

Editorial

Mental health problems in children and young people from minority ethnic groups: the need for targeted research

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**Summary**

In this editorial we argue for the need for better research evidence on the prevalence of child mental health problems in minority ethnic groups, service utilisation among these groups and whether some service barriers are specific for certain groups. Without such evidence it is not possible to influence policy and practice so that evidence-based and appropriate services can be designed and offered to these populations. The terms ethnicity, race and migration are often imprecisely defined, and mental health needs and outcomes vary between immigrants from different generations. There is also

a complex interplay between minority status and social class, with terms such as ethnicity being a proxy for multifaceted sociocultural and economic variables. However, we need to start collecting better data on children from minority ethnic groups so that these relationships can be understood, services tailored on the available evidence and ultimately better care delivered to this group of children.

Declaration of interest

None.

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It is now widely accepted that ethnicity, race and culture are complex variables, each of which is difficult to define and measure with precision.¹ Ethnicity is viewed as an important component of culture but does not necessarily define the whole culture that an individual may relate to.² However, despite the problems in defining these variables, it is well established that they can influence mental health problems either as proxies for socioeconomic determinants or by influencing the way mental health is understood, services are accessed and interventions are accepted.^{1,2} Socioeconomic factors such as deprivation and disadvantage have a major influence on the genesis and treatment of mental disorders, especially in childhood.³

Therefore, understanding the influence of ethnicity is a prerequisite when trying to understand child mental health problems. The concepts of childhood and mental health are themselves culturally influenced⁴ and thereby influence whether children with mental health problems present to services. Our premise is that we currently lack credible data to effectively plan services for children and young people from minority ethnic backgrounds and this is essential if we are to deliver appropriate care for this group. We do not make assumptions about what may be revealed but argue that such studies are required.

Child mental health policy

Policy initiatives for the prevention and treatment of mental health problems often include discussions of ethnicity, suggesting that its importance is recognised. However, child mental health policies^{5,6} and services ‘borrow’ findings from literature relating to adults. That literature has multiple flaws, such as combining disparate ethnic groups, and treating all Black and minority ethnic

(BME) communities as homogeneous and merely different from a homogeneous White majority. This approach ignores the multiple inter- and intra-group differences within BME groups, and by assuming homogeneity, risks generating stereotypical assumptions. There are further problems in treating all ethnic groups as a single entity, as many aetiological factors (such as child-rearing practices and attitudes; family structure, roles and support; and expectations of children in the community and wider society) are culturally influenced and vary between BME groups.

In England, the National Service Framework⁵ and *Every Child Matters*⁶ are key policy documents that set standards to improve the quality of mental healthcare for children, young people and families. Both policies implicitly expect ethnicity to be taken into consideration in service planning and delivery and state the need to draw on the evidence base. However, currently there is sparse evidence that can be drawn upon to help deliver evidence-based, culturally appropriate care.

Prevalence of child mental health problems and psychiatric disorders in minority ethnic groups

Current research on ethnic variation in the UK and elsewhere is limited and remains largely inconclusive. Findings are often contradictory and it is difficult to generalise from small-scale studies.⁴ Earlier studies primarily focused on the problems among immigrants during what were the initial stages of their cultural adaptation. Studying clinical samples introduces a different bias, as a number of mediating factors (such as referring practices, availability of services, and knowledge of services) can determine service access and use. The UK is not alone in struggling with these issues.⁴

Migration and child mental health

The health of migrant groups is often used as a proxy for that of minority ethnic populations. Stevens & Vollebergh⁷ highlight that research in child migrant groups is of variable quality, as often the

terminology used to define various groups and ethnicity is unclear, and samples vary considerably. Also, not all people who identify themselves as belonging to an ethnic minority are migrants, and not all migrants identify with their original ethnic background. In practice it can be difficult to disentangle the impact of migration and ethnicity on mental health, as comparisons between migrants and populations in their country of origin are not easy to obtain. Comparisons between migrant and non-migrant groups of the same ethnic background can also be misleading, as the process of migration itself is a confounding variable that affects mental health. Different rates of mental ill health in migrant and non-migrant groups may be explained by socioeconomic or educational disadvantages or experience of migration rather than ethnicity *per se*. Prevalence rates may differ in first (migrants), second (parents migrated) and third generations (grandparents migrated) of the same ethnic group as populations assimilate and integrate with the host culture.

National child mental health surveys

The 2004 survey of the mental health of children and young people in the UK provides one source of evidence for prevalence rates of mental health problems and service use in the under-16 population.⁸ The number of minority ethnic groups represented in total is less than 10% of the whole sample, which is proportionally correct in general population terms. As no oversampling techniques were employed for minority groups, their data lack power and reliability. The trends identified from the child mental health survey suggest that significant differences in the prevalence of any psychiatric disorder between ethnic groups may be masked if subgroups are considered as broad collective categories such as South Asian, Black or Black Caribbean, because of potential variation among ethnic groups in mediating factors such as socio-demographic and family characteristics. Therefore, the collective reference to heterogeneous ethnic groups with terms such as 'BME' would mean a readiness to ignore their uniqueness and differences.

Unfortunately, wider European studies do not offer more reliable evidence. A national German study⁹ found that migration had a moderating effect on externalising disorders but not on emotional disorders. The authors argue that this could be because there is no difference or because there is a culturally related bias for non-reporting, although it is unclear whether the authors equate ethnicity with culture. However, it is noteworthy that the sample consisted of 2349 migrants compared with 12 460 non-migrants, and that the migrant groups may have been made up of various ethnicities and cultures. Therefore, the explanation that culture may account for differences may not hold up to scrutiny.

As populations become more diverse and there are demands for both social inclusion and culturally appropriate services, with a need to actively engage patients, services must ensure that they meet the mental health needs of minority groups. This is exceedingly difficult to achieve, given the lack of relevant evidence of prevalence rates of mental health problems and service needs among these groups. Relying on small and early studies may be a disservice for the young people of today, as the population has undergone significant social, cultural and economic changes. First-generation migrants may be in very different positions from third-generation migrants, who may consider themselves British in most aspects of their lives. Although epidemiological studies have provided valuable data regarding the prevalence of psychiatric disorders in the general population, it is not possible to generalise these findings to minority ethnic groups. Consequently, they cannot adequately inform future service

provision, planning and commissioning. It is arguable that without targeted research, we are failing ethnic communities, as neither policy nor practice have quality research to guide their development. Given the lack of evidence we would make the following recommendations.

- 1 Future epidemiological research should select larger stratified samples of ethnic groups to identify the unique characteristics of specific groups and their complex interplay with culture, other social factors (including social class and socioeconomic disadvantage) and child mental health.
- 2 Because of the variation in the demographic characteristics and other possible aetiological factors, there may be differences in the rates of prevalence of mental health problems among different minority ethnic groups. Therefore, the use of broad groupings and collective terminologies for these groups should be discouraged. Data from different ethnic groups should not be merged, as currently we do not have evidence that we are dealing with homogeneous populations.
- 3 Research questions should be clearly specified, and ethnicity needs to be defined and measured in that context¹⁰ given that much research to date has struggled to accommodate ethnicity in a clinically meaningful and relevant way. Any potential conflict is then transparent, and does not hinder the translation of evidence into service models and interventions for children and young people.
- 4 We need to broaden our concept of diversity and think beyond ethnicity, taking into account how other diversity factors such as sexuality and other aspects of culture may affect children's mental health.

Conclusions

Policy, service development and practice should rely on good evidence. It is essential to develop robust methodologies that enable the needs of minority ethnic groups to be quickly identified, given the rapid population changes in the UK and across the Western world, with the influx of asylum-seeking and refugee children. This information is crucial if we are going to identify relevant risk factors and develop appropriate interventions based on fact, for example improve access if access is the problem or have culturally appropriate care if that is the issue. Before we begin to identify the needs of more recent migrants, we should ensure that we consider what we can learn from the needs of children whose parents or grandparents migrated some decades ago.

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psychiatry in pictures

Dr Harley Quinn, the villain from Gotham City with dependent personality disorder

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Dr Harley Quinn is a super-villain, enemy of Batman, whose name was suggested by the Joker as a play with the word 'harlequin' and her original name, Harleen Quinzel. The character was created by Paul Dini and Bruce Timm in *Batman: The Animated Series*, later adapted into the DC Comics' Batman series. Dr Quinn usually dressed as a jester and occasionally appeared in some of Batman's comic books, television episodes and in video games based on the animated series. In the story, Harleen Quinzel did her psychiatry training at Arkham University, and later worked as a psychiatrist at the Arkham Asylum where as an intern she met the Joker as her patient. She quickly fell in love and indiscriminately attached to him during their psychotherapy sessions, finally helping him to escape from the asylum. Afterwards, she changed her name to Harley Quinn, becoming Joker's frequent accomplice and girlfriend. However, the Joker frequently screams at, hazes and maltreats her in their fickle relationship. In these situations, she responds with indulgent tolerance, always submitting to his abuse and intimidation to avoid abandonment.

As opposed to drama movies and TV series, psychiatrists are not common characters in comics, especially in the role of villains, and here again Dr Harley Quinn is the stereotype of a dysfunctional psychiatrist. In particular, she has traits of dependent personality disorder, as well as the antisocial aspects expected in a villain. Luckily, Harley Quinn is not one of the most popular villains in the comic world and hopefully Batman will seek another psychiatrist to solve his neurotic problems.

Mosaic, *Dr Harley Quinn*, created by José Alexandre S. Crippa, 2011, 40 × 40 cm; playing cards, dice, papercraft, toys, coloured glue, mounted on canvas.



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