



Evaluation of a Chinese Mental Health Advocacy and Support Project

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The King's Fund >

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Executive summary

Introduction

This report contains the evaluation of a three-year pilot Chinese Mental Health Advocacy and Support Project supported by the King's Fund. The Project began in October 2006 and employed one full-time Chinese mental health advocate covering all boroughs in the Greater London area.

The aims of the Project were to:

1. Improve access to health care services for Chinese people with mental health needs
2. Improve the experiences of Chinese people with mental health needs using health care services

The objectives of the Project were to:

1. Enable the voice of the Chinese patient to be heard, through providing language and cultural support, and thus ensure that patients receive appropriate and responsive services
2. Build a two-way bridge between Chinese patients and mental health professionals, providing explanations of Chinese cultural background to professionals and relaying information from professionals to patients to reduce the stigma of mental illness among the community
3. Provide continuity and stability in the support received by Chinese patients that would not be available with the conventional use of interpreters.
4. Provide emotional and practical support to Chinese patients and their families, recognising that social welfare is crucial to mental well-being

Methods

While the Project was available to any persons of Chinese ethnic origin living in London, the evaluation focussed on three broad groups within this heterogeneous population: first-generation settlers; new migrants and students in higher or post-18 education. Using realistic evaluation, the evaluation sought to identify and elucidate the mechanisms of access and advocacy occurring within these groups.

The Project evaluation comprised of two components:

1. A quantitative, descriptive component derived from the case notes kept by the advocate: number of clients; client demographics; referral routes

2. A qualitative case-study component consisting of interviews with clients, clients' relatives and care providers to address the research questions posed by the process evaluation

Between the start of the Project in December 2006 and July 2009 when data were collated, a total of 40 clients accessed the Project. For the realistic evaluation, eight client cases were selected and a total of 14 transcripts were analysed with the data set consisting of a mixture of interviews with clients, their family members, care providers and an advocate account.

Key findings and recommendations

1. The provision of a community-based advocacy service is essential to meeting the mental health needs of the Chinese community in London. The community advocacy model used in this Project was successful in:

- improving access to health and social care services among settled Chinese residents
- improving engagement with mental health services for patients with severe mental illness, especially among new migrants
- improving communication and understanding between health professionals and clients across all client groups and in all settings, including general practice, community mental health services and inpatient units
- improving communication and understanding between other services, such as housing and legal services, and clients across all client groups, assisting in issues that were key factors in determining health and mental health and in promoting recovery

The cultural identity and ability to communicate in the two main Chinese dialects used in the UK (Cantonese and Mandarin) were critical attributes of the advocate.

The advocacy provided in this Project was not performed under the statutory provisions of the Mental Health Act 2007 i.e. advocacy provided by Independent Mental Health Advocates (IMHAs) and Independent Mental Capacity Advocates (IMCAs). However, the findings demonstrate the importance of ethnic and cultural identity of the advocate in enabling engagement and effective communication, and the inadequacies of using interpreters in mental health assessments. Current provision of IMHAs and IMCAs is unlikely to be meeting the cultural and language needs of Chinese patients in London, especially given the dispersed nature of the population.

A pan-London Chinese mental health advocacy service should be commissioned to provide advocacy in community settings and under the statutory provisions of the Mental Health Act 2007. The community advocacy should be provided using the model piloted in this Project.

Chinese advocates with Cantonese, Mandarin and English language skills should be trained under the new national independent advocacy qualifications for IMHAs and IMCAs.

2. The CNHLC's counselling service is an important resource that provides culturally and linguistically-sensitive support to the Chinese community in London. Current statutory provision of psychological therapies does not meet the cultural or language needs of Chinese people.

Mechanisms should be put in place to make the CNHLC's counselling service available to a wider population and to make the service available to Chinese people through the NHS. This will also help to ensure viability and sustainability of the service.

3. New migrants are a particularly vulnerable group who require practical assistance to meet their basic welfare needs. Across all client groups, advocacy support in this area was highly valued by both service providers and clients. The advocate worked in partnership with social workers and community psychiatric nurses to ensure that the basic needs of clients were met. Social isolation was also prevalent across all groups but was perhaps experienced more intensely by new migrants, who were also isolated from their family and for whom there is a lack of Chinese community resources.

Better support should be provided to vulnerable groups, such as new migrants, to ensure that they receive appropriate welfare support. This should be achieved by:

- advocates working in effective partnership with care providers
- recruitment of support workers with language skills to mental health teams

A culturally and linguistically-responsive befriending and support service should be set up to tackle social isolation among Chinese people with mental illness and to assist with welfare needs. This should meet the needs of a diverse population and be provided in the two main spoken dialects: Cantonese and Mandarin.

1. BACKGROUND

This report contains the evaluation of a three-year pilot Chinese Mental Health Advocacy and Support Project supported by the King's Fund. The Project began in October 2006 and employed one full-time Chinese mental health advocate covering all boroughs in the Greater London area.

1.1. Setting the context: Chinese in the UK

The earliest Chinese to settle in Britain were predominantly seafarers, cooks and laundry workers who established small communities in the dockland areas of London's Limehouse and the Pitt Street area of Liverpool in the late 19th century (Au & Ping, 1997). Subsequently, waves of migration throughout the 20th century and continuing into the 21st century have resulted in a population that is heterogeneous – diverse in country of origin, language, culture, skills and education (Figure 1.1).

1.1.1. The current demographic

In 1991, the National Population Census recorded ethnicity for the first time and put the figure for ethnic Chinese in Britain at 164,667 (ethnic group data were not collected on the Northern Ireland Census). By 2001, this figure had climbed to 247,403, making ethnic Chinese the 6th largest non-white minority ethnic group in the UK and forming 0.4% of the total population. However, these figures are likely to be underestimates as the Census would not have included those who were illiterate, those who were in the process of applying for asylum or irregular migrants. Mid-year population estimates by the Office for National Statistics suggest that the number of ethnic Chinese in England stood at 374,200 in 2007. The growth in the Chinese population is largely attributable to net international in-migration. Chinese community representatives believe that this growth is being led by students and economic migrants from mainland China (London Chinese Community Network, 2005). Data from the Higher Education Statistics Agency estimates the number of students from China, Taiwan, Hong Kong, Macao, Malaysia, Singapore and Vietnam to be around 83,000 in 2005/06, giving a proxy estimate for the number of Chinese students in higher education in the UK (HESA, 2007). Estimates suggest that as many as 80,000 work here illegally, with the pace of new arrivals largely explaining why more than 60% of the population cannot speak fluent English (The Sunday Times, 22 January 2006). China's rapid economic expansion is also predicted to have a sizeable impact on the UK Chinese population and its dynamics in the near future.

Geographically, the Chinese population is the most dispersed ethnic minority group in the UK. Although Chinese population density remains highest in the major urban areas, with nearly one third of the population living in London (Census 2001), there are significant numbers outside of these areas. This pattern of settlement has come about largely through the movement of restaurateurs and takeaway owners away

from concentrations of Chinese people in order to reduce competition, resulting in social isolation, especially amongst the elderly. The catering trade remains the largest industry for Chinese people (Census 2001), although this is likely to change as second and third generation UK-born Chinese assimilate into mainstream society, taking up different roles. The number of 'high street' Chinese medicine shops is also growing rapidly and fast becoming the second largest industry for Chinese according to unofficial sources.

Figure 1.1. History of Chinese migration to Britain: a timeline

<u>Late 19th century</u>	The first Chinese to arrive in Britain were the seamen employed on British merchant ships in the late 1860s. By the late 19 th century, they had settled in ports such as Limehouse in London and Liverpool.
<u>1950s – 1960s</u>	Land reforms and the collapse of the agricultural industry in Hong Kong resulted in a second wave of migration as farmers left to seek work in the UK. This was made possible by the 1948 British Nationality Act that gave New Commonwealth citizens the right to live and work in Britain. This Act also opened the door to arrivals from former British colonies, such as Malaysia and Singapore, who brought with them specialist skills, such as nursing.
<u>1970s – 1980s</u>	The end of the Vietnam War marked another phase of Chinese immigration with ethnic Chinese forming nearly 80% of the Vietnamese refugee community in Britain.
<u>1990s – present</u>	The return of Hong Kong to China on 30 th June 1997 also led to further migration of Hong Kong Chinese to Britain while recent years have witnessed a rapid increase in the number of mainland Chinese, especially from the Fujian province, seeking economic freedom in Britain.

1.2. What were the needs for the project?

Very little research has been conducted into the mental health of Britain's Chinese communities and the extent of mental ill health in the community is still not understood, despite recent changes in policy to improve ethnic monitoring in all health services. However, there is little doubt that current service provision is inadequate in meeting the needs of Chinese patients.

1.2.1. Utilisation of mental health services

There is evidence for underrepresentation of Chinese people in services across the NHS including primary and secondary care services (Smaje & Le Grand, 1997) and this pattern does not exclude mental health services – studies have shown that Chinese psychiatric patients are underrepresented in the NHS (Wong & Cochrane, 1989; Li, 1991). The first *Count me in* census of mental health inpatients in England and Wales in 2005 showed that Chinese men and women were also significantly underrepresented in rates of admission to inpatient facilities. This trend has been repeated in all subsequent annual *Count me in* censuses (Commission for Healthcare Audit and Inspection, 2005, 2007, 2007) which again showed that rates of admission to mental health inpatient facilities in England and Wales were lower among the Chinese population compared to the national average.

The underrepresentation of Chinese in mental health services could suggest that the Chinese population experiences better mental health than the general population or that specific barriers to access exist.

1.2.2. Prevalence of mental disorder in the Chinese population

Cross-national studies and studies within the UK have suggested a lower prevalence of mental disorder in the Chinese population (Calderwood & Tait, 1999; Natarajan, 2004; Weissman *et al.*, 1994; Weissman *et al.*, 1996; The WHO World Mental Health Consortium, 2004).

In the two Health Surveys for England that focussed on the health of minority ethnic groups, psychological health measured by the Chinese Health Questionnaire (the validated equivalent of the General Household Questionnaire; which covers general levels of happiness, depression, anxiety, sleep disturbance and ability to cope during the four weeks prior to interview) in a community sample found far lower rates of high CHQ12 scores among Chinese men and women than any other ethnic group or the general population, although in the 2004 survey this difference was not statistically significant (Calderwood & Tait, 1999; Natarajan, 2004). Despite this, Chinese were more likely to be classified as having a severe lack of perceived social support. Social support is significantly associated with mental health and wellbeing.

In psychotic illness, such as schizophrenia where there is a suspected genetic component to aetiology, there is a lack of epidemiological data in relation to the Chinese. Cross-national comparative analyses of prevalence studies of schizophrenia have shown lower rates in China. However, these studies are also subject to difficulties in interpretation due to differences in diagnostic standards, life expectancy, course and prognosis between nations (Torrey, 1987). Lower prevalence rates have been reported in 'least developed' countries compared with 'emerging' or 'developed' countries, with a more benign course of illness in less developed countries suggested to produce the lower prevalence rates (Torrey, 1987; Saha *et al.*, 2005).

Rates of psychosis among ethnic groups in London have been compared and found to be higher among ethnic minorities, although the size of the Chinese sample was too small to draw any definite conclusions regarding incidence in the Chinese population (King *et al.*, 1994). The higher rates among ethnic minorities are thought to be due to the effects of migration and cultural change and the conditions under which minority ethnic migrants live. Higher rates of schizophrenia have also been found among migrant groups, largely in studies examining African-Caribbean and South Asian groups (reviewed in Bhugra, 2004), although this is contested as Nazroo (1997) found that African-Caribbean men were at no greater risk than white men of suffering from schizophrenia or psychosis but were five times more likely to be hospitalised for these conditions. In the same study, Chinese suffered the lowest rates of mental illness (Nazroo, 1997).

Thus, given the differing cultural expressions of mental ill health and pathways to care between ethnic groups, prevalence studies whether examining treatment rates or community samples, have not been useful in elucidating the extent of need within a community.

1.2.3. Barriers to access

Language, culture, poor symptom recognition and stigma are often cited as barriers to access leading to low uptake of health services. The NHS Executive Mental Health Task Force report (Department of Health, 1994) observed that the Chinese and Vietnamese communities were largely 'invisible' to mainstream purchasers and providers. The main areas of difficulty for Chinese families were:

- Lack of English
- Lack of knowledge of their rights
- Cultural differences, including lack of understanding by the statutory sector
- Scattered settlement
- Long and unsociable working hours

These issues continue to be relevant today.

1.2.3.1. Language

The widespread availability of interpreting services in London has to some extent diminished the language barriers experienced by Chinese people. However, this is not likely to be the case for all Chinese: interpreting services are not available throughout the country and are particularly scarce in rural areas; many new arrivals to the country are not aware of the availability of interpreting services. In many community studies, Chinese patients have found interpreting services unreliable and sometimes unprofessional, leading to feelings of anxiety and disappointment (CMHA, 2007; Tran *et al.*, 2008). As the gateway to most other services, the process

of making an appointment to see a general practitioner was considered bothersome and difficult, where difficulty was experienced in negotiating the encounter with the practice receptionist.

In mental health care, where multiple agencies are often involved, the use of interpreters has been considered unsatisfactory, with little coordination of care. The use of interpreters to communicate complex mental health matters to health professionals has also been considered problematic, with Chinese patients having little faith that the health professional has understood their problems.

1.2.3.2. Culture

'Cultural' barriers are harder to define and overcome. In this report, references to 'cultural' influences may be defined as:

When inherited ideas, beliefs, values and knowledge have a bearing on

- explanations for illness or understanding of illness
- health-seeking behaviour
- interaction with health professionals

Given the heterogeneity of the Chinese population in Britain, it is difficult to make generalisations about language or culture. However, for many Chinese people in Britain, traditional Chinese belief systems continue to be held – among first-generation settlers who are now reaching old age, among new migrants who have grown up in Communist China, and among second-generation Chinese, who are able to differentially activate host and native cultural identities (Hong et al., 2001). Among the latter group, there are also those who experience inter-generational conflict, caught between the different values of a traditional upbringing at home and the social norms, contexts and values of British society (Lau, 1997).

Chinese belief systems are based on the 'great tradition' (a system of philosophies, religions and theoretical principles) which is rooted in Confucianism, Taoism and Buddhism (Shih, 1996). These belief systems form the basis of Chinese people's concepts of health and illness. Their bearing on issues relating to mental health and the care of Chinese patients are summarised below.

1.2.3.3. Poor symptom recognition

Chinese concepts of health and mental health are shaped by Chinese philosophies as much as by Chinese medicine. In the first textbook of Chinese medicine, the 'Yellow Emperor's Internal Classic', published around 700BC and probably heavily influenced by the different schools of Chinese philosophies, the holistic theory of body and mind was laid down (Shia, 1997). The theory stated that dysfunction in the somatic system would lead to disruption of mental activity and that any mental derangement would be accompanied by physical symptoms. The close relationship

between mental and physical health has meant that, until the 1980s, psychiatric illness has not been treated as a separate disease category from physical ailments.

These beliefs are still widely held today. In a recent study of the views of Chinese older people, mental and physical health were not considered as separate entities (Tran *et al.*, 2008). Indeed, participants in the study who were suspected to have mental health needs did not identify their symptoms (persistent insomnia, low mood) as mental health problems; neither were these symptoms perceived as ailments that required medical attention. A previous study has shown that symptoms potentially indicative of mental ill health in Western biomedicine were less likely to be medicalised by first-generation Chinese (Prior *et al.*, 2000). Studies have also shown a tendency for Chinese patients to somatise (express psychological distress physically), leading to poor detection of psychiatric illness by general practitioners.

1.2.3.4. Coping strategies

It has been posited that certain character traits and beliefs prevalent in the Chinese population lead to reluctance to seek help when mental health problems arise (Kung, 2004). Self-control and solving one's own problems are valued over seeking help. In CNHLC's study, Tran *et al.* (2008) found concepts of mental health problems being a result of loss of control of thoughts and emotions, and these being a sign of weakness. The use of passive coping strategies such as avoidance, denial, acceptance of fate and minimising the problem were used to deal with the problems (Tran *et al.*, 2008; Green *et al.*, 2002; Kung, 2004).

1.2.3.5. Use of psychological therapies

Chinese people are commonly described as reserved, passive and submissive in the presence of authority. Chinese culture values repression of emotions in the promotion of family harmony. As such, there have been reports that Chinese do not respond well to the use of psychological therapies that require examination of thoughts and feelings (Arthur *et al.*, 1999) and are reluctant to use them (Kung, 2004). However, in an evaluation of a Youth Counselling and Family Therapy Project jointly provided by the Chinese Mental Health Association and Islington Chinese Association (2003-2006), Chinese youths and their parents were shown to respond well to therapy, showing statistically significant reduction of psychological symptoms following a course of counselling. The service, provided by Chinese therapists, not only addressed linguistic needs but provided intra-cultural connection and understanding (Howard, 2006). The service reported overwhelming demand and this may reflect a change in attitude over time to 'talking therapies' and acculturation to Western value systems. The scarcity of linguistically- and culturally-sensitive services has also meant that any need for this type of therapy has not been met.

1.2.3.6. Use of Chinese medicine

Use of traditional Chinese medicine is eclectic and it is common for Chinese people to use a combination of both Chinese and Western medicine, believing that this provides the best treatment (Prior *et al.*, 2000). The extent to which Chinese people choose Chinese medicine for mental health problems is not known. None the less, it is not uncommon for Chinese people to use herbal remedies or tonics for maintaining health and well-being. In clinical practice it is imperative that both Chinese and Western practitioners are aware of any dual use of medicines to minimise the potential of harmful drug interactions occurring and to enable effective management of the patient.

1.2.3.7. Stigma

Social stigma towards mental illness is prevalent in many communities, including the Chinese community. It has been suggested that the stigma of mental illness among the Chinese community in Britain may be particularly acute as a small, encapsulated community (Fenton and Sadiq, 1993). There is anecdotal evidence for intense stigma towards mental illness in community studies and through key informants in the Chinese community.

An assessment of the mental health needs of Chinese young people in Birmingham (Chinese National Healthy Living Centre, 2005) revealed that stigma remains an important issue among Chinese in the UK. The assessment concluded that the majority of Chinese young people and their parents perceive mental illness as being 'crazy' and associated with violence.

It has been suggested that the close-knit family structure of the Chinese community provides strong support for its members. While this may be beneficial, it may generate feelings of guilt and shame, resulting in people feeling stigmatised and unable to seek help (Mental Health Foundation).

It has also been reported that mental illness is concealed for fear of losing face (Yang, 2007). Mental illness is attributed to character flaws and hereditary causes. 'Face' in Chinese culture is viewed in relation to the whole family, rather than to the individual, and the shame and loss of face extends to the whole family.

The vignette provided in Figure 1.2 illustrates how the above factors come together to influence the interface between mental health professionals and Chinese patients and highlights confidentiality issues associated with the use of local interpreters.

1.2.3.8. Cultural competence of services

Chinese mental health patients have often been described as difficult to manage. The main difficulties in the interface between mental health workers and Chinese patients are often (Blackwell, 1997):

- Differences in racial and cultural perceptions, including symbolic and belief systems, and a lack of familiarity with the Confucian tradition
- Differences in family structure and organisation
- Differences in language and communication

These led to failure to engage the patient and their family, failure to provide appropriate support, and sometimes to errors in management. In *Chinese Mental Health Issues in Britain* (1997), Blackwell describes three areas where Western psychiatrists occasionally fall in error when treating Chinese patients:

- ‘Normalising’ behaviour which is the result of mental illness – misconstruing signs and symptoms of mental illness as being normal behaviours within the Chinese ‘culture’, with the result of patients not receiving treatment or receiving inappropriate treatment
- Misinterpreting normal culturally determined behaviour as evidence of mental illness
- Mismanagement – using treatment styles and regimens which are unsuited to Chinese patients, for example, underestimating the importance of the family in treatment decisions

These observations highlight the difficulties in making cross cultural diagnoses faced by British psychiatrists. Blackwell emphasises the need for expert cultural consultancy or ideally referral to a psychiatrist from the same background.

Figure 1.2. An account of the experiences of a Chinese mental patient’s father (CNHLC, 2009)

In a meeting with the psychiatrist and the team involved in the care of his son, an interpreter had been invited to provide interpretation for the father. In a brief chat in the waiting area prior to the meeting, the father had established that the interpreter lived locally and was a mutual acquaintance of the local Chinese residents in the area.

During the meeting, the psychiatrist reviewed the history of the patient, who had been in his care for a number of years, and this included mentioning that a close relative of the family was similarly affected by mental illness, and a hereditary component was likely. This drew immediate anger from the father, and subsequent resentment and mistrust of the psychiatrist. The father considered the disclosure of this information in the presence of the interpreter unnecessary, as this issue had already been discussed. The reason for the anger was the father’s anxiety about how this would affect his other children and their prospects of marriage if the news spread to the community.

1.2.3.9. Service experiences

In 1999, CNHLC published *The Mental Health Needs of Chinese in England: A Report of a National Survey* (Li & Logan, 1999). The study surveyed 401 Chinese people in England and 86 (21.4%) screened positive for past or current mental health disorder. Seventy one of these agreed to be interviewed. The interview data showed that

- 74.3% of the interviewees had encountered difficulties with seeking help
- Of 50 interviewees who had a current mental health disorder, 36.8% given a diagnosis did not know what that diagnosis was
- No one was given counselling, psychotherapy or ECT, which meant that drug therapy was the only option
- 40.8 % and 56.1% had had negative experiences with their GP or psychiatrist, respectively.

The main barriers identified were language, interviewees' perceptions of symptoms as somatic rather than psychiatric in origin, lack of knowledge about statutory services, and lack of access to bilingual health professionals. There were long delays before these people made contact with health professionals (mainly GPs), little use being made of community psychiatric services. The investigators concluded that health advocates and better use of bilingual skills were essential to maximise the effectiveness of health professional-patient contacts.

The Government's response to the independent inquiry into the death of David Bennet and the resulting *Delivering Race Equality* action plan acknowledge that there is inequality and discrimination, both direct and indirect, in mental health care (Department of Health, 2005).

1.2.4. New migrants

In addition to the barriers described previously, it is well documented that migrants, whether official or undocumented, face disadvantage in terms of mental health and access to health care (Institute for Public Policy Research, 2005). It is now recognised that the context of the migration process, and not the stress of migration alone, impacts on the mental health of migrants (Murphy, 1977; Ho et al., 2002). Displacement issues and problems of adapting to a new society can give rise to psychological stress. A comprehensive list of factors associated with increased risk of mental disorder was produced by the Canadian Task Force on mental health issues in immigrants and refugees (cited in Ho *et al.*, 2002):

- Drop in personal socioeconomic status following migration

- Inability to speak the language of the host country
- Separation from family
- Lack of friendly reception by host population
- Isolation from persons of similar cultural background
- Traumatic experience or prolonged stress prior to migration
- Adolescent or senior age at time of migration

For new migrants, refugees and asylum seekers who have recently arrived in a new country, the impact of migration on mental and psychological health is particularly pertinent. Health care is not always first priority in comparison with the need for accommodation, employment and education.

1.2.5. Students

Given that a large proportion of the Chinese population in the UK is composed of overseas students, very little is known about their mental health and wellbeing. Consultation with some leading higher education institutions in London revealed that Chinese students were disproportionately under-represented in student mental health services. Although this was not a concern for all the institutions consulted (as Chinese students were faring well academically and no issues had presented), some expressed key challenges in meeting the specific needs of Chinese students:

- Culture shock; facilitating cultural and social integration
- Improving access to student mental health services

Anecdotally, a large number of Chinese students are purported to carry heavy burdens, with pressure to achieve academically and financial debts to repay. When difficulties arise, saving 'face' predominates and help-seeking is delayed.

1.2.6. Evaluating the Project

While the Project was available to any persons of Chinese ethnic origin living in London, the evaluation focussed on three broad groups within this heterogeneous population: first-generation settlers; new migrants and students in higher or post-18 education. It was postulated that a) the issues giving rise to mental or psychological distress; b) the pathways to the Project, and c) the type of support provided by the Project might be different for each group. For example, among first-generation settlers, inter-generational conflict might be a prevalent issue compared to social isolation among new migrants or peer pressure among students. Using realistic evaluation (Pawson & Tilley, 1997), the evaluation sought to identify and elucidate the mechanisms of access and advocacy occurring within these groups.

2. THE PROJECT

2.1. Aims and objectives

The aims of the Project were to:

3. Improve access to health care services for Chinese people with mental health needs
4. Improve the experiences of Chinese people with mental health needs using health care services

The objectives of the Project were to:

5. Enable the voice of the Chinese patient to be heard, through providing language and cultural support, and thus ensure that patients receive appropriate and responsive services
6. Build a two-way bridge between Chinese patients and mental health professionals, providing explanations of Chinese cultural background to professionals and relaying information from professionals to patients to reduce the stigma of mental illness among the community
7. Provide continuity and stability in the support received by Chinese patients that would not be available with the conventional use of interpreters.
8. Provide emotional and practical support to Chinese patients and their families, recognising that social welfare is crucial to mental well-being

2.2. The advocacy model

Traditionally, advocacy is associated with the legal system, but other forms of advocacy have developed to support and safeguard the interests of vulnerable people in a variety of settings.

The King's Fund's definition of advocacy is:

'Taking actions to help people say what they want, secure their rights, represent their interests and obtain services they need'

In health settings, this includes:

- Helping people to say what their health needs and problems are
- Helping people to obtain their rights to health care
- Representing a person's interest to any agency or individual in the healthcare system

- Ensuring people obtain the services and practical support they need to ensure they, or their dependants are as healthy as they can be

In cases where the support is provided to people who do not speak English, bilingual advocacy also includes interpreting and relaying messages about patients' cultural, religious and social context to health professionals.

In the model of advocacy adopted by this Project, the Advocate used a client-centred approach, performing duties as set out above. However, in addition to advocating on behalf of the client, this Project tested a two-way model of advocacy, in which the advocate would also represent service providers in relaying messages to clients. The cultural bridge that the advocate would provide was a vital component of the advocacy process.

Over its three-year lifespan, the Project provided one full-time Chinese mental health advocate. The Chinese ethnic background of the advocate was essential, as were language skills: the advocate was required to be fluent in English, Cantonese and Mandarin. Over the course of the Project, three advocates were consecutively employed with each one fulfilling these criteria. Two of the advocates received training in advocacy while in post and one had over 10 years experience in health and community advocacy for Chinese disabled and carers.

2.3. Project promotion

Patient advocacy and advocacy in various settings is an unfamiliar term to most members of the lay public and in the Chinese community is a relatively new concept. Thus, in advertising the Project, Chinese versions of the promotion poster and leaflet described the Project as a Chinese Mental Health Support Project.

Project promotion materials (Appendix I) were distributed to Chinese community organisations, various GP practices, mental health trusts and higher education institutions at regular intervals during the Project (Appendix II: List of organisations).

2.4. Users and access routes

The Project was available to any persons of Chinese ethnic origin in Greater London who sought help from its services. No restrictions were imposed on access as one of the major aims of the Project was to improve access to mental health services. Thus, clients could be of any age, background or immigration status, and did not have to be using mental health services or have a diagnosed mental health condition.

Clients accessed the Project by:

- Self-referral
- Referral by the community (Chinese community centres or organisations, family members, friends)

- Referral by mainstream services (GPs, mental health services, social services, voluntary organisations)

2.5. Project activities

Upon referral to the Project, clients attended an initial interview with the advocate in which the needs of the client were elicited and an agreed action plan drawn up. Signed consent for the advocate to act on behalf of the client was obtained within the first two meetings. Detailed notes were kept of all meetings and activities performed by the advocate and stored securely in accordance with data protection legislation. The advocate worked to a set of guidelines drawn up for the Project (Appendix III: Advocacy Guidelines and Professional Boundaries).

The Chinese mental health advocate carried out the following activities with and for clients:

- Attended Care Programme Approach meetings, consultations with GPs, psychiatrists, care coordinators, community psychiatric nurses, social workers, solicitors, other health professionals
- Interpreted at meetings
- Provided information to care teams and to clients
- Made GP and hospital appointments
- Made visits to clients' homes
- Made welfare applications
- Made referrals to other sources of support
- Provided support on an ad hoc basis

3. METHODOLOGY

3.1. Process evaluation

A realist evaluation (Pawson and Tilley, 1997) approach was adopted to evaluate the effectiveness of the Project. The realist approach is a holistic way of evaluating not only the outcomes of an intervention, but also the content and the contexts in which it is operating (Kazi and Spurling, 2000). In realist evaluation, models containing contexts (C), mechanisms (M) and outcomes (O) of an intervention are developed based on existing knowledge. Through data collection and analysis, these models are refined and further developed. Realist evaluations attempt to answer the question 'which intervention works best for whom under what conditions and in what types of settings?' and therefore seek to improve practice within the realities of society.

In this evaluation, CMO configurations were developed for three broad groups in the Chinese population that were considered most in need of the interventions of this Project and who were significantly large and growing sub-populations.

1. First generation settlers who had been resident in the UK for more than 5 years
2. New arrivals who had been in the UK for 5 years or less
3. Students in higher or post-18 education, full-time or part-time

The CMO configurations for each of these groups are shown in Table 3.1 together with predicted barriers and enablers in the pathway. Within and across these broad groups, the process evaluation aimed to address specific research questions that were relevant to the barriers and enablers predicted.

3.2. Research questions

1. What issue does the client want to tackle?
2. Does the advocate support the client in discussing illness with the family or community?
3. What is the kind of cultural explanation done by the advocate in meetings with the health professional?

3.3. Method

The Project evaluation comprised of two components:

3. A quantitative, descriptive component derived from the case notes kept by the advocate: number of clients; client demographics; referral routes
4. A qualitative case-study component consisting of interviews with clients, clients' relatives and care providers to address the research questions posed by the process evaluation

3.4. Sampling

In conducting the process evaluation, client interviewees were initially selected on the basis of the number of contacts they had had with the advocate. Clients who had had at least 5 meetings with the advocate, either alone or in the presence of third parties were invited to interview. Interviews were conducted in the preferred language of the client by the Evaluation Officer or a colleague in a private room at the Chinese National Healthy Living Centre. Care providers or relatives (if relevant) of these clients were also invited to interview. These interviews were conducted over the telephone and written answers to the interview questions were also provided by e-mail in some instances.

Towards the close of the interviewing period, which took place within the first 28 months of the Project, purposive sampling was used in order to generate a sample that would allow the research questions to be addressed. Cases were selected to be representative of the group categories that were defined at the start of the

evaluation. However, as there was low uptake of the Project by students, the sample contains only one student case.

Thus, eight client cases were selected and a total of 14 transcripts were analysed with the data set consisting of a mixture of interviews with clients, their family members, care providers and an advocate account. The sample is described in Table 3.2.

3.5. Data analysis

Interviews, both face-to-face and over the telephone, were recorded, translated (if relevant) and transcribed. All data (interview transcripts, e-mail responses and advocate account) were subjected to thematic template analysis (http://www.hud.ac.uk/hhs/research/template_analysis/index.htm). Data were analysed with the research questions acting as *a priori* themes to guide the initial coding. Data were coded manually by the Evaluation & Research Officer and checked by the grant manager at the King's Fund. The final template and the major themes emerging from the analysis were agreed on by both (Appendix IV: Template analysis: final template). Where relevant, provider views and user views are differentiated in the final template.

3.6. Ethical considerations

Informed consent to participation in the evaluation was obtained from 78% of clients at entry to the Project (Appendix V: Information sheet and consent form) and this could be withdrawn at any time. The information sheet and consent form were available in Chinese and explained to the client by the advocate in the appropriate language. Clients were only interviewed if they were deemed to be in a fit state according to the advocate's judgement and consented to being interviewed. Consent was obtained again immediately prior to the interview. Informed consent to participation in the evaluation was not obtained for clients who were detained under the Mental Health Act at the time of referral to the Project. In these cases, information derived from the advocate's case notes has been incorporated in the evaluation and care providers were interviewed instead. Care provider interviews and other interviews conducted over the telephone were recorded with consent.

TABLE 3.1. Conjectured CMO configurations for each group and the predicted barriers and enablers to achieving the outcomes

	Contexts	Mechanisms	Barriers/enablers	Outcomes
First generation settlers	Mainly Cantonese-speakers from Hong Kong Cultural conflict between generations Isolation among the elderly Lack of English	Need for support identified by family or the community and met by provision of an advocate with Chinese cultural background and language skills	<i>Barriers:</i> Language Stigma Recognition of problem (symptom recognition/denial) <i>Enablers:</i> Support from family or the community	Improved access to services Improved communication and understanding between clients and health professionals
New arrivals	Mainly Mandarin-speaking from China Isolation from family (in homeland) and community Culture shock Welfare issues Lack of knowledge of health and social care system Lack of English	Need for support identified by service providers and met by provision of an advocate with Chinese cultural background and language skills, and provision of practical support	<i>Barriers:</i> Language Isolation Stigma Recognition of problem (symptom recognition/denial) Confidentiality Legal status <i>Enablers:</i> Support from mental health and social services	
Overseas students	From China, Hong Kong, Malaysia, Singapore Initial isolation Culture shock Pressures to achieve (cultural and financial)	Need for support identified by student support services and met by provision of an advocate with Chinese cultural background and language skills	<i>Barriers:</i> Stigma Recognition of problem (symptom recognition/denial) Confidentiality <i>Enablers:</i> Support from student services Support from lecturers/tutors Support from friends	

Table 3.2. Process evaluation: case studies

Case no.	Date of first contact	Age group	Gender	Country of birth	Languages spoken	Need interpreter	Years in the UK	Category	Diagnosis	Referral route	Interviews conducted
3	16/01/07	0-17	F	Hong Kong	Cantonese Mandarin English (not fluent)	No but preferred	3	New arrival	None diagnosed	Referred by Chinese community centre	1. Client 2. Social worker 1 3. Social worker 2 4. Connexions Personal Adviser
4	09/02/07	25-44	M	China	Mandarin	Yes	4 to 5	New arrival (no status)	Psychotic disorder	Referred by Community Mental Health Team	1. Client 2. Cousin 3. Care coordinator
5	22/02/07	18-24	F	China	Mandarin English	No	8	Student	Post traumatic stress disorder	Referred by clinical psychologist	1. Social worker
10	10/07/07	45-64	F	China	Mandarin	Yes	7	First generation	PTSD	Referred by CNHLC counsellor	1. Client
17	30/11/07	25-44	M	China	Mandarin	Yes	1	New arrival (no status)	Psychotic disorder	Referred by Occupational Therapist	1. Advocate
18	07/12/07	45-64	F	Hong Kong	Cantonese	Yes	13	First generation	Anxiety disorder	Referred by CMHT	1. Psychiatrist
19	18/12/07	25-44	F	China	Mandarin	Yes	7 to 8	First generation	Bipolar/ personality disorder	Self-referred	1. Client 2. Social worker
32	20/10/08	45-64	F	Vietnam	Cantonese	Yes	28	First generation	Clinical depression	Referred by daughter	1. Daughter

4. RESULTS

Between the start of the Project in December 2006 and July 2009 when data were collated, a total of 40 clients accessed the Project.

4.1. Client demographics

Demographic data were collected by the advocate at first or second meetings with clients. Clients were grouped for the purposes of the evaluation according to the number of years they reported being resident in the UK. Clients resident for five years or less were arbitrarily classified as new migrants. Clients resident for more than 5 years, and born outside of the UK, were classified as first-generation settlers (Tables 4.1 and 4.2). All clients had been born outside of the UK and 57.5% (23) of the sample were first-generation settlers. There were 4 clients from whom the number of years of residency could not be obtained (cases where clients were being detained under the Mental Health Act, see section 3.6) and one client was a tourist (Not known/none). Of the first-generation settlers, there were two for whom the precise number of years of residency was not known but it was apparent that residency had been more than five years. Only 3 students accessed the Project, making any interpretation of the data difficult. The subsequent analyses therefore make comparisons between the first two groups.

Table 4.1: Years in the UK

Number of years	First generation	New arrival	Student	Not known/none	Total
0-5	-	9	2	1	12
6-10	5	-	1	0	6
11-20	5	-	0	0	5
>20	11	-	0	0	11
Not known	2	-	0	4	6
	23	9	3	5	40

Table 4.2: Category

Category	Number	Percentage
First generation settler	23	57.5
New arrival	9	22.5
Student	3	7.5
Not known/none of the above	5	12.5
Total	40	100

Clients were widely distributed across London although there is a notable lack of clients from boroughs in southwest London (Table 4.3). Westminster (25%), Camden (15%) and Lewisham (12.5%) had the largest number of clients. This may reflect the

promotion strategy (see Appendix II) and the location of the Project in Westminster. Two clients lived in bordering counties and were accepted onto the Project. People from further afield who made enquiries were posted information in Chinese and signposted to relevant local organisations.

Table 4.3: Client borough of residence

Borough	First generation	New arrival	Student	Not known/none	Total
Barking & Dagenham	1	0	0	0	1
Barnet	1	0	0	0	1
Camden	3	1	2	0	6
Croydon	1	0	0	0	1
(Essex)	1	0	0	0	1
Greenwich	1	0	0	0	1
(Hertfordshire)	1	1	0	0	2
Hillingdon	1	1	0	0	2
Islington	1	0	0	0	1
Lewisham	3	0	1	1	5
Newham	1	0	0	0	1
Southwark	0	1	0	0	1
Tower Hamlets	1	2	0	0	3
Walthamstow	0	1	0	0	1
Westminster	5	2	0	3	10
Not known	2	0	0	1	3
Total	23	9	3	5	40

Among first-generation settlers, client age at referral to the Project was distributed towards the older age groups whilst new migrants tended to belong to the younger age groups (Table 4.4). Across both groups, the number of clients in the 25-44 age group was the highest.

Table 4.4: Client age at referral

Age group	First generation	New arrival	Student	Not known/none	Total
0-17	0	1	0	0	1
18-24	0	2	3	0	5
25-44	8	3	0	2	13
45-64	7	1	0	1	9
≥65	3	1	0	0	4
Not known	5	1	0	2	8
Total	23	9	3	5	40

Across all groups, more women than men accessed the Project, with 60% of clients being female (Table 4.5).

Table 4.5: Client gender

Gender	First generation	New arrival	Student	Not known/none	Total
Male	9	4	1	2	16
Female	14	5	2	3	24
Total	23	9	3	5	40

No clients had been born in the UK. Clients' country of birth reflected the pattern of migration of Chinese people to the UK, with the majority of first-generation settlers coming from Hong Kong and the majority of new migrants coming from mainland China (Table 4.6).

Table 4.6: Client country of birth

Country of birth	First generation	New arrival	Student	Not known/none	Total
China	5	7	2	2	16
Hong Kong	14	2	1	0	17
Malaysia	3	0	0	0	3
Singapore	0	0	0	1	1
Vietnam	1	0	0	0	1
Not known	0	0	0	2	2
	23	9	3	5	40

Not all clients had legal right to remain in the UK. Immigration status varied between groups (Table 4.7). Of new migrants, four (45%) had no leave to remain in the UK.

Table 4.7: Asylum seekers and irregular migrants

Immigration status	First generation	New arrival	Student	Not known/none	Total
Asylum seeker	1	0	1	0	2
Irregular	1	4	0	0	5
Unknown	0	0	0	1	1
	2	4	1	1	8

Clients' language abilities matched their country of birth, with most first-generation settlers being able to speak Cantonese (the main language of Hong Kong; alone or in combination with other languages) and new migrants being able to speak Mandarin (the official language of the People's Republic of China) (Table 4.8). Despite the majority of first-generation settlers being in the UK for more than 10

years (Table 4.1), only 7 (30%) could speak English and this ranged from being able to have a basic conversation to fluency.

Consistent with English language ability, clients who spoke no English (67.5%) stated that they needed an interpreter, while two of the remaining clients did not need but would prefer the support of an interpreter (Table 4.9).

Table 4.8: Language combinations spoken by clients

Languages	First generation	New arrival	Student	Not known/none	Total
Cantonese only	9	1	0	2	12
Mandarin only	6	7	0	1	14
Cantonese and Mandarin	1	0	0	0	1
Cantonese and English	6	0	0	2	8
Mandarin and English	0	0	1	0	1
Cantonese and Mandarin and English	1	1	1	0	3
English and Japanese	0	0	1	0	1
Total	23	9	3	5	40

Table 4.9: Interpreter needed?

Interpreter needed?	Number	Percentage
Yes	27	67.5
No	11	27.5
No but preferred	2	5

4.2. Referral to the Project

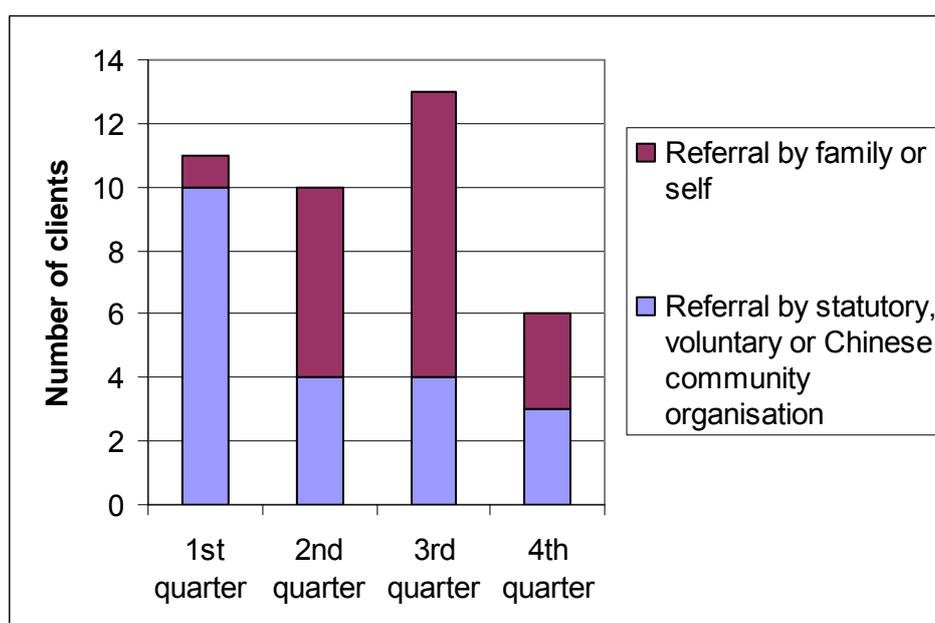
Modes of referral to the Project varied between groups (Table 4.10). Only new migrants were referred to the Project by mainstream voluntary services, while Chinese organisations played a larger role for first-generation settlers, despite English language proficiency being higher among first-generation settlers. Referral to the Project by family members or clients themselves was 57% among first-generation settlers compared to 33% among new migrants. This may reflect the level of settlement of the two groups, with differential access to resources – greater awareness of Chinese community resources among first-generation settlers and their families, and a notable lack of family resources among new migrants.

Table 4.10: Methods of access to the Project

Referred by	First generation (%)	New arrival (%)	Student (%)	Not known/none (%)	Total (%)
A statutory service	6 (26)	3 (33)	2 (67)	3 (60)	14 (35)
A mainstream voluntary service	0 (0)	2 (22)	0 (0)	0 (0)	2 (5)
A Chinese organisation	4 (17)	1 (11)	0 (0)	0 (0)	5 (12.5)
Family	7 (30)	0 (0)	1 (33)	1 (20)	9 (22.5)
Self	6 (26)	3 (33)	0 (0)	1 (20)	10 (25)
Total	23 (100)	9 (100)	3 (100)	5 (100)	40 (100)

Referral methods to the Project changed over time with referrals made by family or self increasing with time from 9% in the first eight months to 60%, 69% and 50% in the subsequent quarters, respectively (Figure 4.1). Referrals dropped in the last quarter as promotion of the Project ceased towards the end of the funding period.

Figure 4.1. Referral to the Project between December 2006 and July 2009 (32 months) by family or self compared with statutory, voluntary or Chinese organisations



4.3. Presenting problems and diagnoses

As a client-centred advocacy Project, the issues for which clients needed support from the Advocate were identified and prioritised by clients themselves. The range of needs expressed by clients is shown in Table 4.11. Some gave more than one priority. Fifteen clients did not identify any needs and these were clients who had been referred by other agencies – 30% of first-generation settlers and 44% of new migrants. First-generation settlers were more likely to have expressed needs

compared to new migrants and this is perhaps due to a larger proportion of new migrants having severe mental disorders that impacted on their ability to make informed judgements (see Table 4.11). While five clients requested referral to Chinese-speaking psychological therapies, eight actually received care from CNHLC's counselling service.

Table 4.11: Priorities expressed by clients at first meetings with the advocate

Client priorities	First generation	New arrival	Student	Not known/none	Total
None – referred by another agency	7	4	1	3	15
Referral to Chinese-speaking psychological therapy	3	1	1	0	5
Physical health problems	3	0	0	0	3
Language support	2	0	0	0	2
Welfare support	2	0	0	0	2
Resolving family issues	2	2	0	0	4
Making a complaint to statutory services	2	0	0	0	2
Housing	1	0	0	0	1
Immigration status	1	1	0	0	2
Financial difficulties	1	0	0	0	1
Practical support (welfare, housing, employment)	1	1	1	0	3
Emotional support	1	1	0	0	2
Home visits by advocate	1	0	0	0	1
Information or guidance*	2	0	0	1	3
Repatriation to country of origin	0	1	0	1	2
Gambling addiction	1	0	0	0	1
Total	30	11	3	5	49

* Sought by family members on behalf of or in relation to clients' mental health problem

Clients' diagnoses are shown in Table 4.12. Twenty six clients (65%) had formal diagnoses and one had no diagnosis but had been detained under the Mental Health

Act. The remaining 13 clients had approached or been referred to the Project with psychological or emotional difficulties, and were not in receipt of specialist mental health services. These problems ranged from financial difficulties or family issues to suicidal ideation or self-harm. Of these clients:

- 5 were referred to the CNHLC’s counselling service
- 5 received advocacy or practical support
- 2 were supported to access their GP
- 1 was referred to social services

Of those with formal diagnoses, four out of five (80%) new migrants had an unspecified psychotic disorder compared with two out of 16 (12.5%) first-generation settlers having a diagnosis of schizophrenia. A total of six clients (2 first-generation settlers, 3 new migrants, 1 other) had been detained under a section of the Mental Health Act while receiving support from the Project. Only one new migrant had a diagnosis for a common mental disorder but this was accompanied with psychotic symptoms.

Table 4.12: Client diagnoses

Diagnosis	First generation	New arrival	Student	Not known/none	Total
Major depression	5	0	0	1	6
Mixed anxiety and depression	1	0	0	0	1
Depressive disorder with psychotic symptoms	2	1	0	0	3
Panic disorder with depression	1	0	0	0	1
Obsessive compulsive disorder	1	0	0	0	1
Severe post-traumatic stress disorder with severe depressive disorder	1	0	1	0	2
Bipolar disorder	3	0	0	0	3
Schizophrenia	2	0	1	2	5
Psychosis/ Psychotic disorder not specified	0	4	0	0	4
No diagnosis	0	0	0	1	1
Not in receipt of specialist care	7	4	1	1	13
Total	23	9	3	5	40

4.4. Template analysis

Three major, linked themes emerged from the interview data: language; cultural differences; and family issues.

4.4.1. Language

Provider perspectives

English language ability varied from clients being able to speak fluently (generally among the student and younger settler groups) to speaking very little or none at all (among the new migrant group). The majority of clients (67.5%) spoke little or no English and language was a major issue in many aspects of the care journey and the advocate's role.

Interpreting

Providing interpretation in a variety of settings was a significant role of the advocate. In health care settings, such as GP consultations and in mental health services, where interpreters should be provided, they were not always available. Certain GP practices were found not to provide interpreters and in hospital or emergency settings, services encountered difficulties finding interpreters. The ability of the advocate to provide language support at short notice was valued by service providers.

Where interpreters were used in mental health services, the quality of interpreting was found to be variable by mental health professionals and this impinged on their ability to make accurate assessments of the patient's mental status.

In these situations, the input of the advocate was considered 'invaluable' in offering an opinion on the quality of different interpreters.

'we get interpreters but sometimes we just know that they're really, really awful and sometimes we get interpreters and they seem quite good but we can't tell because until we get somebody independent to say to us "well actually that one was quite good", because the client's opinion is quite subjective so we can't always take their word for it, but having [the advocate] there who [is] in the position to say... that's been absolutely invaluable, then it's given us an idea who to ask for on a regular basis'

Social worker (19)

In all other settings, including liaison with social services, housing departments and legal services, the language support provided by the advocate was essential, as interpreters were not available.

Isolation

The lack of English of most of the clients precluded them from many sources of support, including opportunities to make friends and using services such as day centres, support groups and 'talking' therapies.

Lack of friends was more common among newer migrants who tended to be from China and to be suffering from severe illness. Social isolation was an issue that service providers found difficult to tackle.

Advocate vs interpreter

In addition to the language support provided by the advocate, service providers appreciated the benefits that an independent advocate could bring to patients.

The independence of the advocate from mental health services meant that support could be provided to the client that was not within the direct remit of mental health service providers, or beyond their capacity with the resources available, for example in supporting physical health.

'sometimes we're so completely consumed with dealing with her mental health issues that it's quite easy to let go of the other things that are not mental health-related, like the fact that she needs to go to see her GP, the fact that she has got physical health problems, the fact that she needs to be busy during the day, those kinds of things that we can lose sight of 'cos we're so busy trying to contain a crisis, so that's useful. And I know that [the advocate] has been able to go to the GP with her a number of times and that's been invaluable from our point of view'

Social worker (19)

The continuity of support provided by the advocate was also valued.

'[The advocate's] work is very useful, especially from a social worker's perspective – we are normally there for the short term – [the advocate] will be able to provide longer term support'

Social worker 1 (03)

Service providers felt that the working relationship with the advocate was one of partnership and joint-working. The advocate was able to provide support during the professional absence of the care provider.

'I'm the person who knows [the patient] the best at this Centre I wasn't expecting that if I said to someone at your Centre that if she has a pressing issue "Do you think you could keep an eye on it while I'm away" ...obviously not taking over our role, we wouldn't expect people to do that ... but the fact that they were able to say "Yes, I'll give her a call once a week if there's anything pressing that she needs done" ... When I came back [the advocate] had obviously picked up that [the patient's] mental health was not 100% and contacted my colleagues here to see what they could do in my absence and so it really felt like there's some real, proper joint working going on and sort of managing the client together.'

Social worker (19)

Engaging with patients was an area that service providers felt the advocate contributed to significantly, where language and cultural identity of the advocate were crucial factors.

'Initially we found it difficult to engage with [the patient] – he hardly speaks English, hardly, so the only way of contacting or engaging with him was for someone to speak his language. Mainly the language is a problem, the second thing is the very day that [the advocate] came he himself likes to talk, to work with [the advocate] – it could be the language or the cultural difference: "she is a woman from my country, I am happy, let me talk to her"'

Care Coordinator (04)

The advocate helped mental health workers to engage with patients in different ways.

'[The advocate] acted as a link person when [the client] decided that she would not engage with our service... I felt [the advocate's] encouragement to [the client]... made it easier for her to acknowledge that professionals were not acting against her best interest. [The advocate's] involvement at one stage enabled home visits to take place as [the client] seemed 'safer' with her being there and would entertain others only if [the advocate] were present.'

Social worker (05)

The advocate, in contrast with an interpreter, provided independent and directive guidance for the client, where the tone of voice used was important in conveying messages to the client. The advocate's input facilitated improvement in the client's understanding of the situation and compliance, and in managing the expectations of the client.

'when [the advocates] hear that whatever it is I'm saying to [the patient] she's not hearing me, it's really reiterating and also because it's not coming from me, 'cos I think she perceives that I have so much more power than I have, so her expectations sometimes can be quite off the wall, so just having somebody else explain to her in her language directly... I can hear the difference in tone between the interpreter and the advocate, except for the really good interpreter we have who if I say something in a firm tone I can hear her tone get firm too, so from that point of view somebody who's not impassionately explaining what I'm saying, I find that really invaluable because so much gets lost in interpretation'

Social worker (19)

Basic language support provided by the advocate also facilitated patient compliance.

'Interpreters aren't there to read appointment letters – [the advocate] was able to let [the patient] know when the next appointment was – so this increased compliance.'

Psychiatrist (18)

User perspectives

While the service providers valued the wider role of the advocate, clients were focussed on the practical support provided, especially in terms of language support.

'[The advocate] helps with the interpretation only. I think as long as she is there to interpret for me, I am very happy and grateful'

Client (19)

However, as the advocate's relationship with the client developed, it was clear that clients developed an emotional dependence on the advocate.

'[The advocate] did help me after I was admitted to the hospital. But she was not there when the police came to knock at my door. I refused to open the door! I was not informed or warned beforehand and [the advocate] was not there to advise me.'

Client (19)

'I was very nervous at the time because it was a new environment again and strangers who I didn't know, I was very nervous but [the advocate] reassured me. My memory is very bad; lots of questions [the advocate] could answer for me... I felt very safe. Having [the advocate] there makes me less nervous... if not my heart would beat very fast, I would be very nervous, and when I get home I get very ill'

Client (10)

The ethnic identity of the advocate was also important for some clients

'My English isn't very fluent, so I am shy talking in English, so I rely on [the advocate] to talk on my behalf. I will talk more about my own things to Chinese people so with [the advocate] I could talk about myself'

Client (03)

4.4.2. Cultural differences

Provider perspectives

For service providers, there was a 'struggle' to differentiate behaviour that might be attributable to culture or to mental illness. This was made more difficult by the language difference and the use of interpreters. The quality of the interpreting was paramount to successful assessment of the patient. The advocate's role was in providing cultural information and relevant past history of the client.

'there are times when there are things that come up that we wonder are they cultural things that are arising or is this because of her mental health, is what she's actually saying factually correct? So there are times when because it's an interpreted interview you can't really gauge her emotion, there's one particular interpreter we use very regularly, she's fantastic, with her

I do take the risk and say “Does she to you seem to be speaking faster than she normally does or does she seem to be following what we’re talking about or does her concentration seem to be good?” so those sorts of mental health-related issues where we’re not sure whether what she’s saying is coming from a cultural perspective or whether it’s a function of her mental health.

...having somebody [the advocate] whose mental health is completely intact whose saying actually in China that’s quite normal... and it’s been kind of in [the patient’s] absence filling in the gaps in terms of actually this is the context of her growing up, within the context of her life experience in China, so that’s been useful.’

Social worker (19)

In one instance, the input of the advocate resulted in a change in diagnosis for the patient.

‘Before [the advocate] came in, [the patient] was diagnosed with schizophrenia. But after spending time talking with [the patient] and [the advocate], we realised it wasn’t schizophrenia – it was more an anxiety type disorder – so there was a major difference in diagnosis... [The patient] described seeing people in front of her at night time – this was misinterpreted when we used interpreters – we realised it was a manifestation of her illness.’

Psychiatrist (18)

The advocate provided support in understanding cultural beliefs and family structures and values.

‘since coming over here it’s different because [the client’s father has] actually learnt how to show his emotions to the children and [the advocate] was able to tell me that it’s not always gonna be as easy as that, ‘cos sometimes the fathers don’t always know how to do this and it’s not expected of them, and even when they were in Hong Kong, and resolving family conflict and how it’s resolved back in Hong Kong, that it was always left to the female to do or the elders, so in that sense it did help me in terms of when I’m working with the family, to understand their culture a bit more, and adapt the kind of work I was doing with them to meet their needs.’

Social worker 2 (03)

There was also a role in tackling adjustment issues.

‘I don’t know if this is a cultural thing – [the client] feels isolated and finds London very unfriendly and feels that she may be picked on because she is Chinese. [The advocate] and I have had to explain that London is a big city and can be unfriendly. There could be instances of racism, but [the client] is finding it difficult to adjust because she sticks to the Chinese community.’

Connexions Personal Adviser (03)

The use of Chinese medicine by patients was an issue that caused conflict.

'There are times when we can be at odds with the psychiatrist as well – she uses a lot of Chinese medicine – we did used to have a psychiatrist who absolutely doesn't believe in it.'

Social worker (19)

'At one point [the patient] was taking three different herbal remedies but they all contained the same ingredient. [The advocate] was able to convince her to take only one.'

Psychiatrist (18)

User perspectives

Cultural differences were not a pertinent issue for clients. As mentioned previously, practical aspects of daily living and language support were the primary concerns of the clients. However, there was a role for the advocate in explaining the structure of and systems within the English health and social care services.

4.4.3. Family issues

New arrivals and students

The absence of family was common for new arrivals and students, who also tended to be Mandarin-speaking and have diagnoses of severe illness. Family were either not living in the UK or dispersed in other parts of the country.

Isolation and lack of support was a common feature of the problems experienced by this group. Stigma and language barriers were factors in contributing to the isolation.

'Since I moved, he doesn't have anybody else in England, no family, very few friends, with that kind of illness people are afraid to know him, afraid to get close to him, so he has few friends. I am his closest relative in England – with me being [in Leeds] I don't know what's happening to him.'

Cousin (04)

Provider perspectives

There was expectation that the advocate would provide a befriending role to tackle the isolation and as part of the strategy to engage the patient.

'I think if apart from seeing me weekly if it was possible for [the patient] and [the advocate] to be seeing each other ...if he's having a regular person talking to him, engaging him, speaking his language, that would be more beneficial to him than looking for interpreter with different people [each time]'

Care Coordinator (04)

The input of the advocate was also very practical in areas such as housing and immigration.

'when [the client] was referred to me, [the hospital] wanted me to find out exactly what happened and [the client's] legal status, although they did ask me what they should do with him.

For [this client], he also needed someone consistent and could speak the language to help with the communication between the ward and himself. On many occasions, [the client] rang me at the office and asked me to pass on messages to the ward staff.'

Advocate (17)

The advocate was a useful link between professionals and the client's family – in relaying relevant information from family to service providers and providing reassurance to family by keeping them informed of the client's situation.

'[The advocate] has had cultural input in working with [the patient] and also connecting us with his family. I gave the [cousin the advocate's] number so he spoke to [the advocate] – a lot of things we didn't know like he hasn't got any family in China, when he said he wanted to go to China the [cousin] told [the advocate] we should not allow him to go to China because his parents live in Moscow, and number two, giving the assurance to his [cousin] that we are trying our best or that [the patient] is doing well'

Care Coordinator (04)

User perspectives

Among this group of clients, language support and practical difficulties were the main issues, although the continuity provided by the advocate was later valued. The family valued the support provided by the advocate in their absence and the advocate also helped in explaining illness to the family.

First generation settlers

For first generation settlers, the family situation was often a causative or compounding factor in the mental illness. Support from the Project was often accessed by family members (normally children of first generation parents) who felt that a culturally sympathetic service would be beneficial to the patient. The following case study is representative of other family cases that accessed the Project in the later stages that are not recorded here.

'My mum has counselling to deal with family issues and coping with recent development. She has been extremely stressed and has grown depressed from the pressure of having a large family as well as being a multiple carer.'

Daughter (32)

Cultural behaviours influenced the way the families dealt with the problem and sought help.

'Last year was a crisis year at home as my mum was dealing with my sister's suicide attempt and depression, my grandmother lived with us and was bed-bound and doubly incontinent and another sister has learning disability and is completely dependent on my mum as well. My mum is very obedient and didn't complain much about not getting more help from my aunts to care for their mum.'

'As a family we have all opened up more and started to talk about things that we struggled with. This didn't happen before the incident, as we were a typical Chinese family who didn't talk or deal with emotions.'

There were communication difficulties between older and younger generations.

'My Cantonese is very basic so even when I speak to my mum about things there is a lot lost when I don't understand fully what she means and I don't know the words to communicate to her in Chinese. I think the language thing is quite a major issue in terms of communicating between the younger and older generation.'

The services of the Project were sought on behalf of parents to 'empower' them to gain more control and speak directly. The cultural identity of the advocate was also an important factor in the decision to seek help from the Project.

'I approached your services because I wondered if it would empower my mum to be able to speak in her own language to professions in the mental health field. Then she would be more in control and also speaking directly instead of through a translator may also help. I think also that a Chinese person would understand more about the cultural pressures and circumstances.'

5. DISCUSSION

Did the Project meet its intended outcomes?

Overall, the Project was highly successful in providing effective, culturally-sensitive support to its users. In the light of the findings presented here, the term 'user' refers to both the statutory service providers and clients who accessed the Project. The intended outcomes of the Project were:

1. Improved communication and understanding between clients and health professionals
2. Improved access to services for clients

The findings demonstrate a clear role for the Chinese mental health advocate in improving communication and understanding between health professionals and patients – not only in providing linguistic and cultural support during meetings but also in providing an independent, external link through which information could be

passed in both directions. Contrary to the conventional role of an advocate in working on behalf of a single client, the advocate on many occasions was also advocating for service providers, for example, in reinforcing their messages, often against the wishes of the client, but clearly acting in the best interests of the client.

The Project also achieved the second outcome of improving access to services. Through the provision of an advocate of the same cultural and linguistic background, the Project hoped to break down any barriers to mainstream services that might be perceived by the Chinese community. Indicators for this might be:

- an increase in self-referral rates and referrals by family members as a measure of change in the perceptions of Chinese community members
- number of referrals made to other services by the advocate

In the first eight months of the Project, only 9% of referrals were made by family or clients themselves (Figure 4.1). This increased to 60% and 69% in the second and third quarters of the Project, perhaps suggesting that members of the community were more willing to seek help, although the increase might also be attributed to increased awareness of the Project.

Family or self-referrals were mainly associated with less severe illness and emotional problems. In these cases, the advocate accompanied clients to GPs and made referrals to mental health services and the CNHLC's Chinese-speaking counselling service¹. A referral to social services over child protection issues was made in one case.

All referrals made to the Project by statutory services were for clients with severe diagnoses. In these cases, the advocate improved patient compliance and engagement with mental health services. Some of these patients were also referred to the CNHLC's counselling service.

For service providers, language support was also highly valued but the advocate added an additional dimension to the role of the interpreter, providing an independent voice. Service providers often found it difficult to engage with Chinese patients and in these circumstances, the advocate was often working to support the provider. The advocate also acted as a link person, relaying client past history and cultural contexts to the provider and relevant information to the client.

Culturally-sensitive psychological therapies

¹ The CNHLC's counselling service is provided by a Cantonese-speaking systemic psychotherapist and a Mandarin-speaking trainee on placement studying for a professional doctorate in counselling psychology.

The lack of culturally-sensitive psychological therapies is widely acknowledged and there has been debate over whether this form of therapy is acceptable to Chinese people. In this Project, only five clients requested referral to a Chinese-speaking therapist, while eight in total were considered to be able to benefit from and were actually referred to the CNHLC's counselling service. Although these numbers are low, the availability of the CNHLC's service as a cultural resource is relevant given the lack of therapists with Chinese language skills in the NHS.

While it is generally believed that psychological therapies benefit patients with common mental disorders and mild psychological distress, patients with severe mental illness who were referred to the CNHLC's counselling service were also found to benefit. Issues such as isolation and loneliness that were frequently co-localised with severe illness, especially among new migrants, were the likely reasons that these therapies were found to be helpful. Indeed, National Institute for Clinical Excellence guidelines for the treatment of schizophrenia recommends a comprehensive range of interventions, including working with local black and minority ethnic voluntary groups to ensure that culturally appropriate psychological and psychosocial treatment is provided to people from diverse ethnic and cultural backgrounds (NICE clinical guideline 82, 2009).

Students

At the start of the Project, there was anecdotal evidence that Chinese students were a vulnerable group who were under-represented in student counselling services at a number of higher education institutions. Despite promoting the Project at universities and student societies, there was little response with only three students accessing the Project. The access routes were by referral from statutory services, community organisations and family and not through university student services as conjectured. The lack of uptake may suggest that there is little mental health need among the Chinese student population (despite the additional stressors caused by the need for cultural adjustment that frequently place international students at greater risk for psychological problems than home students) or that the Project failed to reach those in need, either in promotion or the type of service provided. Given the increasing cultural diversity of the student population and the large proportion of Chinese students in London, the needs of international students should be reviewed by education institutions so that culturally-appropriate services can be provided where they are needed.

Severe mental illness among new migrants

The evaluation focussed on the two main groups that accessed the Project – first-generation settlers and new migrants. The data reveals patent differences in demographics between these two groups that are consistent with the migration history of Chinese people to the UK. However, there are also interesting differences

in diagnoses between these two groups, although any interpretation of the data is tentatively made due to the small size of the sample.

- No new migrants were receiving care for common mental disorders, apart from one who also had psychotic symptoms. This may reflect inequitable access to health services, with new migrants only entering the system with severe mental illness and at crisis point, as suggested by three out of five in receipt of care having been compulsorily admitted to hospital.
- New migrants experiencing psychoses were less likely to have a specific diagnosis. This may be due to the shorter duration of time in contact with services or language and cultural differences making diagnostic assessments difficult. Differences in symptom patterns in schizophrenia between ethnic groups have also been suggested, although this area requires further research (Bhugra, 2004).

The mental health of migrants in the UK has been the subject of much research (reviewed in Bhugra, 2004). However, the smaller population size and lower illness rates have made studies of the Chinese population difficult and the bulk of studies focus on African-Caribbean and Asian groups. With current literature leaning towards social and cultural factors being significant contributors to mental illness, the lack of research on Chinese in the UK, as a comparison group, is a missed opportunity to further understanding of both causative and protective factors in the aetiology of mental illness.

What issues did clients want to tackle?

The case study evaluation revealed differences between the issues that clients in the first generation and new migrant groups faced. For new migrants, practical issues such as immigration and welfare, and language issues were the primary concerns. For first generation settlers, these were also issues but the range of issues was much broader. The differences are not clear cut and this is not surprising, as the groups were arbitrarily defined, with five years of residence set as a threshold. The differences are likely to be associated with length of residence in the UK, circumstances of the migration (with new migrants tending to have migrated under irregular circumstances), immigration status and diagnosis.

For some clients, the benefits of having an advocate were not initially recognised, and they appreciated only the language support provided. The continuity provided by the advocate became valued as the advocate-client relationship progressed and in some cases clients also developed emotional dependence on the advocate. Although the provision of emotional support, within professional boundaries, was one of the objectives of the Project, the dependence of the client on the advocate might be an area of concern, given the vulnerability of this client group, and the potential

for staff turnover. However, three advocates were employed on the Project with no significant difficulties for clients in the transitions.

In the original CMO configurations, isolation from family was a characteristic of the new migrant group and this was borne out in the Project findings. Social isolation and lack of support from friends and family was a significant issue among new migrants. The advocate's input was crucial in enabling engagement with mental health services and supporting the basic health and welfare needs of this group. However, the broader support needs of this group were not met.

Issues of changing demography

The changing demographic landscape of the Chinese population in London and the rest of the UK has not been matched in provision of Chinese community resources. The support needs of Mandarin-speaking new migrants are not met by the Chinese community centres or organisations that are largely run by Cantonese-speaking Chinese people and used by older generation migrants. The result is a sense of marginalisation among this group, not just by mainstream society but also by the established Chinese community that is primarily Cantonese-speaking. There is a distinct lack of community and voluntary resources to tackle the social and cultural isolation of this group, especially when problems such as mental ill health arise.

Did the advocate support the client in discussing illness with the family or community?

In posing this question, assumptions were made about the stigma of mental illness and its impact on the client's relationship with family members and friends within the context of strong family identity and values.

It has been suggested that the close-knit family structure of the Chinese community offers protection against mental ill health. While the findings of this Project neither support nor refute this hypothesis, they show that the family situation and cultural influences sometimes contribute to mental illness. In these cases, the cultural identity of the advocate was an important asset in the mediatory role of the advocate, both between client and family, and between health professionals and family.

Stigma associated with mental illness was not captured in the evaluation, although this may be because those affected by stigma would not have approached the Project for this very reason. Clients who approached the Project themselves or who were referred by family were more likely to be suffering from common mental disorders or psychological distress which carry less stigma than severe mental disorders. Those with severe mental disorders were more likely to be socially isolated, placing emphasis on practical issues. There was also little evidence of a high prevalence of somatisation. Clients who self-referred or were referred by family

expressed their difficulties in psychological or emotional terms. Of clients who had clinical diagnoses, the majority accepted their diagnosis.

What is the kind of cultural explanation done by the advocate in meetings with health professionals?

Cultural explanations for client behaviour or reasoning were generally provided to health professionals outside of meetings with clients, with clients' consent. The type of culture-related information that the advocate provided included:

- client history and its cultural context
- client beliefs around medication and the use of Chinese medicine
- Chinese family structures and values

However, the cultural input of the advocate during meetings was less obvious. The advocate felt that the process of interpretation itself often went beyond the linguistic and carried cultural nuances that were difficult to capture.

For clients, there was not an explicit need for cultural explanation but the cultural identity of the advocate was a crucial factor in enabling them to access the Project.

Based on the findings, the conjectured CMO configurations proposed at the start of the Project have been revised and show the mechanisms and outcomes of the advocacy process for each client group (Table 5.1). CMO configurations for health and social care professionals have also been created based on the findings (Table 5.2).

TABLE 5.1. Refined CMO configurations for each group and the barriers and enablers to achieving the outcomes

	Contexts	Mechanisms	Barriers/enablers	Outcomes
First generation settlers	<p>Mainly Cantonese-speakers from Hong Kong</p> <p>Cultural conflict between generations</p> <p>Isolation among the elderly</p> <p>Lack of English</p> <p>Family issues</p>	<p>Self- and family referral</p> <p>Cultural identity and language skills of advocate</p> <p>Cultural explanation for professionals and language support</p>	<p><i>Barriers:</i></p> <p>Language</p> <p>Recognition of problem (symptom recognition/denial)</p> <p>Family issues</p> <p><i>Enablers:</i></p> <p>Support from family or the community</p>	<p>Improved access to services</p> <p>Improved communication and understanding between clients and health professionals</p>
New arrivals	<p>Mainly Mandarin-speaking from China</p> <p>Isolation from family (in homeland) and community</p> <p>Culture shock</p> <p>Welfare issues</p> <p>Lack of knowledge of health and social care system</p> <p>Lack of English</p>	<p>Service provider referral</p> <p>Language skills and practical support for the client</p> <p>Language and advocacy skills to engage clients</p>	<p><i>Barriers:</i></p> <p>Language</p> <p>Isolation</p> <p>Confidentiality</p> <p>Legal status</p> <p><i>Enablers:</i></p> <p>Support from mental health and social services</p>	<p>Improved compliance and better engagement with services</p> <p>Improved communication and understanding between clients and health professionals</p>
Overseas students	<p>From China, Hong Kong, Malaysia, Singapore</p> <p>Initial isolation</p> <p>Culture shock</p> <p>Pressures to achieve (cultural and financial)</p>	<p>Self-, family and service provider referral</p> <p>Cultural identity and emotional support</p> <p>Cultural explanation for professionals and language support</p>	<p><i>Barriers:</i></p> <p>Stigma</p> <p>Recognition of problem (symptom recognition/denial)</p> <p>Confidentiality</p> <p><i>Enablers:</i></p> <p>Support from mental health and social services</p>	<p>Improved communication and understanding between clients and health professionals</p>

TABLE 5.2. CMO configurations for health and social care professionals: advocacy mechanisms

Context	Mechanism	Outcomes
Mental and physical health professionals e.g. psychiatrists, GPs, CPNs, social workers	Cultural explanation Improved quality of interpretation Continuity Befriending	Greater understanding of user Greater confidence in their impact on user
Social care services e.g. social workers, housing officers Other e.g. benefits agencies, legal services	Interpretation Continuity Befriending	Greater understanding of user Greater confidence in ability to improve the user's situation

6. KEY FINDINGS AND RECOMMENDATIONS

1. The provision of a community-based advocacy service is essential to meeting the mental health needs of the Chinese community in London. The community advocacy model used in this Project was successful in:

- improving access to health and social care services among settled Chinese residents
- improving engagement with mental health services for patients with severe mental illness, especially among new migrants
- improving communication and understanding between health professionals and clients across all client groups and in all settings, including general practice, community mental health services and inpatient units
- improving communication and understanding between other services, such as housing and legal services, and clients across all client groups, assisting in issues that were key factors in determining health and mental health and in promoting recovery

The cultural identity and ability to communicate in the two main Chinese dialects used in the UK (Cantonese and Mandarin) were critical attributes of the advocate.

The advocacy provided in this Project was not performed under the statutory provisions of the Mental Health Act 2007 i.e. advocacy provided by Independent Mental Health Advocates (IMHAs) and Independent Mental Capacity Advocates (IMCAs). However, the findings demonstrate the importance of ethnic and cultural identity of the advocate in enabling engagement and effective communication, and the inadequacies of using interpreters in mental health assessments. Current provision of IMHAs and IMCAs is unlikely to be meeting the cultural and language needs of Chinese patients in London, especially given the dispersed nature of the population.

A pan-London Chinese mental health advocacy service should be commissioned to provide advocacy in community settings and under the statutory provisions of the Mental Health Act 2007. The community advocacy should be provided using the model piloted in this Project.

Chinese advocates with Cantonese, Mandarin and English language skills should be trained under the new national independent advocacy qualifications for IMHAs and IMCAs.

2. The CNHLC's counselling service is an important resource that provides culturally and linguistically-sensitive support to the Chinese community in London. Current statutory provision of psychological therapies does not meet the cultural or language needs of Chinese people.

Mechanisms should be put in place to make the CNHLC's counselling service available to a wider population and to make the service available to Chinese people through the NHS. This will also help to ensure viability and sustainability of the service.

3. New migrants are a particularly vulnerable group who require practical assistance to meet their basic welfare needs. Across all client groups, advocacy support in this area was highly valued by both service providers and clients. The advocate worked in partnership with social workers and community psychiatric nurses to ensure that the basic needs of clients were met. Social isolation was also prevalent across all groups but was perhaps experienced more intensely by new migrants, who were also isolated from their family and for whom there is a lack of Chinese community resources.

Better support should be provided to vulnerable groups, such as new migrants, to ensure that they receive appropriate welfare support. This should be achieved by:

- advocates working in effective partnership with care providers
- recruitment of support workers with language skills to mental health teams

A culturally and linguistically-responsive befriending and support service should be set up to tackle social isolation among Chinese people with mental illness and to assist with welfare needs. This should meet the needs of a diverse population and be provided in the two main spoken dialects: Cantonese and Mandarin.

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Appendix I: Project leaflet

The contact details you will find useful:
請與我們聯絡

Mental Health Advocate: Mandy Lau
Address: Chinese National Healthy Living Centre
29/30 Soho Square, London W1D 3QS
(Nearest tube stations: Tottenham Court
Road, Leicester Square)
Tel: (020) 7287 0904 **Fax:** (020) 7534 6546
Email: mandy.lau@cnhlc.org.uk
Website: www.cnhlc.org.uk

*Advocate is able to speak English, Cantonese and Mandarin
All information is kept confidential*

計劃統籌: 劉姑娘
地址: 全國華人保健中心
29/30 Soho Square, London W1D 3QS (最近地鐵站:
Tottenham Court Road, Leicester Square)
電話: (020) 7287 0904 傳真: (020) 7534 6546
電郵: mandy.lau@cnhlc.org.uk
網址: www.cnhlc.org.uk

此計劃提供英語、廣東話及普通話服務
所有資料絕對保密

Chinese Mental Health Advocacy Service

----- *To provide mental health support for
the Chinese Community*

華人心理保健計劃

----- 給華人社區的心理健康支持服務

全國華人保健中心
CHINESE NATIONAL
HEALTHY LIVING CENTRE

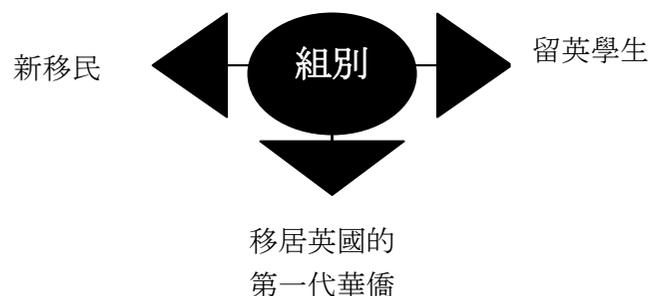
King's Fund

英皇基金資助

計劃目的

- 鼓勵華人使用英國主流心理健康的服務
- 減低華人社區對健康的誤解及觀念
- 提高華人對心理健康的理解及關注
- 改善華人身心健康

服務對象



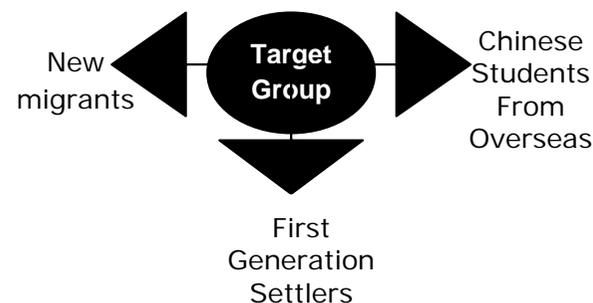
我們提供的服務範圍包括

- 代言及為用者爭取相關的權益
- 為用者向有關之專業人士表達其個人意願
- 單獨的聆聽服務及個案跟進，為用者提供貫切的支援
- 提供不同類別的中文版本心理健康資料
- 轉介及鼓勵用者使用適當相關的主流心理健康服務

The aims of the project are to

- Encourage Chinese people to use mainstream mental health services
- Reduce the stigma of mental health amongst the Chinese community
- Increase the awareness and understanding of mental health
- Improve mental health well-being

Who are our services for?



What kind of services do we provide?

- Advocacy: interpretation, on behalf of users to express their wishes
- One-to-one listening meeting and follow-up casework to provide continuous support
- Provision of mental health information (in Chinese)
- Signpost and encourage users to use appropriate mainstream mental health services

Appendix II: List of organisations sent Project information or leaflets

Chinese community organisations

- Bishop Ho Ming Wah Association
- Camden Chinese Community Centre
- Chinese Association of Tower Hamlets
- Chinese Church of London
- Chinese Community Centre
- Chinese Information and Advice Centre
- East London Chinese Community Centre
- Hackney Chinese Community Service
- Haringey Chinese Centre
- Islington Chinese Association
- North London Chinese Association

Chinese mental health organisations

- Chinese Mental Health Association
- Vietnamese Mental Health Service

Local and mainstream organisations

- Age Concern Westminster – Covent Garden Day Centre
- Age Concern Westminster – Elgin Day Care Centre
- Age Concern Westminster – Leonora Day Centre
- Age Concern Brent
- Asian Community Care Services - Brent
- St Margaret's Drop-in Centre
- Westminster Mind

Universities and Colleges

- Middlesex University, Student Union
- Goldsmith College, International Office
- Birkbeck College, School Office
- University College London, Student Union
- University of Westminster, International Office – International Student Adviser
- University of East London, International Office
- London Metropolitan University, International Office

Primary Care Trusts

- NHS Camden
- NHS Westminster

GP practices in

- Barnet
- Camden
- Kensington and Chelsea
- Southwark
- Tower Hamlets
- Westminster

Mental Health Trusts

- Barnet Enfield & Haringey Mental Health Trust
- Camden & Islington NHS Foundation Trust
- Central & North West London NHS Foundation Trust (via Focussed Implementation Site Project Manager)
- East London NHS Foundation Trust
- South West London & St George's Mental Health NHS Trust
- Speedwell Mental Health Centre (South London & Maudsley NHS Foundation Trust)
- West London Mental Health NHS Trust (had their own interpreter and advocate – were not interested in this service)

Acute Trusts

- Chelsea & Westminster Hospital NHS Foundation Trust
- Guy's & St Thomas' NHS Foundation Trust
- Homerton University Hospital NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- Tavistock & Portman NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- University College London Hospital NHS Foundation Trust

Social Services

- Barnet
- Camden
- Islington
- Westminster

Appendix III: Advocacy Guidelines and Professional Boundaries

Advocacy Guidelines & Professional Boundaries

(Source: Advocacy in Action UK course handout_2007 / Newham Advocacy Review Group 10/04/96 and incorporated by the ELAC)

Advocacy should:-

- Empower the people wanting advocacy. Act in accordance with the client's wishes and instructions.
- Provide information about the range of services available, people's rights to services and what standards services should meet.
- Support clients in making decisions and putting the decisions into practice.
- Help to make improvements in services.
- Advise and inform staff in other services about what people expect from those services.
- Challenge and respect clients' best interests.

Advocacy must:-

- Act on behalf of the client who decides what they want and help the client to put across what they want.
- Encourage clients to speak up for themselves and help them to become more confident about dealing with organisations and staff.
- Give clients the information they need to make their own choices.
- Help clients to ask for services that suit them and respond to their needs and to make complaints.
- Share cultural information with organisations and give feedback on the needs of people from different communities.
- Challenge discrimination when representing clients.
- Pick up on gaps in the services and notify the relevant organisations.
- Accompany people to meetings with organisations.
- Treat as confidential all the information they receive about clients.

Boundaries & Ethics:-

Confidentiality

The Advocate will keep information about clients private and safe and not pass it on to people other than the team unless the clients have said they can. Consent from the clients is needed at all times.

Equal Opportunity

The Advocate will treat all people fairly and equally and comply with the CNHLC equal opportunity policy.

Independence

The Advocate can do things that are important to the client and not have to please other people or groups. Advocates can help clients to access services and self advocate.

Advocates can advise authorities/services about how they can modify policies and procedures to prevent discrimination which in turn would meet the needs of clients.

Receiving gifts from clients / service users

This will comply with CNHLC Policy.

The Advocate will not ask clients for money.

Friendships / Personal relationships with clients

Personal relationships with clients are discouraged, as it could lead to the Advocate's professional role being compromised.

Personal limitations

The Advocate will be aware of his/her personal limitations and boundaries. The Advocate should be clear and honest about how they can and cannot help clients.

Time and Resources

The amount of time and resources allocated to a client should be carefully thought through and prepared. These need to match clients' needs and the standard of service being delivered.

Quality, Monitoring and Evaluation

The Advocate will have regular supervision and keep detailed case notes. The Advocacy Project will be evaluated.

Safety

Advocates should not put themselves or others at risk in any situation.

Complaints, Policies and Procedures

This will comply with CNHLC Policies and Procedures.

Appendix IV: Template analysis: final template

<p>1. What issue does client want to tackle?</p>	<p>1. Language difficulties (lack of English)</p> <p>2. Physical health problems</p> <p>3. Immigration status</p> <p>4. Practical issues</p> <p>5. Emotional support</p> <p>6. Disagreements with medical intervention</p> <p>7. Parenting issues</p> <p>8. Would like more friends</p> <p>9. Recovery</p> <p>10. Empowerment (for a family member)</p>	<p>1. Communication with professionals</p> <p>2. Inconsistency in provision of/lack of provision of interpreters</p> <p>3. Advocate as interpreter</p> <p>1. Communication with professionals (GP)</p> <p>2. Inconsistency in provision of/lack of provision of interpreters</p> <p>3. Advocate as interpreter</p> <p>1. Communication</p> <p>1. Benefit applications</p> <p>2. Housing</p> <p>3. Employment</p> <p>1. With diagnosis</p> <p>2. Stopping taking medication</p> <p>1. Lack of self-confidence</p> <p>1. More control</p> <p>2. 'Speaking directly'</p>	<p>a. with hospital doctors</p> <p>b. with GPs</p> <p>c. written communications</p>
<p>2. Does advocate support client in discussing illness with community or family?</p>	<p>1. Lack of family</p> <p>2. Lack of friends</p> <p>3. Communication between care team and family via advocate</p>	<p>1. Isolation</p> <p>2. Lack of support</p> <p>3. Family dispersed</p> <p>1. Feeling of being stigmatised by others</p> <p>1. Lack of English of family</p> <p>2. Lack of English of friends</p>	

	4. Addressing family issues	3. Addressing family issues 1. Advocate as intermediary between client and family 2. Advocate as intermediary between family and health professionals (HPs)	a. explaining illness
3. Family issues	1. Cultural issues 2. Difficulty recognising mental health problems 3. Family situation contributing to mental illness 4. Children seeking help for first generation parents	1. 'Typical Chinese family' 2. Chinese counselling service 3. Pressures 4. Priorities 5. Generational differences 6. Parenting 1. Denial 1. Language difficulties 2. Lack of awareness of availability of services	a. not talking about or dealing with emotions b. not asking for help from relatives a. cost issue a. large family b. caring responsibilities a. delaying help-seeking a. communication difficulties (language)
4. What is the specific role of the advocate?	1. Cultural explanation for both health professionals and clients 2. Role as interpreter	1. Difficulty distinguishing cultural behaviour from mental health 2. Use of Chinese medicine 3. Helping with diagnosis 4. Explaining the health/welfare system to clients 5. Explaining Chinese culture/beliefs to HPs 1. In mental health settings: in emergency situations or when interpreters not available 2. In GP consultations	a. family mores

		<p>5. Partnership approach</p> <p>6. Flexibility</p> <p>7. Managing expectations of the client</p> <p>8. Informing HP about relevant past history</p>	<p>c. keeping client focussed on the problem</p> <p>d. improving clients understanding as to what's happening</p> <p>a. providing support during professional absence</p> <p>b. trusting relationship with family</p> <p>a. suggesting alternative explanations for behaviour</p>
5. Feelings and views of clients		<p>1. 'helplessness'</p> <p>2. Practical and emotional dependence on advocate</p> <p>3. Grateful for service</p>	<p>a. feel 'safe'</p>
6. Other	<p>1. Comparison with Vietnamese Mental Health Services</p> <p>2. Patients sectioned under the Mental Health Act</p>	<p>1. Comprehensive service provided by Vietnamese Mental Health Service</p> <p>1. Lack of involvement of advocate in sectioning process</p>	<p>a. funding issues</p>
7. Barriers to progress	<p>1. Immigration status of client</p> <p>2. Mental illness</p> <p>3. Family issues</p> <p>4. Language</p>	<p>1. Changeable state</p>	

Appendix V: Information sheet and consent form

Participant Information Sheet

CHINESE MENTAL HEALTH ADVOCACY AND SUPPORT PROJECT

You are being invited to take part in the evaluation of this project.

This project aims to help Chinese people in London with mental health problems to access the help and support they need. To help us find out if we are achieving our aims and how the process is working, we will keep detailed records of the work we do. This will include:

Some personal information about you

Any information you give to the Mental Health Advocate or other health professionals that you see when you are with the Advocate

We would also like to interview you about your experiences of the project. This interview would be conducted by our evaluator and may be recorded to make it easier for us to analyse.

All of this information will be kept confidential. It will be held in a secure place, and only shared for research purposes with the evaluator.

You will have access to all of the information that we hold about you.

If the information is published in any form it will have your name and address removed so that you cannot be recognised from it.

We will destroy all information held about you after three years.

We will give you a copy of any material that comes out of the evaluation, so you can see how you have helped us learn from and improve our service.

We hope that this evaluation will help us to provide better services in the future.

You do not have to take part in this evaluation, but your participation would be very much appreciated. Please take time to consider if you would like to take part.

If you decide not to take part, this will not affect the support you will receive from this project.

If you decide to take part, please sign the consent form attached. You will also be given a copy to keep.

Many thanks for taking the time to read this sheet.

Consent Form

CHINESE MENTAL HEALTH ADVOCACY AND SUPPORT PROJECT

1. I confirm that I have read and understand the information sheet. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. و
2. I understand that my participation is voluntary. و
3. I understand that I will be interviewed and that this may be recorded. I give my consent for any interviews I give to be recorded. و
4. I agree to take part in the evaluation. و
5. I agree to take part in the evaluation give permission for the organisation to use information I give but do not wish to be interviewed. و
6. I do not wish to be part of the evaluation. و

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of person taking consent	Date	Signature

_____	_____	_____
Evaluator	Date	Signature