared concerns about the number of Black children in youth-offending services who had never engaged with CAMHS, which resulted in escalating mental health concerns and crises.

HM Inspectorate of Probation (2021) found that Black and mixed-heritage boys who were involved with youth offending services (YOS) had access to specialist

services relating to speech and language. Still, referrals were not always made, or when they were, it was never sufficiently followed up to check if the young people engaged. This suggests the need for professionals to be proactive, firstly by acknowledging the need for these young people to access these services, by addressing concerns relating to the trust of professionals, and by having more flexibility with regard to engagement. For example, a YOS manager had written on one of the case files that "the family did not engage due to their Jamaican heritage" (HM Inspectorate of Probation, 2021, p. 6); there appeared to be no reflection on how this approach may not have been appropriate or that the worker might need to consider doing things differently. The ethnicity of the worker was not noted, as this did not appear to be of importance to the young person and their family; rather, it was their skills in listening and understanding that were deemed important. The lack of appropriate intervention and support from professionals leaves the boys on their own, with their possible concerns and barriers not fully explored.

HM Inspectorate of Probation (2021) reported that in 2018, a large number of Black children were given higher rates and longer custodial sentences than White children. This may be in relation to the unconscious biases that people in power fall foul to when making decisions about the lives of Black boys and young men. This is supported by recent reports from the Youth Justice Board and Ministry of Justice (2021), which found that Black boys were more likely to serve a greater

portion of their original sentence than their White peers, making it harder for them to get out of the system. These boys are, then, experiencing injustices which need to be thought about when making decisions about their lives.

Winnicott (1956) writes that all children have an antisocial tendency that is part of emotional development and that this antisocial behaviour is likely due to deprivation and losing someone whom they had positive experiences with up to a certain point. For example, a child being excluded from school could be a child deprived of their friends, possible positive adult relationships, positive experiences of learning and so on. But when this deprivation is experienced for a long period of time it is hard for the child to hold onto those positive experiences. Ward (2012) proposes that antisocial tendencies are unconscious communications that something is not right. The hope is that families and schools will understand the communication underlying the antisocial behaviour and respond appropriately. If they do not, it tends to spread into society. However, research indicates that this understanding is more elusive than one would like. Further, the more antisocial behaviour spreads out, the less likely it becomes that they are well understood as communication, and the more likely they are to be responded to with harsh punitive punishments (Ward, 2012). Lowe (2014) states that this is when the antisocial tendency turns into crime. This is particularly true for Black adolescent boys and men who are disproportionately excluded, imprisoned, and discriminated against. Research into work carried out in the YOS

found that Black and mixed-heritage boys found it important to have a positive relationship with their YOS worker, and feeling listened to and understood was noted as being an important factor for supporting and promoting meaningful and effective engagement (HM Inspectorate of Probation, 2021). These YOS workers may be those who understood and received the boys' communications through their behaviours. A YOS manager recognised the mental health needs of these boys and commented that mental health and social services needed to be more proactive and creative in their engagement.

***Social services***

Several factors relating to inequalities and accessibility issues in the Black community stem from social issues. It is, therefore, important to understand what part social services play in helping these young people and their families. In 2021, it was reported that Black boys are less likely to be referred to Early Help than their peers (HM Inspectorate of Probation, 2021). If early intervention had been made during their younger years, some of these adolescent boys in crisis may have had different pathways. Early help services shared that referrals were more likely to be made by GPs; however, Black boys and their families were less likely to attend medical appointments than their White peers. This leaves these families' difficulties unrecognised and thus not referred for support (HM Inspectorate of Probation, 2021). This further suggests that professionals need to work within at-risk communities and alongside parents whose children are struggling. As trust

has been identified as a barrier, services may need to display commitment and patience to enable relationships to form with these families and to increase the likelihood of positive outcomes, e.g., lessening the school-to-prison pathways. Morgan et al. (2017) suggest that addressing the social needs of BAME patients will likely lead to improved clinical outcomes and engagement with services.

### *Conclusion*

This review illustrates that services are not doing enough for Black boys and their families. Although there has been research into understanding the issues affecting this demographic, policies and initiatives need to avoid a 'colour-blind' approach. There is a sense that race inequalities have become accepted as a part of life in the UK. However, action needs to be taken to shift the dial and to give future generations of Black boys a fairer chance to live fulfilling adult lives and have better mental health outcomes.

This review highlights the breadth of information one must keep in mind when working with BABs, from their families' colonial history, the biological and psychological processes associated with adolescence, the impact of societal pressures, and their racialised experiences. All of these elements need to be held together if we wish to understand the needs of these boys. It is a lot to remember, which is why professionals may find it challenging, preferring to assume a colour-blind approach instead. Understanding the representation of referrals of BABs

will help us know if there are still ongoing inequalities for this group in the area of mental health, and the analysis of the experience clinicians have with this group may give insight as to why this may be the case and whether these elements form part of their work in thinking about BABs.

# Methodology

### *Aims of the study*

This project takes the form of an inquiry into the representation of Black adolescent boys (BABs) in referrals to inner-city CAMHS and clinicians experience working with them. The study has two main aims. The first is to understand whether the number of young people referred to CAMHS represents the local population. My focus has been on Black adolescent boys. This patient group was chosen based on my experience of working in a CAMHS, where I often questioned why we saw so few BABs in treatment. To answer this question, I needed to understand whether BABs are referred to access treatment. The audit aimed to understand whether the number of BABs referred to CAMHS is in proportion to their numbers in the local borough, which would indicate whether CAMHS meets the mental health needs of BABs in the borough. Based on the paucity of BAB referrals observed during my time in the CAMHS team, the hypothesis has been that BABs are underrepresented in referrals to CAMHS.

The second aim of this study has been to understand clinicians' experiences of working therapeutically with BABs in CAMHS. For example, how do clinicians understand their patients' emotional and behavioural difficulties? By taking part, the participants were asked to consider this patient group and reflect on their clinical practice. It was hoped that participating in the study would provide a

space for the clinician to consider and reflect on their experience in a way that may be helpful for future work with BABs and their families.

***Research design***

The study has a mixed-method design conducted in two stages, so as to address the separate but related research questions. The first stage was quantitative, where an audit examined the number of referrals of BABs received in a calendar year compared to other ethnic groups. 2019 was the year chosen for data collection. Data from 2020–2021 was not used due to the possible impact that COVID-19 and Black Lives Matter (BLM) protests may have had on referrals into CAMHS. For example, the pressure on the NHS was very intense, and people were not allowed to leave their homes, which would have reduced accessibility to services that often make referrals to CAMHS, such as GP surgeries and schools. The BLM protests may also have impacted referrals into CAMHS because of improved awareness of Black mental health, which may have increased referrals or heightened Black communities' lack of trust in services (Memon et al., 2016), which might, conversely, have decreased the number of referrals. These variables could not be controlled, so I therefore collected data only from 2019 (January–December) to accurately represent BABs referred to CAMHS. The audit results were compared to the only available local borough population data for adolescents from 2019 (see also Limitations).

The second stage of the study was qualitative and involved interviewing CAMHS clinicians about their experiences of working with BABs. The interviews were semi-structured, and I invited participants to describe and reflect on their experience of working with BABs, considering the social context they lived in and the participant's view on how their team considers sameness and difference in their clinical practice. A reflective thematic analysis (RTA) was used to analyse the data to ascertain whether there were patterns across the experience of participants. The process of analysis will be described in more detail later in this chapter.

***Recruitment***

Initially, I wanted to interview professionals who were likely to be making referrals to CAMHS, e.g. GPs, safeguarding leads in school and social workers. This would have been interesting to get a sense of how referrers are making decisions regarding whom to refer to CAMHS. However, discussing this in group and individual research supervision, it was felt that recruitment would be difficult, particularly due to the time limitations of the project. Due to my completing the research in the context of psychoanalytic psychotherapy training, I then wanted to interview child and adolescent psychotherapists (CAPTs). However, CAMHS offers a wide range of professional disciplines and training. For example, the CAMHS team comprised clinical psychologists, systemic therapists, nurses, and cognitive behavioural therapy (CBT) therapists, to name a

few. Focusing on just one discipline would thus misrepresent what CAMHS offers regarding the experience with this patient group.

With the above in mind, purposive sampling was used to recruit clinicians from varying backgrounds and professions. I was keen for the participant sample to be diverse in terms of gender, race, cultural background, and varying length of experience in their respective roles. Initially, I wanted to interview four to six participants; however, the inclusion of a quantitative element meant a limitation on the scope of the qualitative element. Therefore, only four participants were recruited.

Participants had to meet the following inclusion criteria:

- Participants had to be working in the generic CAMHS at the time.
- Participants needed to have at least three years of experience in assessing and providing treatment to children and adolescents within mental health services for children.
- Participants must have past or current experience working within a mental health clinical role with boys aged 11–17 with African or Caribbean heritage.

The participants were required to have at least three years of experience to ensure they were fully established within their clinical role and understood the processes

of assessing and treating children and adolescents with mental health difficulties. Initially, I had wanted to recruit clinicians who had been in the specific CAMHS team for at least three years; however, due to significant staff changes in the team at the time of recruitment, I had to adjust the inclusion criteria to two years. The clinicians needed past or current experience working with BABs to be able to share their clinical experiences with this patient group rather than their perception of what it might be like.

Recruitment included written invitations sent by a service-wide email, which included an information sheet and consent form providing a summary of the project and criteria for participation (Appendix A). Recruitment also took place through presentations in team and discipline meetings. However, there was initially not much response from the team. Email reminders were sent out, with some responses. However, at least 10 clinicians told me they had not worked therapeutically with BABs. Four respondents said they had worked with children of African or Caribbean heritage under the age of 10 but not adolescents. One clinician also wanted to verify whether working with adolescents from specific countries such as Somalia and Eritrea would suffice. This question was interesting because it raised questions about how people identify themselves and how society may identify them. According to this clinician, who had worked with the Somali and Eritrean communities for many years, they would rarely classify themselves as ‘Black’. They would, however, identify more with their country of

origin. I felt that this experience would be relevant to the research project, but unfortunately, the participant was not interviewed due to no further response. Nevertheless, this clinician brought food for thought when considering how adolescents and their families may identify.

By the end of recruitment, four participants were identified and agreed to be interviewed about their experiences of working with BABs. Two participants were CBT therapists with a White ethnic background, and two were from an ethnic minority background, one of whom was a CAPT and the other a trainee CAPT.

***Interviews***

All participants were invited to partake in an individual, semi-structured interview. An interview schedule was developed, informed by my interests, the relevant literature, and discussions with my research supervisor. Questions explored participants' experiences working clinically with BABs based on one case example or more. The questions also tried to understand participants' views regarding barriers that BABs may face and whether sameness and difference are thought about in their teams. The latter was essential, as team ethos and processes can impact clinical practice. I needed to understand the participants' experiences of working with this patient group within their team and work context. However, the interviews were also led by the individual's exploration of the topic, and I

was therefore flexible in allowing for follow-up questions to explore what emerged in more depth. Throughout each interview, I facilitated the conversations and encouraged a conversational reflection and exploration of the experience of working therapeutically with BABs with African and Caribbean heritage.

The one-hour interviews were to be held face-to-face. However, the first two participants wanted their interview online due to ongoing Covid restrictions, and working from home was a common practice at the time. I agreed to this and decided to conduct also the other two interviews on Zoom. Separate Zoom links were sent to each participant, including using a passcode. Although I would not be in the same room as the participants, overall, this was more convenient and accessible for the participants. They all had access to Zoom, a tool they often used.

Although face-to-face interviews can provide more data regarding verbal cues and body language responses, which can provide unconscious information beyond what the participants say, I realised that this was not a significant part of the chosen methodology, RTA. However, Jenner & Myers (2019) found private participant interviews to be key to collecting highly personal stories and perspectives. Participants were asked to have a private space where they would not be interrupted for up to 90 minutes.

I was concerned about potential technical difficulties when working on Zoom. Therefore, more time was allocated to complete the interview, and the participants were given a number to call at the beginning of the interview should the connection be lost. The participants also had my email address (from documents provided beforehand) should they have difficulties connecting. In the event of adverse or any other unexpected outcomes, participants were to be offered to end the interview, reschedule, or offer a debrief if needed. There were no technical difficulties with any of the interviews.

### *Ethical considerations*

Before commencing the research study, I had to consider its ethics, particularly with the qualitative aspect of the project. I had to gain ethical approval from the Trust Research Ethics Committee (TREC) to make sure that the project upheld ethical principles. For example, when recruiting participants, I first created public-facing documents[5] to be sent out to potential participants. The public-facing documents made clear what would be expected of the participants and how their data would be managed. These documents were important for participants to give informed consent—any follow-up questions potential participants had were answered.

---

[5] See appendix A

Participants agreed that any information about them would be de-identified if used for the research project. Consent was also gained for sharing information regarding cases they chose to discuss on a general level. Participants were also made aware that they were responsible for anonymising these during the interview and talking about them in a general rather than in an identifiable way. Research data was anonymised, encrypted, and transferred electronically within the UK. All electronic data and hardcopy data underwent secure disposal. All participants were informed that they could withdraw from the project up to three weeks after the interviews without any consequences. No participants withdrew from the project.

Participants were part of a team and had their support structure and supervision that they were encouraged to use if needed. I included this in the debrief letter, reminding the participants of all the support available to them, including their trust's confidential counselling service.[6] The debrief letter was sent out after the interview was completed.

The main ethical concerns were participants' well-being and collating and managing data confidentially. To this end, I used pseudonyms for all participants

[6] See appendix A

to ensure anonymity to protect participants and their patients. The names chosen aimed to reflect the cultural or religious background of the BABs discussed to ensure that this part of their identity was not lost while also making sure that the names were common enough not to be identifiable. As mentioned, I put things in place to ensure participants felt safe and well-informed.

## Data Analysis

### *Audit*

The CAMHS team granted permission to access data to investigate whether the percentage of referrals of Black boys aged between 11 and 17 corresponded to the percentage of this demographic in the local population. This data was sent by the administration team, who used Excel spreadsheets to collate information about patients e.g., referral dates, gender, and ethnicity. When data was sent to me, it was accessed securely using a trust-encrypted device. Before the data could be analysed, I used local population data[7] in order to calculate the expected representation in referrals based on the ethnicity, gender, and age-span of young people in the borough. Gender was considered as a factor that may skew data. However, local data reported that the borough's young people aged 0-17 consisted of 51% boys and 49% girls. We would, therefore, expect the percentages for recorded ethnicity to display no significant difference between boys and girls (see

[7] See Appendix B for local Population data where identifiable information has been redacted.

Limitations). I calculated the expected percentage of referrals by ethnicity and age[8]. The data was based on the demographics of the total local population[9]. A discrepancy between the CAMHS and local population data was the age range.

This project initially focused on BABs aged 11–17 years, but when I first looked for local population data for adolescents, all I could find was ethnicity data for those aged 13-17. Although this was not ideal, I had ethnicity data available. Unfortunately, I later discovered that I had made an error and that the data was for 2015 and not 2019. Therefore, I looked for more recent data. This was proven difficult. Eventually, I was able to find the local population data for 2019. However, the ethnicity data was only available for 0 to 17-year-olds. I therefore tried to look for further local population data through research on the published data of the Local Authority, NHS, and Clinical Commissioning Group. However, I could not find the breakdown of ethnicity for adolescents only. The local population data available covered young people aged 11–15 and 16–24 years. Due to the research's focus on adolescents, the audit data was refined to include only referrals of adolescent boys between 11–15 (see Limitations). Unfortunately, I was unable to access the ethnicity population data for this age range. Therefore, I used ethnicity data for young people aged 0-17 to calculate estimations of expected percentages for boys aged 11–15 (See Tables 1 & 2 in

[8] Please see Table 2 in Findings chapter
[9] See Appendix B

Findings). This meant that I assumed that the calculated breakdown for ethnicity for 11-15 would hold (see Limitations).

Another discrepancy between the CAMHS and local data concerned the categorisation of ethnicity. Initially, I had grouped adolescent boys who were of mixed heritage into their identified minority ethnic group. For example, patients who identified their mixed heritage as ‘mixed Black African and White’ would have been categorised as ‘Black’ (see Introduction). However, the local data had a population figure for ‘mixed’ with no specification of mixed racial identities. Therefore, for the audit, all the patients in CAMHS were categorised under ‘Black, Asian, White, Mixed and Other’. This will be discussed in more detail in the Limitations chapter.

The CAMHS data was provided on an Excel spreadsheet. Filters were used to exclude referrals of girls and anyone aged 10 and below and aged 16 –17. I noted the number of referrals received for boys aged 11–15, then created a table to note the number of referrals of each ethnicity. The percentage of received CAMHS referrals for each ethnicity was calculated and compared to the calculated expected representation of referrals based on local population demographic data[10].

[10] Please see Table 3 in Findings chapter.

***Interviews***

Four interviews were completed, and RTA was used to analyse the data. RTA is a method used to explore and interpret datasets and tell a story about patterns of meaning (Braun & Clarke, 2006), which allowed me to put my own subjectivity at the approach's core. This reflexivity enabled me to conceptualise and conduct the thematic analysis.

I was completing the study as part of my psychoanalytic training. Therefore, there was an acknowledgement that my interpretation of the data would be through a psychanalytic theoretical lens. Therefore, the psychoanalytic framework became part of the method itself. The RTA approach acknowledges that the researcher is a part of the research process and recognises how their prior experiences, assumptions, and beliefs will influence it. This acknowledgement helps monitor the impact of my subjectivity and potential bias throughout the research process. Therefore, before and after the interview, I took notes about participants' comments and my own thoughts before, during, and after the interview. RTA is about "the researcher's reflective and thoughtful engagement with their data and their reflexive and thoughtful engagement with the analytic process" (Braun & Clarke, 2019, p. 594). I continually examined my beliefs, judgements, and practices during the research process and considered how these may have influenced the data.

I believe that experiences and meanings should be interpreted with the view that they are produced and reproduced socially through inter-subjective and subjective construction. Therefore, in keeping with the qualitative philosophy of the RTA method, epistemological considerations regarding the data were interpreted through a social-constructionist lens. The analysis was, therefore, inductive, and the themes were driven by the data and not my theoretical interest or a need to fit into a specific coding frame. The interviews were based on participant experience, so the data had to be strongly linked to the themes. Many themes did not link with the specific questions but were very informative. I had to select themes that answered the research question. It was important for me to be mindful that a qualitative analysis does not try to provide a correct answer (Braun & Clarke, 2013).

After the interviews were completed and transcribed, the research followed Braun and Clarke's (2006) six-step thematic analysis method. I familiarised myself with the data, taking a high-level view of it whilst taking note of first impressions. The initial codes were generated and then grouped according to similarities within each interview. Semantic and latent themes were generated and then compared across interviews to see if there were any patterns of meaning. After that, themes were reviewed and re-reviewed. In reviewing the themes, it was evident that there was a lot of cross-over and links across the interlinked interviews—making it difficult to define and name overarching themes. Six themes were initially

defined and named. However, due to the limited word count, I deemed this too many themes to report. Therefore, I re-reviewed the themes and found that some correlated with each other, so these were grouped together, while others became subthemes[11]. The three final themes were deemed representative of the data and relevant to the research question. A report was produced to present the findings of the research study, presented in detail in the following chapter.

[11] See Appendix F.

# Findings

## Audit

An audit was completed to determine whether Black adolescent boys (BABs) were underrepresented in the number of referrals into an inner-city CAMHS clinic. The data focused specifically on boys aged between 11–15 in 2019, before the Covid-19 pandemic[12]. For the purpose of the audit, 'adolescent' refers to boys aged 11–15[13]. 184 adolescent boys were referred. Local population ethnicity data for adolescents 11-15 were not available. Therefore, the researcher used the available ethnicity data for 0-17 for calculations (please see Tables 1 & 2). The representation of Black boys in these referrals will be examined in the context of the calculated[14] local population demographics of the borough of interest, illustrated in Table 3.

**Table 1**

| Ethnicity | Raw local population ethnicity data (N=34,129) | Raw calculations of local population ethnicity data aged as a fraction of total | Raw calculations of local population ethnicity data as a percentage | Rounded percentage used in audit |
|---|---|---|---|---|
| Black | 2,504 | $\frac{2504}{34129}$ | 0.073 | 7% |
| Asian | 3,731 | $\frac{3731}{34129}$ | 0.109 | 11% |
| White | 12,763 | $\frac{12763}{34129}$ | 0.373 | 37% |

[12] See Methodology.
[13] See Methodology.
[14] See Table 3.

| | | | | |
|---|---|---|---|---|
| Mixed | 2,039 | $\frac{2039}{34129}$ | 0.059 | 6% |
| Other | 1,241 | $\frac{1241}{34129}$ | 0.036 | 4% |
| Not recorded | 11,830 | $\frac{11830}{34129}$ | 0.346 | 35% |
| **Total** | **34,129** | $\frac{34129}{34129}$ | **1** | **100%** |

**Calculation of local population ethnicity data for 0-17 (2019)**

**Table 2**

| Ethnicity | Rounded percentage of local population ethnicity data aged 0-17 | Raw calculation of local population ethnicity data aged 11-15 based on 0-17 percentages | Raw calculations of local population aged 11-15 as a number | Rounded local population ethnicity data aged 11-15 based on 0-17 percentages (N=5,169) | Assumption of local population ethnicity data aged 11-15 used in audit |
|---|---|---|---|---|---|
| Black | 7% | $0.07 \times 5169 =$ | 361.83 | 362 | 7% |
| Asian | 11% | $0.11 \times 5169 =$ | 568.59 | 569 | 11% |
| White | 37% | $0.37 \times 5169 =$ | 1912.53 | 1,912 | 37% |
| Mixed | 6% | $0.06 \times 5169 =$ | 310.14 | 310 | 6% |
| Other | 4% | $0.04 \times 5169 =$ | 206.76 | 207 | 4% |
| Not recorded | 35% | $0.35 \times 5169 =$ | 1809.15 | 1,809 | 35% |
| **Total** | **100%** | **1** | **5,169** | **5,169** | **100%** |

**Calculations of local population ethnicity data (2019)**

**Table 3**

| Ethnicity | Total population of young people in the borough (N = 5,169) | Number of CAMHS referrals (N= 184) | Representation of CAMHS referrals against population total |
|---|---|---|---|
| Black | 362 (7%) | 9 (5%) | 29% under-represented |
| White | 1,912 (37%) | 85 (46%) | 24% overrepresented |
| Asian | 569 (11%) | 19 (10%) | 9% under-represented |
| Mixed | 310 (6%) | 25 (14%) | 130% overrepresented |
| Other | 207 (4%) | 10 (5%) | 25% overrepresented |
| Not recorded | 1,809 (35%) | 36 (20%) | 53% under-represented |
| **Total** | **5,169** | **184** | |

**Representation of referrals of boys aged 11–15 (2019)**

The audit found that 9 (5%) adolescent boys who identified as Black were referred into the CAMHS service in 2019. According to the local population data, this number of BABs aged 11–15 amounts to an underrepresentation. Were referrals proportionate to population, we would have expected BABs to make up at least 7% of referrals. Therefore, Black adolescent boys were found to be 29% underrepresented in the CAMHS data. The data showed a difference in the representation of referrals across ethnicities. White adolescent boys were overrepresented in referrals by 24%, whereas Asian adolescent boys were underrepresented by 9%.

It is also important to note that, similarly to the local population data, an extensive amount of ethnicity data was not recorded. The CAMHS and local data showed that over 20% of ethnicity data went unrecorded, meaning that some of the adolescents underrepresented in CAMHS referral may be found in the 20% not recorded (see Limitations).

### *Age*

As discussed in the Methodology chapter, boys referred into CAMHS aged 16 and 17 could not be used due to not having comparable local population data for this specific age. However, I wanted to know the number of referrals that had to be excluded (Table 4 below). It was found that 20% of the CAMHS referrals received into the team in 2019 were aged 16 and 17. This suggests a spike in referrals for this age group. This is interesting and could be related to the transition into college and adulthood. This may be an area for future research.

**Table 4**

| Age at referral | Number of CAMHS referrals (N=230) |
|---|---|
| 11-15 | 184 (80%) |
| 16-17 | 46 (20%) |
| **Total** | **230** |

**Representation of referrals according to age (2019)**

### *Gender*

The data collected was based on males only. Therefore, it was important to look at the gender norms in the borough. The local data showed that boys (51%) and girls (49%) were at nearly equal representation in the borough; therefore, gender would not be a significant factor that would eschew the data.[15]However, local population data was available for gender according to age[16], but not ethnicity. Therefore, I had to use the ethnicity data for ages 0–17 to calculate the expected representation of CAMHS referrals according to population data for ages 11–15, as this data was unavailable (see Limitations).

### *Ethnicity categories*

The local population data presented ethnicity in 5 categories: 'White, Black, Asian, Mixed and Other'. Therefore, the available CAMHS ethnicity data had to be grouped to make the two sets comparable. Adolescents identifying as 'mixed Black and Caribbean' were grouped under 'Mixed'. In the CAMHS data, 'Other' included adolescents who identified as 'Other' along with the countries they identified with, such as 'Other Iranian' and 'Other Kurdish'. The CAMHS data provided more information to have a better understanding of how patients categorised themselves. However, this information was not available from the local population data. Categorising ethnicity is complicated. The local population was more explicit for young people than for the whole population. The local

[15] See Appendix B.
[16] See Appendix B.

population data[17] identified that 34% of the whole population are from Black (7%), Asian (17%) and Mixed/Other (10%) groups; however, 'Mixed and Other' was put into one category. This highlights that even in the same publicised data, categorisations can differ, which is problematic. This highlights how difficult it can be to collect ethnicity data when people and organisations have different understandings of categorisation in terms of race, culture, and ethnicity.

The 'Mixed' adolescents were overrepresented by over 100%. This is a very high percentage. This could indicate increased mental health needs for 'Mixed' heritage children, possibly due to identity-related issues, which need further research. I was interested in how many of the boys identified as 'Mixed' with an African and/or Caribbean heritage were referred to CAMHS. Although the data is not comparable, it could be informative. Table 5 illustrates that 6% of the adolescent boys who identified as 'Mixed' also identified as Black. This is higher than the percentage of Black adolescent boys (5%). Suppose I had local population data of mixed-heritage boys and grouped them based on their ethnic minority group (see Introduction); we may have found a difference in representation percentages. Adolescents from the 'Other' category were also overrepresented (25%), indicating that more referrals than expected are being made to CAMHS.

[17] See Appendix B

**Table 5**

| Ethnicity | No. CAMHS Referrals (N = 184) |
|---|---|
| Mixed - Black | 10 (6%) |
| Mixed - Asian | 2 (1%) |
| Mixed – Other | 13 (7%) |
| Other ethnicities | 159 (87%) |
| **Total** | **184** |

**Representation of referrals of boys aged 11-15 based on the 'Mixed' category (2019)**

## Summary

The audit found that Black adolescent boys were underrepresented in CAMHS referrals in 2019. According to the local population data, CAMHS received only 71% of expected referrals. Asian boys were also underrepresented, but CAMHS received more than expected referrals for White adolescent boys. Adolescent boys who identified as 'White, Mixed and Other' were overrepresented in CAMHS referrals, and mostly so for 'Mixed' children, which needs further research. It is important to note that these results are limited due to the lack of specific data on ethnicity for adolescents 11–15. However, these results indicated discrepancies in referrals into CAMHS based on ethnicity.

It is essential to highlight that not all ethnicity data was recorded. CAMHS were found to have more ethnicity data recorded than the local data. 75% of CAMHS data where ethnicity was not recorded was not requested (rather than not supplied), which may highlight issues around data collection.

**Reflexive Thematic Analysis**

I used reflexive thematic analysis (RTA) to analyse the interview data of four participants. Similarities and differences were found across the interviews, from which themes emerged. Many of these themes were recurring, but three overarching themes were identified with subthemes, including:

1) Invisibility of Black adolescent boys (BABs)

- Needs and behaviours should be better understood
- Diversity of CAMHS

2) Responsibility of clinicians and services

- Self-awareness and self-reflection
- The importance of holding intersectionality in mind
- Prioritisation of equality, diversity, and inclusion

3) Building trust

- Building trust in the community can increase accessibility
- Parental engagement

The themes will be presented below with quotes from participants. Participants will be referred to as numbers, e.g., P1. So as not to add further to the invisibility of BABs, they will be referenced using pseudonyms. The diagram below illustrates the case studies presented by participants so that readers can get a sense of the BABs.

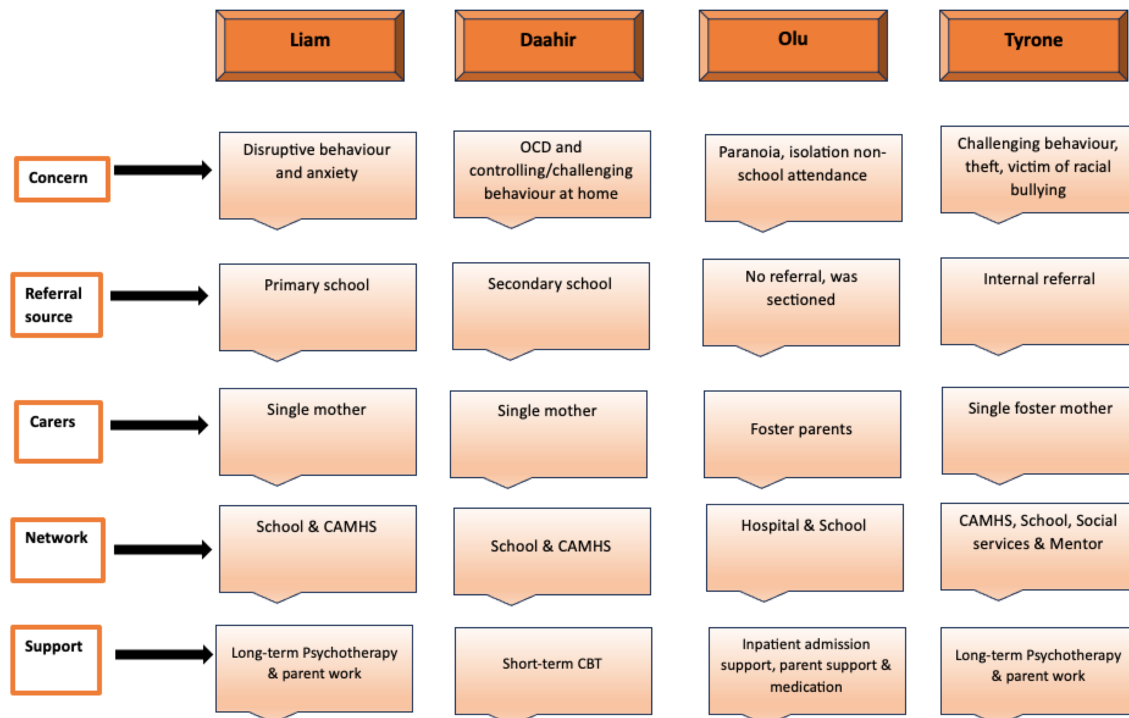



**Figure 1. Case summaries of BABs**

### 1. *Invisibility of Black adolescent boys*

Across the interviews, participants described their experience of their patients' mental health struggles as not being recognised. Liam's[18] behaviour was not thought about as communication of his emotional difficulties; Daahir's learning needs were not being prioritised and assessed; Olu's decline in mental health went unnoticed, and Tyrone's social worker felt he had had "too much therapy" despite it being clinically indicated by therapists that he needed more. The interviews highlighted how the emotional needs of the boys were not always at the forefront of professionals' minds, particularly in the professional network, whereby the

[18] The names have been changed to protect anonymity.

participant had to hold this in mind. This theme will be illustrated through two subthemes—**'Needs and behaviours should be better understood'** and **'Diversity of CAMHS'—**to capture what participants felt was needed for BABs to be more visible in mental health services. Interestingly, two (P4 and P2[19]) of the four participants could not describe a BAB they had worked with in their current CAMHS team but had to think of previous cases they had worked with. The fact that half the participants had not worked with BABs in their current CAMHS role perhaps illustrates the paucity of referrals.

***Needs and behaviours should be better understood***

Participants shared several concerns about what was understood about their young person's behaviour in the network around them. The participants discussed how the way that others in the professional network experience their young person can impact what is offered and how the young person and their family are responded to.

P1 shared her concern that if Tyrone was not a looked-after child, he might not have had the long-term therapeutic intervention he had received from CAMHS:

[19] P2 used an example from her work as a nurse in an adolescent inpatient service

> I was thinking more about if Tyrone, my patient, was not a looked-after child; I feel something would have been picked up on. You know, by that time, he would have been excluded, permanently excluded from school and then perhaps he would have gone to a PRU, and you know, perhaps he would have ended up, you know, getting involved in some form of criminal activity because of all his experiences. (Interview 1, p. 8)

P1 suggests that if Tyrone had not been a child of the state, which was aware of his history and difficulties, his behaviour may have been viewed through a behavioural lens rather than a mental health lens. There is an idea from P1 that looked-after children have more access to therapeutic support due to the presence of professional involvement. P1 raised a concern that Tyrone would probably have been excluded or become involved in criminal activity if he had not had a network around him.

P4 shared similar thoughts about Liam, who was not a looked-after child but whose primary school had a good understanding of his emotional needs. However, at the time of transition to secondary school, there was more focus on his behaviour than his mental health:

> So, one school had a very accurate idea of the mental health difficulty, the other one had a very different idea that it is a behavioural thing, and he is a very naughty boy. However, it was a mental health difficulty. But because, you know, a privileged lens was used on Liam in secondary school, which has nothing to do with him, just an idea that has been projected onto him. (Interview 4, p. 6)

P4 suggests that the secondary school may have been using a biased lens to understand Liam's behaviour. P4 suggests that the labelling of Liam as a "naughty boy" reflects how he was viewed by the school.

P2 shared how Olu's mental health was able to deteriorate without much intervention from professionals in his life. He was not attending school, which did not seem to be a concern. P2 described how his network lacked curiosity about his behaviour:

> I noticed a lot of that would happen, where those kinds of things will not get picked up by other people in the network because they would interpret it as just a teenager being defiant or just not being bothered to go to school rather than a young person that's struggling with their mental health. Obviously, that was not always the case. We would get

> referrals from the school. But for this boy, it felt like he got unwell without anybody noticing. It used to freak me out how often that would happen when people would get super unwell in the privacy of their homes without others picking up on it, or maybe people picked up on their acting strange, and they did not do anything about it. (Interview 2, p. 7)

P2 highlights how behaviour could be minimised and go unnoticed in the professional network. In Olu's situation, non-attendance at school was a sign of Olu isolating himself from others and going into a mental health crisis that led to his admission into the hospital.

P3 also spoke about her concerns about how Daahir's difficulties were understood. P3 raised her worries with the school that he may have learning difficulties that were hindering his learning and treatment, as he did not seem able to engage in the CBT work:

> They were just like; we just have not got around to it. You know it is just not our priority. Moreover, we should make it one because he is in

> year 10 now, so we need to crack on with it. So, I need to talk with Mum about whether I do the referral. (Interview 3, p. 6)

P3 also reported Daahir's feelings about school:

> He hates school. He finds it boring. He finds it hard. Obviously, if he got a diagnosis, he would probably go to the SEN school… it's just the little things: he cannot tell the time. He cannot write with a pen. (Interview 3, p. 7)

Despite raising her concerns with the school, P3 reported that Daahir's needs were not being recognised or prioritised at the level they should be. P3 was left feeling like she had to take responsibility and make the referral despite this being the school's remit. P3 described Daahir's negative view of the school, which may be linked to his difficulties learning.

***Diversity in CAMHS***

Across all the interviews, there were repeated references to the BABs needing opportunities to work with professionals and clinicians with whom they could identify, suggesting that there is a need for a representation of different ethnicities, cultures, and genders across the CAMHS workforce.

P2 shared how Olu was more open to staff members who shared his identity in the ward where she worked:

> We were very lucky in the inpatient ward I worked on; many people who worked there were from the local area. Furthermore, there was young Black and Asian staff. So, it was not the majority White, and that made a difference. Because this boy found it quite hard to engage with people at the best of times, but when a young Black male member of staff would talk to him, who was from a similar background to him, you notice that he would open up a lot more. He would be more willing to engage. (Interview 1, p. 2)

P2 highlighted that young people need services that reflect who they are. They can feel invisible if they do not see themselves in the people helping them. P2 refers to it as 'luck' that Olu was in a diverse ward, so he had access to Black male staff who could understand his needs and make him feel heard. P3 made similar reflections:

> I am a White woman, you know, how can a young person as a brown, Black boy, or brown Black girl, or non-binary person feel brave and safe in the space if the person helping might be part of the problem for

> them? How do we ensure they feel safe and brave in these spaces with somebody that, you know, will never fully understand or will never have to experience the same things they have experienced? And support them through that kind of stuff?
>
> (Interview 3, p. 7)

P3 thought about her position as a White woman and how this may impact young people from ethnic minority backgrounds. She questioned whether they could feel safe and trust professionals if they feel that they will not be understood. P3 wonders whether clinicians who may not have experienced some of the difficulties that ethnic minorities do would be able to fully support the young person.

P1, a person of colour (POC), agreed with P3 and P2 as she described how beneficial she felt it was for Tyrone to have a therapist who also was a person of colour:

> I think me being a Black woman and his previous therapist, a Black male, I think both of those experiences no doubt will have been helpful for him, trying to figure out his identity in relation to, you know, his, his Blackness… it is important for [Black boys] to be able to also have

> a connection to, to the other. I guess he has got his foster mum, but also, to see Black in the institution, though, in the CAMHS, you know. He has got a Black social worker now who has just started. He has a Black mentor at school; I think these would have been very important experiences for him… you know, being able to explore his identity safely. (Interview 1, p. 2)

P1 further confirms P3's ideas about the safety a shared identity can create for BABs. Tyrone's main concerns have been around his identity and experiences of racism, so having diverse professionals in the network may have helped have his identity crisis thought about and understood in different ways. In Tyrone's case, the network appeared mindful of this, as a diverse professional network supported him.

P2 and P1 shared that their current CAMHS is diverse, but they noticed clinicians and practitioners from ethnic minority backgrounds tended to be in lower waged positions.

P2 described the staff on the ward:

> There is this hierarchy of banding in the profession, and then, like, the people seen as the lowest banding were like the healthcare assistants

> and support workers. Yeah. But they were the people who spent the most time with the patients; they were the most diverse demographic. (Interview 2, p. 4)

P1 described the CAMHS team:

> There are more Black clinicians, including one who is a senior, which is a big deal, I think, especially in a CAMHS team like ours. Most of the representation is trainees, and that which goes without saying is problematic because it is like if we look at the distribution of Black clinicians, they tend to be on the lower end of the bands. (Interview 1, p. 10)

Here, both participants highlight a possible problem in the system whereby diversity in the workforce comes with a difference of power. Black professionals are not often in positions of power but are deemed to know the children better. This suggests inequalities in the system.

P4, a POC who is the more senior of the clinicians interviewed, reported how things had changed over time and that, although the leadership is still predominately White, he can see himself reflected in the team and how this

differed from his experiences as a trainee. P4, however, highlights that changes to making CAMHS more diverse are slow:

> I think that the leadership team is very White. But when I look into the team, I see myself reflected back, and it is very, very nice working in CAMHS. You know, it is very, very nice to see trainees from a diverse background, you know when I trained, I was the only person of colour on the training… I still feel we've got a long way to go. (Interview 4, p. 8)

2. ***Responsibility of clinicians and services***

Patients who access mental health provisions are expected to be assessed and treated by clinicians and services providing the best care. Across all interviews, the data revealed that clinicians and services need ongoing reviews of clinical practices through supervision to understand one's biases when working with BABs.

Three subthemes were evident across the interviews that illustrated what the participants felt their responsibilities were regarding their role as clinicians, in their discipline and within a mental health service. These subthemes were '*Self-*

*awareness and Self-reflection*', '*The importance of holding intersectionality in mind*'**,** and '*Prioritisation of Equality, Diversity, and Inclusion*' (EDI).

***Self-awareness and self-reflection***

All four participants shared that a mixture of feelings arose when working with BABs. At times, some of these feelings concerned engagement levels that made the participant feel not good enough, and at other times it was feelings of affection due to a growing therapeutic relationship. Reflection and supervision were important to process these feelings.

P3 spoke about working with Daahir and how frustrated she would get when she felt he was not engaging in the work:

> I have to do a lot of self-reflection. I would come out of sessions feeling quite frustrated, you know, I felt like I was hitting my head against a brick wall sometimes. And sometimes I also came out feeling like I just spent an hour lecturing a teenager instead of anything else… Because CBT is, you know, if you do not engage in it, it will not work. And if we are not engaging them, you know, if we have a waitlist, the space can be offered to somebody else, and he can come back when he is ready kind of thing? That is the kind of discussion we had. So yeah. Oh, no,

> hopefully, I did not reflect in the room. But when I came out [of the session], you know, I did have to take it to supervision and try to come up with new ways to engage. (Interview 3, p. 2)

P3 helps us understand how clinicians begin to feel disheartened when working with young people who appear to find it difficult to use what the clinician has to offer. P3 shared her worry that her disengagement through thinking of the waiting list may have reflected in the room with Daahir. The mention of the waiting list highlights external pressures that may impact how P3 responds to Daahir and his apparent lack of engagement. P3 highlights how clinicians may find it hard to mask these feelings and that Daahir may pick up on them. P3 was feeling stuck. However, P3 shared her ability to take ownership of her feelings that things were not working and take it to supervision to explore. This enabled P3 to use another mind to help her think about other ways to engage Daahir and reflect on her work with him.

P1 similarly shared her need to reflect on her feelings when working with Tyrone. P1 was experiencing racist abuse in the sessions with him and described how this made her feel:

> It has been hard. And it has made me not look forward to working with him sometimes, and it has made me feel very defensive and protective

> of my identity, but also, it has kind of made me reflect on how difficult it must be for him being both a looked-after child and a child with mixed heritage, you know, having a foster mum who is not from the country his parents are from, having to find his place in the world and figure out what kind of a Black boy he is almost all on his own. And, you know, I have had a feeling, I guess, I have got a feeling of how it feels to be him at school, in a way, to be misidentified. And feel confused about your identity. I think there have been a lot of confused feelings in the sessions, especially when I feel pretty outraged and upset when he is racially attacking me but then identifying me as having the wrong ethnicity. However, I still feel attacked and defensive and upset about it. And I feel confused about that. I feel confused about why I feel so upset. (Interview 1, p. 3)

P1 reported having powerful negative feelings towards Tyrone when he would racially attack her. Despite experiencing this, P1 shared how she used her countertransference[20] to understand how Tyrone may have been feeling about his own experience of racial bullying at school and his confusion about his identity. It appears to be essential for P1 to name these feelings and acknowledge them to understand Tyrone. However, it highlights how difficult it can be for a clinician

[20] Emotional responses elicited in the therapist by specific qualities in his/her patient.

to manage these feelings whilst also holding the patient's feelings. Similarly to P3, P1 shared how she used supervision to think about these feelings.

P4 was the only participant who did not express any negative feelings toward his patient or difficulties in the work. When speaking about Liam, he reported that his "overriding feeling was very warm" and that Liam would "engender much warmth" in him. P4 was also the only participant who reported that he did not use supervision to discuss his work openly with Liam:

> In terms of the clinical work, there was no challenge. But bringing some of these issues to supervision was a challenge. I had a very good supervisor but was very limited when thinking about sameness and difference. I found myself consciously not bringing the material to clinical supervision and finding my way with it because, without sounding too arrogant, I knew what I was doing. (Interview 4, p. 3)

P4 did not appear to trust his supervisor to think about his work with Liam due to concerns that Liam's differences would not be considered. Perhaps this also had to do with P4's difference from his supervisor. Nonetheless, P4 didn't feel that he could reflect on this in supervision and felt he had to depend on his mind. P4 suggests that there can be barriers in supervision that can impact the quality of supervision available to clinicians.

***Importance of holding intersectionality in mind***

Across the interviews, as the participants would describe the BABs that they worked with, it was evident that they had to think about different aspects of their identity to understand their difficulties and experiences. A few participants mainly reflected on how the social identities of BABs, e.g., race, gender, and disability, can impact a young person's experiences in therapy and affect accessibility.

P3 shared her struggles to engage Daahir, some of which she reported may be due to an undiagnosed disability. Despite there being no diagnosis, P3 shared how she had to adapt her way of working to accommodate Daahir:

> Yeah, so we tried to make it more interactive cause, you know, he thinks he might have ADHD. And I kind of agree with that. And so we tried to make sessions more active. So, I printed things on the walls in the next session to make it more active. And when we got there, he was tired and did not want to do that. So, if we do something else, then the session after, I will say let us try and be active again; he decided he did not want to do it anymore. Then I was thinking maybe it needed a bit more structure to it. So, I created an actual like OCD pamphlet thing that we would go through; it seemed to work. (Interview 3, p. 2)

In the extract, P3 highlighted how Daahir struggled to focus and how she had to be flexible to keep him engaged. P3 demonstrates how she had to keep Daahir's possible disability in mind to adapt her way of working to suit his needs so that he might be successful in treatment. P3 had to keep thinking about how to engage Daahir until she found something helpful, such as the "OCD Pamphlet", which appeared to give him something concrete to hold onto after the session. P3's experience highlighted the importance of keeping the patient's experiences in mind, particularly concerning their identity, to give them the best support.

P1 also spoke about her need to understand and work with Tyrone's foster carer's distrust of services. His foster carer was described as a Black single woman, which was something P1 shared that she had to think about in the extract below:

> So, this foster mum is very mistrustful of services and institutions, and they have had, you know, lots of experiences of racism from social workers and from the NHS. She had many experiences of hostility from services that made her mistrustful and distrustful of White professionals in these institutions. So, the parent worker did tell me, you know, before I started seeing Tyrone, that it has taken her years to establish a rapport with this foster mum, and it takes her a long time to warm up to people. (Interview 1, p. 5)

P1 conveys that the parent-worker being aware of the foster carer's experiences of racism from White professionals enabled this to be thought about in the service, making work with Tyrone possible. It appeared necessary for the parent-worker to relay these experiences that the foster carer had had to P1, allowing P1 to keep this in mind when working with the network and think about how the foster carer may experience her. A rapport had to be built in order for the foster carer to "warm up" to P1. Although P1 is a POC, she could be viewed as an ally or enemy of the foster carer because of her role as a professional in the network.

The intersection of the clinician and the patient's intersectionality needs to be held in mind because of the complexities of identities in the therapeutic relationship. P2 described how she had to think about her identity and what privileges she may hold:

> I was seeking support and advice from other people because I was aware that, you know, there was a power difference. Not only was I a nurse who was in control of a lot of the things that happened day-to-day on the ward, you know, I am also a White middle-class woman. And there are some differences, and me coming in and telling him what to do was quite annoying. It made me think about how I approach things and how there might

> be some conversations I could be a part of, but it might be more appropriate to get advice from other people. (Interview 2, p. 3)

P2 thinks about her seniority in the ward, her difference in gender, race and class, and how this may be linked to her difficulties reaching Olu, as she shares that he would often not respond to her. In recognising her position concerning Olu, she sought help and support from other colleagues and started a dialogue about how she could approach Olu differently.

***Prioritisation of equality, diversity, and inclusion***

Inequalities often contribute to psychological difficulties for individuals and groups, and multiple layers of inequalities create marked differences in emotional well-being. Therefore, equality, diversity, and inclusion (EDI) are vital aspects of mental health work and must be integrated into practice. All participants shared that their CAMHS services are trying to create spaces and processes to keep EDI at the forefront of people's minds when considering patients and each other as a workforce. However, there was a sense that EDI is only prioritised sometimes.

P3 shared her experience of difficulties leading an EDI initiative in the team:

> I do not have time to do it properly. I was doing my job plan yesterday, and I am on 50 hours a week. So, erm, yeah, and I discussed with my manager that I need a case taken off me or not attend certain meetings, so I have time to properly do the EDI stuff if they want me to do it. But then, it is never done; it is not my priority… I could go weeks like, oh my God, I have done nothing for a month. I have not, it is like on my to-do list, but it is always the one thing that gets moved over for next week. (Interview 3, p. 9)

P3 shared how to prioritise EDI work in the team; she needed to be allowed to have the space. P3 highlights that no matter how much she wanted to prioritise the EDI work, she would have to do it outside her working hours, which seemed unfair. P3 shares her guilt about how EDI can easily be side-lined and constantly is. Despite asking her supervisors for help with this, it is made clear that it is not a priority, as arrangements are not made to accommodate the time needed to arrange EDI-related work for the team.

P3 added that when she can do EDI-related work and create opportunities for the team to think about EDI issues, there is a sense that the responsibility lies with her rather than the team:

> I sent an email around saying crack on, discuss this, and I came back from annual leave and got an email from my manager saying it was not structured, it was not an upheld space. And I was like, guys, we are all adults; you do not need me there to discuss this. I sent you an email about what to discuss; I gave you points. You could all have input into this. (Interview 3, p. 9)

P3 shared her frustration that the group felt uncontained due to her absence and found it difficult without a facilitator. P3 wanted the group to "crack on" without her and highlighted how thinking about EDI needs to be a thing that happens continuously and is everyone's responsibility. Not having a lead destabilised the group.

P4 mentioned something similar where he shared his thoughts that the service hierarchy can dictate whether or not EDI is taken to be a priority:

> I was pleasantly surprised. We have a team manager who has put EDI first, and it shows. I think it has been reflected in the makeup of the team. (Interview 4, p. 8)

P4 suggests that the team manager can play an essential role in prioritising EDI in a team. It appears that his team manager is interested in EDI. P4 recognises this, as he also comments that the team is more diverse, which may highlight the team manager's efforts to create a diverse workforce.

### 3. *Building trust*

The third theme that was apparent across interviews centred around the community and accessibility of mental health services for BABs and their families. There appeared to be a consensus that building trust was crucial for engaging and reaching families from Black and ethnic minority backgrounds. The subthemes which will serve to illustrate this theme further are '*Building trust in the community can increase accessibility*' and '*Parental engagement*'.

#### ***Building trust in the community can increase accessibility***

There was a consensus across the interviews that there needed to be more effort to engage the communities that these boys come from and to understand the barriers that they face.

P2 shared her experience of working with families with different views about mental health based on their cultural and religious beliefs. P2 shared how

important it was to have a shared language with the family in order for them to engage with professionals:

> She believed she was possessed by something. And so it was even more frightening in a way, but also how she made sense of it. It was how her parents made sense of it. And rather than going in with their [mental health team] medicalised view and being like, oh, that is a load of rubbish. No, I want to deal with your brain's neurotransmitters and chemicals rather than putting that agenda forward. From watching other people and their responses, I understood you could sit alongside some of those beliefs and opinions. You do not have to, you know, barrel in and quash; you can sit alongside it and be like, okay, that is your opinion, our opinions this, let us work together. (Interview 1, p. 5)

P2 states how important it is to work alongside families for good outcomes. Doing so builds trust, and families are more likely to engage. This suggests professionals need to come from a place of understanding rather than present a medicalised/psychological stance in order to help build a rapport with the family; there can be shared learning.

P3 also shared that services need to be aware of the barriers that families face that may impact their access to CAMHS. When families are perceived as not engaging

because they are not attending sessions, there needs to be more curiosity about why they may not attend rather than assuming they are disengaging:

> And it is making sure that we are thinking about the family's race, religion, cultural background, and ethnicity, how that impacts this space and how that might impact them accessing our service. Instead of saying, oh, they have missed these sessions, we will close them. It is like, well, why did they miss these sessions? Like, what… what could their barriers be? (Interview 3, p. 8)

P2 and P4 spoke about the environment provided for these families and how this can impact how they access mental health services.

P2 commented on the buildings and transport implications:

> We often expect people to come to us here at the CAMHS and travel in from wherever they live. It might not be easy to get here, might be expensive, erm… and that creates a significant barrier like the location, the environment where we offer other support, is in this huge old building full of history. A lot of feedback I have had from young people

> I have worked with is that they find the building intimidating and horrible and do not want to come in. (Interview 2, p. 8)

P2 reported that there needs to be ongoing thinking about the practicalities of how patients access CAMHS and how this can present a barrier to treatment. P2 shared how young people have yet to find the CAMHS building approachable and highlighted the expectations that services put on patients to come to CAMHS. P2 suggests that getting to know these families by being curious about their circumstances may allow these families to be more open so that CAMHS can accommodate them where possible.

P4 raised the hostile environment that can be created for ethnic minority families that can impact accessibility:

> I think only in about 2018 was a newspaper, I think, in Bristol, which did a feature about the Home Office being housed in a police station. And I suppose that just gives you an example of the confusion between what these organisations offer and whom they offer it to. So, I think the hostile environment has done huge damage to Black communities in terms of them accessing services. Now, this whole idea of harvesting data is used to the detriment of the families. So, when I first trained at

> the clinic that we worked in, we were asked to take evidence and information from these patients when they were referred to prove that they had recourse for accessing the services. And we refused to do it because we knew the barrier and the damage that would cause. (Interview 4, p. 6)

P4 highlights a systemic issue whereby families are made to feel that they need to prove that they should have access to resources they are entitled to. Similarly to P2, P4 suggests that the environment we provide for Black and ethnic minority families impacts whether they access services. They need to feel safe and trust the space that CAMHS provide. P2 and P4 report that these families struggle to feel safe and access services.

***Parental engagement***

Across the interviews, parents were deemed very important in the success of the treatment offered to their children. Each participant mentioned ongoing contact with parents during treatment, but some factors impacted the treatment outcome.

For example, P2 shared that Olu's parents found it hard to advocate for him and get him the proper support:

> I think parents especially were unsure how to approach school or elicit their help and support. From my memory, I think school was just a bit… I am about to badmouth them, but the school was not massively supportive. And I think the parents just, rather than fighting, just accepted it, which I completely understand because I think many parents feel unsure about how much they should fight things… I do not think his parents understood what was happening to him. (Interview 2, p. 7)

The parent did not trust that the school could help them and offer their needed support. P2 appears worried about "badmouthing" the school but pinpoints how the parents were unsure of what was happening to their child and did not feel they could voice their concerns or opinions about Olu. P2 suggests that the parents felt powerless and accepted what the professionals said.

P2 contrasted with other parents who are able to advocate for their children and get support for them before they hit a crisis. P2 suggests that some families know how to ask for help and advocate for themselves. They are better able to engage with CAMHS because they have more confidence and feel more in control.

P2 gave an example:

> You know, I have just, I worked with a White young person recently, erm… and she had quite a lot of sessions, and she was doing a lot better at the end of it. Parents were asking for onward support, so I referred them to another service—they have had much support from that service. And that service has sent them back to me for more support, and I think, oh my gosh, this child does need support, but I am not sure they need the level they are requesting. But they are getting it because they know what to say and what words to use to navigate the system. Sometimes, that is depressing and frustrating. (Interview 2, p. 10)

P2 suggests that clinicians need to keep in mind that some parents may need clinicians to advocate for them and try to understand their concerns. Through building trust, parents can develop more confidence to advocate for their children. For example, P4 appeared to have a good relationship with Liam's mother, with whom he shared that it took him a while to build a rapport. P4 described Liam's mother as someone who supported the psychotherapy, which he pinpointed as very important for Liam to allow himself to engage in the work:

> She prioritised this boy's psychotherapy. You know, his first and foremost. And I think he recognised that it is almost like complete

> permission from Mum to use his therapy in the way he wanted. (Interview 4, p. 5)

Despite Liam's mother's support for the psychotherapy, P4 shared how tricky the parent work was and how it took a while for him to build a rapport with her, particularly when discussing the father's absence, which appeared to be a prominent feature of Liam's therapy. According to P4, the parent work allowed Liam to ask more about his father, as his mother could think about this in the parent work:

> Working with Mum, it was tricky to think about the impact of his father's absence, and it took me a long time to get there with her. So, I did not want her to feel blamed. So, I was conscious of that. And that probably impeded me initially, but she was open to thinking about that. Thinking about it with her allowed us to have space in her mind, which then allowed this boy to ask questions, you know, about the absence more. So, she was a fantastic parent to work with. (Interview 4, p. 5)

However, sometimes parents find it challenging to support the therapy, particularly if they struggle with their child's behaviour at home. P3 shared how

Daahir's mother found it hard to manage his OCD behaviours and trust P3's advice:

> Whereas, you know, or like, mum will wash it [the cup] and put it to the side, and then one of his siblings will use it. He will then have these meltdowns where it is quite toddler-like. If he does not get what he wants or what he thinks he deserves, he will go into, like, a very, I would say toddler-like, tantrum for quite a few hours. And there is Mum, who does everything she can to stop this. So, like, he will get everything he kind of requests when he does this. So, I asked Mum to stop doing that because, like, there is this learned behaviour there. But then, you know, understandably, she finds it really, really difficult. (Interview 3, p. 4)

P3 highlights how hard it can be for parents to implement certain strategies at home, mainly when there is challenging behaviour. In not doing so, Daahir's goals were not being met, resulting in a need for further treatment:

> Yeah, it was supposed to be six top-up sessions from the previous, so the last time he improved, he met his goals. And then I think when the support ended, I think the family kind of, I guess, I guess stopped

putting in, putting in the work a bit. So he declined as OCD traits came back. (Interview 3, p. 2)

P3 reports how families also need to support the young person's treatment so that they can meet their goals. If not, there is a risk of re-referrals into CAMHS. Families need to be invested in order for treatment to be successful.

## Limitations

I recognise that there are a number of limitations within this research. The local population data limited what could be investigated and presented in the audit. For example, the local population ethnicity data for differing age groups were unavailable; therefore, estimations had to be calculated based on ethnicity data for ages 0–17 instead of 11–15. It would have been ideal for me to have specific ethnicity data for this age group, but it was not possible. This discrepancy limits the data because the ethnicity of the local population may differ between different age groups. I acknowledge that the lack of specific ethnicity data impacts the audit results and the reliability of the conclusions. However, I have used local population data according to age and gender to calculate estimations of expected ethnicity representations, which can give some indications about the referral representation into CAMHS. It would be recommended that future local population ethnicity data be presented according to age groups, as 0–17 is too wide a range and doesn't consider that age can be categorised into different stages of development, e.g. infancy, mid-childhood, early adolescence, and late adolescence. I acknowledge that the audit results are inconclusive due to the estimations of ethnicity for the specific age group.

Although data was not missing for age, the age range data available for the local population data was limited. The local population data used for young people was

only available for ages 4–10, 11–15 and 16–24; however, my focus was on 11–17 (see Methodology). 4–10 is a very big age range that includes early childhood and middle childhood, so it could not be used in the data. Therefore, the audit data had to be adjusted and only use referrals of adolescent boys aged 11–15. The 16–24 category went beyond adolescence, and the age limit for referrals to CAMHS is 17. This meant that I had to exclude the referral data of boys aged 16 and 17, which was 20% of the referrals (see Findings). This was a limitation to the research because this is towards the end of adolescence when access to CAMHS is coming to an end. The high number of referrals suggests more need during this transition to adulthood and possible further studies. It is hard to ascertain whether BABs would have been underrepresented in this age group.

I initially wanted to group mixed heritage adolescents based on their ethnic minority parents' races. This was based on research by Ho, Kteily & Chen (2017), who discuss the complexities of being mixed race and how a mixed race person is more likely to be identified by others and identify themselves in relation to their ethnic minority race. However, this was impossible due to limited data on how the 'mixed' young people were identified in the local population data. So, I do not know how many 'Mixed' children identified as mixed with, e.g., Black or Asian heritage. However, this category of ethnicity was overrepresented by a considerable amount in referrals to CAMHS, which highlights the need for services. However, as mentioned, the ethnicity data used are estimations, so these

results are not conclusive, although they help us understand that 'Mixed' children are possibly presenting with mental health difficulties at a higher rate, and this is being recognised by professionals who refer them. Further research is needed to ascertain the needs of this patient group.

The lack of ethnicity data in CAMHS and local population data was a limitation. This impacted the audit results because some Black adolescent boys who are underrepresented in referrals may be found in the unrecorded data. We have, therefore, been unable to understand the ethnicities of adolescent boys referred to the CAMHS team in 2019. This is also the case for local population data. Ethnicity should be as important as age and gender, where no information was missing for either data set.

The generalisability of the results is limited by the small sample of interviews and the fact that the data is based on only one CAMHS service. However, the findings have given us an idea of clinical experience with BABs in the UK, which the literature lacks. Due to conducting a mixed method design, there was limited time and space to interview more than four participants. More interviews may have added weight to some of the findings and patterns. However, recruitment was difficult, and not many clinicians had worked with BABs, which further supports the audit results that a small number are referred. Despite the limitations, this

research project has shed light on the clinical work with BABs and helped us get a picture of the representation of referrals into the CAMHS team of interest.

## Researcher's Reflections

I am a Black British woman of African heritage training as a Psychoanalytic Child Psychotherapist in a CAMHS clinic. A researcher's positionality informs every aspect of the research process, from research question development to interactions with research participants. In this chapter, I will describe my reflections.

Throughout the research project, I have had to reflect on how my personal and professional identity influences the research at every stage. I had a background in working with adolescent (predominately Black) boys at risk of serious youth violence and criminal exploitation, who often presented with anxiety, low mood, and emotional regulation difficulties. Therefore, when I began working in CAMHS, I expected opportunities to work with this patient group. However, this did not seem possible despite the requests. There didn't appear to be many referrals or requests for child psychotherapy.

This sparked my interest in whether CAMHS received referrals for this patient group, and I wanted to learn from other clinicians what it was like to work with Black adolescent boys in therapy. However, I wondered if I felt that I, as a

Black researcher, had a responsibility to research Black patients, particularly due to limited research in the field of child psychotherapy relating to working with differences (Lowe, 2014). Although this area is growing[21], I wondered whether my experiences as a minority in a predominantly White profession made me more inclined to research inequalities and accessibility to patient services. Speaking to colleagues in my team, there appeared to be a shared concern that BABs were not commonly accessing therapy.

My motivations to research this area were further fuelled by experiences in research workshops, where I would share my research progression at different stages. For example, my peers would ask, 'Why boys and not girls?' or 'Why Black children and not other minority ethnic groups?'. These questions helped me think about the rationale behind the project. However, other responses, such as the comment 'Don't make it political' after a presentation of what was being investigated, triggered my defensive feelings because there was a suggestion in the comment that I would make it personal. The reality is that it is hard to separate the personal from the political when thinking about the experiences of Black patients, and indeed my own experiences as a Black person living and working in a predominately White country and profession. I wondered if I would have responded the same way if the senior researcher was a POC.

[21] Bailey, Yeh & Madu, 2022; Nevers-Ashton, 2023 focus on the experience of Black children and young people..

Perhaps not, as it may have felt like it came from a place of understanding. It is important to note that the research was carried out after the Black Lives Matter protests, which were political and did influence my interest in Black men's mental health. I had to keep in mind my relationship with the topic when recruiting and interviewing, as I was at risk of projecting my feelings related to my own racialised experiences in the workplace onto White participants and research peers.

Another thought concerned the feeling that this question came from a place of unconscious bias, that when Black researchers investigate Black experiences, there might be a political element to it. However, talking about inequalities and race can evoke different feelings in different people. For example, when I shared possible interview questions, some responses from research peers made me think. Questions such as 'Was race and difference a feature of your work?' may bring uncomfortable feelings if it had not been a part of their work. I explored this further with the research group to understand why this might be the case, as it seemed to me a standard question. However, it became clear that no one in the workshops had worked with this patient group; therefore, it was difficult for them to think about it and relate to the research question. It is usual for people to gravitate to what they are familiar with, so I acknowledged that I gravitate more to thinking about the Black experience and inequalities in my work as it is a part of my own life experiences. Therefore, the research groups

provided meaningful conversations that helped shape the interview questions and know what to consider when recruiting participants.

At every stage, I had to reflect on how I and the research process may have shaped the data collected. Within the current study context, I had to consider that my role within the team and the discipline I am specialised in may influence my interactions with the participants. I noticed clinicians from the same field had a shared language. I did not have to ask for further elaboration as much as when interviewing participants from a different discipline. For example, the Child Psychotherapists would use psychoanalytic terms that I understood and was familiar with; however, when the CBT therapists mentioned specific terms related to how they work, I had to ask more. I acknowledge that the similarities and differences with the clinicians may have impacted participants' willingness to talk openly about their experiences, which may have shaped what was said. However, with interviews, it can be hard to know what influences what the participants say and do not say, which is why the analysis and interpretation of the data are important. I needed to consider how my professional background, experiences, and prior assumptions might influence my interactions with participants. I ensured the participants interviewed had yet to work on cases with me. However, it is also important to highlight that each clinician will have their own experience of their team, so it was helpful to understand participants' different experiences.

When I began the research project, I referred to the patient group as ‘Black adolescent males’. However, after reading about the adultification of Black children, I realised I might be adultifying this patient group and decided to refer to them as ‘boys’ rather than ‘males’. This was important because, during the literature search, it was apparent that language can be harmful, especially in how people are described and viewed. It is essential to acknowledge that although young people are adolescents, they are still vulnerable children. This change happened before the interviews were carried out, meaning the final wording was in place for the questioning and throughout the study.

As a Black researcher investigating inequalities in accessibility to services for a minority group, I found the literature search sometimes challenging. I had to take multiple breaks when reading articles and books related to Black mental health and inequalities within services, as the research illustrated how Black families and other ethnic minority groups continue to face constant inequalities and discrimination and how little is done to change this in service-provisions and quality of care. In those moments, it was necessary for me to reflect on the arising thoughts and feelings so that they would not influence the interpretation of the research. Nevertheless, the interpretations of the interviews would inescapably be made through the psychoanalytic lens of a Black female

researcher, which was an essential aspect of the research. After each interview, I looked at reflective notes and noted how much the participants appeared to care about the BABs they spoke about, and their reflections on their experiences.

I had prior assumptions that interviewing White participants would be more challenging than interviewing POC participants. I expected there to be some discomfort, primarily due to feedback from research groups. However, I found that this was not the case and that the White participants were very forthcoming about their positions as White middle-class women and their difficulties when working with differences. It could be argued that the participants interviewed were open to thinking about their work with BABs.

When completing the RTA analysis and developing the themes, I noticed that my initial themes were long sentences that tended to include 'BABs'. For example, I had the theme of 'understanding the intersectionality of BABs is important in therapy', which was shortened and refined to 'the importance of holding intersectionality in mind' as a subtheme under the overarching theme of 'Responsibility of clinicians and services'. I would put BABs in each theme and subtheme. On reflection, there was a sense that I was in touch with the invisibility of BABs and was unconsciously attempting to create visibility. This was important to notice and acknowledge because it shaped the research themes. The study found that BABs were not represented in referrals, but the

interviews clarified that BABs use treatment when they access the right services at the right time with the correct clinician.

In conclusion, I acknowledge that my identity—personally and professionally—affects my relationship with and perspective on the research subject and how much power they hold. However, these aspects have been monitored and reflected on to produce a meaningful and transparent research project. A researcher cannot wholly reject their racialised and cultural positionality; when conducting a research project, however, I can acknowledge and understand how this may influence my interpretations. This research was personal and professionally driven, which has allowed me to be an outsider (as a woman and CAMHS clinician who has not worked with a BAB in CAMHS) and an insider as a Black person living in the UK. Although the research process was challenging, from proposal to analysis, I have gained some understanding of clinical work with BABs and how they are represented in referrals. The next chapter will discuss the implications of the findings and think about how these findings can be helpful in teams and services.

# Discussion

The outcome of this research has provided insight into the representation of BABs referred to CAMHS and clinicians' experiences working with them. However, the results should be interpreted with caution due to the limitations of this research project. This chapter discusses the research findings and attempts to bring together the quantitative and qualitative aspects of the project. The limitations and potential consequences of the design are also discussed. The chapter ends with several recommendations for clinical practice and future research.

## Visibility of Black Adolescent Boys

The participants' experiences with BABs bring to light how visible this patient group is when it comes to their behaviours but how invisible they are regarding their vulnerabilities and emotionality (Waddell, 2002). This finding echoes previous research such as Malek & Joughin (2004), who investigated the representation of CAMHS referrals for children and young people and found lower rates of referrals for Black and Asian children and young people compared to their White peers. In line with the hypothesis, the audit demonstrates that BABs (11–15) were underrepresented in referrals to CAMHS during the period chosen for the study. This finding echoes previous research, such as Malek

(2004), who also linked the underrepresentation of BABs in CAMHS to their overrepresentation in adult services. The investigated CAMHS team received 71% of what would be expected for this patient group, which suggests that BABs in the borough are not getting enough mental health support from CAMHS. It could be argued that CAMHS has a threshold and that the other 29% of BABs are accessing mental health support from other youth mental health services, some of which are targeted based on gender and race. However, CAMHS is the primary mental health hub with processes to keep the links between GPs, schools, and other services.

Furthermore, BABs are more likely to develop depressive symptoms due to the likelihood of racialised experiences (English, & Lambert2014); if CAMHS are not receiving the referrals, they are likely to fall through the gaps until there is an escalation and—eventually—a crisis (HM Inspectorate of Probation, 2021). Early intervention is imperative for Black children and young people's mental health to build resilience and address the underlying problems to prevent the development of more serious mental health problems in adulthood. These underlying problems, according to Singh et al. (2013), could be due to migrant issues within the family where there is a likelihood of being excluded, facing discrimination and family breakdown. |If referrals are not made to the appropriate services and appropriate treatments are not offered, there is an increased risk of adolescents becoming adults admitted as inpatients (Chui et al., 2020). In England, it has been found

that by adulthood, the risk of Black men diagnosed with psychosis is nearly three times higher than that of White men (NHS Digital, 2021a). As illustrated by the research completed by the HM Inspectorate of Probation (2021), many of the youth offending services (YOS) Black and mixed (African and/or Caribbean) heritage adolescent boys had never had any CAMHS involvement at the time they became involved with the youth offending services.

The audit does not answer why this is the case, but it does suggest that a proportionate number of BABs are not getting access to CAMHS. Based on the literature that BABs are over-represented in the youth justice system and are more likely to be excluded from school (HM Inspectorate of Probation, 2021; Lammy, 2017), we would expect there to be an overrepresentation of referrals due to an understanding that criminality and exclusions are typically linked to social, emotional, and behavioural difficulties. However, this result may suggest that the understanding of the behaviours neglects emotional causes, which supports research that suggests externalised behaviours from boys are not often viewed as a dynamic of depression or other emotional difficulties (NICE 2005; 2015). Therefore, CAMHS may not be the initial port of call for some professionals and the families of these boys.

The audit results confirm existing evidence (Fernandez, 2015; Bignall et al., 2019) that Black and Asian communities are underusing mental health services.

We need to better understand treatment pathways and outcomes, not only referral data. Nevertheless, referrals of Black and Asian boys were all lower than would be expected given the average percentage of representation in the local population; therefore, it could be argued that CAMHS are failing to attract referrals in proportion to the borough's demographics for ethnic minorities. However, this was different for ‘Mixed’ and ‘Other’ ethnic adolescent boys, who were overrepresented in referrals. The findings further support Arogundade et al. (2023), who also found that both children and adolescents of Black and Asian backgrounds were underrepresented in referrals to Sheffield CAMHS and ‘Mixed’ children were overrepresented. This suggests that this may not be a localised issue but a wider concern. It could be argued that mixed-heritage children are overrepresented due to the increased likelihood of having a White parent, which makes them more likely to access services. This links with comments made by Participant 2 (see Findings, p. 95), who suggested that the parent of a White young girl knew how to get access to services, as compared to Black parents who did not know how to get support. But this also highlights the increased need for mental health services among this patient group, who are reportedly overrepresented in the care and youth justice systems (McVeigh, 2014). Therefore, an overrepresentation in referrals into CAMHS is expected.

While the findings are informative and support previous and recent research, it's important to address the issues that arise when compiling data. The local

population and CAMHS data had a significant number of ethnicities labelled as 'not recorded', which means that we don't have a full understanding of the ethnicity of all the adolescent boys referred to CAMHS in 2019. This is troubling because an important aspect of their identity was left unrecorded, with the majority of cases noted as 'not requested' by CAMHS. This may be due to a lack of information provided by the referral source or missing data that wasn't followed up on by CAMHS (see Limitations for more information on data collection implications). Nonetheless, the collected ethnicity data reveals a significant disproportionality. This could be attributed to the referrer, as CAMHS can only work with children and young people who have been referred. However, White adolescent boys were overrepresented by 24%, suggesting other factors impacting referral numbers concerning ethnicity to CAMHS. It would be beneficial for referrers, such as local schools and GPs, to be made aware of these findings, as it may increase the diversity of referrals and help referrers reflect on why they consider CAMHS treatment suitable for some young people and not for others.

***Problematisation of behaviour or curiosity***

Several of the participants described concerns that BABs' behaviours were not met with curiosity and understanding. This was particularly prevalent when a BAB was not supported by a professional network who could think together about their experiences and needs. Schools were deemed an essential part of the

network, who were more likely to notice a change in behaviour and make referrals to CAMHS. However, the participants also described the consequences of schools not understanding the BABs' behaviour or not being proactive. The participants shared how school inaction can lead to an escalation in behaviour and crisis. For example, Olu's non-attendance did not raise sufficient alarm, Daahir's school did not prioritise assessing his learning needs, and Liam was labelled "naughty" (in Findings p. 71). It could be argued that too much pressure is put on schools to recognise mental health concerns and make referrals; however, due to schools having such regular contact with the young people in their care, they are in the best position to recognise mental health difficulties, rather than specialist mental health services, which depend on professional and family referrals (NHS Digital, 2018).

Participants described how the way in which a BAB is perceived can impact the support they receive and the referral pathway. For example, Olu was not in therapy but in an inpatient facility, which helped illustrate what can occur when the reasons behind certain behaviours are not explored. Non-attendance at school usually indicates something is wrong and needs further understanding and exploration. Adolescence is a difficult period, often involving acts of defiance and problematisation of behaviour by adults; however, it is also a period of physical and psychical transition, which makes adolescents vulnerable to low moods and anxiety (Waddell, 2002). With this in mind, participants raised

concerns that BABs' behaviours are not being thought about as carefully as they should be, which may impact the care and support they access.

It could be argued that Olu was being adultified in the sense that his non-attendance at school was seen as an adult decision rather than his perceived adolescent omnipotence, and so his vulnerabilities were not considered (Davies & Marsh, 2020). One might have hoped that the school would have investigated the non-attendance and made a referral to CAMHS due to sudden withdrawal and isolation. It is beyond the scope of this research project to investigate exactly why Olu was not referred to CAMHS. However, based on the participants' responses, we can speculate that a lack of curiosity regarding his behaviour may have led to a crisis. It might be argued that Olu's parents could have made contact with CAMHS. However, all referrals of BABs discussed with participants were made through professionals. This aligns with qualitative data indicating BAME families' reluctance to access professional support and help (Mantovani et al.,2016).

Participants suggested unconscious biases play a part in making decisions about BABs' treatment pathways. Negative labelling was an indicator of the dangerous lens that some young people are seen through when recommendations are being put in place, which can ultimately affect their sense of self-worth and their relationship to seeking help. For example, if BABs are being perceived as

naughty, as Liam was, this both reflects and perpetuates society's negative views of Black boys and men (Cushion, 2011). This project's results provide a clearer understanding of Rice's (2018) research, which reports how adolescent boys disconnect and disengage from healthcare services during adolescence. By the time they reach adolescence (normally a time of turmoil), they may have already felt misunderstood by services. They would thus need the network to make more of an effort around them to engage and understand their ambivalence. Professionals must understand that this can be a barrier to BABs seeking help. Singh et al. (2013) found that incidents such as Black men dying in mental health units after being restrained can create a lot of anxiety in communities, leading to beliefs about mental health services that can impact help-seeking. For instance, ethnic minorities might fear being misdiagnosed by psychiatrists, which might result in them not receiving the help they need. It is possible that Black men are being misdiagnosed due to racial biases, which can lead to them being offered treatment that doesn't meet their needs. This appears to start from a young age, where BAB's behaviours are often misunderstood, and unconscious biases play a role in the type of treatment they are offered. This pattern continues into adulthood, where Black men are more likely to be locked up in wards than given appointments to see a psychologist (Singh et al., 2013). It is clear that mistrust of services is exacerbated by racism in society, not just in mental health services. Laws such as the Mental Health Units (Use of Force) Act 2018, also known as 'Seni's Law' (named after Olaseni Lewis, a Black man who died as a result of

restraint), are needed to protect mental health patients from disproportionate and inappropriate use of force. However, the research also shows that when BABs are able to access therapy, they can engage and benefit from it. By understanding the meaning behind the behaviour, professionals working with BABs can break down those barriers and better meet their needs (Lowe, 2014). Professionals need to use a lens of curiosity rather than one of problematisation.

***Diversity in CAMHS***

Participants reported the importance of BABs seeing themselves reflected in the services that they access. The need for a diverse workforce was evident through examples in interviews, where BABs had responded well to working with Black male staff, as compared to White staff (see Findings pp. 74-75). Having the opportunity to work with clinicians with a visibly shared identity may promote engagement. This supports Stein's (2018) research, which reports the importance of who it is that delivers the intervention and what the intervention is when working with Black patients. The POC participants reported that having a shared identity, such as race, helped the BABs they worked with to engage better in the therapy and made exploring identities and issues more manageable. The clinician working with Liam reported how beneficial it was for him to work with a male POC clinician to help explore some of his difficulties related to the loss of a parental object. Although this was not explicitly discussed with Liam, working in the transference and offering Liam long-term therapy allowed some space to

explore unconscious processes relating to paternal absence. This is important and gives further understanding to King's (2020) research, which reports how boys need to be offered different ways to be male. King (2020) found that having a male therapist gave the BAB permission to be vulnerable and be helped. Although a therapist is not there to be a role model to the BAB, it could be suggested that the mere presence can be helpful, having a male in a room ready to hold and contain some of their complex and sometimes terrifying feelings.

The findings suggest that having a shared identity with the clinician can also provide a sense of safety for BABs. This was spoken about concerning safety to explore issues such as racism and discrimination, which may not be spoken about with a White clinician (see Findings, p. 75). By seeing a therapist who shares a visible similarity to them, assumptions may be made that there is an understanding of what the BAB may experience, making the space less threatening to engage with. However, HM Inspectorate of Probation (2021) reports that the professional's skills mattered more to Black boys than their ethnicity. What mattered was that they were listened to and understood.

Having said this, it is not always practically possible to match patients with clinicians based on preferences such as shared ethnicity. Patients must be assessed case by case, and there may be occasions where working with a clinician with a shared identity may not be the best option. Indeed, sameness can feel

threatening to some patients. Therefore, regardless of race, gender, religion, or any other protected characteristics they identify with, young people need to be met with curiosity, understanding, and patience.

An unexpected finding of the research regards inequalities regarding pay in the CAMHS workforce depending on ethnicity. Participants reported a lack of Black clinicians, particularly in senior roles, who were reported to be predominately White. This is important because it highlights inequalities in the services. If there are inequalities within the system, then this would impact the service users. Recent research supports these findings that Black British men are the most disadvantaged group when looking at the NHS gender pay gap data (Appleby, Schlepper & Keeble, 2021). Black British staff were more represented as support staff and earned less on average than White staff. If the current research suggests BABs need access to Black male clinicians, how can this need be met if they are the most disadvantaged group in the mental health workforce? Ross et al. (2020) report that work is being done to increase ethnic minorities in senior roles, for example, through the Workforce Race Equality Standard policy initiative, introduced in 2015, which allows for greater scrutiny into how the NHS performs on race equality over time. Change needs to continue to take place from the top–down rather than the bottom–up to be effective and meet the needs of children and adolescents in the community and the CAMHS workforce. There cannot be

an expectation for BABs to trust and engage in systems where they cannot see versions of themselves in the professionals they meet.

## Clinicians and Services: Cultural Responsivity and Reflective Practice

### *Approaches to working with BABs*

Participants described vivid examples of working with BABs, describing different approaches used within the work. They reported the need for flexibility within their therapeutic framework, continuous self-reflection, and self-awareness. This was particularly the case when engagement was deemed problematic; participants reported frustration, feelings of inadequacy, wanting to end the intervention, and experiencing the BAB as challenging. The emotional reactions from the clinicians may have been in response to the BAB feeling disconnected from the clinician and what was being offered. For example, Olu was reportedly non-responsive to offers of support from his White female clinician, who needed to discuss hygiene with him due to self-neglect and poor hygiene. This left the clinician feeling consistently rejected. However, this clinician kept on trying and was able to put herself in his shoes as a Black boy receiving advice about his body from a White woman. This inward reflection helped the clinician ask for help from a male staff member, to whom Olu responded well. This finding helps us understand how emotional reactions can be evoked in clinicians, which can stop thinking. However, when clinicians can reflect on these feelings, there is more opportunity to understand the behaviour

presented to them. The clinician realised that Olu felt embarrassed about receiving help from a woman about his hygiene, which is common in adolescence when the body is often central. This clinician reported how valuable it was for her to learn from other staff members despite being in a more senior role. She highlighted how valuable support staff were in how they were able to interact with the young people in different ways, largely because many of the support staff in the mental health service she worked for had grown up in the local area.

Racial discrimination was only mentioned regarding one of the BABs, who had experienced direct racial bullying. Tyrone’s therapist described her experience of aggressive and challenging behaviour from him, which evoked her ambivalent feelings about her patient. She movingly described how hard it was to be in a room with Tyrone’s angry and painful feelings while acknowledging the importance of using this to understand how he was feeling and experiencing her. The therapist and Tyrone were both victims of racism in the room at different stages of the work. Instead of the therapist ending the sessions, she recognised Tyrone’s process, whereby he needed to identify as the aggressor to protect himself and be more in control. We can examine the experience of racism through the lens of Davids's (2011) concept of the 'internal racist organisation', which he believed exists in every person and can be triggered as a defence mechanism against primitive anxieties. According to Davids, racist attacks are not simply projections onto a person or group but rather an unconscious organisation within

the mind. For this internal racist organisation to develop, the patient must first be aware of racial differences and their significance in the outside world and then use the process of projection to disown the unwanted parts of themselves onto the therapist to alleviate their anxieties (Davids, 2011). The therapist must then hold onto these projections and identify with them, rather than reacting in a typical manner (Davids, 2011), in order to create a safe environment for the patient. Failure by the therapist to maintain this role can trigger racist attacks. In the case of P1, she acknowledged that assuming the role of the victim was necessary for Tyrone to feel secure in the face of bullying. Davids's ideas help us to understand that racist thinking can be a response to primitive anxieties rather than a moral failing. Although P1 was subjected to painful projections, her attempt to understand Tyrone's experience of racism and its enactment in therapy was useful. If Davids is correct, and racism exists in every individual's mind in a racist world, then therapists have a responsibility to investigate its origins, development, and functioning (Davids, 2011). However, the therapist also recognised that Tyrone’s ability to do this in the room with her meant that he felt safe enough to explore the parts of himself that were confused about his identity and internal racism. This can be hard for clinicians to withstand, but the therapist was faced with a BAB who was confused about his identity, and he was trying to communicate to her how he felt by putting her in his position as the victim. When clinicians cannot reflect and try to understand the behaviours presented to them in the context of the child’s history and racialised experiences, they are at risk of

projecting and discriminating against their patients (Gibbs, 2009). These behaviours need to be met with sensitivity and flexibility to understand the processes that are occurring.

It is, therefore, essential that clinicians consider intersectionality when working with BABs. A consideration of intersectionality can help one understand how systems of inequality based on protected characteristics such as race, gender, and disability combine to create unique dynamics and effects. For example, it would be important for clinicians to consider how a BAB might have experienced discrimination as a boy and as a Black person growing up in the UK. It can be said that society has conditioned boys and men to be less in touch with their emotions or feel shame or weakness regarding accessing support (Fortunato, 2005). They often feel they have an image to uphold, which can function as a barrier to asking for help. Clinicians working with BABs need to consider this alongside possible racial discrimination. This supports previous research, suggesting that therapists need to be culturally sensitive and meet the needs of patients rather than patients fitting the frame of therapy (Lanyado & Horne, 2006).

***Use of supervision***

The participants described their use of supervision when working with BABs and how pivotal it was to have a space to reflect on their counter-transference

reactions[22]. It is not something clinicians should be left to think about on their own, mainly if the feelings are powerful, making projection and enactment likely; it is the clinician's responsibility to bring these feelings to supervision to understand the therapeutic relationship better.

Clinicians all appeared to use their supervision to help them understand some of the difficulties they face within their work, such as engagement levels. P3 had this concern with Daahir when he seemed resistant to the structured CBT work to help with his OCD symptoms. P3 reported that with the help of supervision, she had to work out other ways to engage Daahir and be flexible within the therapeutic frame she was working in.

CBT is a therapeutic intervention that is structured and time-limited; however, due to Daahir's suspected learning disability, it appeared hard for him to retain the information; therefore, the intervention needed to be adapted. Like with Olu, when their needs were responded to, the BABs engaged. This aligns with the need for their behaviours to be met with curiosity and understanding to get better positive treatment outcomes. This suggests that the more clinicians work flexibly and are culturally responsive, the more engagement levels are likely to increase.

[22] Emotional responses elicited in the therapist by specific qualities in his/her patient.

However, the quality of supervision is just as important as access to it. The findings suggest that some supervisors may not consciously think about difference and sameness, making it harder for clinicians to bring their thoughts and ideas concerning their work with BABs (see Findings, p. 83). If clinicians do not trust their supervision space to explore some of these aspects of young people, themselves, and their work, this can impact how BABs are understood and worked with. One of the participants, a POC, reported that their supervisor could not help them think about race and difference. Since it was not the focus of the research, this was not further explored in the interview. However, the clinician made it clear that there was a barrier. This may be based on the clinician's relationship with their White supervisor. Previous research has shown a tendency for ethnic minorities in the psychology field to feel that their experiences in placements that are impacted by racism are often avoided (De Angelis, 2023). The same research reported that supervision often overlooked racialised service users' experiences. However, it could be argued that the clinician could have made attempts to discuss issues related to race. However, the power dynamics in the supervisor-supervisee relationship can sometimes make this task more complex. The supervisor is there to guide and oversee the supervisee's performance. Therefore, the supervisee may find it too risky to bring up ideas about race, culture, and identity if they are unsure about their supervisor's stance. Burkard, Johnson, Madison & Knox (2006) report that supervisees of colour often experience culturally unresponsive supervision more frequently and with

more negative effects than their White counterparts. Therefore, supervisors should take the lead in discussing these issues so the onus is not on the supervisee.

All aspects of clinical practice should be culturally responsive. However, this can be difficult because psychology tends to have supervisors offering supervision based on their experience in clinical work rather than formal supervision training, favouring the individual rather than contextual approaches to mental health problems. This is problematic mainly if supervisors deem differences to be 'dangerous and a threat' to their therapeutic frame, as Fleming (2020) found, which leaves clinicians unable to bring these ideas to a supervision space. Regardless of the race of the supervisor or supervisee, when working with BABs, it is evident that the clinician needs to think about and challenge their own racial biases, attitudes, and stereotypes to be culturally responsive and effective in their practice, which is in line with the literature (Caldwell, 2014; Bradley, 2014; Davids, 2011).

***Prioritising equality, diversity, and inclusion***

There must be opportunities within the teams to reflect on clinicians' biases, such as through clinician discussions, training, or shared learning. The participants reported that their CAMHS teams have processes and initiatives in place to think about EDI. However, this was not always made a priority; it can sometimes be brought up as an 'afterthought' when discussing families, or there is a failure to

allocate protected time to those leading initiatives related to EDI. One of the clinicians reported that time had to be made for EDI outside of work hours, which makes it more difficult for them to make it a priority themselves.

When the time was allocated to explore issues around racism, religion, or issues related to EDI, clinicians reported resistance and avoidance within the team. Clinicians commented that varying levels of commitment to EDI within the team can make thinking difficult. This suggests that there is an individualistic rather than a 'whole team' approach, which can mean that clinicians feel unable to express themselves freely, perhaps worrying that their views might be rejected. This suggests the importance of having someone leading and facilitating these spaces to provide containment and safety. This was evident in the data when one participant reported how her absence from an anti-racism reflective group destabilised it. Though frustrating for this participant, it highlighted how hard it can be for CAMHS teams to sit with anxieties related to EDI when there is not an allocated person to hold the space.

However, this can be costly to those expected to hold the space or be the spokesperson for EDI. Dawson et al.'s (2019) research helps us to better understand this process, as they reported that tackling the longstanding and systemic problem of race inequality can quickly become located with individuals, particularly those from marginalised groups, some of whom tend to be too low in

the hierarchy to influence decision-makers such as board members. Clinicians reported that their CAMHS are making more efforts to prioritise EDI, which one clinician reported may be due to their leader being a person of colour, in addition to being dedicated to the issue.

In conclusion, if there is an expectation for clinicians to work effectively with BABs and their families' experience of discrimination or provide them with a space within which to talk about inequalities, clinicians need to be able to do so with one another, allowing the opportunity for learning and reflecting on their practice. Clinicians must master their own racially related issues (Bradley, 2014; Horn, 2006) but be able to explore this within a team to inform their practice.

**Community: Focus on Building Trust**

Participants described the importance of building trust with the community to increase accessibility. One important factor that was deemed helpful in building trust was having a shared language with the families. It was found that understanding how BAME families view mental health in their culture and religion was more beneficial than overwhelming families with medical and psychological jargon. Such jargon merely served to create a distance between clinicians, patients, and their families, with the risk of deterring them from accessing help or speaking openly about their ideas regarding mental health. Families need to feel able to speak openly without judgment. If services were to

engage families from different cultural backgrounds, where there are often ideas about mental health linked to religion and tradition, they would need to work alongside them (Mantovani et al., 2016). This reinforces the need for curiosity and understanding of the patient's mental health and how this intersects with their culture and identity. Clinicians may sometimes have to work with the 'triple stigma' (Mantovani et al., 2017) that some of these families experience concerning mental health, and professionals must ensure they do not add further weight to this.

Alongside having a shared language, it was found to be essential to understand why BABs and their families were not accessing mental health support. The audit and interviews found that the referrals of BABs were not representative of local ethnicity demographics. Therefore, their families were also not accessing support. All participants said that if families are not engaging, there should be more follow-ups with the families to understand why they no longer want the service. CAMHS should gather this data so as to better understand what they might be able to do better to engage families or support them to access services. It could be due to external circumstances, a lack of trust, or a negative experience. Asking for help is not an easy task, particularly for families from BAME groups (Memon, 2016), but once they have sought help, it might also not be easy to take up the help if the service is not culturally responsive.

Alongside trying to understand the barriers faced by BABs and their families, mental health service providers need to make sure to offer a safe environment, providing a space where families feel they have a voice and that services are trying to meet their needs. CAMHS must ensure they are not unwittingly creating hostile environments for these families, which can stop them from accessing the correct support. The assessment stage is the family's first impression of CAMHS. Therefore, clinicians need to be aware that this experience may impact the likelihood of the families engaging. However, CAMHS is stretched, and assessment is often just one session. After that, new clinicians tend to be introduced, which can perhaps unsettle families, especially if there has been a long wait for assessment or treatment (NHS Digital, 2022). Creating positive first experiences with CAMHS for these families can increase the likelihood of participation and change the narrative that mental health services are discriminatory and unapproachable (Meechan, 2021).

The findings suggest that Black families might struggle to advocate for themselves and their children. This is concerning because services depend on families seeking support and sharing information. In Olu's case, his parents felt powerless when they saw that he was struggling with his mental health, and they felt unable to seek help until he had deteriorated. This is evidence that BABs could easily fall through the net, particularly when their difficulties are internalised. Perhaps the family did not feel kept in mind, especially when he had

stopped attending school without it being followed up. Families need to feel supported and kept in mind to seek help and share their concerns. Only then can trust be built and developed. One participant did report that some parents can advocate for their children, but only if they know their rights and have information easily accessible. Participants highlighted the importance of empowering parents and their need to feel included in the assessment and treatment of their children and adolescents.

***Parental engagement***

Building a rapport with parents was deemed necessary for BABs to engage in therapy. Some parents were more invested than others in the therapy; however, the more clinicians focused on building a rapport, the more parental investment increased.

Parents tend to access CAMHS when they are worried about their child's mental health, and they sometimes have their own mental health needs, thus seeking a safe environment within which to share and lessen their worries and allow a space for clinicians to offer help. One of the participants highlighted her difficulties when a parent was perceived as unsupportive of the work with her son—such as not following the strategies recommended by the clinician—and how this unconsciously impacted the work. The CBT intervention's effectiveness in lessening symptoms depended on the BAB doing his homework and on the

family—particularly his mother—putting things in place at home. In response, the clinician offered the mother parent work and discovered that the parent was struggling with aggressive behaviour at home and that she also needed her own support alongside her son's work. This suggests that, for some families, there needs to be a whole-family approach. This supports research that including parents in treatment adds benefits beyond outcomes achieved by individual therapy alone (Dowell & Ogles, 2010). It can be helpful for therapists to involve parents in the therapy process to gain a better understanding of the intergenerational issues that may be impacting a child. For instance, some parents may have adopted a parenting style that emphasises total obedience without thinking, which can negatively affect their relationship with their child. According to Fletchman-Smith (2011), this type of parenting can be traced back to slavery, where disobedience was not tolerated, and slaves had to suppress their emotions to survive. As a result, therapists should consider the possibility of intergenerational trauma that may be biological, social, or psychological in nature.

Participants agreed that when BABs see their parents invested in their treatment, they can engage with and use the space. Participants shared that building a rapport with parents was essential and helped the progress of the work with the BABs. This highlights the importance of parent work in therapy and how BABs and other

young people need their parents and guardians to support the therapy and have a space to discuss their own anxieties and concerns about their child.

## Conclusions, Further Research, and Recommendations

This small research project has attempted to investigate an extremely complex subject; thus, there is scope for further investigation into several of the areas it touches on. The findings largely supported existing research but raised several questions about the care offered to BABs and their families. UK research on race and child mental health is typically based on professionals' commentary rather than on patients, and this is especially so regarding children and adolescents. This may be due to ethical implications. However, the less research is done on the voices of BABs, the more silenced they are.

This research project has raised interest in the visibility of BABs, the accessibility of services in BAME communities, and the cultural responsivity of CAMHS. The representation of referrals of adolescent boys differed across ethnicities, with there being fewer referrals for Black boys than expected. However, there were higher numbers of referrals for Black boys aged 16–17 in comparison to ages 11–15. This highlighted an increase in need and possible point of crisis, when mental health needs are more likely to be recognised, as participants mentioned in interviews. Nevertheless, discrepancies in referrals were found across ethnicities, which this research suggests may be due to how professionals recognise mental

health difficulties in different communities, how families access services and the stigmas associated with mental health in different communities.

This research concluded that BABs behaviours need to be met with curiosity by professionals, those who refer, and those who assess and offer treatment. School was found to be an important part of the network, being the best placed to work with CAMHS to offer the best support for BABs and their families. However, this research has highlighted that clinicians need to be aware of unconscious biases both within themselves and within the wider network. An important aspect of the work with BABs was to consider intersectionality and adultification. If clinicians do not make use of supervision to reflect on their countertransference, unconscious biases, and how to better engage with BABs with flexibility, there is a risk of disengagement from the patient and the clinicians themselves.

This research has raised concerns about the CAMHS workforce and diversity. It found that the BABs may benefit more by seeing more clinicians who reflect them in services, and it was suggested that this would increase relatedness and trust. There needs to be more opportunities for BABs to work with clinicians of colour. However, regardless of the question of shared identity, this research showed that what is important is that clinicians attempt to understand BABs in terms of the different parts of themselves they bring to treatment, e.g. race, gender, or disability. For this to be possible, CAMHS teams need to prioritise

EDI initiatives and opportunities for clinicians to think about EDI-related issues in their clinical practice.

In conclusion, services and clinicians need to build trust with BABs and the communities they come from. It is necessary to have a shared language, understand cultural differences in the context of mental health, and recognise mental health needs. Engaging parents was found to be an important element in increasing the best possible outcomes for BABs. A whole-family approach was found to be most supportive of BABs and increase engagement in treatment.

The following recommendations are based on the findings of this research project.

*Clinical recommendations*

- Further investigation is needed to understand the factors that impact the representation in referrals of BABs to CAMHS. It is recommended that CAMHS liaise with referrers and local services to understand the disproportionate levels of referrals and how this can be improved to reduce the likelihood of admission into inpatient wards in adulthood.
- It is essential for education, social and healthcare services to have a better understanding of how mental health difficulties present in BABs. This would enable them to offer appropriate support and signpost them to

relevant services. Failure to do so can lead to unmet needs and services being offered only when in crisis, which can have serious implications. It is important for clinicians to explore and understand how various aspects of identity shape the experiences of BABs in the world. Understanding intersectionality can help inform culturally responsive practices, leading to sustained engagement and a better understanding of BABs by their clinicians.

- To establish trust with children, young people, and their families, clinicians should avoid using clinical language during direct work. Instead, they should try to understand the family's perspective on mental health and develop a shared language that everyone can understand. This will help in building stronger relationships and improving communication between clinicians and families.
- Services and clinicians need to provide commitment and patience to the Black community and form better relationships in order to bring about better outcomes and accessibility to mental health support.
- Supervision is crucial in providing safe and effective care and driving service improvements within teams. It is recommended that issues related to sameness and difference form a necessary part of supervision to ensure it is explored within the therapeutic relationship.
- CAMHS services must ensure that ethnicity data is collected and recorded properly for accurate patient information.

*Research recommendations*

- The audit indicated that a high number of 16–17-year-old adolescent boys are referred into CAMHS. Further research is needed to understand why this may be the case and whether referrals are more likely to be made at the point of crisis and transition to adulthood.
- The audit reported an overrepresentation of mixed-heritage adolescents referred into CAMHS by over double the expected number of referrals. This is concerning as it indicates an increased number of mixed-heritage children presenting with mental health difficulties. Further research is needed to understand why this may be the case.
- The differences in the number of referrals of adolescents from different ethnic backgrounds highlight potential issues in the referral process. Conducting interviews with potential referrers of children and young people to mental health services may help gain a better understanding of why some are referred while others are not. It is important to investigate these issues to ensure that all individuals receive the mental health support they need.
- This research reported that some BABs are referred to CAMHS; however, during recruitment, it was difficult to find clinicians who had experience working with these patients. This suggests that more research is needed to

better understand the treatment pathway and how to improve treatment uptake for this group of patients.

- The research aimed to explore the experiences of clinicians working with BABs in mental health services. However, it would have been beneficial to also include BABs themselves in the study, to obtain their first-hand accounts of their experiences with CAMHS. Conducting future research by interviewing BABs individually or as part of a focus group could provide a platform for their voices to be heard, allow them to provide feedback, and assist in the improvement and enhancement of the quality of mental health services.

# References

Adams, A., Realpe, A., Vail, L, A., Buckingham, C., Erby, L., & Roter, D. (2015). How doctors' communication style and race concordance influence African–Caribbean patients when disclosing depression. *Patient Education and Counselling*, 98(10), 1266–1273.

Argogundade, T., Shibib, S., Melton, W & Younis, A (2023). A service evaluation of referrals to Sheffield Community Child and Adolescent Mental Health Services (CAMHS) by ethnicity and areas of deprivation. *BJpsych Open.* Retrieved from *http://*doi:10.1192/bjo.2023.365

Altman, N. (1995). *The Analyst in the Inner City: Race, Class, and Culture Through a Psychoanalytic Lens*. Hillsdale NJ: Analytic Press.

Appleby, J., Schlepper, L., & Keeble, E. (2021). *The Ethnicity Pay Gap in the English NHS. Nuffield Trust.* Retrieved from https://www.nuffieldtrust.org.uk/sites/default/files/2021-04/nuffield-trust-ethnicity-pay-gap-web3.pdf

Ayo, Y., Morley, D., & Steven, W. (2020). Delivering culturally competent services. In L. Theodosiou, P. Knightsmith, P. Lavis and S. Bailey (Eds.*) Children and young people's mental health: early intervention, ongoing support and flexible, evidence-based care* (pp.57-67). England: Pavillion Publishing.

Bailey, T. K. M., Yeh, C. J., & Madu, K. (2022). Exploring Black adolescent males' experiences with racism and internalized racial oppression. *Journal of Counselling Psychology*, 69(4), 375–388.

Barber, J.P., Barrett M.S., Gallop. R., Rynn M.A., & Rickels, K. (2012). Short-term dynamic psychotherapy versus pharmacotherapy for major depressive disorder: a randomised, placebo-controlled trial. *Journal of Clinical Psychiatry*, 73, 66–73.

Bernard, C., & Harris., P. (2018). Serious case reviews: The lived experience of Black children. *Child and Family Social Work*, 24(2), 256-263.

Bignall, T., Jeraj, S., Helsby, E., & Butt, J. (2019). *Racial disparities in mental health: Literature and evidence review.* Retrieved from https://raceequalityfoundation.org.uk/wp-content/uploads/2022/10/mental-health-report-v5-2.pdf

Bonovitz, C. (2009). Mixed race and the negotiation of racialised selves: Developing the capacity for internal conflict. *Psychoanalytic Dialogues*, 19 (4), pp 26- 441.

Bradley, J. (2014). Being "Black" in the transference: working under the spectre of racism. In F. Lowe (Ed.) *Thinking space* (pp.106-129). London: Routledge

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3,* 77–101.

Braun, V., Clarke V. (2013) *Successful Qualitative Research: A Practical Guide for Beginners.* Thousand Oaks: Sage Publications.

Braun, V., & Clarke, V. (2019). Reflecting on reflective thematic analysis. *Qualitative research*, 11 (4), 589-597.

Brooks, O. (2014). Race and our evasions of invitations to think: how identifications and idealisations may prevent us from thinking. In F. Lowe (Ed) *Thinking space (*pp.33-55*)*. London: Routledge.

Broussard, B., Goulding, S.M., Talley, C.L., & Compton, M. T. (2012). Social distance and stigma toward individuals with schizophrenia: findings in an urban, African American community. *Journal of Nervous Mental Disorders*, 200 (11), 935-940.

Burkard, A., Johnson, A.J., Madson, M., & Knox, S. (2006). Supervisor Cultural Responsiveness and Unresponsiveness in Cross-Cultural Supervision. *Journal of Counselling Psychology,* 53(3), 288-301.

Cadwell, L. D, & White, J.L. (2014). African-centered therapeutic and counselling interventions for African American males. In K. C. Vaughans & W. Spielber (eds.), *The psychology of Black boys and adolescents,* Vols, *1-2.* (pp. 505-521). Praeger: ABC-CLIO.

Chang, D.F, & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, 56, 521–536.

Chui, Z., Gazard, B., MacCrimmon, S., Harwood, H., Downs, J., Bakolis, I., Polling, C., Rhead, R., & Hatch, S. L. (2021). Inequalities in referral pathways for young people accessing secondary mental health services in south-east London. *European Child & Adolescent Psychiatry*, 30*,* 1113–1128.

Cordaro, M., Tubman, J.G., Wagner, E.F., & Morris, S.L . (2012). Treatment process predictors of program completion or dropout among minority adolescents enrolled in a brief motivational substance abuse intervention. *Journal of Child & Adolescent Substance Abuse*, 21, 51–68.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review,* 43*,* 1241–1299.

Cushion, S., Moore, K., & Jewell, J. (2011). *Media representations of black young men and boys. Report of the REACH media monitoring project*. Retrieved from https://orca.cardiff.ac.uk/id/eprint/28559/1/2113275.pdf

Cwik, M., Jay, S., Ryan, T.C., DeVylder, J., Edwards, S., Wilson, M.E., Virden, J., Goldstein, M., & Wilcox, H.C. (2021). Lowering the age limit in suicide risk screening: Clinical differences and screening from predictive ability. *Journal of the American Academy of Child & Adolescent* Psyhiatry, 60(5), 537-540)

Dalal, F. (2006). Racism: Processes of Detachment, Dehumanization, and Hatred. *Psychoanalytic* Quarterly, 75(1), 131-161.

Dalal, F. (2021). The ethics of supervision: Reciprocity, emergence, and prefiguration. *Group Analysis*, 56(1), 62–80.

Dawson, J., Sampson, F., Rimmer, M., Buckley Woods, H., West, M & Nadeem, S (2019). *Evaluation of the NHS Workforce Race Equality Standard (WRES)* [online]. NHS England website. Retrieved from: www.england.nhs.uk/publication/evaluation-of-the-nhs-workforce-race-equality-standard-wres

Davids, M. F. (2011). *Internal Racism: A Psychoanalytic Approach to Race and Difference*. Basingstoke: Palgrave Macmillan.

Davids, M.F. (2020). Psychoanalysis and black lives. *The International Journal of Psychoanalysis*, 101(5), 1039-1047.

Davies, J., & Marsh, N. (2020). Boys to men: the cost of 'adultification' in safeguarding responses to Black boys. *Critical and Radical Social Work*, 8(2), 255-259.

De Angelis, T. (2023, January 1). *Increasing supervisor savvy around culture, race, and identity Culturally responsive supervision includes learning about employees' perspectives, experts say.* Retrieved from https://www.apa.org/monitor/2023/01/culturally-responsive-supervision

Department for Education. (2019). *School exclusion: a literature review on the continued disproportionate exclusion of certain children*. (DFE-RR869) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/800028/Timpson_review_of_school_exclusion_literature_review.pdf

Dolev, T., Zilcha-Mano, S., Chu,i H., Barrett, M.S., McCarthy, K.S & Barber, J. P. (2018). The Process of Change in Ethnic Minority Males Undergoing Psychodynamic Psychotherapy: A detailed comparison of two cases. *Psychoanalytic Psychotherapy,* 32 (2), 157-180.

Dowell, K.A., & Benjamin M. O. (2010). The effects of Parent Participation Child Psychotherapy Outcomes: A meta Analytic review. *Journal of Clinical Child and Adolescent psychology,* 39(2), 151-62.

DuPont-Reyes M.J., Villatoro A.P., Phelan J.C., Painter, K & Link, B.G. (2020). Adolescent views of mental illness stigma: An intersectional lens. *American Journal of Orthopsychiatry,* 90 (2), 201-211.

English, D., & , S. F. (2014). Longitudinal Associations between Experienced Racial Discrimination and Depressive Symptoms in African American Adolescents. *Developmental Psychology,* 50 (4), 1990-1996.

Fernández de la Cruz, L., Llorens, M., Jassi, M., & Krebs, G. (2015). Ethnic inequalities in the use of secondary and tertiary mental health services among patients with obsessive–compulsive disorder. *British Journal of Psychiatry*, 207 *(*6),530-535.

Fernando, S. (2017). *Institutional Racism in Psychiatry and Clinical Psychology*. Palgrave: Macmillan.

Fleming, A. (2020). Child psychotherapists' fantasies about working with cultural differences. *Journal of Child Psychotherapy*, 46(2), 168-190.

Fletchman-Smith, B. (2011). *Transcending the Legacies of Slavery. A Psychoanalytic View.* London: Karnac.

Fortunato, J.V. (2005). Reauthoring the story of sexual abuse and gender socialisation: A narrative approach to treatment for adolescent boys. *Dissertation Abstracts International,* 66(4), 2305.

Francis, S., & Welsh, T. (2011, August 6). *London riots: Youth services cut in half since the unrest. BBC News.* Retrieved from https://www.bbc.com/news/uk-england-london-58030259

Gibbs, I. (2009). Race, culture, and the therapeutic process. In M. Lanyado & A. Horne (Eds.), *The handbook of Child & Adolescent Psychotherapy: Psychoanalytic approaches*, (pp.114-123) London: Routledge.

Gill, K., Quilter-Pinner, H., & Swift, D. (2017). *Making the difference: Breaking the link between school exclusion and social exclusion.* Retrieved from *https://www.ippr.org/files/2017-10/making-the-difference-report-october-2017.pdf*

Gutman, L. M., Joshi, H., Parsonage, M. & Schoon, I. (2015). *Children of the New Century: Mental Health Findings from the Millennium Cohort Study*. London: Centre for Mental Health.

HM Inspectorate of Probation. (2021). *The experience of black and mixed heritage boys in the youth justice system.* Retrieved from https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2021/10/The-experiences-of-black-and-mixed-heritage-boys-in-the-youth-justice-system-thematic-report-v1.0.pdf

Ho, A. K., Kteily, N.S & Chen J.M. (2017). "You're one of us": Black Americans' use of hypodescent and its association with egalitarianism. *Journal of Personality and Social Psychology*, 113 (5),753-768.

Holmes, D. E. (1999). Race and countertransference: Two "blind spots" in psychoanalytic perception. *Journal of Applied Psychoanalytic Studies*, 1(4),319–332.

Holmes, D.E. (2006). The wrecking effects of race and social class on self and success. *The Psychoanalytic Quarterly*, 75(1), 215-235.

Husain, M.I., Waheed, W., & Husain, N. (2006). Self-harm in British South Asian women: psychosocial correlates and strategies for prevention. *Annals of General Psychiatry*, *5*, 7. https://doi.org/10.1186/1744-859X-5-7

Institute of Race Relations. (2023). BME statistics on poverty and deprivation. Retrieved from **https://irr.org.uk/research/statistics/poverty/**

Jenner B. M., & Myers K. C. (2019). Intimacy, rapport, and exceptional disclosure: A comparison of in-person and mediated interview contexts. *International Journal of Social Research Methodology*, 22(2),165–177.

Khan, L. (2017, July 6). Against the Odds: Putting young Black men's Wellbeing first [Blog post]. Retrieved from https://www.centreformentalhealth.org.uk/blogs/against-odds-putting-young-black-mens-wellbeing-first

Khan, L., Saini, G., Augustine, A., Palmer, K., Johnson, M., & Donald, R. (2017). *Against the odds: Evaluation of the Mind Birmingham Up My Street programme. Centre for Mental health.* Retrieved from https://www.mind.org.uk/media-a/4300/ums-report.pdf

Khanna, N. (2010). If you're half black, you're just black: Reflected appraisals and the persistence of the one drop rule. *Sociological Quarterly.* 51(1), 96–121.

King, T.L, Sheilds, M., Sojo, V., Daraganova, G., Currier, D., O'Neil, A., Kinf, K., & Milner, A. (2020). Expressions of masculinity and associations with suicidal ideation among young males. *BMC Psychiatry*, 20:228.

King, C (2019). Race, mental health and the research gap. *The Lancet Psychiatry*, 6 (5), 367-368.

Klein, M (1932). *The psychoanalysis of children.* London: Random House.

Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psychoanalysis, 2*, 99–110.

Knipscheer, J.W., Sleijpen, M., Mooren, T., Ter Heide, F.J., & Van der Aa, N. (2015). Trauma exposure and refugee status as predictors of mental health outcomes in treatment-seeking refugees. *British journal of Psychiarty Bulletin*, *39*(4),178-82.

Lammy, D. (2017). *The Lammy Review, 2017, An independent review into treating and outcomes for Black, Asian, and Minority Ethnic individuals in the Criminal Justice System.* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf

Lanyado, M., & Horne, A.(2006). Introduction. In M. Lanyado & A Horne (Eds.) *A question of Technique: Independent Psychoanalytic approaches with children and adolescents* (pp1-15) New York, NY: Routledge.

Lemma, A., & Young, L. (2021). Working with traumatised adolescents: a framework for intervention. In J. Stubley and l. Young (Eds.) *Complex trauma: The Tavistock model* (pp.95-111). London: Routledge.

Levy, K.N., & Scala, J. (2020). Transference. In V. Zeigler-Hill and T.K Shackelford (Eds.) *Encyclopaedia of Personality and Individual Differences* (pp. 5564-5568). Switzerland: Springer.

Lindsey, M. A., Banks, A., Cota, C. F., Lawrence Scott, M., & Sean, J. (2018). Review of Treatments for Young Black Males Experiencing Depression. *Research on Social Work Practice, 28*(3),320-329.

Lowe, F. (2014). Thinking space: the model. In F. Lowe (Ed,) *Thinking space (pp.10-32).* London: Routledge.

Malek, M. & Joughin, C. (2004). *Mental health services for minority ethnic children and adolescents*. London: Jessica Kingsley.

Malik, S., Ryder, M., Marsden, S., Lawson, R. & Gee, M. (2021). *BAME: A report on the use of the term and responses to it Terminology Review for the BBC and Creative Industries.* Retrieved from https://bcuassets.blob.core.windows.net/docs/csu2021325-lhc-report--bbchighres231121-132836254614117870.pdf

Mantovani, N., Pizzolati, M., & Edge, D. (2016). Exploring the relationships between stigma and help seeking for mental illness in African descended faith communities in the UK.*Health Expectations*, *20*(3), 373-384.

McManus, S., Bebbington, P., Jenkins, R., & Brugha, T. (2016). *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Retrieved from https://openaccess.city.ac.uk/id/eprint/23646/1/mental_health_and_wellbeing_in_england_full_report.pdf

McIntyre, M., Parveen, N., & Thomas, T. (2021, March 24). Exclusion rates five times higher for Black Caribbean pupils in parts of England. *The Guardian.* Retrieved from https://www.theguardian.com/education/2021/mar/24/exclusion-rates-black-caribbean-pupils-england#:~:text=Figures%20show%20that%20in%20Cambridgeshire,more%20than%20five%20times%20higher

McVeigh, T. (2014, February 23). Mixed-race children 'are being failed' in treatment of mental health problems. *The Guardian.* Retrieved from https://www.theguardian.com/society/2014/feb/23/mixed-race-children-mental-health

Meechan, H., John, M., & Hanna, P. (2021). Understandings of mental health and support for Black male adolescents living in the UK. *Children and Youth Services Review*, *129*. Retrieved from https://doi.org/10.1016/j.childyouth.2021.106192

Melanie Klein Trust. (n.d.). Projective Identification. Retrieved from https://melanie-klein-trust.org.uk/theory/projective-identification/#:~:text=Phantasies%20of%20projective%20identification%20are,desired%20aspects%20of%20his%20psyche

Memon, A., Taylor, K., Moebati, L., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study on Southeast England. *British Medical Journal Open, 6* (11). Retrieved from https://doi.org/10.1136/bmjopen-2016-012337

Ministry of Justice. (2020). *Her Majesty's Prison and Probation Service Offender Equalities Annual Report 2019/20. Ministry of Justice Official Statistics Bulletin*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/938345/hmpps-offender-equalities-2019-2020.pdf

Morgan, C., Fearon, P., Lappin, J., Heslin, M., Donoghue, K., Lomas B, Reininghaus, U., Onyejiaka, A., Croudance, T., Jones P.B., Murray, M., Doody, G.A & Dazzan, P.(2017). Ethnicity and long-term course and outcome of psychotic disorders in a UK sample: the ÆSOP-10 study. *British Journal of Psychiatry*, 211,88–94.

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough., & Target, M. (2015). Beyond a diagnosis: The experience of depression among clinically referred adolescents. *Journal of Adolescence*, *44*, 269-279.

Money-Kyrle, R. (1956). Normal Countertransference and Some of its Deviations. In D. Meltzer (Ed.) *The Collected Papers of Roger Money-Kyrle* (pp.330-342). Strathclyde: Clunie Press.

Nevers-Ashton, N (2023). "You're black, I'm black": art therapy, race, autism, and domestic abuse. *International Journal of Art Therapy*, 28 (1-2), 20-27.

Ngwenya, N., Chikwari, C.D., Seeley, J & Ferrand, R.A (2023). Are concepts of adolescents from the Global North appropriate for Africa? A Debate. *BJM Global Health.* Retrieved from https://doi.org/10.1136/bmjgh-2023-012614

NHS Digital. (2018). *Mental Health of Children and Young People in England, 2017: Summary of key findings.* Retrieved from https://files.digital.nhs.uk/A6/EA7D58/MHCYP%202017%20Summary.pdf

NHS Digital. (2020). *Survey conducted in July 2020 shows one in six children having a probable mental disorder.* Retrieved from https://digital.nhs.uk/news/2020/survey-conducted-in-july-2020-shows-one-in-six-children-having-a-probable-mental-disorder

NHS Digital. (2021). *Mental Health Act Statistics, Annual Figures - 2020-21.*Retrieved from https://files.digital.nhs.uk/D8/C5C652/ment-heal-act-stat-eng-2020-21-easy-read.pdf

NHS Digital. (2021a). *Psychotic disorders: Ethnicity facts and figures.* Rerieved from Psychotic disorders - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

NHS Digital. (2022). *Waiting times for children and young people's mental health services 2021.* Retrieved from https://digital.nhs.uk/supplementary-information/2022/waiting-times-for-children-and-young-peoples-mental-health-services-2021-2022

NICE. (2019). *Depression in Children and Young People: Identification and management in primary, community and secondary care.* Retrieved from https://www.nice.org.uk/guidance/ng134/evidence/full-guideline-pdf-6836038382

Office for National Statistics. (2020). *Child poverty and education outcomes by ethnicity.* Retrieved from https://www.ons.gov.uk/economy/nationalaccounts/uksectoraccounts/compendium/economicreview/february2020/childpovertyandeducationoutcomesbyethnicity

Pieterse, A.L., Todd, N.R., Neville, H.A., & Carter, R.T. (2012). Perceived racism and mental health among Black American adults: a meta-analytic review. *Journal of Counseling Psychology*, *59*, 1–9.

Rafai, K. (2019). *S.M.I.L.Eing Boys Project.* Retrieved from https://universoulartist.com/#section_page-10406

Rankine, C., & Loffreda, B. (2016). Whiteness and the racial imaginary. In C. Rankine, B. Loffreda, & M.K. Cap (Eds.) *The racial imaginary: Writers on race and the life of the mind* (pp. 13–22). Fence Books.

Rice, S.M., Purcell, R., & McGorry, P. D. (2018). Adolescent and young adult male mental health: Transforming system failures into proactive models of engagement. *Journal of Adolescent Health, 62*(3) S9-S17. https://doi.org/10.1016/j.jadohealth.2017.07.024

Rohleder, P. (2014). Projection, Overview. In T. Teo (Ed) *Encyclopaedia of Critical Psychology* (pp 1520-1522). New York, NY: Springer.

Ross, D., Jabbal, J., Chauhan, K., Maguire, D., Randhawa, M., & Dahir, S. (2020). *Workforce race inequalities and inclusion in NHS providers*. Retrieved from https://www.kingsfund.org.uk/publications/workforce-race-inequalities-inclusion-nhs

Singh, S. P., Islan, Z., Brown, L.J., Gajwani, R., Jasani, R., Rabiee, F & Parsons, H (2013). Ethnicity, detention and early intervention reducing inequalities and improving outcomes for Black and minority ethnic patients: the ENRICH programme, a mixed-methods study. *Programme Grants Applied Research*, 1 (3). Retrieved from hhttps://doi.org/10.3310/pgfar01030

Stein, C. (2018). *Mind your language: how men talk about mental health*. Retrieved from https://shop.menshealthforum.org.uk/products/mind-your-language-how-men-talk-about-mental-health

Sue, D.W., Capodilupo, C.M., Torino, G.C., Bucceri, J.M., Holder, A., Nadal, K.L., & Esquilin, M (2007). Racial microaggressions in everyday life: implications for clinical practice. *American Psychologist*, 62, 271–286.

Thomas, L. (1992). Racism and Psychotherapy: Working with Racism in the Consulting Room – An Analytical View. In J. Kareem and R. Littlewood (Eds) *Intercultural Therapy: Themes, Interpretations and Practice,* (pp.133–145). Oxford: Blackwell Scientific Publications.

Waddell, M. (2002). *Inside Lives Psychoanalysis and the Growth of the Personality*. London: Routledge.

Wang, Q., Qu, Y & Ding, R (2020). Adolescents in collectivist cultures, History, theory and culture in adolescence: culture and cultural beliefs. *The encyclopedia of child and*

*adolescent development*. Retrieved from https:doi.org/10.1002/9781119171492.wecad320

Ward, A. (2012). The "English riots" as a communication: Winnicott, the antisocial tendency, and public disorder in Broken bounds. In C. Reeves (ed.) *Broken Bounds. Contemporary Reflections on Antisocial Tendency,* (pp.147-160). London: Karnac.

We are Break Through. (2022, January 11). Break the cycle ending school-to-prison pipelines in the UK. [Blog post] Retrieved from https://www.wearebreakthrough.org/blog/break-the-cycle-ending-school-to-prison-pipelines-in-the-uk

Weissman, M.M., Wolk, S., Goldstein, R.B., Moreau, D., Adams, P., Greenwald, S., Klier, C.M., Ryan, N.D., Dahl, R.E., & Wickramaratne, P. (1999). Depressed Adolescents Grown Up. *Journal of the American Medical Association, 281(18), 1707-1713.*

Winnicott, D. W. (1956). The antisocial tendency. In D. W. Winnicott (Ed.), *Collected Papers: Through Paediatrics to Psychoanalysis* (pp. 306–315). London: Karnac Books.

Williams, E.D.G. (2022). *Black boys' mental health help-seeking: Exploring perceptions, barriers, and social processes.* (Unpublished PhD thesis) University of Michigan.

Wing, N. (2017, September 19). When the Media Treat White Suspects and Killers Better Than Black Victims. *Huffington Post.* Retrieved from https://www.huffingtonpost.co.uk/entry/when-the-media-treats-white-suspects-and-killers-better-than-black-victims_n_59c14adbe4b0f22c4a8cf212

Yi, K.Y. (1998). Transference and Race: An Intersubjective Conceptualization. *Psychoanalytic. Psychology*, *15*,245-261.

Youth Justice Board and Ministry of Justice. (2021). *Youth Justice Statistics 2019/20: England and Wales.* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/956621/youth-justice-statistics-2019-2020.pdf

**Appendix A** – Public-facing documents

The Tavistock and Portman
NHS Foundation Trust

Dear All,

My name is Sharon Komakech, I am a Child and Adolescent Psychotherapist in doctoral training in the North Camden CAMHS team. I am about to embark on my Doctoral Research Project as part of my Child and Adolescent Psychotherapy training. I am contacting you to see if you would be interested in taking part.

The project title is: **Are Adolescent boys from African and Caribbean heritage underrepresented in referrals to Child Adolescent Mental Health services (CAMHS) and what experience do clinicians have with this group?**

I am interested in exploring clinician's thinking and experience of working with black adolescent boys between the ages of 11-17. I am hoping this may also provide clinicians with a space to consider and reflect on what it is like to work with these children and adolescents and learn from this for their own practise.

I would like to invite anyone who works within the [redacted] CAMHS clinics, has at least two years' experience working in assessment and/or treatment and has had experience working with black adolescent males (11-17 years), to take part in an interview to discuss your experiences. These interviews will be guided by me and last between 60 and 90 minutes. They would take place within your usual place of work.

If you would be interested and willing to take part please find attached a participant information sheet for your information.

Best wishes,

Sharon Komakech

skomakech@tavi-port.nhs.uk

The Tavistock and Portman NHS
NHS Foundation Trust

**Consent Form**

**Project title:** Are Adolescent boys from African and Caribbean heritage underrepresented in referrals to CAMHS and what experience do clinicians have with this group?

**Name of researcher:** Sharon Komakech

- I___________________________________voluntarily agree to participate in this research project. ☐
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to three weeks after the completion of the interview. ☐
- I understand that the interview will be digitally recorded and transcribed as described in the participant information sheet. ☐
- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk. ☐
- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher. ☐
- I understand that it is my responsibility to anonymise any examples referring to cases I chose to discuss during the interview. ☐
- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications. ☐

**Contact details:**

Researcher: Sharon Komakech Email: skomakech@tavi-port.nhs.uk

Supervisor: Dr Rachel Abedi Email: rabedi@tavi-port.nhs.uk

Participant's Name (Printed):_____________________________________

Participant's signature: ______________________________ Date: ____________

**Thank you for agreeing to take part in this study.**

**Your contribution is very much appreciated.**

The Tavistock and Portman NHS
NHS Foundation Trust

**Are Adolescent Boys from African and Caribbean heritage underrepresented in referrals to Child Adolescent Mental Health services (CAMHS) and what experience do clinicians have with this group?**

You have been given this information sheet to invite you to take part in a research project. This information sheet describes the study and explains what will be involved if you decide to take part.

**What is the purpose of this study?**

As part of this study I want to understand the representation of referrals of Black adolescent boys aged between 11-17 to CAMHS and explore clinician's experiences of working with this patient group in a CAMHS setting.

**Who is conducting the study?**

My name is Sharon Komakech.

I'm a researcher working for The Tavistock and Portman NHS Foundation Trust where I am training to be a Child and Adolescent Psychotherapist. This project is being sponsored and supported by The Tavistock and Portman Centre and has been through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex.

**What will participating in this project involve?**

The project is an inquiry into the experience of clinicians working with black adolescent boys (11-17) in a CAMHS setting. For this you will be invited to take part in an individual interview. This will mainly be for you to talk freely about the topic with some prompts from myself. During the discussion I would be interested to hear about how you think about (from your training and experience clinically) issues face by black adolescent boys and what your personal experience is of working clinically with this group of young people.

All interviews will last between 60 and 90 minutes and will be audio recorded. These interviews will be aimed to be conducted face to face, however, if this is not possible due to COVID-19 they will take place via telephone or video link. If it is possible to complete the interview face to face it will take place at your usual place of work to try and suit everyone involved. No extension to your usual working hours will be necessary.

**Do I have to take part?**

No, it is completely your choice whether or not you take part in the study. If you agree to take part, you can withdraw without giving any reason at any time up to three weeks after the interview. This timescale has been decided as the data will then be being processed and analysed. If you decide to withdraw all data collected or about you it will be destroyed immediately.

**Criteria to take part in the study:**

- Currently working for [redacted] CAMHS and/or [redacted] CAMHS.
- At least two year's experience assessing and/or providing treatment within a CAMHS team.
- Have previous or current experience of working with black adolescent boys 11-17 years in a CAMHS setting.

**What will happen to any information I give?**

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 10 years after the study has finished. The interview will be audio recorded and transcribed by myself.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in analysing this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

Quotes from the transcript will be used in the write-up of the project but these will be de-identified. However, please note, it is possible that other colleagues who know you well may recognise you in some of the quotes used, although every effort will be made to prevent this. Any extracts from what you have said that are quoted in the research report will be entirely anonymous.

All electronic data will be stored on a password-protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 10 years.

If you would like more information on the Tavistock and Portman and GHC privacy policies please follow these links:
https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/
https://www.ghc.nhs.uk/privacy-notice/

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

There will be limitations to the confidentiality of information provided if it is deemed yourself or someone else is at risk.

**What will happen to the results of the project?**

The results of this study will be used in my Research Dissertation Project and Doctorate qualification. It may also be used in future academic presentations and publications.

I would be happy to send you a summary of the results if you wish. Please contact me to request this if it of interest to you.

**What are the possible benefits of taking part?**

There will be no direct benefits for you. However, by taking part you will be given the opportunity to consider this growing area of practise. It is hoped that it will provide a space for you to consider and reflect on your experience in a way that may be helpful for future work.

**Are there any risks?**

No, there are no direct risks. However, I am aware that it may be a challenging topic that involves possible unconscious beliefs which some may find uncomfortable. If needed details of a confidential service you can access will be provided.

**Contact details**

I am the main contact for the study. If you have any questions about the project or would like to discuss this further please don't hesitate to contact me. My contact details are:

Sharon Komakech
Email: skomakech@tavi-port.nhs.uk
Telephone: 02089382232
Address: 120 Belsize Lane, London NW3 5BA

Alternatively, any concerns or further questions can be directed to my supervisor:
Dr Rachel Abedi
Email: rabedi@tavi-port.nhs.uk

If you have any concerns about the conduct of this research, the researcher or any other aspect of this research project please contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

**Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research please complete the consent form provided**

The Tavistock and Portman NHS
NHS Foundation Trust

Dear Participant,

I am writing to thank you for your contribution to my Doctoral Research Project. I hope you found it as interesting as I did.

If following taking part there are any issues that are concerning you I hope that you can access the support network around you (colleagues, supervisor and managers). However, if this isn't possible there is a confidential counselling service provided by Tavistock and Portman Health NHS Foundation Trust:

**Counselling at**

To help with health and wellbeing matters, the HR department at the Tavistock and Portman NHS trust have available a counselling service provided by Care first, an independent provider of professional employee support services. Care first employs professionally qualified counsellors and information specialists who are experienced in helping people to deal with all kinds of practical and emotional issues such as wellbeing, family matters, relationships, debt management and workplace issues.

You can self refer as follows:

the login details provide on the intranet which you can access by searching 'Care first – Employee Assistance Programme'. Or you can call Care first on 0800 174319 where you can speak to a professional counsellor or information specialist in confidence.

The service is free of charge for employees to use. Care first is available 24 hours a day, 7 days a week, and 365 days a year and is accessible by phone or online.

If you have any questions or would like further information here are my contact details:
Email: skomakech@tavi-port.nhs.uk
Phone: 07961221843

If you have any concerns about how the study has been conducted please contact myself, my supervisor Dr Rachel Abedi (rabedi@tavi-port.nhs.uk) or Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Kind regards,
Sharon Komakech

# **Appendix B** – Local population data

N3 | *fx* 2019

**GLA 2021-based Interim Projections 'Ca** | [Index] | **Unrounded**

*Source: GLA Intelligence, © June 2023*

GLA require all figures to be rounded to the nearest 100 for publication purposes and the correct variant and source quoted.

| | Age | 2021-2041 Trend | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Summary Age groups: Persons** | | | | | | | | | | | | | | | |
| **Total** | **All Ages** | | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### |
| 'Pre-school' | 0-3 | | 9,155 | 8,934 | 8,448 | 8,100 | 7,857 | 7,625 | 7,592 | 7,661 | 7,758 | 7,924 | 8,036 | 8,121 | 8,206 |
| 'Primary' | 4-10 | | 14,958 | 14,590 | 14,346 | 13,868 | 13,548 | 13,196 | 12,810 | 12,407 | 12,075 | 11,688 | 11,484 | 11,408 | 11,387 |
| 'Secondary' | 11-15 | | 10,199 | 10,236 | 10,337 | 10,318 | 10,429 | 10,364 | 10,112 | 9,848 | 9,531 | 9,319 | 9,056 | 8,796 | 8,538 |
| 'Young Adults' | 16-24 | | 31,974 | 31,559 | 31,167 | 31,714 | 34,743 | 36,343 | 36,907 | 36,860 | 36,875 | 36,896 | 36,501 | 36,221 | 36,191 |
| 'Younger Working Age' | 25-44 | | 78,879 | 77,753 | 76,636 | 73,730 | 74,534 | 75,088 | 75,634 | 76,124 | 76,738 | 77,569 | 78,570 | 79,406 | 79,948 |
| 'Older Working Age' | 45-64 | | 46,446 | 46,990 | 47,578 | 47,738 | 48,314 | 48,661 | 49,103 | 49,261 | 49,345 | 49,326 | 49,206 | 48,964 | 48,792 |
| 'Younger Pensioner Age' | 65-74 | | 14,058 | 13,982 | 13,826 | 13,712 | 13,598 | 13,679 | 13,798 | 14,110 | 14,498 | 14,940 | 15,427 | 16,013 | 16,597 |
| 'Older Pensioner Age' | 75+ | | 11,087 | 11,287 | 11,253 | 11,404 | 11,677 | 11,909 | 12,126 | 12,355 | 12,550 | 12,737 | 12,920 | 13,079 | 13,257 |
| **Summary Age groups: Males** | | | | | | | | | | | | | | | |
| **Total** | **All Ages** | | #### | #### | #### | 99,685 | #### | #### | #### | #### | #### | #### | #### | #### | #### |
| 'Pre-school' | 0-3 | | 4,707 | 4,553 | 4,338 | 4,096 | 3,971 | 3,858 | 3,863 | 3,906 | 3,961 | 4,049 | 4,108 | 4,152 | 4,196 |
| 'Primary' | 4-10 | | 7,609 | 7,380 | 7,266 | 7,023 | 6,867 | 6,686 | 6,450 | 6,252 | 6,069 | 5,880 | 5,756 | 5,716 | 5,716 |
| 'Secondary' | 11-15 | | 5,052 | 5,169 | 5,217 | 5,217 | 5,231 | 5,169 | 5,049 | 4,926 | 4,758 | 4,650 | 4,548 | 4,406 | 4,280 |
| 'Young Adults' | 16-24 | | 14,600 | 14,285 | 14,046 | 14,311 | 15,663 | 16,445 | 16,777 | 16,818 | 16,907 | 16,918 | 16,773 | 16,667 | 16,630 |
| 'Younger Working Age' | 25-44 | | 37,781 | 37,145 | 36,329 | 34,955 | 35,163 | 35,284 | 35,472 | 35,691 | 36,021 | 36,493 | 37,033 | 37,543 | 37,893 |
| 'Older Working Age' | 45-64 | | 22,875 | 23,042 | 23,218 | 23,064 | 23,191 | 23,244 | 23,357 | 23,338 | 23,262 | 23,136 | 22,979 | 22,706 | 22,557 |
| 'Younger Pensioner Age' | 65-74 | | 6,520 | 6,417 | 6,310 | 6,285 | 6,256 | 6,266 | 6,337 | 6,522 | 6,726 | 6,953 | 7,150 | 7,457 | 7,684 |
| 'Older Pensioner Age' | 75+ | | 4,585 | 4,696 | 4,695 | 4,734 | 4,836 | 4,965 | 5,045 | 5,139 | 5,221 | 5,299 | 5,384 | 5,446 | 5,524 |
| **Summary Age groups: Females** | | | | | | | | | | | | | | | |
| **Total** | **All Ages** | | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### |
| 'Pre-school' | 0-3 | | 4,448 | 4,381 | 4,110 | 4,004 | 3,886 | 3,766 | 3,729 | 3,754 | 3,797 | 3,875 | 3,928 | 3,969 | 4,010 |

| | Age | 2031 | 2032 | 2033 | 2034 | 2035 | 2036 | 2037 | 2038 | 2039 | 2040 | 2041 | Census Year to current Year 2011-23 | % | 5 Year Change 2023-28 | % | 10 Year Change 2023-33 | % | 15 Year Change 2023-38 | % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Summary Age groups: Persons** | | | | | | | | | | | | | | | | | | | | |
| **Total** | **All Ages** | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | **-3,224** | ***-1.5%*** | **4,336** | ***2.0%*** | **9,592** | ***4.4%*** | **14,811** | ***6.8%*** |
| 'Pre-school' | 0-3 | 8,293 | 8,383 | 8,471 | 8,554 | 8,643 | 8,735 | 8,829 | 8,911 | 8,984 | 9,048 | 9,101 | -3,152 | *-29.3%* | 411 | *5.4%* | 846 | *11.1%* | 1,286 | *16.9%* |
| 'Primary' | 4-10 | 11,468 | 11,593 | 11,720 | 11,897 | 12,037 | 12,156 | 12,275 | 12,377 | 12,467 | 12,550 | 12,631 | -2,167 | *-14.1%* | -1,712 | *-13.0%* | -1,476 | *-11.2%* | -819 | *-6.2%* |
| 'Secondary' | 11-15 | 8,259 | 7,957 | 7,760 | 7,605 | 7,538 | 7,581 | 7,662 | 7,736 | 7,851 | 7,926 | 7,976 | 1,074 | *11.6%* | -1,308 | *-12.6%* | -2,604 | *-25.1%* | -2,629 | *-25.4%* |
| 'Young Adults' | 16-24 | 36,321 | 36,463 | 36,333 | 36,109 | 35,875 | 35,481 | 35,008 | 34,407 | 33,761 | 33,132 | 32,545 | 4,459 | *14.0%* | 158 | *0.4%* | -10 | *0.0%* | -1,936 | *-5.3%* |
| 'Younger Working Age' | 25-44 | 80,468 | 81,110 | 81,826 | 82,417 | 83,121 | 83,887 | 84,609 | 84,879 | 84,822 | 84,652 | 84,434 | -10,606 | *-12.4%* | 3,482 | *4.6%* | 6,738 | *9.0%* | 9,791 | *13.0%* |
| 'Older Working Age' | 45-64 | 48,487 | 48,210 | 48,005 | 47,853 | 47,758 | 47,662 | 47,688 | 47,721 | 47,810 | 47,846 | 47,923 | 5,751 | *13.4%* | 545 | *1.1%* | -656 | *-1.3%* | -940 | *-1.9%* |
| 'Younger Pensioner Age' | 65-74 | 17,223 | 17,817 | 18,309 | 18,768 | 19,093 | 19,391 | 19,542 | 19,570 | 19,521 | 19,458 | 19,277 | 620 | *4.7%* | 1,748 | *12.8%* | 4,630 | *33.9%* | 5,892 | *43.1%* |
| 'Older Pensioner Age' | 75+ | 13,478 | 13,728 | 14,032 | 14,320 | 14,713 | 15,140 | 15,596 | 16,075 | 16,581 | 17,098 | 17,663 | 799 | *7.2%* | 1,011 | *8.5%* | 2,123 | *17.8%* | 4,166 | *35.0%* |
| **Summary Age groups: Males** | | | | | | | | | | | | | | | | | | | | |
| **Total** | **All Ages** | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | **-6,171** | ***-5.7%*** | **1,813** | ***1.8%*** | **4,144** | ***4.1%*** | **6,568** | ***6.4%*** |
| 'Pre-school' | 0-3 | 4,241 | 4,288 | 4,333 | 4,377 | 4,422 | 4,469 | 4,517 | 4,557 | 4,594 | 4,627 | 4,653 | -1,709 | *-30.7%* | 250 | *6.5%* | 475 | *12.3%* | 699 | *18.1%* |
| 'Primary' | 4-10 | 5,772 | 5,842 | 5,909 | 6,000 | 6,071 | 6,132 | 6,193 | 6,247 | 6,294 | 6,339 | 6,382 | -1,044 | *-13.5%* | -930 | *-13.9%* | -777 | *-11.6%* | -439 | *-6.6%* |
| 'Secondary' | 11-15 | 4,123 | 3,975 | 3,861 | 3,779 | 3,752 | 3,785 | 3,832 | 3,871 | 3,929 | 3,966 | 3,991 | 418 | *8.8%* | -621 | *-12.0%* | -1,308 | *-25.3%* | -1,298 | *-25.1%* |
| 'Young Adults' | 16-24 | 16,664 | 16,699 | 16,643 | 16,529 | 16,398 | 16,194 | 15,968 | 15,677 | 15,368 | 15,076 | 14,813 | 1,310 | *8.7%* | 327 | *2.0%* | 198 | *1.2%* | -768 | *-4.7%* |
| 'Younger Working Age' | 25-44 | 38,236 | 38,665 | 39,103 | 39,471 | 39,894 | 40,330 | 40,746 | 40,952 | 40,991 | 40,969 | 40,901 | -7,490 | *-17.5%* | 1,749 | *5.0%* | 3,819 | *10.8%* | 5,668 | *16.1%* |
| 'Older Working Age' | 45-64 | 22,329 | 22,090 | 21,933 | 21,780 | 21,690 | 21,607 | 21,575 | 21,553 | 21,554 | 21,544 | 21,582 | 1,718 | *8.0%* | -265 | *-1.1%* | -1,311 | *-5.6%* | -1,692 | *-7.3%* |
| 'Younger Pensioner Age' | 65-74 | 7,933 | 8,182 | 8,353 | 8,544 | 8,630 | 8,730 | 8,772 | 8,764 | 8,694 | 8,648 | 8,521 | 180 | *3.0%* | 884 | *14.1%* | 2,087 | *33.3%* | 2,498 | *39.9%* |
| 'Older Pensioner Age' | 75+ | 5,653 | 5,779 | 5,925 | 6,058 | 6,257 | 6,460 | 6,666 | 6,864 | 7,106 | 7,312 | 7,551 | 446 | *9.9%* | 419 | *8.4%* | 960 | *19.3%* | 1,899 | *38.2%* |
| **Summary Age groups: Females** | | | | | | | | | | | | | | | | | | | | |
| **Total** | **All Ages** | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | #### | **2,947** | ***2.6%*** | **2,522** | ***2.2%*** | **5,448** | ***4.7%*** | **8,243** | ***7.2%*** |
| 'Pre-school' | 0-3 | 4,052 | 4,095 | 4,137 | 4,178 | 4,221 | 4,266 | 4,313 | 4,353 | 4,389 | 4,422 | 4,448 | -1,444 | *-27.7%* | 162 | *4.3%* | 371 | *9.8%* | 587 | *15.6%* |

Index | OVERVIEW | Comparators | BoroP Summry | BoroP | BoroM | BoroF | BoroCoC | BoroPopDw | BoroFert | WardP Summry | WardP | WardM | WardF | Wa

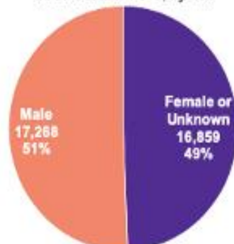
## POPULATION SEGMENTATION: JSNA

### OVERALL DEMOGRAPHICS (NUMBER: 34,127)

### START WELL: 0-17

#### GENDER

Young people aged 0-17 in are 49% Female and 51% Male.

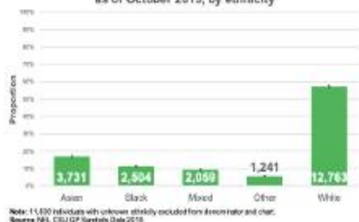



#### LOCATION

The population aged 0-17 in is most concentrated in the centre and north west of the borough.

#### ETHNICITY

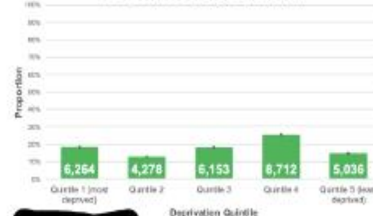
57% of young people in are from White ethnic groups.




#### DEPRIVATION

A significantly higher proportion of young people live in the most deprived areas (18%) compared to the least deprived areas (15%).

The highest proportion of young people (26%) live in Quintile 4.



# DEMOGRAPHICS

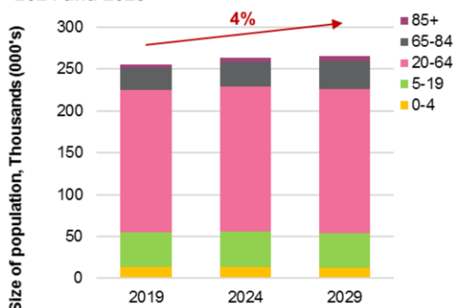
## Population projections to 2029

The [redacted] population is just over 255,500 people. This population size is expected to increase to 265,351 by 2029, an increase of 4%.

The highest expected growth is in the older age groups. The 85+ age group will rise from 4,388 to 6,253. The 65-84 group will rise from 26,774 to 33,165 people.

The working age population will remain the largest population overall.

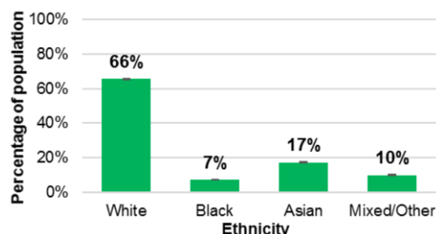
**Population growth for [redacted] 2019, 2024 and 2029**




Source: GLA 2016-based population projections

## Ethnicity

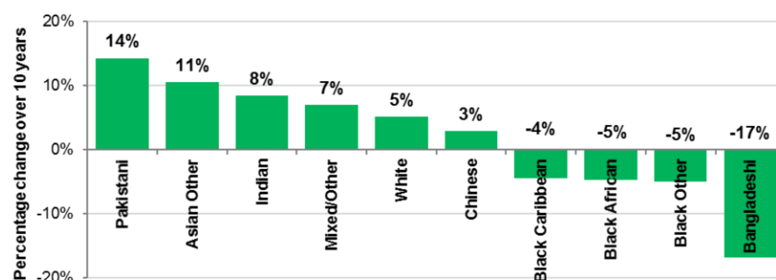
**Proportions of ethnic groups in [redacted] 2019**




[redacted] has ethnically diverse populations, with BME groups accounting for 34% of the whole population in [redacted]

The ethnic diversity is expected to remain stable over the next decade in [redacted] The ethnic groups with the highest projected population growth is Pakistani (14%) in [redacted] will see a reduction in the Bangladeshi population.

**Percentage change in proportions of ethnic groups, 2019 to 2029**




Source: GLA 2016-based population projections

# **Appendix C** – Interview schedule

The Tavistock and Portman NHS
NHS Foundation Trust

**Draft semi-structured interview schedule for clinicians working with or have worked with black adolescent boys in CAMHS**

**Title:** Are Adolescent boys from an African and Caribbean heritage underrepresented in referrals to CAMHS and what experience do clinicians have with this group.

**Welcome:** explanation of it being a semi-structured interview lasting between 60 and 90 minutes. Remind participant that they are welcome to talk freely about their experience of working with black adolescent boys as a CAMHS clinician. I will explain that they can discuss specific cases (past and present) that may feel relevant to the interview.

**Introduction**

- Please can you introduce yourself and tell me about your current role in your CAMHS team.
- Can you tell me a little about your discipline and the assessment and/or treatment you offer children, young people and families?

**Experience of working with BAB**:

- Can you tell me about a specific case where you have worked with a BAB either in the past or present, in your CAMHS clinic? (who referred, presenting issues, treatment offered, had they been offered anything before)
- How was it for you during sessions?
- How has it left you feeling following sessions with this young person/s?
- What do you think were the most challenging aspects to the work and how did you manage them / seek support?
- In what way, if at all, do you think the work helps/helped the young person?
- Has race or differences been a feature in your work with the young person/s, and if so, how?
- What was it like working with the family? (parent work, family work, support)
- How was it working with the network around the BAB? (experience of meetings/risk/safeguarding)

# **Appendix D** – Interview transcript example

**Interview 3**

**Researcher**
Hello, please can you introduce yourself and tell me about your current role in your CAMHS team.
**Participant 3**
My name is X and I am a CBT CAMHS therapist and supervisor within X CAMHS.
**Researcher**
Can you tell me about your discipline and the assessment and treatment you offer children, young people, and families?
**Participant 3**
Yeah, so we do an assessment. So, once a referral comes through it's screened, so I do some of the screening. And then I go to referral meetings to deem whether it's appropriate. We allocate it out to practitioners who are qualified to do the assessment. And the assessment consists of two to three meetings with the family, the school, young person. The family decide how they want it done, depending on the age of the child, and can be face-to-face over the phone or online. And then we'll write up a report. And if it's deemed suitable, we'll take it to MDT, and discuss it, to what modality will be given to and then we'll offer to family if they decline it, then they decline it, if it's accepted, they go on a wait list. And in my specific modality which is CBT, which is cognitive behavioural therapy, where essentially, we, I guess it's a form of therapy, where we support people in gaining coping strategies, mechanisms to manage whatever is going on with them. Whether it's PTSD, OCD, anxiety, low mood, essentially, it's kind of rewiring the way that we process our thoughts and our reactions to situations, and we offer, short term or long term.
**Researcher**
Thank you. In terms of the research today, can you tell me a bit about a specific case where you've worked with a black adolescent boy in the past or in the present in your CAMHS clinic?
**Participant 3**
I currently work with one black adolescent boy, [redacted] background. He is going into year 10, which would make him 14. And he has some learning needs. We don't really know what they are, because he hasn't had a test. But there's definitely, you know, people are aware, at school they support him as if there is a diagnosis or what they think is a bit of a delay. He has OCD traits, high anxiety. And he has been on and of our service for about two years. And I've been working with him for four months, I think five months. He came as a short piece of work as top up of CBT. But however, it became apparent that, it was going to be longer. So yeah, I'm still supporting him. And his mum.
**Researcher**
When you say it became apparent that he needed longer, can you tell me a little bit about That?

# **Appendix E** – Theme coding and development examples

| Row | A | B | C |
|---|---|---|---|
| 2 | open up a bit and start realising you know what impact it could have on him as he got older, | Helped him understand the impact his anxieites could have on as he grew older. | importance of future thinking for YP |
| 3 | same concerns continued. | | |
| 4 | Researcher | | |
| 5 | And I wonder how was it for you, during sessions with him? | | |
| 6 | **Participant 3** | | |
| 7 | I have to do a lot of self-reflection, I would come out of sessions feeling quite frustrated, | working with this young person brought a lot of frustration that needed a lot of self-reflection | self-reflection is important for clincians |
| 8 | you know, kind of kind of felt like I was hitting my head against a brick wall sometimes. | | |
| 9 | And sometimes I also came out feeling like I just kind of spent an hour giving a teenager a | | |
| 10 | lecture, instead of anything else, just kind of it's been, you know, like, if we don't use this | there was a feeling of the sessions not having an impact, and that she was talking at the young person rather than it being a collabortaive experience | clincians can feel ineffective |
| 11 | space, then like, there's nothing we can really do at the moment. Because CBT is, you know, | | |
| 12 | if you don't engage in it, then it's not going to work. And we're not engaging them, you | To do CBT work there needs to be a level if engagement that was difficult with this YP. | CBT needs engagement for effectiveness |
| 13 | know, if we have a waitlist, we can be offered a space to somebody else, and he can then | | waitlist pressures vs engagement levels |
| 14 | come back when he's ready kind of thing? That's kind of discussions we had. So yeah, I have | there is a worry that the clincian's frustrations with the YP was present in the work. | clincians worry of own negative feelings in the work |
| 15 | to admit, I did, you know, oh, no, hopefully, it didn't reflect in the room. But when I came | | |
| 16 | out, you know, I did have to take it to supervision, and, you know, try and come up with | supervision was used to think about different ways to engage the YP | use of suppervision to think about how to engage yp |
| 17 | new ways to engage. And you know, and I would come up with a new way, and then that | | |
| 18 | would seem to work for one session. And then I bring it, we would continue it to next | one way didn't work for this young person there was a need to be flexible and attuneed to the YP's needs | need for flexibility when working with difference |
| 19 | session, and then he wouldn't want to engage that way again, so we'd have to come up | | |
| 20 | with a new way to engage every session. | | |
| 21 | Researcher | | |

Interview 4 | Interview 3 | Interview 2 | Interview 1

## (1) experience working with Tyrone and differences

**Experience of bullying and racism at school can put BAB at risk of exclusion**

**BAB's aggression in therapy needs to worked with and understood**

**Parents experience of services can impact uptake of support**

**Therapy can be difficult for BABs but helpful**

**Clinician with shared identity can be helpful**

**The investment of the parent worker determines what is offered to families**

## experience working in a CAMHS team thinking about EDI

**White families are more likely to access therapy**

**CAMHS is shifting in its approach to think about EDI**

1.93 EDI needs to be invested in or it will be tokenistic

1.94 EDi isnt properly integrated into dicusions but tehre are dedictated spaces

1.103 BLM has had an impact on how orgaisations are responsing to issues around race

1.05/106 things are shifting in CAMHS related to thinking about race and difference

**BAME families seek help when there is a crisis**

**Clinician's need to be committed to thinking about difference**

**The more diverse a CAMHS team is the more difference is thought about**

**BABs are invisible to MH services**

**Themes**

1) Understanding the intersectionality of BAB's is important in therapy/the importance of holding in mind intersectionality
2) Clinicians need a space for self-reflection and self-awareness when work with BAB's/ self-awareness and self-reflection is pivotal
3) BAB's needs and behaviours should be better understood/ met with curiosity?
4) Diversity in CAMHS and prioritisation of EDI is important/
5) Level of parental engagement can impact the outcome of therapy with BAB's/parental engagement can impact therapy outcome
6) MH services need to build trust with Black families to increase accessibility/ Building trust with communities can increase accessibility