Mental Health Services for Children & Young People
SIS linguist focus group – 06/06/2023

Attendees representing 8 language communities.

- Portuguese (mainly Brazilian)
- Chinese (mainly from mainland China)
- Arabic (mainly from Syria, Sudan, Egypt)
- Farsi and Kurdish Sorani (Iran)
- Dari and Pashto (Afghanistan)
- Polish

What mental health (MH) and wellbeing (WB) issues are young people (YP) in your community facing?

- PTSD

Asylum Seeker children and YP have often witnessed terrible violence (war, death, torture, rape, assault) either in their country of origin or during their journey to the UK.

- Depression and anxiety

For asylum seeking children and YP the uncertainty and insecurity of their situation in the UK (housing, money, education, immigration status) and concerns for family and friends left behind.
For children of Chinese and Arabic origin the pressure from parents and family to excel in education.

- Neurodiversity e.g. autism, ADHD

The long waiting times for diagnosis can lead to further wellbeing issues.

- Self-harm
- Social Isolation and friendship issues, not fitting in at school
- Substance Abuse

What cultural attitudes or behaviours might influence recognition of or acceptance of MH issues for YP in your community?

This varied according to the country/culture of origin and the circumstances of the individuals and families e.g. level of education, exposure to British culture, urban vs rural, level of English

Polish and Portuguese speakers generally seemed to have a good understanding of MH issues, are open and accepting, seek out help. The less English the parents speak the less they know about support options and tend to ignore any MH and WB issues they observe in their children, if they are getting their English under control they are more willing to seek out help and support.

Arabic, Dari and Pashto speakers were less able to recognise and accept the concept of MH. It is rarely discussed except in terms of "Normal or Crazy" and therefore is very stigmatised. Children showing symptoms of MH or WB issues are often consider naughty, melodramatic or difficult and the expectation is they should be able to sort themselves out. They are unlikely to seek professional help and support. In addition to stigma, there is a general belief that physical health issues are more important and prioritised by patients.

MH is not prioritised as an issue for many Newcomers who are trying to make new lives, practical issues such as insecure housing, finance, employment, immigration status are seen as more important.

All participants talked about the cultural divide between 1st generation migrant parents and their children who are born and/or educated here in the UK. Cultural differences around parenting styles and expectations of acceptable methods e.g. corporal punishment is common place in many countries but illegal in the UK, Afghan girls are don't usually mix with boys but British culture allows this to happen freely.

There is frequently confusion and conflict over the different rules and boundaries which cause difficulties for the parent/child relationship. This can be further exacerbated if the parent is disempowered by the language gap and a lack of knowledge and information which can result in social services involvement and concerns that children will be taken into care.

It was also noted that domestic violence can be an aggravating or resulting factor of the challenging situation.

A further concern was raised about the culture clash between MH practitioners and their patients from other cultures e.g. asking direct questions about suicidal thoughts and what methods a patient had considered was very troubling for the Farsi speaker because conversations of this nature would never happen in Iranian culture and are therefore shocking and difficult to engage with. They could be perceived as suggestions and encouraging rather than as a diagnostic tool.

Despite the professionalism of Community Interpreters around impartiality, confidentiality and being non-judgemental (all of which is explained to patients at every session), some patients are still worried about an interpreter coming from the same community and may not feel safe to discuss MH concerns.

What MH services for YP locally are you aware of?

- CAMHS
- Seaside View Child Development Centre
- B&H Wellbeing Service
- Young Minds
- AMAZE and ASSERT (and other unspecified charities)
- East Sussex Young Asylum Seeking Service

Concerns were raised about

- difficulties making or getting appointments
- only getting referrals for serious acute issues e.g. suicidal
- lack of specialist services
- long waiting times for diagnosis
- long waiting times to be seen by specialist services

The Farsi speaker told us about an Iranian (Farsi speaking) counsellor who worked in East Sussex (seeing UASC) and was impressed by their ability to distinguish between the problems caused by cultural clash and actual mental health concern and give appropriate advice on how to manage it.

There was no mention of wellbeing boosting services or activities.

Are these services known about in your community and do people know how to access them?

General agreement that outside of speaking to the GP there wasn't much knowledge of specialist services.

A few concerns were raised about GPs as gatekeeper

- Its challenging to get an appointment
- GPs have very limited time to talk to patients, maximum of 10 mins in a session and this is doubled when using an interpreter

- GPs don't habitually ask about patient's wellbeing so the onus is on the patient to bring this to the GP which, if their culture doesn't recognise or accept these issues, is unlikely
- People don't know how to prevent their wellbeing issues progressing to mental health concerns and only go to the GP when they're in crisis.

What other services do you think would be helpful to support YP with their MH and WB?

More culturally informed MH workers (like the Iranian person in ES) with specific knowledge of the culture not just general cultural sensitivity.
Earlier intervention in schools where a lot of the problems could be observed and picked up and referrals made to wellbeing support services.

There are limited numbers of counsellors based in the schools and the effectiveness of school based interventions seemed to vary massively between schools.

Education programmes about wellbeing and mental health delivered to students and parents in schools.

- explaining the attitudes to MH and WB in the UK to help Newcomers orientate and understand behaviours and terminology
- differences in parenting norms and rules particularly around corporal punishment.
- finding the right language to describe MH and WB can be challenging because these concepts and terminology don't always exist.
- warning signs to be looking out for

There was a query about whether there are elements in the National Curriculum that address NH and WB.

Reduce the waiting times for treatment and help e.g. one young person was waiting 1 year for help around self-harming

Better promotion of alternatives to NHS e.g. MIND or YMCA Downslink

Communities could help more and there is probably informal help available within communities if this was sought out

Increase capacity for SIS Volunteer Social Prescribers (and caseworkers) to offer their really valuable service; helping people to get referral into other services such as MH. Interpreters had observed how successfully this has worked with some of their clients.