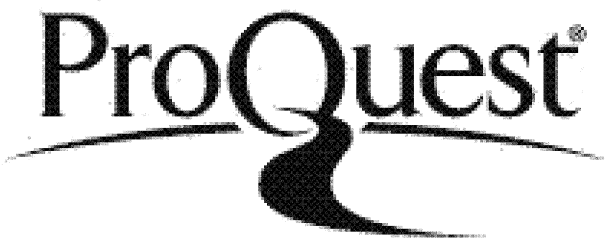
"A brother from another mother": Mentoring for African/Afro-Caribbean adolescent boys

Hilary Garraway

D.Clin.Psy. thesis (Volume 1), 2007
University College London



ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

OVERVIEW

This thesis is divided into three parts. Part one is a literature review which explores African/Afro-Caribbean adolescents' relationship to help. It focuses on adolescents' perceptions of mental health problems and services and also adolescent help-seeking, with a particular focus on African/Afro-Caribbean adolescents. Part two of the thesis describes a qualitative study which explores the experiences of mentoring for African/Afro-Caribbean adolescent boys. Focus groups and interviews were carried out with mentees and mentors and Interpretative Phenomenological Analysis was used to analyse their accounts. Part three of the thesis is a critical appraisal of the research which provides a more personal reflection and explores some of the issues faced in conducting the research.

Table of Contents

Tables

ACKNOWLEDGEMENTS

This thesis is dedicated to my father who died suddenly on 15th June 2006 – thanks for being a true mentor.

Thanks to my family, Hosten, Hayley and Joshua - thanks for your love, encouragement and understanding, especially when we had less time together because I needed to work.

Thanks to my UCL supervisor, Nancy Pistrang, for your consistent encouragement, thorough feedback and your expertise; I have learnt a lot.

Thanks to my external supervisor, Debbie Madell, who helped to initiate this research project.

Last but not least, thank you to all the mentors, mentees and staff who made this research possible – thank you for your welcome, your friendship and your willingness to take part – and especially to Lloyd Curtis (mental health project co-ordinator), for your tireless dedication to make it happen!

Part 1: Literature review

How do African/Afro-Caribbean adolescents perceive mental health problems and services, and what psychological help do they seek?

Abstract

Some reports suggest that mental health services are not meeting the needs of young people from cultural minorities. This review focuses on adolescents' perceptions of mental health problems and services and adolescent help-seeking behaviour, with a particular focus on African/Afro-Caribbean adolescents. Some of the influences on African/Afro-Caribbean young people, which affect these perceptions and behaviours, are also discussed. Adolescents tend to have negative and stigmatising perceptions about mental health problems and services. Help-seeking is low, particularly for boys, and adolescents often prefer to seek informal help through long-term, well established relationships. This review highlights the need for more research into help-seeking amongst African/Afro-Caribbean adolescents and suggestions are made for future studies, as well as discussing some of the clinical implications of this literature review.

1. Introduction

African/Afro-Caribbean[1] adolescents often need to cross both a cultural and generational gap in order to access psychological help - from adults who are predominantly white, and working from a Western worldview. The National Standard Framework for Children, Young People and Maternity Services states "the mental health needs of minority communities are currently not being specifically met within many mainstream services..." (Dept.of Health, 2004 Para 5.2, page 13). The reasons why services are not meeting these needs are complex, but this literature review focuses on three related questions. Firstly it asks, "How do African/Afro-Caribbean adolescents perceive mental health problems and services?"; secondly "What help do these adolescents seek for these problems?"; and thirdly "What factors influence their perceptions and help-seeking behaviour?" In addressing the first two questions, the review considers research with adolescents to provide a context, before focusing on African/Afro-Caribbean adolescents. The third question is addressed briefly by examining some of the key influences which may shape African/Afro-Caribbean adolescents' perceptions and help seeking behaviour, based on the adult literature. The introduction describes the method and terminology used within this review and briefly outlines the prevalence of mental health problems and levels of service use for this client group.

1.1.Method of the review

A literature search was carried out using PsycINFO and Google Scholar databases. The search was limited to papers in English, written since 1985, and

[1] Throughout this review African/Afro-Caribbean refers to anyone who is non-white and non-Asian and has at least one parent who is from African or Caribbean descent.

did not include books or dissertations. References from papers and from experts in the field were also used.

Literature on adolescents' perceptions of mental health problems and services was found by combining search terms for adolescents (adolescent, teenager, youth, young, juvenile and minor) with terms for perceptions (perceptions, attitudes, views, opinions) and then combined with the following terms – CAMHS (child and adolescent mental health service), mental, mental health and mental illness. Literature on adolescents' help-seeking was found by combining "help-seeking" with the search terms for adolescents. Both these searches were then combined with terms for African/Afro-Caribbean (Afro-Caribbean; black; African-American; Caribbean; Caribbean-American; Caribbean-born; Caribbean-British; Caribbean-origin; British-African-Caribbean; Black-Caribbean and West Indian). The African/Afro-Caribbean adult literature was also searched for key reports and papers, to consider the wider influences on African/Afro-Caribbean adolescents. However this was not an exhaustive search because the focus of this review is on adolescents.

Studies that covered the 13-18 year old age range were included, even if the study used a wider age range. Papers on general ethnic minorities were included if the findings referred to African/Afro-Caribbean populations. Papers were included if they focused on community and outpatient services but not inpatient services. Fifty articles met the criteria; twenty-nine articles were also reviewed within the adult literature.

1.2 Terminology

Within the literature, a range of terms are used to refer to a person's cultural background such as culture, difference, race, ethnicity etc. and some debate over which is most appropriate. For convenience the word "culture" will be used within this review, unless citing other authors. "Culture" has been defined as "the shared history, practices, beliefs and values of a racial, regional and religious group of people" (D'Ardenne & Mahtani, 1999, cited in Patel et al., 2000, p. 44). This review focuses on people who are from non-white and non-Asian, African and Caribbean descent and the term African/Afro-Caribbean will be used, unless citing other authors.

It is important to recognise that within African/Afro-Caribbean populations, there is vast diversity. Therefore to summarise findings is in danger of losing sight of the individual – at best, diluting this variety and at worst, strengthening stereotypes and prejudice. Amongst African/Afro-Caribbean adolescents there are many other key variables such as gender, birthplace, education, socio-economic status, religion and family structure that contribute to making each person an individual. Each one of these variables will affect individual perceptions and behaviour. Therefore culture needs to be seen as just one of these many variables. This is particularly relevant when considering cultural minority groups in both the USA and the UK, where there is consistent evidence that these groups generally have lower incomes, socio-economic status and educational levels, than the cultural majority; for example, 70% of UK cultural minorities live in the 88 most deprived neighbourhoods (Social Exclusion Unit,

2002, cited in Lowe, 2006). It is also important to recognise that there are many similarities across cultures and that most of the participants, in the reviewed literature, have been described by the researchers as "Black *British*" or "African *American*" and therefore identified with more than one culture. However this review seeks to highlight any findings relating to African/Afro-Caribbean adolescents and considers whether culture influences beliefs and behaviour, regarding mental health problems.

1.3 The prevalence of mental health problems and service use by adolescents

Approximately 20% of British adolescents have mental health difficulties (Audit Commission, 1999; Offer, Howard, Schonert & Ostrov,1991). For example one report states that 10% of white children and 12% of black children have a mental health problem (Meltzer, Gatward, Goodman & Ford, 1999, cited in Buston, 2002). Despite this need, the majority of adolescents do not access services - with the rate of service use varying between 13-36% (e.g. Bui and Takeuchi, 1992; Kodjo & Auinger, 2004; Leaf et al, 1996; Pumariega, Glover, Holzer & Nguyen, 1998; Saunders, Resnick, Hoberman & Blum, 1994; Sourander et al., 2004).

There are no conclusive factors associated with mental health service use, although a number of studies suggest an association between using medical health services for physical health problems and the use of mental health services (e.g. Bergeron et al., 2005; Gasquet et al., 1997; Saunders et al.,1994; Sourander et al., 2004; Verhulst & Van Der Ende, 1997). Possible reasons for

this may be that those who are already seeking help in one area find it easier to ask for help in another area or that health professionals are able to detect psychological needs. One of the largest and most detailed studies separated service need and service use and found that service need was related to a history of abuse, poor health, suicidal ideation and being female, whereas service use was related to suicidal ideation, prior informal help-seeking, being white and of higher socio-economic status, having a medical check-up in the last year and parental marital status (Saunders et al., 1994).

The relationship between service use and cultural background initially appears unclear, with some studies suggesting that African/Afro-Caribbean adolescents are under-represented in services (e.g. Kodjo & Auinger, 2004; Cuffe et al.,1995) whereas other studies report that they are over-represented in services (e.g. Bui and Takeuchi,1992). However these apparently conflicting results are explained by socio-economic differences rather than culture. African/Afro-Caribbean adolescents are over–represented in lower socio-economic groups (O'Hare, 1989, cited in Bui and Takeuchi, 1992) and therefore have greater contact with social agencies, which in turn leads to higher referral rates through such agencies (Takeuchi et al., 1993). They are therefore more likely to enter services through coercive pathways, compared to white adolescents, who are more likely to self-refer or be referred by families. However, when socio-economic variables are controlled for, the association between service use and culture disappears. Therefore the strongest predictor for service use is socio-economic background, rather than culture (Takeuchi et al., 1993), which is mirrored in the adult literature (e.g. Keating, Robertson, McCulloch & Francis,

2002) and was also found in a literature review on parental help-seeking (Zwaanswijk, Verhaak, Bensing, Ende & Verhulst, 2003).

In conclusion, adolescents under-use services, with only about a quarter of those needing services actually accessing them. African/Afro-Caribbean adolescents are less likely to self-refer to services, compared to adolescents from other cultures. However they have a higher likelihood of coming from lower socio-economic backgrounds, which in turn, is associated with more coercive pathways to services, through contact with other agencies.

Quantitative measures of service use do not necessarily reflect rates of help-seeking or provide explanations for rates of service use. This is because some adolescents may seek help elsewhere or, despite asking for help, for example, at primary care, do not reach mental health services. Some researchers have suggested that this is related to adolescents' perceptions of mental health (e.g. Sheffield, Fiorenza & Sofronoff, 2004). The next section focuses on these perceptions, before going on to consider help-seeking behaviour.

2. Perceptions of Mental Health Problems and Services

2.1 Perceptions of mental health problems by adolescents

Fourteen studies were found which focused on perceptions of mental health problems and these were predominantly based on school samples (see Table 1). These studies show that adolescents find mental health quite difficult to define. However, when they do, they report stigmatising and stereotypical views of

mental illness, such as being "abnormal", "different", and "dangerous" and "out of control" (Armstrong, Hill & Secker, 2000; Watson, Miller & Lyons, 2005). Definitions given by adolescents include deviating from a person's normal behaviour or from social norms; the range of "normality" seems to be based on personal experience, and is strongly influenced by the media. For example, in a study using focus groups to discuss vignettes of different mental health problems, delusions were seen as part of a mental illness because they

Table 1:Studies on Perceptions of mental health problems and services

Authors	Country	Number	Sample and Design
Armstrong et al, 2000	UK	120	School 11-16yr olds; focus groups based on vignettes, and qualitative interviews
Buston 2002	UK	32	Service users 14-20yr olds; 100% white; qualitative interviews
Corrigan et al 2005	USA	303	School 13-19yr olds 61% white; quantitative using vignettes & questionnaires
Draucker 2005	USA	64	Service users as adolescents (18-21yr olds) parents, staff; retrospective qualitative interviews
Dubow et al 1990	USA	1384	School 13-18yrs old; 85% white; quantitative questionnaires
Gibson & Possamai 2002	UK	20	Service users 12-17yr olds; qualitative interviews
Gonzalez et al 2005	USA	5877	Community 15-24 yr olds; 77% white; nationwide survey
Secker et al 1999	UK	120	School 11-16yr olds; focus groups based on vignettes, and qualitative interviews
Sheffield et al 2004	Australia	254	School 15-17yrs old 89% white; quantitative questionnaires
Smith 2004	USA	100	School; boys 12-18yrs old; 100% white; qualitative interviews, using free association
Street et al 2005	UK	120	Cultural minority service users and staff, 12-25yrs old; questionnaires, focus groups, interviews, mapping services
Teggart & Linden 2006	UK	88	Service users and parents; Quantitative questionnaire and focus groups
Timlin-Scalera et al 2003	USA	35	School 14-18 yr olds, parents & school staff; 100% white; qualitative interviews
Watson et al 2005	USA	415	School 13-19yr olds; 79% white; quantitative questionnaire

could not be explained and were beyond the adolescents' personal experience, whereas depressive symptoms were not labelled as mental illness, because they could relate to these symptoms and provide circumstantial explanations (Armstrong et al., 2000; Secker, Armstrong & Hill, 1999).

Stigmatising beliefs seem to be particularly strong when adolescents believe that a person is responsible for their condition or when they are perceived as dangerous (Corrigan et al., 2005). However beliefs become less stigmatising if adolescents have personal experience of mental health difficulties (Sheffield et al., 2004; Watson et al., 2005). There is also a gender difference reported within the literature, with girls being less stigmatising and more sympathetic towards those with mental health problems than boys (e.g. Sheffield et al., 2004; Watson et al., 2005).

Several studies have found that adolescents identified the following factors to help with psychological well-being: a sense of belonging, positive self-image, family and friends, having people to talk to and personal achievements; boredom was identified as the main cause of mental health problems. (Armstrong et al., 2000; Secker et al., 1999)

2.2 Perceptions of mental health services by adolescents

Perceptions of services seem to depend on whether participants have had personal experience of services or not. Therefore this section will separate studies using clinical samples from those using non-clinical samples, and review the findings for each group separately.

Non-clinical Samples

A number of studies, which are mainly American, school- based surveys, found that mental health services were perceived as inaccessible, ineffective, unfamiliar and therefore difficult to trust (Armstrong et al., 2000; Dubow, Lovko & Kausch, 1990; Gonzalez, Alegria & Prihoda, 2005; Timlin-Scalera, Ponterotto, Blumberg & Jackson, 2003). However these negative views maybe due to lack of knowledge about services. For example, one study found that over half of adolescents interviewed did not know about services (Dubow et al., 1990).

Two major concerns seem to be a lack of confidentiality and the associated stigma (Armstrong et al., 2000;Dubow et al., 1990; Gonzalez et al., 2005; Timlin-Sclara et al., 2003). For example, adolescents have described services in terms of severe pathological ideas such as organic brain damage and chronic mental health (Smith, 2004). Adolescents also reported that problems were too personal to discuss and that they could manage their problems alone (Dubow et al., 1990)

Boys are more negative about services than girls (reflecting the findings about perceptions of mental health). For example, Gonzalez et al. (2005) found that boys were up to 54% less likely to have a positive attitude towards services, than girls. However as adolescents get older the odds of a positive attitude increase, which suggests that young adolescent boys have the most negative views about services (Gonzalez et al., 2005).

Clinical Samples

A small number of studies interviewed adolescents who had personal experiences of services, and participants reported a wide range of perceptions: some very positive and some that were similar to the negative perceptions reported by non-clinical samples. An example of a well-designed study is by Teggart and Linden (2006) who used questionnaires and focus groups with both adolescents and parents, in CAMHS services across Northern Ireland. The strengths of their design included the use of triangulation (using both questionnaires and focus groups to obtain both parents' and adolescents' views); peer facilitation of the focus groups and two researchers independently analysed the data and then compared their results. The findings of this, and other studies, highlighted five main concerns which seem to be reported by service users: a lack of information about services and inaccessibility; a lack of consultation during treatment and feeling out of control; a lack of confidentiality; an inability to trust professionals, particularly when they felt passed from one to the other and a sense of being stigmatised (Buston, 2002; Dogra, 2004; Draucker, 2005; Teggart & Linden, 2006). Another example of such findings was reported by Draucker (2005), who identified three main risks of mental health treatment, which he termed "pitfalls." The first pitfall was "They'll think I'm crazy" - relating to fears of stigma and over-medication. The second pitfall was "They'll tell my business" - relating to a lack of confidentiality. The final pitfall was "They won't have a clue" – relating to professionals' inability to relate to youth.

Adolescents' relationships with staff seem to have an important impact on perceptions. For example, CAMHS users described positive experiences of treatment that were associated with professionals who had good therapeutic skills, such as taking the individual seriously, being approachable, empathic, and showing understanding. In contrast, professionals who were perceived as sceptical about adolescents' viewpoints, aloof and overly formal were reported in relation to negative experiences of treatment (Buston, 2002; Teggert and Linden, 2006). Other factors which seem to contribute to positive perceptions are the availability of psychological input, a lack of emphasis on medication, effective outcomes, easy access and continuity of care (Buston, 2002; Mental Health Foundation, 1999).

2.3 Perceptions of mental health problems and services by African/Afro-Caribbean adolescents

The participants in the studies discussed in the previous section were predominantly white. The authors of these studies concluded (based on findings from the small number of cultural minority participants) that perceptions of both mental illness and services were similar in both majority and minority cultural groups. However this may be because there were few participants from cultural minority groups, and therefore their views were not fully represented (Armstrong et al, 2000; Corrigan et al., 2005; Street, Stapelkamp, Taylor, Malek & Kurtz, 2005; Draucker, 2005; Secker et al., 1999; Sheffield et al., 2004; Watson et al., 2005). However some cultural differences were reported - adolescents from ethnic minorities placed greater importance for mental well being on family relationships, and in particular on the extended family,

compared to whites (Armstrong et al., 2000). Non-white adolescents were more concerned about developing a mental illness; had more apprehension about mental illness labels being used as means of social control; and were more likely to believe that people could improve with extra motivation, love or medication, compared to white adolescents (Watson et al., 2005).

An extensive study, which focused specifically on cultural minority adolescents, was commissioned by the children's charity, Young Minds, who produced a detailed report, "Minority Voices" (Street et al., 2005). The researchers interviewed both staff and adolescent service-users (mainly 16-18 year olds) from various minority cultural backgrounds around the UK, mapped services and studied four services in-depth. The cultural minority service users were particularly concerned about a lack of confidentiality and stigma. They did not relate to the term "mental health" because they associated this with "madness," and as a result, feared being labelled as "mad". Another concern reported by African/Afro-Caribbean adolescents was poor continuity of care, which hindered the opportunity to develop trusting relationships with staff, and resulted in clients repeatedly needing to tell their story. This is particularly relevant, considering that the therapeutic relationship between a professional and adolescent is seen to be one of the most influential determinants of how services are perceived. Services were perceived as inaccessible and staff were perceived as not providing adequate information about services and medication. Another concern was a lack of consultation, particularly relating to the choice of staff they saw, in terms of gender and cultural background. Often they did not know where to go for help or whether they were eligible for services, for

example, some families believed that GPs only provided help with physical issues (Street et al., 2005).

Lack of cultural awareness by staff has been reported as a major concern, and barriers (which also exist for non-minority adolescents) such as the fear of stigma, are intensified when staff do not understand different cultures or lack the skills to relate across cultural barriers (Street et al., 2005). A few studies which interviewed service users found that African/Afro-Caribbean adolescents reported that staff made inaccurate cultural assumptions. Due to a lack of cultural minority staff, African/Afro-Caribbean adolescents are more reluctant to trust that they will be understood by predominantly white therapists (Cauce et al., 2002; Draucker, 2005; Street et al., 2005). Professionals shape young people's experiences and adolescents tend to believe that it is the "luck of the draw" whether they receive the right help or not. However when adolescent services are perceived as helpful, they have long waiting lists, implying that adolescents want to use services when they are seen as relevant and effective (Street et al, 2005). The authors also proposed that "some sort of befriending role" could help cultural minority adolescents to access mental health services.

2.4 Conclusions on perceptions of mental health problems and services

In conclusion, perceptions of mental health problems and services by adolescents, and in particular African/Afro-Caribbean adolescents, are generally negative and stigmatising, with mental illness being defined in terms of being different to social norms. The main concerns about services (voiced by both

service users and non-service users) are a lack of information about services and treatment, lack of confidentiality, stigma and an inability to trust professionals.

However there are three reasons why the results (although quite negative) may be biased towards a more positive representation of adolescents' perceptions. Firstly, the majority of the studies used school samples, which exclude adolescents absent due to health problems, expulsion or truancy and therefore exclude the views of those who may be more at risk of psychological difficulties. Secondly, girls have more positive perceptions than boys and girls were over represented within the studies. For example, Secker et al.(1999) noted that twice as many girls were recruited for their study. Thirdly, it is likely that the studies of service users were more likely to recruit those who had more positive views on services; those with negative views are more likely to disengage from services and not volunteer for research. Also their views of services may change over time, for example participants may feel a greater pressure to present positive views while they are still receiving a service. One study (Draucker, 2005) attempted to avoid this bias by using retrospective interviews, though the findings are still in line with other studies.

The majority of studies on adolescents' perceptions consisted of predominantly white participants and these studies suggested that there were no major cultural differences within adolescents' perceptions of mental health problems and services. This finding may have been different if larger minority samples had been used. However one study was found that focused specifically on adolescents from minority cultures and the findings showed that African/Afro-

Caribbean adolescents reported a number of cultural barriers and in particular a lack of cultural awareness amongst staff (Street et al., 2005).

3. Help-seeking by adolescents

3.1.The relationship between perceptions and help-seeking

Help-seeking is a behaviour rather than an intention and involves relying on others, in order to manage a problem or receive treatment, advice or support. It has been defined as "a process of translating the very personal domain of psychological distress to the interpersonal domain of seeking help"(Rickwood, Deane, Wilson & Ciarrochi, 2005, p.1). Understandably, the way that young people view their mental well-being and services, influences the help they access and so negative attitudes lead to under-utilization of adolescent mental health services (e.g. Dubow et al., 1990). It therefore follows that attempts to change perceptions should result in changes in help-seeking. For example, Hall and Tucker (1985) found that as conceptions of mental health become "more professional and less stereotypic" (Hall & Tucker, 1985, p. 907), then African-Caribbean's attitudes about help-seeking become more positive. Also anti-stigma campaigns have been found to help to change attitudes and help-seeking intentions (e.g. Naylor, Cowie, Talamelli & Dawkins, 2002). Regardless of how services are in reality, it is the *perception* of these services that adolescents remember, and which influence their future help-seeking (Buston, 2002). For example, how "culturally competent" a service is viewed, affects cultural minority adolescents' decisions to engage with the service (Cauce et al.,2002).

3.2 Models of help-seeking by adolescents

There are a number of stage models of adolescent help-seeking, mainly adapted from adult models. The process is divided into stages, and at each stage, different variables can affect the final outcome. For example Andersen's Behavioural Model of Health Care Use (1973) was used as a framework by Bergeron et al. (1995) who proposed four factors that influence help-seeking :

1. Predisposing factors, present before the problem arises e.g. gender, ethnicity, socio-economic background
2. Enabling factors, which influence their ability to access services e.g. social support, transportation
3. Perceived need, which includes awareness of problem, ability to face daily demands, reaction to social situations and level of distress.
4. Evaluated need, such as a diagnosed disorder.

However this model only describes the factors influencing help-seeking and does not describe the process involved. Verhulst and Koot's model (1992, in Zwaanswijk et al., 2003) consists of different levels and between each level there is a filter, through which the adolescent must pass in order to reach the next level. These filters are:

Filter 1 -Recognition of the problem by adolescent and their decision to consult a G.P

Filter 2 - G.P. recognises the problem

Filter 3 - G.P. decides to provide treatment

Different variables, such as the severity of the problem, gender of child and interview style of the GP, influence the decisions that are made at each filter, and these determine the final outcome. This model recognises that help-seeking is not one process but is a series of smaller steps and also highlights the barriers to help-seeking, though describes help-seeking as a simple, linear process.

Cause et al. (2002) proposed another model and one of its strengths is that it recognises informal help as well as professional help. This model separates the help-seeking process into three stages: recognising that there is a problem, deciding to seek help and then choosing from where to get this help. It also emphasizes that this rarely works in a linear fashion and that each stage can interact with each other, therefore highlighting different pathways to gaining help.

Rickwood et al. (2005) have criticised most models as being descriptive rather than explanatory; they have proposed a linear model, which focuses more on psychological factors. First a person becomes aware of a problem, which must then be expressed to others in a way that feels comfortable to the help-seeker. If sources of help are available, and accessible, then the help-seeker must be willing to disclose their problem and access this help. This model proposes a sequence of stages, moving from awareness to willingness to seek help:

Awareness ⟶	**Expression** ⟶	**Availability** ⟶	**Willingness**
and appraisal of problem	of symptoms and need for support	of sources of help	to seek out and disclose to sources

Murray (2005) proposed a more systemic model based on an earlier stage model by Butcher and Crosbie (1977). She agreed that stage models of help-seeking had some relevance, but that they failed to include two key factors: "problem legitimisation" and prior help-seeking pathways. Firstly, "problem legitimisation" describes the process by which someone decides whether their problem warrants outside help or not, according to social norms. Young people often seek problem legitimisation from adults, in order to define a problem and this process interacts with help-seeking at any stage. Secondly, Murray suggests that previous help-seeking shapes future help-seeking and so those providing help, as well as those seeking help, determine whether someone will access help in the future. Views on help-seeking are therefore not static because they change according to experiences.

Murray stresses that this model is more fluid than other stage models, because a person may go forwards or backwards between stages, instead of systematically moving from one stage to the next. The strengths of this model are that it recognises that help-seeking occurs within a social environment and that it is more complex than just a linear process. It also highlights the influence of the past, which Murray describes as the "river of previous help-seeking", which needs to be crossed, and which can be a "positive" or "negative crossing". If it is

not crossed, then a young person is left with the awareness of their problem but unable to gain help. This model highlights the importance of adults providing positive experiences of receiving help to aid both the present but also future help-seeking. It also highlights the importance of legitimising psychological problems, which has implications for education about mental health issues and what constitutes a valid need for help.

3.3 Help-seeking by adolescents

Over thirty studies were found on help-seeking in adolescents (see Table 2 for summary of studies). This section summarises the main findings from these studies and gives some examples. Overall, the key finding is that help-seeking in adolescents is low, relative to need. For example, Saunders et al. (1994) carried out a large scale, school-based survey in the USA, and found that more than half (54%) of those who said that they needed professional help, had not sought help. Nearly two-thirds of another American school sample had not sought help for issues such as depression, suicidal thoughts and substance misuse (Dubow et al., 1990) and three quarters of a Canadian sample had not sought help for psychological difficulties (Bergeron et al., 2005). In the UK 72% of a community sample had not sought help for psychological problems, either formally or informally, in the previous month and approximately 80% of adolescents had not consulted a GP, even when they reported suicidal thoughts (Biddle, Gunnell, Sharp and Donovan, 2004).

Table 2: Studies on Help-seeking

Authors	Country	Number	Sample and design
Armstrong et al, 2000	UK	120	School 11-16yr olds; focus groups based on vignettes, and qualitative interviews
Barker & Adelman 1994	USA	471	School 16-20yrs old; 70% Mexican-American; quantitative questionnaire
Bergeron et al 2005	Canada	1092	Community 15-24yr olds; quantitative questionnaires
Biddle et al 2004	UK	1276	Community, 16-24yrs old; quantitative questionnaires
Boldero & Fallon 1995	Australia	1013	School; 11-18yrs old; quantitative questionnaires
Bui and Takeuchi 1992	USA	3191	Service users (over 5yr period) 13-17yrs. 4 cultural groups
Cuffe et al 1995	USA	478	School 11-13yrs 83% white
Davies et al 2000	USA	49	College; 15-24yrs old; focus groups incl. 1 group of cultural minorities
Draucker 2005	USA	52	Service users as adolescents (18-21 yr olds) parents and staff; retrospective qualitative interviews
Dubow et al 1990	USA	1384	School 13-18yrs old; 85% white; quantitative questionnaires
Flisher et al 1997	USA	1285	Community 9-17yrs old and parents; 49% white; quantitative questionnaires
Garland et al 1996	USA	662	2-17yr olds in foster care and foster parents
Gasquet et al 1997	France	3287	School 12-20yr olds.
Gonzalez et al 2005	USA	5877	Community 15-24 yr olds; 77% white; quantitative nationwide survey
John et al 1993	Canada	1587	Community 12-16yr olds
Kodjo et al 2004	USA	3963	School 11-21yrs 67% white; quantitative questionnaires
Leaf et al 1996	USA	1285	Community 9-17yr olds and parents
Murray 2005	UK	55	School,13-14yrs old; white; qualitative interviews
Offer et al 1991	USA	497	School, 16-18yrs old; 89% white; quantitative questionnaires
Pumariega et al 1998	USA	2528	School 11-16yrs 3 cultural groups

Raviv et al 2000	Israel	512	School, 14-16yrs old, 100% Israeli; quantitative questionnaires
Rickwood et al 2000	Australia	2721	Collection of studies - school and service users; 12-24yrs old; GPs, youth workers, teachers; focus groups, quantitative questionnaires
Saunders et al 1994	USA	17193	School 11-16yrs 92% white; quantitative questionnaires
Schonert-Reichl and Muller 1995	Canada	221	School 13-18yrs; quantitative questionnaires
Sears 2004	Canada	644	School 13-18yr olds; quantitative questionnaires
Sheffield et al 2004	Australia	254	School, 15-17yrs old; quantitative questionnaires
Street et al 2005	UK	120	CAMHS staff and cultural minority service users;12-25yrs old; questionnaires, focus groups, interviews, mapping services
Smith 2004	USA	100	School; boys 12-18yrs old; 100%white; qualitative interviews, using free association
Sourander et al 2004	Finland	2348	Community longitudinal sample 8/18yrs, parents, teachers
Takeuchi, Bui & Kim	USA	3191	Service users (over 5yr period) 13-17 yrs. old; 4 cultural groups
Timlin-Scalera et al 2003	USA	35	School 14-18yr olds and parents; 100% white; qualitative interviews
Yeh et al 2003	USA	1338	Youth in services e.g. child welfare parents; 6-17yr olds; 44% white; quantitative questionnaires
Zachrisson et al 2006	Norway	11154	School 15-16 yr olds; quantitative questionnaires
Zwaanswijk et al 2003	Holland	1120	Community 11-18 yr olds; quantitative questionnaires

Informal and formal help

Adolescents prefer informal sources of help, such as friends and family, rather than formal help from professionals (Boldero and Fallon, 1995; Dubow et al., 1990; Offer et al., 1991; Raviv, Sills, Raviv & Wilansky, 2000; Rickwood et al., 2005; Saunders et al., 1994; Timlin-Scalera et al., 2003). For example, Rickwood et al. (2005) found that adolescents avoided sources of help which involved talking to strangers, such as professional help, which they said would make them embarrassed and fearful. They believed that their family could help them more than professionals apart from issues they did not wish to disclose to family, such as suicidal thoughts and drugs. These findings were based on a detailed research programme, which incorporated nineteen different studies, using a variety of populations and methods; the authors also devised and standardised their own help-seeking measures.

The majority of studies of adolescent help-seeking have used non-clinical populations and therefore this preference for informal help may be due to the adolescent perceiving their problems as too minor to seek professional help. However this seems to be unlikely: Sheffield et al. (2004) found that even when adolescents had significant mental health problems (measured by the Depression Anxiety Stress Scale), they were most likely to seek help from family (56.5% of their sample) and friends (47.8%). Raviv et al. (2000) suggest that this is because adolescents prefer to seek help casually from people who know them because it is less threatening than formal help. Studies suggest that adolescents are more likely to request help from familiar people who are already part of their lives, within trusted, established relationships such as parents, teachers and

youth workers. Adults are chosen as sources of help if they appear available, trustworthy, able to understand their problems, and if they have had similar problems in the past (Rickwood et al., 2005; Timlin-Scalera et al., 2003).

One way in which help-seeking can be facilitated in young people is through the provision of mentoring schemes, in which adolescents can develop an informal relationship with an adult, who provides the mentee with guidance and support. The research literature suggests that mentoring can make a positive contribution to the lives of adolescents. However the literature also highlights that in order to attain positive outcomes, certain standards of good practice need to be adhered to, such as mentoring relationships lasting for at least six months and the use of good matching procedures. A meta-analysis of fifty-five community or school-based youth mentoring projects found some positive benefits, as measured by a wide range of psychological, social and behavioural outcomes (Dubois, Holloway, Valentine & Cooper, 2002). Outcome studies have shown associated improvements with mentoring, such as increased self-esteem (e.g. Dubois & Silverthorn, 2005; Yancey, Siegel & McDaniel, 2002); improved relationships with other adults, particularly with parents (e.g. Tierney, Grossman & Resch, 1995) and reduced substance misuse (e.g. Beier, Rosenfeld, Spitalny, Zansky & Bontempo, 2000; Tierney et al., 1995).

Certain aspects of the mentoring relationship have been identified as important for effective mentoring, such as the mentor's focus on building the relationship, rather than being goal-orientated (Sipe, 2002) and being activity-based rather than focusing on emotionally focused conversations (e.g. Davidson, Redner,

Blakely, Mitchell & Esmhoff, 1987; Sipe, 2002). Other factors have been identified as facilitating the mentoring relationship, such as trust, mutual benefits to both mentor and mentee, the mentor's sense of efficacy and shared life experiences (Linnehan, Weer & Josh, 2005; Philip & Hendry, 2000).

Different theoretical ideas have been proposed to explain how mentoring works. One suggestion, taken from developmental psychology, is that mentoring acts as a compensatory or protective factor that helps to build resilience in adolescents (e.g. Rutter, 1987). Attachment theory has also been used to explain mentoring. Rhodes (2002), for example, suggested that mentors act as alternative or secondary attachment figures, helping adolescents to develop healthier internal working models of relationships and a healthier view of themselves. Rhodes (2002) proposed a model of mentoring in which the mentoring relationship was characterised by empathy, trust and mutuality. She suggested that the mentoring relationship helped young people in three key ways; firstly, by improving social skills and emotional well being; secondly, by improving cognitive skills through communication and thirdly by being a role model and advocate. Rhodes (2002) also suggested that improved relationships, particularly between adolescents and their parents, was a mediating factor within the mentoring process.

Gender Difference

Girls seek help significantly more than boys, both formally and informally (Bergeron et al.,2005; Boldero & Fallon,1995; Gasquet et al 1997; Gonzalez et al.,2005; Raviv et al., 2000; Rickwood et al., 2005; Saunders et al., 1994; Schonert-Reichl & Muller, 1995). For example, Rickwood et al. (2005) found

that for both genders, help-seeking from family declines as adolescents become older; however help-seeking from friends increases for girls but not for boys, which remains fairly constant. Girls seem to transfer their help-seeking from family to friends, whereas boys do not. In terms of formal help-seeking, boys are more likely to seek help than girls at about 12 years old, but then as they enter adolescence this pattern is reversed (Boldero & Fallon,1995; Rickwood et al., 2005). A school-based survey found that girls were more likely to identify a need compared to boys, but once needs were identified, there was no significant gender difference in asking for help (Saunders et al., 1994). Some authors have suggested that boys may delay help-seeking until issues become more severe, possibly because of social pressures to fit into their peer group, to live up to a strong macho image and to hide emotional vulnerabilities (Davies et al., 2000; Timlin-Sclara et al., 2003). However a number of studies suggest that boys perceive their problems as less severe than girls, increasing their delay in seeking help (Biddle et al., 2004; Dubow et al., 1990; Raviv et al., 2000). Boys may also be more likely to use denial, avoidance or express problems externally, through violence and substance abuse, whereas girls are more likely to express emotions and seek support (Raviv et al., 2000; Timlin-Sclara et al., 2003).

Factors which influence help-seeking

Two of the key influences on help-seeking, which have already been discussed, are perceptions of services and prior help-seeking experiences (Biddle et al., 2004; Murray, 2005; Rickwood et al., 2005; Timlin-Scalera et al., 2003). For example, Biddle et al. (2004) carried out a community based survey and found that adolescents were four times more likely to consult a G.P. if they had sought

help in the past, regardless of the source of help. Rickwood et al. (2005), based on their collection of studies, suggested that help-seeking was also facilitated by "emotional competence", the ability to identify and manage emotions, which they found to be stronger in girls. However emotional competence only seems to facilitate informal help-seeking and does not affect the level of formal help-seeking (Rickwood et al., 2005; Timlin-Scalera et al., 2003). "Help-negation" describes when help is not used, even when a problem is recognised and when help is available, and this is particularly related to feelings of hopelessness and suicidal ideation (Rickwood et al., 2005; Saunders et al., 1994). School based surveys have found that adolescents are also hindered sometimes because they do not know how to access help (Timlin-Scalera et al., 2003; Sheffield et al., 2004).

Certain beliefs hinder help-seeking, for example, a common belief reported by adolescents is that people should solve problems on their own (Davies et al., 2000; Flisher et al.,1997; Saunders et al., 1994; Sheffield et al.,2004). Other common beliefs are that it is a sign of weakness to ask for help, that they should not burden others (Timlin-Scalera et al., 2003) and that their problems are minor compared to their parents and do not warrant outside help (Armstrong et al., 2000). There is also the fear of what others will think; the belief that the problem will go away with time (Dubow et al., 1990; Flisher et al.,1997) and that others are not able to help (Sheffield et al., 2004). Those with an internal locus of control are more likely to seek help than those with an external locus of control, and this is related to feeling empowered to request help (Schonert-Reichl & Muller, 1995).

Self-image has been found to be related to help-seeking, but this relationship varies depending on whether the help is formal or informal. Raviv et al (2002) compared the process of self-referral to the process of referring a friend (which was seen as less threatening to self-image), using different scenarios and questionnaires. The findings suggested that adolescents who had a positive self-image were less likely to seek formal help. One explanation of this finding is that needing help was inconsistent with their view of themselves and professionals were seen as a threat to their self-image. The authors suggested that adolescents balanced the severity of their problem with the threat to self-image, in order to decide whether to seek help or not, which has also been suggested by Schonert-Reichl and Muller (1995). However for informal help-seeking, those with a more positive self-image sought help more often from family and friends, who were seen as less threatening than formal help (Raviv et al., 2002). However these results can be interpreted in the opposite direction – that they have a positive self-image *because* they have been able to access help previously from family.

Two key developmental issues occur in adolescence - independence and intimacy (developing peer relationships). Help-seeking may be a challenge to these because seeking help can undermine independence and also can threaten peer relationships because of stigma (Davies et al., 2000).

Severity and persistence of problems seem to predict greater help-seeking (e.g. Barker and Adelman,1994; Biddle et al.,2004; Garland et al.,1996; Raviv et al.,

2002; Sheffield et al., 2004; Sourander et al., 2004; Timlin-Scalera et al., 2003; Zachrisson, Rodje & Mykletun, 2006). Zachrisson et al. (2006) found a dose-response association between symptom levels (in anxiety and depression) and help-seeking, that is, the more severe the symptoms, the more adolescents sought help. Related to this, the degree of distress and impairment caused also facilitated help-seeking (e.g. Leaf et al., 1996; Rickwood et al., 2005). If severity is one of the main predictors for help-seeking, this may explain why boys access help less, if we assume (as stated earlier in the section on gender differences) that boys have a higher threshold for severity than girls (e.g. Biddle et al., 2004; Dubow et al., 1990; Raviv et al., 2002).

There also appears to be a relationship between formal help-seeking and age with help-seeking increasing towards late adolescence, compared to early adolescence (e.g. Gasquet et al., 1997; Schonert-Reichl & Muller, 1995; Zwaanswijk et al., 2003).

Help-seeking occurs within a social context of roles and networks. Boldero and Fallon (1995) surveyed adolescents within schools and found that adolescents considered the range of help available, within their network, weighed up the suitability of each source of help according to problem type and then sought appropriate help. For example, teachers were used for educational problems, parents for interpersonal problems, and professional help for problems such as substance abuse and depression. Help for interpersonal problems was sought the most, and help with family problems sought the least. (Boldero and Fallon, 1995). Another school-based study, using interviews, found that minor issues

were usually taken to friends and more serious issues, particularly concerning relationships, to those older than themselves, such as a cousin, brother or teacher, rather than to friends or parents (Timlin-Scalera et al, 2003). Stronger social support seems to lead to greater use of informal help, presumably because help is available through this social network. However, this means that those with poorer social support are less likely to use informal help and therefore maybe at greater risk, particularly because adolescents do often not access formal help (Saunders et al., 1994; Sheffield et al., 2004).

Adolescents with service users in their family seem to be more likely to seek help (Bergeron et al.,2005; Zwaanswijk et al., 2003). Zwaanswijk et al. (2003) found that parental psychopathology was significantly associated with adolescents' own perceptions of problems and likelihood of seeking help, after controlling for other variables. Formal help-seeking may be modelled by the family and therefore may become less stigmatising and adolescents may become more informed. In another study, Timlin-Scalera et al. (2003) interviewed adolescents in schools and found that help-seeking was facilitated by suggestions from others and openness to discuss emotional issues in the home.

3.4 Help-seeking by African/Afro-Caribbean Adolescents

Eight studies on help-seeking were found, that included African/Afro-Caribbean participants within their sample. Seven of these were American studies using quantitative measures and one was a British report, "Minority Voices" (Street et al., 2005), mentioned in the section on perceptions. In terms of whether there are

any cultural differences within adolescent help-seeking, the results are quite mixed.

Three of these studies suggest that there are no cultural differences and conclude that cultural minorities should not be stereotyped or treated as different (Barker & Adelman,1994; Gonzalez et al., 2005; Saunders et al., 1994). Gonzalez et al. (2005) found no cultural differences in terms of willingness to seek treatment, level of feeling comfortable talking to a professional and level of embarrassment. Saunders et al. (1994) found no significant differences between African/Afro-Caribbean and white American adolescents in either recognising need or requesting help. However, they did find a significant interaction between socio-economic levels and culture for requesting help. Therefore, even though need was identified, African/Afro-Caribbean adolescents of low socio-economic background found it harder to ask for help.

However these three studies surveyed predominantly white American and Mexican participants, so there may have been social pressure for African/Afro-Caribbean participants to conform to white majority viewpoints.

Other studies suggest that African/Afro-Caribbean people are more positive about services than whites. In one study African/Afro-Caribbean parents of service users reported significantly fewer barriers to treatment than white parents (Yeh, McCabe, Hough, Dupuis & Hazen, 2003). In this study, a questionnaire was used which included an acculturation scale to measure affiliation to American culture. African/Afro-Caribbean respondents who scored

more highly on acculturation reported more similar barriers to whites. A community-based survey found that African/Afro-Caribbean adolescents were twice as likely than white adolescents to have a positive attitude towards services, despite low service uptake (Gonzalez et al., 2005). However in their conclusions, Gonzalez et al. (2005) recognised that this may not be an accurate finding because of a possible recruitment bias - those who are more negative about services would be less likely to respond to a community survey (Gonzalez et al., 2005).

However, other studies suggest the opposite, that is, that African/Afro-Caribbean adolescents are more reluctant than white adolescents to seek formal help. The five studies found, which conclude that African/Afro-Caribbean adolescents are more negative about formal help, have good methodology and include the detailed report, "Minority Voices" which has already been discussed in the previous section. For example, Kodjo and Auinger (2004) found, within a large American school sample, that African/Afro-Caribbean adolescents were significantly more likely than whites to not know how to access services, not have access to transportation or have someone to take them, not want their parents to know and were more concerned about what professionals would say to them. Bui and Takeuchi (2002) used service data over a five-year period and divided their sample into different cultural groups to compare cultural differences, within one American state. They found that African/Afro-Caribbean adolescents stayed in treatment for significantly less time than whites (Bui and Takeuchi, 2002). Draucker (2005) interviewed service-users and found that African/Afro-Caribbean adolescents had more negative attitudes to help-seeking

than white adolescents, and suggested that this was because of historical patterns of racism, with African/Afro-Caribbean people being more reluctant to seek help from predominantly white professionals. African/Afro-Caribbean adolescents seem to rely on friends, family and the church more because they know and understand them better (Draucker, 2005) and because they are unsure about the effectiveness of professional help for them (e.g. Cuffe et al., 1995).

Research has highlighted some other cultural differences. For example, an American, school-based survey found that white adolescents were more likely to seek help from friends compared to African/Afro-Caribbean adolescents, who preferred to seek help from family (Offer et al.,1991). Another American school survey found that African/Afro-Caribbean adolescents were more likely to report a higher tolerance to emotional distress than whites and they were more likely to seek help when issues reach crisis point (Cuffe et al., 1995).

Street et al. (2005) carried out an extensive study using focus groups and interviews with cultural minority service users of CAMHS, throughout the UK, to produce the report "Minority Voices". They found that a common pattern of help-seeking, reported by these service users consisted of an adolescent first asking for practical help from an adult within the community, a "community gatekeeper", such as a youth leader, teacher, religious leader or traditional healer, in order to develop a relationship of trust. As trust developed they then felt able to ask for help with psychological difficulties. Mentoring is one way in which this pattern of help-seeking could be facilitated, although there is some evidence in the literature, to suggest that mentoring with African/Afro-

Caribbean adolescents is only effective if the mentoring programme is culturally sensitive and when mentees and mentors are matched according to a shared cultural background (e.g. Dubois et al., 2002; Keating, Tomishima, Foster & Alessandri, 2002). There is also a vital need for these "community gatekeepers" to have knowledge of mental health issues and to be able to direct young people to appropriate services (Cauce et al., 2002; Street et al., 2005).

Street et al. (2005) also found that African/Afro-Caribbean adolescents can be confused as to whether the issues that disturb them are due to individual problems or because of their culture, such as feeling inferior or alienated. This can be compounded by professionals, who sometimes apply cultural stereotypes to African/Afro-Caribbean adolescents, forgetting that they have often been born in the UK, which adds to their confusion around identity (Street et al., 2005).

3.5 Conclusions on help-seeking

To conclude this section on help-seeking, there is a low rate of service use, relative to psychological need, for adolescents in general, and in particular for African/Afro-Caribbean adolescents. Adolescents prefer informal help – particularly within established long-term relationships. Boys seek help significantly less than girls, possibly because there are more social pressures on boys not to seek help, particularly from friends, and they are less able to recognise need, which they identify as being less severe than girls. There are a number of factors which influence help-seeking such as problem severity, level of social support and beliefs about help-seeking. This is based on studies within

different countries, using a range of methodologies and samples from schools, community or services. However a weakness in all the studies is that they do not refer to any of the proposed models of help-seeking behaviour. Therefore the literature does not provide an adequate theoretical basis for this behaviour which could help to develop a greater understanding of the processes involved.

There is limited research on help-seeking in African/Afro-Caribbean adolescents, and only one study was found which focused specifically on cultural minority adolescents. The research suggests that African/Afro-Caribbean adolescents are more negative about seeking formal help and tend to delay help-seeking until crisis point, compared to white adolescents. However a few studies suggest that there are no cultural differences or that African/Afro-Caribbean adolescents are more positive about services than white adolescents.

4. Influences on African/Afro-Caribbean Adolescents

Cauce et al. (2002) describe help-seeking by cultural minorities as occurring by "an interaction between family and individual choice, cultural values and beliefs regarding mental health and help-seeking and contextual and systemic factors." (p.46). It is important to recognise that adolescents do not live in a vacuum, and that their perceptions and behaviour develop within the context of family, culture, and the society in which they live. To review the relevant adult literature is beyond the scope of this review, but this section summarises key issues to highlight some of the influences on adolescents.

4.1 African/Afro–Caribbean perceptions on mental health problems and services, and help-seeking behaviour – overview of the adult literature

As seen from the adolescent literature, the family is one of the primary sources of help which adolescents use. Therefore adult perceptions and experiences of services, beliefs about mental illness and the modelling of their own help-seeking behaviour are likely to have a profound impact on adolescents.

A key report, "Breaking the Circles of Fear" (Keating et al., 2002) describes the relationship between services and African/Afro-Caribbean people as a vicious cycle of fear. African/Afro-Caribbean populations are wary of using services and feel that they are not able to meet their needs. They therefore avoid services until problems reach crisis point, at which point services are likely to be reached through coercive pathways, such as compulsory admission. This then confirms services' perceptions of African/Afro-Caribbean populations, as being violent, difficult to manage and in need of medication and hospitalisation. This in turn confirms suspicions within the African/Afro-Caribbean communities that mental health services tend to hospitalise, overmedicate, misdiagnose and stereotype, which feeds back into a fear of services (Keating et al., 2002). This pattern is also seen in American literature (e.g. Cooper et al., 2003; Sanders-Thompson, Bazile & Akbar, 2004; Snowden, 1999).

A number of other key reports have been produced recently e.g. "Inside Outside" (National Institute for Mental Health in England, 2003), "Delivering Race Equality" (Dept. of Health, 2003) and the most recent report, "Count Me In" (Dept of Health, 2005). The latter report found that African/Afro-Caribbean

people are three times more likely to be admitted to hospital and are almost twice as likely to be detained under the Mental Health Act. The issue of racism within institutions is evident in each of these reports, and other issues identified include difficulties in accessing services - particularly psychotherapy; limited support for carers; lower satisfaction with services; lower GP involvement in care; few African/Afro-Caribbean professional staff; and poor support for African/Afro-Caribbean community initiatives and joint working. A few studies have found that G.P.s were less able to diagnose psychological need in African/Afro-Caribbean patients (Gillam & Jarman, 1989, cited in Street et al., 2005; Shaw, Creed, Tomenson, Riste & Cruickshank, 1999). Shaw et al. (1999), for example, found that G.P.s recognised depression and anxiety within 27% of African/Afro-Caribbean patients compared to 52% for White Europeans. However the reports also highlighted improvements which are being made to make services less threatening and more effective.

Other studies report cultural differences regarding perceptions of mental health. Hall and Tucker (1985) used questionnaires with over 500 white American and African/Afro-Caribbean teachers and found that white participants scored closer to scores of mental health professionals than did African/Afro-Caribbean participants and that they valued counselling for their children more than African/Afro Caribbean participants. The authors concluded that African/Afro-Caribbean adults had a different conceptualisation of mental health and that this explained their reluctance to access services, which they perceived as less effective, than whites.

4.2 Influences from Family

There are a number of studies on help-seeking by parents for adolescents and they highlight the importance of parents' ability to recognise problems, and then to encourage adolescents to seek help (e.g. Flisher et al., 1997). Street et al. (2005) conclude that the influence of African/Afro-Caribbean parents is underestimated and often has more influence than within British families. McMiller and Weisz (1996) found that African/Afro-Caribbean parents are only about a third as likely to contact professionals as white Americans, and only do so when problems become severe.

A number of studies highlight cultural differences in distress thresholds. Lambert et al. (1992) suggested that parents set thresholds for distress, at which point they will seek help. They set the threshold by considering a "typical" child within their community, with which to compare their own children, and that this benchmark is different for different communities. Within their study, Lambert et al. found that a sample of parents and teachers in Jamaica were found to have a higher threshold for children's problems, compared to an American sample; the Americans also believed more strongly that these problems were ingrained in their child's personality, as opposed to being more transient (Lambert et al., 1992). Another study found that white parents were significantly more likely to rate their adolescent's mental health as worse than African/Afro-Caribbean parents do, even after controlling for psychiatric disorder and functioning (Roberts, Alegria, Roberts & Chen, 2005).

Some studies report how families view services in negative ways. For example CAMHS services are seen by African/Afro-Caribbean families as having significant authority and control and that these services can be used as a form of social control, resulting in the loss of their children, who may become institutionalised (e.g. Lowe, 2006; Takeuchi et al., 1993).

4.3 Influences from African/Afro-Caribbean cultures

Within African/Afro-Caribbean communities there are different worldviews, which are generally more holistic and systemic than Western worldviews. These worldviews lead to some theories of mental health which are not usually recognised within Western mental health services, for example, the African balance theories of emotion (being too hot or cold) or religious ideas of curses causing some emotional problems, and the use of prayer, deliverance, herbs and other traditional medicines (e.g. Cinnirella & Loewenthal, 1999; Curtis & Lawson, 2000; Snowden,1999).

There are some cultural differences in how mental illness is diagnosed, for example, African/Afro-Caribbean people are less likely to see thought disorder as a symptom of schizophrenia and instead focus more on unusual behaviour (Pote & Orrell, 2002) There are also differences in how depression is viewed, e.g. Lawrence et al. (2006) found that it was linked more to worry and to loneliness, than in white participants.

There are also general attitudes within African/Afro-Caribbean communities which influence help-seeking, such as the importance of willpower, "getting on

with life" and the idea of "chilling" as a way of reducing stress or anger (Poulin et al., 1997 cited in Cauce et al, 2002). Psychiatry is sometimes viewed as intrusive and that problems should be kept within the family (Keating et al., 2002) and that help should only come from mutual support within the community or by using religious or traditional helpers (e.g. Snowden, 1998).

Services can assume that there are no language barriers because African/Afro-Caribbean people use English. However words can have different meanings and differences in accent and the use of patois English can lead to misunderstandings and communication problems.(Fatemilehin & Coleman, 1999; Lawrence et al., 2006)

Adolescents from African/Afro-Caribbean backgrounds are more likely to experience risk factors, associated with mental health problems, because of their culture. A Racial Investigation Report, for example, found that African/Afro-Caribbean children were four times more likely to be excluded from school for fewer and less serious offences than white children and were less likely to re-enter education (Keating et al., 2002). The Fourth National Survey data (Dwivedi, 2002, cited in Street et al, 2005) showed that African/Afro-Caribbean families had lower incomes, remained unemployed for longer, had poorer working conditions and poorer housing.

Researchers have also highlighted the historical context of slavery, colonialism and the abuse of power, which influences current relationships between a predominantly white profession and African/Afro-Caribbean patients. This also

affects how an African/Afro-Caribbean person develops their self-identity, growing up in a Western society (e.g. Hickling & Hutchinson, 1999). One study (Schnittker, Freese & Powell, 2000) suggested that African/Afro-Caribbean patients were more reluctant to agree with genetic or family-based explanations for mental health problems, than whites, because they related these ideas to historical proposals of being genetically inferior.

4.4 Influences from Western cultures

African/Afro-Caribbean adolescents who live within a Western culture are also influenced by this culture, as portrayed by the media, peers and education. Within Western society, service users are stigmatised, based on traditional views of "madness." These ideas are threatening and so people respond by avoidance or ridicule (Naylor et al., 2002). British lay beliefs about schizophrenia, for example, include the ideas that patients are dangerous, less trustworthy and of lower intelligence (Furnham and Rees, 1988). The majority of media portrayals of mental health problems are negative and these strongly influence people's perceptions of mental health; for example, in one study on adolescents' perceptions of mental illness, all participants cited television as a main source of information (Philo, 1996, cited in Secker et al., 1999).

4.5 Conclusions on influences

In summary, African/Afro-Caribbean adolescents are influenced by the general population's stigmatising views of services and by adult patterns of help-seeking

within African/Afro-Caribbean communities, described as the "Circles of Fear". Higher thresholds of distress are tolerated due to perceptions of services as being less effective and relevant for them. Cultural influences affect how mental health problems are defined and what constitutes appropriate help and historical relationships such as slavery may still influence current relationships to help.

5. Conclusions and Future Directions

One of the initial findings of this review was the small number of studies that have specifically focused on African/Afro-Caribbean adolescents and mental health. However, the initial questions posed in the introduction will now be considered.

Firstly, how do African/Afro-Caribbean adolescents perceive mental health problems and services? The research suggests that these are perceived in negative and stigmatising terms; the predominant defining characteristic of mental illness, for adolescents, is being different to themselves and to social norms. There also seems to be a gender difference; boys perceive mental health problems as more stigmatising than girls. African/Afro-Caribbean adolescents do not appear to hold different views than adolescents in general, sharing concerns about lack of confidentiality, stigma, hesitance to trust professionals and limited knowledge of services or how treatment is provided. However, they also report concerns about a lack of cultural awareness and the need for more time to develop trusting relationships with staff. They also report more concerns about treatment being used as social control and overmedication, which resonate

with findings in the adult literature about the relationship between African/Afro-Caribbean communities and services. However, this is based on studies which predominantly used white participants and because there was a small number of African/Afro-Caribbean participants, their views may not have been adequately represented. Therefore more research needs to be done to explore whether or not there are any cultural differences within adolescents' perceptions, using larger samples of cultural minority adolescents. Only one study was found (Street et al, 2002) which specifically focused on the perceptions of cultural minority groups and this study interviewed service users, predominantly about CAMHS services. Therefore more research is needed to explore the perceptions of mental health and services, within non-clinical samples of African/Afro-Caribbean adolescents.

Secondly, what help do African/Afro-Caribbean adolescents seek for mental health problems? This review found that help-seeking is disturbingly low amongst adolescents, relative to need, and more so in African/Afro-Caribbean adolescents, who tend to delay formal help-seeking until crisis point. Therefore, although self-referral is low, they are more likely to enter services through coercive routes, via referrals from other agencies, reflecting the pattern seen in adults. Again, there is a clear gender difference, with boys being significantly less likely to seek help, possibly due to social pressures and poorer emotional competence. Adolescents prefer informal sources of help and in particular, one study (Street et al., 2005) found that African/Afro-Caribbean adolescent boys reported a particular help-seeking pattern; boys would develop a relationship with an adult in their community, such as a youth worker, and initially the focus

of this relationship was on practical help, but as trust grew, this relationship also provided psychological help.

However there is a lack of research on help-seeking by African/Afro-Caribbean adolescents and therefore more research is needed. There is a lack of research which directly considers the theoretical models of help-seeking and this is an area of research which could be developed, in particular for African/Afro-Caribbean adolescents. Considering some of the stage models of help-seeking, such as those proposed by Cause et al. (2002) and Rickwood et al. (2005), it would be useful to explore what factors facilitate help-seeking at each stage. Also, the model proposed by Murray (2005) suggests two important influences in help-seeking – problem legitimisation and prior help-seeking pathways. Problem legitimisation within African/Afro-Caribbean communities would be a particularly useful area of research, for example, to explore how cultural influences affect the process of problem legitimisation, and how that in turn influences help-seeking behaviour. It would also be useful to test the hypothesis that Murray proposed; that help-seeking is hindered by negative experiences of prior help-seeking and is facilitated by positive, prior experiences.

Thirdly, what are some of the influences on perceptions and help-seeking for African/Afro-Caribbean adolescents? The research suggests that within African/Afro-Caribbean communities there are particular family and cultural influences, which hinder help-seeking in African/Afro-Caribbean adolescents, such as apprehension of services, stigmatising views within the general population and different cultural beliefs about managing mental health

difficulties. Again, further research would be useful in this area, for example a study using qualitative methodology could be used to explore the cultural factors which influence African/Afro-Caribbean adolescents' help-seeking attitudes and behaviour.

The findings within this review suggest that African/Afro-Caribbean boys are less likely to seek formal help than other client groups, and that this is associated with their age, gender and cultural background. Therefore it is particularly important to explore how this client group can be supported in accessing psychological help. One suggestion, made by Street et al., (2005) is that "some sort of befriending role" could help cultural minority adolescents to access mental health services and mentoring is one way in which such a role could be provided. The research literature suggests that mentoring can contribute to constructive change in adolescents, when certain standards of good practice are followed, such as culturally matching mentors with mentees. Research also suggests that African/Afro-Caribbean boys are most likely to seek help through an established relationship, within their community, such as within a mentoring scheme. Therefore another useful area of research would be to explore a relationship such as mentoring for African/Afro-Caribbean boys and to see what factors help to maintain these vital relationships and whether they can provide psychological help. This pattern of help-seeking in African/Afro-Caribbean boys also has clinical implications; for example, psychologists could work in partnership with community groups who are providing long-term relationships, such as mentoring. This partnership could provide mutual support and understanding between psychology services and community groups; this could

enable psychology services to develop more culturally appropriate practice and enable African/Afro-Caribbean communities to develop a greater understanding of mental health and to support their young people within a culturally appropriate context.

REFERENCES

Anderson, R. & Newman, J, (1973) Societal and individual determinants of medical care utilisation in the United States. *Milbank Memory Fund Quarterly 51*, 95-124.

Armstrong, C., Hill, M. & Secker, J. (2000) Young people's perceptions of mental health. *Children and Society, 14*, 60-72.

Audit Commission (1999) *Children in mind: Child and Adolescent Mental Health Services.* Audit Commission Publications: London.

Barker, L. & Adelman, H. (1994) Mental health and help-seeking among ethnic minority adolescents. *Journal of Adolescence, 17*, 251-263.

Beier, S., Rosenfeld, W., Spitalny, K, Zansky, S and Bontempo, A. (2000) The potential role of an adult mentor in influencing high-risk behaviors in adolescents. *Archives of Pediatrics and Adolescent Medicine, 154*, 4.

Bergeron, E., Poirier, L., Fournier, L., Pasquale R., & Barrette, G.(2005) Determinants of service use among young Canadians with mental disorders. *Canadian Journal of Psychiatry, 50*, 629-636.

Biddle, L., Gunnell, D., Sharp, D. and Donovan, J. (2004) Factors influencing help seeking in mentally distressed young adults: a cross-sectional survey. *British Journal of General Practice, 54*, 248-253.

Boldero, J & Fallon, B. (1995) Adolescent help-seeking: what do they get help for and from whom? *Journal of Adolescence, 18*, 193-209.

Bui, K. and Takeuchi, D. (1992) Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology, 20*, 403-417.

Buston, K. (2002) Adolescents with mental health problems: what do they say about health services? *Journal of Adolescence, 25*, 231-242.

Butcher, R. & Crosbie, D. (1977) *Pensioned Off: A study of the needs of elderly people in Cleaton Moor.* University of York: York.

Cauce, A., Domenech-Rodriguez, M., Paradise, M., Cichran, B., Shea, J., Shebnik, D. & Baydar, N. (2002) Cultural and contextual influences in mental health help-seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology, 70*, 44-55.

Cinnirella, M. & Loewenthal, K. (1999) Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. *British Journal of Medical Psychology, 72*, 505-524.

Cooper, L., Gonzales, J., Gallo, J., Rost, K., Meredith, L., Rubenstein, L., Wang, N. & Ford, D. (2003) The acceptability of treatment for depression among African-American, Hispanic and white primary care patients. *Medical Care, 41*, 479-489.

Corrigan, P., Lurie, B., Goldman, H., Slopen, N., Medasani, K., & Phelan, S. (2005) How adolescents perceive stigma of mental illness and alcohol abuse. *Psychiatric Services, 56*, 544-550.

Cuffe, S., Waller, J., Cuccaro, M., Pumariega, A., & Garrison, C. (1995) Race and gender differences in the treatment of psychiatric disorders in young adolescents. *Journal of American Academic Child and Adolescent Psychiatry, 34*, 1536-1543.

Curtis, S & Lawson, K. (2000) Gender, ethnicity and self-reported health: the case of African-Caribbean populations in London. *Social Science and Medicine, 50*, 365-385.

D'Ardenne, P. & Mahtani, A. (1999) *Transcultural counselling in action.* London: Sage.

Davidson, W.S., Redner, R., Blakely, C.H., Mitchell, C.M. and Esmhoff, J.G. (1987) Diversion of juvenile offenders: An experimental comparison. *Journal of Consulting Clinical Psychology,* Vol 55.

Davies, J., McCrae, B., Frank, J., Dochnahl, A., Pickering, T., Harrison, B., Zakrzewski, M & Wilson, K. (2000) Identifying male college students' perceived health needs, barriers to seeking help, and recommendations to help men adopt healthier lifestyles. *Journal of American College Health, 48*, 259-267.

Department for Education and Skills and Department of Health (2004) *The National Service Framework for Children, Young People and Maternity Services.* Department of Health: London.

Department of Health (2003) *Delivering Race Equality: A framework for Action. Mental Health Services, Consultation Document,* Department of Health: London.

Department of Health (2005) *Count me in: Census of inpatients in mental health hospitals and facilities in England and Wales.* Department of Health: London.

Draucker, C. (2005) Processes of Mental Health Service Use by Adolescents with Depression, *Journal of Nursing Scholarship,37,* 155-162.

Dogra, N. (2004) Commissioning and delivering culturally diverse child and adolescent mental health services. *Current Opinion in Psychiatry, 17*, 243-247.

Dubois, D.L., Holloway, B.E., Valentine, J.C. and Cooper, H. (2002) Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology,* Vol 30, 2.

Dubois, D.L. and Silverthorn, N. (2005) Natural mentoring relationships and adolescent health: Evidence from a national study. *American Journal of Public Health,* Vol 95, 3.

Dubow, E., Lovko, K. & Kausch, D. (1990) Demographic differences in adolescents' health concerns and perceptions of helping agents. *Journal of Clinical Child Psychology, 19*, 44-54.

Dwivedi, K. (2002) *Meeting the needs of ethnic minority children.* London: Jessica Kingsley Publisher.

Fatimilehin, I. & Coleman, P. (1999) "You've got to have a Chinese cook to cook Chinese food !!"Issues of power and control in the provision of mental health services *Journal of Community and Applied Social Psychology, 9*, 101-117.

Flisher, A, Kramer, R., Grosser, R., Alegria, M., Bird, H., Bourdon, K., Goodman, S., Greenwald, S., Horwitz, S., Moore, R., Narrow, W. & Hoven, C. (1997) Correlates of unmet need for mental health services by children and adolescents. *Psychological Medicine, 27,* 1145-1154.

Furnham, A. & Rees, J. (1988) Lay theories of schizophrenia. *The International Journal of Social Psychiatry, 34*, 212-220.

Garland, A., Landsverk, J., Hough, R. & Ellis-MacLeaod, E. (1996) Type of maltreatment as a predictor of mental health service use for children in foster care. *Child abuse and Neglect, 20*, 675-688.

Gasquet, I., Chavance, M., Ledoux, S.& Choquet, M. (1997) Psychosocial factors associated with help-seeking behavior among depressive adolescents. *European Child and Adolescent Psychiatry, 6*,151-159.

Gillam, S & Jarman, B. (1989) Ethnic differences in consultation rates in urban general practice. *British Medical Journal, 299*, 953-957.

Gonzalez, J., Alegria, M., & Prihoda, T. (2005) How do attitudes towards mental health treatment vary by age, gender, ethnicity/race in young adults? *Journal of Community Psychology, 33*, 611-629.

Hall, L. & Tucker, C. (1985) Relationships between ethnicity, conceptions of mental illness and attitudes associated with seeking psychological help. *Psychological Reports, 57,* 907-916.

Hickling, F. & Hutchinson, G. (1999) Roast breadfruit psychosis: disturbed racial identification in African-Caribbeans. *Psychiatric Bulletin, 23*, 132-134.

John, L., Offord, D., Boyle, M. & Racine, Y (1993) Factors predicting use of mental health and social services by children 6-16 years old. *American Journal of Orthopsychiatry, 65*, 76-86.

Keating, F., Robertson, D., McCulloch., A. & Francis, E. (2002) *Breaking the circles of fear: A review of the relationship between mental health services and African and Caribbean communities.* The Sainsbury Centre for Mental Health: London.

Kodjo, C & Auinger, P. (2004) Predictors for emotionally distressed adolescents to receive mental health care. *Journal of Adolescent Health, 35*, 368-373.

Lambert, M., Weisz, J., Knight, F., Desrosiers, M., Overly, K. & Thesiger, C. (1992) Jamaican and American adult perspectives on child psychopathology: Further exploration of the threshold model. *Journal of Consulting and Clinical Psychology, 60*, 146-149.

Lawrence, V., Murray, J., Banerjee, S., Turner, S., Sangha, K., Byng, R., Bhugra, D., Huxley, P., Tylee, A. & Macdonald, A. (2006) Concepts and causation of depression: A cross-cultural study of the beliefs of older adults. *The Gerontologist, 46*, 23-32.

Leaf, P., Alegria, M., Cohen, P., Goodman, S., Horwitz, S., Hoven, C., Narrow, W., Vaden-Kiernan, M. & Regier, D. (1996) Mental health service use in the community and schools: results from the four-community MECA study. *Child and Adolescent Psychiatry, 35*, 889-897.

Linnehan, F., Weer, C. and Josh, U., (2005) African –American students' early trust beliefs in work-based mentors. *Journal of Vocational Behaviour,* Vol 66, 3

Lowe, F (2006) Containing persecutory anxiety: Child and Adolescent Mental Health Services and black and minority ethnic communities. *Journal of Social Work Practice, 20*, 5-25.

McMiller, W & Weisz, J. (1996) Help-seeking preceding mental health clinic intake among African-American, Latino and Caucasian Youths. *Child and Adolescent Psychiatry, 35*, 1086-1094.

Mental Health Foundation (1999) *Bright Futures: Promoting children and young people's mental health.* Mental Health Foundation: London.

Murray (2005) Young people's help-seeking: An alternative model. *Childhood, 12*, 479-494.

National Institute for Mental Health in England (2003) *Inside, Outside. Improving mental health services for black and minority ethnic communities in England.* National Institute for Mental health in England, Department of Health: London.

Naylor, P., Cowie, H., Talamelli, L. & Dawkins, J. (2002) *The development of adolescents pupils' knowledge about and attitudes towards mental health difficulties.* Project report to PPP Healthcare Medical Trust:London.

Offer, D., Howard, K., Schonert, K. & Ostrov, E. (1991) To whom do adolescents turn for help? Differences between disturbed and nondisturbed Adolescents *Journal of American Child and Adolescent Psychiatry, 30,* 623-629.

O'Hare, W. (1989) Poverty in America: Trends and new patterns. *Population Bulletin, 40,* 56-61.

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Aruna, M., Miller, A. & Nadirshaw, Z. *Clinical psychology, "race" and culture: A training manual.* BPS Books:Leicester.

Philip, K and Hendry, L.B. (2000) Making sense of mentoring or mentoring making sense? Reflections on the mentoring process by adult mentors with young people. *Journal of Community and Applied Social Psychology,* Vol 10.

Pote, H & Orrell, M. (2002) Perceptions of schizophrenia in multi-cultural Britain. *Ethnicity and Health, 7,* 7-20.

Poulin, F., Cillessen, A., Hubbard, J., Cole, J., Dodge, K. & Schwartz, D. (1997) Children's friends and behavioural similarity in two social contexts. *Social Development, 6,* 225-237.

Pumariega, A., Glover, S., Holzer, C. & Nguyen, H (1998) Utilization of mental health services in a tri-ethnic sample of adolescents. *Community Mental Health Journal, 34,* 145-156.

Raviv, A., Sills, R., Raviv, A. & Wilansky, P. (2000) Adolescents' help-seeking behaviour: the difference between self- and other-referral. *Journal of Adolescence, 23,* 721-740.

Rhodes, J. (2002). *Stand by me: The risks and rewards of mentoring today's youth.* Harvard University Press:Harvard.

Rickwood, D., Deane, F., Wilson, C. & Ciarrochi, J. (2005) Young people's help-seeking for mental health problems. *Australian Journal for the Advancement of Mental Health, 4,* 1- 34.

Roberts, R., Alegria, M., Roberts, C. & Chen, I. (2005) Mental health problems of adolescents as reported by their caregivers. *Journal of Behavioural Health services and Research, 32*, 1-13.

Rutter, M (1987) Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry,* Vol 57.

Sanders-Thompson, V, Bazile, A. & Akbar, M. (2004) African Americans' perceptions of psychotherapy and psychotherapists. *Professional psychology: Research and practice, 35*, 19-26.

Saunders, S., Resnick, M., Hoberman, H. & Blum, R. (1994) Formal help-seeking behavior of adolescents identifying themselves as having mental health problems. *Journal of American Academic Child and Adolescent Psychiatry, 33*, 718-728.

Schnittker, J., Freese, J. & Powell, B. (2000) Nature, nurture, neither, nor: Black-white differences in beliefs about the causes and appropriate treatment of mental illness. *Social Forces, 78*, 1101-1130.

Schonert-Reichl, K. & Muller, J. (1995) Correlates of help-seeking in adolescence. *Journal of Youth and Adolescence, 25*, 705-731.

Secker, J., Armstrong, C. & Hill, M. (1999).Young people's understanding of mental illness. *Health Education Research, 14*, 729-739.

Shaw, C., Creed, F., Tomenson, B., Riste, L & Cruickshank, J. (1999) Prevalence of anxiety and depressive illness and help-seeking behaviour in African Caribbeans and white Europeans: two phase general population survey. *British Medical Journal, 318*, 302-306.

Sheffield, J., Fiorenza, E. & Sofronoff, K. (2004) Adolescents' willingness to seek psychological help: promoting and preventing factors. *Journal of Youth and Adolescence, 33*, 495-507.

Sipe, C. (2002) Mentoring Programs for Adolescents: A research summary. *Journal of Adolescent Health, 31,* 251-260

Smith, J. (2004) Adolescent males' view on the use of mental health counselling services. *Adolescence, 39*, 77-82.

Snowden, L. (1999) African-American service use for mental health problems. *Journal of Community Psychology, 27*, 303-313.

Snowden, L. (1998) Racial differences in informal help seeking for mental health problems. *Journal of Community Psychology, 26*, 429-438.

Social Exclusion Unit (2002) *Minority ethnic issues in social exclusion and neighbourhood renewal.* Office of the Deputy Prime Minister: London.

Sourander, A., Helstela, L., Ristkari, T., Ikaheimo, K., Helenius, H. & Piha, J. (2004) Child and adolescent mental health service use in Finland. *Social Psychiatry and Psychiatric Epidemiology, 36*, 294-298.

Sourander, A., Multimaki, P., Santalahti, P., Parkkola, K., Haavisto, A., Helenius, H., Nikolakaros, G., Piha, J, Tamminen, T., Moilanen, I., Kumpulainen, K., Aronen, E. Linna, S., Puura, K & Almqvist, F. (2004) Mental health service use among 18-year old adolescent boys: A prospective 10-year follow-up study. *Journal of American Academic Child and Adolescent Psychiatry, 43*, 1250-1258.

Stiffman, A., Chen, Y., Elze, D., Dore, P., & Cheng, L. (1997) Adolescents' and providers' perspectives on the need for and use of mental health services. *Journal of Adolescent Health, 21*, 335-342.

Street, C., Stapelkamp, C., Taylor, E., Malek, M. & Kurtz, Z. (2005) *Minority Voices. Research into the access and acceptability of services for the mental health of young people from Black and minority ethnic groups.* Young Minds: London.

Takeuchi, D., Bui, K. & Kim, L. (1993) The referral of minority adolescents to community mental health centres. *Journal of Health and Social Behaviour, 34*,153-164.

Teggart, T. & Linden, M.(2006) Investigating service users' and carers' views of child and adolescent mental health services in Northern Ireland. *Child Care in Practice,12*, 27-41.

Tierney J.P., Grossman, J.B. and Resch, N.L. (1995) M*aking a Difference: An Impact Study of Big Brothers/Big Sisters.* Philadelphia. Public/Private Ventures.

Timlin-Scalera, R., Ponterotto, J., Blumberg, F. & Jackson, M. (2003) A grounded theory study of help-seeking behaviors among white male high school students. *Journal of Counseling Psychology, 50*, 339-350.

Verhulst, F. & Koot, J., (1992) *Child psychiatric epidemiology: concepts, methods and findings.* Sage Publications: Beverly Hills, CA.

Verhulst, F. & Van Der Ende, J. (1997) Factors associated with child mental health service use in the community. *Journal of American Academic Child and Adolescent Psychiatry, 36*, 901-908.

Watson, A., Miller, F. & Lyons, J. (2005) Adolescent attitudes toward serious mental illness. *The Journal of Nervous and Mental Disease, 193*, 769-772.

Yancey, A.K., Siegel, J.M. and McDaniel, K.L. (2002) Role Models, ethnic identity and health-risk behaviors in urban adolescents. *Archives of Pediatrics and Adolescent Medicine* Vol 156, 1

Yeh, M., McCabe, K., Hough, R., Dupuis, D. & Hazen, A. (2003) Racial/ethnic differences in parental endorsement of barriers to mental health services for youth. *Mental Health Services Research, 5*, 65-77.

Zachrisson, H., Rodje, K. & Mykletun, A. (2006) Utilisation of health services in relation to mental health problems in adolescents: A population based survey. *BMC Public Health, 6*, 34-41.

Zwaanswijk, M., Verhaak, P., Bensing, J., Ende, J. & Verhulst, F. (2003) Help-seeking for emotional and behavioural problems in children and adolescents; a review of recent literature. *European Child and Adolescent Psychiatry,12*, 153-161.

Part 2: Empirical Paper

"A brother from another mother": Mentoring for African/Afro-Caribbean boys

Abstract

African/Afro-Caribbean adolescent boys can sometimes be difficult to engage with mental health services and one possible way to provide support to this client group is through mentoring. This qualitative study focused on the experiences of mentoring with African/Afro-Caribbean adolescent boys. A combination of focus groups and interviews were used with mentees and mentors; Interpretative Phenomenological Analysis was used to analyse their accounts. The findings suggest that mentoring provided a positive role model and confidant for the boys, within a relationship that was both family-like and professional. This relationship was facilitated by shared life experiences and occurred within a social context, providing peer-group support. Both mentees and mentors benefited from the mentoring relationship, although some difficulties were also reported, particularly regarding endings. The findings are discussed with reference to the broader literature on mentoring, along with suggestions for further research.

Keywords: **Mentoring; African; Afro-Caribbean; Adolescents; Qualitative**

Introduction

Mentoring has been described as "a relationship between an older, more experienced adult and an unrelated younger mentee – a relationship in which the adult provides ongoing guidance, instruction and encouragement aimed at developing the competence and character of the mentee" (Rhodes, 2002, p.3). Attachment theory and developmental psychology suggest that mentoring works by acting as a compensatory or protective factor to build resilience in adolescents (e.g.Rutter,1987). Rhodes (2002) suggests that it also improves social skills, emotional well-being, and cognitive skills and provides youth with a role model and advocate.

An extensive study, which mapped CAMHS services within the UK and interviewed cultural minority adolescents, recommended that "some sort of befriending role," such as mentoring, would be beneficial to help cultural minority adolescents access mental health services (Street, Stapelkamp, Taylor, Malek & Kurtz, 2005, p.5). Mentoring may therefore be helpful for African/Afro-Caribbean[2] adolescent boys, who are particularly difficult to engage in services (e.g., Bui & Takeuchi, 1992; Cuffe, Waller, Cuccaro, Pumariega, & Garrison, 1995; Draucker, 2005; Kodjo & Auinger, 2004; Yeh, McCabe, Hough, Dupuis & Hazen, 2003). This poor engagement with services is associated with three factors – age, gender and culture. Firstly, estimates of service use, for this age group, range from 13-36% (e.g. Bergeron, Poirier, Fournier, Roberge & Barrette, 2005; Kodjo & Auinger, 2004; Leaf et al., 1996;

[2] Throughout this paper African/Afro-Caribbean refers to anyone who is non-white and non-Asian and has at least one parent who is from African or Caribbean descent.

Saunders, Resnick, Hoberman & Blum, 1994; Sourander et al., 2004), and low service use is related to negative perceptions of services (e.g., Buston, 2002; Dogra, 2004; Draucker, 2005; Teggart & Linden 2006). Adolescents prefer informal help, from friends and family (e.g. Boldero & Fallon, 1995; Dubow, Lovko & Kausch, 1990; Offer, Howard, Schonert & Ostrov, 1991; Rickwood, Deane, Wilson & Ciarrochi, 2000; Saunders et al 1994;Timlin-Scalera, Ponterotto, Blumberg & Jackson, 2003).

Secondly, boys perceive services more negatively than girls (e.g., Draucker, 2005; Gonzalez, Alegria & Prihoda, 2005) and are less likely to engage with services (e.g., Bergeron et al 2005; Biddle, Gunnell, Sharp & Donovan, 2004; Boldero & Fallon, 1995; Gonzalez et al., 2005; Rickwood et al., 2005; Schonert-Reichl & Muller, 1995). Boys and girls seek less help from their families as they enter adolescence, but girls transfer help-seeking to peers, whereas boys do not. This lack of help-seeking in boys has been attributed to poorer emotional competence and inability to recognise need (Saunders et al., 1994; Rickwood et al, 2005), higher distress thresholds in boys (Biddle et al., 2004; Dubow et al, 1990; Raviv, Sills, Raviv & Wilansky, 2000) and social pressures to cope alone (Davies et al, 2000; Timlin-Scalera et al., 2003).

Thirdly, African/Afro-Caribbean adolescents are more reluctant to seek professional help than white adolescents (Cuffe et al., 1995; Draucker, 2005; Saunders et al., 1994) with lower rates of self-referrals or referrals by families, compared to white majority cultures (Cuffe et al., 1995; Kodjo & Auinger, 2004; Yeh et al., 2003). African/Afro-Caribbean adolescents report concerns

about whether Western services can relate to their cultural backgrounds effectively (Draucker, 2005; Cuffe et al., 1995; Street et al., 2005) and have more concerns than their white peers about services being used as a form of social control (Watson, Miller & Lyons, 2005). A vicious cycle develops, which has been named within the adult literature as "Circles of Fear" (Keating, Robertson, McCulloch & Francis, 2002); this consists of delayed help-seeking until problems reach a crisis, at which point services are likely to be reached through compulsory admission or forensic routes; this then confirms services' views of African/Afro-Caribbean populations as being violent and in need of high levels of medication and hospitalisation; which in turn confirms the fears held within African/Afro-Caribbean communities that this is how services will treat them. Service use is also avoided because of different cultural understandings of mental health and preferences to use traditional or religious healers (e.g. Cinnirella & Loewenthal,1999; Curtis & Lawson, 2000; Snowden, 1999). There may also be a reluctance to seek help from a largely white, Western profession, based on historical, abusive relationships between white and African/Afro-Caribbean communities (Hickling & Hutchinson, 1999; Schnittker, Freese & Powell, 2000).

Instead of using services, African/Afro-Caribbean adolescent boys report a common help-seeking pattern of developing a relationship with an adult in their community, such as a youth worker. Initially the focus is on practical help, but as trust grows, these relationships also provide psychological help (Street et al., 2005; Cauce et al., 2002). One way that these relationships can be provided is through mentoring schemes.

The majority of mentoring research is American and has used quantitative methods. These studies have measured the effectiveness of mentoring and have identified factors associated with positive outcomes. A meta-analysis of fifty-five community or school-based youth mentoring projects found some positive benefits, as measured by a wide variety of psychological, emotional, social and behavioural outcomes (Dubois, Holloway, Valentine & Cooper, 2002). However, effect sizes were small and the authors concluded that mentoring only has positive effects when mentoring schemes follow certain standards of good practice, such as good screening for mentors, good matching procedures, mentoring that lasted at least six months and ongoing training for mentors. Positive outcomes include reductions in substance misuse (e.g. Beier, Rosenfeld, Spitalny, Zansky & Bontempo, 2000; Tierney, Grossman & Resch, 1995); reduced aggression (e.g. Dubois & Silverthorn, 2005; King, Vidourek, Davis & McClellan, 2002;Tierney et al., 1995); improved relationships with other adults and in particular with parents (e.g. Tierney et al., 1995); improved self-esteem (e.g. Dubois & Silverthorn, 2005;Reisner, Petry & Armitage, 1989; Yancey, Siegel & McDaniel, 2002) and improved academic achievement (e.g. Slicker & Palmer, 1993;Thompson & Kelly-Vance, 2001). Mentors also report benefits such as developing skills and coming to terms with their own childhood experiences (e.g. Philip, Shucksmith & King, 2004).

A number of aspects of the mentoring relationship have been identified as important. For example, successful mentoring focuses on building the relationship, rather than being goal-orientated (Sipe, 2002) and is characterised

by emotional closeness (Dubois & Neville, 1997; Liang et al 2002; Morrow & Styles, 1995) though the latter may be less important for older adolescents (Darling Hamilton & Niego, 1994; Zimmerman, Binenheimer & Notaro, 2002). Effective mentoring tends to have more structure, such as regular contact, and is activity based, rather than focusing on emotionally focused conversations (e.g. Darling et al, 1994; Davidson, Redner, Blakely, Mitchell and Esmhoff, 1987; Langhout, Rhodes & Osborne, 2004; Sipe, 2002). The development of trust has been identified as a key factor in maintaining the relationship (Linnehan, Weer & Josh, 2005). Other factors which facilitate the relationship are the existence of mutual benefits for both mentee and mentor (Linnehan, 2003; Philip & Hendry, 2000) and the mentor's sense of efficacy (Parra, Dubois, Neville & Pugh-Lilly, 2002).

Some studies suggest that mentoring may be less effective for African/Afro-Caribbean adolescents than for adolescents from other cultural groups. For example, Royse (1998) found no differences between African/Afro-Caribbean adolescents who had African/Afro-Caribbean mentors and those with no mentors, on measures such as school absences, levels of self-esteem and attitudes to substance misuse. Keating, Tomishima, Foster & Alessandri (2002) evaluated a mentoring project and found improvements for white mentees, compared to a waiting list control group, but reported that mentoring was less effective for African/Afro-Caribbean mentees, based on outcome measures such as criminal behaviour and self-esteem. The authors concluded that African/Afro-Caribbean adolescents needed a more culturally sensitive mentoring programme. This raises the question as to whether mentoring is more effective with a mentor

from the same cultural background or not. Findings are mixed, although Dubois et al.'s (2002) meta-analysis suggests that matching is beneficial and it is regarded as good practice to match for cultural background when possible (Linnehan et al., 2005).

Research on the effectiveness of mentoring has focused on quantitative outcome measures, such as school performance and behavioural changes. However, there has been little focus on how mentoring is experienced by those directly involved or the psychological processes involved in mentoring. Few studies have used qualitative methods and those found were conducted by the same group of researchers in Scotland, with an all-white sample of participants (Philip & Hendry, 1996, 2000; Philip et al., 2004). Philip and Hendry (1996, 2000) and Philip et al., (2004) interviewed young people and mentors, to explore the processes of mentoring and their experiences of it. They identified five types of mentoring relationships and concluded that different mentoring styles suit different groups of adolescents. For example, boys were most likely to use classical mentoring (a one to one relationship with an adult) whereas girls also valued peer mentoring. The adolescents identified trust, empathy, flexibility and long-term relationships as key components of good mentoring. They valued mentors who showed them acceptance, had a similar background or life experiences to themselves, shared humour and related to them informally. A key benefit of mentoring was that it helped young people to develop healthier relationships with parents and peers. The mentors also benefited, such as making sense of their own past experiences; developing social skills and problem solving skills; and using mentoring as a step into related professions, although

they also identified difficulties such as setting appropriate boundaries. The underlying processes found were the development of trust; confidentiality; balancing dependency and autonomy; trying out ideas and identities within the relationship; the importance of continuity and the careful management of endings.

How African/Afro-Caribbean adolescent boys experience mentoring is an area that has been neglected by researchers. One unpublished study explored mentoring for 8-14 yr old African/Afro-Caribbean boys, in which eight mentees and their mothers were interviewed using individual semi-structured interviews. Qualitative analysis of the data showed that the boys valued the mutual understanding, which they shared with their mentors, because of their similar cultural backgrounds and it helped the boys to acquire new skills, develop self-worth and self-identity as an African/Afro-Caribbean boy (Hibbert, unpublished)

In summary, mentoring research has provided evidence that mentoring can benefit both mentees and mentors. Research has also identified key components of successful mentoring such as trust and long-term, flexible relationships. However these findings are predominantly based on large- scale American studies measuring quantitative outcomes. Little research has explored the psychological processes involved in mentoring, such as how trust is established, and how mentoring is experienced by those involved. Research on help-seeking indicates that African/Afro-Caribbean adolescents do not readily engage with mental health services; mentoring could provide a valuable source of support to

help this client group manage psychological difficulties. However, there are no published studies which explore the experience of mentoring with African/Afro-Caribbean adolescent boys, and therefore there is a need for research in this area.

The current study focuses on mentoring for African/Afro-Caribbean boys who have psychological difficulties. It explores the relationship between African/Afro-Caribbean mentors and African/Afro-Caribbean boys, aged between 13-18yr olds. The aims of the research are to investigate the psychological processes within mentoring and how mentoring is experienced by both mentees and mentors. A qualitative methodology, Interpretative Phenomenological Approach (IPA: Smith & Osborn, 2003) was chosen because it focuses on the individual experiences and perceptions of participants. The study addresses the following questions:

1. What factors help and hinder the formation of the mentoring relationship?
2. What are the perceived benefits and costs of establishing this relationship for both mentee and mentor?

Method

Participants and Setting

Mentors and mentees were recruited as participants, through a mentoring scheme run by Boys2Men, called ASPIRE. Boys2Men is a non-statutory project in West London, working specifically with African/Afro-Caribbean boys. The mentoring scheme runs in conjunction with other activities such as life skills training groups, family support and leisure activities. Boys2Men employ a mental health project co-ordinator who works in partnership with the Community Adolescent Mental Health Service (CAMHS) to work specifically with mentees who have psychological difficulties. The inclusion criteria for the mentees was that they were currently attending the mentoring project and that they had recent contact with CAMHS (within the last year). Their contact with CAMHS was assumed to suggest that these mentees had some sort of psychological difficulty, though no psychological measure or formal assessment was carried out within the study to confirm this. The mental health project co-ordinator attended the weekly referrals meetings at CAMHS and, as well as social work training, had had some specific training in mental health and was therefore familiar with assessing psychological difficulties. The co-ordinator invited all those mentees who had been referred by CAMHS to participate in the research and most mentees selected for the research had been referred to the mentoring project by CAMHS. The co-ordinator then looked through the project's database of current mentees to identify any further mentees who had had some contact with CAMHS and invited those mentees to participate. Once a mentee had given their consent for their mentor to be contacted, then their

mentor was also invited to participate (see appendices 2-5 for consent forms and information sheets).

There were 30 mentees within the mentoring scheme, from which 16 were invited to take part. Three mentees declined to take part, leaving 13 mentee participants. Their age ranged from 12 to 17 years; all had at least one parent from an African/Afro-Caribbean background, and over half were Jamaican. Nine of the thirteen boys had no consistent contact with their fathers and only one boy lived with both parents. Four of the mentees attended a pupil referral unit or had home schooling, and the remainder attended school or work. Two were referred to Boys2Men by the Youth Offending Team and seven had police records. The remaining eleven were referred from CAMHS and had diagnoses including depression, schizophrenia and ADHD. Four had been mentored for less than six months; six had been mentored for between six months to a year and three had been mentored for between one to three years.

There were 47 mentors at Boys2Men and five were recruited for the study. The original aim had been to recruit 12 mentees and 12 mentors. However there were fewer mentors than planned because mentors could only be recruited if their mentee had given their consent and most mentors had more than one mentee. The five participant mentors were all African/Afro-Caribbean men in their thirties or forties, who had completed the Boys2Men mentoring training programme.

Procedures

Mentees

Focus groups were used as the main method of data collection for the mentees because it was thought that groups would probably be less threatening than individual interviews and the mentees were familiar with attending group sessions at Boys2Men. Focus groups encourage discussion, help people to clarify their ideas, and can encourage participants to raise issues which may feel too threatening to raise individually (Kitzinger, 1995). Two focus groups were run, with five mentees in the first group and eight in the second group, and both lasted about an hour. The researcher facilitated the focus group and the mental health project co-ordinator was also present. Food was provided and the focus group began with an icebreaker exercise, to create an informal atmosphere.

In order to guide the focus group discussion, a focus group schedule was written, in line with suggestions from Wilkinson (2003). The aim was to explore the factors that helped and hindered the mentoring relationship; the costs and benefits of mentoring; and prior expectations of mentoring. This focus group schedule was piloted on a group of African/Afro-Caribbean, adolescent boys at a youth offending project, based at Boys2Men. This focus group schedule was amended in the light of their feedback (see appendix 7 for final draft) and in particular, it was decided to avoid the term "mental health" because this term was perceived as offensive.

One of the limitations of focus groups is that they can hinder participants voicing individual opinions, particularly if they believe that they are different to

group norms or if there are concerns about confidentiality (Kitzinger, 1995). In view of these limitations, each mentee, on completion of the focus group, was asked to consider volunteering for an individual interview. From the 13 mentees who attended the focus groups, 8 volunteered to be interviewed individually. These individual semi-structured interviews were arranged within a few weeks of the focus group to allow time for reflection on the group discussion. Additional questions were added to the focus group schedule and this amended schedule was used as a prompt within the interviews (see appendix 8), which lasted about half an hour.

All the focus groups and individual interviews took place in rooms within Boys2Men, and they were audio taped and then transcribed verbatim.

Mentors

The researcher conducted an individual semi-structured interview with each of the five mentor participants, at Boys2Men. An interview schedule for mentors was written (see appendix 9), based on the questions used with the mentees, that is, focusing on factors that helped and hindered the mentoring relationship; the costs and benefits of mentoring; and prior expectations of mentoring. Each interview lasted about an hour and was audio taped and transcribed verbatim.

Ethics

Ethical approval was obtained from the Brent Medical Ethics Committee (see appendix 1 for approval letter). Two key ethical issues were considered in the design of this study. Firstly, the mentees were under eighteen years old and had psychological difficulties. Therefore the researcher tried to ensure that each

mentee clearly understood the research. For example, some of the participants had reading difficulties and therefore the mental health project co-ordinator talked through the information sheet with each participant. Information sheets and consent forms were written for parents/guardians for those mentees who were not Gillick competent (see appendix 6). However all mentees were assessed by the mental health project co-ordinator as Gillick competent and therefore parental consent was not requested. The second main ethical issue was that of confidentiality and in particular, that mentee participants would maintain confidentiality regarding the focus group discussions. Each mentee participant agreed to keep the discussions confidential, as part of their signed consent and this was emphasised at the beginning and end of each focus group.

Method of Analysis

The transcripts of the interviews and focus groups were analysed using Interpretative Phenomenological Analysis (Smith, Jarman & Osborn, 1999; Smith & Osborn, 2003). This analysis was chosen because it focuses on the personal meanings which participants give to experiences, and is particularly well suited to exploring psychological processes. Initially, each transcript was read a few times in order to become familiar with the data. Secondly, interesting and significant points within the transcript were noted in the left-hand margin of the transcript. Observations made while attending Boys2Men project were also used to inform the analysis, regarding significant aspects of the mentoring relationship. The transcript was then reviewed again, with these points in mind, and emerging themes were recorded throughout the transcript, in the right-hand margin. It was decided to analyse the data from the mentees first because their

experiences were the primary focus of the study and so the analysis was first done with the two transcripts from the focus groups. These emerging themes were then clustered according to whether they related with each other in some way, and each cluster was labelled, to form superordinate themes. The transcripts from the individual interviews with the mentees were then analysed in the same way, but using the list of superordinate themes from the focus group data as a starting point for this analysis, in order to identify different or recurring themes. A list of themes from the mentees was then compiled from this analysis.

Then the transcripts from the mentors' interviews were analysed using the same procedures. The analysis of the mentors' data was done in two ways – the first way was to approach the data from scratch and to develop a new list of themes which was separate from the mentees' data and secondly, the mentors' data was analysed using the list of themes from the mentees' data, as a starting point for the analysis. However there was so much overlap between the data from the mentees and mentors that it was decided to use the latter approach, that is, to combine the themes from both groups of participants.

At each stage of the analysis, the themes were checked against the original data to ensure that they reflected the participants' views and examples from the data were used to illustrate themes. The analysis led to a final table of superordinate themes, which reflected the key findings from all the transcripts (see appendix 10 for examples of each stage of this analysis).

There are three main credibility checks incorporated into the design of the study, considering guidelines outlined by Elliott, Fischer and Rennie (1999). Firstly, the researcher's supervisor reviewed a sample of transcripts to check that the analysis appeared logical and that the themes were consistent with the original data. Secondly, there was a discussion with the supervisor to arrive at a consensus about the themes. Thirdly, data were obtained from more than one source, that is, from both mentor and mentee, to get two different perspectives of mentoring. The researcher had also planned to present the results of the analysis to the participants, in order to check that the results correctly reflected their experience (testimonial validity). However this was not possible within the timescale of the study, due to major restructuring of the Boys2Men project.

Researcher's Perspective

As the researcher, I was aware that I held positive views on the value of mentoring and these were based on my previous experience as a youth and community worker and as a supervisor for mentors, within an educational mentoring agency. Although I come from a white British background, I also have some understanding of African/Afro-Caribbean communities, through counselling work in Uganda and having a husband, and family, from this cultural background. I was also aware of findings from my literature review on African/Afro-Caribbean adolescents, which suggested that the mentees might hold quite negative expectations of receiving help.

Results

Overall the participants described the mentoring in very positive terms. The analysis produced four superordinate themes and these, along with their component themes, are listed in Table 3. There was considerable similarity between the accounts from the mentors and mentees and so these themes reflect the central ideas from both of these groups of participants. The first three superordinate themes describe the nature of the mentoring relationship, including possible factors which facilitate its development, whereas the final superordinate theme focuses more on the benefits of this relationship.

Quotations are used to illustrate each theme. The source of each quotation is indicated by the letter M for mentors and B for mentees (boys), followed by the participant's research number. F1 indicates quotations from the first focus group and F2 indicates quotations from the second focus group; it was not always possible to identify the person speaking from the recording of the focus groups.

Table 3: Themes derived from the IPA analysis

Superordinate Themes	**Themes**
1. 'Brother from another mother'	1.1 'A male role model'
	1.2 'Just between me and him'
	1.3 'Whatever time..he'll be there'
2. 'Down the same road'	2.1 'They know where we're coming from'
	2.2 'They've got tips of how to go through it better'
	2.3 'They could explain the situation to whoever needs it'
3. 'Everyone needs to blend in and gel'	3.1 'You ain't the only one'
	3.2 'Did I mention that it was fun?'
4. 'A little push in the right direction'	4.1 From 'prison' to 'pizza'
	4.2 'I've learnt that I can't do everything by myself'
	4.3 'Making a difference'
	4.4 Changing families to change communities
	4.5 'It's a learning curve for me as well'

Superordinate theme 1: 'Brother from another mother'

The mentoring was experienced as informal and flexible, like a family relationship, but from someone outside of the family, as this extract of consecutive comments from a focus group shows:

'.. a mentor is like a family that's not blood relative, he's basically, right, he's a brother
-A brother from another mother
-A brother or sister, like, who you can trust.' (F1)

The mentor was seen as a role model, who was available when needed and who could act as a confidant, within a mutual relationship.

Theme 1.1: 'A male role model'

Both mentors and mentees described the mentor as a father or older brother, providing a role model of what it meant to be male. For some of the mentors, their cultural background was important here because they were able to provide a positive, black role model in comparison to some of the more negative black role models portrayed through the media and music. Also noted, both by mentees and mentors, was the importance of being black men in professional roles, as one mentor described:

'A lot of the black role models are the wrong ones...a footballer, a drug dealer, a DJ-that's all they see themselves and that's based on their imagery...so we can raise their self-esteem and they can see that they have options, not all of us are drug dealers, not all of us are violent, not all of us have braids..." (M5)

This role was particularly important because the majority of boys did not have fathers living with them. Both mentors and boys described mentoring as filling this gap within the family structure, although the mentors also expressed that there were limitations in what could be provided:

'..they are like a male figure – like if you don't have a Dad.' (F2)

'..he provides the education of how to be a man..but maybe the young person needs to understand and experience the fact that there is a relationship between this father figure and his mother and the mentor can't provide that..." (M3)

The mentoring relationship enabled the mentors to model to the boys that men could talk about emotional issues without this threatening their manhood and it also provided an opportunity for the mentees to talk to another male, as opposed to their mothers, which was increasingly important as they matured:

'..cos with your Mum you're talking to a woman and that's really different than when you're talking to a boy, like there's more stuff to say.' (B7)

Mentors described how the attitudes of parents towards the mentoring had a significant impact on how successful the mentoring was, which was also recognised by some of the mentees. For example one mentor described how a father had said to his son: *"..don't forget you're my son and don't let any man tell you what to do.."* (M1). However the mentor had then worked with the father in order to encourage him to have more contact with his son, so that the mentoring could be reduced. Mentors described how important it was to be clear about their role and to build a good relationship with the whole family.

Theme 1.2: 'Just between me and him'

The boys described how their mentor was someone that they could confide in, particularly because the mentor was not part of their family. Mentees could offload emotions and secrets, such as trouble they had been involved in, and often this was compared to the more limited information they told their mothers. They spoke in terms of complete confidentiality, though one mentee noted that confidentiality would be broken in certain cases, but there was still the security

of knowing that this would be handled professionally, compared to how the family might manage it:

'Cos there's some things that you can tell your mentor and he will promise that he won't tell your Mum...but it can get to the stage where they have to say it, but he'll notify the person first, but with family they won't.' (B5)

Although this was a comforting aspect of the mentoring for the boys, it sometimes raised a dilemma for the mentors of how to be a confidant whilst maintaining their professional role. The mentors described the importance of setting clear boundaries at the start of the relationship regarding confidentiality around issues of risk and child protection, but that difficulties could still arise:

'..and they [the mentors] are confused about how to go about it and sometimes the young people are too, they think," wait a minute you're my friend and so you're meant to keep secrets".. but they really are not suppose to keep secrets – so yes there is that conflict..' (M3)

Theme 1.3: 'Whatever time..he'll be there'

Mentoring was experienced, by both mentee and mentor, as very flexible and informal. This was seen as one of the key factors which facilitated the relationship, and both groups of participants described the value of regular contact through impromptu phone calls, texts and visits to the project, alongside planned arrangements. Staff mentors as well as volunteers worked in the evenings and there were examples given by both mentees and mentors of crisis situations in which mentors were contacted in the early hours of the morning. This availability was often contrasted to CAMHS workers or school counsellors who were only available once a week at a set time, within a very structured environment:

'And a thing with a counsellor as well they don't really adapt to the way you want things to be done they'll just say OK we can set an appointment....whereas

a mentor you can talk to over the phone...it is a more flexible thing to get contact.' (F1)

As with the previous theme, there was a tension for mentors between wanting to be available but also setting boundaries around their time. Some mentors provided clear guidelines of when they were available whereas others tried to be more flexible. However this led to mentors sacrificing their personal time and sometimes mentees were disappointed when they found that their mentors were sometimes unavailable:

'Sometimes they don't turn up but that's because most of the time they're busy..' (B6)

This sense of availability also related to the long-term nature of the relationship, as well as their day-to-day availability. When asked about difficulties in the relationship, the most common response was about endings:

'..you can't really get too attached cos eventually you're going to have to leave them – that's a disadvantage.' (F1)

Strong attachments developed between mentee and mentor and so the thought of endings evoked ideas of significant loss for both groups of participants:

'I'd start crying...Yeah, I'd miss him.' (F2)

Some of the boys were unclear about how endings would happen:

'...cos it could be a life mentor, you don't know
- like if you trust that mentor..you'd be thinking why, why, why?...I thought we had something in common.' (F1)

As a result of these strong attachments, some mentors gradually reduced their contact with mentees rather than making a complete break, so that the mentee could still make contact if required:

'I'll still be available at the end of the phone and we can still meet up now and again..because I've had a good relationship with them it would be really bad for me to just cut it off.' (M2)

However some mentors tried to make clearer boundaries around endings:

'The negative side to it is that they become very attached...and we can be in danger of becoming like their fathers – you're always there for me and next minute you've disappeared...so that's why it's important to keep it professional – I'm your mentor, not your Dad.' (M1)

Some mentors had been told to only offer a limited time period, depending on the source of funding, and this also led to tensions:

'It's difficult to have no one to care and then, like, to have someone there but to have to deal with it in a professional kind of way, but it's such a personal relationship...you can't build up a relationship and then just end it after three months..it just doesn't work like that.' (M5)

Superordinate theme 2:'Down the same road'

There was a mutual identification between mentee and mentor, particularly in terms of background and similar life experiences. Most participants identified this as a key factor in strengthening their relationship, because it helped mentors to empathise with the boys and, in turn, for the boys to trust their mentor's advice. It also enabled the mentor to develop a mediating role between their mentee and other adults.

Theme 2.1: 'They know where we're coming from'

Mutual identification was described by both mentors and boys as being due to common backgrounds, similar life experiences, such as problems at school or

being in a street gang, and more minor factors such as similar interests or style of clothes. This led to a greater empathy and understanding from the mentors, whom the boys described as being able to listen effectively and to ask more pertinent questions. Some of the boys compared this relationship to other sources of help who were described as being more judgemental and less in touch with street life and youth culture. It was also important for the mentees to hear about their mentor's past experiences, but only in the context of providing support for their own related issues:

'..they might have been through what you've been through so they can understand.' (F1)

'..they could explain in almost full detail what you're going through and they could understand what you're trying to say-like you might not make sense to certain people.' (B1)

The mentors also recognised the value of having similar experiences, but noted that it was important to treat each mentee individually and not to assume that they knew what they are experiencing. Again this was compared to other adults who were described as sometimes stereotyping young people. A number of the mentors described how encouraging it was for them to be able to use some of their negative life experiences to help their mentees and to show them that change was possible:

'..you can empower another person in terms of through your experience and it makes you feel so good that you've overcome certain things and you can... give back to somebody else...sow a seed in someone else's life and ... see that change..' (M5)

However some mentors spoke about the difficulties, which could arise by over identification, such as becoming too close or reliving past traumas:

'..you can resurrect issues that the mentor has had in the past simply because the mentor is dealing with a young person who is suffering the very same issues..for example child abuse can come back to haunt you...' (M3)

Theme 2.2: 'They've got tips of how to go through it better'

The boys felt that their mentors were able to offer reliable advice, because they had been through similar experiences, which enabled the mentees to trust and respect their mentors:

'..he's telling me the honest truth to help me...with my mentor he'll tell you what happened and the outcome..so that feels like arghh, that could be me basically so I have to listen and take it in..' (B5)

Some of the mentees compared this advice to other helpers who, according to the mentees, were less respected because their advice was based on theoretical knowledge rather than life experience, even if the advice was similar:

'..the mentors have like been through it and the counsellors are the ones that think they're superheroes.' (F2)

The mentors described how they were motivated to help the boys not to "go down the same road" which they had travelled and how sharing their past experiences helped:

'..we had a mentor..who shared a lot about his experiences when he was in prison and I know a couple of young men who listened because they did not want to go down that road but were very close to it..' (M3).

Theme 2.3: 'They could explain the situation to whoever needs it'

The mentors were described as being able to explain situations, concepts and viewpoints to both boys and to other adults, because they were able to understand and relate to both. This ability often developed into a mediating role, for example, mentors negotiated between the police and mentees, they explained

therapeutic terms used by CAMHS workers to mentees and they acted as a mediator within families:

'..that mentor can come in and explain it if he has that trust.. then that's the opportunity for them to understand where these organisations are coming from and what they're trying to do..and then maybe they can explain it to them in a way that they can understand.' (M5)

'..he knows how to talk to children and he can talk to adults as well so he can sort out more stuff..' (B7)

Many of the participants felt that the mentors' ability to relate to the boys on their level was paramount in developing their mentoring relationship:

'..they can relate to you on your level- like some people, even people in your own family, it might be harder to relate to...
- [a mentor] breaks things down more and makes it easier for yourself to understand...' (F1)

Superordinate theme 3: 'Everyone needs to blend in and gel'

The mentoring did not occur in a vacuum, but within the wider context of the Boys2Men project, in which there was an expectation that boys would not only relate to their mentor, but also become part of a wider network of mentors and mentees:

'Here at Boys2Men, the nurturing of a relationship is the focal point – a young man will walk through the door ...and if I don't know him, it will be the B2M hug and hello, how are you? – not just look at you and ask you what you want..' (M3)

Many of the participants described the project's sense of community, fun and comradeship and this was seen to provide a more positive alternative to other peer groups, such as street gangs. Within this sense of community, the participants described the importance of mentors and boys doing activities together, such as meals out and sports, in order to establish the mentoring relationship.

Theme 3.1: 'You ain't the only one'

Within the mentoring project there were organised group sessions as well as unstructured social time. The group sessions focused on different topics such as sexual health, gun and knife crime and life skills training. These sessions often helped mentees to talk about these issues within the group and also individually with their mentors. Being part of a peer group provided a sense of universality and peer support for the mentees:

'..you're round other people that are in similar situations that..makes you feel a bit more confident and that helps you to get things out in the open a bit more..' (B4)

The project was seen by some as having similar qualities to a youth club – an informal place where young people could feel that they belonged and could meet friends, outside of home, school or the street. This social aspect of the mentoring project also enabled the boys to develop friendships with a number of mentors so that they were not dependent on one person.

A parallel peer group also developed amongst the mentors, which provided support and friendships for them:

'..other mentors obviously have encountered things and they will be able to tell you how they coped..so you will be able to learn from that..' (M4)

Theme: 3.2 'Did I mention that it was fun?'

Within the participants' accounts there was a sense of mutual enjoyment of each other's company. Doing enjoyable activities and having fun together was often reported by both the boys and mentors as a key factor in helping to develop the mentoring relationship, particularly at the beginning:

'..most of my mentoring comes from doing things with them...I'll be like – "do you want a game of pool?" – and my mentoring starts...' (M1)

This was expressed more strongly amongst the younger mentees, compared to the older ones; however the project's sports, I.T. facilities and social outings were seen as an integral part of the mentoring relationship for all ages. These activities also helped the mentees to try new activities and develop new interests. Both mentors and mentees described how the mentees were able to talk more freely whilst doing an enjoyable activity together, so that the focus was not solely on them and their problems:

'..so going to another setting..like in a restaurant.. they're enjoying themselves...and then from that, they kind of see you a bit differently cos you're not just telling them what's going wrong...' (M4)

In contrast, some mentees described other relationships with adults, as boring and too serious:

'The doctor kept asking me the same thing every week and he just made you sit in this room for like two hours it was so boring..' (B8)

When this boy was asked how mentors might do therapy differently, if they had that role, this boy replied:

'They might take you in a room but they might like give you a PSP to play with so you're not just sitting down and just listening..' (B8)

When asked what made the mentoring work, another mentee described how the fun side of the relationship provided a contrast to the mentor's more serious input – *"there's a time when you know he's joking and there's a time when ..he talks to you on a serious, serious level.."* (B5). He described that when the mentor was serious, this acted as a prompt for him to listen.

Superordinate theme 4: 'A little push in the right direction'

Various changes occurred as a result of mentoring; these were seen as gradual, positive changes as a result of the mentors giving the boys *"a little push in the right direction."* (B1). The first change that occurred was within the boys' expectations about what mentoring would be like and the boys' relationship to help. There were other psychological changes in terms of changes in behaviour, and improved problem solving skills and family relationships. Family work was an important aspect of the mentoring and changes that occurred within families had the potential of spreading out to the wider community. Finally there was the change seen within mentors, such as finding personal fulfilment in their mentoring work or developing new skills and interests.

Theme 4.1: From 'prison' to 'pizza'

The boys' expectations of the mentoring project, prior to attending, were predominantly negative and so the majority of boys felt pushed to come by their families or referrers:

'..I thought it would be boring like you'd just come here every week and you'd sit down and do your work..I said to my Mum I don't want to go and my Mum said just try it at least first..' (B8)

Often they had been referred to the project because of problems with the police or in school and so it was seen as punishment. They therefore imagined it to be like a borstal, or 'boot camp' which would correct their behaviour. However their perceptions of the project quickly changed once they met with some of the staff, saw the facilities and started talking to the other boys. One mentee described how his expectations changed:

'I thought it was going to be scary – like a youth prison...[on my first day]...I was upstairs in a meeting and they offered me pizza.. I thought OK, it can't be that bad, cos in prison you don't get pizza...' (B5)

Theme 4.2: 'I've learnt that I can't do everything by myself'

Some of the boys reported that, prior to attending the mentoring project, they shared personal difficulties with certain people, such as their mother, but that often they avoided talking about personal issues and tried to resolve problems on their own. Therefore, before the mentoring, many of the boys did not believe that they needed a mentor:

'I never thought I needed a mentor – like I was cool on my own, like I don't need to depend on anyone...you couldn't trust people with it all..like you didn't want to look bad in front of certain people so you just decided to do it on your own even if you had to struggle..' (B1)

This sometimes made it difficult for them to initially engage with their mentors, especially if they had been let down by others in the past, as the following quotation from a mentor illustrates:

'..like them starting to trust you or wanting to open up to you...if you ask him how things are he'll say fine, everything is fine and it's not always the case and you have to do a bit of digging..' (M4)

Some of the boys described learning to trust others within the project, both mentors and other boys, in order that they could talk about personal issues, express emotions with others and learn to ask for help:

'..things you feel that you need to talk about but you feel like you can't talk to a teacher..and you can't really talk to your friends...and you can't talk to your parents...with your mentor you can talk these things out in the open and they can help you deal with it.' (B4)

For some mentees, as they learnt to ask for help, this help-seeking became generalised to other settings, such as school:

'..like when I was in primary school..and say I didn't understand the question I'd just leave it and even if I knew I needed proper help, I wouldn't say nothing about it but now if I don't understand, it shows that I need help... ' (B7)

Theme 4.3: 'Making a difference'

All the participants recounted stories of change and how the mentoring made a difference in both the mentors' and the mentees' lives. For example, some boys had developed new interests and new peer relationships, alongside the mentoring relationship, and some boys reported improved communication within the family and growing confidence at school:

'..before me and my brother always used to argue all the time, but now we don't argue cos my mentor brought us both together.. ' (B8)

'You improve with your mentor..you learn to trust more, right, you learn more verbal and communication skills and you can understand a lot of things better.. ' (F1)

For some of the mentees, the mentoring had made a profound impact on their lives:

'..basically I thought I was a hole without my mentor.. ' (F1)

Both the mentors and mentees described how committed the mentors were to the work and that the mentoring was more than just a job, but a relationship with a person that they cared about. The boys therefore believed that their mentor would do all they could to make change happen, and this was also reflected in the mentors' accounts:

'..[as a mentor, ask yourself] - do you sincerely care or is it just the job and you're going to get a pay cheque at the end of the day?– it's about having a passion for it and letting young people know that you have a passion about what you're doing.. ' (M1)

' [the mentors] listen to you more and if they think it's relevant, you'll see, they'll work hard to do it.. ' (F2)

One of the key ways in which change occurred was through helping the boys to 'think before they act'; this phrase was used by a number of the boys as well as the mentors. The mentoring helped the boys to stop and think about what they were doing and to weigh up the consequences of their actions. They described becoming more reflective, considering others' viewpoints and being more responsible for their actions:

'..I treat myself with care and I think sometimes before doing stuff, if it's going to get me into trouble and that...I never used to think of the outcome – I used to just think, oh, it's fun..' (B5)

'.. being more responsible – like using condoms -like different things like that are going to affect their long term life because when they are young they don't realise, you don't think about the consequences ..so I think it's just guiding the young person to make informed choices..' (M4)

Theme 4.4: Changing families to change communities

Mentors stressed the importance of working with families, and not just the mentees; some of the boys recognised this too. The mentoring offered informal support and parenting training for families and helped them to access other services:

'..[mentors] will talk to the parents, talk to the children and sometimes negotiate in conflict resolution and sometimes also support mum to communicate better to their child..the relationship built with the family unit and the holistic approach ..is actually what makes it work..' (M3)

At times, the mentors found it difficult to divide their time between their mentee and his family because, although their mentee was their primary focus, the wider family sometimes needed considerable time and support:

'..cos [boy's mother] had issues around housing, her tenancy, her benefits and I really couldn't do that cos it would have meant me using up a lot of my time..' (M2)

There was a sense that the mentoring sent out ripples, so that change would spread out from the boys, to their families and then to the wider community. Change also was seen as being passed on to future generations. As one mentor said:

'I'll tell it to the young people - "in 20 years time I don't want to see your sons here in front of me- I want to see him in front of you and you telling him about life"...and that's as far ahead I go – so the last thing I want is 3 generations of family being referred to Boys2Men.' (M1)

Some of the boys also recognised that the mentoring had the potential to affect the wider community. For example, when asked what the mentors gained from mentoring, one boy replied:

'..I think they like it cos they are helping young youths to stay on the straight and narrow..they get a good community.' (B5)

Theme 4.5: 'It's a learning curve for me as well'

The mentors described how they changed and developed as well as the boys; and this mutual development was recognised by some of the boys too.

The mentors gained personal satisfaction from their work as well as developing confidence and acquiring new skills and knowledge:

' When I came here I wasn't a confident speaker...and now that is all behind me..I've certainly grown' (M2)

'.. [the mentors] can learn from you...they learn new ways of how to help their mentees..' (F1)

The mentors described the value of the initial training and ongoing support, guidance and supervision given formally by the mentoring project and also

informally by other mentors and staff. This "mentoring of the mentors" helped them to continue to develop and to help them feel supported in their role.

'It is very, very important for the mentors to get all the training and the support...I think mentors need to be cared for and they also need to be mentored..' (M3)

For some mentors this process of development mirrored similar processes of change that their mentees were experiencing. For example, one mentor talked about the importance of not being self-reliant:

'.. you can't do it all on your own and so you need to be able to call in others and share what's going on..so it's not a job where you're going to be left on your own so you can't have that mindset that you can do this all by yourself..' (M4)

Most of the mentors also reported costs involved in being a mentor- primarily their time which often went beyond their paid hours or because they were volunteers, but also the emotional cost of dealing with difficult situations.

'It costs you a lot – your time, a bit of your emotion as well..but you grow as a person' (M5)

All the mentors talked about the job satisfaction and personal fulfilment that they gained from the mentoring. One mentor described his previous job as being a "*soul destroying job*" in which he felt like "*a cog in the wheel*" compared to the" *life changing experience*" of becoming a mentor:

' when you can see that change [in mentee's lives] it's actually unspeakable, you can't really describe how good it feels..' (M5)

Discussion

This study aimed to explore how mentoring was experienced by African/Afro-Caribbean boys and mentors, focusing on what facilitates or hinders this relationship and its benefits and costs. The mentoring relationship was described by participants as an informal, family-like relationship in which the mentor provided support and guidance. The mentor was seen as someone who was available and who the boys could confide in, but also someone with whom they could have fun. Two factors were particularly important to the boys in facilitating engagement. Firstly, similar past experiences with their mentors helped the boys to develop trust and helped the mentor to develop empathy. Secondly, the mentoring occurred within a wider network of relationships which provided a sense of belonging and universality. This sense of community, along with the mentor's informal approach, seemed to help dispel the negative preconceptions which the boys often had prior to the mentoring. The mentees attributed a number of positive changes to the mentoring, such as learning to ask for help and to think about the consequences of their actions. These changes, in turn, gave the mentors a sense of personal satisfaction within their work and the hope that their investment within these boys' lives could influence the wider community and future generations.

In the words of one boy, and echoed by others, the mentor was "a brother from another mother," reflecting the unique relationship between mentor and mentee. The mentor could offer the boys both a family-like relationship, that was mutual, informal and emotionally close and also a professional-like relationship

offering a confidant outside of the family, a different perspective and the potential for change. The boys described how important this relationship was to them and what they gained from it, which is consistent with the growing evidence within the mentoring literature of the value and benefits of mentoring (e.g., Beier et al., 2000; Dubois et al., 2002).

From both the mentors' and mentees' perspectives, the mentor was seen as a positive role model. This seemed to have two main functions: firstly regarding masculinity and secondly in terms of culture. The mentors were able to role model a father figure and to talk with the boys about issues concerning masculinity. In particular mentors showed that men could talk about their emotions without feeling that their manhood was threatened. The mentors also provided a positive role model of what it meant to be an African/Afro-Caribbean man, compared to more negative stereotypes of black men. However when asked about the importance of similar cultural backgrounds, the boys generally said that it was the similar life experiences, such as problems at school or being in a street gang, that were important to them rather than similar cultural backgrounds. These findings contribute to the debate, within the mentoring literature, as to whether mentees and mentors should be matched on the basis of cultural background (e.g. Dubois et al., 2002; Linnehan et al., 2005). From the accounts of participants in this study, the similar cultural backgrounds did not necessarily facilitate engagement but may have helped to provide a positive black role model. The importance of providing a role model is consistent with Rhodes' (2002) conceptualisation of mentoring; she proposes that this is one of the central aspects of effective mentoring.

Both mentees and mentors in this study talked about the mentoring relationship in terms of being like a father-son relationship and how it could help to compensate for the loss of this attachment when a father was absent or had limited contact. Therefore the mentoring was often seen in terms of a long-term commitment, similar to a parental attachment, in order to provide a consistent, parental figure. Some researchers (e.g., Rutter,1987) have suggested that attachment theory can provide a theoretical explanation for how mentoring works. Bowlby (1973) described the importance of a caregiver who provides a child with a sense of security, reliable care and protection, particularly when the child feels threatened and in a similar way a mentor can be someone that a young person can turn to when they face difficulties and who can provide a sense of safety and care.

However, the strength of this attachment could also lead to difficulties such as negotiating appropriate boundaries and this was seen most clearly concerning the ending of the mentoring relationship. Within the accounts of both mentors and boys, the end of the relationship was anticipated as a significant loss and was often an emotive topic consistent with strong attachments. Therefore, within the mentoring relationship, there was a risk of mutual avoidance between boys and mentors to not discuss the end of the relationship; this was highlighted by comments from some of the boys about being unclear about how or when the mentoring would end. Some mentors expressed concerns that short-term mentoring relationships would actually be detrimental to the mentees in creating an attachment and then withdrawing, leading to a sense of loss and betrayal. In

contrast, mentors described how long-term relationships allowed time for trust to develop and for stronger attachments to form, and that endings could then be gradually prepared for and mutually agreed. These findings are in line with the mentoring literature, which has suggested that effective mentoring needs to be long-term (at least six months) and that endings need to be well managed (e.g. Dubois et al., 2002; Philip & Hendry, 1996, 2000).

Therefore there are some potential risks of mentoring if the relationship is not handled professionally and when guidelines for good practice are not adhered to, particularly in relation to endings and the length of the relationship. There are also other risks or limitations with mentoring and so procedures need to be in place to minimise such risks. For example, thorough background checks and careful selection procedures need to be carried out on all potential mentors to minimise the risk of abusive or ineffective mentoring relationships. Adequate training and ongoing supervision and support also need to be in place to ensure that the mentor is accountable for their work and to ensure that effective mentoring is being provided (Dubois et al., 2002). Other limitations may arise if the mentee's family are antagonistic towards the mentoring, particularly if the mentee feels pulled between their mentor and family or when the mentor makes unrealistic promises or raises expectations that the mentor cannot reach.

The mentoring relationship occurred within a wider social network which provided a sense of community and peer support for both mentees and mentors. As with the mentoring relationship, shared life experiences and similar backgrounds may have helped to facilitate these peer relationships and to foster

a sense of belonging. This broader network of relationships provided a supportive context for the mentoring and seemed to provide group therapeutic factors, such as universality, imitative behaviour and interpersonal learning (Yalom, 1985). This is consistent with findings that adolescents attribute psychological well-being to having a sense of belonging, people to talk to and activities or interests that reduce boredom (e.g., Armstrong, Hill & Secker, 2000). The peer group could also provide an opportunity for "problem legitimisation" which has been proposed as an important precursor to adolescent help-seeking (Murray, 2005). Participants also reported that the social activities were an integral part of the mentoring. This is consistent with previous research which suggests that regular, activity based mentoring is more effective than mentoring based on emotionally-focused conversations (e.g. Darling et al., 1994; Langhout et al., 2004).

Within this study, trust, empathy and acceptance seemed to be key psychological processes which facilitated the mentoring relationship. Some researchers have suggested that these processes are fundamental to effective helping and are common to both informal help, such as mentoring, and formal help, provided by mental health professionals (Barker & Pistrang, 2002;Rogers,1957). The shared life experiences between mentee and mentor, which led to a sense of commonality, enabled the mentors to identify with the boys and as a result, helped the mentors to develop empathy and positive regard. This, in turn, helped the boys to develop trust within the relationship, which is known to be a key factor in maintaining mentoring relationships (e.g. Linnehan et al., 2005). Not only did the mentors have similar past experiences to the boys,

but they also were willing to talk about these experiences, and this genuineness again facilitated the relationship. These findings are consistent with Philip and Hendry (1996, 2000) and Philip et al. (2004) who interviewed White British adolescent mentees and found that mentoring was facilitated by shared life experiences, trust, empathy and acceptance. This is also consistent with findings that young people choose helpers based on their trustworthiness, ability to understand and having had similar difficulties in the past (Rickwood et al., 2005).

Most of the boys had come to the mentoring project with negative expectations, and they often believed that they did not need help. However the boys usually engaged with the mentors and this seemed to then facilitate their engagement with mental health services: mentors played a role in maintaining their mentees' contact with mental health services, for example, by encouraging the boys to attend therapy appointments and explaining services to their mentees and families. This role seems particularly important, given the research showing that adolescent boys tend to avoid help-seeking (e.g., Bergeron et al., 2005; Gonzalez et al., 2005; Rickwood et al., 2005) and that African/Afro-Caribbean boys, in particular, are difficult to engage with mental health services (e.g., Bui & Takeuchi, 1992; Cuffe et al., 1995). Street et al. (2005) have suggested that cultural minority adolescents could be helped to access mental health services through some sort of befriending role, and this study provides an example of such support. The mentoring relationship encouraged the boys to ask for help and for some boys, this generalised to other settings, such as asking for help at school. This is consistent with Murray's (2005) model of help-seeking, in which

she suggests that positive experiences, such as mentoring, facilitate future help-seeking and this ability to ask for help could have significant benefits for these boys in the future.

The qualitative approach used in this study facilitated an exploration of how mentoring is experienced by both mentees and mentors. However, the study has a number of limitations. Firstly, the findings are based on a small, specific sample of African/Afro-Caribbean mentors and adolescent boys and reflect their particular views and experiences. Therefore the results of this study cannot be generalised to other samples of participants or to mentoring projects that exist in other geographical locations. The Boys2Men project also offers other services such as life skills training groups, family support and sports facilities. These other activities may have influenced the mentoring relationship and so the results of this study cannot be generalised to other mentoring projects, which may offer different services and facilities. Another limitation with this study is that there was no measure of psychological well being or psychological assessment carried out with the mentees, and mentees were assumed to have some sort of psychological difficulty on the basis of having contact with CAMHS. This assumption may be inaccurate because boys may have been inappropriately referred to CAMHS. Therefore the results of this study cannot be generalised to other mentees who have diagnosed mental health problems or known psychological difficulties.

There may have been a selection bias in the sample of participants: those who chose to take part may have been more positive about mentoring. The sample

may also have consisted of boys who felt more comfortable speaking within the group or interview setting. Secondly, several factors may have influenced the degree to which participants felt they could talk openly about their experiences. The researcher was a white woman, which may have affected the participants' openness to talk, particularly about issues such as having mentors from a similar cultural background. Some participants may have felt obliged to be positive because they were currently obtaining a service or were a staff member of the project; this positive bias, due to a sense of loyalty, has been noted by other researchers (Staniszewska & Ahmed, 1999). However the use of focus groups appeared to facilitate participants' discussion and both within these and the individual interviews participants were able to express both negative and positive comments. Future studies could minimise this by using retrospective interviews with mentees and mentors who were no longer in a mentoring relationship. Finally, the qualitative analysis could have been strengthened by incorporating additional credibility checks (Elliott et al., 1999), such as the procedure of testimonial validity, which involves gaining feedback from the participants on the results.

Future research is needed to gain a better understanding of the mentoring relationship and to identify the psychological processes which facilitate its effectiveness. For example longitudinal studies which involve interviews at different stages of the mentoring relationship could be used to explore how mentoring varies over time and how mentees' perceptions of the relationship change, as they mature. Further research could explore whether mentoring facilitates future help-seeking, in line with Murray's (2005) model of help-

seeking. The role of shared life experiences could also be explored further, in particular to investigate the ideas, suggested in participants' accounts, that similar life experiences are more important than similar cultural backgrounds in facilitating engagement, although the relationship between cultural background and life experiences are inextricably linked. The importance of the wider social context, within the mentoring project, that was found in this study, points to another fruitful area of research: it would be useful to compare programmes that offer family support and social activities to those mentoring programmes that only provide one to one mentoring. Finally, given the limited amount of research on mentoring specifically for African/Afro-Caribbean boys, studies using quantitative measures of psychological outcomes from larger samples would be useful.

For the boys in this study, mentoring provided a valuable source of support and guidance and positive changes were attributed to this relationship. The findings suggest that mentoring is a valuable resource which could work alongside adolescent mental health services to facilitate adolescents' engagement with services and to complement the work of services; mentors may have a special role to play in modelling emotional competence and encouraging appropriate help-seeking. Mentors who have similar life experiences to their mentees are also able to mediate between mentees and mental health professionals in order to help mentees articulate their current difficulties and to help professionals gain a better understanding of these life experiences. In turn, mental health professionals can support mentors by providing specialised training and consultation. Finally, given the strong attachments that can develop between

mentees and mentors, the ending of the relationship needs to be carefully managed and short-term mentoring should be avoided.

This study gives a voice to African/Afro-Caribbean adolescent boys, who are often reluctant to receive help from mental health services, and highlights the important role that mentoring could provide for this particular client group. However more research is needed to explore the experience of mentoring and the psychological processes underlying its effectiveness for this client group and adolescents in general.

REFERENCES

Armstrong, C., Hill, M. & Secker, J. (2000) Young people's perceptions of mental health. *Children and Society, 14*, 60-72.

Barker, C. & Pistrang, N. (2002) Psychotherapy and social support: Integrating research on psychological helping. *Clinical Psychology Review, 22*, 361-379.

Bergeron, E., Poirier, L., Fournier, L., Pasquale R., & Barrette, G.(2005) Determinants of service use among young Canadians with mental disorders. *Canadian Journal of Psychiatry, 50*, 629-636

Biddle, L., Gunnell, D., Sharp, D. and Donovan, J. (2004) Factors influencing help seeking in mentally distressed young adults: a cross-sectional survey. *British Journal of General Practice, 54*, 248-253.

Beier, S., Rosenfeld, W., Spitalny, K, Zansky, S and Bontempo, A. (2000) The potential role of an adult mentor in influencing high-risk behaviors in adolescents. *Archives of Pediatrics and Adolescent Medicine, 154*, 4.

Boldero, J & Fallon, B. (1995) Adolescent help-seeking: what do they get help for and from whom? *Journal of Adolescence, 18*, 193-209.

Bowlby, J (1973) Separation *Attachment and loss,* Vol. 2. New York: Basic Books.

Bui, K. and Takeuchi, D. (1992) Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology, 20*, 403-417.

Buston, K. (2002) Adolescents with mental health problems: what do they say about health services? *Journal of Adolescence, 25*, 231-242.

Cauce, A., Domenech-Rodriguez, M., Paradise, M., Cichran, B., Shea, J., Shebnik, D. & Baydar, N. (2002) Cultural and contextual influences in mental health help-seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology, 70*, 44-55.

Cinnirella, M. & Loewenthal, K. (1999) Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. *British Journal of Medical Psychology, 72*, 505-524.

Cuffe, S., Waller, J., Cuccaro, M., Pumariega, A., & Garrison, C. (1995) Race and gender differences in the treatment of psychiatric disorders in young adolescents. *Journal of American Academic Child and Adolescent Psychiatry, 34*, 1536-1543.

Curtis, S & Lawson, K. (2000) Gender, ethnicity and self-reported health: the case of African-Caribbean populations in London. *Social Science and Medicine, 50*, 365-385.

Darling, N., Hamilton, S.F. and Niego, S.(1994) Adolescents' relations with adults outside the family. In R. Montemayor, G.R. Adams and T.P. Gullotta *Advances in adolescent development; Adolescent Close Relationships Vol 6* Newbury Park, Sage

Davidson, W.S., Redner, R., Blakely, C.H., Mitchell, C.M. and Esmhoff, J.G. (1987) Diversion of juvenile offenders: An experimental comparison. *Journal of Consulting Clinical Psychology,* Vol 55.

Davies, J., McCrae, B., Frank, J., Dochnahl, A., Pickering, T., Harrison, B., Zakrzewski, M & Wilson, K. (2000) Identifying male college students' perceived health needs, barriers to seeking help, and recommendations to help men adopt healthier lifestyles. *Journal of American College Health, 48*, 259-267.

Dogra, N. (2004) Commissioning and delivering culturally diverse child and adolescent mental health services. *Current Opinion in Psychiatry, 17*, 243-247.

Draucker, C. (2005) Processes of mental health service use by adolescents with depression. *Journal of Nursing Scholarship,* 155-162.

Dubois, D.L., Holloway, B.E., Valentine, J.C. and Cooper, H. (2002) Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology,* Vol 30, 2.

Dubois, D.L. and Neville, H.A. (1997) Youth mentoring: Investigation of relationship characteristics and perceived benefits. *Journal of Community Psychology,* Vol. 25

Dubois, D.L. and Silverthorn, N. (2005) Natural mentoring relationships and adolescent health: Evidence from a national study. *American Journal of Public Health,* Vol 95, 3.

Dubow, E., Lovko, K. & Kausch, D. (1990) Demographic differences in adolescents' health concerns and perceptions of helping agents. *Journal of Clinical Child Psychology, 19*, 44-54.

Elliott, R., Fischer, C.T., & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.

Gonzalez, J., Alegria, M., & Prihoda, T. (2005) How do attitudes towards mental health treatment vary by age, gender, ethnicity/race in young adults? *Journal of Community Psychology, 33*, 611-629.

Hibbert, G. (unpublished UEL thesis) The impact of a mentoring project for African-Caribbean boys with emotional and behavioural difficulties.

Hickling, F. & Hutchinson, G. (1999) Roast breadfruit psychosis: disturbed racial identification in African-Caribbeans. *Psychiatric Bulletin, 23*, 132-134.

Keating, F., Robertson, D., McCulloch., A. & Francis, E. (2002) *Breaking the circles of fear: A review of the relationship between mental health services and African and Caribbean communities.* The Sainsbury Centre for Mental Health: London.

King, K.A., Vidourek, R.A., Davis, B. and McClellan, W. (2002) Increasing Self-esteem and School Connectedness Through a Multidimensional mentoring program. *Journal of School Health,* Vol 72, 7.

Kitzinger, J. (1995) Introducing focus groups. *British Medical Journal, 311*, 299-302.

Kodjo, C & Auinger, P. (2004) Predictors for emotionally distressed adolescents to receive mental health care. *Journal of Adolescent Health, 35*, 368-373.

Langhout, R.D., Rhodes, J. E. and Osborne, L.N. (2004) An exploratory study of youth mentoring in an urban context: Adolescents' perceptions of relationship styles. *Journal of Youth and Adolescence,* Vol 33, 4.

Leaf, P., Alegria, M., Cohen, P., Goodman, S., Horwitz, S., Hoven, C., Narrow, W., Vaden-Kiernan, M. & Regier, D. (1996) Mental health service use in the community and schools: results from the four-community MECA study. *Child and Adolescent Psychiatry, 35*, 889-897.

Liang, B., Tracy, A., Taylor, C.A., Williams, L.M., Jordan, J.V., Miller, J (2002) The Relational Health Indices: A study of women's relationships.*Psychology of Women Quarterly* Vol 26, Issue 1.

Linnehan, F. (2003) A longitudinal study of work-based adult-youth mentoring. *Journal of Vocational Behavior,* Vol 63.

Linnehan, F., Weer, C. and Josh, U., (2005) African –American students' early trust beliefs in work-based mentors. *Journal of Vocational Behaviour,* Vol 66, 3

Morrow, K.V. and Styles, M.B. (1995) *Building relationships with youth in program settings: A study of Big Brothers/ Big Sisters.* Philadelphia Public/Private Ventures.

Murray (2005) Young people's help-seeking: An alternative model. *Childhood, 12*, 479-494.

Offer, D., Howard, K., Schonert, K. & Ostrov, E. (1991) To whom do adolescents turn for help? Differences between disturbed and nondisturbed Adolescents. *Journal of American Child and Adolescent Psychiatry, 30,* 623-629.

Parra, G.R., Dubois, D. , Neville, H.A. and Pugh-Lilly, A.O. (2002) Mentoring relationships for youth: Investigation of a process-orientated model. *Journal of Community Psychology,* Vol 30, 4.

Philip, K and Hendry, L.B. (2000) Making sense of mentoring or mentoring making sense? Reflections on the mentoring process by adult mentors with young people. *Journal of Community and Applied Social Psychology,* Vol 10.

Philip, K. and Hendry, L.B. (1996) Young people and mentoring: towards a typology? *Journal of Adolescence, 19,* p.189-201.

Philip, K., Shucksmith, J. & King, C. (2004) *Sharing a laugh? A qualitative study of mentoring interventions with young people.* Joseph Rowntree Foundation:London.

Raviv, A., Sills, R., Raviv, A. & Wilansky, P. (2000) Adolescents' help-seeking behaviour: the difference between self- and other-referral. *Journal of Adolescence,* 23, 721-740.

Reisner, E.R., Petry, C.A. & Armitage, M. (1989) *A Review of programs involving Students as Tutors or mentors in Grades K-12.* Washington DC. U.S. Department of Education.

Rhodes, J. (2002). *Stand by me: The risks and rewards of mentoring today's youth.* Harvard University Press:Harvard.

Rickwood, D., Deane, F., Wilson, C. & Ciarrochi, J. (2005) Young people's help-seeking for mental health problems. *Australian Journal for the Advancement of Mental Health, 4,* 1- 34.

Rogers, C.R. (1957) The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95-103.

Royse, D. (1998) Mentoring high-risk minority youth: Evaluation of the Brothers Project. *Adolescence,* Vol 33, Issue 129.

Rutter, M (1987) Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry,* Vol 57.

Saunders, S., Resnick, M., Hoberman, H. & Blum, R. (1994) Formal help-seeking behavior of adolescents identifying themselves as having mental health problems. *Journal of American Academic Child and Adolescent Psychiatry, 33,* 718-728.

Schnittker, J., Freese, J. & Powell, B. (2000) Nature, nurture, neither, nor: Black-white differences in beliefs about the causes and appropriate treatment of mental illness. *Social Forces, 78*, 1101-1130.

Sipe, C. (2002) Mentoring Programs for Adolescents: A research summary. *Journal of Adolescent Health, 31,* 251-260

Slicker, E.K. and Palmer, D.J. (1993) Mentoring At-Risk High School Students: Evaluation of a school-based program. *The School Counselor,* Vol 40.

Smith, J.A., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.), *Qualitative health psychology* (pp. 218-240). London: Sage.

Smith, J.A. and Osborn, M. (2003) Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp.51-80). London: Sage.

Snowden, L. (1999) African-American service use for mental health problems. *Journal of Community Psychology, 27*, 303-313.

Sourander, A., Multimaki, P., Santalahti, P., Parkkola, K., Haavisto, A., Helenius, H., Nikolakaros, G., Piha, J, Tamminen, T., Moilanen, I., Kumpulainen, K., Aronen, E. Linna, S., Puura, K & Almqvist, F. (2004) Mental health service use among 18-year old adolescent boys: A prospective 10-year follow-up study. *Journal of American Academic Child and Adolescent Psychiatry, 43*, 1250-1258.

Staniszewska, S & Ahmed, L. (1999) The concepts of expectation and satisfaction: do they capture the way patients evaluate their care? *Journal of Advanced Nursing, 29*, 364-372.

Street, C., Stapelkamp, C., Taylor, E., Malek, M. & Kurtz, Z. (2005) *Minority Voices. Research into the access and acceptability of services for the mental health of young people from Black and minority ethnic groups.* Young Minds: London.

Teggart, T. & Linden, M.(2006) Investigating service users' and carers' views of child and adolescent mental health services in Northern Ireland. *Child Care in Practice, 12*,27-41.

Thompson, L.A. and Kelly-Vance, L. (2001) The Impact of Mentoring on Academic Achievement of At-Risk Youth. *Children and Youth Services Review,* Vol. 23, 3.

Tierney J.P., Grossman, J.B. and Resch, N.L. (1995) M*aking a Difference: An Impact Study of Big Brothers/Big Sisters.* Philadelphia. Public/Private Ventures.

Timlin-Scalera, R., Ponterotto, J., Blumberg, F. & Jackson, M. (2003) A grounded theory study of help-seeking behaviors among white male high school students. *Journal of Counseling Psychology, 50*, 339-350.

Yalom, I (1985) *Theory and Practice of Group Psychotherapy.* New York: Basic Books.

Yancey, A.K., Siegel, J.M. and McDaniel, K.L. (2002) Role Models, ethnic identity and health-risk behaviors in urban adolescents. *Archives of Pediatrics and Adolescent Medicine* Vol 156, 1

Yeh, M., McCabe, K., Hough, R., Dupuis, D. & Hazen, A. (2003) Racial/ethnic differences in parental endorsement of barriers to mental health services for youth. *Mental Health Services Research, 5*, 65-77.

Watson, A., Miller, F. & Lyons, J. (2005) Adolescent attitudes toward serious mental illness. *The Journal of Nervous and Mental Disease, 193*, 769-772.

Wilkinson, S. (2003) Focus Groups. In Smith, J (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 184-204). Thousand Oaks, CA., U.S., Sage.

Zimmerman, M.A., Bingenheimer, J.B. and Notaro, P.C.(2002) Natural mentors and adolescent resiliency: A Study with Urban Youth. *American Journal of Community Psychology,* Vol 30, 2.

Part 3: Critical Appraisal

This critical appraisal covers three main topics; firstly it focuses on the setting for the research, secondly how the data was collected and thirdly the analysis of this data. It then concludes with some personal reflections on the research.

Research within a community setting

This study was based within a community setting which created a number of challenges. Firstly there was the issue of access into the mentoring project and for the research to be accepted by staff members. Taylor and Bogdan (1998) suggest that it is useful to identify gatekeepers within community settings and that a good relationship needs to be established with these gatekeepers, in order for research to progress. I was aware that there were two key gatekeepers within the mentoring project, the director and the mental health project co-ordinator, and that they were pivotal as to whether the research would take place or not. The director of Boys2Men had wanted some research in order to evaluate the mentoring with a view to securing future funding, whereas my agenda was to carry out a psychological study within a limited time period. Therefore, although he was supportive, the research proposal needed to be carefully negotiated to incorporate these different foci. The mental health project co-ordinator was also positive about the research but he was new in post and his priority, understandably, was to establish the mentoring work which provided less time to focus on the research.

Along with these gatekeepers, I was also aware that the mentoring staff in general needed to accept the research and this was evident when I carried out the

pilot study. I was asked a number of questions about the research, reflecting some understandable concerns from staff about how the research would impact on the boys. It has been suggested that African-Americans are more distrustful of researchers due to historical abuse through research (Rodgers & Mance, 2007) though this may be less relevant in the UK. However I was aware of needing to take time to build relationships with all the staff, the importance of gaining their trust and to become part of the team while I was there, rather than appearing as an outsider who was only interested in completing my research. It was also important for the staff to see the potential benefits of the research such as providing an opportunity to reflect on their work and to provide a forum for the boys to voice their views. On reflection, I recognise that my previous experiences of youth work and mentoring, my familiarity with African/Afro-Caribbean cultures and my support of the ethos of the mentoring project helped to facilitate these relationships, which in turn encouraged staff to promote the research project and facilitate the recruitment of participants.

Another challenge of working in the community setting was the recruitment of participants. The mentoring project, for those with mental health difficulties, was a new development, within Boys2Men and therefore needed time to be established, which in turn delayed recruitment. Also, one of the research study's inclusion criteria for mentees was that they were referred from the local Child and Adolescent Mental Health Service (CAMHS) to the mentoring project and so, because this was a new partnership between the CAMHS service and Boys2Men, there were initially few referrals from the CAMHS service, which also delayed recruitment. There were also teething problems with this new

partnership, for example, CAMHS wanted to refer boys between 13-18 years old but Boys2Men only had funding for ages 16-18 years old. This difference in age criteria only became apparent to CAMHS and Boys2Men because of concerns I raised about the limited age range resulting in a lack of research participants. (However Boys2Men were able to negotiate with their funders to widen the age range, which enabled more participants to be recruited). Attempts were made to try and develop the partnership between CAMHS and Boys2Men and to increase the number of referrals to the mentoring project. These included the mental health project co-ordinator attending CAMHS referral meetings and a psychologist from the CAMHS service was assigned as a link worker to raise the profile of the mentoring within CAMHS.

There was sometimes a conflict of priorities for the mentoring project between being involved in the research and in carrying out the day-to-day work of the project. This is another of the difficulties in carrying out research within a community setting, in which research is an additional task to be fitted into an already busy schedule, rather than being an integral part of the work. This meant that although the mental health project co-ordinator was committed to the research in theory, in practice it was sometimes difficult to find the available time for him to discuss the research with me or to recruit participants. This conflict of priorities was sometimes an issue for the mentors as well, which resulted from the mentors' desire to be available to their mentees. In practice, that meant that interviews for the research were sometimes postponed at the last minute, due to issues arising with their mentees which needed to take priority.

Finally, the mentoring project and the CAMHS service were both undergoing major re-structuring during the time of the research with a lot of staff changes which impacted the research. The CAMHS service was splitting into a child service and an adolescent team, with the latter moving to a new site; also Boys2Men underwent a split, in which some of the staff left to develop a new, independent project. These changes had a significant effect on the staff members involved, including the emotional loss of colleagues and the uncertainty of new ways of working and new surroundings, which in turn impacted the research process, both practically and psychologically. Practically, there was a time pressure to interview mentors before they left Boys2Men to begin the new mentoring project and psychologically, these mentors were processing their feelings about leaving the project or changes in the project, and this may have coloured their perceptions of the mentoring work. However, the mentors expressed their appreciation of being involved with the research during this time of change, because the interviews provided an opportunity for them to reflect on their roles as mentors and helped to clarify their values and priorities and so the research became part of this process of change. This split within the mentoring project also raised conflicts regarding the dissemination of the research, with both mentoring projects wanting to use the findings as evaluation for their work.

Along with these challenges, there were a number of advantages in carrying out the research within a community setting, and in some ways this research reflected elements of participatory action research (Nelson, Ochocka, Griffin & Lord, 1998). In order to carry out the research I became a regular visitor to the mentoring project and developed friendships with staff, boys and their families.

This reflects one of the underlying values of participatory action research, which is the importance of supportive relationships between researchers and participants. I experienced the sense of community which was an integral part of the mentoring process and was able to observe the mentoring when boys dropped in to chat to their mentors, which gave me a greater understanding of the mentoring process. Another key value within participatory action research is the involvement of participants within the research process. The involvement of the mental health project co-ordinator, in terms of helping to plan the research, recruit participants and being present at the focus groups, was a way of involving one of the participants. Empowerment is another hallmark of this form of research and this particular study aimed to empower the boys by providing a forum in which they could voice their views and share their experiences. The boys would have been unlikely to participate if the research had taken place in an unfamiliar, clinical setting and so the community setting was central to the research process.

Focus groups and interviews

Considering the literature on adolescent help-seeking, I was aware that adolescent boys may be quite difficult to engage and that they tend to prefer to talk to people they know rather than to strangers (e.g. Rickwood et al., 2005). In order to obtain accounts from the boys, I needed to find a method of data collection that would facilitate their engagement and encourage dialogue. Therefore individual interviews did not seem appropriate because the boys might have felt too intimidated or awkward within this one-to-one situation. Another possibility, which was considered, was peer interviewing. This would

have involved training boys to interview each other which would have been very time consuming and would have limited my involvement in the process of data collection. I decided that focus groups would provide the most useful way to facilitate dialogue, recognising that the boys would feel less intimidated if they were part of a group and that they were already familiar with groups within the Boys2Men project. Focus groups are based on natural group interaction, in which participants are able to explore and clarify their ideas and where comments can prompt further ideas, producing richer data than can be obtained individually (see Kitzinger, 1995). Groups play an important role within the lives of the boys such as groups of friends, street gangs, group work in schools and group sessions at the project and so groups seemed a natural forum in which to collect data.

The two focus groups seemed to work very well and I was positively surprised at the boys' willingness to reflect and discuss. I think a key factor in the success of these groups was the groundwork which the mental health project co-ordinator had done in explaining the research to the boys and to encourage their participation. I think the groups also worked well because of the informal atmosphere and familiar settings. Following the pilot study, I had been aware of the importance of creating a relaxed atmosphere and I had considered a number of options such as playing pool, football, icebreakers and food. I decided that the latter two would be the most feasible and these helped to create a relaxed, informal setting which facilitated engagement.

However, I had a number of concerns regarding the focus groups. One of my concerns was that the group might move towards a group consensus, making it harder for individuals to voice different opinions. Within both focus groups, there were some boys who knew each other and some who did not, and in particular there were two brothers together in the second group. This may have affected the group dynamics, making it harder for those who did not know each other to speak up. I was also concerned that less articulate participants might feel intimidated within a group setting and so their views were less likely to be heard and that some of the boys might not want to share personal issues within the group. However, I ensured that people were introduced to each other at the beginning of each group and that there was time to talk and eat informally, before the discussions started. I also tried to encourage quieter members of the groups to participate within the discussion, by addressing questions particularly to them or giving them extra time to respond. The individual interviews with the boys also allowed space to talk more personally if they wished. This was particularly relevant for some boys who shared more personal experiences and views, particularly about mental health, within the interviews, compared to their more general comments within the group. Another concern which I had about focus groups was the need for confidentiality, and so I stressed the importance of this at the beginning of each group and I asked participants to agree to maintain confidentiality, as part of their signed consent.

Another concern I had about conducting the focus group was managing a group of up to eight adolescent boys on my own. I therefore asked the mental health project co-ordinator to sit in on the group session and to deal with any issues of

discipline. This worked well and was particularly useful for the second focus group, in which the participants were on average a younger age group and were more "giddy". This may have been because it was conducted during a school holiday, whereas the first focus group was run at the end of a school day, and also because some of the participants had symptoms of ADHD and Aspergers Syndrome and there was a more "hyperactive" feel to the group. During this group, the mentoring co-ordinator needed to enforce "time out" for some of the group members to reduce the giddiness within the group. It was very helpful to have someone managing this so that I could focus on the group discussion. However, I was concerned how his presence would affect the discussion, particularly because he was a mentor for a number of the boys. In order to check this, I asked each boy at the beginning of the individual interview how they had felt about this staff member being at the focus group. I also emphasised that the individual interviews gave them an opportunity to say things which they had not felt free to say in the group. Their replies confirmed that his presence in the group had not affected their contributions within the discussions.

I was aware of being a white woman in a predominantly black, male environment and that this could have hindered the participants' openness to talk about certain topics such as whether they preferred mentors from the same cultural backgrounds or not. However, based on the boys' responses, I did not feel that my cultural background hindered the boys to talk, particularly within the group setting where they seemed very relaxed and open, though may have done within the individual interviews. In order to check whether the cultural difference was an issue, I consciously raised the issue of cultural difference

when it seemed appropriate. For example, when some of the boys said that difference in cultural background between mentor and mentee did not matter, I checked whether this was because I was white and encouraged them that I would not be offended if they said that they preferred a black mentor. At the beginning of both focus groups the Caribbean food was a natural way to mention my Afro-Caribbean husband (who had cooked the food) and my familiarity with their cultural backgrounds. I felt that this might have helped to develop their trust in talking about cultural issues. Interestingly, within the pilot study, when I asked the volunteer participants about their views on whether they thought that my cultural background and gender would affect the research, they replied that my educational background would be seen as the main barrier.

One of the strengths of the focus groups was that they gave me an opportunity to see how the boys interacted together and to learn more about them. Also, the groups helped to prepare the boys for the individual interviews by forming a relationship with me during the group and prompting some reflection on mentoring before the interviews.

The focus group schedule seemed to work well and provided the discussion with structure and acted as a checklist for me, in order to cover the main topics. The schedule was based on my research questions and on the research literature on mentoring and help-seeking, considering issues such as open-ended questions and the value of 'funnelling' – starting with more general questions and then becoming more specific (Smith & Osborn, 2003). Although focus group schedules can guide discussion in certain areas it has been suggested that due to

the open-ended questions and flexible approach of focus groups, participants can steer the discussion to topics which are important to them, according to a "hierarchy of importance" (Kitzinger, 1994). This was evident within the focus groups in which topics arose which I had not considered when writing the schedule, such as the relationship between the mentors and the mentees' families.

This form of data collection seemed quite dependent on my individual style and therapeutic skills compared to more structured, quantitative approaches, such as administrating a standardised questionnaire. As a therapist, I valued this opportunity to conduct research based on therapeutic skills and which enabled clients to freely express their views in full. However, I was also aware that I had positive views about the role of mentoring and so I consciously tried to avoid giving verbal or non-verbal responses which would have disclosed my personal views or encouraged certain responses.

Having conducted both focus groups and interviews with the boys, I realise how different the boys were within the groups compared to the one-to-one interviews. The interviews were more structured than the focus groups in that we tended to work systematically through the interview schedule whereas in the groups there was more spontaneous discussion, with the boys being more relaxed and talkative within the groups. Considering that the majority of therapy is based on one-to-one relationships whereas the majority of adolescent relationships are group based, this seems an interesting area to explore further: to consider the value of group work compared to individual work for

adolescents and to gain an understanding of young people's experiences of both forms of therapy.

Analysis

The use of Interpretative Phenomenological Analysis (IPA) seemed appropriate for this study because it provided a method to "make sense of the participants, trying to make sense of their world" (Smith & Osborn, 2003, p.51). IPA assumes that comments made by participants reflect their internal thoughts and emotions about a topic (Smith & Osborn, 2003). This seems to be a reasonable assumption, although there are arguments suggesting that language actually helps to create the experience and so language reflects how people talk about the experience rather than the experience itself (Willig, 2001). Because the analysis is based on what is said, it is therefore limited to the experiences which can be articulated by participants. This was a particular concern regarding the boys, rather than the mentors; the boys sometimes found it hard to articulate certain experiences, particularly within the individual interviews when some of the boys could not think of certain words or found it hard to expand on issues they raised. However in the focus groups there seemed to be a group dynamic in which boys helped each other to verbalise issues.

I was initially quite daunted at the prospect of trying to find just a few main themes from the large amount of data that I had collected and I was concerned that I would need to sacrifice important findings in order to summarise the overall picture. I was aware that IPA is based on the idea that the researcher is interpreting the data and therefore I was concerned that my personal views could

shape the analysis too much so that the final themes would reflect my interests rather than the participants' views. In light of these concerns, I incorporated a number of credibility checks within the design of the research (Elliott, Fischer and Rennie,1999). My supervisor reviewed a sample of my transcripts to check that the analysis appeared logical and that the themes were consistent with the original data and I also collected data from both mentor and mentee, to gain two different perspectives of mentoring. I had also hoped to present the results of the analysis to the participants, in order to check that the results correctly reflected their experience (testimonial validity). However this was not possible, within the timescale of the study, due to the major restructuring of the Boys2Men project. Nevertheless, there was such consistency amongst the accounts from both the mentors and mentees, and the systematic approach led to clear themes, and so I felt confident that the final analysis reflected the participants' views.

One difficulty which occasionally arose in analysing the data from the second focus group was that I could not always distinguish who was saying what. This only became a difficulty when a comment made in an individual interview was similar to one made in the group. Because I could not always identify the source of the comments in the group, I did not know whether this was the same person or an additional person making this comment. I had been aware that this might happen and so I had planned to video the focus groups; however, this was not accepted by the ethics committee, due to concerns about confidentiality.

Initially in the analysis, I structured the categories of themes around my research questions but then I realised that the emerging themes went beyond my original

questions. This seemed to reflect a strength of this qualitative approach; although the research questions could guide the data collection, they did not restrict the results to fit with the researcher's interests but liberated the participants to voice what was important to them.

Personal aspects of the research

This research project reflected some of my personal interests. Having worked in both the NHS and the voluntary sector, I am interested in how these two sectors can work in greater partnership and this mentoring project was a good example of collaborative working. I am also interested in how services can find creative ways to becoming more accessible, particularly to different minority cultures. Having married into an African/Afro-Caribbean family and having worked in Uganda, I am particularly interested in African/Afro-Caribbean cultures and their relationship with services. I am also interested in how accessible services are to youth cultures and this relates to my previous work experience of residential childcare and youth and community work. I have also worked with an educational mentoring organisation and so I have had some direct experience of some of the benefits and difficulties within mentoring.

My expectations prior to the research were that the boys would engage well within the Boys2Men mentoring project because of the youth club atmosphere and because the staff were African/Afro-Caribbean men providing mentoring alongside leisure activities. Having had some experience of mentoring, I also expected that both mentors and mentees would benefit from the relationship but that some of the boys would not want to engage with the mentoring because of

their reluctance to receive help. Because I was aware of these preconceived ideas I consciously tried to put these expectations aside and to approach the research with an open mind, which has been described as 'bracketing the natural attitude' (see Barker, Pistrang and Elliott, 2002).

The participants' accounts were similar to what I expected, although I had not expected the level of commitment and availability that some of the mentors offered. I also had not considered the importance of the peer-group support and sense of community alongside the mentoring, although this became evident as I became involved in the project.

One of my predictions was that their shared cultural backgrounds would be a significant factor in developing engagement between mentor and mentee, whereas the reports from the boys suggested that shared life experiences were more relevant. This idea was supported by comments made in the pilot study that my education, rather than my cultural background, was more of a barrier to engagement with the boys, suggesting that different life experiences may have a greater influence, although culture and life experiences are closely related. However some of the mentors expressed the importance of shared cultural backgrounds for the boys, particularly in relation to the mentors being a positive black role model. Therefore the boys' responses may have reflected the current focus of their mentoring work. They would be more likely to report the value of shared life experiences if they were currently addressing issues which their mentors had also experienced, such as difficulties with the police or in school. However, their shared cultural background may be reported as being more

important if the boys were more focused on issues around their cultural identity, such as being racially attacked. Another explanation is that Boys2Men is a project in which all staff and service users are African/Afro-Caribbean and so the cultural aspect of the mentoring relationship may be taken for granted by the boys and therefore not reported as being an important aspect of the mentoring relationship. However, if the mentoring project employed mentors from a range of cultural backgrounds then the boys may have become more aware of the role of cultural background within the mentoring relationship and may have reported the value of shared cultural background. The boys may also have found it difficult to suggest the value of shared cultural backgrounds with the researcher, because I did not come from the same cultural background as the boys.

I expected that the focus groups and interviews with the boys would be difficult, and this was partly based on my previous youth work but also because the pilot study was a difficult experience, in which the boys were reluctant to talk. However, the boys who volunteered to take part in the research were motivated to be involved and I was pleasantly surprised by how well the discussions developed. I also valued the respect they showed to me and to each other and their willingness to be open about personal issues and be vulnerable in front of a stranger and their peers. I think this was a reflection on the ethos and approach of the mentoring project and their respect for the mentors.

This project highlighted to me the importance of fathers within families, particularly in providing a role model and confidant to their sons. This led me to consider what factors contributed to so many of the boys in this study having

absent fathers. Obviously there are multiple factors involved in this but alongside interpersonal, social and psychological factors, I also became aware of some historical factors which may contribute to the increased number of absent fathers within African/Afro-Caribbean communities. I was conducting this research project during the time of the 200th anniversary celebrations of the abolition of the slavery act and through this I learnt how African male slaves were encouraged by slave masters to produce as many offspring as possible without being committed to one partner and how slavery often separated families, which meant that absent fathers were the norm during that time. The suggestion made by some researchers is that this legacy from slavery has influenced current family relationships within some African/Afro-Caribbean communities (Evering, Klu & Reddie, 2007).

This research study was my first experience of qualitative research. I have found this to be a methodology that answers the sort of research questions that interest me, uses my therapeutic skills and provides a means by which service users can have a voice within research. I have therefore found it a rewarding and positive experience.

REFERENCES

Evering, L., Klu, K. & Reddie, R. (2007) *The Transatlantic Slave Trade and its Legacies* Set all Free Publications: London.

Kitzinger, J. (1995) Introducing focus groups. *British Medical Journal, 311*, 299-302.

Nelson, G., Ochocka, J., Griffin, K. & Lord, J. (1998) "Nothing about me, without me": Participatory action research with self-help/mutual aid organisations for psychiatric consumer/survivors. *American Journal of Community Psychology, 26*, 881-911.

Rickwood, D., Deane, F., Wilson, C. & Ciarrochi, J. (2005) Young people's help-seeking for mental health problems. *Australian Journal for the Advancement of Mental Health, 4*, 1- 34.

Rodgers, C. & Mance, G. (2007) Community-based participatory research: Considerations in developing partnerships between African-American researchers and African-American communities. *The Community Psychologist, 40*, 25-27.

Smith, J.A. and Osborn, M. (2003) Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp.51-80) . London: Sage.

Taylor, S. & Bogdan, R. (1998). *Introduction of qualitative research methods: a guidebook and resource.* New York:Wiley.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method.* Buckingham: Open University Press.

APPENDICES

Appendix 1:
Ethical Approval

Appendix 2:
Information sheet for mentees

WHAT IS IT LIKE HAVING A MENTOR?

INFORMATION SHEET FOR PARTICIPANTS-BOYS

You are being asked to take part in a research study. Before you decide if you would like to take part, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information and discuss it with other people if you wish. Please ask me if there is anything that is not clear, or if you would like more information.

PART ONE – to give you some first thoughts about the project

What is the purpose of this study?
I am interested in mentoring relationships and especially about how they get started. Mentoring is when an older person is paired with a younger person to give the younger person support, act as a role model etc. As part of my research I would like to interview mentors, and boys that have mentors, to find out about what they think of mentoring. Most of the studies done before have used questionnaires to collect information, rather than talking generally to the people involved about what they think. This study gives us the chance to get the views of those directly involved. I am doing this research as part of my training.

Why have you been chosen?
You have been chosen to take part in this study because you are a boy with ASPIRE and have a mentor. All boys at ASPIRE, are being invited to take part in this study.

Do you have to take part?
No – you don't have to take part – it is up to you to decide whether or not to take part. The service you get from Boys2Men will not be changed by your decision to be involved or not. If you decide to take part, you will be asked to sign a consent form to let us know that you have agreed to take part. Also, your parent or guardian will also be asked to sign a consent form to say that they are willing for you to take part.

If you decide to take part, you are free to stop at any point, or refuse to answer a particular question, without giving a reason. If you decide to stop and that you do not want your information to be used in the study, then it will be destroyed at that point.

Will my mentor be taking part?
Your mentor will be invited to take part in the research. If they choose to take part they will not be asked direct questions about you or about your mentoring relationship. If you do not want your mentor to take part in the study you can say no. You do this by NOT ticking the box for question 6 on your consent form.

What will happen if I take part?
1. GROUP MEETING – I will be arranging a group meeting at which I will ask you and other mentees, as a group, to talk about what you think of mentoring. The meeting will be in a private room at Boys2Men – so that others would not be able to hear what is being said. The group would be led by myself and a staff member of Boys2Men. It will last about one and a half hours. With your permission, the meeting would be audio taped so that I have a complete record of the meeting.

2. INTERVIEW. I am also asking for some mentees to volunteer to be interviewed by me, on an individual basis. This would be at a later date, after the group meeting. These interviews would last about an hour and would involve me asking similar questions to those at the group meeting. They would give you a chance to talk about things that maybe you have thought of since the group meeting or didn't share in the group. The interviews would take place in a quiet room at Boys2Men, where no other people would be able to hear what is being said. With your permission, I would tape record the interview with audiotapes, in order to have a complete record of what was said

The group meeting and interview are about *your* experiences of mentoring and so there are no right or wrong answers. The sort of topics that may be discussed are what has helped or what has got in the way of the mentoring relationship, your expectations of mentoring and how they have changed and your views on mentoring and emotional well being.

After the group meeting and the interview, I would type up what was said, word for word – this is called a transcript. If there was something that you said, that you later decided that you did not want me to use within the final analysis, then this could be deleted from the transcripts. However you would need to make this known to me before the analysis of data was completed. The tapes and transcripts would be kept confidential, and then the tapes would be destroyed once the study was completed and the transcripts would be destroyed five years after the study. I would analyse all the transcripts together and draw out main themes from the data.

A £5 HMV voucher will be given to those mentees who take part in the research, as a thank you for their time and involvement.

What are the possible disadvantages of taking part?
It is possible that the group meeting and/or interview may bring up some sensitive issues, related to your experiences of mentoring eg. if the relationship has been difficult. In order to deal with this, I will make sure that there is time at the end of the group and/or interview, for us to talk about how they went and how you are feeling. If necessary, it may be appropriate for you to consider talking to someone else about these issues if that would be useful e.g. your therapist.

What are the possible advantages of taking part?
You may find that this study gives you the chance to think about having a mentor and you may find it useful talking about mentoring with others.
We also hope that the research will be useful to ASPIRE, in developing future services.

Who do I contact if I have further questions or comments?
My name is Hilary Garraway and I will be doing the research. You can contact me at Boys2Men (Tel. 0207 604 5960) or at Brent Family and Child Clinic (Tel. 0208 208 7200).
If you want to talk to someone not involved in the research, there are staff members at Boys2men or Brent Family and Child Clinic who would give you some independent advice.

Thank you for reading Part One. If you are still interested – please go to Part Two.

PART TWO
What if there is a problem?
Complaints – if you want to complain, you should speak to the researcher first. (See contact details in Part One). However if you are still unhappy and want to complain formally, you can do this through the NHS complaints procedure. Details are available via the Brent Family and Child Clinic (Tel 0208 208 7200).
Harm – In the unlikely event that you are harmed as a result of taking part in this study, due to somebody's fault, then you may be able to take legal action. Arrangements are in place, if this happens.

Will my taking part in the study be kept confidential?
Yes. The group meeting and interviews will be kept confidential. Information that is normally collected about boys attending ASPIRE will be collected eg. your age and ethnic background.
GROUP MEETING – At the group meeting I will check that everyone has signed a consent form – agreeing to keep confidential what is said in the group – including those leading the group. With your permission the group meeting will be audio taped
INDIVIDUAL INTERVIEWS – These will also be kept confidential. The only time that confidentiality would be broken is if serious harm eg. child abuse, is disclosed and then the necessary services would need to be informed. However I would talk to you about this before I spoke to anyone else. The interviews, with your permission, will be audio taped.

All tapes of the group meeting and the interviews will be stored in a locked cabinet at a location away from Boys2Men. The tapes will be typed up word for word and these transcripts will be stored on a personal computer and will be accessed by password only. Only myself and my two supervisors would have access to what has been said. No personal details will be kept with the tapes or with the transcripts of tapes. The data will not be passed onto anyone else.

When I have analysed the data I will plan a meeting to share with all participants the main findings of the research. I will tell you the main themes, (without linking it to specific people) which have come out of the research. You would then have the chance to give me your feedback about what I have found out. I will then write up the research and I may use direct quotes from the group meeting or interviews but these will not be linked to individuals and pretend names will be used.

Once the writing up of the research has passed the college's academic requirements the tapes will be erased (Sept 2007). I have two supervisors – and I will discuss the material with them and they will also maintain confidentiality. My supervisors are Dr. Nancy Pistrang (Senior Lecturer in Clinical Psychology at University College, London) and Dr. Debbie Madell (Clinical Psychologist at Brent Family and Child Clinic).

Who has reviewed the study?
Before any research goes ahead it has to be checked by an ethics committee. This research was checked by the Brent Research Ethics Committee.

If you are interested in taking part in this study please contact me, Hilary, or the mentoring co-ordinator at ASPIRE, Boys2Men.

Thank you very much for taking the time to read this information sheet.
Hilary Garraway

Appendix 3:
Information sheet for mentors

MENTORING –WHAT IS IT LIKE BEING A MENTOR?

INFORMATION SHEET FOR PARTICIPANTS-MENTORS

You are being asked to take part in a research study. Before you decide if you would like to take part, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information and discuss it with other people if you wish. Please ask me if there is anything that is not clear, or if you would like more information. Part One tells you about the purpose of this study and what will happen if you take part and Part Two gives you more detailed information about how the study will be carried out.

PART ONE

What is the purpose of this study?
I am interested in mentoring relationships and in particular about how they get started. Mentoring is when an older person is paired with a younger person to give the younger person support, to be a role model etc. As part of my research I would like to interview mentors and boys that have mentors to find out about their experiences of being involved in mentoring. Most of the studies done before have used questionnaires to collect information, rather than talking to mentors and boys themselves about their experiences. This study gives the opportunity to get the views of those who are actually involved in mentoring. I am doing this research as part of my training.

Why have you been chosen?
You have been chosen to take part in this study because you are currently a mentor with ASPIRE and are in a mentoring relationship. All mentors at ASPIRE are being invited to take part in this study. However the boy (or boys), who you are mentoring will be asked for their consent to allow their mentor to take part in this study. If the boy(s), who you are mentoring, do not give their consent, then you will not be able to take part in the study.

Do you have to take part?
No - This study is voluntary and it is up to you to decide whether or not to take part. You do not have to take part. Your role as mentor within ASPIRE will not be affected by your decision. If you decide to take part, you will be asked to sign a consent form to let us know that you have agreed to take part.
If you decide to take part, you can leave the study at any point or refuse to answer a particular question, without giving a reason. If you decide to leave and that you do not want your information to be used in the study, then it will be destroyed at that point.

What will happen if you take part?
I would interview you and the interview would last about an hour. If after this interview, you felt that you would like more time to talk or more time to think about the questions, then we could arrange a second interview at a future date. The interview is about *your* experience of mentoring and so there are no right or wrong answers. The sort of topics that will be discussed are what has helped or hindered the mentoring relationship, your expectations of mentoring and how they have changed and your views on mentoring and emotional well being. The interviews would take place in a quiet room at Boys2Men, where no other people would be able to hear what is being said. With your permission, I would tape record the interview(s) in order to have a complete record of what was said. I would then type up what was said, word for word. If there was something that you said, which you later decided you would not want to be used within the final analysis, then this could be deleted from the transcripts. However you would need to make this known to me before the analysis of data was completed. The tapes and transcripts would be kept confidential, and then the tapes will be destroyed once the study was completed and the transcripts destroyed five years after the study. I would go through the transcripts and draw out the main themes from this data.

As additional information about the mentoring relationship, I would also look at the log that you keep as a mentor, for Boys2Men. This would be to see how often you meet with the boy you mentor and the sort of activities you do together.

A £5 HMV voucher will be given to those mentors who take part in the research, as a thank you for their time and involvement.

What are the possible disadvantages of taking part?
It is possible that the interview may bring up some sensitive issues, related to your experiences of mentoring eg. if the relationship has been difficult. In order to deal with this, I will make sure that there is time at the end of the interview, for us to talk about how the interview went and how you are feeling. If necessary, it may be appropriate for you to consider talking to someone else about these issues if that would be useful e.g. your line manager.

What are the possible advantages of taking part?
You may find that this study gives you the opportunity to reflect on your role as mentor and that you may value talking about the experience of mentoring with someone else. We also hope that the information gathered will be of use to those involved with ASPIRE, in order to evaluate their work and in developing future services.

Who do you contact if you have further questions or comments?
My name is Hilary Garraway and I will be doing the research. You can contact me at Boys2Men (Tel. 0207 604 5960) or at Brent Family and Child Clinic (Tel. 0208 208 7200). If you would like independent advice or information about taking part in this research then please feel free to speak to a staff member of Boys2Men or Brent Child and Family Clinic, who is not involved in the research.

This completes Part One of the Information Sheet. If the information in Part One interests you and you are considering participation, please continue to read the additional information in Part Two before making any decision.

PART TWO

What if there is a problem?
Complaints – if you have a concern about any aspect of this study, you should speak to the researcher initially. (See contact details above). However if you remain unhappy and wish to complain formally, you can do this through the NHS complaints procedure. Details are available via the Brent Family and Child Clinic (Tel 0208 208 7200).
Harm – In the unlikely event that you are harmed as a result of taking part in this study, due to negligence, then you may have grounds for legal action for compensation. Arrangements are in place, if this was to occur.

Will your taking part in the study be kept confidential?
Yes. All interviews will be kept confidential - only myself and my two supervisors would have access to what has been said. The only time that confidentiality would be broken is if serious harm eg. child abuse, is disclosed and then the necessary services would need to be informed. However I would talk to you about this before I spoke to anyone else. I will collect general demographic details, which are routinely collected eg. age, ethnic background.

The interviews will be audiotaped and all tapes of interviews will be stored in a locked cabinet at a location away from Boys2Men. The tapes will be typed up word for word and these transcripts will be stored on a personal computer and will be accessed by password only. No personal details will be kept with the tapes or with the transcripts of tapes. The data will not be passed on to anyone else.

When I have analysed the data I will plan a meeting to share with all participants the main findings of the research. I will tell you the main themes, (without disclosing personal information) which have come out of the research so that you can respond to this with any feedback you have. I will then write up the research as a thesis. When I write the thesis I may use direct quotes from the interviews but these will not be linked to individuals and pseudonyms will be used.

Once the thesis has passed the college's academic requirements the tapes and transcripts will be erased (Sept 2007). I have two supervisors – and I will discuss the material with them and they will also maintain confidentiality. My supervisors are Dr. Nancy Pistrang (Senior Lecturer in Clinical Psychology at University College, London) and Dr. Debbie Masdell (Clinical Psychologist at Brent Family and Child Clinic).

Who has reviewed the study?
This research was reviewed by the Brent Research Ethics Committee.

If you are interested in taking part in this study please contact me, Hilary, or the mentoring co-ordinator at ASPIRE, Boys2Men. (see contact details in Part One).

Thank you very much for taking the time to read this information sheet.

Hilary Garraway

Appendix 4:
Consent form for mentees

RESEARCH PROJECT
CONSENT FORM
For Boys

Name:

Date of Birth:

Title of Project: Mentoring – the Experience of Mentees and Mentors

Ethics Committee (EC) No.:06/Q0408/17 **Principal Investigator: Hilary Garraway**

PART A: TO BE COMPLETED BY THE INVESTIGATOR:

I confirm that I have explained this research project to the volunteer in terms which, in my judgement, are suited to the understanding of the volunteer and/or one of the parents or guardians of the volunteer .

Name of Researcher	***Signature***	***Date***
Name of Person taking consent (if different from researcher)	***Signature***	***Date***

PART B: TO BE COMPLETED BY THE BOY:
Please initial box

1. I confirm that I have read and understand the information sheet dated..... for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that my identity will not be disclosed in any published or written data resulting from this study. ☐

4. I understand that the focus group will be audio taped, and the interview will be audio-taped. These will then be typed up, and the tapes destroyed following the study. ☐

5. I agree to keep confidential what is said in the focus group. ☐

6. I give my consent for my mentor to take part in this study, with the understanding that he will not be asked direct questions about me or our mentoring relationship ☐

7. I understand the above information and agree to take part in the above research project. ☐

Name of Mentee	*Signature*	*Date*

On completion, one copy of this form (the original) is to be kept by the researcher and a copy handed to the mentee to keep.

NOTES TO:

RESEARCHERS

- **Volunteers should be given sufficient information, in a way they can understand, about the proposed research and the possible risks and benefits of participation in the project, including details of common adverse outcomes.**
- **You should explain that taking part in the research is entirely voluntary; volunteers must be allowed to decide whether they will agree to participate in the research project.**
- **Volunteers may refuse to participate in the research project or withdraw from the study at any time.**
- **The volunteer's consent to participate in the research project must be recorded on this form.**

PARTICIPANTS:

- **The researcher will explain the research study to you, and tell you what the possible risks and benefits of taking part in the research are.**
- **You can ask any questions and seek further information, so that you are absolutely clear what you are being asked to do.**
- **It is up to you to decide whether or not to take part in the research.**
- **If you decide to take part you are still free to withdraw from the study at any time, without giving a reason. This will not affect the standard of treatment and care you receive.**

Appendix 5:
Consent form for mentors

RESEARCH PROJECT
CONSENT FORM
For Mentors

Name:

Date of Birth:

Title of Project: Mentoring – the Experience of Mentees and Mentors

Ethics Committee (EC) No.: 06/Q0408/17 **Principal Investigator: Hilary Garraway**

PART A: TO BE COMPLETED BY THE INVESTIGATOR:

I confirm that I have explained this research project to the volunteer in terms which, in my judgement, are suited to the understanding of the volunteer and/or one of the parents or guardians of the volunteer.

Name of Researcher	***Signature***	***Date***
Name of Person taking consent (if different from researcher)	***Signature***	***Date***

PART B: TO BE COMPLETED BY THE MENTOR:

Please initial box

1. I confirm that I have read and understand the information sheet dated..... for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that my identity will not be disclosed in any published or written data resulting from this study. ☐

4. I understand that the interviews will be audiotaped and then typed up, and the tapes destroyed following the study ☐

5. I understand the above information and agree to take part in the above research project. ☐

Name of mentor	*Signature*	*Date*

On completion, one copy of this form (the original) is to be kept by the researcher and a copy handed to the mentor to keep.

NOTES TO:

RESEARCHERS

- **Volunteers should be given sufficient information, in a way they can understand, about the proposed research and the possible risks and benefits of participation in the project, including details of common adverse outcomes.**
- **You should explain that taking part in the research is entirely voluntary; volunteers must be allowed to decide whether they will agree to participate in the research project.**
- **Volunteers may refuse to participate in the research project or withdraw from the study at any time.**
- **The volunteer's consent to participate in the research project must be recorded on this form.**

PARTICIPANTS

- **The researcher will explain the research study to you, and tell you what the possible risks and benefits of taking part in the research are.**
- **You can ask any questions and seek further information, so that you are absolutely clear what you are being asked to do.**
- **It is up to you to decide whether or not to take part in the research.**
- **If you decide to take part you are still free to withdraw from the study at any time, without giving a reason.**

Appendix 6:
Information sheet and consent form for parents/guardians

MENTORING – WHAT IS IT LIKE HAVING A MENTOR?

INFORMATION SHEET FOR PARENTS/GUARDIANS

Your child is being asked to take part in a research study. Before you decide if you would like him to take part, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information and discuss it with other people if you wish. Please ask me if there is anything that is not clear, or if you would like more information.

PART ONE – to give you some first thoughts about the project

What is the purpose of this study?
I am interested in mentoring relationships and in particular about how they get started. As part of my research I would like to interview mentors and boys that have mentors to find out about their experiences of being involved in mentoring. Most of the studies done before have used questionnaires to collect information, rather than talking to mentors and boys with mentors about their experiences. This study gives the opportunity to get the views of those directly involved. I am doing this research as part of my training.

Why has your child been chosen?
He has been chosen to take part in this study because he has a mentor with ASPIRE and is in a mentoring relationship. All boys at ASPIRE, are being invited to take part in this study.

Does he have to take part?
No – he does not have to take part – it is up to you to decide whether or not he takes part. The service he gets from Boys2Men will not be affected by your decision for him to be involved or not. If you decide that he can take part, you will be asked to sign a consent form to let us know that you have agreed for him to take part. Also, he will be asked to sign a consent form to say that he is willing to take part.

If you decide that he can take part, he is free to stop at any point, or refuse to answer a particular question, without giving a reason. If he decides to stop and that he does not want his information to be used in the study, then it will be destroyed at that point.

What will happen if my child takes part?
1. GROUP MEETING – I will be arranging a group meeting at which I will ask your child and other boys, as a group, to talk about their experiences of mentoring. The meeting will be in a private room at Boys2Men – so that others would not be able to hear what is being said. The group would be led by myself and a staff member of Boys2Men. It will last about one and a half hours. With your permission, the meeting would be audio taped so that I have a complete record of the meeting.

2. INTERVIEW. I am also asking for some boys to volunteer to be interviewed by me, on an individual basis. This would be at a later date, after the group meeting. These interviews would last about an hour and would involve me asking similar questions to those at the group meeting. They would give your child more opportunity to talk about things that maybe he has thought of since the group meeting or didn't share in the group. The interviews would take place in a quiet room at Boys2Men, where no other people would be able to hear what is being said. With your permission, I would tape record the interview with audiotapes, in order to have a complete record of what was said

The group meeting and interview are about his experiences of mentoring and so there are no right or wrong answers. The sort of topics that may be discussed are what has helped or what has got in the way of the mentoring relationship, his expectations of mentoring and how they have changed and his views on mentoring and emotional well being.

After the group meeting and the interview, I would type up what was said, word for word – this is called a transcript. If there was something that he said, that he later decided that he did not want me to use within the final analysis, then this could be deleted from the transcripts. However he would need to make this known to me before the analysis of data was completed. The tapes and transcripts would be kept confidential, and then the tapes will be destroyed once the study was completed and the transcripts destroyed five years after the study. I would analyse all the transcripts together and draw out main themes from the data.

A £5 HMV voucher will be given to those boys who take part in the research, as a thank you for their time and involvement.

What are the possible disadvantages of taking part?
It is possible that the group meeting and/or interview may bring up some sensitive issues, related to his experiences of mentoring eg. if the relationship has been difficult. In order to deal with this, I will make sure that there is time at the end of the group and/or interview, for us to talk about how they went and how he is feeling. If necessary, it may be appropriate for him to consider talking to someone else about these issues if that would be useful.

What are the possible advantages of taking part?
He may find that this study gives him the chance to think about having a mentor and he may find it useful talking about mentoring with others.
We also hope that the research will be useful to ASPIRE, in developing future services.

Who do I contact if I have further questions or comments?
My name is Hilary Garraway and I will be doing the research. You can contact me at Boys2Men (Tel. 0207 604 5960) or at Brent Family and Child Clinic (Tel. 0208 208 7200).
If you want to talk to someone not involved in the research, there are staff members at Boys2men or Brent Family and Child Clinic who would give you some independent advice.

Thank you for reading Part One. If you are still interested – please go to Part Two.

PART TWO

What if there is a problem?

Complaints – if you want to complain, you should speak to the researcher first. (See contact details in Part One). However if you are still unhappy and want to complain formally, you can do this through the NHS complaints procedure. Details are available via the Brent Family and Child Clinic (Tel 0208 208 7200).

Harm – In the unlikely event that your child is harmed as a result of taking part in this study, due to negligence, then you may be able to take legal action. Arrangements are in place, if this happens.

Will my taking part in the study be kept confidential?

Yes. The group meeting and interviews will be kept confidential.

GROUP MEETING – At the group meeting I will check that everyone has signed a consent form – agreeing to keep confidential what is said in the group – including those leading the group. With your permission the group meeting will be audio taped.

INDIVIDUAL INTERVIEWS – These will also be kept confidential. The only time that confidentiality would be broken is if serious harm eg. child abuse, is disclosed and then the necessary services would need to be informed. However I would talk to him about this before I spoke to anyone else. The interviews, with your permission, will be audio taped.

All tapes of the group meeting and the interviews will be stored in a locked cabinet at a location away from Boys2Men. The tapes will be typed up word for word and these transcripts will be stored on a personal computer and will be accessed by password only. Only myself and my two supervisors would have access to what has been said. No personal details will be kept with the tapes or with the transcripts of tapes. The data will not be passed onto anyone else.

When I have analysed the data I will plan a meeting to share with all participants the main findings of the research. I will tell the participants the main themes, (without linking it to specific people) which have come out of the research. They would then have the chance to give me their feedback about what I have found out. I will then write up the research as a thesis. When I write the thesis I may use direct quotes from the group meeting or interviews but these will not be linked to individuals and pseudonyms (pretend names) will be used.

Once the thesis has passed the college's academic requirements the tapes will be erased (Sept 2007). I have two supervisors – and I will discuss the material with them and they will also maintain confidentiality. My supervisors are Dr. Nancy Pistrang (Senior Lecturer in Clinical Psychology at University College, London) and Dr. Debbie Masdell (Clinical Psychologist at Brent Family and Child Clinic).

Who has reviewed the study?

Before any research goes ahead it has to be checked by an ethics committee. This research was checked by the Brent Research Ethics Committee.

Thank you very much for taking the time to read this information sheet.
Hilary Garraway

RESEARCH PROJECT CONSENT FORM For Parents/Guardians

Name:

Version 3 20/04/06

Date of Birth:

Title of Project: Mentoring – the Experience of Mentees and Mentors

Ethics Committee (EC) No.:06/Q0408/17 **Principal Investigator: Hilary Garraway**

PART A: TO BE COMPLETED BY THE INVESTIGATOR:

I confirm that I have explained this research project to the volunteer in terms which, in my judgement, are suited to the understanding of the volunteer and/or one of the parents or guardians of the volunteer.

Name of Researcher	***Signature***	***Date***
Name of Person taking consent (if different from researcher)	***Signature***	***Date***

PART B: TO BE COMPLETED BY THE PARENT/GUARDIAN

Please initial box

1. I confirm that I have read and understand the information sheet dated..... for the above study and have had the opportunity to ask questions. ☐

2. I understand that my child's participation is voluntary and that he is free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that his identity will not be disclosed in any published or written data resulting from this study. ☐

4. I understand that the focus group will be audio-taped, and the interviews will be audio-taped and then typed up and the tapes destroyed after the study. ☐

5. I understand the above information and agree for my child to take part in the above research project. ☐

Name of Parent/Guardian	*Signature*	*Date*

On completion, one copy of this form (the original) is to be kept by the researcher and a copy handed to the parent/guardian to keep.

NOTES TO:

RESEARCHERS

- **Parents should be given sufficient information, in a way they can understand, about the proposed research and the possible risks and benefits of participation in the project, including details of common adverse outcomes.**
- **You should explain that taking part in the research is entirely voluntary; parents must be allowed to decide whether they will agree for their child to participate in the research project.**
- **Parents may refuse their child to participate in the research project or withdraw from the study at any time.**
- **The parent's consent for their child to participate in the research project must be recorded on this form.**

PARENTS

- **The researcher will explain the research study to you, and tell you what the possible risk and benefits of taking part in the research are.**
- **You can ask any questions and seek further information, so that you are absolutely clear what your child is being asked to do.**
- **It is up to you to decide whether or not your child takes part in the research.**
- **If you decide that your child can take part he is still free to withdraw from the study at any time, without giving a reason. This will not affect the standard of treatment and care he receives.**

Appendix 7:
Focus group schedule

Focus Group schedule for mentees

INTRODUCTION

- Introductions – of each other and research- and I will be interviewing mentors as well
- Purpose of group – your experience of mentoring in three main areas – getting it started – what helps/problems etc; what you expected and what you get out of it or ways it is difficult or costly.
- Will take about an hour and a half – can break, flexible
- Confidentiality – stays in group; from staff, mentors- exceptions re. harm
- Use of what we talk about – general themes for thesis and project
- Tape recording, NB consent forms – anonymous quotes
- Your choice to talk and what to share - no right or wrong answers – your personal experience – same or different to others –good or bad experience
- Group – sparking of ideas – same or different; in it together, useful for you – to think about what's happening.

MENTORING – brainstorm and discuss what it means to them, their experiences etc. – words to describe mentoring.

1. FORMING THE RELATIONSHIP

Helps/Hindrances

- **What are some of the things you've done together, with your mentor?**

- **What's it been like for you, getting to know your mentor?**
  -When you think about being with your mentor, what words come to mind?

- **What's helped you to get to know your mentor?**
  - any activities/conversations/events?
  - things about them/ about you/ about Boys2Men?

- **Do you think your mentor sees it the same way or differently?**

- **Is there anything that's got in the way of getting to know them?**
  - any activities/events/anything they've said or you've said?
  - things about them/ about you/ about Boys2Men?
  - anything you'd wished had gone differently?
  - anything that nearly blew it?

- **Do you think your mentor sees it the same way or differently?**

- **Does it make a difference or not that they're from similar background to you?**

Costs/Benefits

- **Does it make any difference to you if you have a mentor or not?**
  - to your view of life, of yourself, of others, of your future

- **Is there anything that you get out of having a mentor?**
  -now or in the future

- **Is it a hassle in any way having a mentor?**

- **If it stopped, is there anything you'd miss?**

- **Do you think your mentor gets anything out of it?**

- **Do you think he finds anything tough about mentoring?**

2. EXPECTATIONS

- **Think about before you had your mentor, what did you expect it to be like?**
  - do together/ talk about/ his role?
  - hopes/fears?

- **What was it like for real?**
  - how was that different to what you expected?

- **What do you think your mentor expected?**
  - how was that different to what happened?

3. EMOTIONAL WELL BEING –

- **Brainstorm "CAMHS" – thoughts, feelings, images, words that come to mind**
  - What did you think of services like CAMHS before you went?
  - Have you always felt like this or have views changed – in what way?
  - What does it mean to you to be a service user?
  - And to your family/friends/wider community?
  - Where do these different ideas come from?

- **What helps you with emotional wellbeing** (eg friends, family, place of worship, sport, medication, therapist, mentor?)

- **What do you think the aims of the mentoring project are – do you think it's doing this?**

- **Think of the different people who are in your life now -Does mentoring affect how you are/how you act with any of these people?**

- **What are some of the words that you use to describe yourself?**

- **Does the mentoring affect how you see yourself at all?**

ENDING

- **Is there anything I haven't asked about that you think might be useful for me to know?**
- **How's it been talking about this stuff?**
- **Is there anything you want to ask me?**
- Remind them of confidentiality
- Follow up interviews – ask for volunteers
- My contact details
- HMV vouchers
- Thanks

Appendix 8:
Interview schedule for mentees

Individual Interview Schedule – mentees

1. How did you find the group – feelings after, further thoughts/wished you'd said?
2. Was there anything that you thought of in the group but didn't want to talk about in the group? (Review focus group schedule)

3. What sort of things have you done with your mentor?
4. Who decides what you both do/talk about?

5. What happens if you don't want to contact your mentor or if things go wrong with the mentoring?
6. What contact do they have with your family – how is that for you?
7. What do your family think about the mentoring?

8. What was life like for you before you had a mentor?
9. If you had a problem then – who did you go to? – do you still use them for support as well as your mentor?
10. How did you get involved with Boys2Men?
11. Whose idea was it to go to Boys2Men and get a mentor?

12. When you had difficulties, would you have gone to counsellor/G.P./ mental health services or did you ever use these sort of services?
13. What comes to mind when you think of CAMHS- views on CAMHS?
14. Has mentoring made a difference to these views?

Appendix 9:
Interview schedule for mentors

Individual Interview Schedule for Mentors

INTRODUCTION

- Introductions – of each other and the research - I will be interviewing mentees too
- Purpose of interview – to look at their experience of mentoring in 3 main areas – getting the relationship going – what's helped, hindered it etc, their expectations before and compared to now and about the emotional well being of the mentees.
- Will take about one hour but flexible – can stop, break, arrange a second time etc.
- Confidentiality and anonymous – from other staff, mentees etc.
- Use of data – analysis leading to general themes for thesis and project
- Tape recording - NB. consent form – anonymous quotes
- No right or wrong answers – their experience – good and bad, option to not answer

1. FORMING THE RELATIONSHIP

Helps/hindrances

- **How often have you met and what sort of things have you done together?**

- **How would you describe the relationship?**
  - what words come to mind to describe the relationship?

- **Could you tell me what it has been like for you, starting this mentoring relationship?**

- **Have there been things that have helped to get the relationship going?**
  - any particular activities/events/conversations?
  - any aspects of who you are/who mentee is/ the setting?
  - anything that has helped you to feel closer/ to "click"?
  - what keeps it going?

- **Have there been things that get in the way of the relationship or hinder it?**
  - any particular activities/events/conversations?
  - any aspects of who you are/who mentee is/ the setting?
  - anything that you wished had happened differently?
  - anything that nearly ended the relationship?

- **What do you think the mentee found helpful in getting the relationship going?**
  - how does that compare to your experience?

- **What do you think the mentee found difficult in getting the relationship going?**
  - how does that compare to your experience?

Costs/benefits

- **How does the relationship affect you?**
  - how do you feel when you are together/after meeting?
  - has it made any difference to you / your life/your view of self?
  - are there any benefits from it – now or in the future?

- what does it take out of you – any costs?

- **How would you feel if you did not have this relationship?**
  - what would you miss?
  - what wouldn't you miss?

- **What do you think the mentee gets out of the relationship?**
  - do you think anything has changed for them?

- **What do you think the mentee finds hard in the relationship?**

2. EXPECTATIONS

- **How did you get involved in mentoring?**

- **What did you expect before you started?**
  - what you'd do together, talk about, feel about it, what your role would be?

- **Did you have any dreams of how it would be like?**

- **Did you have any fears/concerns?**

- **How does the reality compare with your expectations?**
  - any time felt let down/frustrated/pleasantly surprised?

- **What do you think the mentee's expectations were?**

- **How do you think their expectations have changed now?**

3. EMOTIONAL WELL BEING

- **What comes to mind when you hear the term mental health services?**
  - what positives/negatives/images?
  - where do these ideas come from?

- **How do you think your mentee experiences mental health services?**

- **Do you think your mentoring relationship affects your mentees emotional well being in any way?**
  - in the short-term?/ in the long-term?
  - their view of themselves?
  - their relationships with family/friends/services?
  - how would their emotional well-being be affected if they didn't have this?

- **Has this mentoring relationship affected your views on mental health services/mental health issues in any way?**

ENDING

- **Is there anything else that we haven't covered that you think might be useful for me to know?**
- **How did you feel talking about these issues?** – check OK
- **Is there anything you want to ask me?**
- Remind them of confidentiality
- My contact details
- HMV voucher and thanks

Appendix 10:
Stages of analysis

Stages of IPA Analysis

Stage One

Extract from transcript of Focus group 2

More life experience than school mentors Share similar life experiences Don't want to see boys end up like that	B6: Like if you have a mentor at school…they haven't been through the experience properly but in Boys2Men probably everyone has gone through same experience and don't want to see us end up like that
Know about mentors past	B8: Yeah I agree. Like X got beaten up when he was younger
Mentors have been through it compared to counsellors	B7: Yeah the mentors have like been through it and the counsellors are the ones that think they're superheros
Mentors know more about the street/ know what we know	B5: …and they don't know everything about the street, but with mentors they know..they don't know everything about the street, but they know things that we know.

Extract from transcript of interview with M2
(I = interviewer)

	M2: One thing that really stands out and what fascinates them is that they, coming through the door, they see black men in a professional setting, and working, that's intriguing to them, not only to them but also to their parents as well cos they don't see a lot of positive role models of men, black men in their lives and once they are in the door it is very difficult for them to leave
Professional black men/ Intrigues boys and parents/positive black male role models/lack of positive role models/ Difficult to leave	I: So what do you think it is about this place that keeps them here?
Flexible, work out of hours, easy to contact via phone, boys expect response if they phone, security from mentors' availability	M2: Because we're not a 9 to 5 organisation –we're sometimes working 18 hours per day, cos we're contactable by phone and they know that if they phone or just flash and hang up they know that we will ring them back. So the security of knowing that and having that around is important to them cos they can..I mean I have had phone calls from young people like at 12 o'clock at night – telling me their problems..

Stage Two

Extract from transcript of Focus group 2

B6: Like if you have a mentor at school …they haven't been through the experience properly but in B2M probably everyone has gone through the experience and don't want to see us end up like that

Value of life experiences to help boys avoid same issues

B8: Yeah I agree. Like L got beaten up when he was younger

B7: Yeah the mentors have like been through it and the counsellors are the ones that think they're superheros

B5: …and they don't know everything about the street, but with mentors they know..they don't know everything about the street, but they know things that we know

Shared knowledge about street

Extract from transcript of interview with M2

M2: One thing that really stands out and what fascinates them is that they, coming through the door they see black men in a professional setting, and working and that's intriguing to them, not only to them but also to their parents as well cos they don't see a lot of positive role models of men, black men in their lives and once they are in the door it is very difficult for them to leave.

Positive black male role models/ Want to stay

I: So what do you think it is about this place that keeps them here?

M2: Because we're not a 9 to 5 organisation –we're sometimes working 18 hours per day, cos we're contactable by phone and they know that if they phone or just flash and hang up they know that we will ring them back. So the security of knowing that and having that around is important to them cos they can..I mean I have had phone calls from young people like at 12 o'clock at night – telling me their problems..

Availability

Stage Three

Extract from transcript of Focus group 2

B6: Like if you have a mentor at school ...they haven't been through the experience properly but in B2M probably everyone has gone through the experience and don't want to see us end up like that

Theme 2.2 'They've got tips of how to go through it better'

B8: Yeah I agree. Like L got beaten up when he was younger

B7: Yeah the mentors have like been through it and the counsellors are the ones that think they're superheros

B5: ...and they don't know everything about the street, but with mentors they know..they don't know everything about the street, but they know things that we know

Theme 2.1 'They know where we're coming from'

Extract from transcript of interview with M2

M2: One thing that really stands out and what fascinates them is that they, coming through the door they see black men in a professional setting, and working and that's intriguing to them, not only to them but also to their parents as well cos they don't see a lot of positive role models of men, black men in their lives and once they are in the door it is very difficult for them to leave.

Theme 1.1: 'A a male role model'

I: So what do you think it is about this place that keeps them here?

M2: Because we're not a 9 to 5 organisation –we're sometimes working 18 hours per day, cos we're contactable by phone and they know that if they phone or just flash and hang up they know that we will ring them back. So the security of knowing that and having that around is important to them cos they can..I mean I have had phone calls from young people like at 12 o'clock at night – telling me their problems..

Theme 1.3: 'Whatever time...he'll be there'