

COMMUNITY ENGAGEMENT PROJECT:
The National Institute for Mental Health in England
Community Engagement Programme (2005/06)

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSING
on the exploration of the mental health needs and experiences
of the Chinese Community in Barnet

RESEARCH TEAM:

Angus Ng (Research Coordinator)
Yein Hiew (Researcher)
Shirley Lok (Researcher)

Chinese Mental Health Association

DATE: March 2007

Funded by the NIMHE
managed and supported by
The Centre for Ethnicity and Health, University of Central Lancashire



Content

Project Team	3
Acknowledgements	4
Executive Summary	5
Introduction	
● The Centre for Ethnicity and Health’s Model of community engagement	6
● Background of Chinese Mental Health Association and the Chinese Community in Barnet	11
● Aims of the Research and Delivering of Race Equality	13
Literature Review	14
Methodology	16
Results and Findings	21
Discussion	35
Recommendations	39
Reflection	41
Reference	42
Appendix	
1. Information Leaflet	44
2. Consent Form	45
3. Semi-structured Interview Schedule	46

Project Team

The following people were involved in the development and delivery of this project:

Angus, Foo Yek Ng is a Malaysian of Chinese ethnic origin. He worked as a teacher in Malaysia a few years ago. He then developed a wander lust and decided to leave Malaysia to gain some experience living and working abroad. Angus started work at CMHA as a volunteer in October 2005.

In May 2006 when CMHA received funding to conduct the Community Engagement Research Project, he was recruited as a research assistant. This project was a totally new experience for him as he became fully engaged with the research involved. He enjoyed interviewing the many participants from all types of backgrounds. He has acquired a new understanding from this research project in terms of mental health knowledge and also research skills.

Yein Hiew was born in Ipoh, Malaysia and came to the UK 4 years ago. She currently works as a freelancer for the Chinese media in London but she has strong interest in community work. Previously, she gained vital experience by working for a Chinese elderly housing support project in Scotland.

Yein was employed as the part time researcher for CMHA and this was the first time she has been involved in a community research project. Her many tasks for the project included developing questionnaires, translating documents, preparing press releases and conducting interviews. This project was very meaningful for her as it allowed her to develop an in depth understanding of the mental health issues confronted by the Chinese community in London.

Yuk Ying Shirley Lok was born in Hong Kong and received British citizenship 13 years ago. She is a middle age mother of two children and has been a full time mother for the past two years. Since May 2006, she has been a Chinese Mental Health Association (CMHA) volunteer and therefore has had the opportunity to fully engage this community based research project.

She has been delighted to be a team member on this research project. It has enabled her to develop her thinking, interviewing, data collection as well as translating skills further. Moreover, she found herself becoming more patience when listening to other people especially after she carried out several interviews with mental health users and their carers. Her roles in this project included interviewing and translating data from Chinese to English.

Acknowledgements

We would like to take this opportunity to thank all the research participants for their time and effort given to this study. A special thanks to NIMHE who provided funding and the opportunity to the Chinese community to partake in this meaningful research project particularly because this is the first Chinese Community Engagement Research Project ever carried out in London. It has been a great opportunity for us to engage the Chinese community, explore their needs and experiences in terms of mental health issues.

Many thanks to UCLan who provided full support for the CMHA research team. The workshops provided by the university were extremely helpful and all the researchers in the group gained so much in terms of mental health knowledge and research skills.

We would like to extend our thanks to Mr. Imran Aziz Mirza, who has been very supportive and met up with the group on a regular basis to ensure that the research work was going on the right direction.

We would also like to thank Mr. Tony Thake, Director of Diversity Barnet, Enfield & Haringey Mental Health Trust in supporting our grant application for this project.

We also feel grateful to our steering group members, Ms. Cecilia Taylor – Manager of Advice and Information Centre of the Edgware Community Hospital, Mr. Igo Tojcic - Joint commissioning manager in Barnet Social Services, and Mr. Dipen Rajyagury - Diversity & equality specialist in Barnet PCT, for their guidance and support throughout the project.

Executive Summary

In 2006, Chinese Mental Health Association (CMHA) received funding from the National Institute for Mental Health in England to conduct a Community Engagement Research Project in Barnet. The project, guided by the Centre for Ethnicity and Health at the University of Central Lancashire who developed the model of community engagement, has given CMHA their full support and guidance throughout the research study.

This was a great opportunity for CMHA to engage the Chinese community in Barnet where there is the largest Chinese population in comparison with any other areas in the country. This research project aimed to explore the service users and carers' experience in the mental health service system and their mental health needs.

Delivering Race Equality in Mental Health Care (DRE) is an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and minority ethnic (BME) status. The vision for DRE is that by 2010 there will be a service characterised by 12 areas (DoH, 2005). The aims of our research project are to address the action plan which will contribute to the delivery of race equality for the Chinese community in Barnet.

Results and findings of the research study show that language barrier still exists to be a major problem for Chinese service users to access health services in primary and mental health care in Barnet. Interpreting service did not seem to be solving the language difficulty in using primary and mental health services. This unmet need has led to frustration, stress, disappointment and feeling of being treated unfairly among the service users and carers.

To improve the current situation, recommendations were made to increase mental health awareness in the community, increase the provision of information resource in Chinese language and enhance cultural training for the health professionals. Traditional Chinese Medicine and acupuncture is highly recommended as alternative treatments in the mainstream services. Furthermore it is suggested that culturally appropriate mental health services provided by the Chinese community organisation is ideal for the support of the users and carers.

Introduction

The Centre for Ethnicity and Health's Model of community engagement

Background to the community engagement model

We often hear the following words or phrases:

- Community consultation
- Community representation
- Community involvement/participation
- Community empowerment
- Community development
- Community engagement

Sometimes these terms are used inter-changeably; sometimes one term is used by different people to mean different things. The Centre for Ethnicity and Health has a very specific notion of community engagement. The Centre's model of community engagement evolved over several years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health (DH) awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire (UCLan) to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The DH had two key things in mind when it commissioned the work; first, the DH wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done.

If all the DH had wanted was a needs assessment and a 'glossy report', they could have commissioned researchers and produced yet another set of reports that may have had little long term impact. However this scheme was to be different. The DH was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; however they would have proven access to the communities they were working with, the potential to be supported and trained, and the infrastructure to conduct such a piece of work. They would be able to use the nine-month process to learn about drug related issues, and how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity and Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams (DATs). It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas of work. These include:

- Substance misuse
- Criminal justice system
- Policing
- Sexual health
- Mental health
- Regeneration
- Higher education
- Asylum seekers and refugees

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people
- People with disabilities
- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual and trans-gender people
- Women
- White deprived communities
- Rural communities

In addition to the DH, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, the National Institute for Mental Health in England, the Greater London Authority, New Scotland Yard and Aimhigher.

The key ingredients of the model

According to the Centre for Ethnicity and Health model, a community engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a host community organisation. This may be an existing community group, but it might also be necessary to set up a group for this specific purpose of conducting the community engagement research.

The key thing is that this host community organisation should have good links to the defined target community¹, such that it is able to recruit a number of people from the

¹ The target community may be defined in a number of ways – in many of the community engagement projects it has been defined by ethnicity. We have also worked with projects where it has been defined by some other criteria, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. users of drug services or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with (e.g. victims of domestic violence, sex workers).

² This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

target community to take part in the project and to do the work (see section on task below).

It is important that the host community organisation is able to co-ordinate the work, and provides an infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day-to-day activities of the project. One of the first tasks that this host community organisation undertakes is to recruit a number of people from the target community to work on the project.

The second key ingredient is the research task that the community undertakes. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects have involved communities in undertaking a piece of research or a consultation exercise within their own communities. In some cases there has been an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme run on behalf of the DH, the process and its outcomes have equal importance. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be the first time that these individuals have undertaken a research project.

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate support and guidance. It is not expected that community groups offer their time and input for free. Typically a payment in the region of £15-20,000 will be made available to the host organisation. It is expected that the bulk of this money will be used to pay people from the target community as community researchers². A named member of staff from the community engagement team is allocated as a project support worker. This person will visit the project for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers throughout the project. The University also provides a package of training, typically in the form of a series of accredited workshops.

The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to form an appropriate steering group to support the project³.

The steering group is an essential element of the project: it helps the community researchers to identify the community they are engaging with, and can also facilitate the long term sustainability of the projects recommendations and outcomes. The community researchers undertake a needs assessment or a consultation exercise. However the steering group will ensure that the work that the group undertakes sits with local priorities and strategies; also that there is a mechanism for picking up the findings and recommendations identified by the research. The steering group can also support individuals' career development as they progress through the project

³ Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

The community engagement team

The community engagement team comprises of senior support workers, support workers, teaching and learning staff, administration team and a communications officer. They work across a range of community engagement areas of specialisation, within a tight regional framework.

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme Advisors
Senior Support Worker		Senior Support Worker	
Support Workers	Support Workers	Support Workers	Drug Interventions Programme
			Citizen Shaped Policing
Teaching And Learning Team			
Administration Team			
Communications Officer			

Programme outcomes

Each group involved in the Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community. The qualitative themes that emerge from the reports are often very powerful. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to

reach communities are formed as a direct result of community engagement projects.

In 2005/-6 the Substance Misuse Community Engagement Programme was externally evaluated. This concluded that:

- the Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.
- the Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.
- most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.

- all DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.
- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.
- The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

Since 2000, over 200-community groups have taken part in one or at least another of the Centre for Ethnicity and Health's Community Engagement Programmes.

Background of Chinese Mental Health Association and the Chinese Community in Barnet

The Chinese Mental Health Association (CMHA) was set up in 1992 and it was formed as a charity dedicated to maintaining and safeguarding the mental well-being of the Chinese community in the UK. The organization has an on going provision of direct services for the Chinese community; these include a supporting people project in Barnet, befriending, user advocacy project, a national Helpline which provides emotional support, weekly user social groups and so on. CMHA also engaged in a national mental health promotion project which aimed to raise mental health awareness and combat the stigmas with regards to mental health amongst the Chinese community between 2002 and 2005. Moreover CMHA is currently conducting a research on carers for people with dementia with the Chinese community in the UK.

CMHA has been working with the statutory units to engage the community in lobbying better mental health services. In 2003, CMHA conducted nationwide events with the Chinese communities in London, Manchester and Birmingham to explore their needs and expectations in terms of mental health services. CMHA had produced a recommendation report for one of the key documents for Delivering Race Equality in Mental Health Care (DRE) – *Delivering Race Equality, Inside Outside* published by the National Institute for Mental Health in England in March 2003.

Apart from the above community events, CMHA have been involving service users in the different forms of consultation which were organised by different statutory departments. The main purpose of user involvement is to let users have their own say in care planning and the improvement of services and policies. This is because mental health service users are experts in their own right. They are the people who can truly talk about the experience in every aspect of the illness and the health care system. Such experiences are an important resource that can help to improve health care services. Such experiences are also an important resource that can help to counter stigma and to convey an accurate image about mental health sufferers.

The Chinese Mental Health Association were interested in undertaking this community engagement research project as this was a great opportunity to engage with the Chinese community in Barnet as well as strengthen their capacity to deal with their own mental health and social needs. The London borough of Barnet is also a good location to carry out the proposed work as it is a focus implementation site for delivering race equality in terms of mental health care. Besides, this engagement research project will potentially help to positively impact on the Chinese community in Barnet as it involves statutory partnerships, training, on-going support and guidance which will greatly strengthen the building block of support networks for the Chinese community there.

According to the 2001 census, the population in Barnet is about 314,564, of which 26% of residents belong to minority ethnic groups. The largest ethnic groups are Indian / Pakistani (27,130), followed by Black African (13,651) and the Chinese (6,379) who are the third highest minority group who live in Barnet. Chinese people make up 2% of the population in Barnet but are the largest number of Chinese residents if compared to any other London borough.

The 2001 census shows that Christians are the largest religious group (over 47%), followed by Jewish (14.8%), Hindu (6.7%), Muslim (6.2%), Buddhist (1.1%) and over 12% of people regard themselves as having no religious belief.

Barnet is one of the most multicultural communities in the UK. A language survey shows 140 other languages aside from English being spoken at secondary school level in Barnet (Minority Achievement Project 1997). The survey also found that almost one third of students spoke a language other than English at home.

Aims of the Research and Delivering of Race Equality

In 2006, CMHA received funding from the National Institute for Mental Health in England to conduct a Community Engagement Research Project in Barnet. The Centre for Ethnicity and Health at the University of Central Lancashire has given full support to this particular research project. Hence, we strongly believe this community engagement project can not only bring people within the community to work closer together, but will also result in more positive health outcomes. Our research project aims to explore the Chinese service users and carers' experience in the mental health service systems and their mental health needs.

Delivering Race Equality in Mental Health Care (DRE) is an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and minority ethnic (BME) status. The vision for DRE is that by 2010 there will be a service characterised by 12 areas (DoH, 2005). The aims of our research project are to address the following points in the action plan which will contribute to the delivery of race equality for the Chinese community in Barnet.

- *“Less fear of mental health care and services among BME communities and BME service users.”*

As the Chinese community is under-represented in the uptake of mental health services in comparison to any other ethnic groups, the project would try to find out the barriers to using mental health services by the Chinese community, particularly in Barnet.

- *“A more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that is culturally appropriate and effective.”*

The research project allowed us to explore more about services and treatments the Chinese users and carers would prefer. Our research participants in Barnet suggested that Traditional Chinese Medicine was a preferable alternative treatment.

- *“A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services.”*

Chinese service users and carers who are to be involved in this project would be given the opportunity to make possible suggestions to the health authority for future service development. The process of engaging service users in voicing out their needs is empowering to the Chinese community which is often viewed as an ‘invisible group’.

Literature review

Chinese Mental Health Issues in Britain

It is well documented that large numbers of the Chinese work in the catering sector. The figures from the 1980s show that more than three quarters of the Chinese community living in Britain were involved in catering industry and working involves hard work, long hours and low pay (www.bbc.co.uk).

Chinese people involved in the catering business, working in such long working hours and stressful working environment could be a vulnerable factor to one's mental well-being, even when people are willing to seek medical attention because of their mental health issues, it may not be possible for them to see a GP as the surgery would not open until mid night. A research study conducted by Watt, Howel, & Lo (1993) to explore the health care experience of a group of Chinese participants in Hull, it was found that many of them were unable to fit into the GP surgery opening hours as their working hours were too long.

When it came to mental health awareness and knowledge, the Chinese community in general was not aware of the mental health services available, whether statutory or non statutory services. A study by Li, Logan, Yee, & Ng (1999) suggested that whereby 24% of their participants were not aware of the statutory services such as GPs, psychiatrists, day centres, community psychiatric nurses, and social workers, nearly half of them were not aware of the voluntary mental health services.

As the studies mentioned above were conducted over 10 years ago, it would be useful to review the current situation the Chinese community is facing. This community engagement research project aims to explore the carers and service users' needs in relation to mental health and to share their experiences in accessing the service system. The research would also find out how the Chinese service users make sense of race equality with regards to access, outcomes and experiences of mental health services in Barnet.

Cultural Characteristics of the Chinese community in the UK

The Chinese communities in Britain are diverse in terms of historical, political and cultural backgrounds, although a majority came from the same Chinese culture, they may speak a variety of dialects. After the 'Opium Wars' which occurred in the mid-19th Century, many Chinese, especially those in Canton and Fujian provinces in southern China started to migrate to other South East Asian counties such as Indonesia, Malaysia, and Singapore (Poston, Mao, & Yu, 1994; Zhu, 1991). After a few generations of settlement in the latter countries, the now overseas Chinese who came from these countries adapted to their new environments and now have a very different way of living if compared to those from Hong Kong, Taiwan or mainland China.

One example of this as Walker & Bodycott (1997) suggest, is the economies have achieved prosperity through varying routes. Diverse social, political, economic, and

cultural structures have formed that serve to differentiate outwardly similar countries and influence their organizational environments and those who work in them. That is, institutions of each nation have developed their own shape, and culture and these, at different levels and emphasis, are worthy of reflection.

However, all Chinese communities do share a common ethno-cultural heritage and code of conduct based on Confucianism which reflected a hierarchical social system. In fact, there is a tendency among many Western academics to view Southeast and East Asian countries as an undifferentiated "Confucian" group (Walker & Bodycott, 1997).

Such social system required respect for people of a higher order, such as the younger generations should respect their elders, wives should respect their husbands, students should respect their teachers, and all citizens should respect authority. For thousands of years, this social hierarchical system has been practiced and handed down from generations to generations in China. It has a vast impact on the social, cultural and political life of all Chinese societies regardless of where these societies are based (<http://en.wikipedia.org/wiki/Confucianism>).

Based on the influence of Confucianism, Chinese people are culturally reverential to the authority. Many are reluctant to express their emotions openly in order to maintain the 'status quo' in terms of social and harmony, or to avoid exposure of personal weakness (Mental Health: Culture, Race and Ethnicity, 2001).

Language Barriers faced by the Chinese Community

Research studies, especially in-depth study looking at the mental health needs of the Chinese community are very limited in the UK. However, when it came to the major barrier to accessing mental health services for the Chinese, almost all the research findings in the last ten years have echoed this problem.

The language barrier is the main issue which the Chinese community have been struggling with in the UK especially amongst the first generation. Although the Chinese community has been in the UK for so long, they still face many issues such as language and cultural barriers. Watt, Howel, & Lo (1993) suggested that the main reason the Chinese in Hull did not use health services appropriately was because of language or communication difficulties. Another study by Li & Logan (1999) suggested half of their participants encountered difficulties when they sought professional help.

Methodology

Recruitment of bilingual researchers

We started to recruit volunteer researchers at the end of May 2006 through the CMHA website, job advertisements in Chinese newspapers and other UK based Chinese media. The candidates were required to be of Chinese ethnic background and able to speak and write in both Chinese and English. The ability to speak in Cantonese and Mandarin was preferred because these dialects are most commonly used in the community. A group of four researchers who responded to the appeal of our advertising campaign were recruited. They were most interested in the opportunity of learning more about doing mental health research and they were keen to work with the Chinese community.

Support for the research team

The University of Central Lancashire provided a series of five workshops to enhance the researchers' skills and knowledge in doing research. Two workshops were to discuss mental health issues and the other three were about research methods and skills. The workshops would also lead on to a University Certificate in Community Based Research and Mental Health upon completion of two assignments which covered both areas. Three researchers had successfully completed their qualifications after finishing the courses. Apart from the training workshops, a support worker from the University of Central Lancashire was meeting up with the group on a fortnightly basis to discuss the progress of the research and the assignments with the researchers. He also offered one to one sessions to individual researchers as and when necessary.

By the end of July 2006, a stakeholder steering group was set up to meet up once every two months whereby the researchers reported their progress and issues surrounding the project of the research project. The role of the steering group was to give advice and support to the research team. Members of the steering group included Cecilia Taylor, Advice and Information Centre manager in Edgware Community Hospital, Igo Tojcic, Joint Commissioning Manager in Barnet Social Services, Dipen Rajyagury, Diversity & Equality Specialist in Barnet PCT, the support worker from UCLan and the researchers from CMHA.

Research Design

We used semi-structured interviews and a focus group to allow participants to state and describe the details of their mental health needs and experiences when accessing health care services. The semi-structured interview consisted of seven parts encompassing:

1. Participants' demographic information;
2. Participants' mental health awareness;
3. Participants' opinions on the accessibility of health services;
4. Participants' experiences in hospital admission;
5. Participants' awareness of health service in Barnet;
6. Participant's awareness of health information resources in Barnet;
7. Participants' needs and expectations of mental health services.

The focus group was structured for participants to discuss the following four areas:

1. How did participants view race equality in relation to mental health services for the Chinese users?
2. How did participants feel they had been treated as a service user when accessing mental health services?
3. What would they like to see for any changes or improvement of mental health services?
4. How could service users and the Chinese community be engaged by the statutory services for the improvement of mental health services?

Participants

Semi-structured interview

In order to fulfil the aim of engaging the Chinese community in Barnet, the inclusion criteria for participants were: Chinese residents in the borough of Barnet; and since service user will be included, only those who were in a mentally stable condition would be considered. No participants will be approached if he/she is detained under mental health legislation at the time of research.

According to the advice from the steering group members, we decided to recruit a wider range of participants from mental health service users, carers to people from the general public. We aimed to recruit 30 participants with a grouping of 15 service users, 5 carers, 5 elderly, and 5 people from the general public. Eventually we were able to recruit 28 participants including 13 service users, 5 carers, 5 elderly and 5 from the general public.

Focus group session

The 28 participants were further invited to take part in a focus group session, participation was purely voluntary. Eventually 4 participants took part in the focus group discussion.

Materials

An information leaflet was developed to explain the aims and procedures of the research project, data protection and the participants' rights to quit the research were also mentioned in the leaflet. A consent form was set out simply for participants to state that they understood the purpose of and agreed to take part in the research. The information leaflet and consent form were written in simple Chinese and English language. A tape recorder was used in the interviews and focus group session whereby verbal consents for recording were obtained from the participants. They were to ensure that the tape reordering was only for the purpose of data collection and would not be used for dissemination or passed on to any third party except for researchers' transcription. An interview schedule and a list of four questions were developed for the semi-structured interview and the focus group session respectively.

Procedure

Engaging the community

In September 2006, the research team organised a health promotion event which aimed to engage the community and to raise mental health awareness and the publicity of the research project among the Chinese service users and carers in Barnet. The approach of 'Forum Theatre' developed by Boal in the 1970s (Fursland, 2001) as a means to communicate with the audience was used in the event.

Five sketches were written up to demonstrate five mental health issues included schizophrenia, obsessive compulsive disorder, depression, dementia and sleeping disorder. On the day, the research team played the sketches and at the end of each sketch, they invited members of the audience to improve the scenario by feedback to the acting team what would be the right way of dealing with the situation, making up their own script, or volunteer to act in what they thought was right.

Ethics Application

Before putting in the ethics application for the research, with the help and support of the support worker and the steering group members, the research team finalised all the materials included an information leaflet explaining the purpose of the research, a consent form and an A4 paper detailing the research focus and an interview schedule. The ethics application was approved by the UCLan's ethics committee in early November 2006.

Data Protection

The researchers were acting in compliance with the confidentiality policy at CMHA. Personal data would not be recorded on the questionnaires or the notes related to the interviews and the focus group session. Personal data is referred to the participants' details as follows:

- Full Name
- Telephone number
- Email address
- Postal address
- Postal code

The name and identity of the participants taking part in the research would not be disclosed at any stage of the research. Participants had the right to access, change and/or delete their personal data in the filing cabinet and from the computers if they so requested.

In the focus group discussion, participants were asked to keep confidentiality of any personal issues they came across within the group. Although topics that were discussed in the focus group were more on a general perspective rather than something to relate to the participants' personal experience, this was to ensure that everyone in the group would feel safe at some point when they feel they would want to express on issues which might appear to be sensitive and personal.

The researchers ensured that the information the interviewees given would be treated as confidential and not to be passed to any third parties unless they gave information which would lead to the idea that either they or someone else could be at risk of serious harm (including child abuse), in which case, CMHA would pass on such information onto the necessary third parties (including the police, a doctor or a social worker for example) in order to try to prevent or stop the harm.

During the period of data collection and analysis, the data was stored in a locked filing cabinet in CMHA whereby only the line manager, the research coordinator of this research and the Chief Executive of CMHA had access to. They had control of and act as the custodian for the data generated by the study. The questionnaires and transcripts of the interviews were to be destroyed once the final report was furnished.

Before the Semi-structured Interview

With the help of the colleagues in CMHA who were working in direct contact with service users, a list of potential participants was built up. The workers contacted the clients initially to get their consent of passing their name and telephone number to the researcher in CMHA for discussion of the research project. After the consent was obtain, one of the researchers called up the clients one by one to discuss the research based on the details set out on the information leaflet. Participants were given 48 hours to consider whether or not to take part in the research. When the client agreed to take part in the research, the researcher would arrange a time and date for the interview.

£20 plus lunch and travel would be given as an incentive to each of the research participant. Some of the participants chose to have the interview at CMHA office and some of them, especially the elderly participants preferred to have the interview at their own homes, in such situation, researchers would go in pair to ensure their personal safety of the visit.

On the day of the interview

The researchers were to present the paper form of the information leaflet and the consent in the language the participant preferred before the interview took place. When the participant had read all the information on the leaflet and was sure to take part in the research, he and she would draw a 'tick' beside the statement indicating his/her agreement to take part in the research on the consent form, also, verbal consent of the interview being tape recorded for the purpose of data collection. The participants were also made known that they had the right to withdraw from the research when they felt they were uncomfortable and they did not have to give a reason for the withdrawal.

Data Analysis

Each researcher recorded and transcribed his/her own interview and focus group session in Chinese and translated the Chinese transcripts into English. The research coordinator then used the thematic content analysis to coding the translated English transcripts. The research coordinator identified line by line in the transcripts that

represented opinions, ideas, feelings and facts, then categorised these areas into themes. The line manager (a trainee health psychologist) of the research project reviewed and coded the transcripts independently, then discussed with the research coordinator to reach consensus on the themes from the transcripts.

Results & Findings

Part One – Demographic Information of the Participants

Q1. Age

N = 28

Age range	Number	Percentage
16 - 18	1	4%
25 - 29	1	4%
30 - 39	8	28.5%
40 - 49	6	21%
50 - 64	8	28.5%
> 65	4	14%

(Table 1)

Q2. Gender

N = 28

Gender	Number	Percentage
Male	11	39%
Female	17	61%

(Table 2)

Q3. Ethnicity

N = 28

Ethnicity	Number	Percentage
Chinese	28	100%

(Table 3)

Q4a. Country of origin

N = 28

Country of origin	Number	Percentage
Born in UK	1	4%
Born outside UK	27	96%

(Table 4)

Q4b. Length of stay in the UK.

N = 28

Length	Number	Percentage
1 - 5 years	6	22%
6 -10 years	7	26%
> 11 years	15	52%

(Table 5)

Q5. Citizenship

N = 28

Status	Number	Percentage
British Citizen	19	68%
Permanent Resident	6	21%
Working Permit/ Student Visa	3	11%

(Table 6)

Q6. Language Ability

Number of participants = 28

Number of response = 62

Participants can choose more than one language

Language	Number	Percentage
English	11	18%
Cantonese	24	39%
Mandarin	20	32%
Hakka	7	11%

(Table 7)

Q7. Religious Affiliation

N = 28

Religion	Number	Percentage
None	11	39%
Christianity	7	25%
Buddhism	8	29%
Taoism	2	7%

(Table 8)

Q8a. Self Report Disability

N = 28

Disability	Number	Percentage
Yes	8	29%
No	20	71%

(Table 9)

Q8b. Type of Disability

N = 8

Type	Number	Percentage
Severe Mental Illness	3	38%
Physical disability	5	62%

(Table 10)

Part Two – Mental Health Awareness

Questions 9 to 12 are statements that we suggested the participants to rate their opinions from ‘strongly agree’ to ‘strongly disagree’.

Q9. “I have enough knowledge to recognise mental illness and symptoms of myself/ or the person whom I care for.”

N = 28

Comment	Number	Percentage
Strongly Agree	4	14%
Agree	12	43%
No Comment	3	11%
Disagree	9	32%

(Table 11)

Q10. “Mental health problems are very common in Chinese community.”

N = 28

Comment	Number	Percentage
Strongly Agree	3	11%
Agree	11	39%
No Comment	7	25%
Disagree	7	25%

(Table 12)

Q11. “If I had mental health problem, I would seek help.”

N = 28

Comment	Number	Percentage
Strongly Agree	10	36%
Agree	15	53%
No Comment	1	4%
Disagree	2	7%

(Table 13)

Q12. “I feel accepted by the community in terms of mental health problems I came across.”

N = 28

Comment	Number	Percentage
Strongly Agree	1	4%
Agree	8	29%
No Comment	6	21%
Disagree	11	39%
Strongly Disagree	2	7%

(Table 14)

Q13. Service user participants' self-reported mental health problems.

Number of participants = 13

Number of responses =102

Participants can choose more than one answer.

M/H Problem	Number
Anxiety	11
Mood Swing	11
Difficulty in Sleeping	11
Depression	9
Poor Concentration	9
Suicidal Thought	8
Flashback	8
No sense of purpose	8
Intrusive thoughts	6
Loss of appetite	6
Emotional withdraw	4
Suicidal attempts	3
Paranoid	3
Delusions	3
Memory loss	1
Hearing voice	1

(Table 15)

Q14. Carer participants' identified mental health problems of their care recipients.

Number of participants = 5

Number of responses = 31

Participants can choose more than one answer.

M/H Problem	Number
Difficulty in Sleeping	5
Anxiety	4
Mood Swing	4
Loss of appetite	4
Depression	3
Poor Concentration	3
Flashback	2
Suicidal Thought	1
Intrusive thoughts	1
Emotional withdraw	1
Memory loss	1
Delusions	1
Dementia	1

(Table 16)

Part Three – Accessibility of services

Quantitative Data Analysis

The following questions were set out to explore participants' opinion on the accessibility of services.

Q15. Would you know where to get help from if you need to seek mental health support?

N = 28

Answer	Number	Percentage
Yes	23	79%
No	6	21%

(Table 17)

Q16. If you know where to get help, where would you get help from?

N = 23

Statutory Service	Number	Percentage
GP surgery	14	59%
CMHA	6	25%
Chinese Centre	2	8%
University	1	4%

(Table 18)

Q17. How long did it take you to make a GP appointment?

Number of participants = 28

Number of responses = 36

Participants can give more than one answer.

Length of time	Number	Percentage
On that day	10	32%
1 day	3	9%
2 days	2	6%
3 – 4 days	8	25%
A week	5	16%
A couple of weeks	1	3%
A month	1	3%
No idea	2	6%

(Table 19)

Q18. Did you need interpreting service at GP appointment?

N = 28

Answer	Number	Percentage
Needed	13	46%
Not needed	15	54%

(Table 20)

Q19. Following question 18, did interpreting service available to you when you needed?

N = 13

Answer	Number	Percentage
Yes	11	85%
No	2	15%

(Table 21)

Q20. How long did it take you to book for an interpreting service?

N = 13

Length of time	Number	Percentage
1 day	1	8%
3-4 days	3	23%
A week	2	15%
Unpredictable	7	54%

(Table 22)

Q21. Was there any reason why you chose not to use the interpreting service?

N = 15

Reason	Number
Able to speak English.	12
Got help from friends & relatives.	2
Did not want to waste public fund because service was not good anyway.	1

(Table 23)

Q22. Have you ever received any information about voluntary services in the Chinese community?

N = 28

Answer	Number	Percentage
Yes	5	18%
No	23	82%

(Table 24)

Q23. Have you ever referred by GP to specialised mental health services such as the Community Mental Health Team or a Chinese community organisation?

N = 28

Answer	Number	Percentage
Yes	11	39%
No	17	61%

(Table 24)

Q24. Which mental health services were you referred to?

N = 11

Mental Health Service	Number	Percentage
Psychiatrist	3	27.5%
CMHA	3	27.5%
Counselling	2	18%
Social Services	2	18%
CMHT	1	9%

(Table 24)

Q25. How long did it take you to be referred to the specialist mental health services?

N=8

Length of time	Number	Percentage
On that day	2	24%
A couple of weeks	1	13%
A couple of months	3	37%
6 months	1	13%
After a year	1	13%

(Table 25)

Qualitative Data Analysis

Difficulties came across when participants were accessing mental health services:

Theme 1: Language barriers

- feeling it difficult to communicate with GPs

Theme 2: Quality of interpreting services

- Quality of interpreting services was poor

Theme 3: Limited time for consultation at GP's appointment

- Time was deemed even more insufficient when participants used the interpreting services

Theme 4: Resources in Chinese interpreting services

- Lack of good quality interpreting services

- Existing service was not good and unreliable

Theme 5: Feeling arise from the above difficulties

- stressed out
- felt misunderstood
- felt disappointed, gave up using interpreting service
- health problems being misinterpreted by the interpreter
- health problems not being treated properly

Theme 6: Alternative ways of dealing with mental health problems

Five participants said they did not seek help from health professionals but dealt with their problems in other ways, such as:

- Talking to friends about their problems
- Walk to release stress
- Let problems pass by watching television programmes
- Worship the perceived disturbing ‘spirit’ which caused mental distress

Part Four: Hospital Admission

Quantitative Data Analysis

Q26. To find out the participants’ understanding of the legal aspect of mental health, a list of items was suggested as follows:

Number of participants = 28

Number of responses = 30

Participants can choose more than one answer

Legal aspects	Number	Percentage
Patient Right	11	36%
Complaint Procedure	10	32%
Sectioning	8	26%
Mental Health Act	2	6%

(Table 26)

Qualitative Data Analysis

Theme 7: Lack of interpreting service and information in Chinese in the hospital

When participants were asked whether they or anyone they knew had ever been admitted to hospital for any mental health problem, only three participants had gone through the experience of hospital admission. All the three participants had never received any Chinese information during admissions. All the three participants did not receive interpreting services in the hospital even when they requested them. All

the three participants did not receive any translated information about medication and its side effect.

Theme 8: Good communication between the doctor and the patient – an exceptional case

One participant, a carer to his grandson who was admitted to the hospital, mentioned that although he did not see any written materials about mental health or side effect, the doctor would call up the family when it was necessary, to discuss about the medication, also let the grandson knew that as a patient he has the right to choose whether or not to take the medication.

Part Five: Awareness of Services in Barnet

Quantitative Data Analysis

Q27. Participants were to choose from a list of statutory and voluntary services in Barnet which they knew were providing mental health supports. The following table shows their responses.

Number of participants = 28

Number of responses = 62

Participants can choose more than one answer

Statutory/ voluntary service	Number	Percentage	Source of hearing the service
Acute services	16	26%	Interpreter CMHA staff Friends/relative Hospital/999
Counselling	16	26%	Hospital/GP Chinese Newspaper Seminar
Psychiatric	11	18%	GP Friends
CMHT	6	10%	Hospital/GP/Chinese nurse Friends Chinese community Centre
Alzheimer’s Society	4	6%	Friends/ library
Carers’ Network	4	6%	Friends Workplace Leaflets
Advocacy services	4	6%	Council Newspaper
Church	1	2%	Friends/ community

(Table 27)

Part Six: Awareness of Information

Quantitative Data Analysis

Q28. Do you think there was enough information available to help access to mental health services?

N = 28

Answer	Number	Percentage
Yes	1	4%
No	16	57%
Not sure, did not notice this issue	11	39%

(Table 28)

Q 29. Have you seen any mental health information in your own language?

N = 28

Answer	Number	Percentage
Yes	9	32%
No	19	68%

(Table 29)

Q30. Following Q29, if you have seen mental health information in Chinese before, did you think the information was sufficient?

N = 9

Answer	Number	Percentage
Yes	2	22%
No	7	78%

(Table 30)

Theme 9: Lack of follow up by the statutory services on the request for Chinese information

The seven participants who thought the Chinese information wasn't sufficient in GP surgeries and hospitals, expressed that although the departments claimed that Chinese information leaflets were available on request, when participants phoned up for the Chinese information material to be sent by post, most of the time, there was no follow up from the departments, no information was received. Participants felt that it was difficult to accessing mental health services; many felt helpless.

Theme 10: Chinese voluntary organisation became the source of information

Participants tend to find out and receive information regarding mental health in Chinese from CMHA weekly newspaper column, newspaper and bus advertisements.

Part Seven: Needs and expectations of mental health services

Quantitative Data Analysis

Q31. What other treatments did you think would be helpful?

N = 16

Treatment	Number	Percentage
Chinese herbal medicine	11	52%
Tai Chi & Martial Art	3	14%
Acupuncture	2	10%

(Table 31)

Q32. What other services did you think would be helpful?

N = 16

Service	Number	Percentage
Chinese counselling	14	30%
Befriending	10	22%
Talks & seminars	7	15%
Talking therapy	7	15%
Social activities	4	9%
Chinese community centre	3	7%
Leisure centre discount for mental health users	1	2%

(Table 32)

Qualitative Data Analysis

Q33. What kinds of treatments and services would you like to receive if you had the choices? This question is for service users only.

Theme 11: Culturally sensitive treatments and services preferred by service users

- Chinese GP
- Chinese counselling
- Chinese herbal medicine
- Alternative treatment in addition to Western medication
- A sustainable financially funded Chinese mental health service

Q34. What kinds of services and support would you like to receive if you had the choices? This question is for carers only.

Theme 11: Culturally sensitive services and support preferred by Carers

- Integrated Chinese & Western medicine for the care recipients
- A Chinese link worker for information & advice

Theme 12: Support for carers needed to be strengthened

- Support from social worker
- Carers' support project
- Social activities
- Training
- Information on Health care system, where to seek help, carers' right, complaint procedure and welfare benefits

Focus Group Session

Data Analysis

In a focus group session with 4 participants (3 service users and 1 from the general public), the following questions were discussed:

Q35. As a Chinese in UK, what does race equality means to you?

This question was composed in accordance with the DRE objectives.

Q36. How do you feel you have been treated as a service user when accessing mental health services?

Q37. What would like to see in any changes or improvement of mental health services?

Q38a. How can a user be engaged by the statutory services for the improvement of mental health services?

Q38b. How can a Chinese Community be engaged by the statutory services for the improvement of mental health services?

The following themes were identified from the focus group discussion:

Theme 13: Language barrier has led to feeling of inequality and distress

- Participants felt being treated unfairly and being ignored when using primary care and mental health services
- Feeling helpless, didn't know how to deal with but tolerate with the problems
- Feeling stressful and strained while using the services.
- Although participants might have been treated unfairly, they could hardly express their feelings and dissatisfactions.

Theme 14: Cultural factor has led to a disadvantage in advocating a better service

- Chinese are culturally passive and non-vocal
- The so-called 'silent community' is unable to voice out their needs
- Chinese community is not united as a community

Theme 15: The lack of good quality interpreting service had lowered the quality of receiving primary care service.

- Time was limited when seeing the GPs
- interpreting services further limited the time for consultation with the GPs
- GP appointments were delayed due to the prolonged time for booking an interpreter
- Interpreter might not turn up without giving any notice

- Quality of interpreters was not guaranteed as they might misinterpret the GP or the participant's conversation
- Not knowing where to complaint

In the focus group discussion, participants also gave their opinion of what they would like to see for the changes or improvement of mental health services.

Themes had been identified as follows:

Theme 16: Reflection of the weakness of the community

- Participants felt that the young Chinese generations should keep learning their own language and culture;
- Parents should play an important role on encouraging their children to keep their Chinese culture and language;
- So when the younger generation work in the health service, they could be able to help their own community;
- Hope to see more Chinese speaking health professionals in the mainstream health services.

Theme 17: Expectation of a more culturally sensitive mental health service

- Participants expressed the authorities should emphasize on cross cultural mental health training;
- The quality of interpreting service should also be improved;
- More effort on the mental health needs of minority ethnic groups.
- Participants hope integrating Chinese acupuncture and Chinese herbal medicine would be come true one day in the mainstream services.

Theme 18: Engaging service users through a specialised Chinese community organisation

- Participants wished the statutory department can support the Chinese organisation (such as CMHA) financially to translate more information into Chinese;
- Expanding services like that in CMHA is a way to strengthen the support for the Chinese community;
- Set up a special unit with a Chinese link worker in the statutory services to deal with Chinese users' problem.

Discussion

Our research results show that language barrier still exists to be a major problem for Chinese service users to access health services in primary and mental health care in Barnet. Interpreting service does not seem to be solving the language difficulty in using primary and mental health services because, even when interpreting service is available, very often the quality is not good and reliable. This led to frustration, stress, disappointment and feeling of being treated unfairly amongst the service users.

This is a small research sample, with only 28 participants included 13 service users, 5 carers, 5 elderly people and 5 people from the general public. However when we look at the Office of National Statistics of Psychiatric Morbidity Survey which shows a one year prevalence rate of 0.5% for psychotic illness, it can be deduced that about 31 (0.5% of total 6,379 Chinese population) Chinese residents in Barnet may suffer from psychotic illness. In this research, it can be deduced that we have recruited about 42% (13/31) of the Chinese residents in Barnet who are vulnerable to psychotic illness.

Almost all of the participants (27 out of 28) were born outside the U.K., working in the catering industry, and more than half of them do not speak English (table 7). When we look at how the participants view their mental health issues, only 3 of them reported that they suffer from severe mental illness. However, when they were to identify from a list of mental health problems such as anxiety, depression etc., all of them reported that they suffer from at least one to two problems. Anxiety, mood swing, insomnia and depression are the most common issues, these together with the other 12 issues on the list, 102 responses were made by the 28 participants (Table 15). This is in line with the fact that 50% of the participants in this research agreed that mental health problems are very common in the Chinese community (Table 12), nevertheless more participants would disagree to the statement that they feel being accepted by the community in terms of the mental health problems they came across (Table 14).

Mental illness is no longer a new topic nowadays. It is very common, and happens everywhere and in every community. However mental illness is still a stigma in Chinese culture, mental health issue is an untouchable topic to discuss in the community. In some cases even when medical attention or support is needed, people are reluctant to seek help.

One of the participants said, *"If you ask me how I deal with my psychological issues... yes I was and am stress, very stress, really depressed, I wouldn't think of going to see a doctor because I don't have mental health problem... but how to sort out my emotion... I just go out and walk."* – A quote from a female respondent.

It is apparent that due to the small number of participants in this research, their issues may not be significant enough to represent the wider picture of the mental health issues in the Chinese community, they are, however, significant in representing the most disadvantageous and vulnerable group who experience stigma and difficulty in accessing health service due to language barrier and cultural factor and the lack of sufficient resources in the statutory services to help overcoming these problems.

Level of mental health awareness is relatively high (Table 11) and in general participants know where to get help from if they need to seek mental health support (Table 17). The majority of participants (89%) expressed that they would seek help if they had mental health problem (Table 13). In reality, when we look at service referral, 11 out of 28 participants had the experience of being referred to other specialised mental health services (Table 24), and the length of time for referral arrangement varied from on the same day to more than a year (Table 25). Results of this research suggested that the time for referral arrangement to specialised mental health service is longer than booking for the GP appointment.

GPs are the first point of contact for participants to seek help, followed by CMHA (Table 18). Most participants booked for a GP appointment on the day or about three to four days (Table 19). For those who need interpreting at their GP appointment, service is often available to them when requested (Table 21), however time for booking interpreting service varied, 7 participants said it was unpredictable when they recalled the time it took for service. In general, participants felt that the existing interpreting service is not good and unreliable; interpreters sometime do not keep the appointment which caused a lot of inconvenience to the participants. Feelings of disappointment, frustration and stress arise because of the inefficiency of interpreting service which limited the already limited time for each GP consultation. A participant said, *"I feel more stress out whenever I have to see my GP, it's not good for my mental health."*

Furthermore, participants' health problems are not fully conveyed in an accurate way or misinterpreted that they feel being misunderstood and not treated properly. Some participants give up using interpreting service and turn to friends and relatives for help, whereas other tolerate with the problem in silence.

On the other hand, when we look at the three participants' experiences during their hospital admission, the situation was not any better. Interpreting service was not available to them even upon request, besides no Chinese information about the admission, the medication or its side effect had been provided in the hospital. A participant who was admitted to the hospital said,

"The information given to me by the nurse was in English. I was never told about the side effects of the medication, but from my experience I knew I would probably get drowsy after taking the medication, whereas if it is injection it should be fine. It would be really helpful if I could have information in Chinese about my mental health condition, the treatment and its side effects." – A quote from a male respondent.

However, based on the opinions of the three participants we got in this study, it is not clear how long ago the participants were admitted to the hospital, we maintain that this is not a representation of the overall and current condition of the hospitals in Barnet. In one case when language barrier was not an issue, a professional practice was reflected in the communication between the doctor and the patient. A carer participant described the situation when his grandson was admitted to the hospital,

"They didn't provide translated information but each time the doctor called up the family to discuss the medication with us. He also let my grandson knew that he has

the choice whether or not to take the medication." – A quote from a male carer respondent.

Information provision is an important aspect of improving awareness and hence access to mental health services. Results of this research show that mental health information in Chinese at GP surgeries and hospitals to help the community access services in Barnet is far from sufficient (Table 28, 29, 30). We consider that for people to get the information they need, it also depends on how proactive they are to search for them. So we asked 10 service users and carers whether they have tried to actively search for service or mental health information, none of them did due to the long working hours in the catering industry. One of the participants said,

"You know the working hours are so long that when you are off, it's already after midnight when the GP surgeries are closed. And life is a tough here; I don't really have time to care about other issues including my health." – A quote from a male carer respondent.

Voluntary organisations such as Chinese Mental Health Association have been providing community services and information, publicising via a wide ranging media outlets from bus advertisement, newspaper column, press release and mailing, became the major information source and support for the most hard to reach group in the community. A participant highlighted that,

"CMHA is an important service because these are exactly what we need – Chinese information, cultural and language support, counselling, and giving us a channel to say what we need, just like in this research project. You have to continue and ideally expand their existing services for the benefit of the Chinese community." – A quote from a female respondent.

Language barrier and the issue of interpreting service at GP surgery were raised most of time during the semi-structured interviews and the focus group, besides the prolonged waiting time for appointments, not related to mental ill health but for physical problems in the hospital was also one of the most painstaking experiences for the participants. Feelings arise from these problems, when summed up, are strongly linked to the sentiment of discrimination as far as equality of health service and experiences are concerned.

The Chinese community in the U.K. is unique in its historical and cultural background, and people's concepts of health and well-being has long been influenced by the traditional Chinese medical model which aims to maintain a holistic sense of balance of the human body. Until today, people still prefer to use the traditional Chinese herbal medicine as a way to counteract imbalance that are regarded as the source of illness, including mental illness. In this research when we asked our service user and carer participants what other treatments they thought would be helpful, most of them preferred Chinese herbal medicine, Tai Chi and acupuncture.

In addition to the Chinese traditional medicine, a culturally sensitive way of medicine treatment, when asked even more specifically what treatments and services the participants would prefer if they had the choices, the expectation of a more culturally appropriate approach for treatment and service in all aspects has emerged. Ideally

participants prefer to have Chinese GPs, Chinese counselling service, an integrated Chinese and Western medicine, a financially sustainable Chinese mental health organisation to provide more comprehensive services, and a Chinese link worker to assist in information and advice for the community. Furthermore, strengthening cultural training for health professionals is suggested. A participant quoted an example of the cultural difference between Chinese and Western ways of looking at mental well-being:

"My psychiatrist suggested me to take a holiday break because I was down, but you know, having a break or not is no big deal for us Chinese. I was down because my children were leaving me when they have grown up. The western psychiatrist thought this was normal to meeting children just once a year and it was not something worth upsetting about. They just didn't understand me, as a Chinese parent this is saddening. If they understand our cultural value more, they would be able to know our psychological needs more." – A quote from a female respondent.

In this discussion so far, we have brought out the issues of language barrier and interpreting service; the insufficient provision of information and the participants' expectation of a culturally sensitive service. All these findings are in consistent to that of the research studies (Yee & Au, 1997; Li & Logan, 1999) in the last ten years.

In this research, we heard the call for a more united community to preserve the cultural understanding and language capacity for the younger generation. This is perhaps the first time we hear the reflection of the weakness of our own community, that if we want to have a culturally appropriate health service, we also have the responsibility to make it work by starting from our families, nurturing more Chinese speaking health professionals to join the mainstream services. One of the participants said,

"It would be so helpful if we could have more Chinese doctors and health professionals. I mean real Chinese, you know sometimes you bump into a Chinese doctor or a nurse, you thought you're being lucky to have found someone who speaks your language, but surprisingly he or she doesn't speak Chinese at all." – A quote from a female respondent.

Whereby voluntary organisation such as CMHA have been engaging the community by promoting and providing access to mental health information, signposting and referring service users to statutory services, let alone the voluntary organisation to deal with the problems, the question of equality of outcome and access to mental health service could hardly be resolved. The following section will set out the recommendations of improving the situation of the existing mental health services for the Chinese community in Barnet.

Recommendations

Chinese interviewees not only discussed their experiences of using the mental health services, they also provided useful opinions of what they would like to see in terms of changes or improvement of mental health services.

Improve mental health awareness in the community

The statutory service should place more efforts in promoting mental health awareness, eliminating stereotypes and discrimination in the Chinese community. Statutory service providers should work closely with local Chinese voluntary organisations such as CMHA in different ways to organise awareness campaigns such as seminars, talks and health events. A workforce consisting members from the statutory service and the Chinese voluntary organisation is suggested to set up to discuss the partnership work and implementation of this point as soon as possible.

Creating a helping community

Chinese people, especially the first generation immigrants, both share the language barriers in this country. The idea of developing a helping community would help to improving health from within the Chinese. The second Chinese generation or simply, British Born Chinese should keep learning their own language and culture in order to contribute to their own community.

The first possible step in its process to create a helping community is to introduce the concept of community health psychology. Projects using a participatory and empowerment approach can be developed to involve people to 'take ownership' of the problem collectively. The project can be facilitated by a health psychologist for the purpose of increasing the likelihood that Chinese people will act in more health-enhancing ways and in lobbying for the creation of community contexts that will enable improved health (Campell & Murray, 2004). CMHA is suggested to seek for funding in the near future to pursue this idea.

Increase information resources in Chinese

The relevant authority should translate more information into Chinese language. The information can include an introduction of mental health services and the way of accessing the service. They could also give financial support to the Chinese voluntary organisation such as CMHA to do the translation. A team consisting members from the statutory service and the Chinese voluntary organisation is suggested to set up to discuss the partnership work and implementation of this action point as soon as possible.

Training for professionals and family carers

Provision of training for a wide range of workers in statutory services of cross cultural awareness is important. Chinese may have very different life perspectives if compared to other ethnicities. Thus cross cultural awareness training would be beneficial for both Chinese and service providers. The quality of interpreting service

should also be improved by proper training. Provision of support, training and information for carers and family members in terms of mental health knowledge and understanding of mental illness is also essential. Meeting should be set up between CMHA and the relevant unit in the statutory service to discuss how this could be implemented in the near future.

Culturally sensitive medical treatments

There are about 20 practitioners registered under the member of The British Medical Acupuncture Society in London. They are legally practicing acupuncture in mainstream hospitals. Despite that, the service is still very limited among the Chinese community. Hence, it is recommended that Chinese acupuncture and Chinese herbal medicine could be widely practiced in mainstream services in the near future.

Strengthening service support for Chinese users

The statutory services like hospitals and all GP surgeries should work, cooperate more closely with CMHA to strengthen the support for the Chinese community. CMHA can act as a bridge between the statutory services and the Chinese community to support the Chinese service users. A Chinese Community Development Worker based in CMHA would be the most effective way to provide support and service to the community in Barnet.

Reflection

All researchers have expanded their knowledge of mental health and research skills after joining the research project. The workshops provided by University of Central Lancashire were useful for the researchers in doing the research work or personal development. The special skills and knowledge which they learned from the workshops allowed them to complete the task easily. Besides, they have also developed their interpersonal skills and knowledge about other cultures while attending the workshops and discussion with other research group members. Furthermore their communication skills also improved through face to face interviewed with different service users, carers and elderly people.

For CMHA, this was a great opportunity to reach the seldom heard group in the Chinese community and to learn about people's life experiences. Chinese respondents are more likely to express their needs and opinion through one to one interview. Hence the semi-structure interviews which we were conducting in this project had collected many good suggestions and recommendations from the service users. CMHA has gained better understanding of the needs and expectation of the Chinese community after this research project. The organisation will endeavour to improve the services in the future for the benefit and the well being of the Chinese community.

Last but not the least, most of our participants appreciated the opportunity they have to speak about their experiences and voice out their needs in this research study, and they expressed that should they be given more opportunities to involve in similar project, they would make effort to help. The Chinese community is not at all a 'silent community', that if they are truly engaged and supported, they would be willing to share their views.

Reference

1. Campell, C. & Murray, M. (2004) Community Health Psychology: Promoting Analysis and action for Social Change. *Journal of Health Psychology*, 9(2), 187-195.
2. The Complete Reference to China's History – ChinaSite.com: History Website: <http://www.chinasite.com/Culture/History.html>
3. Confucianism - From Wikipedia, the free encyclopedia. Website: <http://en.wikipedia.org/wiki/Confucianism>
4. Cowan, C. (2001) The mental health of Chinese people in Britain: An update on current literature. Shadowfax Publishing and Taylor & Francis Ltd.
5. Douglass, A., Bramble, M. G. & Barrison, I. (2005) BMJ National survey of UK emergency endoscopy unit.
6. Li, P. L. & Logan, S. (1999) The Mental Health Needs of Chinese People in England: A Report of a National Survey. Chinese National Healthy Living Centre.
7. Li, P. L., Logan, S., Yee, L. & Ng, S. (1999) Barriers to meet the mental health needs of the Chinese community. Faculty of Public Health Medicine
8. Poston, D. L., Mao, M. X., and Yu, M.Y. (1994) "The Global Distribution of the Overseas Chinese around 1990." *Population and Development Review* 20:631-45.
9. Robbins, C. K. (2002) Traditional Chinese Medicine: A Natural and Holistic Approach. Website: http://www.uspharmacist.com/index.asp?show=article&page=8_1002.htm
10. U.S. Department of Mental Health and Human Services. (2001) Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
11. Walker, A., Bodycott, P (1997). Academic Cultures in Singapore and Hong Kong: Some Personal Impressions. *International Higher Education*, March 1997.
12. Watt, I. S., Howel, D., & Lo, L. (1993) The health care experience and health behaviour of the Chinese: A survey based in Hull. Oxford University Press
13. Yee, L. & Au, S. (1997) Chinese Mental Health Issues in Britain. Mental Health Foundation

14. Zhu, G.H. (1991) "A Historical Demography of Chinese Migration." *Social Sciences in China* 12:57-91.

Appendix 1 - Information Leaflet



Chinese Mental Health Association

Community Engagement Research Project - Chinese community in Barnet

INFORMATION LEAFLET

Chinese Mental Health Association (CMHA) is a charity dedicated to maintaining and safeguarding the mental well-being of the Chinese community in the UK.

CMHA has recently received funding for Community Engagement Research Project. This is funded by the National Institute for Mental Health in England and managed and supported by the Centre for Ethnicity and Health at the University of Central Lancashire. This is the first Community Engagement Research Project looking at the mental health needs for the Chinese community in London. For this unique research project we are going to involve particularly Chinese carers for mental health and service users in Barnet.

The aim of this research project is to explore the carers and service users' needs in relation to mental health and to share their experience in the service system. An approximately one hour semi-structure interview will be conducted with each participant. Participants will also be invited to an optional one hour focus group meeting to discuss general issues around mental health. An incentive of £20 plus travelling expenses and meal will be reimbursed to each participant.

Data collected from interview and focus group discussion will be analyzed and findings of the research project will be used for recommendations in helping local government to improve services in Chinese community in Barnet.

The participation of this research project is entirely voluntary and participants have the right to withdraw from the study at any time during or immediately after the interview or focus group. Participants do not have to answer the questions that they do not wish to and are encouraged to provide information where they can.

If you are interested, or you know any Chinese carers or current or former mental health service users whom you think may be able and willing to help us with this research project, please let us know. If you would like more information about this research, please contact Rebecca or Angus on 0845 122 8660 or email: rebecca@cmha.org.uk, angus@cmha.org.uk

Appendix 3 – Semi-structured interview schedule

Community Engagement Research Project

Chinese community in Barnet

Part One – Personal Details

1. Age

- 15 or under
- 16 – 18
- 19 – 21
- 22 – 24
- 25 – 29
- 30 – 39
- 40 – 49
- 50 – 64
- 65 +

2. Gender

- Male
- Female
- Trans-gendered or Transexual

3. Ethnicity

White

- British
- Irish
- Other (give details) _____

Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Other (give details)_____

Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Other (give details)_____

Black or Black BritishCaribbean

- African
- Other (give details)_____

Chinese or other ethnic group

- Chinese
- Other (give details)_____

4. Were you born in the UK?

- Yes
- No

If no, how long have you lived here?

- less than 1 year
- 1 – 5 years
- 6 – 10 years
- 11 years or more

5. Citizenship

- British Citizen
- Refugee
- Asylum Seeker
- Other _____

6. Languages –

Which languages you can speak and write fluently?

- Cantonese
- Mandarin
- Hakka
- Others _____

7. Other languages

Please list all other languages you can speak and write fluently

- English
- Other _____

8. Religion

- None
- Christian
- Buddhist
- Hindu
- Jewish
- Muslim
- Sikh
- Other (give details) _____

9. Sexuality

- Heterosexual
- Lesbian
- Homosexual
- Bisexual
- Do not wish to answer
- Other (please explain) _____

10. Disability

Do you consider yourself to have a disability?

- Yes
- No

If yes,

- please give brief details _____
- I do not wish to disclose any information regarding my disability

The Disability Discrimination Act 1995 defines a disability as follows: *a person has a disability if he/she has a physical or mental impairment which has a substantial and long term adverse on his/her ability to carry out normal day to day activities.'*

Part Two – Mental Health Awareness

1. For the questions in this part, please rate your answers most reflecting your opinions from the 1 to 5 scale on the right.

	Questions	Strongly agreed	Agreed	No comment	Disagreed	Strongly Disagreed
1	I have enough knowledge to recognise mental illness and symptoms of myself/ or the person whom I care for.	1	2	3	4	5
2	Mental health problems are very common in Chinese community.	1	2	3	4	5
3	If I had mental health problem, I would seek help.	1	2	3	4	5
4	I feel accepted by the community in terms of mental health problems I came across.	1	2	3	4	5

2. Have you or the one whom you are caring ever experienced from the following mental health problem? (Please tick those which applies)

- Depression []
- Anxiety []
- Mood Swing []
- Suicidal thought []
- Suicidal attempts []
- Intrusive thoughts []
- Flashbacks []
- Difficulties in sleeping []
- Emotional withdrawal []
- Poor concentration []
- Memory loss []
- Hearing voice []
- Paranoid []
- Delusions []
- Loss of appetite []
- Other: _____

Part Three – Accessibility of services

1. If you need to seek for mental health support, would you know where to get help from?

If yes,

- 1a. Where would you get help from?
- 1b. If you have accessed help, which services did you access?
- 1c. Did you experience any difficulties? Please explain.

If no, how did you cope?

2. How long does it take you to make an appointment with your GP?
3. If you need an interpreting service during the appointment with your GP, is it available?
4. If you have chosen not to use the interpreting service, please explain the reason why.
5. Did your GP provide you with any information about voluntary services in the Chinese community?

If yes,

- 5a. What was the information given to you?
- 5b. At which stage did the GP provide you with that information?

6. Have you been referred to other specialist mental health services, such as Community Mental Health Team, a Psychiatrist, the Chinese Community Organisation?

If yes,

- 6a. How long did it take you to be referred to?
- 6b. Did you feel that this was adequate / appropriate time?

Part Four – Hospital Admission

1. Have you or anyone you know ever been admitted into hospital for any mental health problem?
Yes ___ No ___
2. If yes, during hospital admission, was there any information provided to you in Chinese?
 - 2a. If yes, what was the information given to you?
 - 2b. If no, do you think you would have liked to have had some information?
3. Did the hospital provide interpreting service to you if you so needed them?
4. With regards to medication, were you given any translated information which could help you to understand the medication and its possible side effects?

5. Are you familiar with the legal aspect of mental health such as the following:

- Mental Health Acts
- Sectioning
- Your rights
- Complaint Procedure
- Other _____

Part Five – Awareness of service and support

1. Do you know of any of the following statutory or voluntary services in the Barnet area providing mental health support?

- | | |
|--|------------------------------|
| <input type="checkbox"/> Community Mental Health Team | How did you hear about them? |
| <input type="checkbox"/> Acute Services | _____ |
| <input type="checkbox"/> Alzheimer’s Society | _____ |
| <input type="checkbox"/> Carer's Network | _____ |
| <input type="checkbox"/> Advocacy Services | _____ |
| <input type="checkbox"/> Chinese Mental Health Association | _____ |
| <input type="checkbox"/> Psychiatry services through your GP | _____ |
| <input type="checkbox"/> Counselling Services | _____ |
| <input type="checkbox"/> Other _____ | _____ |

Part Six – Awareness of information

1. Do you think that there is sufficient information available for you to access mental health services in your area?

- 1a. If yes, what is the most effective method of providing information to you?
- 1b. If not, could you suggest what the service provider could do to improve the information provision?

2. Have you seen any information around mental health issues in your own language?

- Yes
- No

- 2a. If yes, was there enough information in Chinese?
- 2b. If no, Is there any information about mental health issues that you think might be helpful in your own language?

Part Seven – Needs and expectation of mental health services

1. What other treatments do you think might be helpful to you? (for example, acupuncture, Chinese herbal medicine, Tai Chi)
2. What other services do you think might be helpful to you? (for example, Chinese counselling, befriending, social group)
3. (This question for service user only) If you had an opportunity to choose your own treatment and services, what would you prefer?
4. (This question is for carer only) If you are caring for someone at home, what kind of service or support you are hoping to receive?

1st version – 28th July 2006

2nd version – 4th August 2006

3rd version – 7th August 2006

4th version – 15th August 2006

5th version – 12th September 2006

6th version – 10th October 2006