The Perspectives of Mental Health Practitioners Working with Chinese Migrants in Relation to Mental Health Service Delivery and Accessibility

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Abstract

This study develops the research question: the perspectives of mental health practitioners working with Chinese migrants in relation to mental health service delivery and accessibility. The study draws the attention of practitioners to Chinese people, who consist of one of the minor ethnic groups in New Zealand, and provides an opportunity for practitioners to reflect on their current cross-cultural practice.

Many previous studies have focused on the barriers that prevent Chinese migrants accessing mainstream mental health services. This study is particularly interested in the perspectives of mental health practitioners towards Chinese migrants as service users. Ten participants were recruited and attended individual one-hour, semi-structured interviews. The main concepts and themes drawn from the interview transcripts are presented in the findings. The migration journey is a significant life transition for Chinese migrants, which brings a lot of changes. The lower utilization rates of Chinese people in mental health care are associated with many factors, such as socio-demographic backgrounds and culturally related factors such as shame and discrimination, different perceptions of mental health/illness, and use of traditional Chinese medicine. These attitudes and behaviours of Chinese migrants towards mainstream mental health services are rooted in traditional Chinese culture and differ from those of the host society. Filial piety, as one of the significant concepts of Confucianism, provides us with new perspectives in understanding the help-seeking behaviours of Chinese people.

This study has involved ten mental health practitioners, seven of whom are social workers, with specialized knowledge, skills, years of experience and capabilities for working with Chinese people. Participants have here reflected on the strengths, and

challenges and the limitations involved in working with Chinese people. Some recommendations have been outlined for improvements in future mental health practice involving Chinese people.

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Table of Contents

List of Tables

List of Figures

Chapter 1. Introduction

> *Migration, in and of itself, does not precipitate the development of mental illness. Migration, however, does involve changes in environment which imply adjustments on the part of the migrant. These adjustments may be reflected in improved or worsened mental health. There are conditions, nevertheless, under which there is an increased risk of the development of emotional disturbance among migrant groups. These conditions can be specified in terms of characteristics of the sending and receiving communities, characteristics of migrants, and circumstances under which the migration occurs* (Kantor, 1969, quote in Kuo, 1976, p. 297).

New Zealand is well known as an immigration destination and displays a diverse ethnic and multicultural population, with Maori as the indigenous peoples. In the past, the migrants were comprised of mostly white people and English-speaking migrants. Since the Immigration Act 1987 came into force, high qualifications and professional skills have been regarded as the important criteria for migrants (DeSouza, 2006), a large number of Asian people have been attracted to New Zealand. Since then the Asian population has grown at a rate of 3.4 per cent each year on average (Statistics New Zealand, 2003), which is, relatively, growing faster than other population groups in New Zealand. Within the Asian group, Chinese migrants account for the largest proportion; Abbott, Wong, Williams, Au, and Young (1999) noted that Chinese are the largest non-European/non-Polynesian ethnic group in New Zealand. Although the Chinese population has grown quickly over these years, little data has been collected about their mental well-being. My literature search found that most research that has been done in New Zealand targeted Asian mental health issues and discovered Asian migrants have lower access rates to mental health care, and they are likely to delay in utilising services until symptoms became severe (Te Pou, 2008, 2010a, 2010b; Tse,

2004). Only a few studies specialize in Chinese mental well-being locally, thus more studies focusing on Chinese migrants should be undertaken. The information above motivated me and shaped the research question. A list of research-related terms is developed in Appendix 1.

Research Question

"What are the perspectives of mental health practitioners working with Chinese immigrants in relation to mental health service delivery and accessibility?"

This study was intended to explore the following three main themes:
(1). Identification of the impediments that Chinese migrants may experience in accessing and utilising mental health services;
(2). Identification of the challenges that mental health practitioners face in delivering services to Chinese immigrants; and
(3). Determining strategies, solutions, and/or new approaches which would improve professional practice when working with Chinese immigrants.

By interviewing ten mental health practitioners, this study was intended to gain some understanding about the experience of Chinese migrants' access to mental health care, and discover what the challenges are for practitioners in working with Chinese people. As a social work student, I am especially interested in social workers' practice in the current mental health field.

Significance of the Research

Due to the increasing population of Asian New Zealanders, it is necessary to pay attention to the health status of Asian groups by gathering their health data from national and regional surveys. There were several reports that were conducted for Asian New Zealanders, which recognised the increasing health needs of Asian people,

and these suggested sub-groups under the Asian category should be studied separately (Rasanathan, Ameratunga , &Tse, 2006a).

In DeSouza's study (2006), Asian people were found to underutilise health care compared with other ethnic groups, which is reflected in the following aspects:

- Asian people were less likely than other New Zealanders, Maori and Pacific people to have visited a health practitioner (or service) when they were first feeling unwell.
- Asian people were less likely than Europeans to visit a health practitioner doctor, specialist, nurse or complementary healer about a chronic disease.
- Asian women were less likely than other New Zealand women to have had a mammogram or cervical screening test in the last three years.
- Asians were less likely than all New Zealanders to use any type of telephone helpline in the last 12 months.
- Asians also only wanted to see their general practitioner for a short-term illness or a routine check-up rather than visiting for mental or emotional health reasons (DeSouza, 2006, p. 3).

As also suggested in the report of Asian Health in Aotearoa in 2006 – 2007, which includes a large representative sample of Asian people, Asian people are:

> *Less likely to have a primary health care provider; to have seen a range of health professionals in the last 12 months, including medical specialists, pharmacists, and social workers; and to have used a private or public hospital in the last 12 months.* (Scragg, 2010, p. 3)

Although this report targeted Asian people as a group, Chinese consisted of about 36%

of the whole sample (1,492 adults), thus the findings may represent certain characteristics of Chinese people to some extent. Rasanathan, Craig and Perkins (2006) also supported the contention that children and adolescents from the Asian community have lower access rates to general health services.

In terms of mental health service use, the data collected and updated by the National Health Information Service each year suggested low utilization rates of mental health services for Asian population (DeSouza, 2006; Ministry of Health, 2004，2006, 2013a; Te Pou, 2008). For example, Asian clients (1.7%) were the smallest group to be seen by District Health Boards (DHBs) in 2001. In 2002, only 1.9% of 87,576 mental health clients in District Health Boards were Asian, while the group accounted for over 6.5% of the total population. In 2004, Asians consisted of 2.3% of clients to DHB mental health services. In 2009–2010, 3.2% of 120,293 mental health clients identified themselves as Asian, while Maori accounted for 22.4% and Pacific people were 5.5%. Although the number of Asian clients seen by mental health and addiction services has been increasing, the utilization rate is still comparatively low. Asian children and adolescents were also found to have lower rates of utilising mental health services compared with New Zealand European children (Bir et al., 2007).

Tse, Hoque, Sobrun-Maharaj and Kim (2008) suggested that collecting data of migrant groups about "current utilization of mental health services" could help to recognize the needs of migrants (p. 59). According to Tse (2004), the needs of Asian migrants to mental health services have not been fully covered by current research, therefore arguably support and services of mental health providers to Asian clients are not adequate and culturally appropriate. Besides, Te Pou (2008), which was established to play a prominent role for both service users and service providers in the mental health field, suggested that there is a lack of information about overall or specific rates of mental illness or addiction disorders; lack of information about

accessing rates of non-governmental organization (NGO) services; and a lack of information about Asian sub-groups with high risks. Ho, Au, Bedford, and Cooper (2003) identified women, students, older people, and refugees as four high-risk groups that may develop mental health difficulties, and that further research should be done to assess the mental health needs of these groups.

Moreover, Kumar, Tse, Fernando, and Wong (2006) called attention to needs assessment requirements of Asian migrants in mental health services. The Asian Health Chart Book and other reports assert that the demand level of recognizing the health needs of Asian people is the key factor in influencing policy and service development in the future (Ministry of Health, 2006; Rasanathan et al., 2006).

Although the definition of Asian in New Zealand may be different from many other western countries, the term "Asian" includes a large population, and it is composed of diverse ethnicities, religions, cultures, languages and educational backgrounds. In the research by Rasanathan, Craig, and Perkins (2004), the question about whether it was useful to use "Asian" as a research category in New Zealand was asked. The study stressed that the diversity within Asian groups should be recognized. Therefore, it is contended that research that is specifically conducted for Chinese immigrants in the mental health field is urgently required.

Several studies in New Zealand focused on Chinese migrants with mental health issues have pointed out the fact that they have lower rates of utilizing mainstream mental health services (Abbott et al., 1999; Abbott et al., 2003; Kumar et al., 2006). One study participated in by older Chinese migrants with depression found almost no respondents had accessed mainstream mental health services, and they have little information about these services (Abbott et al., 2003). Other research, which was conducted with older Chinese people, found that older Chinese have a lower referral rate, and Chinese service users prefer to choose Chinese-speaking clinicians in the

private sector instead of the public system (Kumar et al., 2006).

These studies called for further insight into the needs of Chinese migrants for mental health services. More research from other countries has targeted the mental health needs of Chinese migrants, and the findings supported that Chinese migrants were underutilising mental health services. Consequently, it is important to perform further studies on the experience of Chinese immigrants utilising mental health services in the New Zealand context.

Broad Description of the Approach to the Study

After two years of studies and several internship opportunities, my curiosity was generated in the mental health field. The interest in doing this research has grown out of a concern about whether the mental health needs of Chinese migrants and their families are satisfied in the New Zealand host society. Relevant literature was reviewed to help shape the research question, and also to provide evidence about the necessity for, and significance of, this study.

Guided by the research question, a qualitative methodological approach has been chosen in order to explore the diverse experience of mental health practitioners of working with Chinese migrants, to find gaps in services, and promote better future practice. The qualitative research focuses on the perspectives of participants, and encourages participants to explore comprehensive information on this topic, and hopefully some potential themes for improvement may emerge in the New Zealand context.

The study started with applying for ethics approval. Then participants were recruited by using my professional networks. I firstly sent emails to the mental health practitioners I knew, and these practitioners helped by forwarding the email to their

colleagues. The participants of this study are professionals who have provided mental health services for Chinese migrants with mental illness. Participants did not need to be Chinese. Previous studies have categorised some "high risk" groups of Asian migrants who may develop mental health difficulties, including older people, women, students and refugees (Ho et al., 2003). Thus this study tried to involve those practitioners who have worked with different age groups.

I conducted semi-structured interviews to collect data and used open questions to allow participants to talk with fewer restrictions, and provide creative answers. Participation information sheets and consent forms, as well as the interview questions, were sent to participants by email before the interviews. Participants were interviewed individually in a neutral, quiet and private place. When analysing data, initial coding and focus coding were applied to each interview transcript, and to create "the most salient categories" (Saldana, 2012). The data analysis procedure will be introduced in Chapter 3.

Overview of Thesis Structure

This study is divided into six chapters. In this introductory chapter, I firstly introduced the research question and the purpose of this study. Then, the significance of this study was explored, and the methodology was also briefly introduced.

Chapter 2, "The Experience of Chinese Migrants in Mental Health Care", provides a review of the academic literature on the experience of Chinese people in accessing and utilising mental health services. The literature review starts with the history of Chinese people in New Zealand, and then presents relevant demographics in terms of mental health service utilization. Some important issues that impact on the mental well-being of Chinese people are firstly introduced and these are followed by several critical factors that affect their mental health service utilisation. Literature conducted

in New Zealand and other western countries is included to obtain more information on this topic.

Chapter 3, "Research Methodology" presents a description and explanation of the design, procedures and processes of the study. This study uses the qualitative methodology which also helped to shape the research question. Ethics considerations and procedures are an important part of research design. The process of recruiting participants and conducting interviews is outlined. The coding and analytic process is presented after the interpretation of participant interviews, which includes initial coding, focus coding, and the development of categories and themes. At the end, the considerations and limitations of the research are discussed.

Chapter 4, "Professional Working Experience with Chinese Migrants in Mental Health Care" reports the study's findings. The findings present the perspectives of mental health practitioners working with Chinese clients in terms of mental health services accessibility and utilisation. Firstly, the relationship between the migration journey and mental well-being are explored. Traditional Chinese cultural values and beliefs are mentioned. Secondly, participants identified some significant issues that have influence on their mental health service use. The important roles of interpreters, bilingual clinicians and general practitioners are evaluated. Thirdly, participants introduced some useful strategies that may be helpful for providing better services to Chinese clients.

Chapter 5, "Discussion of the Findings" presents a discussion of the findings. It uses the previous literature to support, further analyse and develop some important themes. In Part One, filial piety, as the key concept of Confucianism, is introduced, and how filial piety influences Chinese people in mental health care is discussed. Part Two uses Berry's theory of acculturation to analyse multicultural family dynamics. Part Three applies Shulman's interactional model to analyse the symbolic systems of

Chinese people, and discuss the functional roles of social workers in promoting mental health services utilisation.

Finally, Chapter 6, "Conclusion and Implications for Mental Health Practice" reviews and summarises the key themes, discussions and perspectives from previous chapters, and how these findings may impact on mental health practitioners' future practice.

Chapter 2. The Experience of Chinese Migrants in Mental Health Care

Introduction

Much of the mental health care literature in New Zealand acknowledges that Asian migrants have a lower access rate compared with other ethnic groups, and they are more likely to either delay utilisation of mental health services or to avoid treatment until symptoms became severe (DeSouza, 2006; Ministry of Health, 2004， 2013a; Te Pou, 2008). These previous studies provided a firm foundation for the following research on Asian migrants in the mental health field. However, little data on the mental health needs of different sub-groups of the Asian population in New Zealand have been provided in previous studies. Considering the cultural diversity among Asian migrants, each Asian ethnic group has certain social and demographic characteristics (Te Pou, 2008). The differences between these Asian sub-groups may have an impact on their attitudes and behaviours towards mental health services. Therefore, the mental health needs of Chinese migrants, which is an important sub-group of Asian in New Zealand, should be paid attention to. This study will explore research that targeted Asian/Chinese people with mental health issues in New Zealand and overseas.

This chapter starts with the history of Chinese people in New Zealand, and introduces the migration policy and how it shaped the characteristics of Chinese people. Some migration factors that impact on the mental well-being of Chinese migrants are also explored. Then it explores the literature about the experience of Chinese migrants to mental health care. It also introduces some significant factors from previous studies that have impact on Chinese migrants accessing and utilizing mental health services.

The Past and Present of Chinese People in New Zealand

Ng (2001) introduced the history of Chinese settlement in New Zealand, which started from 1865 and continues until the present. In 1865, Chinese people for the first time arrived in New Zealand, and most of them were from the Cantonese-speaking Guangdong province. They worked as gold seekers and perceived themselves as sojourners rather than settlers in New Zealand, because they believed China was their home country and they would go back. From then until the present, Chinese people have experienced four distinct periods and successfully shifted their roles from "sojournism" to settlement in New Zealand. Nowadays, Asians are the fastest-growing ethnic group in New Zealand, with Chinese being the largest ethnic group within the Asian population, which accounted for 45% in 2001, followed by Indian (27%) and then Korean (9%) (Asian Public Health Project Team, 2003; Cheung, 2010; Ho et al., 2003). The number of Chinese migrants in New Zealand has undergone sustained growth in ten years (between 1986 and 1996) from 26,616 to over 81,309 people (Henderson, 2004). Migration policy was one important factor that contributes to current multicultural social dynamics.

Within previous New Zealand immigration policy, which has been modified in 2012, there were three residence streams through which immigrants could apply for residency: the Skilled/Business Stream, the Family Sponsored Stream and International/Humanitarian Stream (Department of Labour, 2008). Each stream includes many different categories. The "Skilled Migrant Category" is a main channel in the Skilled/Business Stream. People who have high qualifications and rich work experience can apply for permanent residence in New Zealand. This category mainly consists of people from United Kingdom/Irish Republic, South Africa, China, India, and the Philippines (Department of Labour, 2008). People who have relatives in New Zealand can come to New Zealand through the Family Sponsored Stream and the

International/Humanitarian Stream (Department of Labour, 2008).

Among all the migrants in New Zealand, skilled migrants are more likely to have good English language skills, while almost half of the Family Parent migrants (49%) and 42% of business migrants rated their English language skills as moderate or poor (Department of Labour, 2008). The most common language spoken by new migrants was English, and followed by Chinese, which includes Chinese dialects, and northern Chinese (Mandarin). Yue, which includes Cantonese, was ranked eighth (Department of Labour, 2008).

Under the immigration policy, there has been an increased number of Chinese people migrating to New Zealand since 1986 under the "Skilled Migrant Category" which especially attracts many people with high qualifications, skills and work experience. Chinese accounted for 15% of migrants, as one of the four main ethnic migrant groups, the others were European (42%), South African (9%), and Indian (8%) (Department of Labour, 2008). A large proportion of business migrants were Chinese people (Department of Labour, 2008). Many elderly Chinese people come to New Zealand to reunite with their children under the Family Sponsored Stream.

In the Longitudinal Immigration Survey conducted by Statistics New Zealand (2008), migrants' demographic characteristics were presented through different categorising methods. When categorised according to "region of origin", migrants from Asian are divided into "north Asia", "south Asia", and "south-east Asia". For example, the survey outlined that Asian migrants were more likely to live in a dwelling owned by a family member; Asians were less likely to report their children to be very settled than most other groups, with the exception of those from south Asia. When migrants were categorised by ethnicity, Chinese accounted for 14.9% of total migrants (36,220). The survey also found that China is one of the main source countries of skilled migrant category migrants, and business migrants were more likely to be

Chinese. This survey was the first comprehensive research study which reported the migration experience of new permanent residents (Statistics New Zealand, 2008), while it is difficult to obtain more specific understanding about Chinese migrants from these findings.

Considering the long history of Chinese migrants to New Zealand, and as the population continues to grow, it is time to pay attention to the mental health needs of Chinese people. Migration has been a turning point in migrants' lives and has significant impact on their mental wellbeing. What is the migration process or the settlement experience of Chinese migrants; how it may influence their mental well-being and pathways to mental health services are important issues to understand.

Migration Process and Mental Well-being

> *While moving from one country and culture to another inevitably entails stress, it does not necessarily threaten mental health. The mental health of immigrants and refugees becomes a concern when additional risk factors combine with the stress of migration* (Canadian Task Force, 1988b, p. i, quoted in Ho et al., 2003, p. 35).

The question "is migration associated with an increased risk of mental illness?" has been discussed in many previous studies (Ho et al., 2003, p. 35). Mental health is affected by many factors including biological health, psychological health, and sociological factors such as employment, relationships and social status, spiritual wellness (Waitemata District Health Board, 2013). Chinese migrants experience a lot of changes during the migration journey, and new social and economic factors may impact on their mental well-being (Bhugra, 2004).

The migration process consists of three stages: pre-migration, migration and

post-migration (Bhugra & Jones, 2001). Pre-migration is the stage that the individuals plan and decide to migrate. Social skills, migration motivations such as "economic or aspirational reasons" play important roles in this stage (Bhugra, 2004, p. 244).

When migration occurs, it contains "physical transition from one place to another" (Bhugra & Jones, 2001, p. 216), and a lot of changes such as loss of social supports and networks. Acculturation also starts in this stage. The following stage is post-migration, which focuses on social and cultural changes for migrants in the host society (Bhugra , & Jones, 2001).

The research in New Zealand suggested the mental well-being of Asian people is similar to that of other ethnic groups: that it is difficult to identify the necessary relations between migration and mental health (Ho et al., 2003). However, some settlement-related issues may cause depression, low mental health and poor adjustment (Henderson, 2004; Pernice, Trlin, Henderson, North , & Skinner, 2009).

Henderson (2004) used "settlement" and "integration" to describe the migration process. Settlement focuses on shorter-term goals relating to how immigrants adapt to basic daily life, such as issues of employment and accommodation. Integration focuses on the co-adaptations between migrants and the host society in a longer-term process. According to Berry (1997), integration is a two-way process which emphasises the participation and cooperation from both migrants and the original people in the host society. Migrants have to contribute to the social and economic well-being of the host society and also retain their original cultural identity. Therefore, some significant factors that relate to the stressful migration process are the following:

Firstly, language is the most frequently identified barrier for migrants to achieve successful settlement (Pernice et al., 2009). Those who migrate at a very young age or are unskilled female dependants, and elderly migrants tend to have poor English at the

time of migration (Ho et al., 2003).

Secondly, migrants may experience changes in socio-economic status, which relate to employment, housing, and social supports. Chinese new migrants were identified as skilled migrants, but they are more likely to experience unemployment or underemployment (Henderson, 2004). Many migrants experience discrimination during their daily lives, especially in work environments. Two studies focusing on Chinese New Zealanders found that unemployment and underemployment were significant factors that have impacts on their mental well-being (Pernice et al., 2009; Rasanathan et al., 2006).

Thirdly, the family unit may often be separated and create new family dynamics such as the "astronauting" pattern. The term "astronauting" means that one or more members of a family returns to their country of origin to work in order to maintain socio-economic levels, while the rest of the family stays in the host country (Henderson, 2004). This family pattern is a product of unemployment or underemployment. However, family separation can cause many family problems, such as marriage problems, parent-child conflict and behavioural problems (Abbott et al., 1999; Henderson, 2004). Different attitudes towards acculturation may also contribute to intergenerational conflicts (Pernice et al., 2009). For example, parents and children in the family may have different expectations and social norms (Te Pou, 2008). Asian students who live in New Zealand without parents might experience loneliness (Ho et al., 2003).

These factors that are discussed above may also be risk or protective factors for the mental well-being of Asian/Chinese migrants. Here, the definitions of a risk factor and a protective factor are in Appendix 1. For example, lack of language proficiency, unemployment or underemployment, post-migration discrimination from the host society, and family separation may contribute to emotional stress or mental health

disorders (Henderson, 2004). Besides, isolation from people with the same cultural backgrounds, lack of social support and networks, people who migrate at very young or old ages, pre-migratory trauma and stress, instability of accommodation, negative attitudes and rejection from the surrounding host people may also increase the risks of mental disorder in migrants (Ho et al., 2003). Social supports were mentioned to be the important protective factors to maintain the mental well-being of Asian people, especially supports from family and friends (Te Pou, 2008; Tse, 2004). These factors will be further discussed in the following sections.

Access and Utilisation of Mental Health Services

As mentioned in the introduction chapter, much of the literature, including a few New Zealand studies and some international research, acknowledged that Chinese migrant groups are likely to underutilize mental health services, and factors that result in Chinese migrants delaying their access and underutilising mental health services have been explored (Ho, Hunt, & Li, 2008; Yang, Phelan, & Link, 2008).

The findings from these studies vary: some findings may be consistent with others, while some may not. When drawing lessons from existing research results, it is important to remember the research was conducted in different countries, and the sample size, and the demographic characteristics of the participants are also different.

Mental well-being of Asian/Chinese New Zealanders

In 2002, a literature review of mental health issues for Asians in New Zealand was published which was the "first Asian-focused document" presented by the Mental Health Commission (Ho et al., 2003, p. ii). This report explored the adaptation problems and difficulties of Asian migrants, and also the factors that impact on their mental health status and their utilization of mental health services. It is important to

highlight that this report provided a firm foundation for the following research on Asian migrants in the mental health field.

According to Ho et al. (2003), four factors are identified that affect the utilization of mental health services: inaccessibility to mental health services; inappropriate services; lack of qualified health care providers for the specific groups; and, the fact that traditional health practices are chosen by most Asian immigrants before they use mainstream services. To be more specific, lack of English proficiency prevents immigrants from being aware of existing services, or understanding organisations and health systems, as well as the benefits in that system; different cultural understandings of mental health play a key role in preventing Asian immigrants from accessing the services; cultural differences in the assessment and treatment of mental illness can lead to many results such as failure to detect psychiatric symptoms; besides, it is common for Asian immigrants to use traditional healing practices or to use both western and traditional methods at the same time, and mental health professionals usually do not know about this situation (Ho et al., 2003).

Another important document is the "Asian Mental Health and Addiction Research Agenda for New Zealand 2008-2012" (Te Pou, 2008). In order to understand the mental health and addiction issues of Asian communities, the research agenda outlined previous literature, and suggested some questions for service providers for reflection and further research. This document provides important basis for this study, and a lot of important information is cited in the report.

These significant studies that focus on the mental well-being of Asian people in New Zealand found that language and cultural barriers played important roles in preventing Asian access to health services (Abbott et al., 1999; DeSouza, & Garrett, 2005; Ngai, Latimer, & Cheung, 2001). A few studies targeting elderly Chinese people have been conducted in New Zealand. For Chinese migrants, some

sub-groups which have a higher risk of mental health issues were identified as the following: adults aged 26–35 years; parents with an absent partner; teenagers and young adults residing in a household without one or both parents; and elderly people (Abbott et al., 1999).

Therefore, these studies conducted in New Zealand as well as those from other western countries will be reviewed to better understand the experience of Chinese people in relation to accessibility and utilisation of mental health services.

Chinese migrants in mental health care

Chinese immigrants are underserved by mental health care systems in many western countries. Some research shows that Chinese immigrants are least represented in inpatient and outpatient services for serious psychiatric disorders, and less likely to use any form of mental health service than the majority population (Chen, Kazanjian, , & Wong, 2009). A range of factors that limit access and utilisation of mental health services were identified in previous studies. Although these factors are classified into different categories as below, they are closely connected and interact with each other.

Many socio-demographic variables that impact on mental health services utilization have been explored, such as gender, age, marital status, socio-economic backgrounds, place of birth, education and length of residence. Findings from these studies involved mixed relationships, which can be positive, negative, or non-significant relationships.

Socio-demographic factors

Gender: While migration may bring new opportunities for women, they may still experience some risks, such as inequality of employment (Lane, Tribe, & Hui, 2010). For female elderly migrants, who have lower self-efficacy and English proficiency, they tend to have lower levels of life satisfaction (Te Pou, 2008). Kung (2004)

suggested that American-Chinese women are more likely than men to seek mental health help when a diagnosable psychiatric disorder is involved. On the other hand, men with high self-esteem are eight times more willing to seek mental health help than women. However, the significant relationship between gender and depressive symptoms could not be measured in Kung's research.

Age: Older Asian migrants are identified as one vulnerable group with high risks, due to their poor English language abilities and lack of social networks they are less likely to participate in outdoor activities (Ho et al., 2003). They may lack emotional support and experience loneliness, isolation and anxiety. Sometimes they may experience pressure when their younger children quickly integrate into the society. Some of them may feel marginalized by the host society, and also rejected by their own cultural groups (Ho et al., 2003). Hassett and George (2002) supported the idea that elderly migrants who come from a non-English speaking background have more difficulties in accessing mental health services, and depression is the major mental illness diagnosed for elderly migrants. However, another study conducted with elderly Chinese with depression showed that age is not linearly associated with depression. For older Chinese who are over the age of 65, the younger ones have the higher possibility of getting depression (Zhang et al., 1997).

Physical health is closely related with mental health status (Abbott et al., 2003). It is found that those who "have had an illness in the past year, self-rated poor health and number of visits to general medical practitioners" (p. 499) are more likely to have depression.

Lack of financial resources is a potential barrier for Chinese immigrants to use mental health services (Kung, 2003). It is common for Chinese immigrants to be self-employed or to have low-paying jobs (Kung, 2004). Therefore, the cost of, and time for, mental health treatment are big concerns. Chinese immigrants do not have

time to receive treatment because of their long work hours, and they are shamed to take leave for treatment (Kung, 2004). Health insurance is an important financial resource. Chinese Americans who do not have health insurance were less likely to seek help from mainstream services (Pang, Jordan-Marsh, Silverstein, & Cody, 2003). It is important to understand the health system in New Zealand is different from America. Whether this factor also prevents Chinese people in New Zealand from accessing mental health care is not covered in this study.

Place of birth: Chen et al. (2009) found out that place of birth has little effect on Chinese help-seeking behaviour. However another research study shows that US-born Chinese of this group are more likely to use and benefit from psychiatric services, since their perspectives on treatment are more likely to match those of Western mental health professionals (Yang, Corsini-Munt, Link, & Phelan, 2009).

Length of residence: Chinese-Americans who have lived longer than 10 years in the United States use less complementary medical services, suggesting that acculturation is an important factor in determining traditional Chinese medicine use (Yang et al., 2009). Blignault, Ponzio, Rong and Eisenbruch (2008) discovered many China-born participants in the study who arrived recently are well educated, and they are more likely to acknowledge some western concepts of mental health and illness.

These socio-demographic factors above are closely related to each other, and combined with the following factors that have influence on the mental health service accessibility and utilisation: language barriers, help-seeking patterns, inadequate knowledge of available services, and cultural differences between service providers and users in understanding and delivering mental health services.

Language incompatibility

Language ability is one of the essential factors that influences the use of mental health

services and service delivery. More importantly, it is not only the English language itself, but also the cultural information behind the language which increases the barrier for Chinese people in accessing services. The common barriers include the low English proficiency of migrants, shortage of mental health professionals from the same cultural background (Kung, 2004), misunderstanding the mental health symptoms due to the language barrier, and lack of appropriate interpreting services (Li, Logan, Yee, & Ng, 1999). Zhang et al. (1997) suggested that Chinese Americans with depression may meet language-based discrimination when seeking mental health care. Language-based discrimination was an important factor that resulted in high rates of utilisation of informal services, and thus Chinese-Americans with emotional problems are more willing to seek help from friends and relatives (Zhang et al., 1997).

Help-seeking behaviour and attitudes

According to Kung (2004), Chinese migrants are likely to use passive coping strategies when they encounter mental health problems such as avoidance, withdrawal, minimizing the problem, wishing the situation would go away, and resignation to, and acceptance of, fate. Leong and Lau (2001) also mentioned that many Chinese families' choices to delay seeking help are to protect the family name and to save "face". Chinese are collectivist and prefer to keep problems within close family members, while health professionals are categorised as "strangers", who are outside the group, therefore it is understandable that family members rather than health professionals are often more involved in seeking-help patterns (Leong, & Lau, 2001). These characteristics, which are rooted in traditional Chinese culture, delayed their help-seeking behaviours. The significant concepts of traditional Chinese culture will be introduced later in the chapter.

Mental health status, attitudes toward acculturation, and socio-demographic characteristics such as sex, age, socio-economic level, and marital status are

examined together as important predictors that can influence help-seeking attitudes and behaviour (Ying & Miller, 1992). In the study, people from lower socio-economic backgrounds were believed more vulnerable than those from higher socio-economic backgrounds. The findings showed that better English ability, being younger, married, and coming from a lower socio-economic background are associated with a more positive attitude in seeking professional help. Acculturation orientations played important roles in introducing the different concepts of mental health, and also encouraging the utilisation of mental health providers (Ying & Miller, 1992).

Besides this, other studies have supported the contention that acculturation has an impact on the help-seeking behaviours (Ying & Miller, 1992; Kung, 2004). Kung's research (2003) suggested that acculturation level has an impact on the help-seeking behaviour of Chinese-Americans regarding emotional distress. The research found that being female and more acculturated increases one's tendency to solicit help from the family circle, perhaps because of greater interpersonal openness. When individuals have a higher inclination to take control and face up to life's challenges and are also highly acculturated, they are particularly likely to seek informal help.

According to Kung (2004), relatives and friends as informal help are the most sought by Chinese people. Besides seeking informal help, some Chinese-Americans with emotional problems seek help from alternative sources such as herbalists, acupuncturists, ministers, or fortune-tellers rather than from mental health specialists and medical doctors.

Blignault et al. (2008) also pointed out that Chinese clients and community members are willing to seek help and support from family members and friends. When seeking help from professionals, general practitioners play significant roles in helping Chinese people to access mental health care (Blignault et al., 2008). Kung (2001)

suggested that, besides psychiatrists, four other professional groups mentioned by Chinese Australians include general practitioners, social and community workers, Chinese herbalists, and psychologists and counsellors.

The use of alternative treatment such as traditional Chinese medicine (TCM) is another reason for Chinese people underutilizing mental health services (Yang et al., 2009). Many Chinese migrants may be afraid of side affects of Western medicine (Kung, 2001); it is common for Chinese people to believe that Western medicine treats symptomatology, while TCM may gradually address the fundamental cause of illness; thus TCM is more effective than Western medicine. TCM might play a prominent role in delayed access to western mental health services, and especially for first-generation immigrants (Yang et al., 2009). This is supported by one Auckland study, which discovered that within traditional medicine, Chinese, Cambodians, Vietnamese and other Asian migrants are most likely to choose Chinese herbal medicines (Ho et al., 2003). However, Chinese Americans do not generally seek cultural-based forms of help such as herbalists and acupuncturists for personal psychological problems, but rather for physical ailments (Kung, 2001). Another study indicated that Chinese-Americans viewed Western mental health professionals as being significantly more able to help treat a mental disorder when compared with a TCM practitioner (Yang et al., 2008).

Family and kin

Family members are often regarded as the main source of support. Abbott et al. (2003) mentioned that filial piety and family support might contribute to low rates of depression. Leung (2002) noticed that family and kin are the main sources for older migrants to get support from social, emotional and financial aspects, such as transportation and communication with the host society. Networking is important, older people can obtain support from well-established Chinese communities. People

who were single, widowed or separated could receive social support if they live with their family members, thus whether or not they were married is not important (Leung, 2002). This argument is in contrast with the findings from Te Pou (2008) which suggested separated, divorced or widowed people are more likely to have mental illness.

Traditional Cultural Beliefs and Values

A few studies have explored the impact of traditional Chinese cultural beliefs and values on the thinking and behaviours of Chinese people towards mental illness and mental health providers (Chan & Parker, 2004; Ho et al., 2008; Sun, Cornforth, & Claiborne, 2008). The following parts will first introduce three important cultural values and belief systems: Confucianism, Taoism and Buddhism. Then, some cultural issues that relate to these traditional values and beliefs will be explored, including lack of awareness or denial of mental illness, stigmatization, misperceptions about Western medicine (Leung, Cheung, & Tsui, 2012), acculturation stress, and lack of availability of culturally sensitive services, and a questioning of the cultural competence of service providers.

Confucianism: Confucianism can be seen as a moral philosophy or Chinese social ethic, It emphasises the importance of moral excellence, and "one's destiny depends mainly on one's moral efforts and a negative outcome is due solely to one's moral failure" (Lam et al., 2010, p. 35). The final goal is to achieve the harmony within self, family, society and universe (Lam et al., 2010). Ethical and moral values include filial piety; respect for elders and ancestor worship (Lam et al., 2010).

The Confucian paradigm emphasises that social harmony and order, the relationship between sovereign and subject, father and son, elder and younger brother, husband and wife, and friend and friend all have impacts on social harmony. Maintaining social

harmony rather than achieving self-worth is the most important task for Chinese people (Lam et al., 2010). Filial piety is a fundamental value of Confucianism, which defines multiple relationships within family between parents and children, especially between father (responsibility) and son (obedience); between husband and wife (mutual respect); and between ancestors and descendants (Ho et al., 2003). The concepts of filial piety will be explored more in the discussion chapter.

Taoism: Taoism believes that "the world is composed of opposing energy sources yin and yan. Therefore "wu-wei" is the best way to deal with life which means "letting things take their own course" (Chan & Parker, 2004, p. 143).

Laozi's Taoism has two principles: "first, human beings must follow natural laws and the Way (or Tao); and second, people must be humanistic (kind, polite, considerate) by following human laws" (Lam et al., 2010, p. 36). The first principle highlights the harmonic relationship between humans and nature, and the second principle means that people should be in harmony with each other.

According to Lam et al. (2010, p. 36), "optimal health is the result of harmony and balance, both within the individual's social environment and the relationship with nature and the universe". Disharmony and imbalance between a person's body and soul may cause illness such as mental disorders. Some mental illness such as depression is often considered as "weakness" in spiritual strength. Thus a healing process is one which brings the "configuration back to balance to restore harmony within the individual" (p. 36).

Buddhism: Folk religions have always been a factor that influences many Chinese people's daily lives (Lam et al., 2010). Buddhism is one of the major religions in China, and the beliefs engage well with the concepts of Taoism and Confucianism. The core beliefs of Buddhism include "performing good deeds will earn positive consequences

and doing bad things will result in negative repercussions" (p. 36). A person's past behaviours may impact on the future "rebirth" (p. 36). Therefore, people with disability or mental disorders may regard these as the punishment for the wrongdoing from previous lives. It is thus more reasonable that people have negative perceptions about mental illness and feel shame in a Buddhism-dominated culture. Shamans are consulted sometimes by women to solve family issues and heal illnesses, including mental illness (Lam et al., 2010).

Implications of traditional cultural concepts

Several previous studies have explored the impact of traditional Chinese culture on the understanding of Chinese migrants towards mental health and illness (Lam et al., 2010; Min, 2010; Yip, 2005). As traditional Chinese beliefs and values affect modern Chinese culture including medicine and health care, it is reasonable that people from diverse cultural backgrounds have different understandings about mental health. There has been a lot of discussion around the concept of mental health in many western countries. The definition of mental health from the WHO constitution (2010) is widely applied (Appendix 1). However, Min (2010) suggested that many concepts of mental health in western countries emphasise individual orientations such as the individual's personality or a state of individual psychosis, which are obviously consistent with the values of individualism. While for Chinese people who are in different social contexts from Western people, concepts of mental health will vary. Min (2010) believed taking into account the Chinese social and cultural contexts is important in correctly understanding the Chinese concepts of mental health. Therefore, understanding the concepts of Confucianism, Taoism and Buddhists may be helpful to understand the cognitions of Chinese people towards mental health, and shame and discrimination, which will be discussed below.

Chinese understanding of mental health

As supported by Min (2010), Confucianism explains the meaning of mental health on four levels: on the personal level, it emphasises "individual's inner moral cultivation" (p. 153), which builds connection with others; on the self level, it highlights "individual practice competence" (p. 153); on the societal level, it stresses the significance of keeping social harmony in daily social life; and on the spiritual level, the individual's life status can be promoted and "all daily life conflicts are transcended" (p. 154). In short, Confucianism believes that individual is connected with outside environments, and the mental health of the individual can be promoted to achieve a highly balanced state of wholeness by both including the difference and promoting agency in daily life (Min, 2010). According to Confucian thought, a moral person has to learn how to control oneself before participating in social life. While Chinese people with mental illness are considered as dangerous and uncontrollable, they are categorized as morally defective and incompetent (Liu et al., 2012).

Many Chinese people with mental health issues and their families may loss of face, and experience shame and discrimination (Liu, Insel, Reed, & Crist, 2012; Yang, & Kleinman, 2008), because the concepts of "face" are rooted in Confucianism. As suggested by Liu et al. (2012), 'Face' incorporates a physical, emotional, social and moral process in Chinese society. Loss of face has significant impact on a person's accessibility to social networks and contributes to stigma. In order to avoid losing face for the individual and the family, individuals who have mental illness and their families almost always delay seeking help. Fatalism, as mentioned before, defined the passive and dependent role of the sick person in traditional Chinese culture. The view of fatalism highly valued one's tolerance of life stresses and suffering (Kung, 2004), which may affect the copying strategies and cause delay in seeking help from mainstream mental health services.

Another important study conducted in the United States by Yip (2005), explored the relationships between traditional Taoism and the mental health of Chinese people. The study also pointed out several differences, comparing Taoistic concepts of mental health with Western concepts of mental health (see Table 2.1).

Western concepts	Taoistic concepts
Self-development Inspire potential of the person and cultivate a sense of self-worth and self-image.	**Self-transcendence** The self-image and self-evaluation for Chinese people depends on "the degree of transcendence beyond secular standards of perception from others" (p. 39).
Social attainment Social functioning, social adjustment, and social achievement are important for the mental well-being of individuals.	**The law of Nature** Social attainment is only a short-term consequence; Chinese people can obtain a peaceful mind if they transcend themselves to the law of nature which is beyond social attainment.
Progressive endeavour Encourage individuals to achieve their personal goals in life	**Inaction** There is no need to encourage personal endeavour, Chinese people should maintain "quiescence" to confront the changing world.
Personal interpretation Emphasises personal interpretation and subjective feelings of wellness or well-	**Infinite frame of reference** Instead of pursuing social achievement, or being confined by human limitations, Chinese people should pursue subtle and

being.	penetrating intelligence and profoundness that cannot be understood by ordinary man.

Table 2.1 The Concepts of Mental Health (Yip, 2005)

As explained above in the table, the main concepts of western mental health encourage the development of individuals. Modern Western concepts of mental health emphasise the relationship between the person and his/her environment. A mentally healthy person should be able to adjust to the social environment and can perform his/her social roles effectively. Feelings of self-worth, satisfaction with roles in life, and positive relationships with others are three major elements that need to be achieved. Also, an equality with, and mutual respect for, the social environment is considered as important for a mentally healthy person to live (Yip, 2005). Thus traditional Chinese concepts of mental health are different from western concepts. Chinese people are more likely to exhibit self-control, self-discipline, self-cultivation and self-transcendence (Yip, 2005). Therefore, a mentally healthy Chinese is expected to show "harmony, interdependence, and loyalty", while "competitiveness, independence, and change" are different expectations for American people (Lee & Chan, 2009). Besides, in terms of treatment processes, Chinese people believe "health is determined by a holistic balancing of vital energy" (Yang et al., 2009, p. 209), thus it is understandable that some Chinese people choose traditional Chinese medicine (TCM) rather than Western medicine. As mentioned earlier, TCM is considered to be effective in protecting people's health and preventing illness from occurring (Wong & He, 2011), while Western medicine focuses on symptoms that are presented.

Chinese people have some popular perceptions of mental health (Yang and Wonpat-Borja, 2012), and some significant examples include: (1) "mystical causes resulting in 'spirit possession' and disturbances in the spirit world" (p. 472); and (2)

people who has mental illness is a form of punishment, which may caused by a moral wrongdoing in past lives, or possibly because of their ancestor's failure (Liu, Leung, & Chi, 2012); (3) mental illness is a western problem of the mind and a typical Chinese individual should not be affected by it. It is obvious that these popular perspectives about mental illness have been influenced by Chinese traditional culture and philosophy. Therefore, being aware of the main concepts of traditional culture can help practitioners to understand these perceptions of mental health.

Shame and discrimination

The stigma associated with mental illness, as one result of traditional Chinese culture, has been a prominent barrier for Chinese clients and their families to accessing and utilising mental health services.

Some research has analysed some core cultural issues such as shame associated with mental illness and discrimination; dependency on family members; and fatalism in relation to negative attitudes to the illness and treatment (Tse, 2004). Lam et al., (2010) supported that the negative effects of stigma include discrimination from the public and fear or not being willing to seek professional help. Stigma may also be a barrier for rehabilitation and recovery.

Due to a prevailing strong loyalty to traditional Chinese values, Chinese people try to avoid bringing shame or stigma to the family (Lam et al., 2010). For Chinese people who want to preserve 'face', they are more likely to have a negative attitude to the illness and treatment, and this may even include giving up participation in all the interventions (Tse, 2004), which may also result in people being not willing to reach out for professional help. The shame may prevent the client from self-disclosing and that makes it difficult to build trusting relationships between the patient and mental health practitioners (Tse, 2004). Moreover, it is common for Chinese immigrants to

"somatise emotional distress" (Kung, 2004, p. 29). Somatisation relates mental or psychological problems to physical problems and it also rejects Western explanations of non-psychotic illness (Hsiao, Klimidis, Minas, & Tan, 2006). Somatisation can also be a reason that for unrecognised mental illness of elderly people (Lam et al., 2009; Yu & Lee, 2012). Their preferences are impacted by the stigma attached to mental illness. As a result, they are more likely to seek medical help from Chinese medicine practitioners and Western physicians rather than mental health practitioners (Hsiao et al., 2006). As supported by Yang et al. (2008), the research findings show that most Chinese American people would find it shameful to use western psychiatric treatment when compared with a practitioner of traditional Chinese medicine to treat a mental disorder.

Besides stigma, discrimination is experienced by many people with mental illness. The perception of mental health in the traditional cultural context has impact on how others in the community perceive them and their family (Tse, 2004). Spencer and Chen (2004) also suggest that Chinese-Americans who speak a different language and have a foreign accent may experience discrimination when accessing services, which can be a critical factor that influences the person's health care decisions.

Whether or not Chinese migrants seek help from mental health practitioners depends on their perception of current mental health treatment, and also their cultural understandings of mental health. As discussed above, Chinese people prefer to believe emotional distress is a personal weakness, and it should be improved through self-control rather than seeking help from mental health practitioners. The trust felt towards mental health professionals may be challenged by the conflicts between Chinese cultural values and current mental health treatment approaches. Chinese people may have a perception that mental health providers may discriminate against them, or they may be afraid of undergoing a western model of assessment and treatment: these may contribute to underutilization of mental health services.

As stated by Hsiao et al. (2006), cultural transmission is mediated by cultural learning, social learning and individual learning (Hsiao et al., 2006). Cultural learning includes "innovation" and "imitation" processes, during which traditional cultural knowledge is changed (p. 39). Social learning happens in daily life activities from generation to generation. Individual learning is a variation on social learning. Social and political factors also influence cultural transmission. In this study, Chinese migrants have been surrounded by new social and cultural environments since they arrived in New Zealand and what their experience has been about cultural learning, social learning and individual learning is important to acknowledge.

Social Workers in Mental Health Field

Around 20% of the total population in New Zealand may experience a mental health issue at some time. Within that, 3% of people are diagnosed as having serious mental or enduring mental illness, and 17% of the population have mental health problems but are not eligible to receive treatment from mainstream mental health services. Social workers are working with many of them in primary health and voluntary social services (Briggs & Cromie, 2009).

Ray, Pugh, Roberts, and Beech (2008) claimed that there is no doubt about the contribution of social work in mental health services. Social workers brought a new understanding which is social model into mental health services which "challenge or complement clinically-oriented medical model of mental illness". Yip (2000) also concluded that social workers in mental health services make a unique contribution to psychosocial intervention and community development.

Social workers play important and different roles in multiple practice settings. In primary care services, mental health social workers work along with general practitioners, in non-government agencies they work along with community support

workers and peer support workers (Briggs & Cromie, 2009). In specialist settings, social workers are members of multi-disciplinary teams. Psychiatrists, psychologists, nurses, occupational therapists, and other allied health professionals are members of the team (Briggs & Cromie, 2009).

Social workers are greatly appreciated by their clients because they can always provide practical support as well as emotional support, counselling and advocacy, and respond positively (Ray et al., 2008). The social environment is also of high importance to social workers. The other role of social workers is to encourage clients widely involved in the services, and develop "systemic approaches" to work with clients and their families (Ray et al., 2008).

One significant role for mental health social workers is supporting and engaging family. Family members provide clients confidence, warmth, and empowerment Kean (2009). The strengths model is often applied by social workers during the recovery intervention which involves hope, healing, empowerment and connection. It is the social worker's role to communicate with the family, and acknowledge their feelings, and provides services to support them in being able to accompany the client.

In this study, 10 participants who provide mental health services to Chinese people are involved, and seven of them are social workers. As a social work student, I am interested in the roles of social workers in mental health field, and also how mental health practitioners from different disciplines work cooperate with each other. It is hoped that the study may identify some roles of social worker in promoting mental health service utilisation.

Summary

This chapter introduces the history of Chinese migrants in New Zealand, and followed

with some characteristics of Asian/Chinese migrants shaped by migration policy. Migration is an important event for Chinese immigrants, while to what extent that migration-related factors have impacted on their mental health status has been discussed. It also provided a summary of previous research concerning the experience of Chinese migrants accessing and utilising mental health services. Socio-demographic factors and cultural factors that impact on service use have been considered. Finally, the important roles of social workers in mental health practice have been introduced.

It is important to acknowledge that factors resulting in Chinese people underutilising mental health services, or delaying seeking help from mental health professionals are likely to relate to the traditional Chinese culture and beliefs such as Confucianism, Taoism, and Buddhism. The language barrier is a significant factor that prevents effective communication between professionals and migrants. Family members and community networks are important support sources for Chinese people and this also impacts on access.

As a result, it is important to understand Chinese people who have strong adherence to traditional Chinese culture may have barriers which impact on their thinking and behaviours towards western mental health care. The multiple connections between these factors should be further explored. This chapter has laid the foundation for this study, and the perspectives of mental health practitioners will be engaged with in Chapter 4.The next chapter introduces the study's research methodology.

Chapter 3. Research Methodology

Introduction

This chapter outlines the research design and implementation by discussing the processes involved in developing and conducting this project. It is divided into two main parts. Part One introduces the conceptualisation of research design, and this is followed by the research journey starting from development and shaping the research question to the conducting of interviews. Part Two explains the data analysis, participants' demographics, and the limitations of the research are explored.

Part One: Research Design

This section starts with how I chose an appropriate methodological approach. Then I introduced the formation of the initial research question, and followed with ethical considerations and procedures. Finally, I explain participant recruitment and data collection.

A Qualitative Focus

Research design is the critical phase during the research process, thus the following questions provided underpinning for the research design (O'Leary, 2010): (1) is the research more suitable to information that reflects quantity, quality or combined? (2) What does the research question suggest? (3) How can information be obtained? (4) Who can provide the information? (5) What are the ethical issues involved? What are other logistical considerations? These questions have been considered and addressed within a qualitative perspective, which not only helped me to make decisions about the type of research, but also shaped the research question to: "what are mental health

practitioners' perspectives of working with Chinese immigrants in New Zealand in relation to mental health service delivery and accessibility?", as introduced in Chapter 1.

Initially, the research idea was to perform further study in New Zealand on needs assessment of Chinese immigrants accessing mainstream mental health services. After reviewing the literature, I found that there had been limited research conducted on this topic in New Zealand, and the researchers are calling for further research to improve primary care, mental health service access and responsiveness for older Chinese and other Asian minority groups. Both large-scale survey and in-depth qualitative studies on the needs of Chinese mental clients are demanded in this field. I as the researcher had more interest in the work experience of mental health practitioners, and was eager to learn more about current social work practice in mental health fields.

A focus of qualitative research is "to represent the complex worlds of respondents in a holistic, on the ground manner" (Padgett, 2008, p. 2). Within the study, I chose the approach to enable the participants to "tap the deeper meanings of particular human experiences" (Rubin & Babbie, 2008, p. 417), and to obtain the latest information and add interpretations (Appleton, 2010).

Curtin and Fossey (2007) also supported that qualitative evidence involves focusing on a person's perspectives, views and experiences, and it allows for continuous discovering and exploring new and emerging findings and encourages responsiveness to these. It also provides a basis to develop collaboration and partnerships between the participants and the researchers (Appleton, 2010).

As a result, using qualitative methodology may capture comprehensive information on this topic, and reflect participants' thinking more profoundly and openly, and hopefully identify new themes in the New Zealand context.

Shaping the concepts: from interest to operationalisation

As chapters 1 and 2 demonstrated, some international and domestic literature has shown concerns exist about the mental well-being of Chinese migrants, and the utilisation of mainstream mental health services. However, in forming my research topic, I started to question how I might explore my key questions and capture relevant information from participants.

After I decided upon the research question, and read though key concepts through the literature review, I decided to talk to other people who have certain understanding of the research topic as an important step before applying for ethical approval.

Accordingly to address the research question, a literature search was conducted through library databases, which includes FAMILYAustralian Family and Society Abstracts Database, Index New Zealand (INNZ), MEDLINE, Social Work Abstracts, Sociological abstracts, and also through Google Scholar. The search key words were entered such as "Asian/Chinese migrants", "mental health/illness", "mental health services/providers/care/treatment", and "access/utilize mental health services".

The search started from literature published in Aotearoa New Zealand. The key words that applied in the search included "Chinese", "mental health" and "New Zealand". The results showed there are about 20 studies that focus on the mental health issues of Chinese migrants from 1992 to 2010.

I met some professionals during the internship. They have rich work experience, and are now currently working in the mental health field. Some of them have Chinese background. Besides reviewing the literature, the research question was discussed with these mental health practitioners to ensure it was an important question that needed to be urgently explored. They agreed that the needs of Chinese people

regarding mental health services should be examined. They suggested that it was my own decision to do either quantitative or qualitative research, but I should always be aware of the purpose of the study, and how the data could be collected. Therefore, the literature search and consultation from mental health professionals contributed to the research topic.

Ethics Considerations and Procedures

Social research is a dynamic and interactive process (Monette, Sullivan, &DeJong, 2008). It can only take place because of the trust and cooperation of those who take part in the research. Ethics highlights the responsibility of researchers towards participants, and the relationships between the researcher and participants should be managed in a responsible and accountable way. My supervisors contributed a lot during my whole research process, and they particularly emphasised the importance of following ethical principles. The ethics application emphasised the ethical principles below:

- Minimize risk of harm

While this study was anticipated to be of low risk, it is possible that practitioners may feel stressed if they have had an unpleasant experience working with Chinese immigrants before. As noted in Participant Information Sheet (PIS), participants have the right to refuse to answer any questions. Before the interview starts, Jing will restate these considerations to participants.

- Respect for persons/privacy, confidentiality

Although the interviews were audio recorded and transcribed, the information that may identify the participants was removed, such as names and organisations they work for. During the interview, participants talked about their specific experience working

with Chinese immigrants. Some of them disclosed certain information about the clients they worked with, however, only non-identifiable characteristics of clients were mentioned during the interview. Some practitioners made comments about the current mental health providers that serve Asian/Chinese people. This information about the organisation was carefully vetted to ensure confidentiality.

To further ensure participants' privacy, I suggested a neutral place for participants to be interviewed outside of their organisations in the first instance. A few participants wanted to be interviewed within their organisations; their requests were agreed to after they understood this decision may compromise their privacy to a degree.

- Informed and voluntary consent and participation

During the interview, practitioners might recall some cases they have worked with that may has been distressing. In the PIS and Consent Form (CF), participants were informed that they had rights not to disclose any information or answer questions that they do not wish to disclose or discuss. Before the interview began, I restated these considerations to participants.

- Social and cultural sensitivity

Whilst this study is focused on understanding relevant considerations working with Chinese migrants, the participants were not limited to Chinese practitioners. Though some participants were identified with a Chinese background, this project was not intended to raise specific cultural issues for participants. I am originally from China, and I am fluent in both the English and Chinese languages, so I was able to be aware of some nuances from Chinese culture, and I also kept in close contact with my supervisors to address some cultural issues in New Zealand context that arose from the interviews as to those who identified as Pakeha or Maori or New Zealanders.

My supervisors and I went through all the questions in the application form several

times before I submitted it. Most importantly, as a researcher I considered ethics at every step of my research: from the questions, to design, through to what is reported. The ethics committee made some comments on the application form, which required me to make amendments until it was approved. The Ethical application was approved by the University of Auckland Human Ethics Committee for a period of three years from 5th of July 2012 (Appendix 2). Then the next step was to recruit participants.

Participant Recruitment

Participants were recruited through practitioners' mental health networks via snowball sampling and third-party recruitment. I initially made contact with practitioners working in the mental health field and those who might know about potential participants. The contacts with practitioners were mainly through email, and a few phone calls. The first email to each practitioner simply introduced the purpose of the study, and how I wanted to recruit participants, and finally I asked them whether they would like to forward the information of this research to other practitioners who may have interest in the topic. I got replies from seven practitioners quickly, and they were all willing to spread the information about my study.

After these practitioners sent this information throughout their networks, people receiving this email could then contact me as to whether they were interested in participating (without the person sending the email knowing). So I sent a second email to those people, which contained the research proposal, participant information sheet and consent form. The research question list was also attached which included three basic questions (Appendix 4):

1) What are the issues for Chinese migrants to access and utilise mental health services? Such as barriers or protection factors?

2) What are the challenges for mental health practitioners to work with Chinese immigrants?
3) Possible strategies, solutions or recommendations to work with Chinese clients and their families.

Most of the practitioners whom I approached to disseminate the study also expressed their willingness to attend the research themselves without formally being asked. There was one main question that was asked by a few practitioners before they sent out the information: does your research focus on Chinese-speaking rather than non-Chinese-speaking mental health practitioners? So I explained to the practitioners that it does not matter whether the participants are Chinese or not, as long as they have work experience with Chinese clients and their families.

Eleven practitioners replied quickly and they showed their interest about the research topic, also providing some suggestions to help me to recruit more participants. One practitioner advertised my research information on the website of their agency, which helped me recruit two participants. Another participant said he would like to arrange a forum with a few of his colleagues including a psychiatrist and two counsellors, thus saving time since they were quite busy. However, according to ethical considerations, I could only conduct one-to-one interviews; and also took into account confidentiality, because it is third-party recruitment, this third-party person should have no knowledge about who is a participant or not, so I explained the situation to the practitioner and expressed my thanks. As participants were not being asked to comment on specific service providers but rather on their own professional perspectives of working with Chinese immigrants, I received ethical approval without needing to obtain the consent of the manager of each agency (see Appendix 3 for the PIS and CF).

A total of 10 practitioners participated in this research project. Interviews lasted approximately one hour and all participants who expressed an interest in participating

completed the interview with the exception of only one participant who cancelled the interview due to an important meeting. This interview was not rescheduled.

The above process of recruitment provided a good opportunity for me to build positive relationships with participants through fast and timely responses to their questions and suggestions, which contributed to the success of the following interviews (DiCicco-Bloom & Crabtree, 2006).

Data Collection

Before the first interview, my supervisor suggested I prepare a list of semi-structured questions, which developed from the three questions that were sent to the participants. I researched interview techniques and procedures (DiCicco-Bloom & Crabtree, 2006; Richards & Morse, 2007), and found out two important parts of the interview should be prepared in advance in order to encourage more voices from participants: how to start the interview, and how to ask questions.

Conducting the interviews

At the beginning of each interview, I briefly talked about the project including the research topic and the main themes, and then outlined the interview plan, and most importantly, explained about the confidentiality of the research, and the rights of participants in the study, which have been outlined in the Participant Information Sheet (PIS) and Consent Form (CF). For example, I emphasized the following information with participants: "the interview will be audio recorded to produce a written transcript, but you may choose to have the recorder turned off at any time; you have the right to refuse to answer any questions I asked, and to withdraw from the research at any time. All the information that may identify you as participants will be removed; when this research is completed, you will be sent a summary of the findings".

After I confirmed with participants about their rights, I turned on the recorder and started the interview. I chose to begin with broad opening questions on the topic, and then asked follow-up questions and more specific questions depending on the responses of the participants. The initial parts of my question list are the following, and a complete list of questions is available in Appendix 4.

To start with:

Could you tell me your experience working with Chinese immigrants?

- How did you feel about that?
- What do you like most/least to work with Chinese immigrants?

Main question one: *What are the primary issues for Chinese migrants to access and utilise mental health services? Are you aware of any barriers or protective factors that would be relevant to access and utilisation of mental health services?*

- In your professional experience, what do you think are the main mental health issues of Chinese immigrants?
  - Could you say some more about it?
- What do you think are relevant issues that have impact on the mental well-being of Chinese immigrants?
- What do you think are Chinese perspectives about current mental health services in New Zealand?
  - How did you get this conclusion? Would you like to give some examples?
- From your work experience, what are the relevant issues that can influence Chinese immigrants to access and utilize mental health services?
  - What are other issues that can be identified as protective factors/barriers?
  - What do you think may cause them to delay in seeking treatment or underutilize available mental health services?
  - Do you think there are differences between Chinese immigrants and Pakeha people in terms of accessing and utilizing mental health services?

Table 3.1 Semi-structured interview questions example

These questions were prepared before the interview. In preparing these questions I considered the various possibilities that might happen during the interview. Practitioners were from diverse cultural backgrounds: some were Chinese, some European, and they had different educational backgrounds and disciplines which may result in their different experience working with Chinese people. It was important to be aware that participants might not answer all of my questions in a particular expected

order, so I concentrated on making sure the interview was focused on three key themes, as introduced in Chapter 1, and also can be seen in Appendix 4, but also allow to participants to talk more about their experience and discover new concepts.

Transcription

To obtain a participant-endorsed transcript, the first step was to transcribe the person's data from the recorder. All ten participants agreed to have their interview audio-recorded during the interviews, which provided complete sources of information for the following transcription. Transcription is a process of documenting the data, and it is crucial step for interpretation (Flick, 2009).

There were several rules for layout and transcription, which were referred to document the participant's interview (Flick, 2009). For example, breaks and incomplete sentences were represented by different symbols in transcripts. Also paralinguist utterances of participants such as sighs were included. Some space in the right margin was left to make notes.

After transcription, a second step was to making contact with participants again to confirm the information was accurately recorded by providing a transcript of the interview. Transcripts as well as the recording were sent through by email at the participant's request. In order to save the time of participants, uncertain segments of the transcription were highlighted where it was not clear what was said, and further questions were raised for participants to examine and comment. Most participants responded to me quickly, and checked for the mistakes in the transcription, and simply answered the questions through email.

Part Two: Data Analysis

Saldana (2012) introduced a helpful and streamlined codes-to-theory model, which helped me to gain an understanding of the basic process from codes and categories to theory: when data is coded, these codes will be categorised to help main themes to emerge, and in order to obtain "more general, higher level, and more abstract constructs" (Richards & Morse, 2007, p. 157).

In this study, the analytic process is in basic form: firstly, rough initial coding of transcript and gather some important codes; secondly, focused coding which helped to develop categories from the most significant codes; At the same time I was keep performing analytic memo writing. It is often possible that the researcher needs to code and recode in order to present the codes and categories in a more logical way. Then, the process of categorizing the data helped the main themes or concepts to emerge, and possibly to develop a theory, which represents a concept of formation: "how we get up to more general, higher level, and more abstract constructs" (Richards , & Morse, 2007, p. 157).

Initial coding process

According to Saldana (2012), it is a good idea to write down the research question, goals of the study, and other main issues on one page and keep referring to it to help focus on the coding decision. Besides, there is a list of questions that may help to code, and I used some of them (Emerson, Fretz, & Shaw, 1995, p.146, quoted in p. 18):

a. What are people doing? What are they trying to accomplish?
b. How, exactly, do they do this? What specific means and /or strategies do they use?
c. What do I see going on here? What did I learn from the notes?

d. What strikes me?

Considering this was the first time I conducted research, and the sample size was small, my supervisor suggested I code manually, which is also recommended by Saldana (2012). After each interview, I started to analyse the transcription by hand-coding. As Charmaz (2006) maintains, the goal of initial coding is "to remain open to all possible theoretical directions indicated by your reading of the data" (p. 46). Whilst this was not a grounded theory study, Charmaz's discussion on coding was helpful as it allowed me to stay open to participant meanings. Thus, as a beginning qualitative researcher, this initial coding was helpful for me to learn how to code data from interview transcripts. The detailed, line-by-line initial coding is more suitable for interview transcripts (Charmaz, 2006). Pre-coding was also applied to highlight some significant quotes or comments from participants, which might be important enough to become "part of the title, organizational framework, or through-line of the report" (Saldana, 2012, p. 16), and also to provide evidence or use as examples to support arguments in the thesis. I did pre-coding through highlighted important words and expressions, sentences, and examples in different colors. An initial coding example is provided, and the source is from participant 2.

Description	
[1]I got training from New Zealand, so I [2]understanding the mental health services system and social support system, that is I understand the [3]main approach that they used that is my advantage. The other one is that I understand Chinese [4]language, (laugh) I can speak Chinese, I understand Chinese [5]cultural background, the way I am thinking is very similar to my client, I can be the [6]bridge between the mainstream services and Chinese clients. Language is another… [7]for example, we see if you go and visit the client, they have difficulty with work and income for their benefits, … but for Chinese clients, it's very [8]hard for them to understand the letter, so you have to explain what happen to the letter, and also why they sending the letter. It's not only [9]the meaning of the letter, also the process. You need to take extra step to support the client. [10] I think this is another difference; you need to take longer time, extra supports and extra steps. [11]I think one thing is about the boundary issue for Chinese practitioners. Because we all can speak Chinese, sometimes clients may [12]ask you a favour. They have [13]high demanding, so they said, "we are	[1] Trained in NZ [2]Understand system [3] Understand approach [4] Language [5] Same cultural background, think similar [6] Professional role as bridge [7]Examples of language [8] Hard to understand the letter [9] Translate the language, and introduce the process [10] Different approach to work with Chinese [11]Set boundary [12] Ask favour

all Chinese, you can help me do more". Sometimes they can be a little bit [14]dependency on you, become dependency. That is the [15]challenge that how to set up boundary. But you need to [16]judge. [17]I think the important thing is having the map in my mind, where we are going, and where is the boundary, clear in my mind. The purpose is to help them [18]develop independent. So some people they may need more time, I feel I have to [19]accept that, for Chinese people, it's [20]different from mainstream clients, they may take [21]longer time, but also spend a lot of time to explain to my client, help them to understand why I need to set up boundary, What is my purpose, why I can help now, where I may have to stop in somewhere, to give them a lot of preparation. I think another [22]challenge is that it is hard for your [23]colleague and team leader to understand you. They always challenge you "why you do so much to your client?" you need to help them to be independent, not dependent on you. But we need to [24]explain to our colleagues and team leader as well why we need extra support for our clients. [25]Re-educate both side, we educate our clients, what is the new Zealand law, what is new Zealand	[13] High demanding [14] Dependency [15] Challenge: set boundary [16] Judge [17] Explanations to set boundary [18] The purpose to Develop independence [19] Accept [20] Different from mainstream clients [21] Longer time, extra supports help clients to be prepared [22] Challenge [23] Understanding from colleagues and team leader [24] Explain and educate colleagues [25] Re-educate both side:

system, what is new Zealand welfare system, what is policy system, what is the law here. Every year we do [26]cultural training, for the mainstream, we utilize [27]Chinese big events, like new year, moon festival, we do a lot of cultural workshops, utilize the event, make both parties [28]understanding better, so much easier to work with… as a team, people support each other. I think for the Chinese migrants, particular for the [29]new migrants, they leave all the natural support behind, so they don't have many resources. Particular for [30]people whom suffering mental illness, they don't know how to [31]release the situation to other people. So they withdraw themselves, [32]isolate themselves. Because still quite strong [33]stigma in Chinese community, So that make quite difficulty. Another [34]challenge for Chinese practitioner to [35]develop new resources for service users.	service users and service providers [26] Provide cultural training for colleagues [27] Chinese traditional festivals [28] Understand each other [29] New migrants lack of resources and supports 30 People suffer with mental illness [31]Disclose information [32] Isolate [33] Stigma [34] Challenge [35] Develop new resources

Table 3.2 An initial coding example

These initial codes from each transcription have been reviewed and written on the paper separately. The initial coding stage of each interview was followed by focused

coding, and writing analytic memo helps to gather codes and categories (Saldana, 2012).

Focused coding

Charmaz (2006, pp. 46, 57) suggested that focused coding searches for the most frequent or significant initial codes to develop "the most salient categories" in the data corpus and "requires decisions about which initial codes make the most analytic sense" (quoted in Saldana, 2012, p. 155). For example, focused coding such as: 1. Language barrier and cultural differences; 2. Stigma (hide information, minimal problems); 3. Worry about confidentiality; 4. Treatment process (limited understanding); 5. Evaluation of using interpreters; 6. Roles of GPs. Therefore, codes from each interview were compared to find out similarity or differences. After focused coding, some categories were created to group these codes. The similar or different codes from one transcript were also compared with codes from other participants.

Writing analytic memos

According to Clarke (2005), "Memos are sites of conversation with ourselves about our data" (p. 202, quoted in Saldana, 2012, p. 32). Saldana (2012) believes that "all memos are analytic regardless of content" (p. 33). Memo writing "should be a creative activity, relatively unencumbered by the rigours of logic and the requirements of corroborating evidence. Memos should be suggestive; they needn't be conclusive" (Dey, 1993, p. 89). Clark (2005) commented that compared with coding, interpreting and analytic memo writing is more important (quoted in Saldana, 2012).

Based on the example of the initial coding introduced above, memos were reflected from several different perspectives:

Firstly, the memo reflected on the research question about factors that impact on

service use: language barrier; lack of available resources; strong stigma associated with mental illness; limited knowledge about systems; lack of networks; supports from agency and colleagues.

Secondly, the memo reflected on code choices such as language difficulties (example); strength of practitioners; challenges of practitioners; supports and resources; stigma; training or workshops.

Thirdly, the memo reflected on the practice implications as follows:

- Use a different approach to work with Chinese clients: practitioners need to "take longer time, extra supports and extra steps".
- Peer group is important to build up relationship, practise new skills, gain support from each other. Find out and build other support resources to help clients.
- Deliver information to Chinese clients, and also educate them about New Zealand social systems.
- It is important to gain understanding form colleagues and team leader. Provide cultural training to the team members through introducing Chinese festivals to the agency and society.
- How to make the most of "authority figure" to build relationship with Chinese clients and gain trust.

Fourthly, the memo helped me to reflect on interest points or new themes: I should explore more about "stigma"; this participant described the situation of Chinese practitioners in mental health setting from "difficulty" or "they have to leave the job" 10 years ago to "much better now", what's the implication for the situation? Anyone else made the comment?

The examples above have supported that writing analytic memos provided me important opportunities to reflect on the information from the data, such as "insightful connections, future direction, and unanswered questions" (Saldana, 2012, p. 33).

Create categories

After focus coding, it was time to organise and group codes into categories. During the process of creating categories, it is important to be aware in qualitative research, that categories do not always have their constituent elements sharing a common set of features, do not always have sharp boundaries, and that "there are different degrees of belonging" (Dey, 1999, p. 69, quoted in Saldana, 2012, p. 155).

Creswell (1998) suggested categories created should not be too many; instead 5 to 6 categories are more appropriate. For example, the categories initially were: 1. practical issues which include language, food, accommodation, employment, financial status, transportation; 2. cultural issues such as shame, understanding of mental health, identity issues, generational gaps; 3. relationship issues; 4. service providers include GPs, interpreters, bilingual clinicians; 5. supports and resources such as community supports, spiritual supports; 6. socioeconomic factors which include the age, gender, duration of residence, financial problems, employment issues of the Chinese migrants. Some of these categories were changed, and new categories were created when more important codes emerged.

Saturation

O'Donoghue (2007) advises the analytic process reaches its end when these categories achieve saturation which means the categories cannot be developed any more even with new data because of this saturation. The data necessary for this research was a critical issue. In this study, my supervisor suggested that whether participants tell me "new things" during the interview in relation to my three research questions might help me to make the decision to stop recruiting participants and conduct interviews. Therefore, initial coding, focused coding and analytic memo writing after each interview transcript helped with data familiarity, creating

important categories and developing significant themes. The process was a good indicator about how much information has been gathered, whether the certain questions have been answered by which participant, and finally to draw the analytic process to a close (O'Donoghue, 2007).

Participant demographics and representation

Flick's form (2009, p. 299) was used at the beginning of the interview to gather information about participants. The form, slightly modified, is below (Table 3.3):

Information about the interview and the interviewee (Flick, 2009, p. 299).
Interviewer:
Date of the interview:
Place of he interview:
Gender of the interviewee:
Age of the interviewee:
Profession of the interviewee:
Working in this profession since:
Professional field:
Special occurrences in the interview:

Table 3.3 Information sheet of participants

Based on the information from the form, 10 participants were involved in the interview: among them are 4 males and 6 females. Their age range is from twenties to fifties. Although the research did not show significant gender and age differences in working with Chinese migrants, further research is suggested in order to evaluate how these parameters may impact on the work experience of practitioners.

Participants consisted of seven social workers, one counsellor, one nurse, and one cultural coordinator. All of the participants had some experience working with Chinese clients. Four participants were first-generation immigrants, because they came from China as adults, and they had migration experience. One participant is second generation who was born in New Zealand and the parents were from China. They were all bilingual clinicians, four could speak Mandarin fluently, and two could also speak Cantonese. The one who was second generation could speak Cantonese but limited Mandarin. Participants with Chinese backgrounds were willing to speak English during the interview, because they were fluent in English and wanted to avoid inaccurate translation.

Limitations of the Research

In relation to research design, the experience of conducting the research helped me as a researcher to learn more towards the research topic. The communication skills are important during the data collection. Building good relationships with participants, and gathering credible data through interviews are influenced by good communication skills. The research skills need to be further developed. According to O'Leary (2007), "there's only so much you can learn from 'reading' about the conduct of research - the real learning comes from the 'doing'" (p. 4).

According to Saldana's (2012) codes-to-theory model, the significant themes or concepts are served to develop an original theory. Although this may not necessarily

happen in qualitative research, it is important to show familiarity with former theories that navigate the whole research process. In the discussion chapter, although several theories were applied to analyse the findings, including Berry's acculturation theory and Shulman's interactional model, I as the researcher have to improve the ability to apply more related theories to the study.

When accessing the findings in next chapter, it is important to remember that participants in this study are from different ethnicities, four participants came from China, and one participant is New Zealand Chinese. They provided some different perspectives about how to work with Chinese clients and families. Three participants work for children and adolescents, three work for adults, and three participants work for elderly people. Besides, two participants work in the community mental health team; and two work in in-patient service; and two participants work in the NGO. Therefore, participants cover different age groups and from different agencies, which may result in different focuses and concerns.

Summary

This chapter introduced the analytical process from the research design to data analysis. Part One firstly explored the reasons for this study to choose a qualitative method, and then how the research questions were decided and shaped. The significant roles of ethics in the research journey were also addressed. Data collection included participant recruitment, conducting interviews and transcription. Part Two outlined the data analysis procedure: initial coding, writing analytic memos, focused coding, creating categories and develop significant themes. Finally, participant demographics were described to help better understanding of the findings in the next chapter. Now the data has been analysed, it's time to present participants' voices in relation to Chinese migrants access and utilising of mental health service.

Chapter 4. Professional Working Experience with Chinese Migrants in Mental Health Care

Introduction

As demonstrated in Chapter 2, there is a substantial body of international literature that documents how the migration journey may influence the mental well-being of migrants (Bhugra & Jones, 2001; Casado & Leung, 2001). Some other studies have also explored the possible factors that limit accessibility and utilization of mental health services for Chinese clients (Leong & Lau, 2001; Yang et al., 2008). There is also some research in New Zealand focused on the mental health issues of Asian migrants, though few targeted specifically at Chinese people with mental health problems (Abbott et al., 1999; Ho et al., 2003; Te Pou, 2008). This chapter presents the main findings of this study about the working experience of mental health practitioners with Chinese migrants. It is divided into three sections.

Part One discusses how the participants consider the migration experience has impacted on the lives of Chinese people, which may have resulted in various changes of both personal and family status. Participants speak about three representative scenarios of Chinese migrants based on their different age groups: adults, children and adolescents and older people. Participants also acknowledged how Chinese traditional cultural beliefs and values influence the thinking and behaviours of Chinese people in relation to mental health and illness.

Part Two presents the experience of mental health practitioners working with Chinese clients and their families. Participants identified some of the barriers and challenges that limit accessibility and utilization of the mental health services, including: the language barrier; limited knowledge of services and systems in New Zealand; delay in

seeking help from Western professionals; and the use of traditional Chinese medicine. The important roles of interpreters, bilingual clinicians, and general practitioners are also explored by participants.

Part Three introduces some useful strategies and recommendations from participants about how to work more effectively with Chinese clients and their families.

Part One: Understanding the Experience of Chinese Immigrants in New Zealand

As acknowledged in chapter 2, cultural norms are believed to affect how Chinese people understand mental health and distress, their help-seeking behaviour, and health literacy concerning the mental health system and resources in New Zealand, which, in turn, have influence on service access rates and service delivery. In order to improve the service accessibility and efficacy, participants believe both service users and service providers have to work together to achieve the goals.

When participants spoke about their experiences working with Chinese clients, they suggested it is always important to start with the lived experience of Chinese clients and their families. Service providers suggested that these questions are critical: "who are the clients?"; "what have they experienced?"; "where have they come from?"; and "what are their stories right now?" For practitioners, it is the all-important process of being familiar with clients, and building reliable relationships, which provides the foundation for the work that follows.

The migration journey

Almost all participants highlighted that the migration process itself may have a great impact on the mental well-being of Chinese clients, which could be the cause of their

mental illness, or that creates barriers to their seeking mental healthcare. One participant expressed that, *"When immigrants leave their country of origin to live in New Zealand, they leave behind a familiar language, culture, community, and social system"* (Participant 3). Therefore, it is important to acknowledge their unique migration experience which may differ from person to person in some ways, despite some common experiences. When and why people migrate has an impact on the migration experience, which will be explored later.

Participants spoke about some challenges that many Chinese migrants encountered during the migration journey: a lack of language proficiency is common for Chinese clients especially older people; some Chinese people have to deal with the problems of unemployment and underemployment, which may result in gambling problems. Others with jobs may have to work long hours in order to support their families, which results in limited time to spend with family members. Financial conditions that are affected by their employment status are important factors for Chinese people in resettling in New Zealand.

The migration experience also contributes to family separation, and the sole parent becomes a representative family type. This will be discussed in the following sections.

> *The child lives apart from one or both parents; the mother struggles to adjust to a new language and culture while trying to take on "the father's roles"; and the father lives alone in Korea working to send as much money as possible to his family, only to come home to a dark empty house*. (Participant 7)

One participant suggested that many Chinese clients had developed mental illness in the first 3 to 5 years since they came to New Zealand, and that there is no difference between age groups.

Several participants in this study also outlined some critical issues that their clients

experience during the migration journey, such as the language barrier, a lack of social networks and a lack of available facilities which may impact on the mental well-being of Chinese people. The following discussion is developed based on different age groups: adults, children and adolescents, and older people.

Adult Chinese migrants

> *Some of them* [Chinese migrants] *that bring them (parents) out, might just be in their thirties and they're trying to set themselves up in a career in New Zealand and they've got little kids, they're trying to live their lives.* (Participant 8)

As introduced in chapter 2, the New Zealand migration policy has attracted many of the Chinese people in their thirties or forties to New Zealand, who have a relatively higher level of education such as a tertiary qualification, and who have accumulated a wealth of work experience. Their English language proficiency can meet the needs of their work and lives in New Zealand. Reasons for their migration differ: to get a better education, a better job or to earn more money, but a common goal is to provide a higher quality of life for family members. Because they may have children to nurture, and/or they may bring their parents to New Zealand from China, they have a heavy financial pressure to support the whole family. Many Chinese migrants have to work hard, so they may have limited time to engage with their children and their older parents. Some participants pointed out that one of the big challenges to working with Chinese clients is that many adult family members are too busy to be involved in intervention processes such as a family meeting.

Another participant also highlighted the changes in the younger generation in terms of cultural beliefs and values after they migrate to New Zealand:

> *Maybe younger people come here are very much want good jobs, good money, good lifestyle, and there's less significant place on extended family and look*

after each other, that perhaps be influenced by individualist society that prevalence in New Zealand. (Participant 3)

As highlighted above, when younger people come to New Zealand, they may find it easier to integrate into the new society, and their traditional cultural values are changed, which means they might have different cultural beliefs from their parents.

Children and adolescents

Participants who have worked with children and adolescents divided their clients into two groups: the first group is those children and adolescents who migrate to New Zealand at very young ages. Those people who were born in New Zealand but whose parents and grandparents are Chinese speaking are categorized as second generation.

As described by two participants, when children and young people come to New Zealand, it is usually not their decision but their parents' decision, which means they are not, perhaps, prepared to leave the country, and may lack motivation to adjust to the new society. They might experience some challenges such as language barriers, how to adjust to a new school environment, and how to build up new relationships with others. Social engagement for children is mainly about how to get along well with their peer groups, and school provides the most important social occasions. In order to build up new relationships, language ability is a fundamental factor. If they have a language problem, they may have difficulty making friends with the rest of the class. One participant points out the important roles of school guidance counsellors, because they can not only support new migrants during school time, but also pay attention to their mental well-being, and cooperate with mental health practitioners during the intervention. Sometimes it may be difficult for Chinese parents to realise whether their child is developing a healthy mental state, especially for the eldest child.

The issue of cultural identity is an important aspect that was highlighted by two

participants. Children and young people can be confused about their own identity, whether they are Chinese or New Zealander, and where they belong.

An example was given about cross-cultural issues that relate to the clients from the second generation. If the child was born in New Zealand, he/she may be fluent in English and more familiar with Kiwi culture, but may understand limited Chinese, which may contribute to communication issues between the children, their parents and grandparents. Besides, those adults, especially older people in the family, may hold strong traditional Chinese cultural beliefs and values, while the children who have grown up in New Zealand may not understand the cultural context. Participant 5 gave an example that relates to cross-cultural issues: *"They* [children] *don't understand why there are things that Kiwi friends can do but they can't do".* (Participant 5)

Participants suggested that, when working with these issues, it is important to start by exploring the family background to help the client understand the cultural background of their parents, and the cultural beliefs held by them.

> *We* [practitioners] *kind of working with them* [children] *and the family, about understanding their culture and where they come from. So a lot of family background, talking about where their parents coming from, talking about what's their life look like growing up here.* (Participant 6)

Several participants reported that children and adolescents may also experience attachment issues and generational differences. It is common for many Chinese parents to work long hours, so children are taken care of by their grandparents; they have very limited time to engage with their own parents, which in turn, has an impact on attachment issues. The generation gaps that exist in many families also influence the relationship between children and parents. One participant explained that: *That's just like the general teenage thing. You know, how the kids have their own live, maybe*

spend time on Facebook, or Twitter or whatever, like computer. (Participant 5)

Mental health professionals reported that they encourage parents to take the initiative and spend some time with their children which may strengthen the family ties. Because adolescents and their parents may have different views on traditional ideas and beliefs, the linkage between these two domains in adolescents and their parents may be different. The conflicts between two different cultures in the family may have an impact on the mental well-being of those children and adolescents, as well as older people. This dynamic will be discussed through Berry's theory of acculturation in Chapter 5.

Older Chinese migrants

As explored earlier (Abbott et al., 2003; Kumar et al., 2006), older Chinese people are more vulnerable and more likely than others to encounter difficulties and challenges during the migration process. Because of language barriers, lack of emotional support from friends and families, and limited involvement with outside activities, older people may experience loneliness, isolation, anxiety, and a feeling of being marginalized by the host society, which may contribute to their mental unwellness. Three participants in the study supported the findings from previous research, such as language barriers and transportation issues. Learning a new language is an extremely difficult task for older people, and Participant 3 mentioned that *"English is an incredibly difficult language to learn, and I think you get disadvantage when you old, your brain is not like the younger people* (Participant 3). Besides the language barrier, many elderly people cannot drive, which limits their range of activities.

> *I think the worst thing is to take people from their peer group, and their environment that they feel comfortable and place they know. They are taken away from their community, and all of their people that they know, and the*

> *language, different cultural practices and throw into New Zealand context, without English, they seem quite isolated.* (Participant 8)

As mentioned by the above participant, lack of social networks is another important issue that is experienced by many older people. One participant described life of some elderly people in New Zealand:

> *They don't understand the language so they don't have enough social networks, that can contribute to depression. The family members such as their children are busy working, studying, they don't have time to social function, lack of facility for the Chinese people, that all can contribute to mental illness. You can't access all the facility here, because of language barrier… They normally go to Asian supermarket to do shopping, and look after their grandchildren, that's probably their life.* (Participant 10)

Many older Chinese people who came to New Zealand do so to reunite with the whole family. As described by participants who work with the older group, normally the main tasks for older people are to take care of family members' daily lives. Some elderly people may have an important task, which is to look after their grandchildren. The term "Cheap, free baby sitters" is used to describe roles of these older people (Participant 8). Because their own adult children are the main income resource for the whole family, and they have to work long hours, quite often they are not available during the day. Therefore, if older people cannot take care of grandchildren, they will spend most of time on their own, leading to isolation and a sense of loneliness.

However, one participant believed older people are *"quite resilient in terms of they come to a new country in the other side of the world at the old age",* and *"they are very responsible for their own well-being, they are holistic about taking therapy or well-being"* (Participant 3).

According to the descriptions by the participants, older people may experience a major shift of their roles in the family and society. In this case, what the underlying issues are for the phenomena and how these may impact on the mental well-being of Chinese older people will be discussed in the following chapter.

Gambling issues

According to the Department of Internal Affairs (2011), problem gambling is gambling that causes or may cause harm to the individual, his or her family, or the wider community. The harmful effects of problem gambling can include: financial problems; problems at work (ranging poor performance to fraud); poor parenting and other relationship problems; family violence; alcohol abuse and mental health problems.

Several participants who help Chinese people with gambling issues mentioned a lot of their clients are new Chinese migrants. For those people who were born in New Zealand, but whose parents are migrants, they are more likely to identify themselves as Kiwi, so they tend to seek help from mainstream groups rather than Asian services.

There are many reasons for gambling behaviours. One participant doubted that one reason could be many Chinese migrants are rich, due to an impact from the migration policy. Some Chinese clients thought gambling is a good entertainment; a good way to escape from their normal life, and release stress and worries, while others may consider gambling as a good investment, or moneymaking business. Here is an example provided by one participant:

> *I have a client who has been in New Zealand about 7 years, at the beginning, he washed dishes in the restaurant, after a few years, he open his own restaurant. Working in the Chinese restaurant means the working hours are quite long, so 7 days a week, and 12 hours in a day, he got very tired and very stressful. Because*

> *in New Zealand, there are not many entertainment that open late, he went to casino for some relief, he felt that the tire and stress all gone when he had fun in gambling. Soon after that, he realized he lost most of his saving, so he self-exclusion.* (Participant 8)

In this case, self-exclusion means the person proposed to prohibit himself to enter the gaming areas of all Skycity operated premises in New Zealand (Skycity, 2013).

It is also possible for Chinese clients to have other psychiatric problems, such as anxiety and depression, which has an impact on their gambling behaviours. Some gamblers may also have a drinking problem. One participant stated:

> *When I work deeper, I might find out the gambling problem probably relate to their mental ability to adjust to the new environment, or problem solving, and then if do a depression test, the screen or anxiety, in some degree they do have some depression, anxiety, or other personality disorder, relate to their behaviour and end up to their gambling.* (Participant 9)

Problem gambling may cause negative consequences for Chinese people such as loss of job, marriage or family break-up, and neglected children. One participant who works for the children and adolescents' team worried about some Chinese mothers and their children who are left by fathers in New Zealand:

> *We* [Practitioners] *had a lot of Chinese mothers left with their kids. Their husbands had fleeced the family money with gambling and then went overseas and left them with nothing… the wife having to learn to live on her own and manage with kids and having nowhere to live.* (Participant 8)

Many agencies are mentioned by two participants as important referral sources and supports, such as mental health agencies, Department of Internal Affairs (DIA),

general practitioner (GP), police, and school teachers. Self-referral and family members are the most common way for Chinese people with gambling issues to receive services, and friends, workmates and church members may also play important roles in identifying symptoms. One participant gave an example:

> *When the gambler borrowed money from others, they always lying and make up reasons such as"my car is broken down, I need money to fix it", people will realise they are lying, so they come to us and ask "how we can help and how we can get money back".* (Participant 9)

When working with Chinese clients with gambling problems, participants argued that intervention should be focused not only on problem-gambling issues, but also acknowledge the information that relates to family issues, personal history, and migration journey.

Cultural beliefs and norms held by Chinese clients and their families

The migration journey is not only the adaptation of Chinese migrants to the new life in New Zealand, but also an opportunity for the host society to experience and understand the unique culture of China. As discussed earlier, self-cultivation and self-discipline are two principles that have been the mainstays of social identity and moral behaviour, and also provide for satisfaction in self-control (Kuo & Kavanagh, 1994).

In terms of access and the utilization of mental health services, participants strongly emphasise the cultural norms and values held by the target group that have an impact on how they define mental health and mental illness, and how they react towards the issue, which includes their attitudes and help-seeking patterns. There are several important cultural related factors that are outlined by participants in this study: the

importance of family and community; multi-cultural family dynamics; and shame associated with mental illness. These will now be considered.

The importance of family and community

An individual's place in life is shaped by responsibilities associated with his or her parents, siblings, and other relatives (Kuo & Kavanagh, 1994). A number of participants point out that it is crucial to understand the important role of family and extended family played in a Chinese person's life, which can help to explain some thinking and behaviours of Chinese clients and their families in terms of mental health and mental illness. Participants use different expressions to speak about their experience of this feature.

One participant categorised Chinese people as "high contact people":

> *They don't want to reveal too much, they don't want to say too much, everything is deep in the family, they do a lot of things within the family; family really close to family, they are community-oriented family, within their own community.* (Participant 1)

Many Chinese people are believed to be family-centred. They give priority to the interests of the family, and keep information shared inside the group. The Chinese community also plays an important role for Chinese people. One participant described a scenario to explain the relationship between community members who shared the same cultural background:

> *When I drive past, there always a group of old Chinese people doing Tai Chi in the morning, or just their own exercise, and I believe the whole concept of public space are really different for us. It is for Chinese people very much to take over public space and being it. That's wonderful.* (Participant 3)

This may explain why they seek help from family members and community in the first place when a person is mentally ill. However, the nature of "high contact people" may limit the communication with the external environment, and prevent Chinese people from building connections with the host society. In relation to this study, it may also impact on the help-seeking patterns of Chinese people and result in low utilisation of mental health care.

On the other hand, three participants mention that the expectations from parents and grandparents are a big pressure for children and adolescents. One of them gave an example about one of his clients, whose failure in his study resulted in his mental health issues:

> *Apparently he* [the Chinese client] *was doing quite well at university. He did telecommunication engineering. The only trouble is he failed a paper and he couldn't make it. I think the pressure of study. You know the expectation of Chinese, you have to do well.* (Participant 1)

Due to cross-cultural issues, children and adolescents who grew up in New Zealand may not be able to understand the demands and expectations from their parents and grandparents, who have been profoundly impacted by traditional Chinese culture.

Multi-cultural family dynamics

Several participants agreed that the older people make great contribution to protect the Chinese traditions through generations in the family. Although many Chinese families maintain Chinese traditional culture, the younger generation may be more familiar with the mainstream culture in New Zealand. Some of them may identify themselves as Kiwi rather than as Chinese.

> *We do have some clients who were born here, but parents are migrants, but*

> *these people they usually don't identify themselves as Chinese, they identify themselves as Kiwi, they might seek help from the Kiwi groups, because their English is more able than their parents who has English as second language.* (Participant 9)

As previously discussed, the concepts of the traditional Chinese cultural beliefs held by parents or grandparents keep changing during the acculturation process. On the other hand, although the younger generation is more likely to recognise the local culture, the traditional cultural beliefs from older members may impact on their values, beliefs, attitudes and behaviours. How to work with such multicultural families is an important issue for practitioners to think about.

> *I think religious beliefs can be important. With that kind of traditions, so continuing… even though we talked about younger Chinese people not being committed to those traditions, but they still do exist in most families because of the old people.* (Participant 5)

Religious belief emerged as an important component of acculturation, and many participants emphasise the important role of faith and religious beliefs in maintaining the mental well-being of Chinese migrants, and also can be a protective factor for Chinese clients' recovery. Participants explain that there is no difference for people who go to temples and believe in Bodhisattva or people who go to church, and the positive impact of religious belief should be recognized. Religion provides Chinese people with a spiritual foundation and a sense of belonging. For example, church groups not only provide spiritual support, but also provide opportunities for Chinese people to meet with their peer groups, and to set up new friendships. The church group also has counsellors, and they have more experience in life so that Chinese clients can talk to them.

Relationships

Participants described many types of relationship, such as parents, peer groups, husband-and-wife relationships, and relationships between generations. Family relationships have a great impact on the mental well-being of Chinese people. These diverse types of relationship have either positive or negative impacts on the mental health of Chinese clients.

> *Jing: How about their peer groups like friends or classmates?*
>
> *Of course, if you have a group of good friends not those friends that cutting together* [frown] *of course, that would not be protective factors.* (Participant 5)

Under different circumstances, even the same kind of relationship can either contribute to the mental illness of Chinese clients, or be the protective factor that helps clients to maintain mental health and recovery. An example was given by one participant:

> *If I have an argument with my parents, I will get very frustrated, if I have a good girlfriend, and she can come and support me, that would be a protective factor.* (Participant 4)

Another participant also pointed out that although most of the time family support conversely can be crucial for maintaining the mental well-being or recovery from mental illness, the conflicts between family members may cause mental problems. (Participant 7)

Shame

One participant believed culture is an important reason that prevents many individuals to disclose their situations or seek professional help in time.

> *I think for me personally, from the way I see it, it's being willing to be openly discussing what their concerns are, because that's what cultural aspects of anybody's culture can actually hold people back. They don't want to discuss. Say "there's nothing wrong with me". Until they really get worse and then once they're overwhelmed by all these stuffs they end up in hospital and that's what we don't want.* (Participant 1)

Two participants believed that shame is a common attitude that is associated with mental illness in many cultures.

> *I think it is shame. It's very common in many ethnicities. People will see that at some point everyone has some mental health issues. It is important to know most people may experience at some point of their life. It is understandable, 'cause life is stressful, we have stressful issues to deal with, grief and loss, and it's very normal.* (Participant 3)

Participants acknowledged that many Chinese clients and their families have negative understandings about mental illness. Those with mental illness are often thought to be mad or being punished. The reputation of the family may be affected, they may be despised by the community, and so Chinese people prefer to keep the information within the family. One participant describes the concerns of the clients and the family: *The client keeps asking about: "Who is going to know about it"; "that's alright if there is nobody know about it"* (Participant 1).

And:

> *Lots of the patients they come to the services, some of they feel stigma, for Asian, the face is important for them, they came to the service, they lose face, and they lose family face. It's not just the patient, also the family…When they come to us, they are mentally very unwell. That's probably the worst patient to look after.*

(Participant 10)

When Chinese migrants come to New Zealand, the influence of potential shame still exists, which prevents them from having a different understanding of mental health and mental illness. Participants believe it is a most difficult thing for Chinese families to recognize and accept the fact that the clients have mental health issues. In relation to this, one participant acknowledged that:

> *They* [the family members] *didn't accept it, no. They knew he* [a Chinese client] *was unwell but they didn't accept the fact that this guy is not pretending. They didn't accept the fact that oh, is he pretending or what? Then they said, "My son is actually unwell". But now that they know that he is suffering from mental health issues they have come to accept that.* (Participant 1)

Participants also pointed out that shame associated with mental illness is an important barrier to Chinese families seeking help from mental health services. Participants find out that only a few Chinese clients are self-referred, and most of them tend to delay seeking help from mental health practitioners until they are seriously ill, which increases the difficulty for practitioners to work with them.

> *We don't get them* [clients] *at a time when things are functioning quite well. We only get them when things have gone really wrong and so it takes quite a bit of time to unravel that.* (Participant 8)

Thus, they do not want to make contact with any people or places that are labelled with mental illness. Therefore, it is understandable that Chinese clients and their families prefer to see a GP rather than a mental health practitioner, and they want to receive treatment in a private setting rather than in public mental health settings. Many participants in this study echoed this situation. One participant gave an example:

> *I have got one of the clients that came through, his family members ask about what services our agency provides, and I said child and adolescent mental health, they said that "we don't want to stay here, do you do private work?"* (Participant 5)

Participant 1 also mentioned the stigma has impact on the attitude of people reacting to mental illness. A client's mother whispered, *"I don't want my son or my daughter to be there* [in the hospital]*"* (Participant 1). Another participant noted, *"I have dreamed one day there will be GP surgery to get your mental well-being check* (Participant 3).

Another consequence for Chinese people responding to shame is that they tend to hide important information from mental health practitioners or to minimise the problem. Disclosure of information may have an effect on the therapeutic relationship, and participants would feel untrusted by the clients. Shame may also hinder the treatment's progress, because it increases the difficulty of working with Chinese clients and families. For example, many older Chinese clients had a history of mental illness when they were in China, and they are trying to conceal the fact from mental health practitioners. Another example is that some Chinese individuals are not honest about their financial situation, the participant in this situation felt untrusted by the client.

> *They* [Chinese clients] *either don't have to disclose or whether the family chooses to keep it quite secret. We find that a bit of a hurdle because it's so much easier if people can be open and tell us things. So that's a bit of a barrier. Their financial situation that I need to know as a social worker often for residential care.* (Participant 8)

Confidentiality is another issue that Chinese clients worry about. Participants mention that Chinese clients sometimes have doubts about the practitioners' professionalism, which reflects the limited understanding of Chinese clients about Western mental

health practitioners. Participants point out that Chinese clients don't want to talk to Chinese clinicians, and they are not willing to involve a Chinese interpreter in the family meeting. While on the other side, practitioners mention that it is possible that the Chinese-speaking clinician knows the client and the family, so to maintain confidentiality, he should let other colleagues take over the case. However, because of the language issues, he is the only one in the team who can communicate with the client. One participant feels helpless when dealing with this situation:

> *It's harder when you know someone personally, sometimes it's embarrassing – and this is confidential – one of our wonderful Chinese nurses knows the granddaughter and he feels that may not be a good position for him to be in. If that happened in a Pakeha situation we would say you step back and we'll do it. But we don't have anyone else to hand it on to.* (Participant 8)

Due to the language barrier, it is necessary to work cooperatively with other professions to provide effective services. How to avoid possible contradictions and problems when taking into account the effects of culture for Chinese people during service delivery is an important issue that needs to be further explored.

Part Two: The Working Experience of Mental Health Practitioners

This section describes the experience of participants working with Chinese clients and their families. Participants identified several issues that may influence mental health service utilization, including the language barrier, limited knowledge of services and systems, delay in seeking help from professionals, and the use of traditional Chinese medicine.

The language barrier

The language barrier not only prevents Chinese migrants adjusting to a new environment, but is also a major reason for under-utilising mental health services.

> *Jing: For the Chinese clients here, what do you think are the main issues impacting on their mental health status?*
>
> *P: Language barriers, they don't get what they need in the community. They are unable to access to health care, most patients come to our service because they are sick, family probably last solution to them before they come to us. The patients here are very unwell, they should be here earlier.*
>
> *Jing: You said before many Chinese people in the community are under-diagnosed, what the main reasons for that?*
>
> *P: The language barrier, they don't see GP, and they don't approach mental health services. Even they had contact with the mental health services in the past, but because of the language barrier, they tend to lose the contact the services afterwards.* (Participant 10)

One obstacle is communication between practitioners and Chinese clients and their families. One participant showed a sense of helplessness under this circumstance:

> *When you can't talk to someone or understand them and they can't understand you, it sets up quite a barrier. The language barrier creates enormous difficulties. It slows the process down and it's hard to get direct feedback.* (Participant 8)

Participants indicated that the language barrier makes the intervention progress slow,

because we need to use interpreters or rely on the colleagues who can understand the Chinese language. Sometimes younger family members who are fluent in English may help to translate during the meeting, but there may be some unintended consequences. This will be discussed later. Several participants reported that they had tried to use some methods to compensate for the language problem; this will be discussed in Part Three.

Limited knowledge of services and systems

Chinese clients may expect that the health system, the welfare system and the social system operate in the same way as in their home country, which results in their limited knowledge about current mental health systems, not being aware of available services, and not knowing how to access services.

Some participants reported that Chinese clients may have limited understanding about the systems and procedures of mental health services in New Zealand. In relation to this, several participants acknowledge that the Mental Health (Compulsory Assessment and Treatment) Act 1992 is a representative example. This Act emphasizes the rights of compulsory mental health consumers and the obligations of mental health clinicians (Ministry of Health, 2012). If there is a situation where a client with a mental disorder might self-harm or pose harm to others, he or she has to be under a treatment process (Ministry of Health, 2012). However, Chinese clients and their families may have no or limited understanding of this Act and the associated procedures, so it is difficult for them to accept and understand the situation when the clients have to be removed from home and go to hospital. On the other hand, the recognition of a mental health problem is believed as the first step in seeking appropriate mental health care, otherwise a lack of recognition is a significant barrier to accessing mental health resources. One participant provides clear statements about the situation:

> *Chinese clients don't understand the process here, like the treatment process; I think that is the hardest process for them is to accept that. They believe "there is nothing wrong with my son", however they have to accept that their son has to be removed from home and put in the hospital.* (Participant 1)

Another example provided by a participant again showed that Chinese people might be expecting the health service system in New Zealand to be the same as that in China.

> *I think it takes a long time for them to trust us and probably our hospital system is very different from what they may have had or may never have had in some of the little country villages I think they would come from.* (Participant 8)

Participants acknowledged that discharging Chinese clients from hospital sometimes can be a difficult task. One participant explains that the in-patient units of mental health services provide 24-hour services which including assessment, treatment and care management, so some Chinese clients and their family members believe they can achieve better goals in the hospital, so they resist discharge. In fact, the in-patient unit has only limited beds for seriously ill patients; the treatment process is expected to be short. However, mental health service provision has become primarily hospital-based in China and patients can access tertiary psychiatric hospitals directly, bypassing the primary and secondary health-care levels (Liu et al., 2011). Most participants believed the differences between mental health systems in the two countries add difficulty in building trusting relationships with Chinese clients.

Delay in seeking help from Western professionals

Participants spoke about how their clients are referred: there is almost no self-referral for Chinese clients except people with gambling problems. The help-seeking pattern of Chinese clients demonstrates the profound impact of Chinese traditional cultural

beliefs have on one's behaviour.

Close family members are the first choice for Chinese clients to seek help. There are two reasons to explain this behaviour: as was explained above, within Chinese cultural beliefs, mental illness is associated with shame. In order to avoid losing face for the whole family, the family members try to keep the secret within the family. Another reason for this is that family members are believed to be responsible for others' health and illness. Therefore, family members always try hard to help the clients until the situation becomes serious.

> *They* [the family members] *would be trying to work with them at home, and then something would have happened that is not working or they can't do any more, or the patient won't take medication, or they might need to be reviewed, and then they bring them in here as a specialist service. Usually when they come to us it's crisis.* (Participant 8)

Another participant admitted that putting older Chinese people into residential care, which may be necessary when someone develops dementia, is a challenge for practitioners:

> *Going to a rest home, I guess a very big issue for Chinese, because the traditional culture no one goes to the rest home, from the family point of view, going to the rest home means family is failed to look after the people, that would be a challenges for family.* (Participant 10)

In addition, keeping the Chinese clients at home may result in pressure for caregivers. One participant gave an example of one client:

> *I have a patient he had a severe dementia he was living at home with her wife, his children went back to China to work, that's why he needed to go to rest home.*

She took him went back to China a year, she didn't want him to live in the rest home, and she tried her best to look after him at home. (Participant 10)

Three participants showed concern about those caregivers in the family, because the caregivers would not give up until they could not manage the client anymore; at that time they are likely to be exhausted, and highly stressed. One participant worried about the caregivers of Chinese clients: *We* [practitioners] *are watching the wife, the carer, burn out more and more. Families are distressed, frightened, sad, grieving, a whole gamut of thing* (Participant 8).

The issue of whether the family members are using an appropriate way of taking care of the client is another concern raised by the participant. For example, sometimes a person with dementia might tell the caregiver what he believes is wrong; one participant suggested that it is better not to argue with the client, the caregiver should just say *"oh yeah, that's your understanding". And then try and move onto another subject* (Participant 8).

When the family members feel they cannot control the situation, they start to look for other help. Participants mentioned it is a long process before family members will access and utilize the mainstream services. They may look for support and resources from friends, elders and neighbours in the community, or traditional Chinese specialists, or religious healers. General practitioners are the most important referral source for Chinese clients: this will be discussed below. Social and community workers, psychologists and counsellors are also mentioned by several participants, although they are not the first options for Chinese people. Why Chinese people develop this unique help-seeking pattern and how it impacts on the service accessibility and utilisation will be discussed in Chapter 5.

Use of traditional Chinese medicine

Many participants showed their understanding about traditional medicine: *"I think lot of herbal stuff people take from China, all herbals can be helpful, we are not averse to that. I see old people try as many natural things as possible"* (Participant 3). And, *"A lot of them won't take western medication so we will try and adapt to allowing them to take both"*(Participant 8).

> *Some Chinese people, they are quite anti-western medical, they were talking Chinese medicine when in the community. And of course for us, we happy for them to continue using the Chinese medicine, as long as the Chinese medicine is not contradicting with Western medicine.* (Participant 10)

The recognition of the use of traditional medicine from participants also reflects their awareness of, and sensitivity to cultural differences. The reasons for Chinese people choosing traditional medicine are rooted in the belief in traditional medicine, which will be discussed in the next chapter.

> *If it comes with a packet or something and we can source it but they won't disclose and that makes it awkward because we don't want to be using something that's going to counteract with their medicines, or going to clash*. (Participant 8)

Participants explained how they deal with the traditional medicine that is taken by Chinese clients. Usually the pharmacist in the team goes through all the medicines, and Google is a good way to search for the information (Participant 3, Participant 8). The pharmacist may find out similarities to the medication that they may prescribe, or whether they may be competing medicines. However, when Chinese people use traditional medicine, many of them do not offer the information of the medicine to

mental health practitioners until they are told to. Mental health professionals are nervous about the possible complications with drug interactions. As a result, participants who work for the elderly clients highlighted the importance of knowing what medicine the client is taking, no matter what kind of medicine it is.

The services of interpreters

Interpreters play a significant role in cross-cultural intervention. Some participants highly valued the work of interpreters, while some insisted that interpreters should meet higher requirements. Almost every participant expressed views about the work of interpreters: *We would never interview without an interpreter* (Participant 8). *Good and helpful to my colleagues* (Participant 4). *Some of them are good* (Participant 7). *It's hard to say the quality of the service provided by interpreters. I only use interpreters when the family have meeting with the doctor* (Participant 1).

And another participant evaluated highly the interpreter she uses:

> *The interpreter I use is occupational therapist, she can speak Mandarin and Cantonese, she has a lot of experience, and I guess cause she is working alongside a lot of clinicians, she is sensitive, knowledgeable and helpful in terms of interpreting what I might not understanding about some thematic things. How people may talk about having stomach ache, it might be anxiety and depression.* (Participant 3)

When asking participants how good interpreters are, one participant described:

> *They* [interpreters] *translate the patient's word by word, that's very important. People want interpreters to translate word by word, so you may know exactly what the patient mean, especially for mental health services, sometimes the information from the patients are important to make the decision.* (Participant 10)

One participant believed that it might be helpful for the interpreter to have similar cultural background with the client, which may avoid misinterpreting or missing message.

> *Jing: You said that sometimes the interpreter couldn't really understand?*
>
> *Yeah, I don't know where the message got lost, but sometimes the message got lost. When use interpreters, it seems to a bit more helpful with the clinician have that background. It's like that we got an Indian clinician in here, even though a lot more family who can speak English, it's just about have an understanding about the cultural background.* (Participant 5)

According to these participants, good interpreters may have two attributes: firstly, interpreters have a similar cultural background to the clients; secondly, interpreters have some knowledge about mental health. One participant also showed understanding about the difficulty of interpreters during the work.

> *Sometimes I came with dementia patients, what they said can't make logical conversation, it is hard, especially for old Chinese clients, they try to relate their mental illness to physical problems, they keep telling you what their problems are. They reflect some degree of mental illness. I can understand sometimes it's really hard to translate, it needs skills.* (Participant 10)

As explained by the participant, Chinese clients may have some different expression of mental illness which mainstream staff may not understand in terms of their different cultural backgrounds, in this situation, good practitioners can make important contributions to the treatment process.

However, there are some situations in which interpreters cannot help. For example, some clients, especially older people cannot understand Mandarin, and if they come

from a very small, far out-lying area of China with a different dialect, it's difficult to get an interpreter for the client (Participant 8). Several participants also mentioned that use of interpreters is a huge cost for the agency, and it also slows the intervention process: *Because we* [practitioners] *can't ask directly and our family meetings are much, much slower and longer when they* [family members] *have an interpreter. It takes twice as long* (Participant 8).

If the interpreters are not available, family members can become the alternative option. Particularly at the beginning of working with Chinese clients, family members play an important role in communicating between clients and the practitioners, such as telephone calling or brief face-to-face meetings. However, asking younger family members to translate conversation may cause some issues.

> *If there's grandchildren – sometimes we've had grandchildren in their twenties and they've been very fluent in English and that's been useful, however, they've been brought up probably away from the environment that their grandparents have been brought up in so you have cultural clashes and viewpoints. Those kids are usually going to university here so their values are different.* (Participant 8)

According to the participant, if the client is from a multi-cultural family, the younger family members are likely to hold different beliefs and values from the clients. As a result, they may not fully understand some cultural related viewpoints of the client. When family members take the role as interpreters, clinicians have to be aware of possible disadvantages.

Two participants raise questions about how to evaluate the quality of the interpreters: one of them states:

> *P: For doctors, they want interpreters translate every word of what the patient's family say, but often the interpreters often use their own sentences to*

translate, they make up own sentences to translate to doctors and the other health professionals, so they can't give you all the information. Especially because I was involved in many meetings and interpreters were involved, myself I can understand Mandarin, so I can feel the quality of the interpreters are not so good. I have to tell my services stop using some interpreters, because of the quality of the interpreter. We do have some trust interpreters and we use them quite often.

Jing: For other Western staffs, you mean they can't tell the quality of the interpreters?

P: Of course, they don't understand Chinese language, so they don't know how good. Sometimes they may be able to feel, because …I give you an example, sometimes patients try to tell doctor 5 to 7 times, but the interpreters only translate once. Of course, doctor may ask what's happening? Why patients talk to me for one minute, the interpreter only translates for 10 seconds? What happening to other sentence? They may be able to feel something has gone wrong. (Participant 10)

Due to the language barrier, Western mental health practitioners might not be able to evaluate the quality of the interpreters. If there are other bilingual clinicians involved in the meeting who can understand the clients, they might provide some feedback to the Western colleagues in the team, otherwise it would be difficult for them to receive accurate, detailed information through interpreters.

Bilingual clinicians

My Chinese clients are fluent in English, the most struggle with English are the parents, the parents they want to understand what has happening, but they are

> *not quite clear, what we often do is we have interpreters, even with our clinicians, they are quite helpful…"*(Participant 1)

Besides interpreters, a number of practitioners appreciated the efforts of their bilingual colleagues.

Participants feel lucky to have colleagues who can speak Chinese in the team, because interpreters are not available in all situations. In relation to this, one participant acknowledged that*: "I think I am being really lucky. We have clinicians in the team who can speak both Mandarin and Cantonese, give advice"* (Participant 3). Also another participant who can speak Chinese explained that:

> *When contacting the family, sometime the family have difficulty communicating through the phone, they will ask me to help that kind of triage process, because it is hard to get interpreter to come just go on for phone conversation.* (Participant 5)

And:

> *We send our Chinese nurses or our Asian nurses off to ask questions and find things out that we don't know. We rely on our nurses and their interaction with them whereas normally I'd just go and find that out myself. I have to go through one of the nurses and we might sit and say now, today we need to know this, this and that. Can you try and find that out?* (Participant 8)

Participants mentioned that sometimes interpreters do not express the meaning clearly to the clients and their families, especially with reference to medication and the treatment process. With bilingual clinicians who can communicate with clients, and also have a mental-health-related knowledge base, they can deliver and explain the information to the family more accurately. However, one participant believed the

involvement of interpreters or bilingual colleagues during the intervention slows the process.

The important role of the general practitioners

The pivotal role of general practitioners (GPs) in help-seeking pathways for ethnic minority groups is highly valued by many participants. Many Chinese clients with mental health concerns and their families might consult with their GP in the first instance. A GP plays a very important role in identifying the warning signs, and is also the most common referral source compared with other Western specialists (Participant 1).

When Chinese clients become stable and can be discharged, they might go back to a GP for follow-up. One participant who works for older people suggested that the language barrier is a significant factor that prevents many older people from contacting a GP (Participant 10).

As mentioned in part one of this chapter, the GP is mostly oriented to physical health, so the profession and the workplace is not labelled as mental illness compared with specialist mental health practitioners, therefore Chinese clients are not negative about seeing their GP. Therefore, the access rate of Chinese clients visiting a GP is relatively high. Chinese clients with mental illness might even go to see a GP first. How to take advantage of this phenomenon to improve the utilisation rate of mental health services is worth considering.

In addition, Chinese clients prefer to register with a Chinese GP, considering the language convenience and shared cultural backgrounds. Participants suggest that GPs need further support from specialised mental health services, so that the GP can provide a timely and accurate diagnosis on the mental health symptoms of Chinese

clients.

In this section, participants shared their working experience with Chinese clients, and identified some important issues that relate to mental health service utilisation; the next part will introduce some useful strategies and recommendation for practice.

Part Three: Useful Strategies and Recommendations from Practitioners

Useful strategies

Participants offered to speak about how they manage to work with Chinese clients and their families, and it becomes clear that Chinese practitioners and non-Chinese practitioners have their different working methods. Most participants talk about how building trusting relationships with Chinese clients can result in a crucial change. Some key guidelines emerge:

1. Word of mouth

One participant used the term "word of mouth" to describe how Chinese people deliver information within the community:

> *If you see a client and he thinks you are good, and this news will spread within the community. If the first impression is bad, your name will be bad in the community. So always do good to make sure your name spread and they will go back to you.* (Participant 4)

Understanding the effect of "word of mouth" is an important way for mental health practitioners to convey useful information widely in the Chinese community. For example, Chinese people may obtain information about mental health services through

their GP. As described above, GPs play an important role concerning the mental health of Chinese people. It is important for mental health practitioners to closely cooperate with GPs and other professionals.

2. Show your expertise

Several participants highlighted the appearance of practitioners has an impact on the clients' first impression of them, and it is the foundation for a good relationship. Age and gender of the practitioners may impact on the sense of trust from Chinese clients towards practitioners: *"I am female, and I am younger compare with most colleagues here, so in terms of the age, kind of the role might be a challenge"* (Participant 5). *"If you have enough grey hair, probably you will have higher access rate because they think you are more mature and knowledgeable"* (Participant 4). *"Although* [one young practitioner] *has 10 years' information and knowledge, but if I came in, they probably listen to me more"* (Participant 6).

Some Chinese people are willing to work with those practitioners from non-Chinese backgrounds but have similar skin colour. *"I think it's funny that colour really makes difference. I am not white not black, but I have the similar colour with Chinese. Chinese people seem to like me, we engage quite well"* (Participant 1).

Many Chinese clients prefer older male clinicians rather than young female clinicians; because they believe the former seem more reliable, and possibly more experienced. The cultural dimension that is related to this perception will be discussed in next chapter.

Maturity competence and conservative dress also affects Chinese clients' initial trust. One participant acknowledged that:

> *When practitioners introduce themselves, they need to let clients know that they*

really understand the New Zealand system; they have to utilize the authority figure to gain the trust from the client. (Participant 2)

Moreover, practitioners can show expertise by providing some opinions, and giving some direction to the clients to help them make decisions. Because the Chinese values of filial piety and deference to authority are expressed in the therapeutic situation by clients not asking questions and by showing outward agreement with the clinician (Tabora & Flaskerud, 1997). It is common that *"the family will go for doctors for help, and they are looking for someone to get them pills or tell them what to do to fix it*" (Participant 6). Thus one participant recommended that, *"for Chinese people, you have to give some advice"* (Participant 2). This opinion is related to the idea that professionals are people of authority, which is presented below.

3. People of authority

Some participants mentioned that many Chinese people tend to believe in professionals especially doctors, and the idea of "professionals being authority people" should be understood and utilized by mental health professionals to build trusting relationship with Chinese clients.

Jing: Are there any issues that can help them [the Chinese clients] *to recover?*

So we talk about the protective factors. I think most patients are good at following the authority, most the patients will do what the doctor told them, and they believe and probably trust the doctor, that's good. (Participant 10)

And,

For example, we always see counsellors or practitioners you are not giving the advice to your clients, but for Chinese people, they always asking you tell me

> *what to do, Chinese clients treat practitioners like the authority people.* (Participant 2)

In response to the above thoughts, Chinese participants suggested it is necessary to use different approaches to work with Chinese clients. One participant gives an example of how to work differently:

> *I think that's the different way even for the mainstream staff to visit clients, they always say: "what is your goal, what do you want to do". For me, I have to go there and tell them: "what is you can do, what will happen if you do, what will happen if you don't do, what I have known when that happen to other people".* (Participant 2)

For Chinese clients, practitioners really need to spend some time to build a trusting relationship with clients. At the beginning of the relationship, practitioners need to take longer time than normal.

> *Just provide help for them, do what they need, for example, they want eat Asian food, you just ask family members to bring, sometimes we can provide some Asian food for them, if the patient want to read Chinese paper, we can bring the newspaper, and we ask the Asian mental health service involved if we need. We encourage the family members and friends come to visit them. Just provide help. Make sure every day we spend some time with the patient, and communication is very important. It costs time to build trust relationship.* (Participant 10)

It is a good idea for practitioners to go and visit the home and spend some time with the client and their family: *"It's easy to overwhelm people, and we went to people's home in their most vulnerable time, being a part of the process with the person and the family"* (Participant 3).

Practitioners can start to work with the clients after a few visits, to understand the client, to identify their needs, and to develop a plan. So it needs to take a longer time when compared with working for mainstream clients.

3. How to show respect to clients

Several participants suggested that practitioners respect Chinese clients by understand their cultural background. Learning a few words in Chinese is a good way to show respect. Although many participants are Western staffs, they can still learn a couple of words such as "hello", use cards and pictures, and body language to communicate with them. One participant gave an example: *"When we talk to the client, say his name is Tom, we don't call him Tom Xu, and instead we call him Mr.Xu to show some respect, in Chinese culture, it's a very important issue"* (Participant 4).

And again:

> *We have a list of languages, words that might be relevant – toilet, food – and we have them in the two languages so they might be able to point to them. But it's very difficult working with someone who doesn't have the language that we use.* (Participant 8)

Several participants indicated that their knowledge of Chinese culture benefited from personal interests and social activities:

> *Fortunately for me, I have many friends are Chinese, not only from Mainland China, most from Taiwan. 25 people came to my house warming, one is European, and others are Chinese* (Participant 1).

Also, punctuality makes clients feel respected. The first two sessions are critical when the initial impression about the services is formed (Participant 4).

Besides this, it is important to respect some habits and customs which Chinese clients have developed in China. One participant gave an example to explain this opinion:

> *About them squatting, not on the toilet, just squatting, never sitting down, and squatting. We've just found over the years lots and lots of ways in which – if we saw one of our patients just sitting squatting on the floor we'd worry about them or get them a chair or think do they need a physio or something. This was a lady who'd come from a country village and that's obviously how she lived her life so we just had to adapt to say that's her way, she's comfy, that's it.* (Participant 8)

Further, "giving face" to Chinese clients is another important way to show respect. Because mental health issues being such big stigma in the community, and Chinese people may have their own explanation about mental health problems which may not be relevant to a purely clinical explanation, still practitioners need to take seriously attitudes towards Chinese understanding of mental illness. As supported by one participant:

> *How you relate it back or reframe it to your clients is vital. In Chinese we call it giving face, we have to give face back to them by not contra meaning too much to the belief.* (Participant 4)

4. Know your advantages and limitations

Chinese practitioners concluded that they themselves have two advantages: one is they were trained in New Zealand, so they understand the mental health services system and social support system, and understand the theories and approaches that are used in the intervention. The second advantage is that Chinese practitioners understand Chinese language, they can speak Chinese, and understand the Chinese cultural background, and their thinking is very similar to their clients so they can bridge the mainstream services and Chinese clients. One participant is from the second

generation, and she was proud that she could understand the Chinese clients: *When I talk to the family, they are kind of relieved of being able to talk to someone that use the mother tongue… at least we understand each other* (Participant 5).

Due to the complex needs of the Chinese clients and their families, several practitioners mentioned that both professional knowledge and personal abilities are important for effective practice. One participant gave an example to support this opinion. How to ask the right questions during interview is an important skill for social workers to learn and master. Because Chinese clients tend to not disclose information, practitioners can get the right answers by asking the right questions. For example:

> *"When did you say you took your medication? Was it ten o'clock or nine o'clock or is it yesterday you're talking about?" and then you start "oh, that's right, you didn't take any medication yesterday eh?". Or "oh, you did say you forgot to take it yesterday". "Oh no, no, I said I took it two days ago." So in other words he's missed two days already.* (Participant 1)

In the example above, the practitioner was trying to find out whether the client had taken the medicine on time. The practitioner used several different ways to ask the same question and finally got the right answer.

Most of the participants are social workers, and they emphasise that, when dealing with the complex dynamics of Chinese clients, not only are social work theory and practice skills very important, but also the abilities needed to apply for mortgage, make budget plan, and use counselling skills are helpful. In other words, to pay attention to those factors that may determine how someone can thrive within their environment, and to be able to work therapeutically.

Overall, participants spoke of some strategies about how they work effectively with Chinese migrants, and they also provided some insightful opinions professionally.

Some gave detailed and practical advice, and some were general thoughts on professional development in the future. These proposals will be explored and discussed in the following chapters.

Summary

The findings from the study evaluate the professionals' perspectives for Chinese migrants with mental health issues in New Zealand in terms of access and utilisation of mental health services.

The first part of the chapter discusses the migration experience of Chinese people in New Zealand. Many Chinese people encounter multiple challenges: language barriers, employment issues, accommodation issues, the lack of social networks (the practical challenges), while during the process of acculturation, Chinese people may experience identity confusion and uncertainty, may feel lonely and isolated, and experience low self-esteem and attachment issues. The mental well-being of Chinese people is affected by both practical difficulties and acculturation stress.

Participants particularly describe the migration experience based on different age groups, including children and adolescents, adults, and older people. Each age group has confronted different situations; participants discussed the issues, coping strategies, and how these issues may affect mental well-being. Then in the following section, participants outlined some cultural beliefs and norms that are held by Chinese clients and their family. Participants acknowledged that understanding those cultural beliefs might help mental health practitioners to understand the attitude and the behaviours of Chinese clients. Family and extended family, the Chinese community, and the shame associated with mental illness have influenced the way of Chinese people recognizing and dealing with mental illness. However, Chinese people are resilient because they are family- and community-oriented people, and the religious beliefs are also

important for them to maintain mental well-being.

The second part of this chapter examined the practice of mental health practitioners who deliver services to Chinese clients and their families. Participants analysed several issues that have an impact on service delivery including the language barrier, a lack of knowledge about the system, services and treatment, delay in help-seeking, and the use of Chinese traditional medicine. Besides this, the services of interpreters and bilingual clinicians were evaluated highly by participants, while some concerns were raised.

In part three, participants provided some useful strategies for working with Chinese clients: be aware of the power of "word of mouth", show your expertise, show respect to the clients, and identify your advantages and limitations.

Having explored the working experience of mental health practitioners with Chinese migrants in relation to access and utilisation of mental health services, the following chapter will discuss the main findings, and explore the social workers' roles in promoting the accessibility and utilisation of mental health services.

Chapter 5. Discussion of the Findings

Now that the participant voices have been introduced, this chapter joins the information from the literature review to explore the following questions: (1) to what extent does Chinese traditional culture affect service accessibility and utilization? (2) how does migration influence the traditional cultural beliefs and values of Chinese people and impact on pathways to mental health care? (3) what are the implications for social work practice?

In response to these questions, the chapter is divided into three parts:

Part One will introduce the traditional concepts of filial piety. In particular, this section will focus on how filial piety influences Chinese people's perspectives on mental health, and their attitude and behaviours towards mental health services, the shame associated with mental illness, the delay in seeking mental health professional help, and the use of traditional Chinese medicine.

Part Two will apply acculturation theory to examine acculturation orientations of different age groups after migration, and also analyse how migration impacts on the concepts of filial piety, and how these might affect mental health service utilisation.

Part Three will apply the interactional model from Shulman (2006) to analyse the "symbiotic" system around Chinese clients. The obstacles and strengths that relate to mental health service utilisation will be discussed. The main functional roles of social workers in engaging the clients and the service providers will be outlined.

Part One: Filial Piety

A number of studies in the literature review asserted that traditional Chinese culture such as Confucianism and Taoism, and religions such as Buddhism have shaped the values and beliefs of Chinese people towards mental health. In the previous results chapter, participants emphasised the importance of family and community for Chinese migrants: the reason for Chinese adults migrating to New Zealand is to pursue a better life for the whole family; Chinese children and adolescents have to study hard meet parental expectations which may cause them mental stress; older Chinese people come to New Zealand to reunite the family and sometimes take caring roles for dependent children.

For Chinese people with mental health concerns, Chinese family members have difficulty in accepting the person has mental health issues, and then family members are more likely to keep the problems secret and provide caregiving before the client go to rehabilitation services; and many Chinese older clients do not want to goes to residential care but choose to live at home. These facts that were identified by participants in this study are influenced by traditional Chinese culture, and filial piety is particularly associated.

Defining filial piety

Filial piety is a traditional virtue for Chinese people and it is a significant concept within Confucianism. There is an old saying that "if you know the family, you do not need to know the individual" (Samovar, 2008, p. 105), and "the community always stands before the individual" (Yuan, 2011, p. 101). In this sense, respecting the older, maintains the harmony and stability of family and society (Yuan, 2011), in other words, duty, obligation, importance of the family name, service, and self-sacrifice to

the elders are the main concepts of filial piety (Ho, Friedland, Rappolt and Noh, 2003).

And specifically, Chinese people should support their parents financially such as care for their physical health, housing needs; treat them with love, respect and sincere concern. Sons, especially the oldest son have the responsibility of taking care of older parents. If the son is married, then his wife is expected to look after the daily life of the parents-in-law (Chappell & Funk, 2011). However, daughters and spouses are more involved due to the changed concepts of filial piety in modern Chinese society (Chappell & Kusch, 2007). It is important to think about how these concepts further developed in migration context, which will be discussed in part two.

Children are required to respect parental authority, which means following the requests from parents, and trying their best to honour one's parents. Filial piety can be one of the academic motivations for Chinese adolescents. Therefore, the privileged position of the elders in the family cannot be ignored. The younger generation in the family may not have equal rights with the older generation. Younger individuals in the family may be regarded as dependent personalities, and their beliefs and willingness may often be ignored.

All people should also show respect for those ancestors who have already died. The funeral ceremony is an important way for the living to show filial piety towards dead people (Yuan, 2011). Whilst participants in this study did not mention funerals, it is an important concept of filial piety. Funeral and visiting ancestors' graves show strong links between descendants and ancestors, and descendants may also trace their cultural roots through ceremonies. Therefore, Chinese migrants, especially older people who are unable to attend funerals or ceremonies of their relatives and friends may experience significant loss.

Filial piety not only refers to the relationships within the family, but also extends to social relationships. “Old” is an honorific title, not flattery according to Yuan (2011). This can explain why some Chinese clients prefer to seek help from older professionals who are perceived as more experienced and more trustworthy. Further, the sense of identity for a Chinese person is influenced by the decisions of their social system and close groups, and the individual has emotional links with organizations and institutions (Samovar, 2008).

The main concepts of filial piety are introduced above. How filial piety may relate to the mental well-being of Chinese migrants, and may affect accessing and utilising mental health care will be discussed next.

The importance of filial piety

> *To forget one’s ancestors is to be a brook without a source, a tree without a root* (Zhang, 2004, p. 215).

The diagram below, which was developed from the findings, outlines some significant factors that impact on Chinese migrants’ service access and utilisation of mental health services. How the concepts of filial piety relate to these factors will be discussed, and, this diagram is further explored in part three when the interactional model is applied. As shown in Fig.5.1:

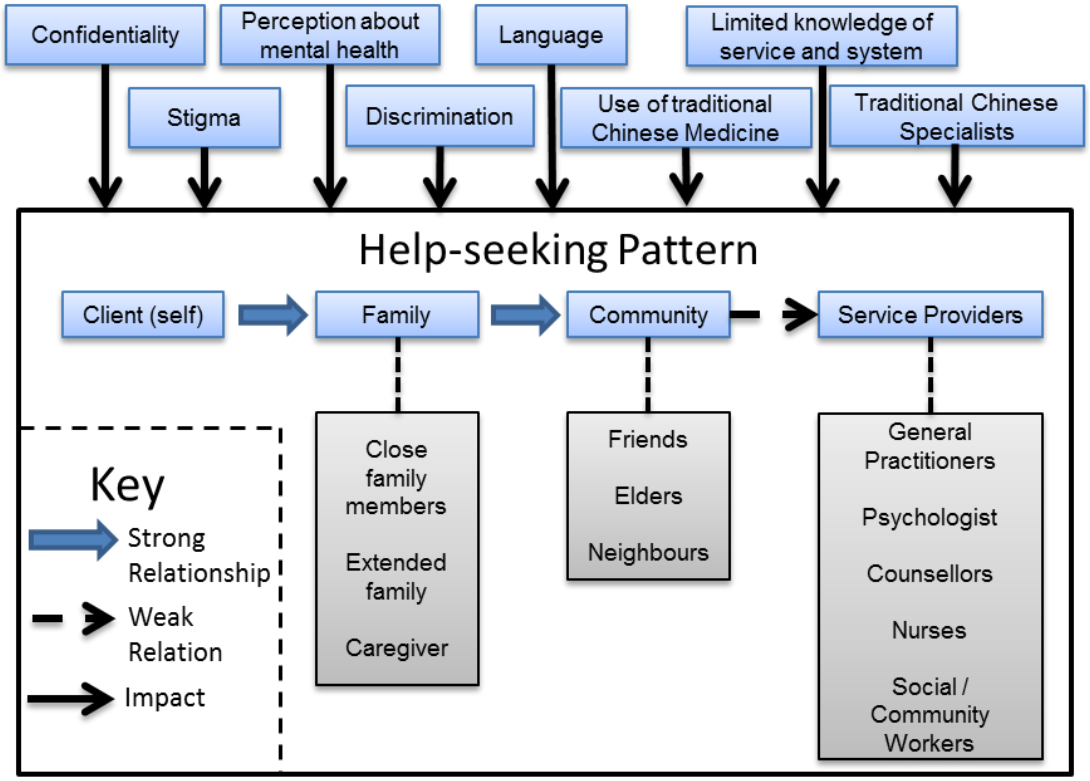

Figure 5.1 Factors relating to service accessibility and utilisation

In Figure 5.1, the seeking-help pattern of Chinese people identified from the findings is presented. This pattern is also consistent with findings from previous studies in the literature review. Close family members are the preferred first choice for many Chinese clients. Extended family members are also important, however, in migration contexts, these people are less likely to be physically present in New Zealand.

Family members may provide both practical and emotional supports to the Chinese clients. Practical supports include transportation and financial support. If caregiving, the family members not only take care of the daily life of the client, but also provide emotional support. Also, family members are more likely to discover the warning signs of mental health issues, and they may influence the health care decision-making of the client. Therefore, family support is suggested as important in maintaining the mental well-being of Chinese migrants, and is beneficial to recovery.

Friends, neighbours and older people in the community are also mentioned as important sources of help in the absence of relatives.

Although it may be a time-consuming process, Chinese clients and families are most likely to finally turn to mainstream mental health services. Among professionals, general practitioners are almost always the first option for Chinese clients and their families, rather than professionals who work in the mental health field, such as psychologists, nurses, counsellors, social and community workers. Due to the language barriers and different cultural backgrounds, interpreters and some cultural organisations act as bridges between Chinese clients and the mainstream mental health providers, and these will be discussed in part three.

As described in Figure 5.1, significant factors such as stigma, Chinese perceptions of mental health, the use of traditional medicine, language barriers, limited knowledge about services and systems are outlined which contribute to the delay in seeking help process, and many of these factors have their roots in filial piety.

Participants in the study mentioned that mental illness is not viewed favourably in many communities and cultures, while the stigma and discrimination experienced by Chinese people with mental health concerns can be understood through perspectives of traditional filial piety: a mentally ill Chinese person is regarded as unable to fulfil their roles in the family as father or son, and build harmonious relationships with other family members and the outside social environment. The person brings shame to the parents and affects the reputation of other family members which in turn tarnishes the family's name in the community. Therefore, family members are more likely to take care of the mentally ill person at home until a condition becomes serious. In this case, participants show their concerns about both the clients and the caregivers, which is to be discussed later.

As one participant suggested, it is important to find out who the important person to talk to is in the Chinese family. Thus, understanding filial piety may help practitioners to identify the person effectively: older people in the family should be considered first, followed by oldest son and his wife.

Further, understandings of filial piety also suggest that caregivers in the family play important roles in caring and supporting the Chinese client, and at the same time can also result in delaying seeking professional help. Understanding filial piety may help practitioners to understand the motivation of these caregivers. As supported by Lai (2011), filial piety clearly defines that family members have the responsibility to take care of the sick person. Seeking formal services may show their inability to fulfil the roles as caregivers, which may bring dishonour to the family name. However, several participants in the study have expressed their concerns about these caregivers. According to Lai (2011), when caring for the client, caregivers may encounter some problems and difficulties and experience stress, tension, and anxiety. These feelings are defined as "caregiver burden". Caregivers are more likely to experience role conflicts and financial stress, while the strong belief in filial piety may be a protective factor for the caregiver in maintaining mental well-being (Lai, 2011). On the other hand, Ho et al. (2003) suggested that acculturation might change the beliefs of caregivers regarding filial piety, and possibly contribute to the decision to put the client in a mental health residential setting or inpatient services. Acculturation theory will be the focus of the next section.

Part Two: Migration, Acculturation, Multi-Cultural Family Dynamics

In accordance with traditional culture and adherence to concepts such as filial piety, many Chinese people are not willing even to leave their hometown where they have

lived for generations, and where their ancestors belong. Thus, migration is an important and major event for many Chinese migrants and numerous studies have examined to what extent migration-related factors impact on their mental health status, as introduced in chapter 2. This study also supports the contention that the migration experience of Chinese people has a great impact on their psychological well-being.

Berry (1997, p. 9) outlined there are two main issues that migrants should deal with: cultural maintenance (to what extent are cultural identity and characteristics considered to be important, and their maintenance strived for); and contact and participation (to what extent should they become involved in other cultural groups, or remain primarily among themselves). The attitudes of migrants toward cultural maintenance and contact and participation serve to develop four orientations of acculturation: integration, assimilation, separation, and marginalization.

	Cultural maintenance **----Yes**	**Cultural maintenance** **----No**
Contact and participation **--- Yes**	Integration	Assimilation
Contact and participation **---No**	Separation	Marginalization

Table 2.1 The four orientations of acculturation, adapted from Berry (1997) and Marlowe (2011)

In this study, considering Chinese migrants as a non-dominant group in New Zealand, integration means Chinese people choose to maintain their original culture, and at the same time positively make contact with local people and participant in social activities. Assimilation means Chinese people decide to make positive contact with the host society but abandon the original culture. Separation means maintaining the Chinese culture and identity and refusing the host society's culture. Marginalisation means Chinese people are not willing to maintain the original culture or make contact with the host society.

Whilst participants in the study did not use the four orientations of acculturation directly, participants did identify that family and community members have different strategies. It is important for mental health practitioners to acknowledge the acculturation strategy of Chinese individuals.

As supported by Berry (1997, p. 11), "individuals and groups may hold varying attitudes towards these four ways of acculturating, and their actual behaviours may vary correspondingly". Referring to the findings, some Chinese people, such as adult Chinese with fluent English and higher qualification, may integrate the traditional Chinese culture with Western Culture; some older Chinese people, especially who hold strong beliefs that are rooted in Chinese traditional culture are more likely to experience separation; while others, such as children and adolescents who migrate at very young ages, and those who were born in New Zealand are more influenced by Western culture, and may not know or know only a little about Chinese traditional culture fit into the assimilation category. The study here identifies that the different acculturation orientations of family members within the family may cause family conflicts, and they have impacts on the mental well-being of Chinese migrants. The findings showed that the values and beliefs that are held by parents, or grandparents, may be quite different from those of children. These different acculturation strategies

may also have impacts on traditional notions of filial piety and disrupt previously established patterns of family interactions, roles and rules.

It is possible for Chinese migrants to capture the opportunities and achieve their goals in the host society, while the associated grief and loss during the migration process cannot be underestimated. Migration brings many socio-economic changes, including loss of social status, new job opportunities, lost connections with communities in the original country, and the necessity to build up new relationships in a new environment.

Importantly, migration may also require cultural changes and adaptations. Changes of clothing and food, and deeper changes including learning to speak a new language, incorporating religious and spiritual elements, and fundamental alterations to value systems, are various manifestations of acculturation that a migrant must attempt to reconcile (Berry, 1997). Berry (1997) defined acculturation as an important process in which migrants psychosocially adapt to the culture of the host society. Ho et al. (2007) also stated acculturation includes "relearning language, incorporating new values, expectations, and beliefs, and altering behaviours" (p. 531).

The literature review in Chapter 2 suggested acculturation is an important stage of the migration journey. Acculturation orientations of Chinese migrants and their family members affect their mental well-being, associated acculturation stress may cause depression (Leung et al., 2012); some socio-demographic factors such as the length of residence may affect acculturation (Yang et al., 2009); and also impact on their attitudes and behaviour towards mental health services.

The findings of this study also show that the Chinese traditional value and belief systems may be challenged. As it is possible that a Chinese family unit consists of multi-generations, and the acculturation orientations of each generation may be

different, and the acculturation of Chinese migrants have an impact on their attitudes and behaviours towards filial piety. Thus, in order to work effectively with Chinese clients, practitioners should be aware of the current family dynamics. Vuong (2010) believed that the family functions of Chinese migrants decide the roles, expectations, and responsibilities of each family member. As introduced in part one, the traditional concepts of filial piety define the roles of family members and their relationships. It is possible that acculturation results in changes in the concepts of filial piety. In this study, how the family function changed and how it is functioning, and how these changes have impacted on the traditional cultural beliefs were the critical topics for practitioners in the interviews.

Multi-cultural family dynamics

The findings from this study demonstrated that participants noted changes in filial piety behaviour in some Chinese families which have settled here. As introduced above, within traditional concepts of filial piety, elders assume a socially integrated and productive social role within the family. This traditional cultural belief system promotes care and respect toward older adults. After migration to the host society, adult children are likely to integrate to the host society and become the mainstay of the family; in order to satisfy the needs of the family members, older people are given new roles and expectations, and their adult children and grandchildren may show less traditional filial behaviours. For those grandchildren who were born in a Western country, it can be more challenging to expect that they understand and follow the principles of filial piety (Pang et al., 2003). Participants affirmed the efforts of elders in maintaining and disseminating Chinese traditional culture among new generations. While according to Berry (1997), older people who prefer to maintain traditional culture and with limited social networks are more likely to be separated. These different acculturation strategies have the potential to strain

relations within Chinse families and across the ethnic community. In fact, acculturation gaps or intergenerational gaps between family members may cause acculturation stress (Vuong, 2010).

Hwang (2006) outlined one type of acculturation stress termed “acculturative family distancing”. “The distancing that occurs between immigrant parents and their children that is a result of immigration, cultural differences and differing rates of acculturation” (p. 398). As reflected in this study’s findings, it is common that parents have to work long hours to support the family in the host society, which results in limited time at home with their children. Moreover, some of them have difficulties in English; they cannot give tutoring to their children. The absence of parents in daily life may cause attachment issues for children and adolescents, and they are likely to receive support from local peer groups, which may cause further acculturative family distancing.

Chinese parents are more likely to have lower acculturation levels than their children. The acculturation levels of siblings in the extended family may be diverse. The older siblings are more likely to commit to the traditional Chinese culture while younger siblings are more likely to assimilate to the mainstream culture in the host society (Vuong, 2010). However, the findings from this study showed the resilience of older Chinese people in maintaining their own health, and positively adapting to their new roles in the family. Pang et al. (2003) supported that older parents may change their expectations of their adult children due to the changing concepts of filial piety.

Besides older family members, children and adolescents in the family may also experience acculturation stress. Participants who work with children and adolescents mentioned that cross-cultural issues are significant especially for those children who are of the second generation. Parents, and especially grandparents, may have strong beliefs in traditional Chinese culture and try to maintain the culture, while children

are more likely to adopt the dominant culture due to the needs of socialization with mainstream society. Therefore, children and adolescents are more likely to adopt either an integration or assimilation orientation.

In relation to filial piety, those children are unlikely to fully understand the concepts. For example, although young people may accept the expectations of their parents towards the academic success, it is possible they cannot understand the important relationship between academic success and the honour of their family name. Moreover, Chinese parents may not pay attention to the psychological well-being of their children, due to a lack of mental health knowledge, and the traditional cultural understanding of health, which involves a common preference to use traditional Chinese medicine.

Use of traditional Chinese medicine (TCM)

Participants who work with older migrants especially, pointed out some older Chinese people may use traditional Chinese medicine and Western medicine simultaneously to deal with their physical and psychological problems (suggesting either an integration or assimilation strategy); while sometimes they may use only Chinese medicine instead of Western medicine, which suggests a separation strategy.

Some practitioners have a greater awareness of Chinese people utilising TCM and are "happy" with that, and also develop coping strategies when Chinese people disclose information about the medicine, such as web-based information to get medical advice, or they involve Chinese clinicians to talk to the family.

As discussed earlier, Taoism views mental illness as just an imbalance of Yin and Yan, and physical and psychological illness are believed to be part of a whole. Choosing to use traditional Chinese medicine supports the traditional understanding

of mental health/illness (Lam et al., 2010). This perception about mental health/illness can be one of the reasons that Chinese people are aware of somatisation of mental symptoms, as introduced in the literature review. However, it is important to note that not all the Chinese people might use traditional Chinese medicine or other alternative medicine instead of Western medicine. The research that was conducted by Yang et al. (2009) found that the first generation may be affected significantly by TCM, while the role of TCM played in health-care decision-making for the second-generation was not so crucial. The second generation tend to use both TCM and western health services. Different attitudes towards TCM in the family may be a form of acculturation stress. It is important to acknowledge that the beliefs over traditional Chinese Medicine and to what degree held by Chinese people are being transformed (Yang et al., 2009), depend on their acculturation orientations: integration, assimilation, separation, or marginalization.

Part one and part two have introduced the concepts of filial piety, which emphasise family relationships and provide some explanation about the attitudes and behaviours of Chinese people in relation to mental health service utilisation. After migration, these traditional cultural beliefs in the family are influenced and interacted with the mainstream culture in the host society (acculturation). More importantly, different acculturation orientations of family members may change the family dynamics to varying degrees. How this information, from parts one and two can contribute to improvements in social work practice will be explored next.

Part Three: Implications for Social Work Practice

The above discussion has shown both before and after migration, how the changes in circumstances have impacted on Chinese migrants' beliefs and behaviours. As introduced in the methodology chapter, seven out of the ten participants were social workers; thus my argument will uses Shulman's (2006) interactional model to

analyse the relationships of clients and systems, and clarify the functional roles of social workers in encouraging and improving the accessibility and utilisation of Chinese migrants to mental health services. The remaining three participants' comments will be discussed in the concluding chapter.

The model is developed based on three assumptions: firstly, people and the surrounding environment have a symbiotic relationship. The term "symbiotic" describes a harmony and balance relationship between individuals and groups, and they need each other to live and grow. Secondly, there are obstacles between clients and the environment which prevent them reaching out for each other. Thirdly, social workers have to believe, access and mobilise the strength and resilience of clients in order to effect to change.

First step: identify the symbolic systems of Chinese people

Based on the findings from the study, Shulman's (2006) interactional model has been developed in Figure 5.2, which basically describes relationship of client, systems and social workers.

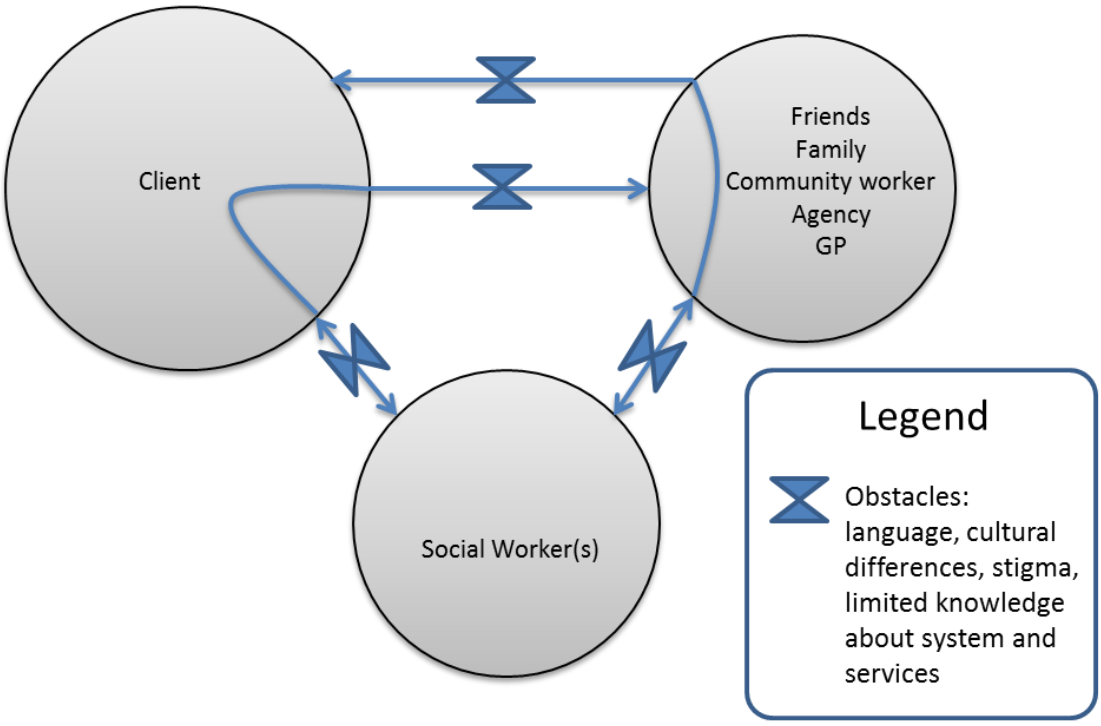

Figure 5.2 Relationship of Client, Systems, and worker(s), adapted from Shulman (2006)

On the left of Figure 5.2 is the Chinese client; on the right is the symbolic system that Chinese people live in. The client is "reaching out" (p. 21) to the system, and the system is also "reaching out" to the client. Based on the previous discussion about the concepts of filial piety, family sometimes stands for the individual, thus the client should be understood within the family. The symbolic system for Chinese people in this study includes friends, family, community members, agencies, general practitioners, interpreters, and bilingual clinicians. However, there are obstacles in the interaction between the client and the system. These obstacles can include language barriers, shame, and limited knowledge about available services. Social workers, who are at the bottom, have the functional roles of communicating with the client, and linking the client to the symbiotic systems, also working with symbolic systems and connecting the system with the client.

Second step: identifying the obstacles in the engagement

According to the interactional model, there are obstacles preventing Chinese clients from engaging with the system, and the system also experiences some challenges and barriers when reaching out to Chinese clients. These obstacles have been identified in the study results and also discussed in parts one and two, as the following:

- Language and cultural differences

Lack of language proficiency played a vital role in blocking the communication between Chinese clients and mental health providers. The cultural differences behind language issues increased the difficulty of mental health practitioners to correctly diagnose the symptoms, and this slows the progress of intervention.

The findings suggest interpreters play significant roles in building communication between Chinese clients and mental health practitioners during the cross-cultural intervention. When interpreters are not available sometimes, bilingual or bicultural clinicians are also helpful in assessment and treatment, co-therapy, community engagement, service development and capacity building (Participant 5). Family members are mentioned as alternative options to translate between the clients and practitioners.

However, it is pointed out by Chen et al. (2009) that engaging interpreters and bilingual practitioners is not sufficient in itself to bridge the gap between mental health services and the Chinese community. Using family members or friends rather than interpreters to translate in clinic settings sometimes is not always considered as appropriate (Hassett & George, 2002).

- Shame and discrimination associated with mental health

The findings show that Chinese people have negative understanding about mental health (which is influenced by traditional Chinese culture), and people with mental health issues experience shame and discrimination in the community. Stigma associated with mental health is a significant obstacle for Chinese people accessing mental health care. As a result, Chinese people are not willing to seek help from mental health providers, whom they believe are associated with stigma. The findings are supported by Yang et al.'s (2008) research. Chinese-Americans with depression reported little stigma if they received treatment at a primary care clinic; contact with psychiatric services (e.g., psychiatric hospitalization) has been found to be more powerfully stigmatizing than other types of treatment (Yang et al., 2008).

- Use of alternative help instead of mainstream services

In this study, many Chinese people were identified as using traditional Chinese medicine. One of the reasons is Chinese people have faith in the Chinese traditional view of health. For example, the literature review introduced that Taoism supports the belief that health is a balance between "yin and yan", and illness is caused by the imbalance of energy. Western medicine is believed to be more effective on the symptoms, but Chinese medicine emphasises the conditioning of the whole body (Lam et al., 2010; Yang et al., 2009).

Another important reason to use alternative help is the influence of stigma. Compared with mental health services, Chinese people are more comfortable in seeking alternative help from herbalists, acupuncturists, ministers, or fortune-tellers (Kung, 2004). Yang et al. (2008) also supported that Chinese people feel shame in using Western psychiatric treatment when compared with using a practitioner of TCM to treat a mental disorder. Use of TCM could present as both a barrier and a potential strength.

- Limited knowledge about health systems and service providers

Chinese people are not familiar with health systems, and they may perceive the system in the host society is the same with that in the original country. They also have limited knowledge about available services and resources. In New Zealand, mental health services are provided through multi-disciplinary teams, consisting of psychiatrists, nurses, psychologists, occupational therapists, social workers (Healthpoint, 2013). In this study, Chinese clients are considered to not understand different roles of mental health professionals.

- Absence of relatives and peer groups

The experience of migration changes the symbolic system of Chinese migrants. It is possible that family members and friends of Chinese migrants remain in China, which would be a tremendous loss to individuals. It is important for them to reconnect with relatives and friends, and explore the possible ways to rebuild the connection.

Third step: discover the strength of Chinese people within family and community

The strong ties between Chinese individuals to the family and community, which are rooted in traditional Chinese beliefs and values, can be regarded as a source of their strength.

Chinese people who have strong beliefs in filial piety are more likely to have strong ties with the family and community. These elements provide social support for individuals in Chinese societies, and this idea is also applicable for Chinese migrants. Abdulahad, Graham, Montelpare, and Brownlee (2012) highlighted "family and social networks have often been considered the most salient aspects of social capital for immigrants" (p. 3). Strong support from family and community provides links to

the original cultural groups, which may reduce the risks of mental illness (Hassett & George, 2002).

Participants in the study indicated that the community also provided the main support to older people. Pang et al. (2003) found that older Chinese may shift in support networks from relatives who are most likely back in China, to friends and neighbours in the community.

Besides this, the motivations for migration are important. Pernice et al. (2009) mentioned that if migrants are looking for change, challenge or better opportunities, it many have a positive impact on their mental well-being. The findings in the study indicated that many Chinese people migrate to seek better education or work opportunities, and to improve living conditions for family members. Thus, the strength and resilience of Chinese people may also be identified from their migration motivations.

Although close family and community may be helpful for Chinese migrants in order to reduce isolation, and maintain and promote mental well-being, family and community as the main supports may result in relational strain and distress (Malmberg-Heimonen, 2010), and limit communication with the external environment. As a result, Chinese people may not able to build connections with the host society, and this reduces the opportunities to access outside services.

Traditional Chinese culture also has a negative impact on the attitudes and behaviour of Chinese people towards mental health care. As stated before, Chinese clients may have a strong dependency on family members or the caregivers, and they are likely to have passive roles during the engagement, which can be challenging for mental health practitioners. Fatalistic beliefs that are held by Chinese people can be one of the reasons for using passive coping strategies. Fatalism, as mentioned in the

literature review, is also an important concept in traditional Chinese culture, and it encourages people's forbearance of life stresses and suffering.

As discussed in part two, multi-generational and multi-cultural family dynamics developed after migration change the roles of individuals within the family. The conflicts can be generated due to different acculturation orientations of family and community members. As a result, the relationships among family and community members can be complicated and distinguished from others.

The functional roles of social workers

Multi-disciplinary teams in the mental health field aim to satisfy the complex needs of individuals with mental health issues. As introduced in Chapter 2, social workers are important members in multi-disciplinary teams who have their own tasks and skills to engage with clients. Shulman (2006) suggested that the differences among professions could be seen through their function roles. In the interactional model, social workers are the helping roles to promote the engagement between Chinese clients and the system.

It is important to help social workers to clarify their functional roles in this helping process, so that both Chinese people and the mental health providers are able to "reach out" for each other. Based on the findings in this study and obstacles identified above, social workers could have the following roles to play:

1. The role of delivering information to Chinese people

It is an important task to provide information about English classes to Chinese people. Through the classes, Chinese people are able to improve their English, and also have opportunities to meet friends, and build social networks. Be aware that older people may feel pressure to go to the class, due to poor English and other age factors, so it is

better to find out classes that satisfy different ages, abilities, and interests, and take into account their specific needs as English language learners.

Provide information about available community resources. It is easier for Chinese people to acknowledge and be familiar with the community resources. Participating in group activities or doing some voluntary work are good ways for Chinese people to build up new relationships and gain support from others in the community (Chan, 2009).

Information on mental health providers and available services in Chinese should be provided and updated regularly. Information about working alongside Chinese clients in collaborative and culturally informed ways should also be offered to family members and caregivers, including information about illness management, residential care, and financial issues. It is important to inform, and suggest to the family, methods of being able to manage a client's illness without degrading the person: knowledge of the symptoms of mental illness, how to deal with the situation, and what would be helpful for their recovery.

2. The role of reducing the impact of stigma

Within the community, social workers should increase community members' awareness and willingness to discuss mental health and reduce stigma and discrimination. Community education is an effective way to educate the people about the different concepts and causes of mental illness and to promote the utilisation of mental health services (Lam et al., 2010; Tieu, Konnert, & Wang, 2010). Pay attention to the education of young people as young people are more likely to contact and participate in mainstream society, and they are more open to new knowledge and tolerant of different viewpoints. As more and more younger people are educated, they will be able to educate and inform families more readily.

- Non-clinical mental health team working in the Chinese community

Chinese clients are not likely to go to an in-patient unit because of the attached stigma (Teng, & Friedman, 2008). Encouraging more qualified volunteer individuals to work in the Chinese community could lower the impact of stigma, and spread knowledge about mental health and mental illness for Chinese people in a more confortable way. In terms of language and cultural barriers, the team may also be the bridge between Chinese clients and the clinical team.

Moreover, as discussed above, the degree of stigma is associated with the physical place of treatment. Contacting Western mental health services may increase the stigma and be an added burden for Chinese people utilising the services. Primary care is usually the first option for Chinese clients to seek help among Western professionals. Thus, engaging GPs to cooperate with mental health professionals can be an effective way to perform mental health promotion and mental illness prevention (Leung et al., 2012). The importance of GPs will be discussed next.

3. The role of building and developing resources for Chinese people

- Peer groups

Social workers should explore and develop more resources to support Chinese clients and their families. Bo Ai She, mentioned by participants, is a great example. Bo Ai She is a mental health peer group organisation, and it provides group support to Chinese clients with mental health needs and their families. This organisation offers the following services: physical fitness and recreational activities; share recovery experiences; educational workshops include English classes; and workshops on recovery skills and techniques. The organisation also develops its own work approach: help the client to set up a personal recovery plan (Bo Ai She, 2013)

- Culturally appropriate programmes

New programmes should be designed for Chinese clients, and Chinese staff can be involved to reduce language barriers. People who come to the programme can speak their own language, and make some Chinese food and share it. Also it is a good opportunity for Chinese people to meet with each other, and build up new relationships. The programme can benefit the caregivers of the Chinese clients. Family caregivers could also have a rest during the day and feel at ease.

- Provide supports for caregivers

As discussed before, caregivers experience conflicts between the traditional cultural expectations and the environment in which they are living. More importantly, it is important to be aware of possible complex emotional stress that caregivers may experience when decisions to institutionalize the client are made (Ho et al., 2003). As shown in Figure 5.1, seeking formal help from mental health providers for Chinese people is the last resort, but when and why to choose this option is related to acculturation (Ho et al., 2003).

Therefore, Chinese family caregivers should positively obtain knowledge and information about available formal services; they should also learn more about skills and resources that can support them as family caregivers (Lai, 2011).

4. The role of providing education and training for mental health practitioners

Asian/Chinese practitioners could educate their agencies and colleagues about Chinese culture, and introduce Chinese culture to the mainstream staff in order to get support from the team leader and the agency.

For example, being familiar with Chinese culture is beneficial for building rapport. Building rapport is a critical component of competency development. Building trust with the client and their significant others will facilitate and enhance the client's participation in treatment. Chan and Palley (2005) suggested that practitioners may improve the therapeutic relationship through recognising and respecting clients' pride in their own culture norms and ethnicity. There are some tips from participants: try to prepare yourself to learn more about Chinese culture, such as some Chinese words and sentences which may help to engage with Chinese clients. It is a good idea to consult with any Chinese staff.

Introducing some major festivals for colleagues can be useful, such as the New Year's Day, the Chinese New Year, Full Moon dinner, and the Dragon Boat festival. These days are important for Chinese families to gather together, have meals, give gifts and send best wishes to each other (Chan & Palley, 2005). Social work practitioners may obtain important information through this kind of group meeting to deal with health and mental health problems in the Chinese community.

Being in touch with traditional Chinese specialists may be an effective means of outreach for Chinese migrants (Chan, 2009). In the findings, participants also talk about the high recognition of professionals' authority, which may contribute to the relationship building if appropriately used. Besides, by gaining respect of a few Chinese people, word of mouth by these members can easily send potential clients from the community.

5. The role of liaising and collaborating within/with agencies

Due to the language barrier and cultural difference during the intervention, it is vital to cooperate with interpreters, and sometimes involve bilingual clinicians, and family members when it is appropriate.

Participating in workshops is an effective way to gain knowledge about clients with different cultural backgrounds. The training should provide information about what the characteristics are of Asian/Chinese clients, and their families; how to understand their migration journey; how their experience, such as family separation and lack of social networks, may affect mental well-being; what are the protective factors or barriers for Asian/Chinese migrants to accessing mental health services. More workshops are needed in order to provide better understanding of mental health practitioners towards Chinese clients.

- The bridge between doctors and clients

Several participants emphasised their roles as bridges between doctors and Chinese clients. Participants as social workers often present information in meetings between doctors and clients. The language that doctors use may be difficult for Chinese clients to understand. One participant gives an example as following:

> *I had a client, I was interviewing him, he just shook his head and said, "I didn't understand* [a] *single word the doctor said". I said "OK, I will explain to you". He said "thank goodness you were there", I said "why?" He said "if it was only between doctor and me, I never understand". I talked to doctor after my client left, I said "my client said you are way over him"; "what do you mean"; "the language you use, he is no way to understand it." She said "well, we will do it again and see what happened." So the next interview, it's really important that you can advocate for your clients, bring the doctor come down to the client's level, cos the client can't go up to the doctor's level, the doctor needs to go down to the client's level, so he or she can understand.* (Participant 1)

Thus, social workers have to negotiate with both doctors and Chinese clients to make sure the important information is delivered and understood.

- Consult with Asian/ Chinese mental health services

Most participants affirm the contribution of Asian mental health services. They suggest that when the clinicians get stuck regarding cultural issues, it always good to involve the coordinators to *"make the movement, make the changes"* (Participant 4).

And,

> *I think for adult mental health, they have Asian mental health coordinator, they have done a lot in communicating and education kind of staff, they are happening, but they are not something you could change immediately. But a lot of them are about education. I was at a transcultural meeting the other week and they had done an awful lot of work in terms of doing e-learning for staff like us – on the Internet.* (Participant 5)

And further:

> *Yes, for us to learn. I think we all work in pretty well together. It's just that we get busy and it takes time to do that but if I can ever bring one of their workers* [Asian mental health service] *on a case, I do it every time because it makes it so much easier for me. And for the client. But you feel as if you know you're going in the right way.* (Participant 8)

The main role of an Asian mental health coordinator is to provide consultation in Asian services for the clinicians in the mental health area of the Auckland District Health Board. For example, meeting foreign language needs, or by using cultural appropriate language. When doing family therapy with clients, it is hard to do the

therapy effectively using second language between the users and clinicians. Their roles also involve checking for the diagnosis and looking at the treatments, reviewing medications (Participant 4).

Chinese Community support workers were also mentioned by participants. They support mental health practitioners such as psychiatrists, nurses, and key workers to work with Chinese clients. These support workers also link Chinese people back to the community, and encourage them to utilize community resources.

The discussion above applied Shulman's (2006) interactional model to identify the symbolic system of Chinese migrants in the study, and highlight the obstacles between the client and the system in reaching out for each other. Thus, social workers are given important roles in helping the client and the system overcome obstacles and engage with each other.

Summary

The discussion of this chapter is family-focused and community-based, and also developed from perspectives of mental health providers. The first part explored the main concepts of traditional filial piety, which is deeply rooted in Confucianism. Then, how filial piety affects beliefs, attitudes, and behaviours of Chinese people towards mental health issues was discussed.

The second part of this chapter discussed how the migration process brings changes to the individuals and their families. The process of acculturation affects the traditional concepts of filial piety, which defines roles of family members. This led to discussions about what are possible acculturation orientations for Chinese migrants in the community and within the family.

The third part of this chapter has applied the interactional model to identify some important functional roles of social workers in bridging Chinese clients and mental health providers, and promotes better cooperation among clients, systems and social workers.

The next chapter will present the conclusion to this thesis, which reviews the previous chapters, and also reflects on how this study may help mental health practitioners in cross-cultural practice.

Chapter 6. Conclusion and Implications for Mental Health Practice

Introduction

This study has explored the experience of mental health practitioners of working with Chinese migrants in relation to the accessibility and utilisation of mental health services. This final chapter summarizes the main findings, and also reflects on the practical value of this study. It also comments on the limitation of the research, and provides proposals for future study.

Linking the study together

Dow (2011) suggests that cultures create unique patterns of beliefs and perceptions as to what "health" or "illness" actually mean. In turn, these patterns or beliefs influence how symptoms are recognized, to what they are attributed, how they are interpreted, and how and when health services are sought. Therefore, it is critical to understand what the cultural beliefs and values that are held by Chinese clients and their families – particularly in migration contexts.

This study explores the connection of traditional Chinese cultural beliefs and values to mental health service accessibility and utilisation through the three questions below:

1. To what extent are the clients affected by Chinese traditional cultural beliefs?
2. To what extent do Chinese cultural beliefs held by clients intermingle with western cultural beliefs?

3. To what extent should practitioners from different disciplines cooperate with each other and provide better services in cross-cultural practice?

There is no doubt that Chinese culture has a long history, and some aspects of the traditional culture may change and develop in different economic, social and political contexts, but the main concepts are inherited from generation to generation. Thus, being familiar with some concepts of traditional Chinese culture may be helpful for mental health practitioners in working with Chinese clients. Filial piety is introduced as a significant concept of traditional Chinese culture, which provides a new perspective to understand underutilisation of mental health services.

Chinese migrants as service users

Migration is one important turning point in a Chinese person's life and brings many changes, and diverse settlement experience has proven impacts on mental well-being of Chinese migrants. Participants described the migration experience of different age groups: adult Chinese migrants, children and adolescents, and older Chinese migrants. Barriers and protective factors that related to settlement issues were identified in the study.

Several significant factors that prevent Chinese migrants accessing/utilising mental health services have been considered in the study findings. These can be divided into two categories: practical barriers and cultural differences.

Practical barriers for Chinese migrants to access and utilise services are: a lack of English language proficiency; a lack of financial resources; an inability to drive; a lack of social support and networks; and having limited knowledge of the system and available services.

Cultural differences also impact on service utilisation. Many Chinese people have different perceptions about mental health and illness from people in the host society. Shame and discrimination associated with mental illness is a big barrier for Chinese people to overcome in seeking mental health care. Use of traditional Chinese medicine is popular among Chinese clients, especially older people, while Chinese clients and families might not inform practitioners about their use of Chinese medicine.

Many of these factors are rooted in traditional Chinese culture. Traditional Chinese cultural beliefs and values such as Confucianism, Taoism and Buddhism have been shown to impact on Chinese attitudes and behaviours towards mental health and service providers.

Mental health practitioners as service providers

This study provides opportunities for mental health practitioners to engage in self-reflection in terms of their practice. Ten participants as service providers in this study have contributed their understanding about Chinese migrants and their families. The knowledge was gained through their years of work experience, and is also associated with personal interest in Chinese culture, engaging with colleagues, and participation in many workshops.

As mentioned before, besides the seven social workers, there were three participants, one nurse, one cultural coordinator, and one counsellor with a social work degree.

The nurse participant believed many mental health nurses have to multi-task, because they need to take some roles for their colleagues with different disciplines. In this study, the participant with a Chinese background often helps a social worker to

communicate with the family and arrange family meetings, or helps an occupational therapist to organise physical activities, or helps doctors to assess the mental status.

The counsellor has a social work knowledge base. This participant believed Counselling skills help the participant to work deeply with the client, and identify the internal strengths and resources of the client. At the same time, social workers have roles of providing practical support and advocacy for clients.

The other participant, a cultural coordinator, provides consultation for mental health practitioners about cultural issues. The participant suggested that as a coordinator, it is important to create a win-win situation: help the mainstream clinicians to solve culturally related barriers during the engagement with Chinese clients, and at the same time satisfy the cultural needs of Chinese clients.

Both Chinese and non-Chinese participants identify their challenges when working with Chinese clients. The language barrier is considered as a significant obstacle that prevents mental health practitioners to engage with Chinese clients and families. Lack of information and understanding about the health system in New Zealand, and being unaware of available services and resources add burdens for Chinese migrants in utilising mental health services. Chinese migrants may have negative perception about Western medicine, and consider traditional Chinese medicine is an alternative option for treatment.

Although there are barriers to work with Chinese migrants, participants showed their strengths by using different strategies to overcome challenges. Participants also evaluated the importance of working cooperatively with practitioners from other disciplines, such as interpreters, bilingual clinicians and general practitioners in overcoming the cultural differences.

Implications for Mental Health Practice

Most participants in the study are working in multi-disciplinary teams. Participants believed multi-disciplinary coordination is important, and team members should respect, support, cooperate and learn from each other in the multi-disciplinary team. The previous chapter discussed possible roles of social workers in promoting the utilisation of Chinese migrants to mental health services: the role of delivering information to Chinese people; the role of reducing the impact of stigma; the role of building and developing resources for Chinese people; the role of providing education and training for mental health practitioners; and the role of liaising and collaborating within/with agencies. The findings in the study can also be applied by mental health practitioners in future practice.

- Knowledge about traditional Chinese culture is important

Some Chinese characteristics: dependency, honor the family name, respect elderly can be understood through traditional Chinese culture. Filial piety, as a significant concept of Confucianism, emphasises multiple relationships between the person and the surrounding environment: to create and maintain harmonic relationships is the goal.

The importance of family and community is defined in traditional Chinese cultural concepts. Participants identified Chinese people as "high contact people"; family members, friends and peer groups in the community are important supports and resources for Chinese migrants, especially for the Chinese elders. For children and adolescents, media, schools, and peer groups are significant channels for them to build up social networks, so practitioners should also be familiar with these channels. Participants also described many types of relationships, including parenting issues, peer groups, husband-and-wife relationships, and considered generation gaps within

the family. These diverse types of relationship have either positive or negative impacts on the mental well-being of Chinese clients. It is important to recognize the migration motivations of Chinese people are commonly made upon the family rather than the individual. As a result, mental health workers should be aware of the importance of traditional Chinese culture, which reminds them to work with the client in the family system: what is the family structure, or how does the family function in terms of the roles of each family member. However, the degree to which traditional values and beliefs impact on Chinese individuals' attitudes to mental health care is diverse, and keeps changing due to individuals' acculturation orientations after migration.

As the literature indicates, shame, guilt and face loss associated with mental illness among Chinese are rooted in traditional Chinese cultures. The stigma of mental illness has a significant impact on Chinese people in their help-seeking behaviours regarding mental health services (Lam et al., 2010). In order to avoid losing face, Chan and Palley (2005) suggested practitioners use a consultation approach, which instead of consulting the clients themselves, older family members and parents are consulted. When Chinese people are involved as helpers, they will likely be positive participants in the intervention. Lai (2004) also suggested that mental health practitioners should not only focus on symptoms, but also be aware of the important roles of cultural beliefs and values that played in health assessment.

It is important to understand the significant roles of family members in the intervention process, and be familiar with them and find out who is the most important person to communicate with. While strong bonding between Chinese people and families and community may prevent Chinese people in the general community from knowing the mental health client, the community may not have the opportunity to directly have contact with people with mental illness. Therefore, media such as TV or newspapers in Chinese may be an important channel to spread knowledge about

mental health, as well as the information about available mental health services. The media has a significant role for the younger generation.

- Understand the influence of migration on individuals and families is important

In this study, it is contended that migration experience has a significant impact on the mental well-being of Chinese migrants in New Zealand. Practitioners should be aware of migration motivations, and discover the resilience of Chinese migrants through the migration experience.

The migration may result in major changes of family dynamics, and altered roles for family members. Participants should be aware of the multiple cultural dynamics in the family, and relationships between Chinese clients and their families. The need to acknowledge community resources is a significant issue that was identified by participants.

The multi-generational and multi-cultural family dynamic also entails new roles for family members, and complicates the relationships. Older Chinese people may be more vulnerable to cultural conflicts due to their strong beliefs in traditional family values (Zhang et al., 1997). As Casado and Leung stated (2001), migrants with strong attachment to the original countries may prevent themselves from integrating into the host society and this may cause depression. According to the value of filial piety, adult children have responsibility to take good care of older parents' mind and the body (Lai, 2010). Therefore, inadequate care and excessive financial requests from other family members are more likely to lead older people to depression (Zhang et al., 1997). Professionals emphasise that understanding the grief experience of migrants can help them provide appropriate services.

- It is good to think about what culturally appropriate services are.

One participant advised: “not to assume anything about anyone, treat people as individuals and to check things out” (Participant 3). When working in cross-cultural contexts, practitioners should have confidence in their abilities to provide culturally appropriate work, but to be aware of and understand the difference. For those who share the same cultural background as Chinese clients and families, it is important to remember all people are different. Practitioners should always ask questions, and consult others on cultural issues, but “don’t treat us [Chinese clients] like aliens, we are all the same, we are all human beings” (Participant 4).

Developing trusting relationships with Chinese clients is important for mental health practitioners. The reputations of mental health practitioners spread in the Chinese community through word of mouth, and Chinese people are likely to trust those well-known and respected famous professionals. Additionally, the belief that “professionals are authority” may reduce the difficulty of building the links between Chinese clients and professionals. Be aware that Chinese people may prefer to work with older professionals rather than young female staff, while professionals should gain trust and respect through their professional competencies.

However, the application of these useful strategies needs further discussion. For example, the IFSW code suggests that social workers should uphold and defend each person's physical, psychological, emotional, and spiritual integrity and well-being and respect the right to self-determination (IFSW, 2012a). However, as mentioned in the findings, professionals are regarded as *“people of authority”*, and Chinese people believe in the knowledge and skills of professionals. In relation to health issues, Chinese people are not accustomed to make decisions for themselves, but look for answers from professionals as to *“right or wrong”* (Participant 6) questions, such as *“do this, do that, do the other thing”* (Participant 2).

Besides, the key philosophies of social justice and human rights contribute significantly to both the purposes of practice and how practice is undertaken. Understanding the concepts of power and empowerment are essential themes of practice (IFSW, 2012b). Chinese people respect and have faith in professional authority, which may benefit practitioners in building trusting relationships with Chinese clients. How practitioners can maintain the balance of power and empowerment is a critical question.

Ideas for Further Research

Considering this study was a very small sampling, the findings may provide some significant examples but cannot be generalized. This study is more focused on individuals' perspectives about work with Chinese migrants, while two participants talked about the cost of providing certain services as a potential barrier to provide better services to Chinese clients. One participant said, *"it's very expensive to keep someone in hospital. It's about fifteen hundred a day. On average it's about fifteen hundred a day, because you've got doctors, nurses and 24/7"* (Participant 8). Also, *"To keep someone on our books in the community, its two hundred and fifty dollars a day, just to keep someone in our books so we try and discharge people to their GPs when they're well enough* (Participant 1). Some Chinese clients seek help from professionals because the services are free, but one participant wanted Chinese people to carefully consider how to use these services and obtain better mental well-being. Involving interpreters to work with Chinese clients is also a huge expense for the agency. Therefore, how the broader working environments such as agencies and social policy impact on mental health accessibility and utilisation should be further studied in the future.

As we discussed before, the cooperation between mental health practitioners from different discipline is important to provide cross-cultural services. In this study, many

participants work in multidisciplinary team. Orovwuje (2010) highly confirmed that multidisciplinary team work can maximize the effectiveness and capacity of mental health services. And it is so important for social workers to work together with other professionals to help clients during the recovery process (Ray et al, 2008). In contrast, Brown, Crawford and Darongkamas (2000) discovered that professionals in the team share tasks or work from outside their field of expertise can cause lower efficiency. Working in multidisciplinary team can erode the sense of professional identity. Therefore, further research should be done about how mental health practitioners should cooperate with others but at the same time protrude different professional roles.

The following are some specific questions that related to the topic, which could be explored in future research:

- A large qualitative study involving the mental health needs of Chinese migrants, including their expectations of the health system.

- Evaluate the mental health sectors that provide services to Asian/Chinese clients.

- Evaluate current strategies that have been applied to Asian/Chinese clients.

- Explore possible methods or strategies that may encourage Chinese clients to have higher rates of access.

- Explore what role different religious beliefs play in the area of Chinese mental health.

- Further explore the help-seeking behaviour patterns of Chinese clients, and suggest positive ways to influence these.

Final Words…

This research was inspired by many previous local and international studies which suggested that Chinese migrants and their family members are likely to experience barriers to access, and to underutilise the available mental health services in the host society. Much previous research has focused on barriers to service access, and has used the broad category "Asian" as a research target. This research targets specifically Chinese migrants, and wanted to explore the experiences of Chinese people in accessing and utilizing New Zealand mental health services, and how mental health practitioners may promote the services and enable the help-seeking behaviours of Chinese people.

This study is small-sample research, thus the results will not represent the overall features of the service users or service providers. However, this study supported some important findings from previous research conducted in Asian mental health, which illustrated that by using "Asian" as a category to conduct the research, it is possible to obtain useful information about the needs of sub-groups.

Through the interviews with ten participants, the study presents a snapshot of current practice in the mental health field with cross-cultural issues. The findings, combined with the literature review, provide a wealth of knowledge about Chinese migrants as service users and mental health practitioners as service providers. The reasons for conducting this research initially involved the hope, for myself as a researcher, that I may gain some important information about current mental health providers' attitudes towards Chinese people; through the interviews, mental health practitioners may have an opportunity to reflect about what their strength and challenges are in cross-cultural contexts. Participants will also receive findings of this study, thus they may share useful strategies or recommendations from each other that may be useful for future practice.

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Appendix 1: Definitions

Asian

According to Statistics NZ (2003), the term *Asian* commonly refers to people who come from Asia, including people coming from West Asia, e.g. Afghanistan, Nepal, South Asia, covering the Indian sub-continent, East Asia covering China, Hong Kong, Taiwan, North and South Korea, Japan, and South East Asia covering countries like Singapore, Malaysia, Philippines, Vietnam, Myanmar, Laos, and Kampuchea. While People in New Zealand define Asian people as Chinese and other East and Southeast Asian peoples (Rasanathan et al., 2006a).

A risk factor

A risk factor is defined as "an experience or demographic feature that correlates with an increased likelihood of mental disorder" (Te Pou, 2008, p. 23).

A protective factor

A protective factor is "an experience or demographic feature that is associated with positive mental well-being" (Te Pou, 2008, p. 23).

Chinese migrants

The term *"Chinese migrants"* in this study refers mainly to people who were born in Mainland China, Hong Kong, Taiwan. When referring to other previous research, Chinese may also include Singapore Chinese, Malaysian Chinese, and those who entered New Zealand or other western countries under an immigration program.

Mental health

In this paper the definition of mental health from the World Health Organisation is "Mental health can be conceptualised as a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2010, Factsheet 220).

Mental illness

Mental illness here is defined as "any clinically significant behavioural or psychological syndrome characterised by distressing symptoms or significant impairment affecting a person's ability to function" (Ministry of Health, 2006, p. 77).

Mental health sector (Mental health practitioners)

Mental health sector is defined as "the organisations and individuals involved in mental health to any degree and at any level" (Ministry of Health, 2006, p. 77).

Mental health service provider

This paper uses the following definition: "An organisation providing as its core activity assessment, treatment or support to consumers with mental illness and/or alcohol and drug problems" (Ministry of Health, 2006, p. 77).

Appendix2: Ethics Approval

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE

05-Jul-2012

MEMORANDUM TO:

Dr Jay Marlowe
Counselling, HumServ & SocWrk

Re: Application for Ethics Approval (Our Ref. 8093)

The Committee considered your application for ethics approval for your project entitled **Mental health practitioners perspectives of working with Chinese immigrants in New Zealand** .

Ethics approval was given for a period of three years with the following comment(s):

The Committee notes that, against the Committee's advice, the researchers have declined to notify the managers of the relevant mental health agencies that their employees are participating in this research.

The expiry date for this approval is 05-Jul-2015.

If the project changes significantly you are required to resubmit a new application to UAHPEC for further consideration.

In order that an up-to-date record can be maintained, you are requested to notify UAHPEC once your project is completed.

The Chair and the members of UAHPEC would be happy to discuss general matters relating to ethics approvals if you wish to do so. Contact should be made through the UAHPEC ethics adminisatrators at humanethics@auckland.ac.nz in the first instance.

All communication with the UAHPEC regarding this application should include this reference number: **8093**.

Appendix 3: Documents Provided to Participants for Informed Consent

Participants Information Sheet (participants)

THIS FORM WILL BE STORED SAFELY FOR SIX YEARS

Project title: **The mental health practitioners' perspectives of working with Chinese migrants in New Zealand**

Researcher: **Jing Xu**

Hello, my name is Jing Xu. I am a Master of Social Work student at the University of Auckland. I would like to invite you to take part in a study about "the mental health practitioners' perspectives on working with Chinese migrants in relation to mental health service delivery and accessibility". This letter provides an overview of information about the study to help you to decide whether you want to take part in this research.

What is the study about?

I would like to speak with mental health practitioners individually to understand the following themes:

(1). Identification of the impediments that Chinese migrants may experience in relation to the access and use of mental health services

(2). Identification of the challenges that mental health practitioners face in delivering services to Chinese immigrants

(3). Determining strategies, solutions, and/or new approaches which would improve

professional practice when working with Chinese immigrants.

Through this study, it will be possible to identify critical issues and ways that mental health practitioners can deliver culturally appropriate services to Chinese immigrants. The focus of this study is on your professional perspectives of working with Chinese migrants in mental health settings rather than upon the specific workplace practices of your agency or organisation that you have been or are currently employed.

What would be involved?

You are invited to participate as a mental health practitioner who has experience working with Chinese immigrants. I will interview you individually whenever it is suitable for you, and the interview location will be suggested in a neutral place outside your office to ensure your confidentiality. During the interview, you will be asked several questions, and a list of questions is attached at the end of this information sheet. The interview will be facilitated by Jing Xu and should take approximately 1 hour. The interview will be audio recorded to produce a written transcript. Only myself and my supervisor will have access to these audio recordings which will be kept confidential. The electronic data from the interview will be burned onto CD and kept in Dr Jay Marlowe's office. Transcripts will be securely stored in locked filing cabinets in the Faculty of Education for a period of six years. After this time, all data will be destroyed.

What are your rights and choice?

Participation in this research is voluntary. You have the right to refuse to answer any questions asked, and to withdraw from the research at any time. Although the interview will be audio recorded and transcribed, I will remove any information that may identify you as the participant. Even if you agree to being recorded, you may choose to have the recorder turned off at any time.When the interview is completed, you are also entitled to a copy of your digital recording of the interview, as well as your

transcripts. If you want to make changes or update for what you said in the interview, or you want to withdraw all the data, you will need to inform me within four weeks after you receive your recording and transcript. After this time, you will not be able to change or remove the data.

Will you hear about the study?

When this research is completed, you will be sent a summary of the findings. It is hoped that the summary will provide a local New Zealand context to consider the most relevant issues for promoting responsive and appropriate mental health services for Chinese immigrants.

Who is doing this study?

Jing Xu(student):

Email:
jxu090@aucklanduni.ac.nz

Work phone: 0212861021

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Phone: 09-6238899 ext48562

Questions

If you would like to participate, or you have any questions about this study, please contact Jing Xu to discuss the project further. Her email address is jxu090@aucklanduni.ac.nz

Thank you for taking time to read this Participant Information Sheet.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 05-Jul-2012 for (3) years, Reference Number …8093…

Participants Consent Form

THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Project title: **The mental health practitioners' perspectives of working with Chinese migrants in New Zealand**

Researcher: **Jing Xu**

If you agree to participate in the research project as described in the Participant Information Sheet, please complete this form.

I _____ (write your name) have read the Participant Information Sheet, have understood the nature of the research and why I have been selected. I have had this study explained to me and I acknowledged the following:

- I understand that it is my choice to participate or not participate in this study.
- I understand that the focus of this study is on my professional perspectives of working with Chinese migrants rather than upon specific agency practices.
- I have had enough time to think about whether I want to take part in this study or not.
- I understand that I can choose not to answer any questions, and I am free to withdraw my participation at any time.
- I understand that I can withdraw my data from the study up to four weeks after my interview.
- I understand that the interview will be audiotaped and transcribed.
- I understand that I may choose to have the recorder turned off at any time.
- I understand that I will receive a summary of findings from the study.
- I understand that data will be kept securely for in locked filing cabinets in Dr Jay Marlowe's office in the Faculty of Education for a period 6 years, after which it will be destroyed.
- I DO / DO NOT (circle one) wish to receive a copy of my digital recording from the interview, as well as the transcripts.
- If I want to edit transcripts of the recordings, I understand that I will need to inform Jing Xu by email within 4 weeks after I receive the transcripts.

- Although absolute confidentiality cannot be guaranteed, I understand that if the information I provide is reported/published, this will be done in a way that does not identify me as the source of it.

Signature _____ Date _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON …

05-Jul-2012 FOR (3) YEARS REFERENCE NUMBER .8093

Appendix 4: Interview Questions

Semi-structured interview questions

To start with: Could you tell me your experience working with Chinese immigrants?

- How did you feel about that?
- What do you like most/least to work with Chinese immigrants?

Main question one: *What are the primary issues for Chinese migrants to access and utilise mental health services? Are you aware of any barriers or protective factors that would relevant to access and utilisation of mental health services?*

- In your professional experience, what do you think are the main mental health issues of Chinese immigrants?
    - Could you say some more about it?
- What do you think are relevant issues that have impact on the mental well-being of Chinese immigrants?
- What do you think are Chinese perspectives about current mental health services in New Zealand?
    - How did you get this conclusion? Would you like to say some examples?
- From your work experience, what are the relevant issues that can influence Chinese immigrants to access and utilize mental health services?
    - What are other issues that can be identified as protective factors/ barriers?
    - What do you think may cause them to delay in seeking treatment or underutilize available mental health services?
    - Do you think there are differences between Chinese immigrants and Pakeha people in terms of accessing and utilizing mental health services?

Main question two: *What do you think are some of the challenges for mental health practitioners to work with Chinese immigrants in mental health settings?*

- Form your professional perspective, what are your experience working with Chinese immigrants?
    - Have you experienced challenge during your work?
    - Would you like to outline what these challenges are?
    - What did you do at that time?
    - What do you think would be helpful in that situation?
- In your work experience, are there any particular issues that happened when you work with Chinese immigrants?
    - What do you mean by that?
- Do you think there are changes happened for Chinese immigrants in their understanding of mental health / mental illness?
- Do you think cultural values and beliefs influence Chinese immigrants' understandings and choices in terms of the mental health treatment?
- Are you aware of any other mental health services that specifically provided for Chinese people?

Main question three: *In relation to the issues you identified, what do you think are some possible strategies, solutions or recommendations that would create more effective practice with Chinese immigrants?*

- What are needs of Chinese immigrants for mental health services?
- What do you think is important or may be helpful when working with Chinese people in mental health setting?
- What is a culturally appropriate service for Chinese immigrants would like?