Exploring the experiences of young people from an ethnic minority background in accessing and engaging with CAMHS.

Catherine Wintermeyer

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Abstract

Introduction: Research studies have found that there are inequalities in health services, particularly mental health services, for people from Black, Asian and minority ethnic (BAME) backgrounds in the UK. Studies providing this evidence have mainly been in relation to adult services. Children and young people (CYP) from BAME backgrounds represent a significant, and growing, proportion of CYP in the UK (Department of Health, 2004). It is argued that child and adolescent mental health services (CAMHS) do not currently meet the needs of BAME CYP with mental health difficulties (MHD) and that there is a lack of necessary research in this area (Fatimilehin, 2007). It is therefore necessary that research is conducted with YP from a BAME background to examine their experiences within CAMHS. This study, therefore, aimed to explore the experiences of YP from an ethnic minority background in their experiences of their MHD and accessing and engaging with CAMHS.

Method: This study aimed to explore these experiences using a qualitative methodology. Participants that had been discharged from two local CAMHS services were recruited. Four female YP between the ages of 16-18 years were interviewed using semi-structured interviews and data was analysed using Interpretative Phenomenological Analysis (Smith et al., 2009). Firstly, individual interviews were analysed and superordinate and subordinate themes were developed for each participant. These individual themes were then used to develop the group themes to capture similarities and differences of experiences across participants.

Results: An overview of some key individual themes for each participant were presented. Three superordinate and eight subordinate themes emerged from the data in the group analysis. The superordinate themes were ‘*difficulties speaking out’, ‘confusion: navigating different perspectives’* and *‘evolving sense of self and experiences’.*

Discussion: The key findings from the study are discussed in relation to the wider literature. This study adds to the limited literature around experiences of CYP from ethnic minority backgrounds around their MHD and accessing MH support for these. Strengths and limitations of the study are discussed. Finally, potential implications including areas for future research are presented.

Table of Contents

List of Tables

List of Figures

Key Terms

CAMHS	Child and Adolescent Mental Health Services
CYP	Children and young people
IPA	Interpretative Phenomenological Analysis
MH	Mental health
MHD	Mental health difficulties
MHS	Mental health services
YP	Young people

Chapter One – Introduction

This study, which explores the experiences of young people (YP) from an ethnic minority background in accessing and engaging with Child and Adolescent Mental Health Services (CAMHS), stems from a desire to improve outcomes for children and young people (CYP) with mental health difficulties (MHD), and particularly for those from disadvantaged backgrounds. This chapter will begin by summarising a wide range of literature to provide context for the study. The rationale for the current study and the research aim and questions will then be presented.

Child and Adolescent Mental Health Services

In the UK, there are specific mental health services (MHS) for CYP from the age of 0-18 years called CAMHS. CAMHS services offer support in the community as well as in-patient services. This study recruited from community CAMHS. Community CAMHS are often structured differently according to locality area but many services have different pathways or specific services for assessing and providing interventions for various MHD. MH diagnoses that are given to CYP through CAMHS input include diagnoses around emotion regulation difficulties such as anxiety and depression and neurodevelopmental disorder assessments such as for autism spectrum condition and attention deficit hyperactivity disorder. The two local CAMHS services used for recruitment in this study have a CORE CAMHS pathway – for MHD such as anxiety, depression and OCD and separate pathways and/or services for neurodevelopmental disorders and eating disorders. Historically, CYP in acute crisis were seen within the community CORE CAMHS teams – clinicians would see CYP on physical health wards and then arrange follow-up appointments in the community following discharge.

Referral routes to CAMHS differ according to local services but generally in the UK referrals come into CAMHS through GP, school and other specialist services. Historically, GPs have been the predominant gatekeeper to CAMHS (Edbrooke-Childs et al., 2016). Referrals tend to be screened at some point in the pathway to the service and are either accepted or rejected back to the referrer. As discussed above, CYP can also access ‘crisis’ CAMHS input through attending Accident and Emergency departments, for things such as self-harm or suicidal ideation or attempts. Those who were recruited for the study either accessed their local community CAMHS through the crisis pathway or through being referred to CORE CAMHS by specialist services described above.

In this study, ‘accessing CAMHS’ refers to the process of a referral being made and accepted by CAMHS and ‘engaging in CAMHS’ refers to the experiences of CYP of seeing CAMHS clinicians and receiving any forms of support including assessment or intervention following the acceptance of a referral. CYP are defined according to the current legal definition of individuals under the age of 18. The use of the term YP in this study is to differentiate between younger and older CYP and will be defined as those from the ages of 13-18 years.

Review of the literature

This section will provide a summary of the literature around inequalities in health for people from a Black, Asian and minority ethnic (BAME) background. There has been more research around these issues for adults but where possible, findings from research with CYP will be reported. This section will firstly discuss the terminology that is used in this area, before providing a general overview of inequalities around MH rates and MHS for both adults and CYP from BAME populations and the underrepresentation in mental health (MH) research of these groups. Findings will then be discussed from research that can help to understand these inequalities comprising systemic factors (including intersectionality, power and stigma), cultural influences on MH, help-seeking models and factors more directly related to CYP (including parental influences and CYP’s ethnic identity development). The rationale and the current study will then be described. It will be argued that more research is needed to understand inequalities faced by CYP with MHD from ethnic minority backgrounds in CAMHS. Findings will contribute to the limited evidence base to increase knowledge about YP’s experiences which could suggest ways for how CAMHS can be better developed to serve the needs of CYP from an ethnic minority background.

Terminology around ethnicity, race, culture and ethnic minority groups

It is important to firstly consider the use of the language and terminology in this topic area. The terms ‘ethnicity’, ‘race’ and ‘culture’ are complex concepts which are hard to define, quantify and measure (Senior & Bhopal, 1994). For the purposes of this thesis, each term will be discussed below as well as an overview on the current terminology used for ethnic minority groups in order to provide context for this research area.

Ethnicity & race

Ethnicity can be defined as being a classification of a group that has similar traits, such as language, heritage, religion, geography and culture (Cokley, 2007), but often the discussion of 'ethnicity' is often used as 'shorthand' for ethnic minorities (Pfeffer, 1998). Senior and Bhopal (1994) argue that ethnicity is different from race, and should not be used interchangeably, although it often is. The concept of 'race' and 'racial differences' is now disputed due to the lack of evidence about genetic or biological differences between different 'racial groups' (Betancourt & López, 1993), however, it is generally described as relating more to an individual's appearance, such as the colour of skin. Cauce et al. (2002) argue that 'race' is a difficult construct to give up as it is so embedded in societies; it remains central to identity formation (Williams, 1997), and reflects current prejudices where "skin colour is the most influential immediate factor in assessing ethnic identity" (Daryanani et al., 2001, p. 130).

Culture

There are various ways that culture is defined. Bennett (2005) argues that culture is not just defined by shared ethnicity and language between groups. Culture can be defined as something that is part of an individual's identity and is a shared context where people share things such as customs, beliefs (religious or otherwise) and values, language and social behaviours (Betancourt & López, 1993). Wiese (2010) argues that this system of shared beliefs is used by people within a society to navigate relationships with each other and the world and that this is passed down through generations, often through parenting (Bates & Flog, 1990). Drozdek and Wilson (2007) argue that "culture impacts the regulation and expression of emotions, sets limits of tolerance of specific and strong emotions, and provides lay theories and strategies about handling emotions" (pg. 7). Bird (1996) discusses how culture affects what is perceived as causation for, but also interpretation of behaviours and MHD, the meaning individuals make of this and how they report this to others.

Fenton and Sadiq-Sangster (1996) argue that there are many ways that culture is a 'problematic term'. They argue that culture can often be seen as a fixed entity which can be understood and defined. They argue that it is better to see culture as something that is continually shifting and being redefined and that the concept should not be used as something to determine boundaries between groups of people and societies, such as 'Western' or 'Asian' culture'. Historically, the term 'culture' has also been used to assert hierarchies, where one culture is 'superior' to another (Fenton & Sadiq-Sangster, 1996).

Race, ethnicity and culture are terms that are often confounded and used interchangeably in the literature (Daryanani et al., 2001). Despite the issues with defining these three concepts, Dogra et al. (2012) argue that they all influence MHD; affecting how mental health (MH) is understood and how MHS are accessed and used, as well as often being connected to socio-economic factors such as disadvantage and discrimination (Bhopal, 2009).

Terminology for ethnic minority groups

Most of the literature and policies around inequalities in the UK use the term BAME when discussing groups of people who are from a 'non-white' ethnic minority population (Grey et al., 2013). This term denotes an extremely diverse range of groups of people. The use of the term 'non-white' is also problematic as suggests that 'white' is the norm and represents an 'invariant, normative benchmark' (Goodman et al., 2008). The term 'BAME' is not universally accepted, has limitations and usually occurs after 'non-specific quantifiers' such as 'some' or 'most' (Glover & Evison, 2009). Much of the research base in the UK looks at South Asian or Black African or Caribbean communities living in the UK as these tend to be the biggest minority groups in the UK currently, and comparing these to the majority ethnic group of White British people. Some conclusions from this research about these specific groups have been incorrectly applied to all BAME groups in the literature (Grey et al., 2013). Within any ethnic groups, there are often big within-group differences as well as between-groups and combining large ethnic populations into one singular grouping can hide significant differences (Jonsson et al., 2018). Therefore, this needs to be held in mind when any conclusions are drawn for BAME populations in the literature and whilst reading this chapter. This will be discussed further in relation to this study in the rationale section.

Dogra et al. (2012) argue that in trying to understand CYP and people's MHD, the 'influence of ethnicity' needs to be understood too. They argue that concepts of childhood and MH are influenced by culture and affect whether CYP present to CAMHS. It is also interesting to think about the context that people, and specifically CYP grow up and exist within too. This includes socio-economic factors, gender roles and/or regional differences (Cauce et al., 2002).

For the purposes of this thesis, as the term BAME is currently the most commonly used in British vernacular, policies and the research literature this thesis draws on (Arday, 2018), the term BAME will be used to refer to people who are from any ethnic background other than white ethnic backgrounds (the majority ethnic population in the UK) and includes people from African, Caribbean, South and South-East Asian, and other minority ethnic communities. However, it is recommended that precise ethnic background descriptors are used when reporting research (Bradby, 2003) to ensure blanket conclusions are not drawn, so more precise descriptions of ethnicity will be used where possible.

Inequalities in health across the lifespan

Research studies have consistently evidenced inequalities in health, particularly MHS, for people from minority ethnic backgrounds in the UK (Ali et al., 2016; Messent & Murrell, 2003). Inequalities have been found both in pathways to services and uptake of these services (Bhui et al., 2003). Providing services that are equally accessible for people from minority backgrounds has been on the government's and NHS' agenda for well over a decade (Department of Health, 2004; 2005; 2009; 2014). Many reports into race and inequalities in service provision have discussed the importance of increasing the ability and capacity of services to meet the needs of people from BAME backgrounds (Fatimilehin, 2007). Despite numerous policies stating the need for changes to services, there has still been little written about ways to implement changes discussed (Grey et al., 2013). There has also been research into whether this inequality is due to differing rates of MHD in different ethnic populations. Inequalities in MH rates, MHS and also inequalities in research will be discussed below.

MH rates in BAME communities

Adults

Some research studies have tried to ascertain whether the underrepresentation in MHS is due to there being lower or differing rates of MHD within BAME groups. There is currently inconclusive and mixed evidence around whether people from BAME backgrounds have differing rates of MHD. In 2011, the Department of Health and Social

Care reported that there are higher rates of MHD in BAME groups. However, Goodman et al. (2008) concluded that common MH problems in the main BAME groups in Britain are actually similar to those from a White British background, with some rates being higher and lower for specific populations.

CYP

There is also limited evidence around prevalence rates for CYP from BAME backgrounds, additionally the studies that have been conducted are often well over a decade old. In 2008, Goodman et al. carried out a systematic literature review of all population-based and clinic-based studies in the UK of CYP aged 0–19 for MHD, including all ethnic groups. They concluded that in the UK the prevalence rates of the common MHD (such as anxiety and depression) in CYP was similar to that of White British children, and that for some BAME groups of CYP, MHD rates were lower. They argued that this still accounted for a high amount of MHD within the CYP population though (an estimate of accounting for approximately 10%). They also concluded that for many smaller minority groups, there was not enough data to make any meaningful conclusions about the prevalence rates of MHD. Goodman et al. (2008) also argued that it would be helpful for research to consider whether ethnicity effects vary across different groups of CYP such as differing gender or ages but that very few studies had considered this in the studies they had reviewed.

It has been found that in general, people from BAME backgrounds experience more socio-economic disadvantage than majority white ethnic groups (Cheng & Goodman, 2015). Goodman et al. (2008) discussed how this potential lack of difference in MH rates and an apparent advantage for some groups was surprising considering the socio-economic adversity faced by many families from BAME backgrounds and the association between lower socio-economic status (SES) and higher MHD. They suggested that more research could highlight potential protective factors against MHD for CYP within BAME populations.

Use of MHS

Adult MHS

Studies providing the evidence base for MHS and BAME communities in the UK have mainly been focused on, and have been about, adult psychiatric services (Lowe, 2006). Adults from BAME backgrounds have been found to be less likely to access MHS through voluntary care pathways, instead accessing through compulsory routes (Edbrooke-Childs et al., 2016). They are disproportionally represented in acute and secure inpatient services and often have longer stays which is argued to indicate unequal access to earlier intervention and crisis care services (Mental Health Taskforce, 2016). Keating (2009) argues that people from a BAME background are also rarely proportionally represented in therapeutic settings or psychological services.

CAMHS

The majority of research into BAME communities and MH has focused on adult populations. Fatimilehin (2007) states that CYP from BAME communities represent a significant, and growing, proportion of YP in the UK (Department of Health, 2004) and that their MH needs have been ‘largely ignored’ despite researchers and clinicians consistently discussing the paucity of research and evidence-based practice in this particular area. Malek and Joughin (2004) stated that CAMHS have not been meeting the needs of BAME CYP, with Dogra et al. (2012) saying there is a clear need for research into the use of services and barriers to accessing CAMHS for BAME CYP.

Cauce et al. (2002) argue that there has been an aim to increase ‘culturally competent CAMHS’ for many years as there is a perception that families from BAME backgrounds are not accessing MHS because they are culturally insensitive. ‘Cultural competency’ can be defined as the ability of services to “provide care to individuals with diverse values, beliefs and behaviours, including tailoring delivery to meet individuals’ social, cultural, and linguistic needs” (Betancourt et al., 2003, p. 297). Cauce et al. (2002) argue that understanding how families identify MHD, seek-help and then engage with CAMHS should be a priority as developing ‘culturally competent services’ are ‘no use’ if CYP from BAME backgrounds are not accessing these services.

Underrepresentation in CAMHS

Research that has been carried out with CYP from a BAME background and CAMHS has found that generally CYP and families from ethnic minority backgrounds, including CYP from South Asian communities and African or Caribbean communities, are underrepresented in CAMHS services (Daryanani et al., 2001; Messent & Murrell, 2003) and are more likely to face barriers when accessing MHS (Lavis, 2014). However, there has been a number of methodological flaws in studies comparing population-based and service-based data, such as comparing studies with differing ethnic classification systems (Goodman et al. (2008). Findings have been inconsistent (Hamblin, 2016) and conclusions are often limited as in some studies 30% of ethnic backgrounds are coded as ‘unknown’ (Fatimilehin, 2007). Goodman et al. (2008) discussed how underrepresentation of ethnic minority groups in MHS is usually understood and explained as unmet need (Messent & Murrell, 2003) but argued that it does not always mean this as some population-based studies indicate that some CYP from ethnic backgrounds (such as Indian or African) have lower levels of common MHD and Pakistani, Bangladeshi, Caribbean and mixed-race CYP have similar rates of common MHD compared to White British CYP. It is, therefore, important that more research is carried out to gain a better understanding of factors affecting how CYP from a BAME background access and engage with CAMHS.

Referral routes into CAMHS

Examining referral routes into CAMHS is complex as there are numerous individual and service related factors that impact on mental health and help-seeking behaviours (Anderson et al., 2014). These include a YP’s age, gender, MHD and other contextual factors such as the socio-economic status of families (Edbrooke-Childs & Patalay, 2019). For example, boys are more likely in schools to be seen as needing support for behavioural difficulties than girls (Little & McLennan, 2010). As discussed above, it is indicated that people from BAME backgrounds experience more socio-economic disadvantage than majority ethnic groups (Cheng & Goodman, 2015) which may be affecting referral routes as areas of higher deprivation may have higher numbers of people from BAME communities and more CYP with MHD (Silva et al., 2016).

Some studies have looked into whether certain professions are referring different numbers of CYP from a particular background. Daryanani et al. (2001) found that white children were more likely to be referred by their GP, black and South Asian children by education professionals and specialist doctors, and children from dual-heritage backgrounds by social services. South Asian families were less likely than white families to self-refer or seek help for mild or moderate difficulties (Stein et al., 2003). Messent and Murrell (2003) found that CYP from an African or Caribbean heritage were more likely to present with more severe or urgent difficulties with Skokauskas et al. (2010) discussing from their findings how children from BAME backgrounds are more likely to access CAMHS through compulsory rather than voluntary care pathways, like adults. This has also been associated with more enduring problems and worse outcomes.

In 2016, Edbrooke-Childs et al. focused on CYP with ‘emotional disorders’ (i.e. anxiety and depression diagnoses) in their study looking at associations between ethnicity and CYP’s care pathways through CAMHS. They argued these diagnoses were associated with poorer access to MHS; CYP with internalising disorders such as anxiety and depression are less likely to access help than those with externalising disorders such as conduct disorder (Ford et al., 2007). They also found that for these ‘emotional disorders’, children from BAME backgrounds were more likely to be referred through referral routes like educational professionals or social services compared to White British children who were referred through primary care. Edbrooke-Childs et al. (2016) suggested that there were numerous theories which could explain this; that parents from ethnic minorities might face additional barriers in or be less likely to seek professional support, might have cultural differences in understanding of MHD or may be less likely to be registered with a GP (Edbrooke-Childs et al., 2016). They also provided a breakdown of gender (over half of the sample was female) and ages, something that Goodman et al. (2008) argued was needed to start gaining a fuller understanding of differing rates in MHD and CAMHS access for CYP from differing ethnic backgrounds.

As discussed above, socio-economic disadvantage is likely to play a role in referral routes so it is therefore essential that it is considered when examining referral routes. In 2019, Edbrooke-Childs and Patalay looked at referral routes again for all CYP in CAMHS (not just those with ‘emotion dysregulation’ disorders) whilst also controlling for service area deprivation. They again found that YP from BAME backgrounds were less likely to be referred through primary care compared to YP from White British backgrounds, with YP from Black, South Asian or mixed-race backgrounds more likely to be referred through youth justice or social care routes. This effect was still present when service area deprivation was controlled for, however, these effects were smaller with this additional control indicating that socio-economic status and disadvantage was affecting the relationship between referral route and ethnicity.

CYP and CAMHS research

'Adolescence' is a theoretical construct informed through 'physiological, psychosocial, temporal and cultural lenses' and is generally understood in Western societies as a period between the onset of puberty and becoming more independent and reaching adult life (Curtis, 2015). Commonly, the definition of adolescence includes those aged 10-18, however, defined age ranges can also span from 9-26 years (Curtis, 2015). Adolescence is argued to both be the highest risk period for individuals developing MHD, but also the age group least likely to seek help from MHS (Plaistow et al., 2014). In this study, YP and adolescents will be used synonymously. Despite this, the perspectives of CYP about MHD and the support they received for MHD are rarely explored, making this an under-researched area (Roose & John, 2003; Walker, 2001). Buston (2002) argues that research with CYP around MH and MHD should be prioritised.

Roose and John (2003) argue that generally MHS have been developed without involvement of CYP. Studies that have looked into CYP views around MH provision have found issues around a lack of understanding and trust of MHS, finding these services difficult to access and worries around stigma in relation to accessing services (Street et al., 2005). Plaistow et al. (2014) undertook a systematic review of the 31 studies into CYP and their view of MHS in the UK. Some studies included CYP who had and had not accessed MHS. They concluded that positive factors around MHS included generally positive relationships with MH clinicians. Negative factors found were the stigma around MHD, lack of information around MHS and that their MHD were often medicalised.

From the limited research available, Dogra (2005) argues that evidence indicates that CYP, their parents and MHS have different views and expectations of what CAMHS should offer. This highlights an issue that CAMHS faces in whether they are catering for the needs and expectations of one client or multiple stakeholders i.e. CYP and parents (Garland et al., 2004). Dogra (2005) argues that CAMHS need to consider CYP perspectives during service development as well balancing the tension that CYP perspectives may be different to parent perspectives.

Dogra et al. (2012) also argue that evidence from the limited number of small studies carried out over a decade ago should not be used to impact and inform current service development as the UK population has undergone many recent changes socially, culturally and economically. There is a need for research into all of the issues discussed but also importantly into how MHD are understood in CYP populations, how CYP use services and whether there are any specific barriers for particular groups. As well more research needing to be done more generally with CYP, Plaistow et al. (2014) argue that it is particularly important to actively seek the views of groups who are even less well represented within CYP services, such as those from BAME backgrounds, particularly because of the current lack of evidence around rates of MHD and CAMHS use amongst these groups (Dogra et al. (2012). It is also important to try and understand more about how particular MH disorders are understood culturally and whether this differs between diagnoses such as anxiety and depression compared to 'neurodevelopmental' diagnoses, for example. This will then enable different MHD to be better understood, helping to develop more appropriate evidence-based services and ultimately ensure CYP receive better care (Dogra et al., 2012).

Underrepresentation in research

Despite the previous sections detailing findings from research into BAME communities and MHD, adults and CYP from BAME communities have been and are currently underrepresented (Giuliano et al., 2000) within health-related research (as well as MHS). There are many reasons cited for these differences; lack of trust in the systems around research (Giuliano et al., 2000) and recruitment networks not including individuals from BAME groups, as well as language barriers (Grey et al., 2013). It is often argued that individuals from BAME groups do not want to participate in research, for numerous reasons including not wanting to support oppressive systems and discrimination they have faced in historical research studies. However, Wendler et al. (2005) found little difference in willingness to take part in mainly quantitative research and suggested that rather than focusing on trying to change attitudes of BAME groups towards research, that simply promoting access to research for all groups would be more beneficial. Arday (2018) argued that the inequity in representation in research further perpetuates existing power imbalances and that it is important to explore voices of people from BAME groups to help challenge dominant narratives and norms.

Differences between researcher and participant ethnicity

Given the differences discussed above in experiences between majority and minority ethnic groups in MHS and research, the relative importance around researcher and clinician ethnicity has been explored (Grey et al., 2013). There is currently evidence for and against the narrative that the ethnic identity of researchers is important in encouraging recruitment (Rooney et al., 2011). There is also mixed evidence around whether the ethnicity of clinicians affect how services and relationships with staff are experienced (Rooney et al., 2011). An overview of this research will be discussed below.

Grey et al. (2013) discussed how studies have shown that many individuals from BAME backgrounds are often ‘acutely aware’ of the ‘centrality of whiteness’ and how this is apparent within services and a perception that MHS in the UK do not consider or understand ethnicity differences due to its Eurocentric Western foundations (MIND, 2012). Research studies have indicated that participants and service users from BAME backgrounds feel that BAME practitioners may have more empathy in understanding their experiences (Arday, 2018) and that staff from similar backgrounds are more likely to have greater cultural competence (Fountain & Hicks, 2010).

However, Fountain and Hicks (2010) reported that most participants felt that clinicians being empathic and sensitive was more important to them then having a clinician that was the same ethnicity to them. Rooney et al. (2011) discussed that participants indicated that as long as the researcher could communicate with them (spoke the same language or had an interpreter) that ethnicity was not important to them. Carl and Partridge (2004) also discussed that diversity within-groups can often be greater than between with Rooney et al. (2011) arguing the need to put the issue and impact of ethnicity in ‘context’.

Within qualitative research where the researcher has been from a similar background to the participants, researchers have referenced the potential role that inherent biases may have played and the potential of missing things due to a closeness to the data (Arday, 2018). This is interesting as the same problems mirrored are discussed with researchers not from similar backgrounds as their participants in that they may be looking at issues from their own lens and biases and may miss certain relevant interpretations for this group. Senior and Bhopal (1994) state that researchers need to consider their personal beliefs and values when conducting research, including ‘ethnocentricity’.

Understanding why there might be differences in MH rates and underrepresentation in MHS/CAMHS

The following section seeks to summarise the literature around factors that are thought to contribute to potential differences in MHD rates and inequalities around access and engagement within MHS for people from BAME backgrounds described above. This will not be an exhaustive account of all of the available literature but will focus on the areas deemed most relevant to this study. There are many factors that influence and contribute to a CYP's development and therefore how a CYP experiences their life, MHD, seeking help for MHD and using CAMHS (Takayama, 2010). The picture is very complex with 'overlapping top-down and bottom-up factors' (Li, 2010). Therefore, this section will firstly discuss, systemic factors (discrimination, intersectionality and power dynamics), cultural influences on mental health and then help-seeking models, stigma and the effects of immigration/migration. Factors that have a direct impact on CYP's development and experiences will then be presented, including family and parents, language and communication, age, gender and identity, including ethnic identity.

Most of the literature is drawn from adult populations which is often then assumed to be the way to understand BAME CYP issues (Dogra et al., 2012). This is problematic as there has not yet been enough research into this area as to whether the experiences are the same for CYP and adults, and this cannot and should not be assumed because CYP are a separate group of individuals with differing contexts and pressures. This further highlights the need for research into the experiences of CYP from a BAME background to better understand these experiences.

However, as CYP grow up within various systems and structures (Bronfenbrenner, 1979), it is also important to understand issues experienced by adults in their communities and wider society as these adults will be parents and other family members of CYP. Therefore, findings from the literature into adult BAME groups are discussed here as these are likely to have an effect on CYPs upbringing and how they, for example, seek help and how or whether they are supported to seek help. It might also be that these issues are important factors for CYP so could be important to understand further, however as discussed, this should not be assumed. It is important to keep in mind that whilst CYP may share both protective and risk factors with adults based on their ethnicity, CYP also face unique stressors and 'pathways to care' (Bradby, 2007).

Systemic factors; discrimination, intersectionality, power dynamics

Arday (2018) argues that for people from BAME populations, MHD are 'deeply rooted' in numerous systemic issues including racism, stereotyping, intersectionality and power dynamics. Li (2010) also argues that there is often more of a focus on 'difference', stereotypes and problems within BAME communities rather than the systems and social, economic and power relations that often serve to reinforce inequalities whilst reinforcing low expectations of people from BAME populations (RAWOrg, 2010).

Research has found that many people from BAME communities have experienced racial/ethnic stereotyping, stigmatising and discrimination (Arday, 2018), with Grey et al. (2013) concluding that participants felt their negative experiences with MHS were affected by the racially discriminatory systems within which their MHS sat (Grey et al., 2013). McKenzie and Bhui (2018) argue that there is institutional racism in MHS; both with unfairness in treatment in terms of which interventions are offered and also outcomes of these interventions. They state that there is a current 'tolerance' of practices and inability to 'monitor, challenge and change' discriminatory care, with structural power relationships maintaining both of these issues.

Li (2010) states that ethnicity is inseparable from 'socio-economic, biological, political, historical and cultural factors'. Dogra et al. (2012) argues that there is a 'complex interplay' between minority status and social-class and that the term 'ethnicity minority' is often a 'proxy' for 'multi-faceted' socio-economic and cultural variables. When thinking about BAME groups, intersectionality must be considered. Various factors including ethnicity, social-class, age, education, income, sexual orientation, religious beliefs, disability and gender all intersect with ethnicity and affect power between groups, particularly negatively affecting marginalised and minority groups (Halvorsrud et al., 2018) and often resulting in cumulative disadvantage. Issues in the current research base are compounded by investigating differences between majority and minority ethnic groups without capturing information about or comparing different ethnicity groups sharing similar socio-economic circumstances (Hawes et al., 2016). Social causation theory posits that impoverished social circumstances increase the risk of developing MHD (Mossakowski, 2014). Therefore, socio-economic difficulties and the role they play with BAME and MHD issues needs to be understood better and considered in all research studies in this area.

As discussed above, Grey et al. (2013) argue that there is a ‘centrality and authority of whiteness’ in our society. Typically, majority groups hold more power than minority groups and these power dynamics are ‘reflected and replicated’ in MHS in the UK, with McKenzie & Bhui (2018) arguing that this becomes embedded in attitudes and practice within MHS. These include opportunities and status afforded to the majority group, which is often mediated by socio-economic status (McKenzie & Bhui, 2018). This is compounded for people with MHD from BAME populations as generally health professionals are perceived to have power and authority over service users. The predominance of the Western bio-medical model within MHS might be an added barrier and power differential as people might fear their own understanding of MHD might be ‘undermined and pathologised’ (Williams et al., 2006). There are also inherent power imbalances between adults and CYP (Thomas & O'Kane, 1998) regardless of ethnicity but this adds another layer to power inequalities for CYP from BAME backgrounds.

Cultural influences on MH

The current MH context in the United Kingdom sits within a Eurocentric paradigm, with Western assumptions and representations of MH, which may influence the way people from BAME communities are diagnosed (Fernando, 2004). NHS MHS are founded upon Western medical models of understanding with clinicians generally being trained within psychiatric and psychological frameworks with particular positions around psychological distress, which often do not translate across different cultures (Li (2010). Current medicalised Western views around MHD can include that there are sets of symptoms that cluster to form diagnoses, with evidence-based intervention to ‘treat’ these diagnoses. It is important to recognise that differing socio-cultural frameworks will affect recognition and responses to MHD by both individuals and MH clinicians (Li, 2010).

There are different cultural constructs of psychological distress; ethnicity and culture influence differences in the way MHD are perceived and understood, how MH symptoms present and how individuals cope (Brown, 2003). This affects help-seeking and use of MHS as well as perceptions and experiences of working with clinicians (Arday, 2018). Li (2010) argues that models of MH ‘reflect social and cultural ideas about illness and normality’ and influences what is acceptable, which can shape access to formal MHS (Memon et al., 2016).

Arday (2018) discusses how some people from BAME populations feel that their culture does not see symptoms related to stress or depression as being legitimate and that instead there is a narrow view of MHD that is associated with culturally unaccepted behaviours like aggression (Keating, 2009). Some MHD are argued to not be recognised, or even trivialised within families, friends and wider communities (Arday, 2018). Some cultures, even those within the majority ethnic group, perceive MH symptoms as somatic symptoms (instead of psychological) so express mental distress through physical symptoms (Memon et al., 2016). Grey et al. (2013) argues that for some individuals, their religious beliefs and cultural expectations suggest that interventions such as praying or family and/or community input are more beneficial than medical or psychological intervention (Grey et al., 2013).

Help-seeking models

Some theoretical models have been developed to try and understand inequality of access to health services and help-seeking behaviour. One model views access to services as occurring through decisions made by an individual which is influenced through their position in society, socio-economic factors and availability of services (Andersen & Newman, 1973). Andersen and Newman (1973) argue that socio-economic and demographic factors account for a significant variation in individuals from BAME populations accessing services (both physical and MHS).

Cauce et al. (2002) developed a three stage theoretical model to explore the influence of ethnicity on YP's perceptions of help-seeking behaviour for MHD including anxiety and depression. Stage 1 was referred to as 'problem recognition', Stage 2 the 'decision to seek help' and Stage 3 the 'service selection'. They posit that cultural and contextual issues influence all three stages. However, they also argued that more research needs to be done around many other aspects of cultural and contextual influences on help-seeking such as the potential role that religious or spiritual gatekeepers play in help-seeking for YP from ethnic minority backgrounds. They also argue that this model is not linear and that the stages are interrelated. In 2002, Cauce et al. argued that there is a dearth of knowledge around the process of help-seeking for CYP from ethnic minority backgrounds and that policies which try to increase help-seeking have been made from extrapolating findings from research with adults or younger children, with a lot of these samples including participants primarily from ethnic majority populations. In 2020, there is still not that much more known about this area which highlights the need for further investigation.

Both of the above help-seeking models highlight that cultural and societal influences affect service use, which is reflected in the MHS access and engagement literature for BAME populations described. Grey et al. (2013) argue that the dominant discourses about BAME populations using MHS need to be disassembled with Li (2010) arguing that concepts such as 'low psychological mindedness' is used as a stereotyped way to frame difficulties with working with BAME groups and to justify the reasons for low MHS use amongst BAME groups.

It is also important to consider the evidence base around other factors that can impact on help-seeking, such as gender and how this might interact with factors such as ethnicity. In 2010, Nam et al. suggested that gender was a significant predictor of attitudes towards seeking psychological help and that ethnicity also moderated this difference. However, this study recruited participants from a university setting and more research with differing populations needs to be carried out to further understand this potential relationship. It would be helpful for more research to consider both gender and ethnicity (and other important factors such as age) in trying to further understand help-seeking for both CYP and parents (and other factors) and whether anything could help to support or improve help-seeking for these populations.

Role of stigma

Link and Phelan (2013) theorise that stigma is a concept constructed by factors including labelling, stereotyping, status loss, and discrimination, with Li (2010) arguing that stigma is reliant on cultural concepts. Masuda et al. (2009) state that in MH, stigma is directed towards those who seek help for MHD and those that receive a label of a psychiatric disorder and that it is a barrier in help-seeking and accessing MHS (Grey et al., 2013).

Generally, there is stigma around MHD across all ethnic groups and cultures. Keating and Robertson (2004) argue that in society, MHD have historically been trivialised and not seen as a 'legitimate illness' which has affected how people view those struggling with MHD and from this, help-seeking behaviours. Numerous studies have shown that MHD are viewed by individuals and communities as negative or traumatic experiences (Arday, 2018) which can lead people to conceal symptoms or delay help-seeking which often results in crisis situations rather than accessing earlier intervention (Memon et al., 2016).

Corrigan (2004) argues that help-seeking is affected by two aspects of stigma; public stigma and self-stigma. It was posited that public stigma reflects the general public's negative attitudes towards MHD and prevents people seeking help to avoid being labelled or discriminated against, whereas self-stigma is internalised stigma and means people do not seek help to avoid negative effects to their own sense of self. Corrigan (2004) states this relies on the assumptions that stigma comes after recognising/labelling a MHD rather than whether these stigmatised views affects problem recognition. Keating and Robertson (2004) argue that this can make it more difficult for BAME individuals to disclose MHD as there is a discourse within some communities of developing greater resilience or turning to faith as the only legitimate intervention. With some communities, there is a great worry around confidentiality and others finding out about them accessing MHS (Street et al., 2005).

Papadopoulos (2009) discussed the differences between individualistic and collectivist cultures and how this might impact on mental health stigma. Papadopoulos (2009) posited that the defining difference between individualism and collectivism culture is a 'primary concern for oneself in contrast to the group(s) to which they belong'. Papadopoulos (2009) argued that their study results seemed to partially support the hypothesis that the more stigmatising a culture's views are on MHD, the more likely that collectivism could explain these views and conversely, that the more positive a culture's views are on MHD, the more likely individualism explains these views. The relationship between stigma and sense-of-self within cultures that might be considered more individualist versus collectivist would be helpful to better understand through future research.

More recently there have been attempts to try and increase awareness and reduce stigma, however, it is argued that this has been positioned within and directed towards the majority ethnic population framed by the dominant white perspective (Grey et al., 2013) in media campaigns trying to reduce MH stigma such as 'Time To Change' or 'Heads Together'. There is no recent research as to whether this has changed help-seeking behaviour in adults or CYP, with Thompson et al. (2004) stating that stigma is a key factor in the under-utilisation of MHS by CYP from BAME backgrounds.

Immigration/migration

Migration is an additional factor when thinking about BAME groups. Many people from BAME populations are not migrants and those that do identify as being migrants do not always identify with their original ethnic background (Dogra et al., 2012). Comparisons between migrants and non-migrants from the same ethnic background are complex as migration is a confounding variable affecting MH (Dogra et al., 2012). MH needs may differ for people from BAME populations that were born in the UK compared to those that were not, and this is another consideration that needs to be kept in mind when thinking about BAME groups. Takayama (2010) argues that looking at generational factors rather than purely ethnicity status may be a better approach to take in comparing groups and findings. This is something to consider with CYP from BAME groups as some CYP will be the first generation to be born or grow up in the UK versus some who are the third or fourth generation to be born and grow up here which will undoubtedly affect how their lives and MHD are seen and experienced.

This may also be true for CYPs parents, with some being born and growing up in the UK and others emigrating later, which will likely affect their personal experiences as well as their parenting. For those that have emigrated, Arevalo et al. (2015) describes the process of acculturation which occurs post-migration. Berry and Sam (2006) argues that this process includes people assimilating beliefs and values from both their ‘heritage’ culture and their new ‘host’ culture. Berry (1997) also argues that language proficiency is important and affects how people ‘locate social and economic resources’ and adapt to their new surroundings, which could reduce adaptation-related stress.

Current influences on CYP

It is also important to consider the context of social, economic and political influences on particular generations and cohorts of CYP (Wyn & Woodman, 2007). Current educational pressures and the growth of social media are said to be something that is currently affecting CYP and for some, adversely affecting their mental and physical health, although impacts are still debated (Eckersley, 2011).

Each generation of CYP face different challenges. Hamblin (2016) discusses how CAMHS have changed over the past 10 years through shifting constructions of MHD, and argues these are related to changes in UK governmental policy. Hamblin (2016) argues that in the past CYP MHD were often seen as being influenced and even produced by socio-economic difficulties but that currently, MHD are seen as socio-economic problems, needing to be acted upon to prevent ‘socio-economic burden’ in the future. Rose and Abi-Rached (2013) argue that the impact of policies including austerity policies, the impact of social media and factors such as the current pressures in schools around exams are affecting MHD.

Parents

Parents or main caregivers are generally key gatekeepers to MHS for their CYP, often facilitating CYPs’ access to formal MHS. Parental attitudes and how they, for example, perceive MHD may, therefore, influence help-seeking behaviours of CYP and CYP accessing MHS. However, there has not been much research into how parents from all/any ethnic backgrounds seek help for their CYP or access CAMHS or exploring this from their perspective (Rowland, 2016) and even less so for parents from BAME backgrounds.

Edbrooke-Childs et al. (2016) posit that parental understanding of their child’s MHD and options for treatment affect referrals to CAMHS. Armitage et al. (2020) argue that parenting a CYP with MHD increases demands on parents. Studies into this area highlights parents’ feelings of powerlessness and helplessness (Thomson et al., 2014) and emotions such as shame, guilt, shock and fear (Oldershaw et al., 2008).

There has been some research into factors affecting parental help-seeking for CYP (Boulter & Rickwood, 2014) with Gronholm et al. (2015) reporting that particularly for adolescents, parental attitudes towards MHD are strong facilitators or barriers to accessing support. Kolvenbach et al. (2018) concluded that parents from all ethnicities face significant barriers in trying to access MHS for their children, however, parents from minority groups seemed to have additional barriers. They suggested that these included factors such as “stigma and discrimination within their communities, shame and denial of their child’s mental health issues, lack of trust in the system, different cultural beliefs about mental health issues and discrimination from within the system” (Kolvenbach et al., 2018, p. 106)

Migration/immigration has been discussed above but it could also be helpful to consider the impact of generational shifts in the understanding of MHD and how parents might have differing views to their children around MHD due to these shifts, regardless of differences related to migration/immigration. Generational shifting of attitudes around MHD and support for MHD could be helpful to consider more in future research studies to further understanding these potential differences and how they might affect factors such as help-seeking.

Language and communication

Language can be one of the main barriers to accessing MHS (Arday, 2018). For some people from a BAME background, English might not be their or their parent's first language. This is listed as one of the main barriers for accessing MHS in adults (Grey et al., 2013) but also represents other difficulties for those that do access services. Fountain and Hicks (2010) discuss how receiving a diagnosis mainly relies on individuals explaining their experiences to professionals and therefore, language and how someone expresses themselves will inevitably have an impact on accurate assessment and diagnosis. Memon et al. (2016) stated that communication of MHD is often subtlety influenced by 'culturally specific nuances' which can be lost in conversations and particularly within medical settings. Arday (2018) reported that BAME students felt their feelings were often misunderstood or misinterpreted by MH professionals. Fountain and Hicks (2010) also found that when service users and providers spoke the same first language, that their satisfaction with MHS was higher. There is limited research around language and influences on BAME CYP and how this could affect communication within CAMHS and around MHD, but it is a factor that could also be relevant for this group in perpetuating inequalities given the noted effects on adults from BAME populations.

Identity; developing ethnic identity and links to MH

Adolescence is a period of someone's life which is acknowledged as being a key time for the development and formation of identities in several domains (Erikson, 1968). This includes the development of identity of being part of an ethnic group (Phinney, 1992). Caldwell et al. (2002) stated that developing a racial or ethnic identity is an important and essential part of identity formation for those from a BAME background and is something that has been neglected in research (Greig, 2003). Adolescents may, therefore, have a better understanding of their identity compared to younger children and may have had more experiences of difference, inequality or otherwise.

Forming a healthy, developed identity is seen as being essential to mental well-being in an individual (French et al., 2006), with Greig (2003) arguing that it is related to certain aspects of MH functioning, for example, a strong sense of ethnic identity has been correlated with a positive sense-of-self and helpful coping styles (Phinney, 1992; Smith et al., 1999). Hinshaw (2009) argues that MHD can impact negatively on identity consolidation and independent functioning. Research has found that the construct of ethnic identity was less salient for White adolescents; they were less likely to think about their own group membership and how their group related to others (Phinney & Tarver, 1988) compared to adolescents from BAME groups. Hamblin (2016) argues that ethnicity impacts on CYP's well-being and MH in diverse ways, influenced by individual factors such as gender, socio-economic inequalities and responses from MHS. Greig (2003) argues that research exploring adolescent MH must incorporate exploring developmental factors such as the young person's ethnic identity as well as socio-cultural factors.

Ethnic identity and discrimination

There is mixed evidence around whether (and if so how much) a person's ethnic identity influences the relationship between discrimination and experiences of MHD (Yip et al., 2008). Discrimination due to group membership, and particularly being from a BAME population, is argued to lead to psychological distress for some individuals (Williams & Williams-Morris, 2000). However, Yip et al. (2008) argues that each study has used different populations across differing ages, making it hard to compare and make generalisations. Overall, ethnic identity seems to both 'buffer' and 'exacerbate' effects of discrimination for people from BAME backgrounds (Williams et al., 2003). This result has also been found with adolescents from BAME backgrounds (Sellers & Shelton, 2003), although as with most of the research reported here, the vast majority of the research has focused on adult populations so currently limited conclusions can be drawn (Williams et al., 2003). However, Astell-Burt et al. (2012) found that experience of racism was associated with worse psychological well-being in adolescents, but that the negative effect racism had on well-being decreased with age of the adolescents.

Summary of literature review

In conclusion, there are numerous factors that seem to affect and compound the inequalities in MHS for BAME adults, and to a certain extent CYP, and these have been discussed above. Wider influences such as systemic factors including intersectionality, discrimination and power have been discussed and are argued to increase inequalities in MHS for BAME populations. Cultural influences and understanding of MHD, help-seeking and the role stigma seems to play a role in different experiences of BAME groups within MHS has also been discussed. Factors directly relating to the CYP were also discussed, such as parental influences and ethnic identity development which can help to start to unpick and understand why these inequalities might be present for CYP in MHS too. These sub-sections can be taken together as a starting point to begin to understand how these interlinking systems affect how CYP from a BAME background experience their lives, MHD and accessing and engaging with CAMHS. However, specific research with BAME CYP needs to be undertaken to fully explore these factors (and potential other factors) further.

Rationale for study

Arday (2018) argues that gaining perspectives from MHS users from BAME groups about their experiences of MHS and the barriers and facilitators for accessing and using MHS has the potential to translate into ‘tangible and effective’ ways to develop services and provide greater equity for all ethnic groups. Li (2010) also argues that being able to meaningfully discuss and gain a greater understanding of differing perspectives of MHD will help improve engagement and outcomes with MHS.

Despite the calls to action for research into CYP, MHD and CAMHS, many of the studies are now close to or over a decade old. In 2016, Edbrooke-Childs et al. stated that there is little current evidence about differences in CAMHS use in the UK for CYP from BAME backgrounds. As discussed earlier in this introduction, most of the literature in this area has come from research with adult populations and it is often assumed that experiences and inequalities faced will be the same for CYP from BAME backgrounds. However, this should not be assumed and research needs to be conducted directly with CYP from BAME populations to better understand their experiences. Dogra et al. (2012) argue that research into CYP from BAME groups and how they experience MHD and CAMHS will allow for a better understanding of factors leading to inequalities and difficulties, which can then help tailor interventions for these groups.

Edbrooke-Childs et al. (2016) highlighted that they were unable to explore reasons for differences in care pathways within CAMHS qualitatively with CYP from BAME backgrounds. They also highlighted that exploring perceptions of CYP from a BAME background is vital to understanding findings and developing services that are equally accessible to all CYP. Using qualitative methods in studies allows for a richer and more in-depth understanding and ensures that individual experiences are captured. It is important to provide CYP with opportunities to give their own perspective on issues affecting them. Qualitative methods allow CYP to speak about matters important to them without as many researcher-led constraints (as there often is with quantitative research) and to use their own language in doing so (Claveirole, 2004). Therefore, this study will use qualitative methods to explore experiences for this particular group of YP.

This study will recruit YP that are teenagers instead of younger CYP. This is because of the literature described above around ethnic identity development which suggests that adolescents will have a better sense of their ethnic identity (Phinney, 1992) and, therefore, are more likely to be able to discuss and explore experiences of their MHD and using CAMHS, as well as this in relation to their ethnicity, in a one-to-one interview setting. Although literature indicates adolescence may continue until 26 (Curtis, 2015), the upper age bracket will be 18 as this is the cut off age for using CAMHS services.

As discussed throughout this introduction and as with any individuals and groups of people, ethnic minority communities and individuals within these differ in multiple ways both within and between groups. This is also seen in differences in clinical presentations and differences in pathways to and attitudes about MHS within and between groups, with current research indicating that MHS are struggling to provide services for these differing needs (Fernando, 2010; Li, 2010). It is, therefore, important to state why this research study will recruit YP from any BAME group generally when issues with this design in research studies has been discussed throughout.

Arday (2018) argues that most studies in the evidence base have either grouped all ethnic minority groups under one heading (i.e. BAME) and not thought about differences between these groups or researched a specific group within BAME populations, often focusing on a particular issue or sub-group within this population. Arday (2018) argues that it is important to examine whether there are similarities across BAME populations to identify any mutual or similar experiences that could be applied across the majority of the

BAME populations in the UK. It is important to state which BAME groups have participated in studies though to ensure transparency in the evidence base (Dogra et al., 2012) and this study will be explicit with this. Ideally, CAMHS would be developed by a wide range of people from various communities, ages and backgrounds to meet individual needs. However, in the current climate there are both limited resources and increasing demand for CAMHS, influenced by austerity policies, organisational structures and the way the NHS is set up. Therefore, research into how CAMHS in its current structure could be developed to support CYP from all minority ethnic backgrounds who experience disadvantage or different experiences to the majority due to belonging to an ethnic minority group could be beneficial. This study aims to explore experiences of individual YP from an ethnic minority background to gain an understanding into their experiences of using CAMHS and then also whether any experiences are similar across the YP to help increase knowledge and inform the evidence base.

As discussed at the beginning of this introduction, there are a variety of MH diagnoses that are given to CYP within CAMHS. These diagnoses represent a vast array of presentations and experiences. Edbrooke-Childs et al. (2016) argue that researching a specific subgroup of MHD, i.e. emotion regulation issues such as anxiety or depression as opposed to neurodevelopmental disorders, can be beneficial in undertaking research to build this evidence base, as this negates an added difficulty of uncertainty around differences in prevalence of differing MHD across BAME groups. As research indicates that CYP with MHD categorised under the ‘emotion regulation’ sub-group of anxiety and depression diagnoses seem to also be the least likely to access help (Ford et al., 2007) this study will look into experiences of CYP from a BAME background with diagnoses around anxiety and depression and emotion regulation issues including self-harm to explore this further. This will also enable there to be some common experiences with YP to explore as they will potentially have had some shared or similar experiences of MHD with a similar MH diagnosis. They are also likely to have had similar experiences within CAMHS in terms of care pathway due to their diagnosis. As differences may be great across ethnic background, this will allow for some comparisons across similar experiences to be gleaned to further knowledge in this area.

The current study

In light of the lack of research in this area and rationale presented, this study is an exploratory qualitative study exploring experiences of YP from an ethnic minority background of their MHD and accessing and engaging with CAMHS for their MHD. Findings from this study will contribute towards the literature around this under-researched but important research area and this knowledge could also be used to help develop CAMHS services.

Research aims

The overarching research aim is to explore how YP from an ethnic minority background experienced their MHD and accessing and engaging with CAMHS for their MHD. A greater understanding of these experiences could help to elucidate potential barriers or facilitators in accessing and engaging with CAMHS and how CAMHS could be better developed to serve needs of CYP from ethnic minority backgrounds.

Research questions

Following from the research aims, three interrelated research questions were asked to explore the YP’s experiences.

1. What are the experiences of YP from an ethnic minority background of their MHD before accessing CAMHS?
2. What are the experiences of YP from an ethnic minority in accessing CAMHS support for their MHD?
3. What are the experiences of YP from an ethnic minority background in engaging with CAMHS for their MHD?

Chapter 2 – Method

This chapter presents the chosen methodological approach of Interpretative Phenomenological Analysis (IPA) and the rationale for this and provides an explanation of and why alternative methods were not chosen. It will also outline the method for this study, including the design, sampling and recruitment strategy. The data analysis process, ethical considerations and quality checks undertaken for this study are also presented.

Design

A qualitative design using semi-structured interviews was chosen to explore the experiences of YP from an ethnic minority background in accessing and engaging with CAMHS. The interviews were all transcribed verbatim and then analysed using the IPA (Smith et al., 2009) methodological framework. Analysis was initially conducted for each of the individual participant's interviews and then analysis was undertaken at a group level across all four interviews to capture similarities and differences across participants' experiences and to identify superordinate and subordinate themes.

Methodology

Qualitative methods are not one set of approaches, but are a group of approaches (Mason, 2002) which allow an examination of the lived world of the participants. They allow for a detailed understanding of multi-layered and complex experiences to be captured (Willig, 2013) and for exploring and understanding experiences in which context is key to understanding (Mason, 2002). Exploratory research questions are best approached through qualitative research methods as these can highlight shared and unique experiences of participants and may identify novel aspects and a depth of understanding of experiences that are not captured by standardised quantitative measures (Willig, 2013).

However, as with all methodological approaches, there are also limitations within qualitative methods. Qualitative research tends to have much smaller sample sizes meaning that results cannot be generalised, although this is often not the aim of qualitative research methods (Smith et al., 2009). However, qualitative research designs can provide rich and detailed data about experiences and this is the aim of this study. In qualitative research, it is important for researchers to be as transparent as possible with their own biases and life experiences as there is more opportunity for this to be brought into the work and impact on interpretations of data (Johnson & Onwuegbuzie, 2004).This will be addressed more in the 'reflexivity statement' presented later in the chapter.

Interpretative Phenomenological Analysis

IPA is a methodological framework which focuses on individual lived experiences and meaning making of experiences (Smith et al., 2009). IPA is a considered to be a valuable way to explore and capture experiences within health research (Smith, 2011). As IPA looks at making sense of experiences, this methodology was chosen as the most appropriate method for this research as this is an exploratory study seeking to explore the experiences of YP's MHD and how they experienced accessing and engaging with CAMHS for their MHD. IPA also allows for the YP's language to be retained in the analysis process, which is important when conducting research with CYP (Roose & John, 2003). In IPA, there is a sense-making process and interpretation of experiences by the individual but then the researcher also makes an interpretation of this during the analysis – this is called the double hermeneutic (Smith et al., 2009). IPA has been informed by the following three main areas around philosophy of knowledge: phenomenology, hermeneutics and idiography (Smith et al. 2009) and these are discussed below.

The first influence on the IPA methodology is phenomenology. Phenomenology in IPA is concerned with gaining an understanding of an individual's experience of a given phenomenon (Smith et al., 2009). Smith et al. (2009) argue that an individual is affected by relationships, cultural experiences and language. However, Langdridge (2004) argues that despite the importance these factors have for individual experiences, many of these processes are unconscious so cannot be 'comprehensively acknowledged' by participants. Phenomenological research aims to explore and capture as closely as possible the way a phenomenon is experienced (Giorgi, 2008).

The second influence on IPA is hermeneutics which is the 'theory of interpretation' (Smith et al., 2009). This suggests that people continually try and interpret, understand and make sense of their own experiences and the world (Smith et al., 2009). As discussed above, whilst completing IPA the researcher is engaged in double hermeneutics as they are "trying to make sense of the participant, who is trying to make sense of what is happening to them" (Smith et al., 2009, pp. 3). Therefore, Smith et al. (2009) argue that because of this, it is vital for the researcher to acknowledge the key role they play in the analysis process and the importance of documenting the researcher's influence on the data. This process is called reflexivity. It is hoped that in engaging in reflexivity, the researcher’s personal position and the influence this has on the analysis will be transparent throughout the process.

The third influence on the IPA methodology is idiography. Idiography focuses on the ‘particular’ and is about exploring an individual’s experiences at a detailed and specific level (Larkin, Watts & Clifton, 2006). Smith et al. (2009) argue that the IPA methodology allows for examination of data in detail and focuses on an individual’s understanding of a particular phenomenon (an event, process or relationship) in a particular context. This is why IPA studies have small samples so that detailed analysis can be completed at the individual level before this analysis is completed at a group level, although IPA can also be used in single case studies too (Larkin et al., 2006).

Alternative methodological approaches

Thematic analysis (TA;(Braun & Clarke, 2006) was considered for this research. TA is a method that shares many similarities with IPA but also important differences. IPA looks at both the unique experiences of individual participants as well as seeing if there is shared meaning across participants (Smith et al., 2009) whereas, the focus of TA is looking for recurring patterns across an entire dataset (Braun & Clarke, 2006) which can lead to losing the individual’s perspective. TA allows the consideration of social context that informs understandings of individual experiences (Clarke & Braun, 2013), which is also something that is important in this research. However, it was decided that as this study is an exploratory study, it is important that individual perspectives are not lost, particularly given that the YP might be from very different ethnic backgrounds. The social context can also be examined if the YP describes this in their interviews as affecting or influencing their experience.

Grounded theory (GT) was another qualitative approach considered. GT aims to determine patterns within data and develop theories from these patterns (Walsh et al., 2015). However, as GT has a focus of developing an ‘inductively GT about a phenomenon’ (Strauss & Corbin, 1998) and this study seeks to explore experiences rather than develop hypothesis or theories, IPA was chosen.

Semi-structured interviews

One-to-one interviews were chosen as the most appropriate method for this study design, as recommended by Smith et al. (2009) for IPA studies as they allow for rapport with the participants to be developed and are well suited to in-depth discussions around personal experiences (Smith et al., 2009). Individual interviews provide the space for participants to talk about topics they would like to discuss and allow this be done using their own words. It was felt that as this was an exploratory study wanting to gain and hear voices of YP from ethnic minority groups about their experiences that it would be important that they could use their own words to discuss these experiences.

A semi-structured interview is where the researcher asks a number of open-ended questions that are based on a semi-structured interview guide (Smith et al., 2009). This topic guide lists a number of areas deemed to be important to be covered within the interview (Jamshed, 2014). A semi-structured interview approach, instead of unstructured or structured, was chosen for this study as this approach provides a clear framework for interview which helps to facilitate conversations and allows for further exploration of given answers. It was felt that this provided a flexible enough approach, framework and structure to cover a broad range of topics considered to be important to be covered (such as pre-referral to CAMHS, referral and then what happened for the participant in CAMHS) but that it would also allow the participants space to reflect on topics of conversation they would like to discuss and not place restrictions on the interview (Jamshed, 2014).

Method

Sampling

Smith and Osborn (2007) discuss how there is no ‘right sample size’ but that IPA requires smaller numbers of participants than other qualitative methods (such as thematic analysis). Smith et al. (2009) suggest that between four and ten interviews is appropriate for a doctorate study using IPA methodology and emphasised that a greater number of participants does not equate to the better quality of the work. Therefore, for this study, my aim was to recruit between four and ten participants. I had to stop recruitment early for this study in March 2020 due to COVID-19 restrictions, however the minimum number of four participants were recruited for this study. This number allowed me to examine and explore in-depth each individuals lived experiences and then also explore unique and shared experiences of the whole sample.

Purposeful sampling is often used in IPA. IPA researchers aim to recruit as homogeneous a sample of participants as possible for analysis (Smith & Osborn, 2007) so that 'similarities and differences relevant to the psychological processes' can be explored and so that the research questions are more like to have 'meaning' for participants (Smith et al., 2009). Homogeneity of the participants for this study was carefully considered. As previously discussed, I recruited across all BAME groups (and the differences between BAME groups can be great as well as within ethnic groups too) which introduces heterogeneity into the sample. However, there will be similarities between YP in terms of their experiences of and being an YP from an ethnic minority in the UK using CAMHS and this will be interesting to consider across experiences and allow for potential understandings to help increase the evidence base. As the IPA methodology is concerned with firstly looking at each interview transcript individually in detail, this will allow for each participant's experience to be considered, before looking for similarities and/or differences between experiences across participants in the group analysis. The inclusion criteria for participants including having MHD around anxiety or depression to enable potentially similar experiences with similar MHDs and within CAMHS (in terms of care pathway) to be explored and for a homogenous group as possible in terms of MHD to be recruited as participants.

Inclusion and exclusion criteria

The 'Inclusion' and 'Exclusion' criteria for participation in the study are presented with a rationale for each criterion in Table 1 below:

Table 1. *Inclusion and Exclusion Criteria*

Inclusion Criteria	Exclusion Criteria	Rationale
YP aged 13-18 years old	YP not aged 13-18 years old	Previous research indicated YP in this age range might have more of an understanding of their identity (Phinney, 1992)

YP from an ethnic minority background (any ‘non-white’ background)	YP from a white ethnic background	This was a primary focus and an essential criterion for the study
Accessed two local CAMHS services and now discharged	YP currently accessing CAMHS/discharged from any other CAMHS than two local ones recruiting within	The field supervisors felt as if participating in the study could impact on current care if currently under CAMHS (so participants should be discharged to participate)
Accessed CAMHS for MHD under CORE CAMHS for emotional regulation issues, i.e. anxiety and depression diagnoses and for crisis presentations if seen by community CAMHS	Accessed CAMHS for anything other than CORE CAMHS i.e. neurodevelopmental assessment, eating disorder or psychosis	To try and ensure as much homogeneity as possible in terms of experiences and interventions offered within CAMHS
Accessed CAMHS when 13 years old or older (for any amount of time)	Accessed CAMHS when under the age of 13 years old	To try and ensure as much homogeneity as possible in terms of experiences and interventions offered within CAMHS
Discharged from CAMHS within the past 24 months (from date of ethical approval)	Discharged from CAMHS over 24 months ago (from date of ethical approval)	To try and ensure that experiences were recent enough so that participants could remember experiences
Able to speak, read and write English to a proficient level	Not able to speak, read and write English to a proficient level	Language is important to convey understanding in IPA research (Smith et al.,

		2009) and it was felt not having a proficient level of English might impact on experiences and increase heterogeneity of sample
Able and willing to give informed consent if over 16 (or parent/guardian able and willing to provide informed consent if participant under 16)	Unable or un-willing to give informed consent if over 16 (or parent/guardian unable or willing to provide informed consent if participant under 16)	Providing informed consent is necessary for in participating in research studies

Young Dynamos

A local youth research advisory group called Young Dynamos was consulted throughout this project; in the initial planning stages of whether to undertake this research study, to the planning of the study design, development of the interview schedule and procedures and also in considering the analysis and findings. Young Dynamos is made up of YP from both ethnic majority and ethnic minority groups and those that have and also have not accessed CAMHS. This collaboration was invaluable in undertaking this research.

Interview Schedule

As discussed in the methodology section above, interviews were conducted using a semi-structured topic guide developed using the IPA methodology (Smith et al., 2009). The topic guide included open-ended interview questions and prompts to try stimulate conversations about the participant’s lived experiences whilst also trying to not overly influence the areas discussed. This was important so that participants felt able to talk about what they wanted to discuss in the interview. It is important in qualitative research in general to use participant’s own words but it felt very pertinent for this study that participants felt able to use their own words to describe their experiences as YP’s perspectives are currently not as present in the current research literature.

The interview topic guide (see Appendix 1) was developed through considering the research questions, pre-existing literature on pertinent topics that had been found to impact experiences, Smith et al. (2009) recommendations, conversations with my thesis supervisors (both academic and field) and through discussions with Young Dynamos throughout the planning of the project. The topic guide was furthered shaped through going through a draft with Young Dynamos and through piloting the schedule in a pilot interview with a member of Young Dynamos.

Pilot interview

I completed a pilot interview with a YP from Young Dynamos to make sure that my topic guide would be acceptable to YP, would cover potentially important topics and encourage conversation without putting too many limitations on the topics that could be covered in the interview. The young person was from an ethnic minority background and had also accessed CAMHS. After my pilot interview, I made some changes to the topic guide such as asking participants what they were doing at the time instead of making assumptions and asking them about school or college. The YP I piloted the interview with also made me aware of the importance of asking about religion as well as ethnicity – this was not something I had included in my topic guide before.

Procedure

Recruitment

Participants were recruited using purposeful sampling. Recruitment was conducted through two local CAMHS services – I had a field supervisor in both services to act as a link for each service to aid recruitment. There were two avenues that participants were recruited through. Firstly, letters were sent out to eligible participants that had been discharged up to the past two years and secondly, CAMHS clinicians also let eligible participants know about the study before their discharge from CAMHS.

For one CAMHS service, their electronic record database was downloaded and the local administrator compiled a filtered list of YP that fit the inclusion criteria. The local field supervisor then sent out letters to all eligible participants. For the other, the local field supervisor sent out letters to all those that were eligible. If the participant was over 16, this was sent out directly addressed to the participant and if the participant was under 16 the letter was sent addressed to their parent or guardian. The documents in the letter pack included: a cover letter giving a brief overview of the study, the appropriate Participant Information Sheet(s) (PIS), GDPR information sheet and the appropriate Consent Form(s) (CFs) for the age of the YP (i.e. PIS and CFs for parents too if they were under 16) (see Appendix 2).

For both CAMHS teams, I attended locality team meetings to let clinicians know about my study and to encourage them to let any YP who were eligible know about my study before discharge. I provided my information packs and also provided clinicians with consent-to-contact forms (see Appendix 3) for any eligible YP to fill out. I sent out reminder emails to clinicians about my study at three time points over the seven-month recruitment process. Posters were also put in the CAMHS waiting rooms. One CAMHS had a Facebook page so the poster was also posted on this to advertise the study.

Four female participants consented to and took part in the study. Three participants contacted me either via email or phone to express their interest in taking part in the study after receiving information in the post with one participant sending back their consent form and contact details to their local CAMHS service.

Two parents and one grandparent contacted me about their son/grandson taking part in the study. One boy was not eligible for participating as they were accessing CAMHS in different locality and the other two parents/grandparents said they would talk to their child about participating and did not get back in contact with me. One clinician told me that one of their male clients about to be discharged expressed interested in participating but they were not offered the consent-to-contact form to fill in and they did not contact me independently about participating after being given the study information. No other clinicians let me know about whether they had informed eligible participants about the study.

Interviews

Participants were given a choice over the date and time and also location of interviews (own home, buildings within Trust used or the University of Leeds [UoL] buildings). Two of the participants chose to have the interviews take place at a UoL building, one at a local NHS Trust building and one at the participant's own house. The interviews lasted between one hour and 12 minutes and one hour and 48 minutes. All interviews were audio recorded. Participants were given a gift voucher (£10 LoveToShop) after participating and travel expenses were also reimbursed with a LoveToShop voucher (for the closest amount of the travel costs to £5 voucher denomination).

I reiterated to participants that they were allowed to take breaks if they wanted during interviews and that they did not have to speak about anything they did not feel comfortable with. I also reiterated that participants could complete the interview in two sittings if they would prefer to try and ensure that participants felt as comfortable as possible. Participants were offered an opportunity to debrief after the interview and were told they could ask for their data to be removed up to two weeks after the interview had been completed. This opportunity was provided to give participants time to reflect on the interview and the answers they gave.

The interview topic guide was followed but used flexibly according to the participant’s answers and what they wanted to talk about; participants were asked to elaborate if brief answers were given and I used direct prompts that had been developed to use when necessary. Before the interview, I checked eligibility information for the study such as age, diagnosis, when they had been discharged and what kind of support they had from CAMHS. I also ensured I gained enough contextual information from the participants during the interview to help to put their experiences in context.

Before and after the interviews, I made notes on my reflections to document my initial thoughts and aid my reflexive position. This included how I initially made sense of their experiences and any feelings that arose for me during their interview.

Transcription

All interviews were audio recorded and then transcribed. I transcribed the first interview to familiarise myself with the process and the remaining three interviews were transcribed by a university approved transcriber. Any identifying or potentially sensitive data was removed from the transcripts. After I received each transcript, I re-listened to the audio recording whilst reading the transcript to check for accuracy of the transcription of the interview and to edit any errors.

Data analysis

The six stages of the IPA analysis methodology as recommended by Smith et al. (2009) was followed for the analysis of the data and is described below. I attended an IPA workshop at the University of Derby which provided additional support for using the IPA methodology as a novice IPA researcher. I also kept a reflexive diary (see ‘Reflexivity’ section below) and discussed each stage with my thesis supervisors and peer IPA support group. I analysed each interview separately in its entirety before moving on to the next interview. After completing the individual analysis, I then moved on to the group analysis process as described below.

Step 1. Reading and re-reading: building familiarity

For the first stage of the analysis process, I printed each interview transcript on A3 paper with wide margins to give space to make comments down both sides of the transcript. I read and re-read the transcript and re-listened to the interview to ensure I was immersed in the data. I made notes about my own feelings during the interview and any other interesting ideas within the data and about the interview. I also underlined any parts of the text that initially stood out to me. I also started to develop pen portraits for each participant including a general overview of the participant and my thoughts on the interview from my reflexive diary before and after conducting the interview.

Step 2: Initial noting

I then began a detailed, line-by-line analysis of the transcript to further immerse myself in the data, to start to develop a comprehensive understanding of the data and to start to analyse the meaning of each of the participant's experiences. As Smith et al. (2009) advised, I made notes on the transcript around three 'principles of data': descriptive information (use of words/phrases and general comments on what participants had said), linguistic features (use of non-verbal language) and conceptual ideas (considering meaning). I used a different coloured pen for each of these three types of codes and wrote these down the right-hand margin of the transcript. An example of this can be seen in Appendix 4. I also highlighted any particular quotes that I thought stood out from the data to make sure that I could look back during later stages to check my themes had incorporated these quotes/ideas. I brought my transcripts to thesis supervision and to my IPA peer support group to check out my thinking. I went through each transcript at least three times during this step.

Step 3 and 4: Developing emergent themes and searching for connections

I then re-read all of the notes and codes from step 2 and started to develop emergent themes which incorporated these codes. I wrote these emergent themes in the left-hand margin of the transcript. I then typed up all of these emergent themes into a Word document. I also copied over each participant's highlighted supportive quotes into a separate Word document. At this point, I clustered and re-clustered the data to develop superordinate and subordinate themes. These were refined numerous times. I re-read the full transcript again to ensure that the themes were grounded in the participant's experience and that the themes captured these experiences. I made maps of these superordinate and subordinate themes with corresponding quotes on a separate word document for each participant (see Appendix 4 for an example). I shared this process at various points with my thesis supervisors and also with my peer IPA support group. These themes were then re-clustered and re-named a number of times before reaching the final superordinate and subordinate themes for each participant.

Some key themes from this stage of the analysis are presented in the results chapter under each pen portrait, with theme names emboldened. I have not presented the entirety of each individual analysis as there was overlap with the group themes, therefore, I have presented the themes which felt to be pertinent to each individual's experience and would be helpful to give a sense of their individual experience.

Step 5: Moving to the next case

I then repeated the above four steps for each participant's interview before moving onto the group analysis.

Step 6: Looking for patterns across cases

Each participant's individual themes were reviewed and whether themes were related across participant's experiences was considered. Themes that were related were amalgamated and refined and superordinate and subordinate themes were then clustered and re-clustered to try and capture experiences across the group level. Some of the theme names were changed to try and capture the essence of the experiences for all participants. Supporting quotes were then also copied over into a separate word document. I also produced a table capturing which participants experienced which superordinate and subordinate themes and a theme map to check that the themes captured all of the patterns within the data.

As with the above steps, I shared this process at each step with my supervisors and had discussions around these with the IPA support group. The discussing of the themes aloud as well as starting to present them in a formal written format helped refine the themes during this process. Other potential interpretations of the data were continually discussed during these meetings as well as discussions around reflexivity. This will be discussed further in the results chapter. I also shared a draft of the individual themes and group themes with the Young Dynamo group- we discussed these in depth and my thinking behind the themes which added to the quality checks (discussed below).

Individual and group analysis

Initially I was going to mainly focus on the individual analysis in the write-up so that each participant's individual experiences could be heard and better understood for this exploratory study and only briefly present group themes. However, when I completed the group analysis stage, there seemed to be many similarities and patterns which stood out across interviews and the analysis. Therefore, it was felt that both individual and group themes would be presented, but that the main focus would be the group analysis to understand better YPs experiences from ethnic minority groups as a whole as well as individual experiences.

Ethics

Researchers have an ethical obligation to consider any potential risks of participating in research studies and to try and limit these risks where possible (Orb et al., 2001). For this study, there were numerous ethical considerations which are detailed below.

Ethical Approval

Ethical approval for this research was sought and granted by the North West - Greater Manchester East Research Ethics Committee and HRA and HCRW Approval was granted on the 27th June 2019 (see Appendix 5 for confirmation letters). Research and Development approval was obtained from the two NHS Trusts used for recruitment. The ethical issues for this study are presented below.

Ethical Issues

Contacting potential participants

One ethical issue for this study was sending letters to YP that were eligible participants that had been discharged from CAMHS. This was carefully considered with thesis and field supervisors. It was decided that the potential harm of YP being sent a letter after discharge was offset by the potential benefits the YP might find in having the opportunity to participate in the study which may also help better develop CAMHS services for future YP. The most up-to-date address held on the 'NHS Spine' was checked against the address on the CAMHS database in case participants had moved. If the sender was unsure about this, the letter was not sent out.

Informed consent

All eligible participants were sent out a letter pack with all of the study documents including the PIS and CF. The PIS outlined the rationale behind wanting to do the study and what participating would involve. I provided participants the opportunity to ask questions when they first contacted me about taking part and after going through the PIS again at the beginning of the interview before they signed the CF. I also provided a debriefing sheet (see Appendix 6) after the interview. All of the participants said they would like to have a summary of the study. All participants provided their own informed consent as they were all over the age of 16 so parental consent did not need to be sought.

Anonymity and confidentiality

Participants were informed that any potentially identifiable information such as names and location would be removed or changed in the thesis write-up. Participants were asked whether they wanted to choose their own pseudonym; none of the participants chose to do this. Participants were also advised to only talk about topics they felt comfortable discussing and should say if they did not want to answer a question(s). They were also informed that anonymised direct quotes from their interview would be used within the report.

Payment of participants

It was felt to be important to ensure that participants were paid for their time and it was decided that it would be appropriate to offer a voucher for this. The type of voucher and amount offered was also discussed in supervision and with the Young Dynamos.

Managing withdrawal from the research

Participants were able to withdraw their consent for their interview to be used in the study up to two weeks after the interview date. Participants were reminded this at the end of the interview and that they would not need to provide a reason for withdrawal. No requests were made by participants to withdraw their interview from the study.

Participant distress

It was recognised that the interview topics had the potential to be upsetting or cause distress for the participants due to the nature of the topic. This was also considered at length in planning the project. The PIS detailed this and I reiterated at the beginning of the interview that participants did not need to talk about topics they did not wish to talk about and that we could have breaks at any point of the interview or complete the interview in two sittings if that felt better. I also reminded participants that we could stop the interview at any time.

During the interviews, none of the participants appeared to become distressed. One participant became upset at one point in the interview but did not need a break and wanted to continue the interview. A debriefing sheet was given to all participants at the end of the study providing contact details should they have required further support.

Disclosure of risk

Disclosure of risk was considered for this study, particularly because of the age of the participants. Contact details for a parent/guardian for each YP was collected and it was reiterated that I would contact their parent/guardian if any risk issues arose in the interviews. If any risk issues were identified, YP and their parents would have been signposted to services within the community as detailed on the ‘debriefing sheet’ or if there appeared to be an immediate risk (to self or others) they would have been signposted to attend A&E or contact 999. If this occurred, thesis supervisors would have been informed and the events documented in supervision notes. None of the participants disclosed any risk in their interviews.

Lone working policy

One of the interviews took place at the participant’s house and so lone working policies for the UoL were followed. I let my supervisors know where and when I was conducting the interview and checked-in after the interview had finished and I had left the participants house.

Data storage

I recorded interviews using one of the UoL encrypted electronic dictaphones. After the interview, the recording was transferred to my UoL secure ‘m’ drive (which is password protected and something only I can access) and then deleted from the dictaphone. All electronic data is currently stored on my UoL secure ‘m’ drive in accordance with the UoL’s Data Protection Policy. Transcripts were anonymised before being stored on this secure drive. Hard copies of the CFs are being securely stored at the UoL. The printed hard copies of transcripts were already made anonymous by deleting any personal information such as names or places discussed in the interview before being printed and these were stored safely whilst not in use.

Quality checks

To ensure that all qualitative research is reliable and valid, two key frameworks for quality checks were developed by Elliott et al. (1999) and Yardley (2000, 2008) and these were used to quality check this research. Elliott et al. (1999) quality checks were: reflexivity, providing contextual information about the sample, grounding the data and providing examples, coherence, accomplishment of general and specific tasks in the research and accurately reporting for the reader. Yardley (2000) discussed how the following were important in quality checking data: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. A discussion of quality checks in relation to the current study will be presented in the discussion chapter below.

To try and ensure I was appropriate and sensitive to different cultural understandings throughout this research process and to facilitate reflexivity during this study:

- As I am a novice IPA researcher, I attended an IPA analysis course at the University of Derby to develop my knowledge and confidence in using the IPA methodology.
- I planned my project with the youth research advisory group Young Dynamos. We discussed initial plans, developed the study materials such as the interview topic guide and the PIS and CFs. I also discussed my ideas with a clinician from a BAME background too. As discussed above, I piloted the interview topic guide with one member from the Young Dynamos. I also brought my analysis of the data and emerging themes to a remote group meeting to discuss this analysis. Although these views cannot represent all views of people from all BAME populations, this has helped me be mindful of my biases and things I may be unaware of due to my ethnicity as well as from YP's perspectives too.
- I utilised regular supervision throughout the research study. In the data analysis stage of the study, I shared extracts of transcripts and emerging themes and patterns within the interviews – for both the individual and group analysis at every stage. Alternative potential interpretations of the data were carefully considered and themes were continually clustered and re-clustered.

- I was also part of a small peer IPA working group (set up within my cohort for those completing IPA studies) to provide mutual support and gain different perspectives during the process to refine my analysis and add to the quality checks carried out.
- I kept a reflective diary throughout the process to document my own personal reflections throughout this process, and particularly before and after each interview and during the analysis process. This helped me to notice what was brought up throughout this process and to be mindful of this throughout the process. I shared reflections in supervision (both with academic and field supervisors) and also discussed some of these at various points with the Young Dynamos. I have included some of these reflections in 'reflexivity boxes' in the results chapter.

Reflexivity

As discussed above, it is important when using IPA methods to recognise the influence and effect that researchers' own beliefs and views will have on the analysis process (the double hermeneutic). Reflexivity is considering these factors throughout the research process and includes understanding and stating one's own position (Claveirole, 2004). Snelgrove (2014) argues that it is impossible for a researcher to 'put aside' or 'bracket' their prior knowledge and assumptions but that processes put in place can help to identify assumptions and acknowledge the impact of these on the analysis. Senior and Bhopal (1994) argue that researchers need to recognise the influences their personal values and ethnicity have on their research topics and this should be made transparent within the process to demonstrate that findings are trustworthy (Finlay & Gough, 2008).

In thinking about my own experiences and lens that I bring to this topic, I have continually considered my own position in approaching and conducting this research. I have presented examples of reflexivity relating specifically to my data analysis in text boxes throughout the results chapter. The following statement should support the reader to understand my position which should inform the judgment of the quality and validity of the research.

Reflexivity statement

Currently, clinical psychologists and those in clinical training are not generally representative of the multi-cultural communities we have in the UK. There is a documented need to rectify the failure within MH research to represent all sections of society equally (Rugkåsa & Canvin, 2011) and to explore how CYP from BAME populations experience their MHD in the UK. This has posed a real dilemma for me as there is a real need to do research in the area and I am passionate that more research is conducted in this area, however I am from the majority white ethnic group and it may be seen that I cannot understand the issues faced by BAME groups (so, therefore, I may not be best placed to undertake research into this area). It is acknowledged that this issue should be something that all ethnic groups consider to influence change and that the small numbers of researchers and clinicians from BAME groups should not always have to be the voice/researcher for this area either. However, this been an ongoing tension for me in choosing, planning and undertaking this research as I do not want to perpetuate the difficulties in this area. After speaking to many different people (lay people and CYP and clinicians from a range of ethnic backgrounds), I decided that it was important to do this research to help contribute to increasing the evidence base. In conducting this research, I aimed to promote the importance of considering and gaining multiple perspectives in MH research but do not want to perpetuate any problems in this research area by, for example, making over-generalisations. This study will not be a comprehensive representation of how to understand CYP from BAME backgrounds experiences of CAMHS but aims to be an initial exploratory study gaining perspectives with this particular group of YP.

As I have grown up being in a majority ethnic group, I never had to think of my ethnic identity whilst I was growing up. It was important to keep issues with inherent power imbalances between adults and children, researchers and participants and majority vs. minority ethnic status (Balen et al., 2000) in mind whilst undertaking this research as I am a white, middle-class woman who is training to be a Clinical Psychologist. I am also currently completing my elective clinical placement within CAMHS and work with YP clinically meaning that I had a different understanding of CAMHS when I undertook the interviews than when I was planning the project, which will have influenced how I understood and interpreted experiences. Other factors of note to consider was that I was also an adult interviewing YP which introduces another layer of difference.

I was aware of my assumption that YPs experiences around their MHD and accessing and engaging with CAMHS might have been impacted by their ethnicity from the literature base I had read in planning the study and speaking to YP in clinical sessions on my current placement and YP within Young Dynamos. I tried to ensure that the interview topic guide and prompts were open so that participants could discuss their own experiences. I also had an assumption that MHD are something that caused the YP distress and that accessing support was an aim and seen as something that could be helpful. I was also aware that YP might have different views on this too and to allow them to speak about their own experiences and views around MHD in the interview.

Chapter 3- Results

This chapter presents the results from the study. Firstly, I will present an overview of the sample and 'pen portraits' for each of my four participants. These pen portraits include key themes that stood out from individual analysis of the individual participants' interviews. The group analysis is then presented with a detailed discussion of superordinate and subordinate themes. My reflections are included throughout in 'reflexivity boxes.' Quotes from participants are included in both sections in italics and line numbers are indicated. If quotes have been merged, this is indicated by '…' and both line numbers are provided.

Overview of participants

Participants were four female YP aged from 16-18 years from ethnic minority backgrounds who had accessed and engaged with CAMHS for their MHD in the past two years. Demographic information about each participant (which is important for putting their experiences in context such as age, ethnicity, MHD, referral route to CAMHS and how long ago they were discharged from CAMHS) is provided in Table 2 and is also discussed further in the pen portraits. For confidentiality purposes I will give an overview of other demographic information such as their immediate family and household and their further education. One young person had no siblings with one having one younger sibling and the other two having 1 older and 2 younger siblings. All four lived with both parents at home. All four of the participants were in further education – studying for A-Levels and/or B-techs, all were studying a Psychology or Health and Social Care subject. All of the contextual information about each participant was provided by the participants in their interviews rather than service records. Therefore, for some of the presented information, such as time spent being seen by CAMHS (Table 2), approximations are given from the information provided if participants could not remember exact details.

Table 2. *Demographic information of participants*

Participant pseudonym	**Age**	**Self-description of ethnicity**	**Self- description of MHD**	**Referral route to CAMHS**	**Input within CAMHS**	**Time discharged from CAMHS**
Nadira	16	British Bangladeshi	Anxiety (suicidal ideation/attempts)	A&E then accessing CAMHS	Two short-term crisis team inputs with follow-up sessions with community CAMHS clinician (no information provided on amount of sessions/length of each input)	~1.5 year ago
Raeni	17	British mixed heritage (Black Caribbean and White)	Anxiety and OCD	School counsellor referral to CAMHS	Approximately a few months of weekly CBT therapy sessions with a community CAMHS CBT therapist	~ 1 year ago
Chloe	18	British mixed heritage (South East Asian and Black Caribbean)	Anxiety, misophonia and OCD	GP referral to CAMHS	Approximately a few months of weekly CBT therapy sessions with a community CAMHS trainee CBT therapist	~2 years ago
Syeda	16	British Bangladeshi	Anxiety and low mood (suicidal ideation/attempts)	A&E then accessing CAMHS (was on waiting list for CAMHS from GP referral too)	One short-term crisis team input with one follow-up session with community CAMHS clinician, 1 longer-term input (crisis team support then weekly sessions with a community CAMHS psychiatrist for approximately a couple of months)	~6 months ago

Pen Portraits

In this section I will introduce each participant. I interviewed four female YP called Nadira, Raeni, Chloe and Syeda. I will give a summary of each participant, give an overview of their journey to CAMHS and discuss individual key themes from each of their interviews. I wanted to ensure that each participants' individual stories were presented in this research as well as similarities and differences across all four interviews for the group analysis. Because of this I have provided an overview of key individual themes that came from each of the individual interviews in the pen portraits, the presentation of these key themes is separate and different to the group analysis themes (although each account has been part of the group analysis). Text that is emboldened indicates a theme from the individual analysis. Terms each participant used will be used throughout this write-up such as 'mum', 'dad' and 'aunty'. Most participants also said that they would describe their time being with CAMHS as being 'seen by CAMHS' so this will mostly be how their time with CAMHS will be described below. I have provided my reflections at the time of interview in the main body of text but have included any reflections whilst writing this thesis up in text boxes.

Nadira

Nadira was the first YP I interviewed. She is 16 and identifies as British Bangladeshi. Both of her parents were born and raised in Bangladesh, they married and then emigrated to the UK where they started their family. Nadira discussed how her first language is English and that she is *"not good at Bengali" (line 173)* whereas Bengali is her parents' first language and they are *"not good at English" (line 164).* She has found that her sister who speaks Bengali fluently and her maternal aunty has been helpful in acting as a translator when she has not been able to communicate about some of her feelings and experiences with her parents. Nadira discussed how she is a Muslim but that she is "*not that religious" (line 307).* She says she has recently chosen to start wearing a headscarf but does not wear it all of the time. She said her parents are more religious than her but encourage her to make her own decisions about things such as wearing her headscarf. Nadira has been to Bangladesh on numerous occasions with her family. Nadira described how she did not feel that different in terms of ethnicity from peers at school or where she lives as she lives in a diverse area.

Nadira said she wanted to take part in the study as she wanted to *'help others'* as she had found that '*CAMHS was helpful'* for her. She chose to have the interview in a participating Trust NHS building and her older brother accompanied her to the interview but sat outside. The interview lasted for 1 hour and 12 minutes.

Journey to CAMHS.

Nadira described her MHD as mainly being around anxiety, feeling overwhelmed and having panic attacks. She said she received a diagnosis of anxiety from CAMHS. Nadira described two brief periods with CAMHS and that both times she accessed CAMHS input through attending A&E in acute distress after taking an overdose of tablets. She was then seen by a CAMHS clinician on the ward and then had some follow-up appointments in the community before discharge. She saw a different CAMHS clinician each of these times.

Before her admissions, Nadira had been struggling in school with anxiety and panic attacks, which were affecting her in her lessons. Nadira accessed pastoral support at school for this but as her MHD deteriorated, her school teachers called in her parents to suggest that they needed to take her to the GP to access more formal MH support through CAMHS. Nadira described her experiences with the GP as ‘unhelpful’ as they said they “*can’t do anything about it*” *(line 357)* and this did not lead to any referrals to any appropriate services such as CAMHS for support. For her first admission, Nadira was advised to attend A&E by her GP and was sent to A&E in a taxi by school the second time. Nadira was not clear of the details and timeline of these experiences. She was then told that CAMHS would come to see her by the physical health doctors on the ward.

Nadira reported that she found it most helpful to speak to the CAMHS clinicians about her difficulties as she felt like they listened to her. Nadira felt that her second input with CAMHS was the most helpful as she felt the clinician ‘listened to her more’ and signposted her to other places that could support her. She also reported that a translator was used with her parents during her second time with CAMHS which she found helpful– she could not remember whether this was the case with her first input from CAMHS. Nadira said that she was not aware that she was going to be discharged in advance of when her sessions stopped but that she felt OK about this as she felt better and knew where she could go for support if she needed it again. She was discharged from CAMHS over a year ago.

Nadira felt as if her experiences accessing and whilst being seen by CAMHS were not impacted because of her ethnicity. She described that both of the clinicians she saw were white but felt like this did not affect her experiences. “*They were white… I was OK with it, I don't really mind… even if I feel like, when I saw the person from CAMHS so, he's* *seen other cultural people as well. So if I explained to him, he would understand." (line 590).* She at first reported that she felt personally like it did not impact her experiences but that it might impact other people from different backgrounds to their clinician: "*No cos my story is different to others, others they might think about their culture and other people might not think about their culture" (line 673)* but then discussed how because her last CAMHS clinician was from a different background, he might not have fully understood her parents viewpoint and that this might have been different if he had been from a similar background: "c*os then he would know like, erm how my parents, what my parents are thinking or what my parents wanted to say, how they look at my point of view as well and that kind of thing...Yeah I think that was missing, but because of the translator it was OK" (line 638).*

Main themes from interview

From Nadira's description of her experiences, a key theme coming through her account was that there were multiple **differing perspectives** about her experiences and what would be most helpful to support her. She had various input from others who were interpreting her experiences differently and suggesting different things as ways to help her feel better. These included her own shifting understanding about what was happening for her and also perspectives from her family (including parents and her aunty) and their family, cultural and religious beliefs around MHD, school's perspectives and then perspectives from services such as her GP, A&E and then CAMHS. These will be discussed further in the group analysis sections below. There was a real sense of **confusion** from these perspectives around her MHD and what was going on for her, and also what would best help.

Another key theme coming through Nadira's description of her experiences was her initial **physical understanding** of her MHD and explanation of her difficulties at the time. She described a sense of confusion about what was happening: "*It was kinda confusing, I thought I was having a heart attack because I saw movies and they were like put their hand on the heart, and like [Breathes heavily] so I thought I was having a heart attack" (line 225).* Nadira discussed how it was her first-aider at school that firstly gave her a different way of understanding of her experiences and that she was not experiencing a heart attack and that it was a panic attack instead. She also had an individualised view of her problem that her admission to A&E was a mistake and she should have 'dealt with it better': "*I took* *it too deep. It was just, I was more stressed about friendship and stuff and school" (line 132)* and that it should not have happened as she was a *"nice girl"*.

Nadira described that her **parents were 'upset' and 'shocked'** by finding out she was struggling through school and not understanding these experiences: "*my dad knows how I am and he found it kind of shocking cos I'm always helping others...I even did...I really like helping others" (line 277).* It seemed as if Nadira and her family had an understanding that 'being a nice person' would protect from MHD. There was a sense that MHD were not discussed within her immediate family *"I told my mum, but my mum...she's not good at English, she doesn't even know about this stuff a lot" (line 164)* or family culture *"some people, that are Bengali, they don't know erm what mental health is, they only know, they think it's like for people that go to a mental hospital". (line 568).* She said that their differing first language affected her ability to communicate and express how she was feeling to her parents and that they were unsure of how to help her during this time. Nadira described how her parents were supportive of her in practical ways of attending appointments with her but not emotionally supportive of her *"my mum would come but she's really like emotional so my dad would come as well and they would cry sometimes as well, saying like ah we didn't expect her to do this because she's a really mature girl." (line 202).*

Nadira described **difficulties in expressing herself**, this was both in terms of it being harder to communicate with her parents because of their differing first language: "*Yea, cos er I want to tell him how I feel, I'll say like mum I feel a bit down but that's the only thing I can say to her" (line 534)* and also to others, teachers at school and her GP: "*sometimes my English isn't very good, I honestly get words, I start talking and then I forget half way through" (line 537)*".

In the interview, Nadira seemed to **minimise experiences** including those around her admission to hospital: "*it wasn't that deep. I took it too deep. It was just, I was more stressed about friendship and stuff." (line 132).* However, she also described how her A&E doctors and school felt like her MHD were **serious** too: *"I had to talk to the doctor as she was not comfortable to talk to me and she was saying I think you need to go CAMHS because you seriously need someone to talk to… I want you to see a CAMHS doctor in the morning she will tell you how to overcome your feels and stuff" (line 140)* and school said "*unless you have a medical note you can't come back to school so I had to wait for three* *weeks to calm down, then CAMHS gave me a medical note and with that medical note I went back to school" (line 236).* This seemed to build a picture of Nadira having a sense that she was experiencing something 'serious' that was 'not normal'.

Nadira describes how she was not sure what CAMHS was or what the input would be as her understanding of MHD came from the dominant Bangladeshi culture she grew up within which saw mental health as only being for 'mental people' and so was initially worried that she was going to have input from CAMHS: *"So when I came to CAMHS, I thought I was going to go to mental hospital… So, I kind of like scared…. When I found out that was just I could talk, I like…. it's worth it and I like... it actually helped me a lot" (line 571).* Nadira discussed how CAMHS was a very helpful experience for her, particularly the second time and there was a sense of a pre and post CAMHS difference in feeling understood and heard. There was a sense that her experiences were **normalised** and **validated** and that as the CAMHS clinicians were not shocked by her experiences and listened to her this led to her feeling more contained which helped. The second CAMHS clinician giving her information on where she could go for support in the future seemed to provide her with a sense of safety and certainty that she could be supported again or not feel so alone again in future if she were to experience difficulties again

Reflection on the interview

Nadira was my first participant and I was both apprehensive and enthusiastic going into this interview. I found Nadira to be very open and chatty, there was a sense in the interview that she was wanting to make sure she was helpful to me and that she 'wanted to give back'. I was already primed to this because she said that is why she wanted to participate but a couple of times in the interview she also started an answer with "*oh yea, I don't know if this is helpful or not but when…" (line 407).* Nadira also made reference to the fact she sometimes struggled to express herself 'even in English' throughout the interview and at some points I did struggle to understand some words she said- this made me reflect on her description of people sometimes finding it hard to understand her and the parallel process of this happening for me in the interview too. I found myself saying '*yea*' and '*mhmm*' a lot during the interview as she was talking – after the interview I reflected on whether I did this as it was my first interview and I was nervous and trying to make her feel comfortable or whether I would have still felt the need to reassure her whilst she was talking because of how she was in the room even when I felt more comfortable with conducting the interviews.

At the end of the interview, Nadira reported that she enjoyed participating: *"It was actually good cos I got to talk about it" (line 692).* This made me think about how she might not have had an opportunity to talk about her experiences without taking part in the interview and it seemed to be a helpful experience for her. It also made me think more widely about how this might be the case for many other YP that have been discharged from CAMHS who might not have had the opportunity to talk about their experiences, although this is unlikely to be a helpful experience for all YP.

Raeni

Raeni was the second YP I interviewed. She is 17 and identifies as being British and mixed race. Her maternal grandparents are from a South East Asian country and her mum was born there too but was brought up mainly in England. Her parental grandparents are from a Caribbean country. Raeni discussed how she was uncertain of whether her dad was born in Britain or the Caribbean but had grown up in England too. Both of her parents first language is English and this is the language they communicate in at home. Raeni said that her family are Christian, her dad is stronger in his faith than her mum but overall "*we're not like strong with it, and go to church every week" (line 757).* Raeni said that she attends a diverse school and has never thought about her ethnicity and whether it has affected her experiences: "*I know that my background is very complicated like different places but it's just, it's not really been an issue" (line 246)* and "*it's very, cause there's a lot of mixed in school, so, yeah, it's normal" (line 1070).*

Raeni said she wanted to take part in the study as she was studying subjects where it would be interesting to find out more about research studies. Raeni chose to have the interview take place at her house, this was the only interview that took place at the participant's house. The interview lasted for 1 hour and 15 minutes.

Journey to CAMHS

Raeni reported that she received the diagnoses of anxiety and Obsessive Compulsive Disorder (OCD) from CAMHS. Raeni described that she had struggled with her mental health since she was in primary school. She said that her mum 'noticed' her difficulties and things she struggled with before she did and has been trying to find therapies to help her since. She described 'trying' counselling, homeopathy and other services she could not remember before accessing CAMHS. Raeni discussed how she accessed CAMHS through a school referral. Raeni said that she had shared with school her difficulties who then referred her to the school counsellor. She saw her school counsellor for numerous sessions who then suggested that she would benefit from accessing support with CAMHS and they agreed that the school counsellor would refer her to CAMHS. Raeni said she and her mum had gone to the GP in the past (before her school had referred her to CAMHS) and did not remember that anything ever came from these appointments such as any referrals for support, therefore, mum independently sought treatment out for her instead. Raeni said that she felt it was 'better' that the referral to CAMHS went through school instead of the GP as she felt school had more influence than the GP in getting the referral accepted, especially as they had already been doing sessions with her: *"No, I think it was good that it went through the school counsellor, cause I feel that that's like the, more influence than the GP, because like, I don't know, the counsellor like having sessions with me thought that was best" (line 680).*

Raeni said that she accessed Cognitive Behavioural Therapy (CBT) within CAMHS for a couple of months and then told her mum she wanted to stop these sessions as she found the focus of the therapy unhelpful and felt the CBT therapist was pushing her too quickly with the tasks in and out of sessions which was making her more anxious. Raeni said she did not feel able to share this with her therapist so just told her mum who then let the therapist and CAMHS know and then she was discharged. Raeni said she has tried other treatments since her CAMHS discharge, such as hypnotherapy, but that she has still not found any therapy as helpful as homeopathy for her MHD. Raeni reported being discharged from CAMHS just over a year ago.

Raeni described how she did not feel as if her ethnicity played a role in her input with CAMHS "*I never thought that I was treated differently, no" (line 1066*) or her experiences in life more generally. She said that her ethnicity or family background was not discussed in CAMHS "*No, I don't think we ever talked about it other than like getting the background information like, I don't think so. (line 974).*

Main themes from interview

One of the main themes coming out of Raeni's interview was a sense of **searching for the right therapy** for a long time. She described struggling with her thoughts and feelings and that she knew she 'wasn't normal compared to the others' since primary school. Throughout the interview, Raeni discussed how she felt that that homeopathy had been the only helpful therapy for her, and that CAMHS had not been helpful for her. She used words such as *"eventually we found homeopaths" (line 349)*, suggesting that she had been trying to find something to help 'cure' her difficulties for a long time. She said that homeopathy was helpful as it: "*like stopped, like the whole anxiety basically, and I felt that was it I thought yeah I've finished, then it came back" (line 355)* and that "*think the only positives, treatment, therapy that I got, was the homeopathy, that was the first time I did it, because I don't think anything else worked" (line 1158)*.

There was a real sense from Raeni in the interview that **she and her mum were a team**, trying to seek out support that would help her 'get rid' of her MHD. She described how her mum was continually researching different therapies that could be helpful for her. Raeni described that there was a shift from when she was younger: *"I think the early therapies and stuff that I don't really remember that much was my mum, like trying to seek out for me" (line 385)* to when Raeni was older and able to discuss with her mum. Throughout the interview, Raeni used 'we' to describe her and her mum going through these experiences together: *"We did do lots of like therapies, we went to lots of people" (line 344)* and "*I think it was just like you knowing between us that we did want help, that we did make that go away." (line 385).* Raeni described a difference in how much she would share with her mum and dad: "*I don't know, like he knew it was going on, but he just, he never really asked me about it, he never like took part or was a part of it, you know" (line 407)* and "*I don't really tell him, like it's hard to speak to him about all that side" (line 425).*

Raeni discussed how she initially felt like her CBT therapy was helpful but then felt as if it was going too quickly as it had a "*focus on the most anxious thing...rather than just going like steps, it was almost like she was pushing me too much, like, yeah, and it didn't feel, like I just didn't want to do that anymore" (line 1088).* Raeni said that she felt **unable to share** with her therapist and instead told her mum she wanted to stop "*I feel like the CBT part that she like did, the therapy that she did, could have been more gradual instead of being straight in focussing on it as well so much, and that's why I stopped because it just made me like feel worse, yeah" (line 870).*

Throughout the interview there was a sense of **things unsaid**. She described how no-one in her family knew about her MHD except her mum, dad and brother. Raeni described one incident with her dad which hinted at events in her family history that were not spoken about: *"There was one time when I was having a panic attack, I was upstairs…mum and dad knew, and my dad was like, I think he was just frustrated and he was like well this is how someone else was before something happened, I don't really know what he fully said, so maybe there was someone, like I don't know, no one's told me anything about it" (line 508).* She also described not having spoken to her dad about his life or history "*I don't know if he was born there or in England" (line 486)* or speaking to her family or friends about her experiences: "*I don't tell like my friends or anyone else really as much as my mum, but I also don't tell mum everything as well, like, I hide a lot of things, it's like, so, yeah, I do tell people but not everything" (line 570).* Raeni also described how she did not think that her ethnicity had any impact on experiences but that she had also not really considered it: "*No, I never, I think on a basic level I do think I'm like British but then it does get complicated, yeah, no I've never really thought about, I don't know" (line 1036)* and that she had not discussed this with her mum or dad *"Not really, I know like, where I'm from, like country-wise, like the basic thing, no I've never talked to them about it" (line 256).*

Reflection on the interview

Raeni did not elaborate on answers as much as the other participants and at times gave very short answers and so this felt like a harder interview to facilitate. To a lot of follow-up questions, she reflected that *'I've never thought about it"(line 986)* or *"I don't know" (1152).* It made me wonder whether this was because she had never thought about the topics we were discussing or whether she had and minimised her experiences or did not feel comfortable sharing her thoughts on these with me. In answer to a prompt about whether she felt her ethnicity had affected any of her experiences when she said: "*No, I never, I think on a basic level I do think I'm like British but then it does get complicated, yeah" (line 1036),* I wondered whether she was saying that her background was complicated to me as a white person or that she herself felt it was complicated. I felt a pull to explain why I was asking these questions, although I was aware that we had gone through the information sheet where it had explained about why the study was recruiting YP from an ethnic minority background to explore their experiences. I also reflected that it might just have been that Raeni did not think her ethnicity was a 'big part' of her identity that affected her experiences.

Chloe

Chloe was the third YP I interviewed. She is 18 and identifies as being British and mixed race. Both of her parents were born and raised in England. Her mum is black and her maternal grandparents moved to England from the Caribbean and her dad is white and her paternal grandparents are from England. Chloe and her parents all speak English fluently as their first language and this is the language mainly spoken in the home, Chloe and her mum also speak their local Caribbean dialect at home too. Chloe said her mum is a Christian, her dad is an atheist and she is ‘somewhere in-between’. Chloe was the only participant that explicitly talked about her ethnicity and culture and difficulties she has experienced growing up because of this. She said that she was the only one of her ethnicity in her primary school and for a lot of her time at secondary school.

Chloe’s reasons for taking part in the study were “*I thought it’d be good research I thought I’d be able to put my point across and I thought it’d be quite helpful”* (line 1784), she also said that she was interested in the results to inform the subjects she was currently studying. We carried out the interview at the UoL, Chloe’s mum dropped her off at the university but she came alone to the building. The interview lasted for 1 hour and 48 minutes.

Chloe talked a lot about her ethnicity in relationship to her identity and how this affected her growing up. She described struggling to work out where she fitted at school and home throughout the interview and felt like there were differences between her parents’ parenting which she attributed to cultural, as well as gender differences. In the pre-amble at the beginning of the interview where I asked general questions about the participant’s life, Chloe started to discuss her experiences because of her ethnicity straight away in answer to a question about how she was finding school: *“If we’re talking about like ethnic and racist stuff I’ve found it... it’s quite a mono-cultured area I’d say… at my primary school, and at my high school it wasn’t that diverse at all so I always did feel quite different to everyone else, and I never knew why until I got to high school… I do think that growing up in quite a working class but quite mono-cultured area has affected my experience, yeah” (line 161).*

She also reflected on feeling different within her household too: “*when I’m with my mum’s family from the Caribbean I feel too British but then when I’m with my dad’s family, I feel too Caribbean and we do stuff that’s different to each world, I’ve never really known where I fit in really.” (line 328).* She described how she did not feel able to share this with her mum or dad: "*wouldn't talk with my dad but I don't know what he would have said, cause he doesn't really, he would have just made me feel better, he wouldn't have really known what to say I don't think." (line 303) … "it's, probably conscious with my mum but unconscious with my dad." (line 340).* She felt as if her mum was much stricter than her dad, especially around her education and understand this in terms of their differing cultures and upbringing.

Journey to CAMHS

Chloe describes her MHD as anxiety, misophonia (a sensory difficulty to noises that can cause emotional and physiological responses; NHS, n.d.) and OCD. She said that she had a sense of the name and 'diagnosis' from researching on the internet with her mum for the first two difficulties but that CAMHS also gave a diagnosis OCD when she accessed support. She discussed how she had not seen misophonia as a MHD until her input with CAMHS but still did not explain it as a MHD to other people: *"I'd say it is mental health, if I'm telling people…I tend to say it's a sensory issues cause people grasp that I think easier… more than trying to explain that something like eating physically hurts my head…" (line 743)…"I thought mental health was anxiety and stuff like that…, it was only post having the treatment that I thought of it as a mental health condition" (line 759).*

Chloe described that she noticed difficulties "w*hen I was seven, so quite young, really young…I didn't know what it was I just thought I was a bit weird" (line 484).* She had shared that her mum noticed she was struggling in certain situations such as meal times when she was older. Chloe described that she had a panic attack when she was at secondary school and this led to her and her mum searching together on the internet about her experiences to try and understand what was going on for her. Chloe described that her dad was aware of her MHD but it was not something they ever talked about: "*my dad still doesn't know really what's up… he knows that have got some things that I do to calm myself down but he just doesn't really understand, not that he's not tried to understand he just can't get his head round it" (line 677).*

Chloe said that as she felt her MHD getting harder to deal with alone, she made an appointment with her GP who then referred her to CAMHS. She had an awareness of CAMHS through her mum who said that CAMHS helped those struggling with MHD. Chloe went to this GP appointment alone as she had been going independently to the GP for the past couple of years. Chloe said that neither she or her mum had shared her MHD with her school or her wider family.

Chloe accessed CBT within CAMHS with a trainee CBT therapist after some time on a waiting list. Chloe said that she was struggling with a few different things at the time of starting therapy and that she was told to ‘pick an issue’ to work on within therapy. She said she felt she had to make this decision ‘on the spot there and then’ which she found difficult to do and did not feel able to share this with the therapist. Chloe described her discharge as difficult as she had not felt ready to be finished with the input and felt as if she had no other support outside of this still. Sometime after discharge, she shared her MHD with a teacher at school as felt she needed additional support during her exams who was very supportive and found a support group for ‘people with misophonia’ for Chloe on Facebook as well. Chloe said she feels has been the most helpful thing for her so far as she had still felt alone and not understood with her experiences of her MHD even after her input with CAMHS. Chloe had been discharged almost two years ago from CAMHS when she was interviewed.

Chloe firstly discussed how she did not feel as if her ethnicity had affected her experiences of her MHD or her time during CAMHS: “*Possibly for someone else, cause everyone I spoke to was white British, but I don’t feel like my mental health condition really is affected by cultural differences and I feel like they’re all very professional they all understood what was going on” (line 1491).* She then went on to describe how it might have affected her experiences on occasion and described a time where her therapist seemed shocked when her dad came with her to a session once: *“I didn’t feel like I was treated any differently, but I think there was a possibility that I was treated differently” (line 1582) …“I don’t know, just cause like when I … went with my dad to one of the sessions, and I don’t know if it was that they were shocked seeing me with a different person or shocked to see me with someone that was white” (line 1586).*

She discussed how her mixed heritage was never discussed and she felt like it would have been helpful for her and her therapist to talk about it: *“Possibly, yeah definitely I think that might have helped, me get across my personal circumstances better” (line 164)… “so that they’ve got a better understanding of me and my background as well, I think it could have helped when I was talking about my family, cause quite a lot of my triggers are the family…I think that could have been discussed that it might be a cultural difference rather* *than just a family difference and that could have helped me understand and better approach situations I'd say." (line 1645).*

She also described how she felt as if she did notice a difference in how she felt attending appointments in a building where there was more diversity in people in the building than, for example, her GP surgery: *"I felt comfortable there so, cause it was quite diverse, and then when I went to my GP at home it was normal for me ... but equally it was looking round and everyone looks the same and it was like I wonder if they all think that I'm the same" (line 1707) ... "I definitely, and at the time, that's not just hindsight either, at the time I remember going in and thinking this is so much more multicultural, it's really a nice environment" (line 1721).*

Main themes from interview

A main theme from Chloe's interview was her experiences of her identity and often **feeling different** and **feeling alone** because of her ethnicity but also because of her MHD. She described that she felt very alone particularly for her MHD for a long time. She said that MHD such as anxiety and depression were discussed a lot at her primary and secondary school in things like assemblies but that she had not recognised the things she was struggling with as being MHD until she went to her GP.

Chloe described a journey of not being aware that her MH experiences were difficult (as well as her experiences of ethnicity) to then **keeping these experiences a secret** from people to then having some **positive experiences of sharing** with people. She described that she found some part of her CAMHS experiences helpful, such as being able to talk to someone external to her family and friends about her life and MHDs in depth and that she learnt about some more helpful ways to cope. She described finding talking to a psychology teacher at school who found a Facebook support group for her as the most helpful thing as she felt like she had a space where people understood her experiences and she **felt connected** to people. She said that she had not yet shared her experiences on the FB support group but had just found reading other people's posts very helpful.

Chloe described her experiences when growing up of trying to work out who she was and where she fitted within her context. A theme of **becoming more comfortable and confident** with her identity and experiences and **speaking out** also came through Chloe's account. Chloe described that this was more in relation to her ethnicity and being able to speak to peers about feeling very different but that she also had been able to share with friends about her MHD too. She described how she found the subjects she is currently studying helpful for her to learn about areas such as ethnicity and discrimination. She said this has provided opportunities and has **empowered** her to talk to her peers and teachers more about her own experiences.

Reflections on the interview

Chloe's interview was the longest interview out of the four. She seemed warm and open in her answers throughout the interview. She appeared engaged and as if she had thought about her experiences and what she wanted to share with me before the interview. Chloe independently brought up a lot of experiences of her ethnicity and her MHD and her journey into CAMHS and seemed comfortable in talking about these experiences – she described how she had had a lot of conversations about these already in her lessons at school. I reflected both during and after the interview that this meant I had not needed to use as many prompts from the semi-structured topic guide as with other participants. I also felt as if I recognised some of her experiences from conversations I had with supervisors and Young Dynamos as well as peers whilst planning the project and from my reading of the literature. I wondered if this meant that I did not follow up on some of the topics she brought up to gain her understanding as I should have in the interview, for example, around her sense making of generational and cultural differences on parenting and also understanding on issues such as MHD.

During the interview, Chloe got quite tearful speaking about some aspects of her experience. She did not want any breaks and wanted to carry on – she said she was OK and that it was just because she had not spoken about a lot of things in depth for a while "*I've not thought about it for a while yeah, so I've blotted it out" (line 536).* She said although she was used to talking about her experiences of ethnicity, she was not used to talking about her MHD. I found this difficult to manage as it then meant I was asking her questions whilst she was upset but I felt like I should accept her decision that she wanted to keep

Reflexive Box 1. Reflection on Chloe's pen portrait write-up.

I was aware when writing up Chloe's pen portrait that this section is much longer than other pen portraits. The interview was longer than the others and I was conscious that I wanted to make sure I gave a proper overview of her interview and experiences as I have the other participants but felt like to do this meant that this section would be longer.

going without a break in the interview and she did not appear to be distressed enough that I felt like I should pause or end the interview.

Syeda

Syeda was my fourth and final YP I interviewed. She is 16 years old and identifies as being British Bangladeshi. Her mother was born and raised in Bangladesh, her father was born and raised in England but his parents are from Bangladesh and emigrated to the UK before he was born. Syeda says that English is her and her dad's first language but that he can speak Bengali fluently too, she says that her mum has limited knowledge of English so they tend to speak in a mixture of Bengali and English together at home. Syeda has been to Bangladesh with her immediate family to visit wider family. Syeda is a Muslim and said in the interview that she is *"not as religious as she should be*" (line 1073). She said that the area she lives in and her primary and secondary school was mixed and that *"it's kind of normal to see a lot of diversity around" (line 260)*.

Syeda also wanted to take part in the interview as she thought it would be a good opportunity to learn about being a participant as she is currently learning about research studies. We carried out the interview at the university, she came with a friend who waited in a local café during the interview. The interview lasted for 1 hour and 27 minutes

Journey to CAMHS

Syeda describes that she was given diagnoses of anxiety and depression from CAMHS. She talked about how in hindsight she realised she had been struggling with these difficulties since primary school but was not aware of 'what it was'. She did not share these difficulties with anyone until secondary school. She said that she started to experience panic attacks frequently at school so was referred to the school nurse for sessions. She said that these did not help so her teachers called in her parents for a meeting to say that they should take her to the GP as she would benefit from a referral to CAMHS. Syeda described going to the GP twice, the first time she went with her mum and described finding it difficult to 'open up' as she felt uncomfortable. She said that she went by herself the second time and was able to be 'more vocal' about her MHD. Syeda reported that from this second appointment she was told she was being referred to CAMHS but had no awareness of what CAMHS was. She was then told she had been put on a waiting list for CAMHS but had forgotten about this referral by the time her MHD reached a level where she required two hospital admissions when she was in acute distress. It was unclear whether Syeda had taken, or was planning to take, an overdose of tablets as she described putting tablets in her mouth. When in hospital for the first admission, she was seen on the ward by a CAMHS clinician. She said she had a follow-up appointment due in the community but then was admitted for a second time. She was then assigned a psychiatrist and attended weekly sessions for a couple of months whilst also seeing a youth worker with a separate third-sector agency in parallel. She agreed with her psychiatrist's suggestion to discharge her from CAMHS about six months ago and this was also around the time her input with the youth worker stopped.

Syeda described how she felt it was for the best that she had to have two hospital admissions to then access CAMHS as: *"I think it is better how it kind of played out I feel like because the hospital admission I feel like kind of made my parents understand how serious it was, whereas if it was just like a referral they'd think it was just like an appointment type thing, I don't think they'd understand how severe it actually was." (line 901.)*

She described seeing her youth worker as a lot more helpful for her than her sessions with her CAMHS clinician. She described that this was because of the content of what they discussed in sessions but also because she felt like she could relate to the youth worker better because of their shared characteristics: *"the youth worker…. she was really helpful, her one to one sessions were actually really really helpful… she was Asian, so she was Pakistani and she was female, she was easier to relate with" (line 984).* She also described how she felt like gender was the most important factor for her in her experiences with MH workers: "*[the] sessions with the psychiatrist that I was assigned, in CAMHS, they weren't helpful at all" (line 967) … "I think that is because, I think it's because, mainly because it was a man and not a female." (line 979).* Syeda said that she did not feel able to share with her clinician that she would have preferred a male worker*: "I'd feel like I'm just causing too much trouble…. I don't know, I felt like it'd be, I'd hurt his feelings, I don't know, I just felt unkind" (line 987).*

Overview of interview

A key theme that emerged from Syeda's account was the **need for people to take her seriously** and **understand** her. Throughout her account, she discussed people in her life that did not seem to 'understand' her MHD and that she was struggling (her mum, wider family such as cousins and her school counsellor) and people that understood her MHD and the impact it had on her (her sister, dad and her youth worker). The factors Syeda discussed when talking about how or why she felt people understood her were if she felt they were taking her seriously and seeming to actively listen to her. She felt if they made jokes about her or did not appear to give her their full attention that they did not understand her.

She described family (both immediate and wider) views on MHD and that her mum did not understand her experiences. She described a **difference in how she related to each of her parents** which affected how much she felt understood by them. She discussed how she felt like she could speak to her dad more and that he understood her experiences better because they both spoke English as their first language *"it is easier to speak to my dad because obviously there isn't that language barrier cause I'm not as good in Bengali, like I don't know the technical terms for stuff." (line 526)* but also because her dad also grew up here *"cause my dad is from here so he understands more, so my mum doesn't really." (*line 1539).

She described a sense of **not wanting to share her experiences** or for her family to share her experiences: *"those from back home they just thought I was ill they didn't know what it was, they just said oh are you still ill...because they wouldn't understand it they'd just laugh at it" (line 654)* and that blame was assigned to those that experienced MHD in her culture *"some days you're happy, and there's, it's your mind like you just have to think correctly and there's, that's just it, it was just happy or sad." (line 620).* Despite her feeling as if her dad understood her better, she still described a sense of worry and surprise from her parents when school informed them of the difficulties she was experiencing: *"they were really worried, yeah, I think it was just they were really worried they just didn't know what to do." (line 735) ... "my parents keep saying how I'm a really young age and they don't understand" (line 384) … "I think they were kind of surprised cause they never expect it." (line 429).*

Syeda also received many **differing perspectives** about her MHD from others in her life. She described how her religion played a part in her experiences, both in changing her behaviour when she was really struggling to cope but also how her family encouraged her to pray more. She described getting various input from school – talking to her teachers, accessing support through the school nurse and then the school counsellor, then accessing the GP and then CAMHS and other services such as the youth work team. She described finding her sister very supportive and seemed to put this down to her sister being a good listener *"she understood that…like some people when they speak about it they're kind of put it back on themselves not actually listen to you they speak about their stuff, whereas she, she's a good listener, she lets me speak around, she will, yeah she's really supportive." (line 558).*

Syeda described how the input from CAMHS and her youth worker helped her in different ways. She described that she found it helpful that CAMHS gave her a label and a concrete 'diagnosis' for her experiences, helping her experiences to feel **validated**: "*my psychiatrist at the time…he kind of told me that I had like depression and anxiety, before that I just thought it was just anxiety" (line 360).* This also seemed to **normalise** her experiences for her and helped to make them not seem scary which frightened her. Her dad attended some appointments with CAMHS with her too and this seemed to help her feel more understood by him.

Reflections on the interview

Syeda seemed to be open to speaking about her experiences with me from the start of the interview. She spoke about her experiences in a very measured and logical way, she gave dates for her admissions and wanted to tell me about her experiences in a chronological way. Syeda seemed to remember more detail than the other participants – she had been discharged most recently out of the participants but she also shared that she had chosen to share her experiences with two other people since she had been discharged. This made me reflect on the process of speaking aloud with people about experiences to make sense of them – as far as the other participants had shared, Syeda was the only one who said that she shared all of her experiences with her MHD and CAMHS with others afterwards and this seemed to be reflected in the way she gave a clearer account of her experiences and provided specific details such as dates in the interview. This was different compared to the other interviews where they said they had forgotten more of the timeline and details– however, her experiences within CAMHS were also more recent. This could have led to a sense that she did not find the process as confusing so I was aware of this when analysing her account as her descriptions of her time with CAMHS still seemed a confusing one for her at the time.

Syeda shared at the end that she found doing the interview a helpful experience for her as she said it helped her to refresh the timeline of experiences as she had not spoken about it all in long time.

Reflexive Box 2. Reflections on the individual analysis.

As described and expected, all participants had different experiences that they shared with me in the interview. However, I was struck by the similarities between Nadira's and Syeda's experiences. As I was aware that they both shared the same heritage and had similar family histories, I was cautious to not try and draw too many similarities or analyse their interviews differently because of this. I did reflect that I think I would have noticed similarities between their experiences such as them accessing CAMHS in very similar ways and struggling with speaking to their parent(s) who did not speak English even if I had not known their backgrounds but this cannot be known for certain.

I wanted to ensure that each individual story and experience was 'heard' and I found myself wanting to give a comprehensive narrative about all of the details to do each participants 'story' 'justice'. This was compounded as I felt like I did not want to focus on the wrong thing or give unjust analysis about the salient things from their experiences and interpretations around these, being from the majority ethnic group and also with the age differential. I utilised supervision continually during the analysis and write up process to consider this and the impact it was having on my analysis.

I was also surprised that three out of the four participants did not seem to think that ethnicity played much role (if any) in their experiences and reflected that those that felt this, reported that being around a diverse mix of ethnicities in their school and community environment was normal. Although they did not explicitly discuss their ethnicity having a role in their experiences, I wanted to make sure I had an open mind going into the analysis for their interviews in case things came up related to ethnicity, cultural or other differences in the interpretation of their interviews and lived experiences.

Group analysis

Whilst each participant had very different and unique stories and experiences, there were similarities across experiences for participants. These were grouped together into three superordinate themes, with subordinate themes within these. The three superordinate themes are: ‘**Difficulties in speaking out**’, ‘**Confusion: navigating multiple perspectives**’ and ‘**Evolving understanding of self and experiences**’. Although the similarities between the accounts have been organised into three superordinate themes, the experiences they capture are interconnected and related. The themes capture the shift and journey the participants described in their interviews – from when they were experiencing their MHD alone, to when these experiences were shared and/or noticed and then accessing support for MHD and how/whether this created any changes for the participants. These were not purely linear processes though – and the themes occurred and re-occurred across different time-points for the participants. There were also differences across experiences in themes too and this is described in the write-up of these themes below.

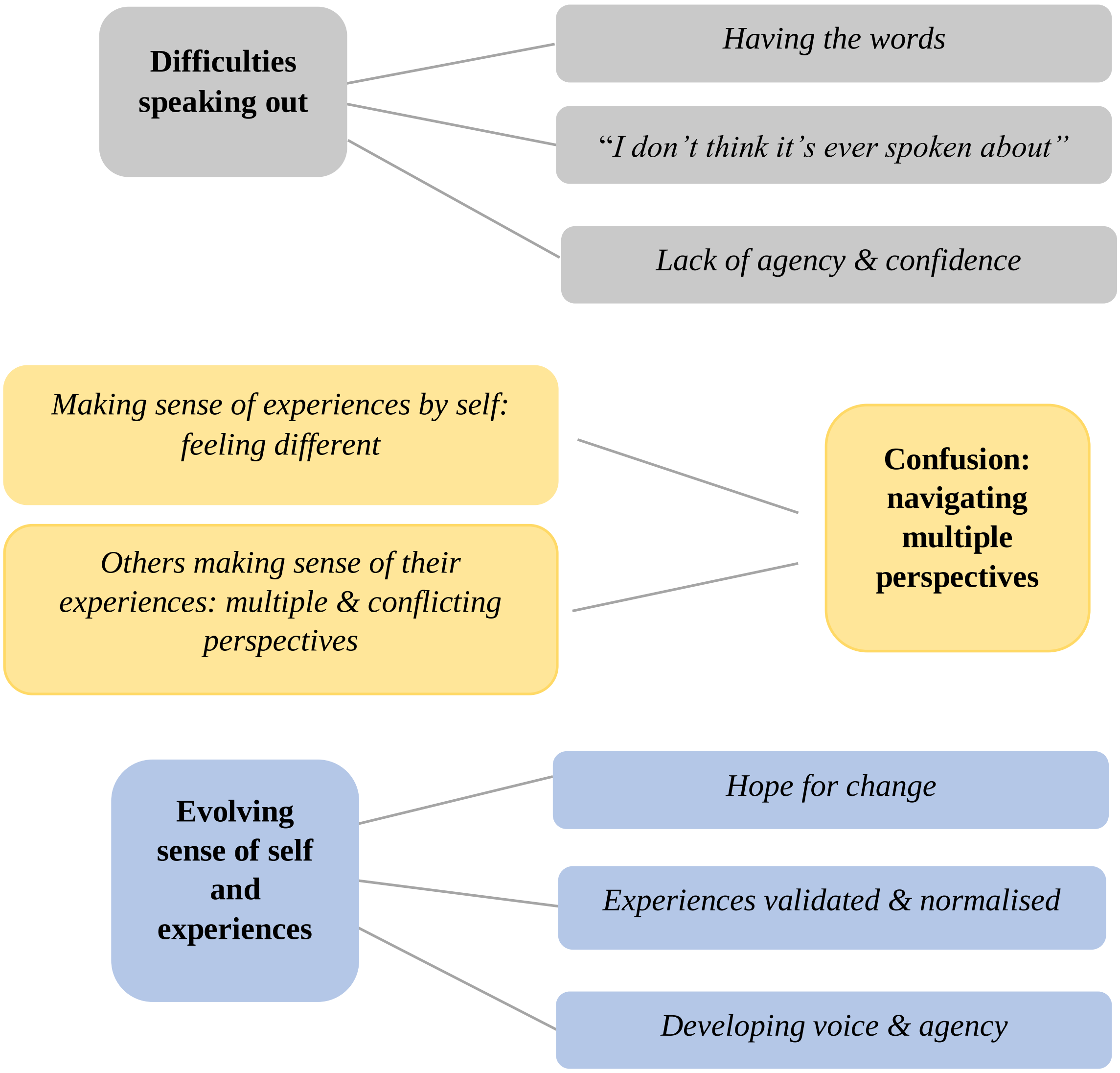
The results of the group analysis are represented in a thematic map in Figure 1. Table 3 shows the superordinate and subordinate themes and which of these represent each participant’s experience. Quotes have been included below to provide examples and to illustrate each theme.

Reflexive Box 3. Reflections on the wider context in which I undertook the group analysis stage.

Here, I wanted to reflect on what was going on in the wider context as I came to undertake the group analysis. I started the group analysis at the beginning of lockdown in England in March 2020 because of the COVID-19 pandemic. The current pandemic has again highlighted inequalities faced by ethnic minority groups, evidenced by the disproportionately high death rates from COVID-19. I was also in the process of refining my group themes during the time when George Floyd was murdered in America and the Black Lives Matter protests that were sparked from this around the world, which further highlighted inequalities specifically faced by black people.

Throughout this project, I have tussled with whether I am the ‘right’ person to undertake this research and felt responsibility to not perpetuate problems in this area, for example, through using unhelpful and harmful stereotypes of particular ethnic minority communities, and the current context compounded these feelings. This was something I continually discussed during remote supervision sessions to try and ensure that I continued to analyse the data using the IPA framework and not become too ‘stuck’ in making interpretations from the data because of this. However, I have endeavoured to make sure that the themes are still grounded in the data.

Figure 1. *Theme map of the group analysis superordinate and subordinate themes.*



N.B. The above theme diagram is presented to illustrate the three superordinate and eight subordinate themes and not to depict that the three themes are connected in a linear manner. The three superordinate themes captured are interconnected and related and occurred and re-occurred across different time-points for the participants.

Table 3. *Overview of group themes across participants.*

		Participants			
Superordinate Themes	**Subordinate Themes**	Nadira	Raeni	Chloe	Syeda
Difficulties speaking out	***Having the words***	✓	✓	✓	✓
	"I don't think it's ever spoken about"	✓	✓	✓	✓
	Lack of agency and confidence	✓	✓	✓	✓
Confusion: navigating multiple perspectives	***Making sense of experiences by self:*** ***feeling different***	✓	✓	✓	✓
	Others making sense of their experiences: multiple and conflicting perspectives	✓	✓	✓	✓
Evolving understanding of self and experiences	***Hope for change***	✓	✓	✓	✓
	Experiences validated and normalised	✓	✓	✓	✓
	Developing voice & agency	✓	x	✓	✓

Theme 1: Difficulties speaking out

This superordinate theme captures the experiences and '**difficulties speaking out'** that all participants had in speaking aloud about their experiences. Participants described difficulties in their ability to communicate with their parents about their difficulties, feeling able to speak out in terms of the stigma around their difficulties and the lack of self-confidence and agency to do this. Participants also described their experiences when they did 'speak out' or if their MHD were brought into the open by others. There was a sense from all participants that they felt unable to share their MHD for the above reasons and also felt shame about experiencing difficulties but then these was brought out or noticed by other people in their life and this started conversations with parents/external services, leading to receiving support from CAMHS. This superordinate theme has been split into three subordinate themes: ***'having the words', "I don't think it's ever spoken about"*** *and* ***'lack of agency and confidence'*** which capture this journey in their experiences of feeling silenced and unable to share their experiences of MHD and then speaking out.

Having the words

The subordinate theme '***having the words***' emerged from all four interviews and related to all participants experiencing difficulties in verbally communicating and sharing their MHD with their parents and others. For two of the participants (Nadira and Syeda) they have a different first language to both or one of their parents and they described how this sometimes made it difficult to communicate about things such as their MHD. Nadira described how she found it hard to explain to her parents how she was feeling: "*I can't explain as well as I'm not good at Bengali" (line 256)* and *"I couldn't explain to her what a panic attack was. My mum couldn't pronounce it, she was like 'panish attack'…I was trying to explain, and my mum and dad were just talking to each other like…erm hello I'm here." (line 543).* Syeda described similar struggles communicating with her mum about how she was feeling but felt like as her dad's first language was English that*: "it is easier to speak to my dad because obviously there isn't that language barrier cause I'm not as good in Bengali, like I don't know the technical terms for stuff" (line 446).*

Both Nadira and Syeda described how they struggled to find the words to explain concepts they were feeling such as 'anxiety' and said that they were not even sure if some words had a direct translation from English to Bengali:

Nadira: "*Erm, I think 'cos mental means crazy so they kind just think I'm mental or something" (line 556).*

Syeda: "It was hard cause I kept stuttering cause I didn't know the, like, how to say anxiety in Bengali, I looked but there was no word for it, or I was just anxious, it was quite hard" (line 1494).

For the other two participants (Chloe and Raeni) who had the same first language as their parents, they also discussed problems in communicating with them, particularly with both of their fathers about their feelings and their MHD. They discussed how they were unsure about how to start the conversation with them about their experiences as these types of issues were not a usual topic of discussion between them:

Raeni: "I don't really tell him, like it's hard to speak to him about all that side, the anxiety side of things, so it's me and my mum, she just leaves me to talk" (line 425).

Chloe: "Well I've never really had a conversation with him about it, he's just, yeah, never been that, not, not on that closeness with him for that sort of stuff I'd say." (line 685).

'I don't think it's ever spoken about'

The subordinate theme *'I don't think it's ever spoken about'* relates to the sense of stigma that all participants described feeling about their MHD as well as a sense that MHD were not well understood or discussed in their family environment. All four participants described not feeling able to speak about what was going on with their immediate family members and feeling alone when they first started experiencing difficulties, furthering a sense that their experiences were a scary and negative. All participants also described still not feeling able to share about their either past or current MHD and input from CAMHS with wider family members and most of their friends now.

Nadira and Syeda discussed why they did not feel able to share more explicitly. In their interview they both referred to Bangladesh as 'home'. They both directly talked about the role that views '*back home*' (Syeda, *line 397*) played in this. Both of them described how their parents did not share with their family members that they were struggling with MHD, with Nadira's reasoning because "*Yea, cos in his country I don't think there's [inaudible] so obviously when he calls his family and they ask what's wrong with me, he has to say I'm just poorly, if he says that, they're gonna take the wrong meaning cos they are from Bangladesh so they are gonna think I'm mental, I'm a psycho kid. So that's why." (line 555).* Syeda also mirrored these reasons *"those from back home they just thought I was ill they didn't know what it was, they just said oh are you still ill...because they wouldn't understand it they'd just laugh at it" (line 654).*

Syeda made a direct comparison between her mum and dad's understanding of her MHD and that she felt this was because her dad grew up in England and her mum in Bangladesh and that this impacted their understanding of MHD: "I *think my mum has kind* *of a backwards mind set" (line 465)* and *"cause my dad is from here so he understands more, so my mum doesn't really" (line 1539).*

Nadira and Syeda also made comments more generally about how they thought MHD was discussed and thought about in Bangladesh. Both Nadira and Syeda used the word 'old-fashioned' to describe views about MHD that were different to the Western narrative around MHD they had received from CAMHS, with Nadira describing her family in Bangladesh as: "*they're old fashioned…old fashioned as in... if they think different than me they might think that I'm mental problems, mental issues and like I'm going to see a psychologist, I'm gonna get like I might break everything" (line 248)* Syeda described a view that MHD were more seen to be a choice that people made *"some days you're happy, and there's, it's your mind like you just have to think correctly and there's, that's just it, it was just happy or sad." (line 620).* However, Nadira discussed that 'despite' her parents being from Bangladesh that they would understand: "*No not to be honest, cos, my parents even though they are from Bangladesh they have been there…if I can't explain anything, I ask my sister to explain and then they would understand. But they'll still understand" (line 302).*

Nadira, Chloe and Syeda discussed that they felt that their family members had different beliefs around MHD according to whether they grew up in the UK or how long they had lived here with Nadira saying: **"***they're old fashioned…I don't know if they would, they might understand cos they lived in this country more than my mum but they might not…" (line 248).* All three participants seemed to feel as if the CAMHS perspective on their MHD (that their experiences could be explained by a MH diagnosis that had clear intervention pathways) was a 'better way' of thinking about MHD. Chloe discussed how it was potentially more taboo for her mum's side of the family to speak about mental health, at least with the older generations:

Chloe: *"My mum's side might view it differently because I don't think it's ever spoken about as much, in the Caribbean, from my perception…I don't think it'd be anything that would ever be talked about especially in my grandma's generation… my aunties and uncles, I'm not quite sure, I think they'd have a hard time understanding it, the seriousness of it I'd say" (line 992)… "whereas then my cousins who have been brought up in Britain all their life I think they'd be fine, they'd be like me saying fine to talk about it and everything like that, and perceive it the same way*" (line 1014).

Raeni did not explicitly discuss stigma around mental health, however, she did discuss how she felt as if MHD were not something that was talked about in her family either: *"I don't know, we don't talk about it, I don't really think any of my family outside, like my close grandparents or my aunts and uncles really know about it… (line 452) … "yeah, I don't think we can talk about it, no" (line 459).*

<u>Reflexive Box 4.</u> Reflection on the subordinate theme "I don't think it's ever spoken about".

I was conscious that I did not want to make assumptions in my writing of this section of the participant's description of some of the views held by their families about MHD. I also felt uncomfortable with some of the descriptions given by particularly Nadira and Syeda about their families having 'old-fashioned' and 'backwards mind-sets'. It made me think about the 'colonisation' mind-set that the Western way of understanding and describing experiences, and in this case MHD is the 'superior, best and right' way. However, I also wanted to ensure I accurately reflected their experiences and used their own words throughout the write-up and these were experiences and viewpoints that the participants shared.

Lack of agency & confidence

Another subordinate theme under the superordinate theme of 'difficulties speaking out', was about the process of the YP having their difficulties brought out into the open. This is related to the two subordinate themes of '*having the words'* and language to describe experiences and also stigma and "*I don't think it's ever spoken about"* leading to the participants feeling as if they should not talk about their experiences. However, this superordinate theme of ***'Difficulties speaking out'*** also related to how other aspects such as confidence, agency and power (or lack thereof) the participants seemed to have in being able to bring their experiences into the open and this is captured in the third subordinate theme of '***lack of agency and confidence'***.

None of the participants seemed to describe a conscious decision to share with their parents how they were feeling. This seemed to be at least partly because of the views they had heard about MHD in their families and expectations about what their parents might think or say as well as confidence in bringing up issues about MHD independently. Raeni and Chloe described both of their mum's noticing their behaviour first at home.

Chloe: *"Yeah no I didn't notice until… about XXXX so it was the first time we noticed something, but we still didn't have a name for it I just, my mum just knew that there were certain things that I didn't like. And then it wasn't until we googled it when I had like an episode, panic attack, and we googled it 'cause we thought there's something not right here, and then, I got a name for it …would have been XXXX and it wasn't until XXXX that I went to the doctors." (line 494).*

However, for Nadira and Syeda, they described their school as being the first to introduce the idea that they were experiencing MHD both to them individually as a concept but also to their parents. Both schools organised a meeting with each of their parents to inform them of their child's difficulties. This seemed to have different impacts on each participant, but a shared theme was that something external happened to bring their experiences into the open rather than the YP consciously doing this. Both Nadira and Syeda described a sense of shock from both of their parents when they found out, with Syeda saying: *"they were really worried, yeah, I think it was just they were really worried they just didn't know what to do." (line 735) ...my mum … I don't think she understood cause my parents keep saying how I'm a really young age and they don't understand" (line 384) … "I think they were kind of surprised cause they never expect it" (line 429).*

Theme 2: Confusion: navigating multiple perspectives

This superordinate theme captures the sense of **confusion** that seems to have been experienced by each participant in trying to make sense of their experiences; both by themselves and through **navigating multiple perspectives.** These multiple perspectives came from other people in their life, such as, their parents and family, religious beliefs and school who seemed to provide differing interpretations of their experiences at the time. This was when participants were trying to make sense of their experiences for themselves too. The superordinate theme has been split into two subordinate themes from this: '***making sense of experiences by self: feeling different'*** and **'*others making sense of their experiences: multiple and conflicting perspectives'.***

Making sense of experiences by self: feeling different

The subordinate theme of '***making sense of experiences by self: feeling different'*** related to the participant's experiences of feeling different and confused about their experiences. Participants described feeling as if they were very different compared to their peers due to their experiences with their MHD, which led to them feeling alone too. They also described not understanding what was going on for them as well as having other people not understand them which added to this sense of difference. There seemed to be a sense of shame across participants of feeling the way they did as they did not share about their experiences with family members or friends.

Three out of four of the participants described noticing their MHD when they were in primary school, two (Chloe and Syeda) described not sharing with anyone at the time as they did not have an understanding for their experiences whereas one participant (Raeni) said that her mum noticed that she was struggling. The fourth participant (Nadira) described struggling with her anxiety as she was at secondary school.

Raeni: *"Mum noticed it first when I was in year three, like yeah, but then, it like, I think I noticed it in year four…when like my anxiety started." (line 328).*

Syeda: *"I thought it was just shyness (line 360) ...didn't think it was a big deal, I thought it was like what everyone else used to think cause at that young age. I thought it was normal." (line 331).*

All participants described hearing about mental health at school through assemblies and 'mental health awareness days' with Syeda saying: "*I knew what mental health was, I just didn't know how bad it was" (line 370) … think social media, and yeah, school" (line 374)* with all participants describing that they did not recognise their difficulties as MHD until they got to a point that other people noticed and gave them an interpretation that they were experiencing MHD.

Chloe: "*Yeah so, at primary school we did quite a lot about it and being open and being able to talk about stuff, but because I didn't see it as mental health I wouldn't talk about it, I think now there's so much on mental health that, we do mental health days at school, and stuff like that, but then, they talk about anxiety they talk about depression and stuff like that but they don't really touch on the more, I don't want to say more serious cause obviously anxiety is really serious but..." (line 766).*

Nadira initially interpreted her experiences as something that was physically wrong with her. Nadira linked this directly to trying to fit her experience with the things she was seeing through the Bollywood films she loves watching "*It was, kinda confusing, I thought I was having a heart attack because I saw movies and they were like put their hand on the heart, and like [*breathes heavily*] so I thought I was having a heart attack" (line 225).* Both Nadira and Syeda used physical health terminology to describe their experiences:

Nadira: "*I felt over pressure, I don't know, I felt like over... I couldn't like breath anywhere, like I felt like suffocated sometimes." (line 147).*

Syeda: *"I just had really bad thoughts and like my head was like really like hurting and, and I had like an episode." (line 284).*

As discussed in her pen portrait above, there was also a sense for Chloe that this feeling of difference and being an outsider was compounded particularly in her school environment by her feeling different in relation to her ethnicity as well.

Others making sense of their experiences: multiple and conflicting perspectives

The subordinate theme of **'others making sense of their experiences: multiple and conflicting perspectives'** captures how all participants described how they were provided with numerous and differing perspectives on their MHD and what could help them to 'feel better' with their MHD. There was a sense in this subordinate theme that the participants had to navigate different cultural beliefs and perspectives around their experiences which sometimes or often opposed current Western views on MHD they gained from school and later on in CAMHS.

Family perspectives

The responses and suggestions that each participant's family had were different. Some of the initial responses of the participant's parents of shock and upset have already been captured in the first superordinate theme when difficulties were first brought into the open. None of the participants described experiences of parents seeming to advocate strongly for getting external services like CAMHS involved in supporting them but instead explored other avenues such as spending more time with family, religious beliefs (see below) or alternative therapies such as homeopathy.

Nadira and Syeda both described that their mums would often ask them to spend more time altogether as a family and would often ask them to share with them how they were feeling. Nadira described that although she usually talked to her dad more, they did not talk about this, whereas Syeda felt as if her dad had a better understanding as he checked in with her more. As described in the '*having the words'* subordinate theme, language affected how parental and family perspectives were experienced. Nadira and Syeda both described how they felt as if views around MHD in Bangladesh filtered through to how they initially understood and shared with others about their MHD with Nadira saying: "*I just think that…. I don't know I can't... I think it's hard to, if I was in Bangladesh it's more harder to understand… like, if I had to talk to people in Bangladesh they would find it more harder to understand my situation, they might even blame me for my situation." (line 560).*

There was a sense from both Raeni's and Chloe's account that their mums were supportive of a referral to CAMHS but also did not 'push' for this referral either. Raeni's mum was continually researching therapies that could help, whereas Chloe described hers as just trying to support her as best she could at home by adapting their routines as best possible. Chloe described how although her aunty was made aware by her mum of her MHD, she did not feel understood by her aunty "*I had a panic attack and she just didn't understand it, she was just saying you're childish and stuff like that, so that was probably the worst thing" (line 781).*

Once these experiences had been verbalised either by a parent or by the school, all four participants described feeling more understood by one parent than the other- three out of the four described their mums as understanding them more. As discussed above, Raeni and Chloe described that they did not initially feel comfortable speaking to their dads about their difficulties. However, even when their mums had shared with their dads about their MHD, they still did not feel comfortable discussing these. This added to the sense from participants that they had felt like their MHD should not be discussed.

Raeni: "I *think he understood but he had to step back, like I don't think, I don't know, like he knew it was going on, but he just, he never really asked me about it, he never like took part or was a part of it, you know" (line 407) ... I don't really tell him, like it's hard to speak to him about all that side" (line 425).*

Syeda was the only participant who described her dad as being the most understanding – she attributed this difference in understanding compared to her mum's understanding to the fact that he had been born and brought up in the UK: "*I personally think cause he's grown up here so he's more like educated" (line 613).*

Religious beliefs perspectives

Three out of the four participants (Nadira, Raeni and Syeda) described the role their religion played during this time for their MHD. All three described that their parents suggested using their religious faith to help them during this difficult time either through prayer or directly involving a religious leader. All participants described that the perspective or support offered from this was helpful for different ways which are described below. Chloe said that she did have a Christian religious faith but did not describe religion playing a role in her understanding of her MHD or what support was suggested to her by her parents. Despite the participants describing their religious beliefs and role of religion in their life being helpful, some of the understandings it brought seemed to be at odds with some beliefs held by schools and services that other interventions would be needed alongside religious interventions.

Nadira described how her parents initially turned to their religious faith to try and help her "*the first time I didn't know what to do, erm my dad called a Maulana cos at first he thought I was possessed" (line 649).* She described how she was not sure what was happening initially but that the things he provided with her in this ceremony gave her hope: "*I'm not used to this type of thing and he was doing weird stuff so I was laughing…I had to laugh cos I'm not used to this type of stuff and erm, but that, I think that helped me as every time I had stress I would just hold onto that… [it gave me] hope." (line 341).*

For Syeda, she felt as if her faith played a direct role in her actions before her admission to A&E: "*I think, if I wasn't from Islam I would have probably taken the tablets completely, so that played a big role in the hospital admissions but not in the CAMHS" (line 1302) ..."at the back of my mind that …. I'm just borrowing this life … I have to take care of this body …I was gifted life so I shouldn't just throw it away." (line 1307).* She also said that "*my mum, my aunties told me to pray more …I did start to, and it did help, I did like feel at peace and it did help" (line 1353).*

For Raeni, she described her dad not explicitly encouraging her to use their faith but did make reference to it on occasion: "*No, my dad has spoken to me…about… like how we have like faith in God, and that like helping me, I don't know if he meant it in like an anxiety context or just life but, yeah, we don't really talk about, like, no it's just little bits where it comes through, the Christian faith" (line 1126).*

School perspectives

Three participants experienced input from school during this time, with one experiencing support from school after her CAMHS input. Participants described different support from school, highlighting the inconsistency in approaches across schools and GP surgeries. For those that experienced their school as supportive, each of their schools either directly referred them to CAMHS or had a meeting to encourage parents to gain a referral from GP to CAMHS. There was a sense that this was another time of confusion for the participants and that their mental health had to deteriorate for this then to be taken further by school.

For Nadira, school directly offered a different interpretation for her about her difficulties. As described above, Nadira felt as if she was having a heart attack which she would now call a panic attack and it was a first-aider at her school that offered this interpretation first for her "*then at school, they were like no you're having a panic attack for some reason" (line 226).* She also described a confusing sense of being sent to various different people in one of the lead ups to hospital admission: "*Told... first of all the school, cos it happened at school and the school goes you have to go to the doctor hospital, yea, er the doctors, so I went to the GP first, GP sent me to hospital." (line 392).*

Syeda also described how because she was experiencing panic attacks in many of her lessons, school initially tried to support her within school but then organised a meeting with her parents to tell them about what was going on and suggested they take her to the GP: "*I've had probably feeling like anxiety….used to have panic attacks …got in the way of classes …the teachers referred me to the school nurse and so I had appointments with the school nurse like almost every week….my low mood started being more consistent….head of like the students in my year she recommended that I go to the GP so she called and met with my dad and my mum and said that it'd be best for me to go to the GP" (line 311).* Syeda also described how her teachers and her best friend supported her to access support through a referral to CAMHS. “*At the time no I just did it because my best friend she said it would be best, the teachers said it would be best, so I actually, I was really hopeless at the time so I didn’t really think that anything would work so I just thought we might as well try it but I didn’t think it would work” (line 879).*

With Raeni, she described that her and her mum had been to the GP but that this did not amount to any support from the referrals they had made. She felt as if it was better that her referral to CAMHS went through school: “*I think it was good that it went through the school counsellor, cause I feel that that’s like the, more influence than the GP.” (line 680).*

Chloe described that she did not share with her school at her difficulties until after her input with CAMHS: *“I didn’t tell anyone at school what I was doing, I was having to make up excuses why I was leaving lessons and I was having to explain to teachers, lying to teachers cause, I told the receptionist, receptionist knew, but I think my teachers didn’t know so that was quite difficult” (line 1253).*

GP perspectives

All four participants described going to their GP about their MHD. Participants described varying responses. Two participants were referred to CAMHS after attending their GP and two were not. None of the participants described feeling as if the GP helped them with their understanding of their MHD at the time and they did not receive consistent information and support for their MHD from their GP services.

Raeni: *“Yeah I think we did go to the GP a couple of times, a while ago, before that, but I think they did refer us but I don’t think anything came of it because I don’t remember doing anything, like any therapies, any treatments,* yea*.” (line 664).*

Nadira: *“Oh yea, we went to GP, went to hospital, they didn’t tell me anything about anything. They just said that you have to deal with it yourself…they said that they can’t do anything about panic attacks, so they don’t know what to tell me, and er I have to do stuff for myself” (line 346) …“Not like that but like erm they can’t do anything about it like cos I... it’s not something they can’t give me medicines” (line 357).*

Reflexive Box 5. Reflection on the superordinate theme of ‘confusion: navigating multiple perspectives’

In the analysis and particularly for this superordinate theme, I felt cautious about not wanting to over-interpret the data and attributing perspectives purely to ‘cultural differences’ but I also did not want to stay too close to the data and just provide a narrative around experiences either. I used supervision to try and feel more comfortable with doing this and became more comfortable with the idea of ‘reaching’ in the work but making sure the analysis is still grounded in the data. However, there are still description of the multiple perspectives that participants experienced to illustrate the theme.

Theme 3: Evolving understanding of self and experiences

This superordinate theme captures the process of the **evolving understanding of self** that the participants described throughout their experiences. Most participants described a shift in feeling understood and listened to by people in their lives and then accessing support for the MHD they were experiencing. This process did not seem to happen linearly for participants and there was a sense this was a constant evolution rather than reaching an ‘end point’ of understanding. Each participant described a different experience or service input that caused this shift for them. This shift seemed to happen for participants at different points of their journey and was only attributed to being ‘just because of CAMHS input’ for one participant. Participants described a journey of initially feeling different and alone, having multiple perspectives about how best to support them and then becoming more connected again and feeling more of a sense of agency and control over at least some of their experiences. The subordinate themes under this theme are ‘***hope for change’***, ***‘experiences validated and normalised’*** *and* ‘***developing voice and agency’***. These themes capture the different parts of the experience of the participants in developing a better sense of and feeling more comfortable with themselves and their experiences. There was a sense that participants were making sense of themselves as an individual as well as themselves in contexts such as their family culture.

Hope for change

This subordinate theme relates to the sense of hope and relief that the participants described when external services to their family support became involved in their lives. All participants described an initial state of confusion and a sense of hopelessness that nothing would change with their MHD. Participants then seemed to describe a sense that having input from services helped to alleviate some of this confusion and provided a sense that change could be possible. For Raeni and Chloe, a referral to CAMHS provided this hope and a sense of relief for them both.

Chloe: "*I felt like oh this is good I'm going to get some help, but I had no idea what they were going to do, cause I didn't know what CBT was or anything like that" (line 1171) … "it was a relief, I thought oh they're going to be able to treat it, or something like that" (line 1176)*

Raeni: "*It was good that I was actually getting help, like getting support" (line 633).*

For Nadira and Syeda, this hope seemed to come from being admitted to a hospital ward and being told they would be seen by CAMHS there. Syeda discussed how although this was a difficult time for her that she felt as if accessing support that way was more beneficial for her in the long term in terms of the understanding it gave to her parents about her difficulties: *"I think it is better how it kind of played out I feel like because the hospital admission I feel like kind of made my parents understand how serious it was, whereas if it was just like a referral they'd think it was just like an appointment type thing, I don't think they'd understand how severe it actually was" (line 901).*

Experiences validated and normalised

This subordinate theme related to experiences that seemed to come from input from CAMHS for most of the participants. YP described that their sessions with their CAMHS clinicians gave them a sense that their experiences were common experiences seen within CAMHS, and that they were 'real' and not 'abnormal' experiences. This seemed to provide a sense of normalisation and validation for the participants. This also seemed to represent a positive shift for the participant in understanding about their experiences. Chloe described how having a sense that her MHD were 'real things' was very helpful for her: *"for me it* *was getting the diagnosis, and being able to say to someone I'm seeing CAMHS and it is a real thing" (line 1337).*

Nadira described a sense of worry before seeing CAMHS about what that would look like: *"So when I came to CAMHS, I thought I was going to go to mental hospital… So, I kind of like scared…When I found out that was just I could talk, I like…. it's worth it and I like...it actually helped me a lot." (line 571).* She also described a sense of feeling contained that the clinicians saw other YP with MHD: *"Cos they saw other people same like me…. and they were more easy to talk to, like…. they knew what I was going to say, they knew how I felt, they knew how to make me feel better" (line 579).*

For Syeda, she felt as if CAMHS was helpful for her as the service provided diagnoses for her experiences which helped her to feel as if she was not alone and that other YP also experienced similar difficulties: *"my psychiatrist at the time, he kind of told me that I had like depression and anxiety, before that I just thought it was just anxiety." (line 360) … he showed me the chart like a graph of a normal person who is like a straight line and then the level of like depression on mine so it was quite high, so just like the diagnosis of it" (line 967).*

Participants also described feeling more heard by other people and connected to other people. Three of the participants described this process happening for them through different services, one participant (Raeni) still seemed to be on a journey to feel more understood by (and heard by and connected to) others.

For Nadira, she reported finding her experiences with CAMHS most helpful and directly linked this with feeling more understood by CAMHS: *"CAMHS understood me more." (line 577).* She described that she felt listened to and was given advice about what she could do by her CAMHS clinician– this seemed a helpful process for her to feel contained and be able to cope without long-term MH support: "*he would listen to me proper and he would tell me where I should, could go, like all the doctors they didn't tell me where I could go, but he told me where I could go, like the marketplace…he told me he'd help me, and…. he wrote it down, he even said that he will talk to school because they were being, they keep on pressurising me a bit too much" (line 997).* It seemed that Nadira had not felt this sense of containment from her parents or school previously.

Syeda described a sense of not feeling listened to in her sessions with her clinician in CAMHS: *"We were just speaking, he was speaking most of the time so I didn't really* *speak most of the time*." She also described finding sessions with a youth worker as the most helpful for her as she felt like the sessions were interactive and that the youth worker listened to her and understood her: *"the youth worker…. she was really helpful; her one to one sessions were actually really really helpful…. she was Asian, so she was Pakistani and she was female, she was easier to relate with" (line 984).*

For Raeni, she reported that she did not find her time with CAMHS helpful and felt like the therapy she was undertaking moved too quickly - there was a sense she did not feel understood by the therapist and she said that she did not feel able to share this with her therapist. She described feeling supported and understood at school though: "*yeah, there's like, topics on it like in assembly and stuff so it is known at school like, like being a positive force, yeah" (line 562).* Raeni also stated that she felt that her homeopathy treatment was the most helpful thing for her. This seemed to be because she found that the pills she had been given had 'stopped' her anxiety for her, however, her anxiety then came back and trying homeopathy for a second time did not work again. Despite this second experience, this seemed to give Raeni a sense that she felt like her MHD were something that could treated one way or the other, it was just a matter of finding the right therapy. It seemed as if she had already felt understood and connected to her mum throughout her journey but had not yet made connections with others around this.

During and after input from CAMHS, most participants described a shift in how their parents supported them. All participants had individual sessions with their CAMHS clinician and for some participants, their parents also joined for some joint sessions. Nadira and Syeda described some changes in how their parents supported them at home and that their mums encouraged them to try and share their feelings with them and to spend more time with their families, with Syeda describing some of her mum's advice: "*she actually did give advice to me said to just be downstairs more be more interactive and try and keep your mind fresh and like don't try and think about bad stuff" (line 893)*. For Chloe, she described how she shared with her friends about her experiences "*I told my friend on a school trip, we went to Germany… and they completely understood it…. they haven't changed what they do around me but I think they know sort of, I've got one friend at least that really understands it more." (line 925).* Syeda also described how she felt her dad actually changed his understanding of her from his attending of CAMHS appointments: *"my mum said why don't you ever talk to us about it and my dad said that, she can't just* *open up she'll open up with who she feels comfortable with when she wants to she wants to, so I think that's when I understood that he kind of understood more." (line 606).*

Developing voice & agency

Each participant described a sense of feeling more comfortable with talking about their experiences and had an idea of what helped them move forward after their input with CAMHS. There was a sense that they had found something in their experiences that made most sense to them and they had taken this perspective/way of coping forward. Participants described a shift of having their own ideas about MHD and making sense of this, often separate to their parents' understanding. This seemed to represent that they had or were developing a voice for their experiences, had agency of choosing whether to share these experiences and had a developing ability to advocate for themselves and control their environments more as they were getting older.

For Syeda and Nadira, it seemed as if they felt the perspectives that best fitted for them around their MHD did not match perspectives their parents and family culture had around MHD. There seemed to be a shift with them developing new relationships to the more Western ideas and understandings around their MHD compared to when they first started experiencing difficulties. They described how the support that CAMHS provided was different to the support that had previously received.

Nadira: *"I was saying I have less people that have been there for me, and I think that CAMHS understand me more than other people will…CAMHS understood me more...cos they saw other people same like me... they'd seen other people in situations and they were more easy to talk to, like...they knew what I was going to say, they knew how I felt, they knew how to make me feel better" (line 577).*

It seemed as if most of the participants had an evolving sense of their identity in themselves and how they relate or related to their MHD compared to how they made sense of themselves in their context. Most participants seemed to have a sense of feeling more agency over their current experiences and in 'developing a voice' as they felt more comfortable and confident to speak about these experiences. This seems to represent a shift from the beginning of their journey with making sense of their MHD.

All participants described a different service or person as being the thing/person that understood them more. For Syeda it was having input from the youth worker and being given diagnosis labels for her MHD, Chloe her teacher and the online support group, Nadira CAMHS input and feeling more listened to. It seemed as if all of these things provided one dominant narrative and way of understanding MHD, and these seemed to be more within the current Western way of understanding MHD. For Raeni, she described how she found homeopathy most helpful but did not elaborate on why she thought it was helpful. Raeni was also the only participant that had not seemed to have 'found a way forward' yet and was still looking for something to 'help'.

As discussed above, Nadira and Syeda discussed perspectives some of their family members, particularly those in Bangladesh, had of MHD as being 'old-fashioned' and 'backwards'. This seemed to represent a shift in how they felt about some of these family perspectives as at the time it seemed as if they also felt their experiences were abnormal, whereas now they seemed to reject the idea that their experiences were abnormal.

Chloe described that she found CAMHS helpful for giving her a sense that her experiences were valid and gave her the ability to talk aloud about them: "*it was improvements with me being able to talk about it cause before I couldn't talk about it at all, and although I'm crying now I'm able to talk about it, so that helped" (line 1340).* She described how talking to a psychology teacher at school who she felt knew about MHD was really helpful to helping her feel more understood, this teacher also signposted her to an online support group forum. Chloe described that having a place where she could read about people having similar experiences was the most helpful thing for as made her feel like her was not as different as she had thought for a long time and felt connected to these people: "*was probably the worst bit that no one understood what was really going on with me and how I was feeling" (line 735) …* "*The support group on Facebook, so I've never posted on it but reading other people's stuff and they put help, suggestions and stuff like that, I think that's the best thing for me." (line 975).* This seemed to represent a change for Chloe in having more control over the support she put in place for herself and in developing her confidence to speak about her MHD with others.

Chapter Four - Discussion

Research studies have found that there are inequalities in health services, particularly MHS for people from ethnic minority backgrounds in the UK. Studies providing this evidence in the UK have mainly been within adult services. It is argued that CAMHS services do not appropriately meet the needs of BAME CYP with MHD currently and that there is a lack of necessary research in this area (Fatimilehin, 2007). It is therefore necessary that more research is conducted with YP from an ethnic minority background to examine their experiences within CAMHS. Particularly, qualitative research is needed to further explore the quantitative data found.

This study aimed to explore the experiences of YP from an ethnic minority background of their MHD and in accessing and engaging with CAMHS. It aimed to help further the ‘dialogue’ related to this area and to provide a space for YP to share their experiences. It also aimed to consider the implications from the findings and make recommendations from these.

The research questions were:

1. What are the experiences of YP from a BAME background of their MHD before accessing CAMHS?
2. What are the experiences of YP from a BAME background in accessing CAMHS support for MHD?
3. What are the experiences of YP from a BAME background in engaging with CAMHS?

The methodological framework of IPA was used to design this study - data was collected through semi-structured one-to-one interviews and analysed using IPA. From this analysis, three superordinate and eight subordinate themes emerged.

This chapter will provide a summary of the main findings. It will then discuss these findings in relation to the research questions and in the context of the wider literature. The research study will then be evaluated – strengths, limitations and implications including those for future research will be discussed. Finally, conclusions and final reflections are presented.

Main research findings

In this section, I will discuss each research question in turn and explain how the group analysis themes contributed to answering these research questions. This section is structured this way to discuss the research findings in a coherent way and ensure the research questions are given full consideration.

Research Question 1: What are the experiences of YP from a BAME background of their MHD before accessing CAMHS?

The first research question was to explore the experiences of YP from a BAME background of their MHD before accessing CAMHS. Findings suggested that participants went through various experiences of firstly feeling different because of their MHD and struggling to speak about what was going on for them and their MHD. Their experiences with their MHD were then brought into the open, via different means, meaning that more perspectives through parental, cultural, religious and school perspectives were present which added to the confusion the participants experienced.

The first two superordinate themes ('*Difficulties speaking* out' and '*Confusion: navigating multiple perspectives)* seem to be most related to the participants' experiences of trying to make sense of their MHD before accessing CAMHS. Overall, participants described a confusing and difficult time trying to understand and make sense of their MHD and in then being advised to access formal support through CAMHS (discussed below). Participants seemed to have varying levels of insight into this time when discussing these experiences during the interviews. Most participants described not having spoken about these experiences with anyone after their discharge from CAMHS.

'Difficulties in speaking out'

This first superordinate theme of '*Difficulties in speaking out'* related to the experiences participants described in being able to speak about and share their MHD with their parents and family and also other important people in their life at the time such as friends and or/school. Participants described difficulties with the subordinate theme of '*having the words'* in terms of having a shared language with parents but also knowing how to express their difficulties to their families. This was both with participants who did not share the same first language with one or both of their parents but was also present for the two participants who did have the same shared language, but still had difficulties in discussing this with their parents, particularly their fathers. Participants also described how MHD were not spoken about in their families, and this was captured in the subordinate theme of '*I don't think it's ever spoken about*'. This was discussed in terms of unwritten rules of not speaking about difficulties with stigma around MHD culturally and societally, both in their family culture and more widely in the area they grew up/lived in and also the sense that MHD did not seem to be well understood (or that MHD were not understood within a Western perspective). The final subordinate theme was '*lack of agency and confidence'.* This described the lack of control and confidence participants described in having a sense of what was going on for them and feeling able to share about their experiences with their parents and other adults such as school teachers. Participants described speaking about their MHD for the first time; this was not brought up by any of the participants by themselves to their parents – this was either noticed and discussed by the participants' mothers or their schools. This subordinate theme related to the sense of participants that their experiences were scary and 'not normal.'

'Confusion: navigating multiple perspectives'

The second superordinate theme of '*Confusion: navigating multiple perspectives'* which referred to the confusion participants seemed to experience when their MHD were 'brought into the open' also seemed to relate most to the first research question in their trying to make sense of their experiences. Participants described feeling different and confused about their experiences with their MHD and trying to make sense of their difficulties by themselves. All participants described that this was a challenging and difficult time for them. Participants described not having insight that they were experiencing MHD when they were younger. Most of the participants described noticing difficulties in primary school but not accessing help or support until secondary school. Most participants also described being firstly offered and accessing support for their MHD through their school. Interestingly, participants described being aware of MHD through assemblies at school but not making the link between their experiences and the experiences of MHD they were hearing about at school. Once other people knew, this did not initially seem to help participants. It seemed as if there were many perspectives being offered and that there were sometimes differences between the family's and the school's views of what would be more helpful to support the YP at times. All participants described a sense that their parents did not seem to have an understanding of what they were going through or if they did, knowing how best to help. At least one parent for most participants suggested turning to their religious faith for support, either through prayer or involving a religious leader more formally which most participants described experiences of this as providing hope and/or support. School provided support for three of the participants but then suggested referrals to formal mental health support i.e. CAMHS. Participants described a confusing time where they were trying to make sense of their experiences as well as being given different and often differing perspectives by important people in their lives. Most participants discussed how there was a difference between what some of their family members thought/knew about MHD and what they were being told in school. For example, some participants described a sense that MHD were taboo and scary that only happened to 'mental people' within their family culture, whereas school assemblies talked about that many people would experience MHD and that it was normal and something that should be shared with others.

Research Question 2: What are the experiences of YP from an ethnic minority background in accessing CAMHS support for their MHD?

The second research question was to explore the experiences of YP from an ethnic minority background in accessing CAMHS, i.e. their experience of the referral process. Participants described being referred to CAMHS via various avenues - GP, school and through attending A&E. Some participants wanted to be referred to CAMHS for support and others were not aware of CAMHS before accessing support. Most participants described experiences of not feeling helped by their GPs and although all four went to their GP to access support for their MHD, this only resulted in referral for two participants.

Participants described a sense of relief when they found out they were going to be seen within CAMHS (either through an accepted referral or being told on the A&E ward that they would be receiving CAMHS input). This seemed to provide a sense of hope that they could get help and support for their MHD. Most participants described not knowing what CAMHS was. However, it seemed that having a professional in their life, such as a school teacher, GP or physical health doctor, who explained the role of CAMHS and that they could help, seemed to be provide a sense of certainty for the YP at the time of referral (which they potentially did not have at the time from anybody else).

The superordinate theme of '**Confusion: navigating multiple perspectives'** captures the sense in answering this research question; that participants had to navigate multiple perspectives around what support would be better for them before they were referred to CAMHS or accessed CAMHS through differing referral routes. The superordinate theme of **‘evolving understanding of self and experiences’** - and particularly the subordinate theme of ***‘hope for change’*** - contributed to answering this question in that the confirmed input of CAMHS seemed to represent a start of a shift for participants in how they made sense of their MHD and found ways to cope with these. Participants described a sense, captured by the subordinate theme of ‘*hope for change’,* that the referral to CAMHS would bring about some change for them and their MHD. Participants described a worry that their MHD were going to be present for their rest of their lives and be as difficult as they were finding it at the time of referral. A further explanation of the themes that captured what the experiences of YP were when they started to ‘see CAMHS’ is provided below.

Research Question 3: What are the experiences of YP from an ethnic minority background in engaging with CAMHS for their MHD?

The third research question was to explore experiences of participants in engaging with CAMHS. Participants had unique experiences and feelings about their time with CAMHS but for all participants, the start of their input with CAMHS lead to a shift in the perception of feeling more heard and connected with others. Although not all participants felt like their overall experience with CAMHS was helpful, the input from CAMHS clinicians seemed to normalise and validate experiences for all of the YP. Although most of the participants did not describe their time in CAMHS as their catalyst for change in helping them feel better with their mental health, input from clinicians (follow-up sessions or more structured therapy) helped in their evolving understanding of themselves and making sense of their experiences.

‘Evolving understanding of self and experiences’

The third superordinate theme captures the sense participants described of an ‘*evolving understanding of self and experiences’.* This superordinate theme refers to the experiences of participants and a sense of feeling comfortable with and developing their identity as well as making sense of their experiences. As described above, the initial confirmation that CAMHS would provide support seemed to represent a shift for participants, represented by the subordinate theme of ‘*hope for change’*. They described that having input from a CAMHS clinician who provided information on or worked through helpful coping strategies for YP helped them with their MHD.

Participants described clinicians in CAMHS providing validation for the YP in their experiences and also provided normalisation of experiences that they had found scary, captured in the subordinate theme '*experiences validated and normalised'*. This seemed to cause a shift in how the participants felt about their MHD and themselves more widely. For two of the participants, input from CAMHS seemed to provide a sense of containment. Both participants described a sense that their parents were very confused and shocked that they were experiencing difficulties with their mental health and so perhaps were not able to provide this containment for the participants. Participants described feeling more heard and listened to either by their CAMHS clinicians or through something else after their CAMHS experience. This related to, at least at first, accessing and having input within CAMHS. Participants described these experiences as being helpful as they felt listened to and were able to speak about their experiences to people that did not have emotional responses such as when they spoke to their parents.

Participants also described feeling more connected to others which helped them to feel less alone. Two participants described feeling most heard by people outside of CAMHS – one in parallel of input with CAMHS and one after their CAMHS discharge. Both described how they felt like their input with CAMHS had shifted things for them initially, and may have helped them to then feel more heard by others later on.

This subordinate theme of '*Developing voice & agency'* captures how for each participant it seemed as if they had identified something that fitted best with them as a way to explain and understand their MHD. They felt more confident with having their voice heard and choosing which way(s) were most helpful for them in coping with their MHD. Participants described a sense of finding a way forward – for some this seemed to be in the form of taking on-board the more Western view of their MHD and what could help, one participant described finding an online support group and having someone they found helpful to talk to at their school the best thing to help them and another participant seemed to still be on this journey to finding support that fitted best and was helpful for them.

The other two superordinate themes (*Difficulties in speaking out* and *Confusion: navigating multiple perspectives*) also played a part in the experiences of the YP using CAMHS. There was still a language barrier for some of their parents, this was aided by the use of translators but participants still described times where mutual understanding of concepts were slightly lost in translation. It seemed as if parents had a differing level of input in their child's CAMHS experience and more widely in their experiences too. This might have been related to the views of MHD parents held if these were at odds with the perspective CAMHS took. Stigma still seemed to play a role for the participants during their CAMHS experiences and after; participants did not describe a shift in who their immediate families shared their MHD with following their CAMHS experiences. For some, it seemed as if CAMHS provided a dominant narrative around their MHD which helped if they felt this narrative fitted for them but some participants seemed to find other sources of support and narratives more helpful. For all participants, these multiple and sometimes conflicting perspectives were still present in their immediate environment regardless of whether they had chosen one perspectives that seemed to fit better with them more as they still lived with their parents and family who held these differing views.

Results in wider literature

This next section will describe the research findings in relation to the wider literature. Firstly, results will be discussed in relation to existing research on referral pathways. Results will then be discussed in relation to the literature on help-seeking, understandings of MHD and feeling different, agency, stigma, and language and communication. Following this, results will be considered in light of parental, religious and school influences and identity development. Finally, the literature will be discussed in reference to CAMHS services and ethnicity of clinician. Quotes will not be provided in this section as an illustration of the points below are presented in the results chapter above.

Referral pathways

All participants described going to their GP to try and access support, although only one was aware of CAMHS and was expecting a referral to them. This resulted in referrals for two of the four participants. For one participants who was referred by their GP to CAMHS, they were put on a waiting list for CAMHS input but reached a crisis point and accessed support that way instead. Most participants did not describe a positive experience with their GP in trying to access support. These experiences and referral routes seem to match what has been found in the quantitative research literature (Edbrooke-Childs et al., 2016; Edbrooke-Childs & Patalay, 2019). As discussed in the introduction, recent research into referral routes found that CYP from a BAME background were more likely to be referred through school settings or social services (Edbrooke-Child et al., 2019), were less likely to access through voluntary care pathways (such as GP) and instead accessed CAMHS through crisis routes (Skokauskas et al. (2010). Hinrichs et al. (2012) found that GP referrals to CAMHS are three times more likely to be rejected than referrals from other services. A reason behind GPs not referring all the participants to CAMHS could have been because they thought the MHD were not at a threshold to be accepted by CAMHS. This needs further investigation, however. Stein et al. (2003) also concluded that South Asian families were less likely than white families to self-refer or seek help for mild or moderate difficulties. Generalisations from this current study cannot be made due to the small sample number, however, this does match the experiences of the two participants from South Asian backgrounds- that they both accessed CAMHS through the crisis referral route, even after school had raised their MHD first to their parents and the need to access support for their MHD.

Help-seeking

One participant described how in hindsight it was better that she received CAMHS input after attending A&E in crisis with her MHD to help her parents recognise her difficulties and the 'seriousness' of these. This was a striking comment to consider and highlights the importance in the need to better understand help-seeking behaviour and the role of parents in these. In thinking about help-seeking, Cauce et al. (2002) developed a theoretical model to try and understand help-seeking for adolescents from an ethnic minority background with internalising MHD. The model describes three identifiable stages which occur along the help-seeking process: 'problem recognition', 'the decision to seek help', and 'the selection of a help provider'. They argue that context and culture affects each stage of the model. The findings from this study seem to fit into the model that Cauce et al. (2002) proposed. Help-seeking and facilitators and barriers to help-seeking needs further exploration to try and better understand and then support help-seeking processes.

The findings add to existing research indicating the integral role parents seem to have in facilitating help-seeking. Draucker (2005) suggested a three stage model for how MHD around low mood are acknowledged between YP and their parents. They suggested that firstly YP, parents and professionals ‘deny’ that a problem exists and ‘project’ a ‘normal’ image). They then suggest that YP start to show their distress, with parents becoming aware of this. They posit the final stage is around YP being open about their experiences and wanting to seek help. Stapley et al. (2016) suggested that parents firstly are unaware of any issues then experience ‘emotional turmoil’ and ‘feelings of helplessness’ – parenting experiences. Though parental experiences and perspectives were not explored in this study future research in this area is vital in order to support help-seeking for CYP.

The findings suggest that help-seeking seems to be impacted by understandings around their experience and knowledge of MHD, stigma, ability to communicate through language and agency/confidence to do this. These will be discussed below.

Understandings about MHD

Another finding was that participants described feeling different and confused when trying to make sense of and understand their experiences of their MHD. The participants seemed to echo experiences that had been found in research by Dogra et al. (2007) that the YP and their parents from a Gujarati background did not have a ‘consistent understanding’ of MHD. This is consistent with findings in adults that there were differences between lay and professional perspectives on MHD (Lauber et al., 2003).

Two participants described thinking that they had problems with their physical health and used physical descriptions to describe their MHD in their initial understanding of their experiences. In thinking about the potential cultural understandings of this as both of these participants are from a South Asian background, Johnson and Nadirshaw (1993) discuss how there is often a stereotype held within MHS that people from South Asian backgrounds communicate their distress in somatic or physical terms. They assert that there is no conclusive evidence of this link more so than with any other ethnic group and that this is a harmful stereotype leading health professionals to think people from these backgrounds lack capacity for ‘talking therapies’.

In thinking about the understanding participants gave to their MHD, one participant talked about her love of Bollywood films and that as she saw distress being represented in the films in physical terms, this led to her interpreting her MHD initially as physical health concerns. It would be interesting to see if this interpretation is initially made by other YP from South Asian backgrounds if they also watch Bollywood films, as well as exploring whether media, film or TV portrayal around MHD influences interpretations of other YP around their MHD too, and if so, how this is experienced.

Agency

The finding that participants found it difficult to bring their experiences of MHD to their parents, even if they spoke the same language was interesting and this was captured in the findings by a subordinate theme of '*lack of agency and confidence'*. There seemed to be a shift for participants in developing an increased sense of agency after their input with CAMHS, represented by the subordinate theme of '*developing voice and agency'*. From the review of the literature for the introduction chapter and in trying to make sense of these results, there seems to be little research into agency and the development of agency within YP and whether MHD and input with services such as CAMHS can affect this. This would be interesting to explore with YP more generally in future research and whether this is part of the process of getting older and developing more independence or whether other factors influence this, as well as how this is experienced for more YP with MHD too.

Stigma

As discussed in the introduction chapter, numerous studies have shown that MHD are stigmatised across all communities (Arday, 2018) which can delay seeking help and result in crisis situations rather than earlier intervention (Memon et al., 2016). Masuda et al. (2009) state that in MH, stigma is directed towards those who seek help for MHD and those that receive a label of a psychiatric disorder and that it is a barrier in help-seeking and accessing MHS (Grey et al., 2013). The previous finding that stigma is a key factor in the under-utilisation of CAMHS by CYP from BAME backgrounds is interesting to consider for this study.

Participants described a sense of not feeling able to share what they were experiencing with their parents or many other people, at the beginning of their difficulties and even at the point of the interview some time after discharge. This has been conceptualised in the superordinate theme ('*difficulties in speaking out*') in terms of stigma around MHD as well as general awareness of MHD. It was interesting that in this study, participants did not explicitly discuss this concern around seeking help due to stigma but this was more discussed in disclosing to other family members about their MHD. For example, one participant discussed how she or her immediate family did not share with their wider family about her difficulties because of the stigma and negative views held around experiencing MHD and that they would think she was a ‘psycho kid’. One participant also directly discussed how she felt as if different generations of her family had different views on MHD. She said that although her family who were raised in the Caribbean would not openly talk about MHD that her cousins who were born and raised in Britain would likely talk about MHD openly. She thought this was a ‘generational difference’.

Stigma and its impact on sharing with others seemed to be more explicitly discussed with participants from South Asian backgrounds. They seemed to attribute more negatively held views around MHD with their culture and with people from Bangladesh’s views which stopped them from talking to their family about their experiences. In a study with British Indian families, results indicated that parents feared their children accessing services because of stigma around MHS use (Bradby et al., 2007). It was interesting that in this study, participants did not explicitly discuss this concern around disclosing and then seeking help. This might have been something present for participants and not discussed or was not something they were explicitly aware of. With the other two participants from mixed heritage backgrounds, it seemed as if their views around stigma around MHD in their family were less explicit but were still present and affecting how and why they shared their MHD.

The results indicate that stigma played a role in the participants sharing their experiences and how much their families shared with others but all four participants still accessed support with CAMHS. They did, however, all describe a time of parents or school noticing difficulties and then in the school advising the participants to access formal MHS. This study is not able to consider whether stigma affected the time point at which participants accessed support (i.e. participants could have accessed support quicker if stigma was not as present) or for those that did not access CAMHS at all potentially because of this stigma. More research needs to be done with CYP that experience MHD but do not access CAMHS. This relies on an implicit assumption that help-seeking is the desired outcome for every CYP but this might not be the case and warrants further investigation. Mukolo et al. (2010) argue that in CYP MHS research, stigma has not been ‘well-conceptualised’ despite the assumption it is important and so there are no empirical theoretical frameworks to understand the impact of stigma on CYPs help-seeking behaviours and accessing of MHS. This would also be important to try and understand further to then be able to help reduce the impact on help-seeking.

Interaction between externalised and internalised stigma

As the quotes from the subordinate theme of "*I don't think it's talked about"* show, participants talked about how their grandparents/some wider family members were 'old-fashioned' with their views. In the theme of '*Evolving understanding of self and experiences'*, participants described a sense of feeling as if views held by these family members were incorrect and that they did not have a 'proper' understanding of their MHD, like other people, for example, in CAMHS. As discussed in the introduction, Corrigan (2004) argues that stigma affects help-seeking by affecting two areas; public/external stigma and self/internalised stigma. There seemed to be a sense of 'internalised stigma' about some of the views held in their respective cultures about MHD, with some participants 'choosing' the Western perspective instead. This Western understanding of MH seemed to fit better for some of the participants in understanding their difficulties, despite this potentially being at odds with perspectives held by their families within their home and family culture. This would be helpful to consider in future research to help further understanding about stigma for those CYP from migrant families.

Language and communication

A finding from this research (*difficulties speaking out)* highlighted the difficulty of language and communication for the participants and particularly with participants whose parent(s) did not have the same first language as them. Language was discussed in the introduction in terms of adults communicating with services about their MHD, however, there was no discussion in papers around CYP about communication with their parents and difficulties around this, particularly with parents that were not born in the same country as their child is being brought up in.

The two participants from a Bangladeshi background discussed how they did not have a technical grasp of the language to talk about mental health issues in Bengali but also that there might not be words to directly translate this either. A study around awareness of MHD and MHS carried out with adults from ethnic minority backgrounds (specifically Bengali, Urdu, Tamil and Somali communities) discussed how across all of their focus groups, there was a lack of understanding of western concepts of MHD such as 'anxiety' and ‘depression’ and how particularly in the Urdu female focus group, participants struggled to talk about the concept of anxiety, also reporting that there is no direct equivalent concept in their language (Loewenthal et al., 2012). Loewenthal et al. (2012) concluded how language as well as cultural and religious barriers affected help-seeking for their participants. This was echoed by members of Young Dynamos from South Asian backgrounds in discussions around this finding who shared that they would use or had used the English word for ‘anxiety’, ‘panic attack’ or ‘depression’ when talking to their family in languages such as Urdu, Hindi and Punjabi.

Participants discussed how this difficulty in communicating with their parents affected their ability to discuss their MHD and feel understood by their parents. This was echoed even by the participants that had the same first language as their parents. This language barrier for those that did not share a first language seemed to represent an additional barrier to accessing MH support for the YP and will be important to explore further with larger samples of participants in future research. Only one participant discussed the use of translators as the other participants had at least one parent who attended appointments that spoke English, however, this would also be a useful area to explore in future research too.

Parental influences

As described in the introduction, parents/carers are often key gatekeepers to CYP accessing support for MHD. Peck et al. (2014) state that parents generally fulfil many roles for YP including providing emotional support and that they are likely to be the most important source of support for YP. They argue that this is true across cultures, whereas importance of support from others such as friends tend to vary more across different cultures. de Haan et al. (2018) argue that most YP do not seek support by themselves and that generally accessing and engaging in ‘treatment’ depends on other people such as parents or teachers. The importance of the role of parents in supporting their child to access and engage with CAMHS in this study has again been highlighted in the results of this study. All participants described parental input (or lack of input) during this period, they described how some of their parents were more involved in trying to support them and others were not. They also talked about their input/support whilst they were ‘being seen’ by CAMHS.

Factors such as language and communication and the role this plays between parents and their children has already been considered but in this section, parental problem perception will also be considered. Two participants described how they parents were shocked at ‘finding out’ their child was experiencing MHD, and the other two participants described how their mothers noticed their difficulties.

Bevaart et al. (2014) discussed the role parents play in help-seeking and how parental problem perception is crucial for CYP being referred to specialist MHS, and is a strong predictor of service use (Sayal et al., 2003). Their research investigated the differences in ‘problem perception’ and ‘perceived need’ for professional support in parents and teachers of young CYP aged 5-6 years. They found that more parents from ethnic minority backgrounds perceived fewer problems as problematic than parents from the majority ethnic background, and that these differences could not be explained by severity of problem or socioeconomic factors. There were no differences between teachers’ problem perception and perceived need or parental perceived need. They concluded that this difference in problem perception is a potential factor in why fewer children from BAME backgrounds receive professional support. The authors discussed four reasons why this might be which is of interest to the results found in this study. Reasons proposes included; due to differences in thresholds across different families (and cultures) for behaviour being seen as problematic and what is perceived as a problem, feelings of fear or shame preventing sharing of concerns and/or language and cultural differences affecting problem perception. Although not directly related to MHD here and with a much younger group of CYP than this study, the results seem to match with reasons discussed in this study as to why parents may not have (at least outwardly) perceived their child to be struggling and/or seeking help for them. They argue that parental problem perception and perceived need for care should be seen and studied as separate processes in seeking support for CYP with MHD.

One participant discussed how her father had a better understanding of MH because he was born and raised in England and other participants discussed how family members that had been born in the UK or had lived here for a long time might have differing understandings of MHD. The process of acculturation, as described in the introduction, seems to play a role in how MHD are understood. This could be another helpful avenue to further investigate to increase knowledge around migration and this process and how it affects parenting and then therefore CYP of immigrant parents.

Religion influences

Most of the participants described the role religion played in helping them cope with their MHD. This tentatively fits with the finding that in many minority cultures, religion, prayer and spirituality plays a central role in dealing with distress and is used as a coping strategy (Cauce et al., 2002). Keating and Robertson (2004) argue that for adults from some black ethnic minority backgrounds, having religious faith can impact disclosure of MHD as there is sometimes a discourse that turning to faith is the only legitimate intervention. Participants did not describe religion as a barrier to disclosing MHD in their experience. Participants discussed how parents suggested prayer or turning to religious leaders for support but that this was generally experienced as helpful for participants. They did not discuss how this affected them seeking other support from CAMHS but some parents did turn to religious support at first. One of the participants also described how she felt as if her religion directly impacted what actions she took in acute distress around her overdose and that the teachings of her faith were a protective factor, limiting her overdose attempt. We did not discuss whether she had discussed this with any of her clinicians in CAMHS but this is interesting as the literature focuses on the potentially negative effects and barriers that religion can play but in this case religion was a positive factor. There appears to be little research into different religious faiths and the impact on self-harm to date.

School influences

All participants described how their school discussed mental health and MHD through assemblies and raising general awareness around MHD and ‘it being OK to talk’ about MHD. As discussed in the introduction, there have been recent attempts to try and increase awareness and reduce stigma around MHD. It was interesting to hear from participants that MHD were being discussed at school which seems to be a shift and an attempt to increase awareness of MHD with CYP, although participants discussed how although MHD such as depression and anxiety were discussed they were still not able to recognise these experiences within themselves.

Three participants described support from school staff around their MHD before their CAMHS input and one told school after her CAMHS input and then found this support helpful. It was interesting how for two participants; it was school that explicitly brought their MHD to their parents' attention, although parents might have noticed but not discussed these with their children. In the Bevaart et al. (2014) study described above they concluded that teachers as well as parents also play an important role in problem perception and help-seeking. Another participant was also referred to CAMHS directly through school, highlighting the important role schools can play in being a gatekeeper to CAMHS. This further highlights how necessary it is to undertake research with school teachers and staff as well as parents too to further investigate what support they provide CYP and how this and links between school and MHD could be developed to further support CYP.

One of the participants discussed how important and supportive she found her community support worker. This was only one participant's experience, however, it is understandable that this kind of support could be helpful for YP, particularly if these roles tend to be filled with a greater diversity of people – as there is a current lack of diversity of the CAMHS workforce nationally. It would be helpful to further consider and research the roles third-sector agencies and people such as community link workers and religious leaders have in supporting CYP with their MHD, as the evidence base around this is currently limited.

Identity development

As discussed in the introduction, the development of identity is a key part of adolescence development in the Western context (Erikson, 1968). Bennett (2005) argues that YP from ethnic minority backgrounds have the usual 'developmental tasks' of adolescence and have the additional task of navigating growing up in two or more cultures. Choi et al. (2006) also support this argument that YP have to develop and establish their ethnic identity as well as their self-identity and that developing a 'positive ethnic identity' is a key challenge (Deters, 1997). However, Gupta et al. (2007) argue that the view of 'adolescence' (as defined by Western standards), as the time period where YP develop their independence, transition between childhood and adulthood and separate from their family and parents, is an ideal placed on YP in Western culture. Spencer and Markstrom-Adams (1990) argue that it is usually during adolescence that individuals become conscious of their family culture in parallel to the dominant culture that they are growing up within.

Gonzales and Cauce (1995) argue that developing a positive ethnic identity has direct implications for the psychological health and well-being of individuals. Greig (2003) asserted that research exploring adolescent MHD must incorporate exploring developmental factors, such as the young person's ethnic identity as well as socio-cultural factors, is interesting to consider in light of the results. Only one participants described thinking a lot about her ethnicity and the difficulty she had in trying to make sense of her identity, particular in relation to her ethnicity. She described feeling very different to her peers growing up because of her ethnicity. Most of the participants described not feeling different in terms of their ethnicity in their school or community.

In thinking about this particular finding from the current study, the 'ethnic density hypothesis' (EDH), which suggests that individuals from ethnic minority backgrounds may have better mental health in areas where there are higher proportions of people from the same ethnicity as them (Silva et al., 2016) is useful to consider. This finding has been suggested to be explained because these areas may promote social capital and increase positive social variables such as social support, networks and participation, linking positively to health outcomes and measures of well-being (Arevalo et al., 2015). However, there is currently little evidence supporting the EDH in relation to YP and research into this area has mixed results (Silva et al., 2016).

As discussed in the introduction and above, it appears that societies, for example, within Asian, Caribbean and European countries have different cultural norms that are adaptive for their cultural context (Gupta et al., 2007). For example, Kakar (1985) asserts that a South Asian view around the transition between childhood and adulthood is that the goal is to become competent in helping maintain family structures and not to individuate from the family context. Thompson and Bhugra (2000) suggest there is a need to further explore these differing cultural norms and to create a more in-depth understanding of the different pressures and stresses experienced by YP from ethnic minority backgrounds. The experience of YP growing up within a Western culture as well as within differing family cultures and what this means for them needs further exploration in future research.

In this study, participants were either from Bangladeshi, mixed White and Caribbean or mixed South East Asian and Caribbean heritage. The sample is too small to draw any firm conclusions but of the three participants who felt they had not had any adverse experiences because of their ethnicity at school or in services, all reported being from diverse areas themselves. However, the participant who felt different in her area because of her ethnicity directly related this to being from a non-diverse area and school.

Choi et al. (2006) argue that YP from ethnic minority backgrounds balance two value systems (their own and that of the majority group) and that those from mixed heritage may have greater difficulty in navigating challenges compared to their peers with parents from the same ethnicity.

Eccles et al. (1993) discusses the important role parents can play in helping their children develop their sense of identity, with Eccles et al. (2006) discussing how this is an extra task for parents of CYP from an ethnic minority as this has to be developed in a context of discrimination. Peck et al. (2014) looked into whether parent reports of ethnicity socialisation messages are indirectly related to the development of adolescents’ ethnicity identity and found that they largely were. In this study, YP did not discuss experiences of discussing their ethnicity with their parents. This was, however, not a prompt in the study so it might have been that this was part of their experiences and just not something participants discussed. One YP did discuss making a conscious decision not to discuss her identity and making sense of this in relation to her ethnicity with her mum and unconsciously with her father so this would be interesting to explore with other YP in future research.

CAMHS

There has been little quantitative and even less qualitative research into how CYP from any background experience CAMHS (Edbrooke-Childs et al., 2016). However, from the current evidence base, studies that have looked into CYP views have found that a lack of understanding and trust in CAMHS made it harder for CYP to access as well as worries around stigma (Street et al., 2005). Some participants in this study also discussed how they did not have any awareness of CAMHS before accessing the service but did not discuss lack of trust in services.

Plaistow et al. (2014) found that YP from mainly white ethnic backgrounds described positive factors around CAMHS being around positive relationships with the CAMHS clinicians. Negative factors they found included the stigma around MHD and lack of information around MHS. The current findings seem to mirror some of these findings, although they were not as explicitly discussed by participants. Findings from this study indicated that CAMHS were experienced as more helpful for some YP than others, but that there were helpful parts to each participant’s experience. The experience of being given a diagnosis by CAMHS clinicians, even if they thought their experiences were in line with a particular diagnosis beforehand, seemed to be helpful for all YP as it gave them a name for their difficulties. Participants described feeling as if involvement from CAMHS gave credence and seriousness to their difficulties and helped them to make sense of their experiences.

Ethnicity of clinician

All four participants described how they did not have a preference as to whether their CAMHS clinician was from the same ethnic background as them. Most did also discuss, however, that there would be benefits if they were from similar backgrounds, such as being more aware of their family culture and beliefs. Participants discussed how their ethnicity and culture was not asked about as part of their time in CAMHS, with one participant stating that she thought this would have been helpful for the clinician to understand their experience. This matches findings from Dogra et al. (2017) who found that YP expressed no preferences over ethnicity of their MH clinicians. This finding is in contrast to findings from parents, who felt like having a clinician who spoke the same language as the client would be preferable, as they thought this might be linked to better communication and care. This finding links language to culture which is not always the case, however, this would be useful to consider further in future research.

Strengths and limitations

This study explored experiences of YP from an ethnic minority background in their experiences of their MHD and in accessing and engaging with CAMHS. Edbrooke-Childs and Patalay (2019) asserted that qualitative research was needed in this area to try and make sense of the current quantitative research findings discussed in the introduction that there are differences in referral pathways into CAMHS for CYP from differing ethnic backgrounds. This study has explored how participants have tried to make sense of their experiences of MHD before CAMHS input, at the time of referral and during CAMHS input. Strengths and limitations of this study are discussed below.

Strengths

A key strength of this study is that it has qualitatively explored the experiences of YP from an ethnic minority background in their experience of their MHD and in accessing and engaging with CAMHS. This has been a neglected area of research, despite its necessity and the importance of including views of CYP in order to better develop CAMHS and other services to meet the needs of YP with MHD. The study has provided YP with an opportunity to share their experiences when typically, these voices have been underrepresented and marginalised.

The themes that have emerged from the data could be seen as potential barriers and facilitators to accessing and engaging with CAMHS, however, as discussed, this needs much more investigation and research to better understand these factors. It is also a strength of the research that the findings seem to indicate that there are commonalities across experiences for CYP from ethnic minority backgrounds (as well as findings fitting with previous findings from research with all CYP). These potentially highlight ways current CAMHS services could be improved to better service needs for many CYP from ethnic minority backgrounds. This piece of research has highlighted a number of areas that would be helpful to explore further to bolster the evidence base.

Another key strength of this study is the involvement of the youth research advisory group Young Dynamos throughout the process. This has meant that the study has been closely planned with YP, including those from an ethnic minority background and those that have had input from CAMHS, to ensure that the research study would be appropriate to the participants. This collaboration also improved the quality checks of the study and therefore, the reliability and validity of the findings.

Quality checks

Another strength of this study is that quality checks discussed in chapter two and recommended by Elliott et al (1999) and Yardley (2000) were used throughout the study to ensure the reliability and validity of the analysis. This was particularly important as I am new to the IPA research methodology and I am an ‘outsider’ researcher. These are summarised in Table 4.

Table 4. *Overview of quality checks.*

Area Reviewed	Evidence
Owning one's perspective *(Elliott et al., 1999)*	I have endeavoured to be as transparent as possible about my own perspectives in undertaking this research. In my reflexivity statement, I owned my position as a trainee clinical psychologist, being from the ethnic majority group in the UK, engaging in an elective placement in CAMHS and being a novice IPA researcher. I am aware that more experienced researchers might have provided a deeper level of interpretation or different analysis of the data. Keeping a reflective journal aided me in identifying and becoming more aware of some of my perspectives and beliefs. Conversations with supervisors, peers in the IPA working group and with the Young Dynamos have also aided my reflexivity during the study and I have documented some of these reflections in the results chapter. Despite this, I still struggled with undertaking this research and how much my experiences and views from the aforementioned positions would be impacting the research. This seemed to hold me back at times in the analysis process, however, supervision helped me to ensure that I interpreted the data and did not simply describe it but that I also stayed grounded in the data too during this process.
Situating the sample *(Elliott et al., 1999)*	I provided an overview and table of demographics to provide contextual information on participants to situate the sample. I also presented detailed pen portraits about each participant to provide the reader with additional information about their contexts to better situate their story and experiences.
Grounding in examples *(Elliott et al., 1999)*	I presented quotes in the results chapter to provide evidence for each themes from the data. I also provided a table with an overview of which of the group themes were represented within each participant's experiences to give the reader sense of how themes represented across the data.

Providing credibility checks *(Elliott et al., 1999)*	I completed a number of credibility checks of my themes. The individual and group themes were discussed with my research supervisors who have experience of IPA, the peer IPA support group and Young Dynamos. This was to gain different perspectives to refine my themes, through this process my themes were clustered and re-clustered and the themes were validated. I kept an audit trail of these changes and revisited these to check my thinking during the results chapter write-up. I also discussed the results write-up process with my supervisors. I have provided examples of some of the steps of the analysis process in Appendix 4. Sharing individual and group themes with the Young Dynamo group members provided some helpful insights into their own experiences and those that resonated with participant's experiences and group members felt as if the themes made sense in my descriptions of the interviews and experiences. This helped add to the quality checks around validity as it seemed as if these themes had face value to the members.
Transparency and coherence *(Elliott et al., 1999 and Yardley, 2000)*	Transparency has been established by providing detailed accounts of material development, recruitment, procedures and data analysis. I provided a thematic map to show the relationship between the themes and provide quotes to illustrate how these interpretations and themes come from the data. It is hoped that the reader will see how these interpretations have come from the data.
Accomplishing general vs specific research tasks *(Elliott et al., 1999)*	As discussed above, due to the small sample size of four participants, findings from this study cannot be generalised. However, the findings indicated that there were similarities across experiences of being a YP from an ethnic minority background. I have discussed these findings in relation to other studies from the current evidence base to provide further understandings of the research, however, any conclusions about the findings are made tentatively.
Resonance with readers,	This study is one of the only studies to my knowledge to explore with YP from BAME background their experiences of their MHD and experiences in accessing and engaging with CAMHS. This demonstrates

impact and importance *(Elliott et al., 1999 and Yardley, 2000)*	the utility of the research. Resonance with readers, impact and importance of the study was established by detailing findings in the results section and placing the study within the wider research in the discussion section. The current context of world events such as the COVID-19 pandemics and the increased visibility of the Black Lives Matter movement highlight the importance of trying to decrease inequalities across the board, and in MHS/CAMHS for individuals from BAME communities.
Sensitivity to context (*Yardley, 2000)*	The meanings generated by participants were carefully considered during the analysis process, as was the context within which these experiences took place. I wanted to ensure I gave voice to each participant's experiences and provided demographic information and narratives about their experiences including around their MHD, family and ethnicity, demonstrating the awareness I had for my participant's context.
Commitment and rigour (*Yardley, 2000)*	Commitment to and rigour in undertaking this topic was evidenced through the thorough planning of the project and the in-depth analysis being completed and this process detailed in the write-up.

Limitations

This study recruited a small sample of four participants which was the specified minimum sample size for this study. The recruitment period was also shortened by a month due to the COVID-19 pandemic restrictions which may have limited the final sample of this study. However, as discussed in the methods chapter, Smith et al. (2009) state that smaller sample sizes in IPA studies is preferable and this sample size still allowed for rich and detailed accounts to be collected and analysed. A limitation often levelled at qualitative research is that results cannot be generalised, however, this study did not seek to generalise results and the aim of the study was to be an exploratory inquiry due to the lack of research into this area. Carradice et al. (2002) also argue that it more important that results are compared to the wider literature, with Smith et al. (2009) positing that results from small sample size studies can still provide insights which add to the evidence base.

As discussed in chapter two, homogeneity of the sample is an important consideration in IPA research, however, Smith et al. (2009) discussed that the extent of homogeneity will be dependent on individual studies. The recruitment criteria meant that it was possible that each participants could come from very different ethnic backgrounds to each other and justification for this decision was provided in the introduction chapter. The four participants were from three different ethnic backgrounds which increased the heterogeneity of my sample. As discussed, this was not to say their experiences will have been the same but they shared experiences of being from an ethnic minority background in the UK. It was felt during analysis that there was enough homogeneity within the participants and their experiences to undertake the group analysis. Although I did not have limits on gender in my inclusion criteria, all four participants were female which increased the homogeneity of the study. As well as gender, the final sample did have various shared demographic factors and some shared experiences in common as well as differences. They were all between the ages of 16-18 and had accessed and engaged with CAMHS within the past two years for MHD including anxiety. They were also all studying psychology or health care in further education and were motivated to take part in the research study. Some participants had aims to help other YP like themselves and others wanted to learn more about the research study and process.

One of the inclusion criteria for the study was that YP had to be discharged from CAMHS, and within the past two years, which meant that some YP took part in the interview some time after their discharge. Most participants discussed how they could not remember some parts of their experiences clearly meaning that some experiences may not have been able to be as thoroughly explored. It could be helpful for future research to elicit opinions around MHD and accessing CAMHS using vignettes (Loewenthal et al., 2012) – as this could help to gather CYP views on topics of interest without relying on memory of their own experiences. This was not appropriate for this study design as the aim was to explore own lived experiences but this could be helpful in future research as gaining more views across different areas will increase the knowledge base.

Finally, the focus of this study was around experiences of YP from an ethnic minority background and questions were around their experiences of their MHD and in accessing and engaging with CAMHS. There were also other factors in terms of intersectionality that will have been playing a role in the participants' experiences and that were not directly explored with participants such as gender, socioeconomic factors and class. These factors are interconnected but it would have been interesting to consider this intersectionality too. However, it was not within the scope of the current study but could be useful for future research.

Implications

In the following section, I will discuss some key implications of my research. It is likely that the most immediate implications will be for other researchers and research studies and this will be discussed further in the 'Future Research' section below. However, although the current results cannot be generalised, the findings seem to indicate that there could be implications for YP from an ethnic minority background. Findings also point to implications for schools, parents/families of YP and CAMHS and MH professionals.

A tentative implication from these findings is that there seemed to be commonalities between experiences across the YP from different ethnic minority backgrounds meaning that there could be potential changes that could be made to current CAMHS services that could help to increase equity of services for as many YP from an ethnic minority background as possible. It was also a strength that some commonalities from research in general with CYP seem to occur for those from BAME backgrounds too. However, this needs further exploration, specifically in what changes could be helpful. The findings from this research add to the currently limited evidence base and could be helpful for clinicians and services to be aware of when working with YP with MHD. They could also be helpful to consider for policy makers to better develop CAMHS and other services to support CYP with MHD. However, more research urgently needs to be carried out to see whether these results are found again with greater numbers of YP.

An interesting finding from this study was the important role schools held in each participant's experience of accessing support for their MHD. This was through referring YP to CAMHS or making parents aware of difficulties but also for support for their MHD accessed within schools itself, such as seeing a counsellor. This suggests the importance of schools in YPs' experiences of their MHD and in more formal help-seeking. This is also a concerning finding in the current context of the COVID-19 pandemic because of the nationwide shutting of many schools (as well as most other services). It is likely that many YP who were accessing MH support through schools or that would have been referred to other MH services through schools may not be accessing the same support for their MHD (if any) that they would have received had schools been open, which is likely to detrimentally impact on CYP and how they are coping with MHD.

Despite this indicated importance of school's role with CYP and MHD, most participants described that although MHD were discussed in school, they did not make connections between what they were hearing and their individual experiences which could suggest that the information and support for MHD within schools could be improved. This highlights the role in recognition and response to MHD that schools can, and do play for YP and indicates that MHD could be picked up and support provided quicker both within schools and in improving links between CAMHS and other MHS. The findings also suggest that CAMHS services are still not widely known or understood amongst YP, despite the increased focus on MHD in school.

Participants described some experiences and difficulties echoed by other YP (from all ethnicities, although mainly white ethnic backgrounds) in previous research studies (Street et al., 2005). There needs to be more research into experiences of all YP in general as at the moment, there is not a strong evidence base to capture experiences of YP generally to then compare whether these, or other findings, are specific to YP from ethnic minority backgrounds. However, findings seem to suggest that there is an additional layer of potential difficulties in accessing support from CAMHS for YP from an ethnic minority background. For example, an extra potential barrier is around language and communication if the first language of parents is not the same as theirs and with also potentially differing cultural views and stigma around topics such as MHD. These findings seem to highlight the importance of working with both CYP and their families around MHD, as even if YP have a sense of Western concepts around MHD through their school and wider environment, this could still represent a barrier if parents do not have insight into these concepts which are then also held by CAMHS/other services. If service structures and funding allowed, it could be important to do more family work within CAMHS (if YP consenting) to try and foster mutual understanding of MHD and to collaboratively work on coping strategies that are acceptable within family culture and environment as well to help make changes.

Clinically, the results indicate that it could be helpful for CAMHS clinicians to 'name' ethnicity and potential differences in ethnicity in sessions with CYP. Some participants described that they may have wanted to discuss this with their CAMHS clinician but did not know how or did not feel able to bring this up in sessions. Therefore, clinicians naming this in sessions should provide the opportunity for CYP to explicitly discuss these issues if they would like to. This is also pertinent to other issues of difference (or similarity) such as gender or age differences too. It would be important that clinicians were tentative in this and not assume that factors such as the CYP's ethnicity or cultural background is affecting their MHD. It could also be helpful to explore potentially competing explanations of MHD experiences in sessions with CYP and with families too.

Future Research

This exploratory study was a useful insight into the experiences of four female YP from an ethnicity minority background in using CAMHS. The current findings, as well as previous findings in the literature, indicate numerous areas for future research. It is vital to further understand experiences and what facilitators and barriers there are for accessing support for MHD as well as increasing understanding of what can improve experiences in services too. IPA was the best methodology for this study design and aims but future research should use a wide range of quantitative and qualitative methodology and sampling criteria to add further insight and increase understanding into this multi-factorial and complex area. Other areas that could be helpful for future research are detailed below.

- It would be interesting to explore this research area with more YP and also with male YP too to see if similar themes come up in future research. It is also necessary to explore the understanding and experiences of MHD for younger CYP too as some participants described struggling with their MHD without support when they were at primary school.
- It could be helpful to undertake research with CYP from particular ethnicities as well to further understand particular cultural understandings of MHD, although exploring similarities for facilitators and barriers across ethnic minority groups is helpful, as detailed throughout.
- It is also necessary to try and gain the voices of CYP that experience MHD that do not access MH support through CAMHS. It is important to understand more about whether there are other avenues of support that CYP are finding more accessible and helpful or whether there are a lot of CYP in need of support through services such as CAMHS and are not being referred into or accessing these services.
- It would also be helpful to understand more about whether current underrepresentation in CAMHS is because of lower MHD rates and need within particular communities or

whether there are factors impacting help-seeking for those CYP that could benefit from MH support.

As well as the importance of undertaking more research with CYP, this research has further highlighted the need to carry out research with other people involved in a CYPs life such as with parents, schools, GPs and CAMHS services too. Further research is particularly needed into:

- Parent perspectives and experiences of their child’s MHD as well as parental factors contributing to help-seeking. This could help to elucidate areas that can be developed to better support them to support their child and potentially what could help support parents to support YP before needing to access more formal services such as CAMHS, and during, if they need to access CAMHS.
- Experiences of school staff in supporting CYP with MHD and what could help school staff to further support CYP within school settings.
- Experiences of clinicians within CAMHS and their understanding of barriers to help-seeking and what can impact on CYP’s experiences within CAMHS. Participants did not all access the same pathway in CAMHS, future research with clinicians could be interesting to further understand pathways in CAMHS and how decisions are made about interventions including therapy for CYP.
- The findings from this study also indicated that GP services were not always the best gatekeepers to CAMHS so accessing through these primary care routes warrants further investigation. There is also less research around potential support provided in areas such as community or religious centres or through third sector agencies. This would also be helpful to explore in future research.

Conclusion

In conclusion, this research study qualitatively explored experiences of YP from BAME backgrounds of their MHD and in accessing and engaging with CAMHS. Three superordinate themes emerged from the data in the group analysis and contributed to answering the research questions of the study. Findings indicated that there were similarities as well as differences across experiences for the YP who participated.

Participants seemed to find their experiences of trying to make sense of their MHD a confusing time, where they initially felt different and alone. Then, when difficulties were noticed or brought into the open for parents and other important people in the YP's life such as school, this created more confusion as there were multiple and conflicting perspectives to navigate about what their MHD meant and what could be helpful. CAMHS and schools seemed to sometimes provide different perspectives that was sometimes at odds with some parental and family cultural understanding of MHD. All participants described a lengthy time period of experiencing MHD before accessing formal support through CAMHS. Some participants had initially experienced support for their MHD through school with a school counsellor or other therapies such as homeopathy, whereas, for others, CAMHS was their first experience of MH support. Participants described different experiences with CAMHS; although only one participant would describe her experience with CAMHS as the most helpful thing for her in dealing with her MHD, all participants described helpful experiences from their time with CAMHS, for example, feeling listened to and having their experiences validated and normalised. Participants described an evolving sense of understanding about themselves and their MHD through these experiences.

The themes that emerged from this data seemed to be similar to themes coming up in previous research studies with CYP. Findings indicate that there seems to be extra layers of difficulties and complexities for CYP from an ethnic minority in their experiences of their MHD and in accessing and engaging with CAMHS. Findings also seem to highlight that supporting parents and schools to support CYP with MHD could be crucial. Further research is needed both with CYP but also other people in CYPs lives such as parents, schools and MH clinicians to further understand experiences from all stakeholders to then try and develop services to better meet the needs of all CYP with MHD.

Final Reflections

I found this to be a challenging but extremely worthwhile and interesting research study to undertake. Throughout the process, I constantly wondered whether I was the 'right' person to undertake this research, however, I ultimately believe it should be an aim for all clinicians from all ethnicities working within CAMHS/MHS to help to develop more equitable services for the people we work with. It was a privilege to hear the stories and experiences of the four female YPs that I interviewed and this confirmed my passion for working to improve outcomes for all CYP, but particularly those that face additional layers of discrimination and disadvantage. I am hopeful that the current focus on trying to develop and improve services and outcomes for people from ethnic minority communities remains on the agenda nationally, as well as within MHS and research and that this will translate into increased funding, developing better services and sustained, tangible change for individuals and CYP from ethnic minority communities.

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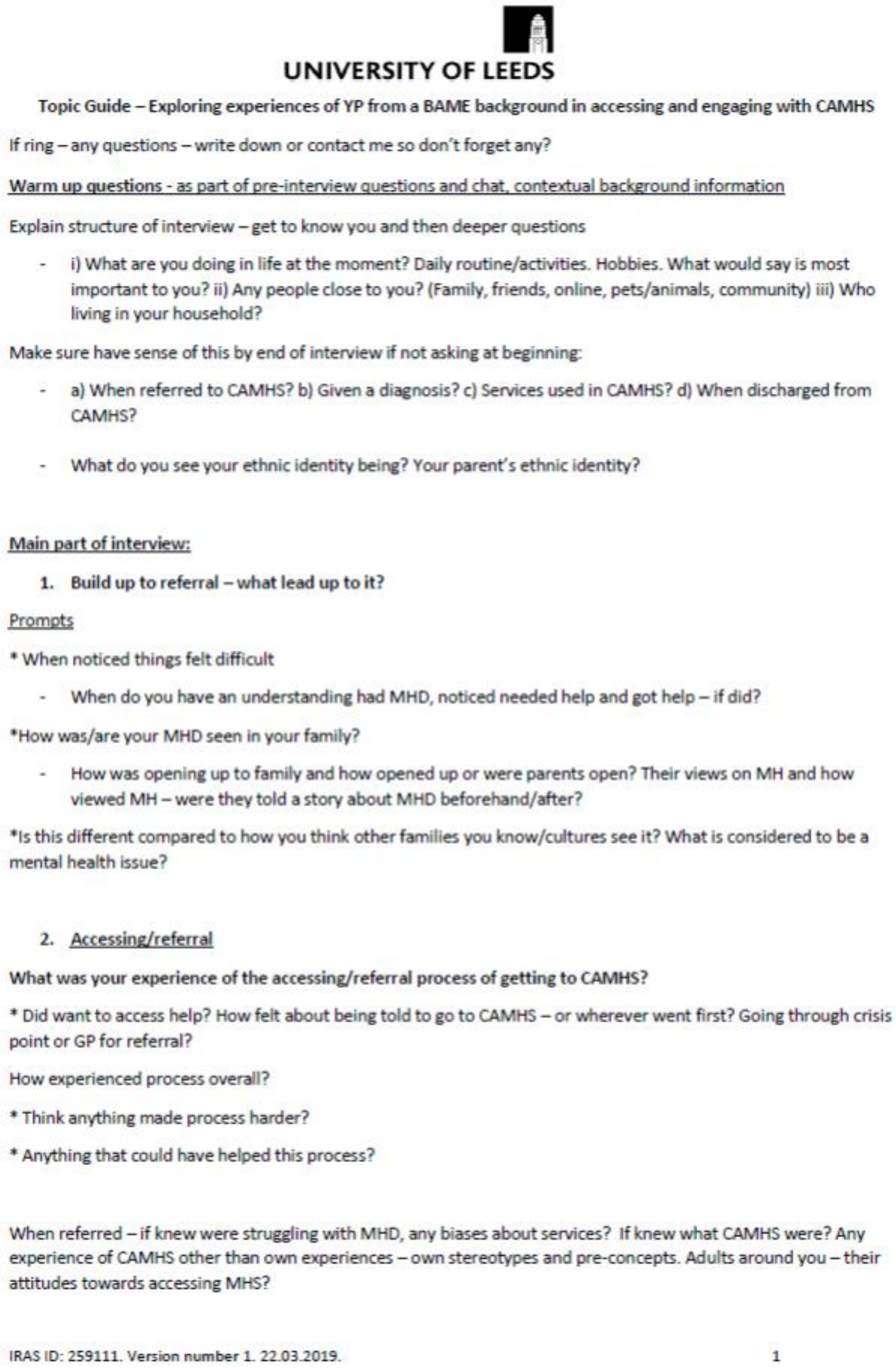
Appendix

Appendix 1 - Topic guide



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Topic Guide – Exploring experiences of YP from a BAME background in accessing and engaging with CAMHS

If ring – any questions – write down or contact me so don't forget any?

Warm up questions - as part of pre-interview questions and chat, contextual background information

Explain structure of interview – get to know you and then deeper questions

- i) What are you doing in life at the moment? Daily routine/activities. Hobbies. What would say is most important to you? ii) Any people close to you? (Family, friends, online, pets/animals, community) iii) Who living in your household?

Make sure have sense of this by end of interview if not asking at beginning:

- a) When referred to CAMHS? b) Given a diagnosis? c) Services used in CAMHS? d) When discharged from CAMHS?

- What do you see your ethnic identity being? Your parent's ethnic identity?

Main part of interview:

1. **Build up to referral – what lead up to it?**

Prompts

* When noticed things felt difficult

- When do you have an understanding had MHD, noticed needed help and got help – if did?

*How was/are your MHD seen in your family?

- How was opening up to family and how opened up or were parents open? Their views on MH and how viewed MH – were they told a story about MHD beforehand/after?

*Is this different compared to how you think other families you know/cultures see it? What is considered to be a mental health issue?

2. Accessing/referral

What was your experience of the accessing/referral process of getting to CAMHS?

* Did want to access help? How felt about being told to go to CAMHS – or wherever went first? Going through crisis point or GP for referral?

How experienced process overall?

* Think anything made process harder?

* Anything that could have helped this process?

When referred – if knew were struggling with MHD, any biases about services? If knew what CAMHS were? Any experience of CAMHS other than own experiences – own stereotypes and pre-concepts. Adults around you – their attitudes towards accessing MHS?

3. Engagement

Tell me about your experience of being under/being seen by/being with CAMHS? (To check again with YD what terminology best to use to ask about this part of the experience – used? Even if didn't actually engage?)

Prompts

* Who did see in CAMHS? How often saw clinicians/whoever? Staff: type of worker, how many saw. Did they explain why saw? If saw lots of different people – how did feel about this? Why team and not 1 person

- How many appointment attended? How much 'engaged'? Where seen – home, school, service?

* What was helpful?

* What was unhelpful?

- What part of CAMHS process felt – confusing/helpful?
- Appointment with parents or on own? How were parents involved in care?
- Any barriers – cultural?
- Think anything could have been changed or improved?
- Help being with CAMHS – at early enough stage?

* Any differences around ethnicity noticed?

- Any staff with similar/same ethnicity – feel more comfortable/understood if same? Any other differences – gender etc?
- Felt treated differently? If so, felt because of ethnicity? If said yes, any other people in CAMHS, peers in groups that felt were more similar?
- Felt worker able to relate to you?

- Cultural or religious aspects?

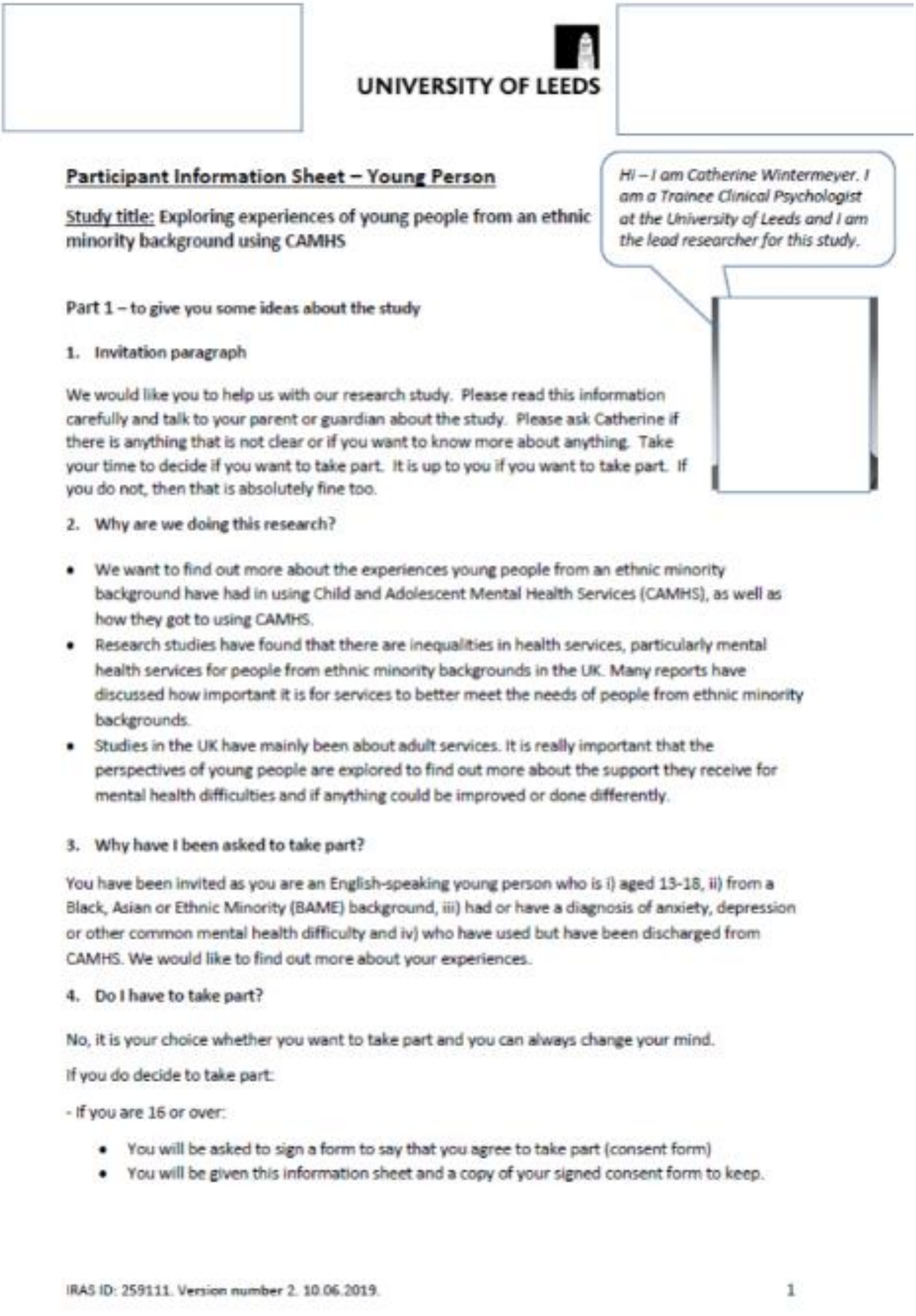
How backgrounds related to experience of CAMHS: ethnicity vs nationality, gender, generation differences & age referred or re-referred?

- **Any concluding comments? Anything not talked about?**

Thank you!

Ask if they want to choose a pseudonym, give and go through debriefing sheet & reiterate that can let me know within 2 weeks if want data to be withdrawn.

Appendix 2 - Participant Information Sheet & Consent Form. As the participants were all 16+, the corresponding PIS and CF are provided below.



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Hi – I am Catherine Wintermeyer. I am a Trainee Clinical Psychologist at the University of Leeds and I am the lead researcher for this study.

Participant Information Sheet – Young Person

Study title: Exploring experiences of young people from an ethnic minority background using CAMHS

Part 1 – to give you some ideas about the study

1. Invitation paragraph

We would like you to help us with our research study. Please read this information carefully and talk to your parent or guardian about the study. Please ask Catherine if there is anything that is not clear or if you want to know more about anything. Take your time to decide if you want to take part. It is up to you if you want to take part. If you do not, then that is absolutely fine too.

2. Why are we doing this research?

- We want to find out more about the experiences young people from an ethnic minority background have had in using Child and Adolescent Mental Health Services (CAMHS), as well as how they got to using CAMHS.
- Research studies have found that there are inequalities in health services, particularly mental health services for people from ethnic minority backgrounds in the UK. Many reports have discussed how important it is for services to better meet the needs of people from ethnic minority backgrounds.
- Studies in the UK have mainly been about adult services. It is really important that the perspectives of young people are explored to find out more about the support they receive for mental health difficulties and if anything could be improved or done differently.

3. Why have I been asked to take part?

You have been invited as you are an English-speaking young person who is i) aged 13-18, ii) from a Black, Asian or Ethnic Minority (BAME) background, iii) had or have a diagnosis of anxiety, depression or other common mental health difficulty and iv) who have used but have been discharged from CAMHS. We would like to find out more about your experiences.

4. Do I have to take part?

No, it is your choice whether you want to take part and you can always change your mind.

If you do decide to take part:

- If you are 16 or over:

  - You will be asked to sign a form to say that you agree to take part (consent form)
  - You will be given this information sheet and a copy of your signed consent form to keep.

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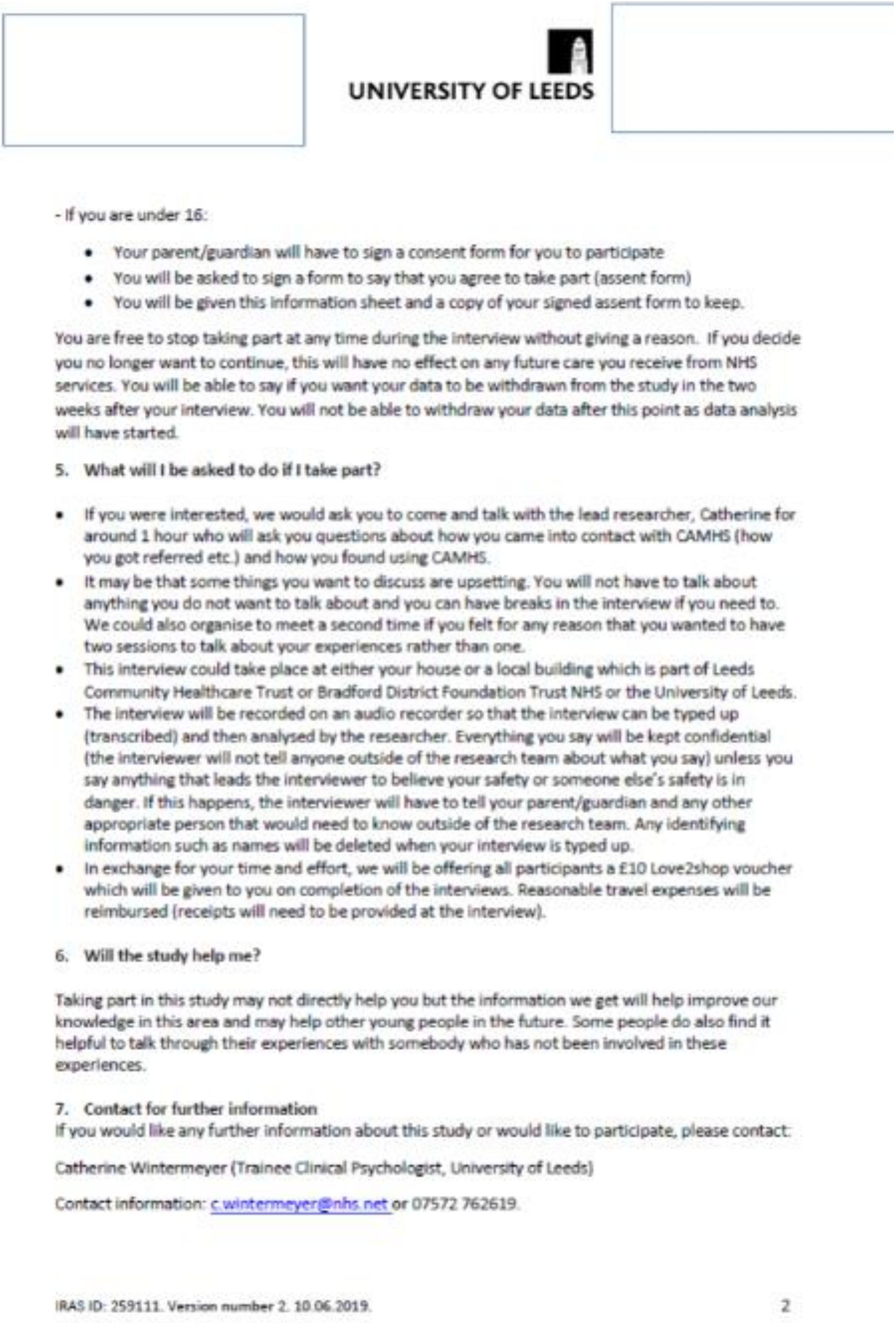

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- If you are under 16:

- Your parent/guardian will have to sign a consent form for you to participate
- You will be asked to sign a form to say that you agree to take part (assent form)
- You will be given this information sheet and a copy of your signed assent form to keep.

You are free to stop taking part at any time during the interview without giving a reason. If you decide you no longer want to continue, this will have no effect on any future care you receive from NHS services. You will be able to say if you want your data to be withdrawn from the study in the two weeks after your interview. You will not be able to withdraw your data after this point as data analysis will have started.

5. What will I be asked to do if I take part?

- If you were interested, we would ask you to come and talk with the lead researcher, Catherine for around 1 hour who will ask you questions about how you came into contact with CAMHS (how you got referred etc.) and how you found using CAMHS.
- It may be that some things you want to discuss are upsetting. You will not have to talk about anything you do not want to talk about and you can have breaks in the interview if you need to. We could also organise to meet a second time if you felt for any reason that you wanted to have two sessions to talk about your experiences rather than one.
- This interview could take place at either your house or a local building which is part of Leeds Community Healthcare Trust or Bradford District Foundation Trust NHS or the University of Leeds.
- The interview will be recorded on an audio recorder so that the interview can be typed up (transcribed) and then analysed by the researcher. Everything you say will be kept confidential (the interviewer will not tell anyone outside of the research team about what you say) unless you say anything that leads the interviewer to believe your safety or someone else's safety is in danger. If this happens, the interviewer will have to tell your parent/guardian and any other appropriate person that would need to know outside of the research team. Any identifying information such as names will be deleted when your interview is typed up.
- In exchange for your time and effort, we will be offering all participants a £10 Love2shop voucher which will be given to you on completion of the interviews. Reasonable travel expenses will be reimbursed (receipts will need to be provided at the interview).

6. Will the study help me?

Taking part in this study may not directly help you but the information we get will help improve our knowledge in this area and may help other young people in the future. Some people do also find it helpful to talk through their experiences with somebody who has not been involved in these experiences.

7. Contact for further information

If you would like any further information about this study or would like to participate, please contact:

Catherine Wintermeyer (Trainee Clinical Psychologist, University of Leeds)

Contact information: c.wintermeyer@nhs.net or 07572 762619.

Thank you for reading so far! If you are still interested, please go to Part 2:

Part 2 - more information you need to know if you still want to take part

8. What if I do not want to do the research anymore?

Just tell the researcher or your parent/guardian at any time. You do not have to give any reasons. There will not be any consequences if you do decided you no longer want to do the interview and nobody will feel angry or disappointed with you. You can also let Catherine know if you want your data to be withdrawn from the study at any point in the two weeks after your interview.

9. What if there are any issues or something goes wrong?

If possible, tell Catherine in person if there is a problem and we will try and sort it out straight away. Or you and your parent/guardian can either contact Catherine or:

Dr Thomas Cliffe t.d.cliffe@leeds.ac.uk or Dr Tracey Smith t.e.smith@leeds.ac.uk (Academic Thesis Supervisors). Address: Leeds Institute of Health Sciences, University of Leeds, Level 10 Worsley Building, Clarendon Way, Leeds, LS2 9NL. Telephone: 0113 343 0815 OR

NHS Patient Advice & Liaison Services: LCHT Tel: 0113 220 8585 BDCT Tel: 01274 251440

10. Will anyone else know I'm doing this?

The people in our research team (please see contact details below) will know you are taking part. A trained professional called a transcriber will also type up (transcribe) the interview – they will have signed a confidentiality agreement with the University of Leeds (this means they will not tell anyone about what you say in the interview). All information that is collected about you during the research will be kept strictly confidential. You will be given a number and a pseudonym (a fake name) which will be used to store any information about you instead of your real name and any identifying information will be taken out of quotes used in publications.

All electronic (i.e. audio recordings and transcriptions) and paper data (i.e. consent/assent forms and consent to contact forms) will be stored securely at the University of Leeds. Once the study is complete, all information will be kept securely for 3 years before being destroyed.

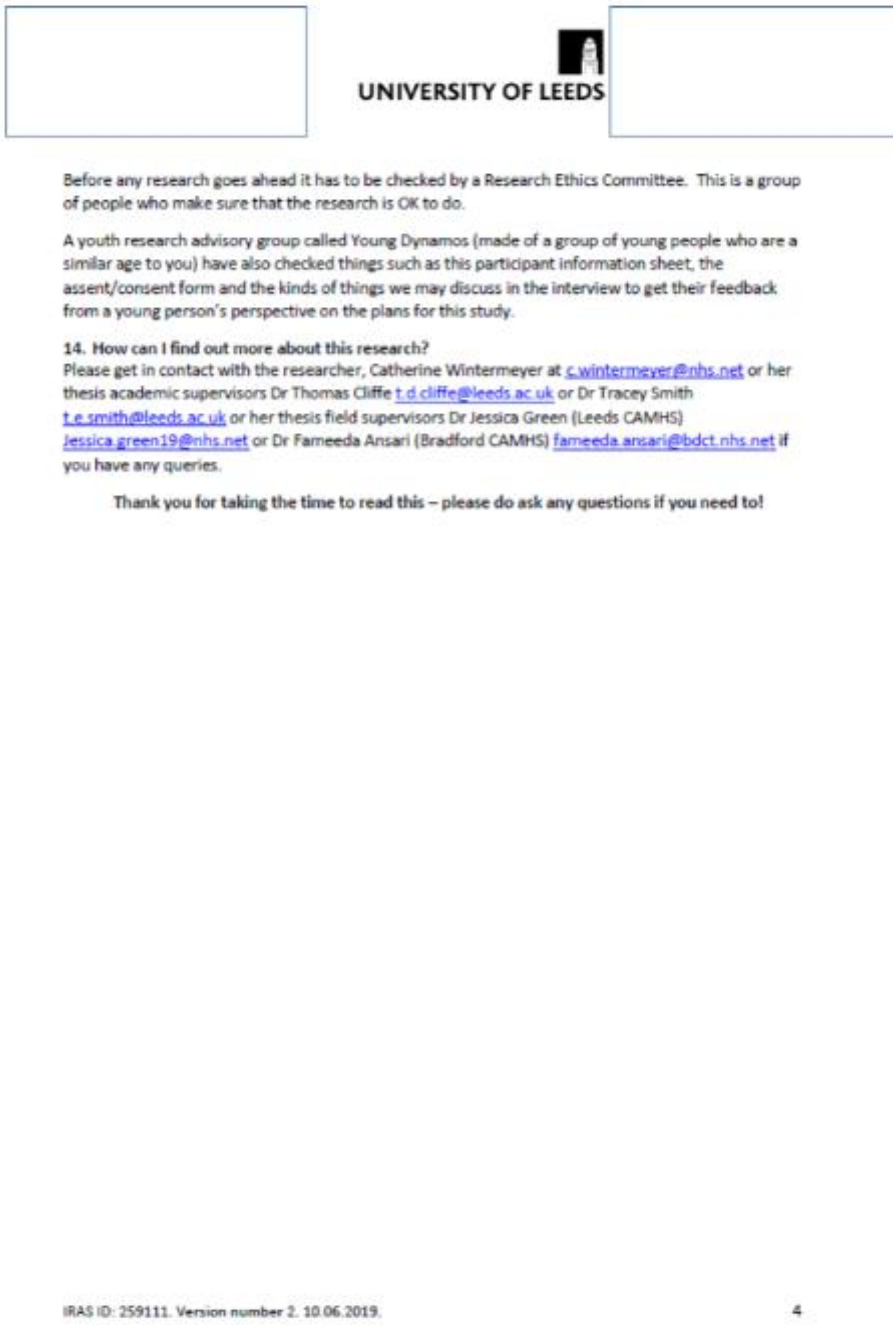
11. What will happen to the results of the research study?

When the study has finished, Catherine will write up this research as part of her doctoral thesis. This may be presented at conferences and meetings and may be published in academic journals. She may also put a brief summary onto websites such as an NHS website or the University of Leeds website. The results will be anonymous, which means that you will not be able to be identified from them. You can ask for a summary of these results once there are available – please indicate on the consent/assent form if you would like a summary (please note it may take up to 24 months for this to be available).

12. Who is organising and funding the research?

Catherine Wintermeyer, a trainee clinical psychologist at the University of Leeds is organising this study as part of her doctoral thesis. The research is being paid for by the University of Leeds.

13. Who has checked the study?



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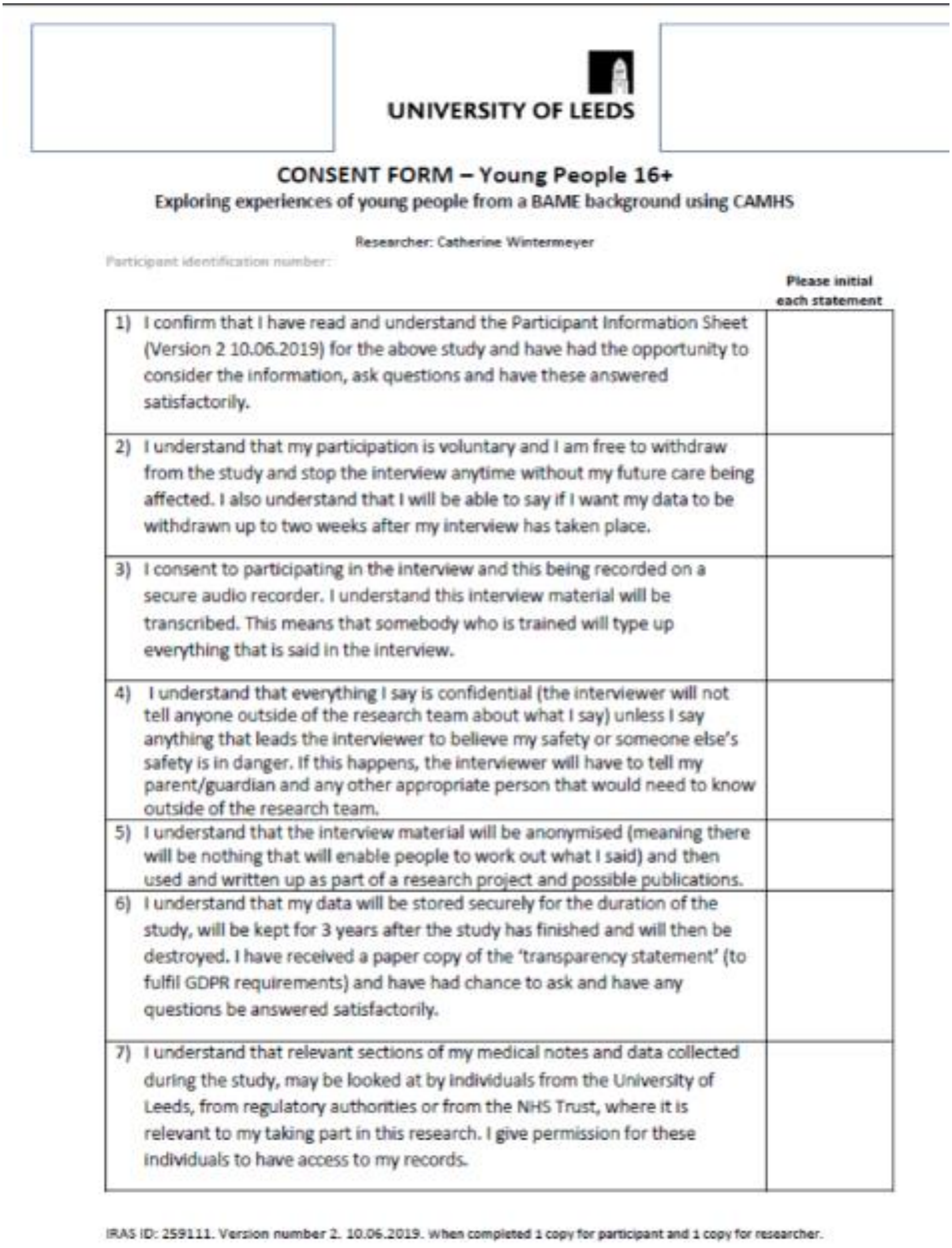
Before any research goes ahead it has to be checked by a Research Ethics Committee. This is a group of people who make sure that the research is OK to do.

A youth research advisory group called Young Dynamos (made of a group of young people who are a similar age to you) have also checked things such as this participant information sheet, the assent/consent form and the kinds of things we may discuss in the interview to get their feedback from a young person's perspective on the plans for this study.

14. How can I find out more about this research?

Please get in contact with the researcher, Catherine Wintermeyer at c.wintermeyer@nhs.net or her thesis academic supervisors Dr Thomas Cliffe t.d.cliffe@leeds.ac.uk or Dr Tracey Smith t.e.smith@leeds.ac.uk or her thesis field supervisors Dr Jessica Green (Leeds CAMHS) Jessica.green19@nhs.net or Dr Fameeda Ansari (Bradford CAMHS) fameeda.ansari@bdct.nhs.net if you have any queries.

Thank you for taking the time to read this – please do ask any questions if you need to!



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CONSENT FORM – Young People 16+

Exploring experiences of young people from a BAME background using CAMHS

Researcher: Catherine Wintermeyer

Participant identification number:

	Please initial each statement
1) I confirm that I have read and understand the Participant Information Sheet (Version 2 10.06.2019) for the above study and have had the opportunity to consider the information, ask questions and have these answered satisfactorily.	
2) I understand that my participation is voluntary and I am free to withdraw from the study and stop the interview anytime without my future care being affected. I also understand that I will be able to say if I want my data to be withdrawn up to two weeks after my interview has taken place.	
3) I consent to participating in the interview and this being recorded on a secure audio recorder. I understand this interview material will be transcribed. This means that somebody who is trained will type up everything that is said in the interview.	
4) I understand that everything I say is confidential (the interviewer will not tell anyone outside of the research team about what I say) unless I say anything that leads the interviewer to believe my safety or someone else's safety is in danger. If this happens, the interviewer will have to tell my parent/guardian and any other appropriate person that would need to know outside of the research team.	
5) I understand that the interview material will be anonymised (meaning there will be nothing that will enable people to work out what I said) and then used and written up as part of a research project and possible publications.	
6) I understand that my data will be stored securely for the duration of the study, will be kept for 3 years after the study has finished and will then be destroyed. I have received a paper copy of the 'transparency statement' (to fulfil GDPR requirements) and have had chance to ask and have any questions be answered satisfactorily.	
7) I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from the University of Leeds, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	

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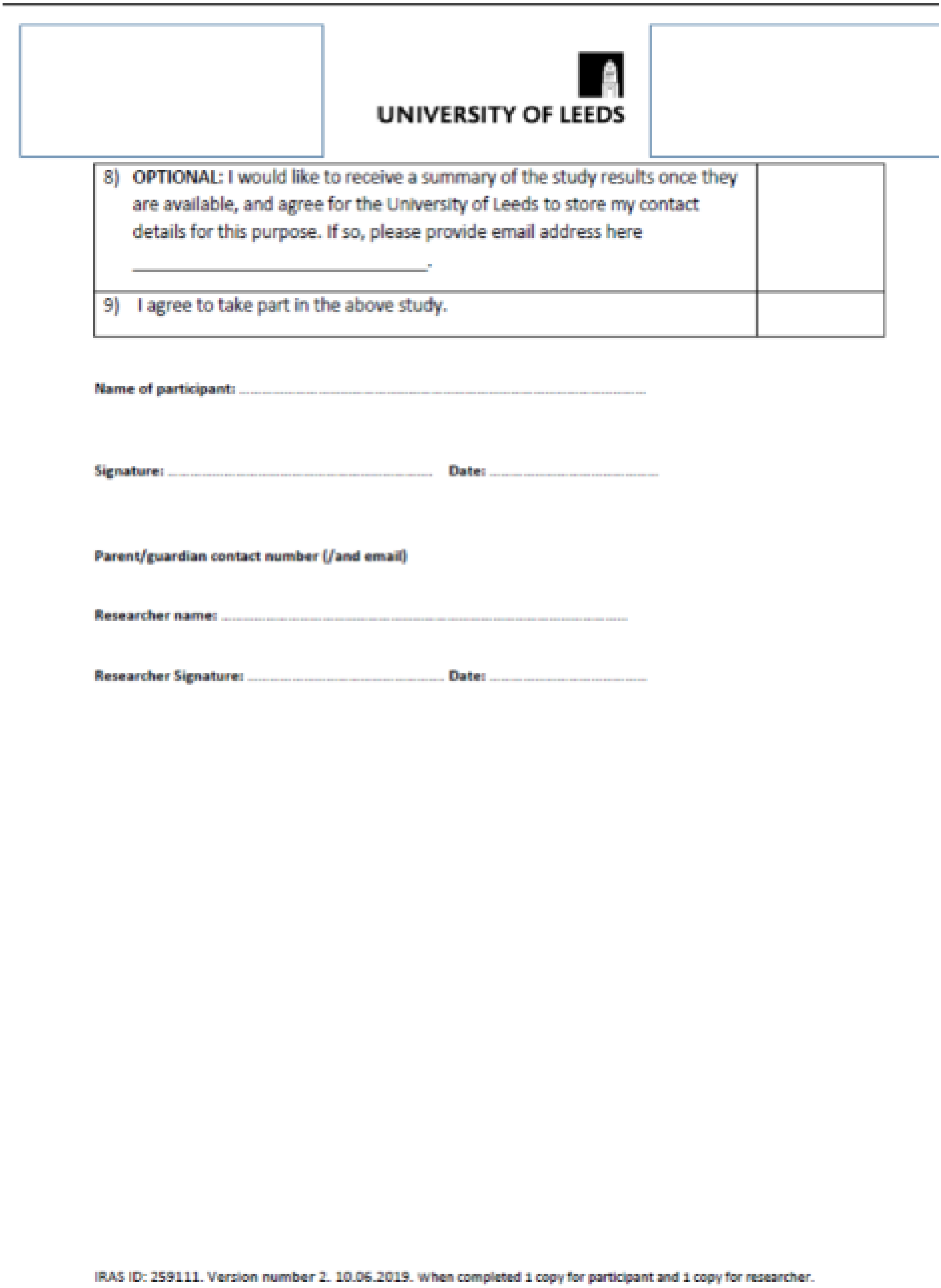

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8) **OPTIONAL:** I would like to receive a summary of the study results once they are available, and agree for the University of Leeds to store my contact details for this purpose. If so, please provide email address here ______________________________.	
9) I agree to take part in the above study.	

Name of participant: ……………………………………………………………………

Signature: ……………………………………………… **Date:** ……………………………

Parent/guardian contact number (/and email)

Researcher name: ……………………………………………………………………

Researcher Signature: …………………………………… **Date:** ……………………………

IRAS ID: 259111. Version number 2. 10.06.2019. When completed 1 copy for participant and 1 copy for researcher.

Appendix 3 – Consent-to-contact form

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Consent to contact for research purpose

TITLE: *Exploring experiences of young people from an ethnic minority background in using CAMHS.*

SPONSOR: University of Leeds.

Researcher: Catherine Wintermeyer.
Supervisors: Academic Thesis Supervisors: Dr Thomas Cliffe and Dr Tracey Smith.
Field supervisors: Leeds CAMHS - Dr Jessica Green. Bradford CAMHS - Dr Fameeda Ansari.

You are being invited to give consent for Catherine Wintermeyer to contact you at some time in the future to invite you to participate in a research study. If you are under 16, your parent will also have to give consent for this.

Are you willing to learn more about the 'Exploring experiences of YP from an ethnic minority background in using CAMHS' study?

If yes, you will be contacted at a later date. You will have no obligation to participate in this study by saying yes to this. You give permission for your details on this form to be passed on to the researcher for the purpose of being contacted to learn more about the above research study.

If no, declining to be contacted will not impact on your future care and you will not be asked to participate in this study again.

YES NO

If yes, please include your contact information below.

Name: ______________________________

Email: ______________________________ **Telephone:** ____________________

Young Person's Signature: ______________________________

Date: ____________

Clinician's Name: ______________________________

If young person under 16 years old:

I give consent for Catherine to contact my child/me {delete as appropriate} to find out more about participating in this study.

Parent/guardian name: ______________________________

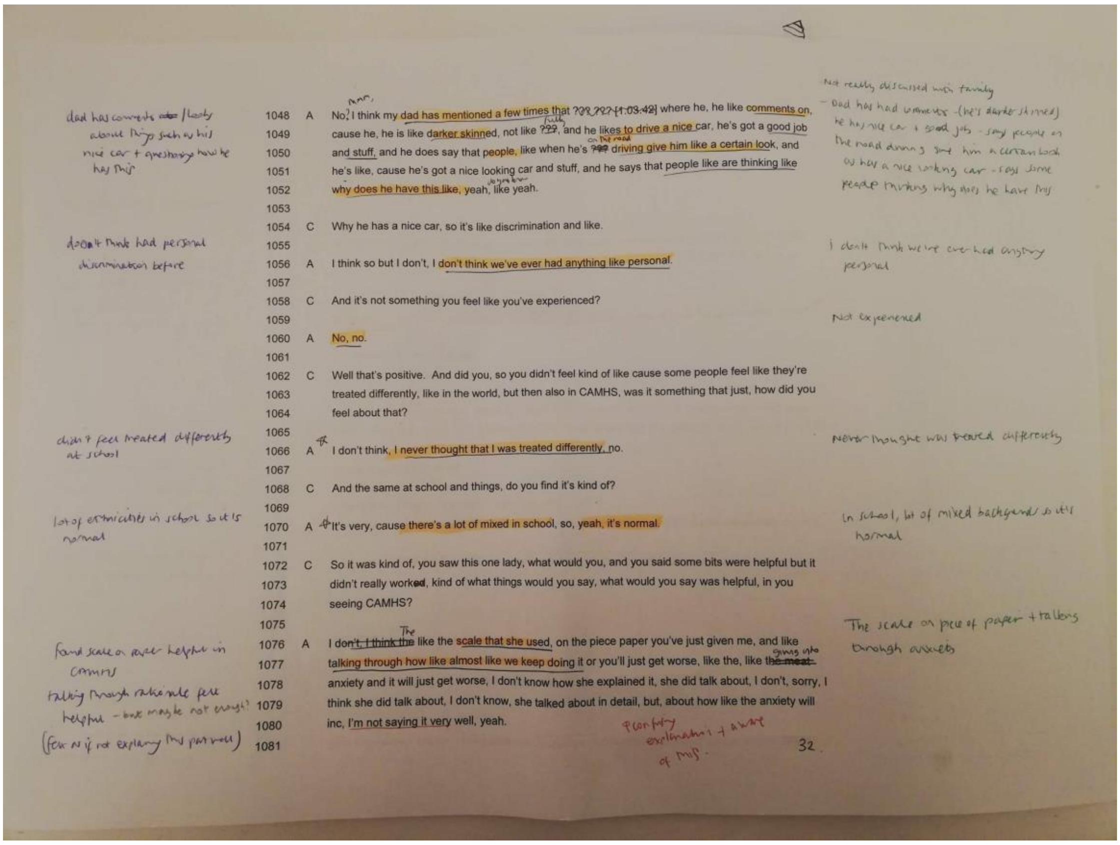
Email ______________________________ **Telephone:** ____________________

Parent/guardian's signature (if under 16) ______________________________

IRAS ID: 259111. Version number 1. 22.03.2019.

Appendix 4 – Examples of analysis

Initial noting of individual transcripts



dad has comments ~~abo~~ / looks about things such as his nice car + questioning how he has this

doesn't think had personal discrimination before

didn't feel treated differently at school

lot of ethnicities in school so it is normal

found scale on paper helpful in CAMHS

talking through rationale felt helpful – but maybe not enough?

(fear N if not explaining this part well)

A No, mm, I think my dad has mentioned a few times that ??? ???~~[1:03:42]~~ where he, he like comments on, cause he, he is like darker skinned, not like ~~???~~, and he likes to drive a nice car, he's got a good job and stuff, and he does say that people, like when he's ~~???~~ on the road driving give him like a certain look, and he's like, cause he's got a nice looking car and stuff, and he says that people like are thinking like why does he have this like, yeah, you know like yeah.

C Why he has a nice car, so it's like discrimination and like.

A I think so but I don't, I don't think we've ever had anything like personal.

C And it's not something you feel like you've experienced?

A No, no.

C Well that's positive. And did you, so you didn't feel kind of like cause some people feel like they're treated differently, like in the world, but then also in CAMHS, was it something that just, how did you feel about that?

A I don't think, I never thought that I was treated differently, no.

C And the same at school and things, do you find it's kind of?

A It's very, cause there's a lot of mixed in school, so, yeah, it's normal.

C So it was kind of, you saw this one lady, what would you, and you said some bits were helpful but it didn't really worked, kind of what things would you say, what would you say was helpful, in you seeing CAMHS?

A I do~~n't, I think the~~ The like the scale that she used, on the piece paper you've just given me, and like talking through how like almost like we keep doing it or you'll just get worse, like the, like ~~the meat~~ going into anxiety and it will just get worse, I don't know how she explained it, she did talk about, I don't, sorry, I think she did talk about, I don't know, she talked about in detail, but, about how like the anxiety will inc, I'm not saying it very well, yeah.

? conformity explanation + aware of this.

32

Not really discussed with family

– Dad has had comments – (he's darker skinned) he has nice car + good job – says people on the road driving give him a certain look as has a nice looking car – says some people thinking why does he have this

I don't think we've ever had anything personal

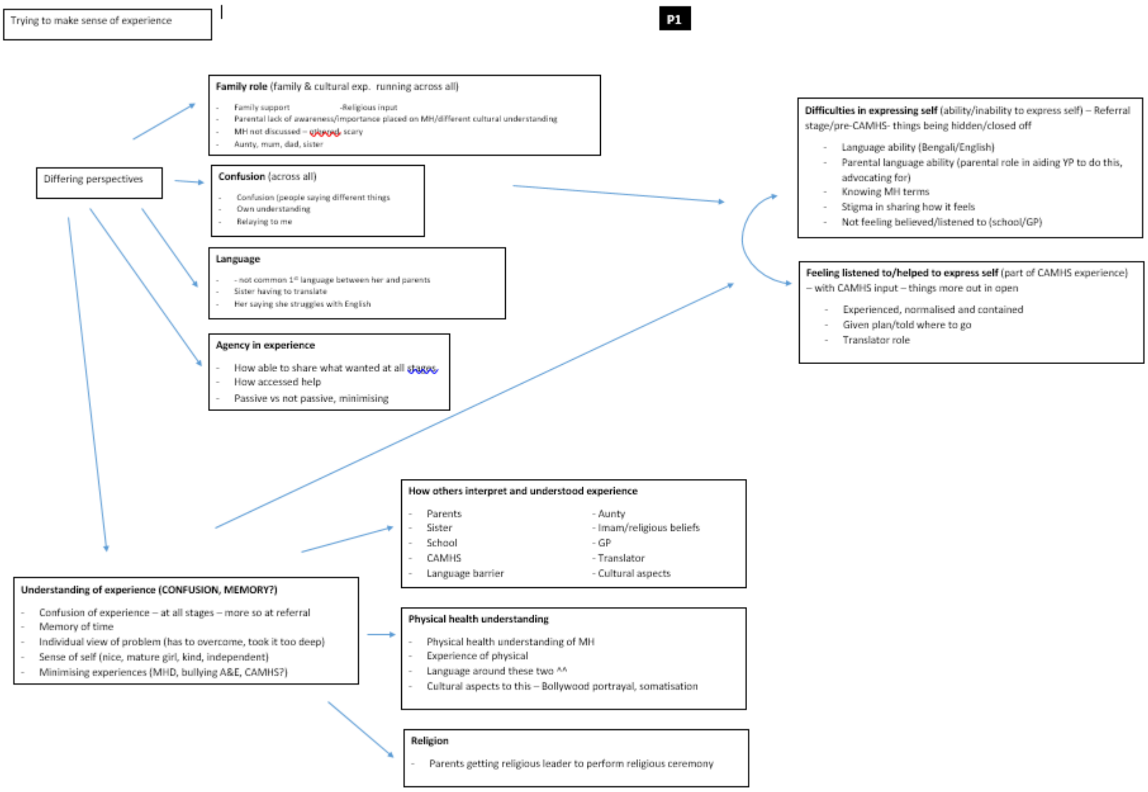
Not experienced

Never thought was treated differently

In school, lot of mixed backgrounds so it's normal

The scale on piece of paper + talking through anxiety

Individual theme map



Family role (family & cultural exp. running across all)

- Family support -Religious input
- Parental lack of awareness/importance placed on MH/different cultural understanding
- MH not discussed – othered, scary
- Aunty, mum, dad, sister

Confusion (across all)

- Confusion (people saying different things
- Own understanding
- Relaying to me

Language

- - not common 1st language between her and parents
- Sister having to translate
- Her saying she struggles with English

Agency in experience

- How able to share what wanted at all stages
- How accessed help
- Passive vs not passive, minimising

Difficulties in expressing self (ability/inability to express self) – Referral stage/pre-CAMHS- things being hidden/closed off

- Language ability (Bengali/English)
- Parental language ability (parental role in aiding YP to do this, advocating for)
- Knowing MH terms
- Stigma in sharing how it feels
- Not feeling believed/listened to (school/GP)

Feeling listened to/helped to express self (part of CAMHS experience) – with CAMHS input – things more out in open

- Experienced, normalised and contained
- Given plan/told where to go
- Translator role

How others interpret and understood experience

- Parents - Aunty
- Sister - Imam/religious beliefs
- School - GP
- CAMHS - Translator
- Language barrier - Cultural aspects

Understanding of experience (CONFUSION, MEMORY?)

- Confusion of experience – at all stages – more so at referral
- Memory of time
- Individual view of problem (has to overcome, took it too deep)
- Sense of self (nice, mature girl, kind, independent)
- Minimising experiences (MHD, bullying A&E, CAMHS?)

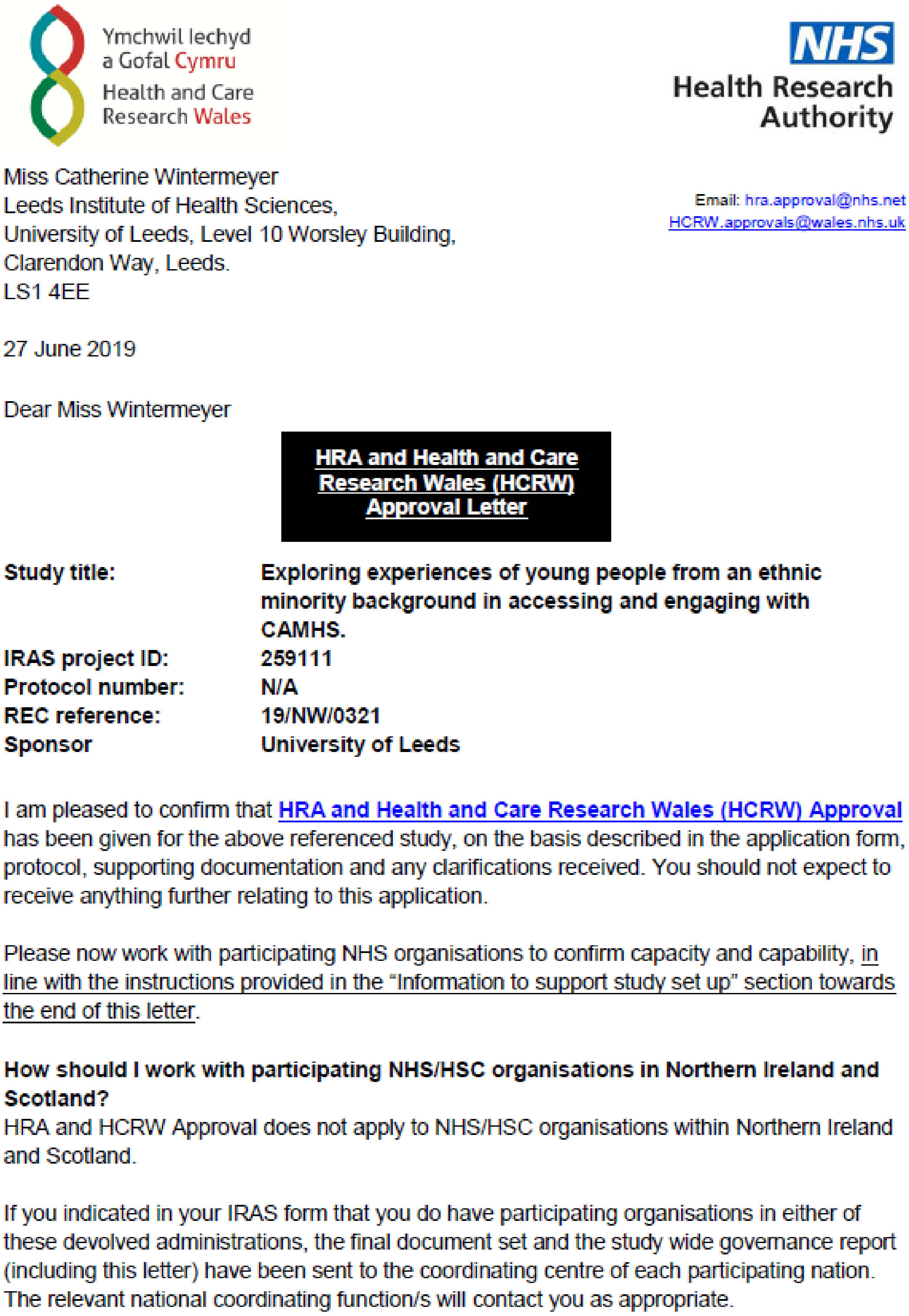
Physical health understanding

- Physical health understanding of MH
- Experience of physical
- Language around these two ^^
- Cultural aspects to this – Bollywood portrayal, somatisation

Religion

- Parents getting religious leader to perform religious ceremony

Appendix 5 - Ethics confirmation



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

Miss Catherine Wintermeyer
Leeds Institute of Health Sciences,
University of Leeds, Level 10 Worsley Building,
Clarendon Way, Leeds.
LS1 4EE

27 June 2019

Dear Miss Wintermeyer

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring experiences of young people from an ethnic minority background in accessing and engaging with CAMHS.**
IRAS project ID:	**259111**
Protocol number:	**N/A**
REC reference:	**19/NW/0321**
Sponsor	**University of Leeds**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **259111**. Please quote this on all correspondence.

Yours sincerely,
Amber Ecclestone

Approvals Specialist

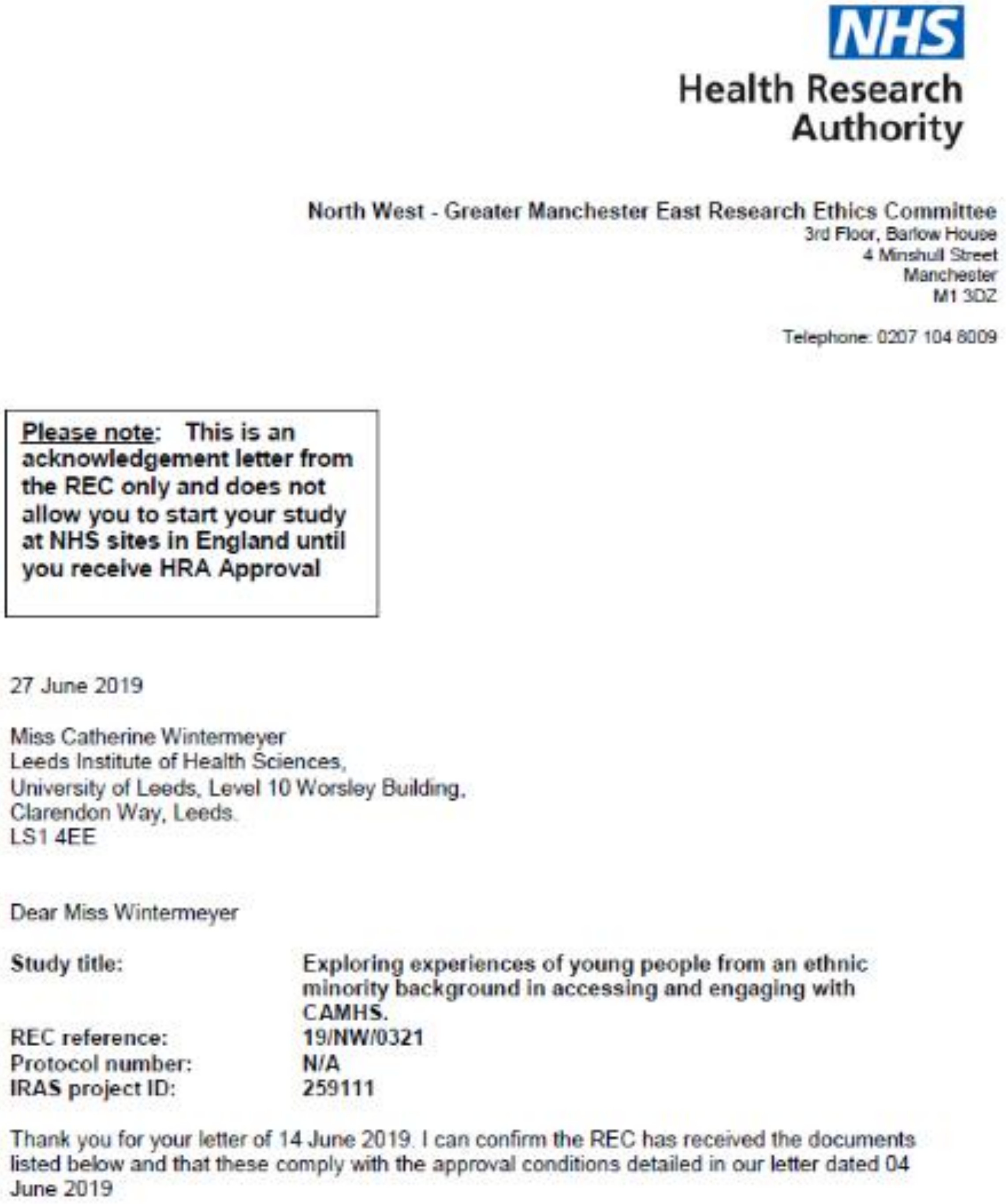
Email: **INSERT for nation of sender** hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

Copy to: *NHS Research Ethics Officer*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Poster v1 22.03.2019]	1	22 March 2019
Copies of advertisement materials for research participants [Leaflet v1 22.03.2019]	1	22 March 2019
Copies of advertisement materials for research participants [Social media advert v1 22.03.2019]	1	22 March 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [2018.19 Liability PI Letter v1 22.03.2019]	1	22 March 2019
HRA Schedule of Events [Assessed]	1	13 May 2019
HRA Statement of Activities [Assessed]	1	13 May 2019
Interview schedules or topic guides for participants [Topic guide for interview v1 22.03.2019]	1	22 March 2019
IRAS Application Form [IRAS_Form_02052019]		02 May 2019
Letters of invitation to participant [Invitation to participate letter 16+ Bradford CAMHS v1 22.03.2019]	1	22 March 2019
Letters of invitation to participant [Invitation to participate letter 16+ Leeds CAMHS v1 22.03.2019]	1	22 March 2019
Letters of invitation to participant [Invitation to participate letter to parents for under 16 Bradford CAMHS v1 22.03.2019]	1	22 March 2019
Letters of invitation to participant [Invitation to participate letter to parents for under 16 Leeds CAMHS v1 22.03.2019]	1	22 March 2019
Other [Consent to contact form YP and parents v1 22.03.19]	1	22 March 2019
Other [Confidentiality Statement for Transcribers v1 22.03.2019]	1	22 March 2019
Other [GDPR study transparency information v1 22.03.2019]	1	22 March 2019
Other [Fieldwork_Assessment_Form_medium_risk_CW thesis v1 22.03.2019]	1	22 March 2019
Other [Information letter about the UoL Trainee Clinical Psychology Doctoral Programme v1 22.03.2019]	1	22 March 2019
Other [Debrief Sheet Parents]	2	10 June 2019
Other [Debrief Sheet YP]	2	10 June 2019
Participant consent form [Pilot Assent YP under 16]	2	10 June 2019
Participant consent form [Pilot Consent Form parent]	2	10 June 2019
Participant consent form [Pilot interview Consent Form YP 16+]	2	10 June 2019
Participant consent form [Assent Form YP]	2	10 June 2019
Participant consent form [Parent Under 16]	2	10 June 2019
Participant consent form [Young People 16+]	2	10 June 2019
Participant information sheet (PIS) [Pilot interview Parent]	2	10 June 2019
Participant information sheet (PIS) [Pilot interveiw Young peeopl]	2	10 June 2019
Participant information sheet (PIS) [Parents]	2	10 June 2019
Participant information sheet (PIS) [Young People]	2	10 June 2019
Summary CV for Chief Investigator (CI) [CW CV for IRAS v1 22.03.2019]	1	22 March 2019
Summary CV for student [CW CV for IRAS v1 22.03.2019]	1	22 March 2019
Summary CV for supervisor (student research) [CV Tracey Smith 2019 v1 22.03.2019]	1	22 March 2019
Summary CV for supervisor (student research) [DrTomCliffe_CV	1	22 March 2019



NHS
Health Research
Authority

North West - Greater Manchester East Research Ethics Committee
3rd Floor, Barlow House
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0207 104 8009

Please note: This is an acknowledgement letter from the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

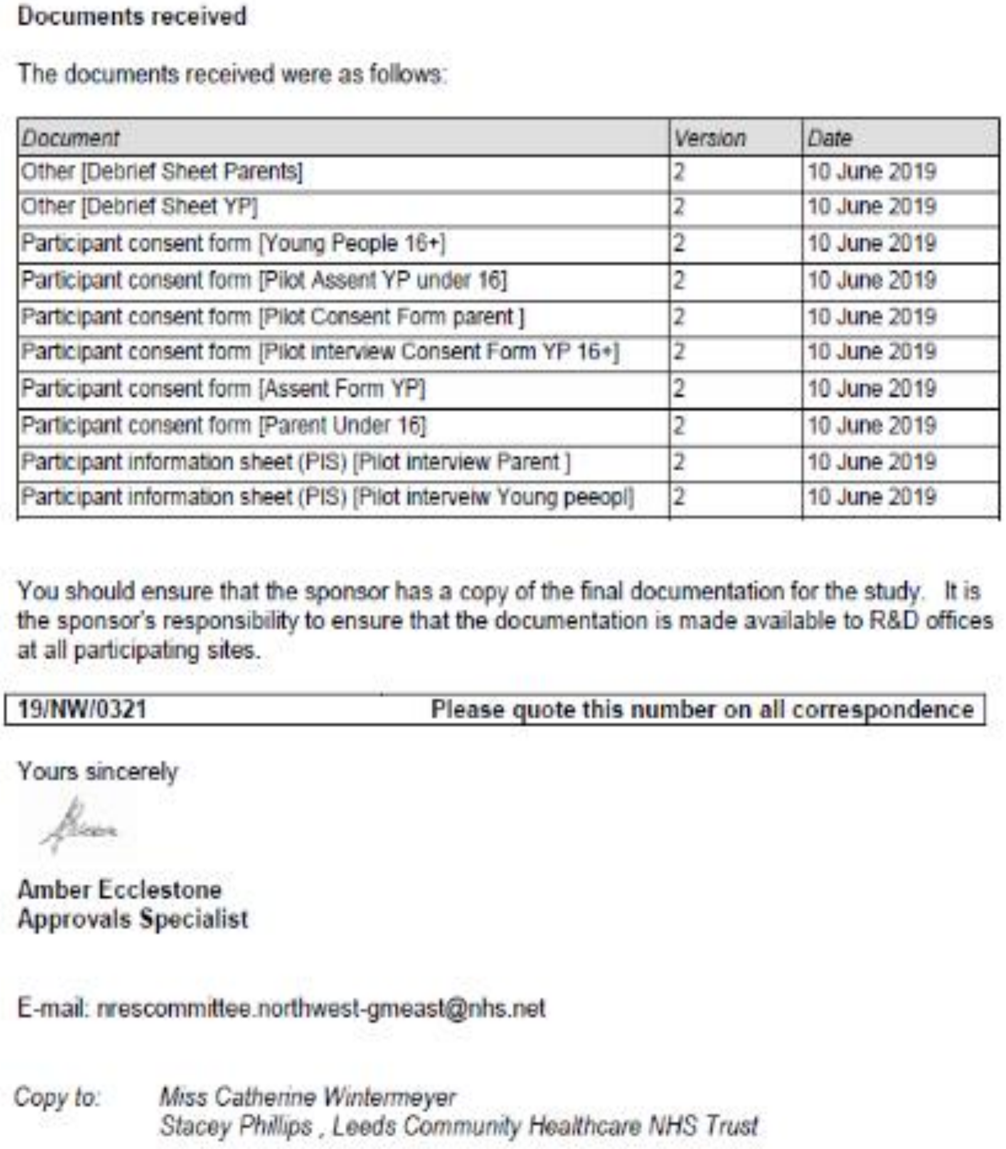
27 June 2019

Miss Catherine Wintermeyer
Leeds Institute of Health Sciences,
University of Leeds, Level 10 Worsley Building,
Clarendon Way, Leeds.
LS1 4EE

Dear Miss Wintermeyer

Study title:	**Exploring experiences of young people from an ethnic minority background in accessing and engaging with CAMHS.**
REC reference:	**19/NW/0321**
Protocol number:	**N/A**
IRAS project ID:	**259111**

Thank you for your letter of 14 June 2019. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 04 June 2019



Documents received

The documents received were as follows:

Document	*Version*	*Date*
Other [Debrief Sheet Parents]	2	10 June 2019
Other [Debrief Sheet YP]	2	10 June 2019
Participant consent form [Young People 16+]	2	10 June 2019
Participant consent form [Pilot Assent YP under 16]	2	10 June 2019
Participant consent form [Pilot Consent Form parent]	2	10 June 2019
Participant consent form [Pilot interview Consent Form YP 16+]	2	10 June 2019
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Participant consent form [Parent Under 16]	2	10 June 2019
Participant information sheet (PIS) [Pilot interview Parent]	2	10 June 2019
Participant information sheet (PIS) [Pilot interveiw Young peeopl]	2	10 June 2019

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

19/NW/0321	**Please quote this number on all correspondence**

Yours sincerely

Amber Ecclestone
Approvals Specialist

E-mail: nrescommittee.northwest-gmeast@nhs.net

Copy to: *Miss Catherine Wintermeyer*
Stacey Phillips , Leeds Community Healthcare NHS Trust

Appendix 6 – Debriefing sheet. As the participants were all 16+, the corresponding debriefing sheet has been provided.

UNIVERSITY OF LEEDS

Young person participant debriefing sheet.

Thank you for taking the time to participate in this research study.

Next steps in research process

Once all the data is collected and analysed, a summary of the findings will be provided if you indicated you would like this on the consent form. Please note the summary may take up to 24 months to complete.

If you want to withdraw your data, please contact me on c.wintermeyer@nhs.net by the (insert date). This is because after this date, the data will have been started to be analysed.

Giving feedback

People react differently after being in studies like this one. Please let us know any thoughts you have about the study after the interview has finished in person now or by email. Honest feedback from you will help us learn. It also gives us a chance to explain anything you still have questions about.

If you are or become upset as a result of joining this study

Most importantly, if you feel upset or distressed by participating in this interview or anything else related to being involved in this study, it is important that you let us know at the time if you can. You can also contact your GP or call 111. There are also other contact details below for voluntary and professional support organisations you can contact for support. **If there is an emergency or immediate risk of harm, please attend an Accident and Emergency Department or call 999.**

National services	
Teenconnect 0808 800 1212 (6pm to 2am) www.lslcs.org.uk/services/connect-helpline/teen-connect	Samaritans 116 123 www.samaritans.org
Childline 0800 1111 www.childline.org.uk	Kooth www.kooth.com
Papyrus 0800 068 4141 www.papryus-uk.org	NSPCC www.nspcc.org.uk
NHSH (National Self Harm Network) www.nshn.co.uk	
Leeds specific:	**Bradford specific:**
MindMate www.mindmate.org.uk	First Response 01274 221181
MarketPlace 0113 246 1659 www.themarketplace.leeds.org.uk	

IRAS ID: 259111. Version number 2. 10.06.2019. 1

Safety tips for young people

- Try to talk to people about what is happening. Often families/ carers welcome a chance to talk openly about concerns.
- If it's hard to put into words, work out with your family or carers a way to let them know if you are really struggling.
- If there is something going on at home or somewhere else that you are worried about, tell a teacher, tutor or trusted adult.
- Try to spend less time alone. Such as spend time with your friends and family, walk your dog etc.
- Plan things to look forward to, even small things.
- Think about ways to care for yourself or things that make you feel good. Everyone is different, for some it is relaxation, for others it can help to help others.

If you have any further questions feel free to ask now, or contact Catherine using the details provided below.

Thank you for taking part in my study.

Catherine Wintermeyer
c.wintermeyer@nhs.net

If you have concerns about this study, or the way in which it was conducted:

- In the first instance, please contact any of the following supervisors of the project using the contact information provided:

Academic Thesis Supervisors: Dr Thomas Cliffe t.d.cliffe@leeds.ac.uk or Dr Tracey Smith t.e.smith@leeds.ac.uk Telephone: 0113 343 0815

Field Thesis Supervisors: Leeds CAMHS: Dr Jessica Green. Email: jessica.green19@nhs.net Telephone: 0113 843 0804. Bradford CAMHS: Dr Fameeda Ansari. Email: fameeda.ansari@bdct.nhs.uk Telephone: 01274 723241

- If your concerns are not dealt with satisfactorily, then you can contact Dr Gary Latchford (Research Director and Joint Programme Director, Clinical Psychology Training Programme). Email: g.latchford@leeds.ac.uk or Telephone number: 0113 343 2732.