



# **8th National Chinese Mental Health Conference**

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**Friday 21st June 2002**

## Acknowledgements

Thanks to all those who contributed to the 8th National Chinese Mental Health Conference, June 2002, in Liverpool.

Special thanks to service users; carers; friends and families; delegates members; speakers; panel members; role play volunteers; individual organisation stall workers; workshop facilitators; translators; interpreters and various organisation representatives, for all their support.

Our sincere thanks to the funding organisations, for their financial contributions and active encouragement.

Special thanks to North West Public Health Observatory for their contribution with the report.

Our success was chiefly due to the hard work of all interested groups and their active involvement, commitment, participation and willingness to make a difference towards enhancing others quality of life.

Billy Ko, who sadly passed away in November 2002, was devoted and instrumental in making that difference.

## 鳴謝(Acknowledgements):

- 感謝所有對在利物浦舉行的第八屆全國華人精神健康研討會作出協助的人士。
- 特別鳴謝以下人士的支持：服務使用者，護理人員，服務使用者的家人及朋友，各代表成員，講者，各專題代表，參與角色扮演的義工，各獨立團體的工作人員，工作坊的促進員，翻譯員，傳譯員及各界的代表。
- 我們亦誠懇地感謝各資助是次活動的團體，除得到他們財政上的支助外，更得到許多主動的鼓勵。
- 此外，亦特別感謝西北公共健康監察對是次研討會報告所給予的貢獻。
- 是次研討會的成功主要歸功于所有興趣團體及其主動的參與，承諾，和願意為改善他人的生活質素的期望。
- 最後，遺憾地向各位宣布，曾對此研討會作出不遺余力的高家熾BillyKo先生于二零零二年十一月离世，在此謹向高先生各方面的建樹致意。

# National Chinese Mental Health Conference Friday 21st June 2002 at Foresight Centre, Liverpool University

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# 1. Summary

The 2002 conference was the first time that the National Chinese Mental Health Conference had been held in Liverpool. These conference excerpts provide a record of the presentations of the various speakers, along with carer and service user accounts, and the responses of a panel of experts in a question and answer session.

Officials from national, regional and local levels of the NHS, and professionals from within the field of mental health participated to hear the views of Chinese users, carers and those of local bilingual interpreters and service providers on Merseyside.

Speakers at the event were:

Louise Ellman MP, who discussed Government strategy and funding in mental health.

Alan Yates, Chief Executive, Mersey Care NHS Trust, outlined the aims of the recently formed trust.

Professor Eddie Kane, NW Regional Director of Mental Health, discussed some of the specific problems and potential solutions relating to Chinese mental health.

Dr. Seng Eng Goh, Consultant Psychiatrist, Service Delivery, focussed on some of the primary concerns regarding Chinese mental health treatment.

Shun Au, Chair Chinese Mental Health Association, outlined the work of the Chinese Mental Health Association and its co-operation with other agencies.

Lakhvir Rellon, Director, Asian Services Directorate, North Birmingham Mental Health Trust, highlighted work carried out in the South Asian communities in North Birmingham.

Professor John Ashton, Regional Director of Public Health (North West), contributed a view on the future of mental health treatment.

Billy Ko, Chinese Mental Health Project (U.K.) outlined some of the potential ways forward for Chinese mental health treatment.

Dr David Li, Clinical Associate Professor, University of Calgary described the mental health service available in Calgary, Canada as a counterpoint to the service provision in the U.K.

Albert Persaud from the Department of Health, discussed the National Black and Ethnic Minority Mental Strategy.

Workgroup sessions were carried out to provide a forum for an exchange of views, to target gaps within the service, and to express potential solutions to a number of issues. The transcripts of the workgroup discussions are to be found in appendix B.

A number of principal issues were raised at the conference: the increased need for bilingual interpreters, mental health professionals and support staff for users and carers; improved staff training and cultural awareness; improvement of the employment prospects for service users; advocacy of mental health issues for service users and carers; round-the-clock availability of interpretation services; the need for a National Chinese Mental Health Association.

A number of recommendations have been made based on the discussions of the day.

The responses from regional level, local Mental Health NHS Trust and from the Department of Health were encouraging in response to these issues, and it is hoped that progress can be made in addressing them.

### 摘要(Summary):

在二零零二年，全國華人精神健康研討會首次在利物浦舉行，以下簡述各演講者的演講內容，護理人員及服務使用者的意見，和一眾專業人士在問答環節的回應。

與會人士包括國家健康服務(NHS)各階層的官員，及來自精神健康界的專業人士。他們均細心聆聽墨西哥華人精神健康服務使用者，護理人員及服務機構所提供的各種意見。

以下為出席研討會人士及其參與的範疇：

- 露蕙絲愛文LouisEllman議員，討論政府精神健康的策略及資助；
- 亞倫耶士AlanYates先生，墨西哥國家健康服務信托總管，總括了近年成立的信托基金的目標。
- 愛狄克恩EddieKane教授，精神健康西北區董事，闡述華人精神健康所面對的問題及可行的解決方案。
- 吳清英SengEngGoh醫生，精神科(傳送服務)顧問醫生，講解治療華人精神健康服務所涉及的問題。
- 歐舜英ShunAu女士，講解華人精神健康協會及協會與其他機構的合作。
- 勒比亞雷龍LakhbirRellon先生，北伯明罕華人精神健康信托董事會主管，總括在北伯明罕南亞人社區的工作。
- 約翰亞士頓JohnAshton教授，公共健康(西北)地區主管，闡述對治療精神健康的展望。
- 李醒獅DavidLi醫生，加拿大卡加里大學精神科臨床助理教授，介紹卡加里的精神健康服務，并与本地提供的服務作比較。
- 阿伯特培素狄AlbertPersaud先生，衛生處代表，討論全國對黑人及少數族裔的精神健康策略。

工作小組時段主要提供了各方面交換意見的機會，並針對若干事宜提出可行的解決方案。此部分記錄在附錄部分。

研討會提出了以下幾個重要事項：

- 雙語翻譯員，精神健康的專業人士及支持服務使用者的護理人員等的需求正在增加。
- 改善員工培訓及加強對文化差異的關注。
- 改善服務使用者的就業前景。
- 向服務使用者和護理人員加強宣揚精神健康的信息。
- 二十四小時的翻譯服務。
- 有需要設立全國華人精神健康協會。
- 將基于是日討論結果來制定相關的建議。
- 鼓勵各地區單位：如本地的國家衛生局，精神健康信托及衛生處等對以上的提案作出回應並跟進。

## 2. Foreword

I am delighted to write this foreword to the proceedings of the Eighth National Chinese Mental Health Conference held at Liverpool University in June 2002. My involvement began in 1994 when Billy Ko asked me to speak at the First National Chinese Mental Health Conference in Birmingham. Billy continued to campaign for national conferences to be organised every year focussing on the Chinese experience of mental health services and I have spoken at all of them. This 8th conference was Billy's last because he died in November 2002. We dedicate this Report to his memory as a champion of Chinese mental health.

The 2002 conference was the first time that officials from national, regional and local levels of the NHS participated to hear the voices of Chinese users, carers and those of the small band of local bilingual interpreters and service providers on Merseyside. Some annual issues were brought up again in Liverpool such as the need for good, bilingual interpreters, mental health professionals and support staff for users and carers. But the responses from regional level, local Mental Health NHS Trust and from the Department of Health were encouraging.

The most significant response was from Albert Persaud, senior Policy Adviser of the Department of Health who announced the launch of the National Black and Ethnic Minority Mental Strategy with three main elements: the reduction and elimination of ethnic inequalities; capacity building within communities; and the development of a specific cadre of community workers in Black and Ethnic Minority communities. This strategy Inside Outside published in May 2003

should lead to improvement in the experience of Chinese users of mental health services.

Cultural awareness of the presentation of mental illness in the Chinese community is clearly necessary as is the development of talking therapies.

I commend this report to you and support its recommendations.

### **Lord Michael Chan of Oxtou**

*Lord Chan has been an advocate of the health and social needs of the Merseyside Chinese community since 1977 when he was Senior Lecturer and Consultant Paediatrician at the Liverpool School of Tropical Medicine. He has been a leader of ethnic minority health and community organisations for the past 25 years. Currently he is Non-Executive Director and Vice-Chairman of Birkenhead & Wallasey NHS Primary Care Trust. He served as Non-Executive Director of the Wirral & West Cheshire Community & Mental Health (1999-2002).*

*He was Director of the NHS Ethnic Health Unit (1994-97), Chair of the Merseyside Chinese Community Development Association (1988-94) and Chairman of Wirral Multicultural Organisation (1997-2003).*

*Nationally, Lord Chan has been Chair of the Chinese in Britain Forum since 1996 and Chair of the Afiya Trust (charity on health of ethnic minorities in Britain) since 1998.*

*He was a Commissioner on the Commission for Racial Equality (1990-95).*

*Since he took his seat in the House of Lords in July 2001, Lord Chan has been speaking on the NHS, health issues particularly of women and children, Ethnic Health, Mental Health and Public Health.*

The Policy context for improving health in England is now more supportive than it has been for a very long time.

We have now had six years of public health initiatives from Whitehall that nail the Government's colours to the mast of health improvement, with a whole series of policies, programmes and projects, complete with many (some would say too many) targets.

Yet in the end, achieving change and health improvement must be a partnership between Government and the people themselves. It helps if the people are aware and motivated to improve their own health.

Without a shadow of a doubt this can be said about the Chinese

Community in England. When it comes to health in general and Mental Health in particular, Chinese interest is in a glass that is definitely half full rather than half empty.

This 8th national conference brought together high-level policy perspectives with grass routes initiatives to improve Mental Health of the Chinese community.

It is a most real and valuable source to take forward and secure real health gains.

**Professor Dr John R Ashton CBE**

Regional Director of Public Health/Regional Medical Officer  
(North West)

### 3. Conference Introduction

#### **Lord Mayor of Liverpool, Councillor Jack Spriggs:**

I come here today with a big welcome from Liverpool City Council for this Conference. It is the first time in Liverpool and we welcome that situation. It is the Eighth Chinese Mental Health Conference and I hope that the message goes out to the people of Liverpool that we are here to debate such an issue of Mental Health. Although mental health does not discriminate on all races, the Conference is right to highlight the issues as far as the Chinese Community is concerned. It will give a much higher profile in highlighting specific problems and will give an opportunity for people to become more aware of the issues and the debate upon the services available. We are proud, in Liverpool, of our Chinese community, the culture and the contribution to our city is much valued. Liverpool is also very proud to be twinned with Shanghai, our sister city, and of the very strong links between us. Many visits are exchanged between our two cities and I do hope that you will enjoy your visit to Liverpool and especially find time to visit our beautiful Chinese Arch while you are here. So may I extend my wishes for a successful Conference to each and everyone here today. We welcome the outcome of this conference where we will gain much information that will be of benefit to us all.

#### **Lord Chan:**

*I am sure you will realise that Liverpool is the first city in Europe that the Chinese came to settle almost one hundred and fifty years ago, so this is a very significant venue for us to hold a National Conference of this nature.*

## 4. Louise Ellman, MP

### Biography

*The constituents of Liverpool Riverside elected Louise Ellman to Parliament on 1 May 1997. She was re-elected in the General Election of 2001.*

*She was a member of the Regional Policy Commission set up by John Prescott and chaired by Bruce Millan, which has identified strategies to tackle regional unemployment and economic decline. She is Chair of the PLP Regional Government Group, a member of the Environment, transport and Regional Affairs Select Committee and a Vice President of the Local Government Association.*

I am very pleased to be invited to contribute to your important conference today. I say that because I think it is fitting that a conference on such a important issue is being held here in Liverpool at a time when the city is regenerating and when so many things are improving so quickly for people in our community. The importance of the Chinese Community is paramount in Liverpool's regeneration. The heart of Liverpool's strength is in its diverse multi-racial and multi-ethnic community. The Chinese Community, the oldest in Europe, is at the heart of that multi-ethnicity and at the heart of enterprise and innovation in Liverpool.

The focus of this Conference is twofold. It is about mental health and it is about developing and accessing mental health services to meet the needs of Chinese people. I see that in the varied speakers that you have here today and the varied discussions that you are going to have. The participants of the Conference are the people who are going to bring the knowledge and experience to deal with both those issues. I think that all of us are aware that mental health nationally is a 'Cinderella' service. Looking at the national picture, at least one adult in six is known to suffer from some form of mental illness at any one time. Mental health is often something that is not recognised properly, and that mental illness is something too often unreported and too often untreated. When we move away from that broad national picture and look at the differing needs of different minority communities in our society, that picture becomes even more marked. The research that has been undertaken on the needs of the Chinese communities and of Chinese people in relation to mental health identifies that Chinese adults are the least likely group to report mental illness and that they have the lowest rates of attendance for mental health services. Surveys that have been done looking at the

life styles and occupations of many Chinese people in the Chinese community have identified the combination of low pay, overcrowded accommodation and poor working conditions as creating the circumstances which make it particularly difficult for those people to access mental health services. I am pleased to say that one of the important things that this Government has done is to put high priority to our National Health Service as a whole with commitments of sustained record high spending levels in our National Health Service. This is a real breakthrough which is of major importance if we are going to make progress. What the Government has done is to identify Mental Health Services as a priority area and as an area deserving of special attention. Significant extra funding is now being provided. The ten-year programme for improvement is now being put in place with extra annual investment of over three hundred million pounds by 2003 –2004. A thousand new graduate primary care mental health workers will be appointed. Five hundred more community mental health staff will be employed to work with general practitioners, primary care teams, NHS Direct and Accident and Emergency departments. By 2004 more than three hundred thousand extra people will receive help from the new primary care mental health workers and five hundred thousand extra people are expected to benefit by additional mental health staff working with individuals. What is happening is that there is extra funding in the National Health Service as a whole, promised at a sustained and increasing level over the next few years. Within that, priority identified to the mental health services, and within that the importance of service provision at all levels at primary care levels within the community. The back up hospital service is also being recognised and it is against that background that I hope the discussions today will take place.

In Liverpool, I think we have a great deal to be proud about. There are two particular things in relation to mental health that I would like to draw attention to. First, the setting up of the new trust, the Mersey Care National Health Service Trust. I am pleased to see that in the agenda today, we have both the Chair and the Chief Executive of that Trust which is already doing excellent work in the field of mental and community health. Secondly, I would like to draw attention to a pioneering initiative concerning mental health, which is already operating by local initiatives at Magistrates Courts. The initiative, which is leading the way nationally, has shown how the mental health needs of people coming to those courts can be addressed and considered for the first time. The focus of today's Conference, of course, is on the provision of mental health services for Chinese people, the number of major questions that will be debated and how are we going to improve services. Is it by having better access to services? Is it to do with more and better interpreters for primary

community care in hospital settings? Is it by recruiting more Chinese people to work in those services? Is it by involving the extensive Chinese voluntary sector more in the design as well as the provision of those services? This Conference is about addressing some of those issues and I hope that the Conference is successful and that when the Conference finishes that will then lead onto more receptive mental health services for all and particularly for the Chinese community.

## 5. Alan Yates, Chief Executive, Mersey Care NHS Trust

### Biography

*Alan Yates has worked in the health service for 26 years. Whilst his early experience was in acute hospitals – Manchester Royal Infirmary, Manchester Royal Eye Hospital, the Christie Hospital – he soon moved into mental health services for the first time in 1982 in Central Manchester. The inner city population contained significant minority ethnic groups and he was involved in early work on cultural sensitivity, translators, etc. for mental health services. In 1986 he moved to Stockport health services which after a time again included mental health, as well as learning disability services. In Stockport he held a variety of posts from Community Services General Manager to Chief Executive of Stockport Healthcare NHS Trust. In July 2000 he moved to be Chief Executive of North Mersey Community NHS Trust, and was subsequently appointed as the first Chief Executive of Mersey Care NHS Trust, a specialist mental health and learning disability Trust covering Sefton, Kirkby and Liverpool, as well as including medium and high secure mental health services. North Mersey Community NHS Trust had a national reputation for cultural sensitivity and work with minority ethnic groups, and Alan is determined that experience is translated and built upon in Mersey Care NHS Trust.*

I am happy that this Conference is being held in Liverpool, where we have the oldest Chinese Community in Europe, and one of the newest mental trusts, Mersey Care.

We are sitting in buildings that were once the Liverpool Infirmary. In the late seventeen hundreds the Infirmary didn't take mental health patients. Mental health was a crime and poverty was reprehensible. At around the time that the first Chinese people were coming from China to Liverpool, because new trades were being opened up and

because of the dwindling of slavery, mental health services were just getting going in Liverpool. There was a doctor called James Curry who had the title First Physician of the Infirmary, and who opened a lunatic asylum, so called, in the Infirmary gardens. Curry was amongst the first to understand that madness was an illness, and so called inmates were not to be bled, kept in dungeons, or beaten until exhausted, which is what had happened before.

I think in Liverpool, some of that pioneering has been dormant for a few years around mental health services and I hope the new NHS Trust will rekindle Liverpool's position at the forefront of the development of mental health services. We have made a start in the last year. We have developed nurse-led crises services. We can tell they are well liked because of the numbers that are coming to the service and using that by choice. We have renewed links with the University Department of Psychiatry and we are developing a Research and Development consortium with neighbouring services. But most of all we have renewed our commitment to service users and carers. In theory it is really important to make sure that the services are what people need and what they say they want.

At the moment we are using 1991 census data to understand the population and it is not only out of date, but also only partially representative of minority ethnic groups. We are looking forward to the 2001 census data being available so we can improve our understanding at population level and its health. However, I would have to say most of our work is for individuals and families because that, in my view, is where it matters. Our predecessor Trust, North Mersey Community NHS Trust and the Health Authority was involved in engaging with the Chinese community in Liverpool. The philosophy was about going into people's homes and trying to respect people's culture, understanding of health and family ways. They went to where people were rather than requiring them to come.

Sometime ago, some very good work was done in developing mental health services for Chinese elders. This involved development of communication cards and a communication pack. In 1997 Doctor David Li led a Mental Health and Research and Development project in Liverpool on health and ethnicity. This was supported by the Ethnic Health Unit and what we obtained from that was a series of recommendations of what might be done. It won't surprise you to know that everything has not been done perfectly, but it was a good start and many things happened as a result of that and acted upon. But in other areas, such as access to talking therapies for those who were unable to speak English, there is still an almost complete gap in the service that is available for people who cannot speak English. You can imagine in the area of talking therapies, that the subtlety and



nuance of language is critical. We also produced information in Cantonese on mental health and the important issue is that it wasn't based on a simple translation of the language, but involved an understanding of the nature of the culture. In David Li's report he quoted Moody: *"if it is true that the quality of services can be determined by the care delivered to the most vulnerable and disadvantaged groups, then the care given to people from black and ethnic minority communities is a good reflection of the overall standard of the services"*. Give yourself the toughest test and measure yourself by that, I think is what is being said.

So what are we doing now? I am very happy that we have a Trust Board and individual members of that trust who are committed to issues of diversity. There is a good understanding that it is not simply saying, *"well we treat everybody the same"* or *"We are pretty anti-discriminatory"*. It goes a lot further than that. For example, we are about to launch a positively diverse initiative across the Trust for Trust employees, to ensure that they have a more profound understanding of the values of the Trust and the values of the Trust are about celebrating diversity, enjoying the benefits of diversity and making sure that different needs are understood. In terms of diversity it doesn't only involve ethnicity, it can be involving people with a disability and we have recently gained a two-tick symbol across the Trust to recognise our approach to people with a disability. We have started development of a race equality scheme and we will have it complete by September of this year and this comes with a commitment from the Trust Board. It would be incomplete not to mention Windsor House, the service that is based in Liverpool 8, where the extensive involvement of health link workers, interpreting services and a burgeoning user forum is being developed. We have very positive links with the Toxteth Health and Community Care Forum. It delights me as I can look around this room seeing members of staff choosing to sit with users of the service, and the friendship and the quality of communication and contact that there is.

I want to commit all of the staff here that are from Mersey Care Trust to the promise that we will listen. Soon after I arrived in this job, a service user representative said *"Thank you for listening, but then people like you always have, it is the action which has always been the troublesome bit"*. So we promise to listen and act and where there are good ideas we plan to use them, where there are ideas where we think there are some difficulties we will explain why, because it is right that we are accountable.

I have not mentioned the connections we enjoy with the Chinese community and we are delighted that the community has a setting like the Pagoda Chinese Centre, which is excellent in terms of

cultural, community and educational developments. It is not sufficient to expect the statutory sector to deliver on its own. We have good partnerships with local communities, minor ethnic communities and good relationships with the voluntary organisations in the area. Those good relationships need turning into something better. I was asking a group of staff if anybody is really profoundly happy with what we are doing at the moment? I think the answer is no, none of us are totally satisfied. We have a terrific opportunity, at the moment, in the creation of those organisations that are going to commit themselves specifically to mental health issues, and in the environment that we have both financially and in terms of expectations of development.

### **Lord Chan:**

*If I might say, on behalf of the Chinese community in Liverpool, we have been working for about twenty years in regards to services for the Chinese community, particularly for interpreted services and certainly to ensure that the services that are provided are mainstream, rather than added on. I think that is a very important thing. Almost all of the Chinese people in this room can tell you that they have had community people helping them to access services. What we want is mainstream provision for services, so that it would not necessarily be on the part of the patient or the carers to look for help, but rather the service provides the help that patients require. I think that message is so important for all ethnic minority groups, where they come from a different cultural background and have not had the benefit of the use of optimal quality mainstream services.*

## **6. Professor Eddie Kane, NW Regional Director of Mental Health**

### **Biography**

*On 1 April 2002 Eddie was appointed Senior Advisor on Mental Health and High Secure Services for the new Directorate of Health and Social Care based in Leeds. This is a joint post, covering the North and Midlands.*

*Previously, he was the Director of Mental Health Services for the NHS North West Regional Office and former Acting Director of the High Secure Psychiatric Services Commissioning Board. He was formerly the Director of MH & PLD for the NHS Executive in London and Chief Executive of West London Healthcare NHS Trust.*

*He has worked at Board level in both the public and private sector organisations since 1986.*

*Before becoming CEO of West London Healthcare he was Managing Consultant for OASIS plc specialising in organisational re-engineering in public and private companies.*

*He has a long-standing service and research interest in mental health and is a visiting Professor in the Division of Neuro-Sciences and Psychological Medicine in Imperial College.*

What I want to do is highlight a few points in four areas: The Chinese population, some key points from a study that was done in 1996 in London and Liverpool as the basis for data collection which I think highlights some of the issues that remain problems and challenges. I will also talk about some of the challenges in responding to those issues and then to talk a little bit about progress, but also progress in terms of what we need to do as well as what has already been done. There are lots of positive things going on in Liverpool, London and Birmingham, but I just want to highlight some of the important issues that we need to handle.

Looking firstly at population. There are about 160 thousand Chinese people living within the UK, about 140 thousand of them in England. The point I want to emphasise here is that this is a very diverse and dispersed group of people, and I think one of the first key and critical challenges in the NHS. I am surprised that we have not risen to this challenge, how to offer services to people from ethnic minority groups who are dispersed over a wide area. For example, the issue of asylum seekers and trying to offer them services which are culturally sensitive to them and which can focus on their needs. We have to re-invent how we might do it. There is a real challenge here that I don't think the NHS has addressed in how to deliver services to a diverse, but dispersed population. I think we are beginning to rise to some of the challenges of how to deliver services in some cities in the country, where there are majority ethnic groups. Trying to tailor services that are culturally sensitive and linguistically adept and adapted is one challenge for a concentrated group, but where people are dispersed and diverse, it is complex and difficult. I hope that with the discussions and presentations today that some answers to that challenge might begin to emerge.

If we could move onto the 1996 study. This was a wide ranging study carried out across England. It included data collection in Liverpool, but it highlighted some worrying issues. We have not got as far to addressing these concerns as perhaps we may have done when such

a clearly stated report was produced. The first critical issue was knowledge barriers and lack of access to bi-lingual professionals, this was highlighted by every single person who was interviewed in the study. These were people who were both using and delivering mental health services. A wide range of people were asked to respond to this survey, and one of the top issues that came out of it was the difficulty for people knowing what services were available to them, and actually being able to access those services through having access to bi-lingual interpreters. Lots of suggestions and schemes have been set up and were identified, for example, people in an individual's family being asked to translate.

One of the things that came out of the data was the concern that people had about data confidentiality. One of the challenges I will mention later on is how can we actually make better use of what is a scarce resource, the professional bi-lingual translator.

Another critical point was the perception by people of symptoms of somatic rather than psychiatric nature. By that, I mean that many people felt the symptoms that they were experiencing were signs of a physical illness rather than a serious mental health problem. The difficulty with that is that the longer that goes on, often the more seriously ill the individual becomes. They become engaged with services at a very late point in their illness and it is difficult to then help somebody. Typically, up to 50% of people with schizophrenia will recover completely, provided there is some reasonably early intervention in their illness. If it gets later, the chances of recovery become less. This is a critical issue of understanding what symptoms mean and using that as a basis for seeking the right sort of help.

A critical aspect is a lack of knowledge about statutory services. 25% of people who were questioned had no idea that there were any services available to them from the statutory sector. These people, who were working in and around the community or had used services themselves, said that only when they became very ill and were effectively engaged in services did they realise that there were services available. They relied largely on networks that they had previously established.

The next point is a key one, general practitioners were seen as pivotal in delivering service. They were the point of access for many people. Community workers reported that individuals in the community saw GPs as being crucial. Part of the problem that the survey found was that many people never got beyond the contact with the GP. If they were lucky enough to be in touch with a GP who had a good interest in mental health problems, was diagnostically adept, and was actually used to offering treatment that may have not have been such a



disaster. If they were in contact with GPs, as many individuals were, who's only response available to them was to offer medication, then this becomes a significant barrier to people, because they are not getting access to specialist services that other people may do. If you combine that with the complication regarding the lack of bi-lingual interpretation you see a significant pattern of disadvantage to the individuals who are just using the GP as their main point of contact.

The next point concerns the lack of talking therapies. Of the people using the services who were interviewed, only two had contact with any other aspect of the statutory services other than receiving medication, or an infrequent out patient appointment, which was normally to adjust the medication.

The other point highlighted by virtually every single person, whether user or people working with them, was the high level of stigma around mental ill health within the communities that the people were living. There is a stigmatisation of individuals with mental health problems. I have no answers to this at all, but I hope that some of the debate today may begin to highlight it. This level of stigmatisation was a significant reason why people didn't seek help, and why they were often cagey about whom they contacted, even when they were in an extreme level of mental ill health. So there is a significant issue about education and it is another level beyond the stigma that all people who have used mental health services will have experienced at one time or another. This is a top layer, which even the people closest to the individual find it difficult to recognise and deal with the mental health of the individual. This group, who are using contact services, were generally people who had no employment and were on the fringes of the society that they lived in. Many people with mental ill health problems experience this lack of work and social exclusion.

If you combine all these things together it portrays a fairly difficult situation for a Chinese person living in the UK with a mental ill health problem. There seems to be few routes to turn to in this study. I think we really have to rise to these challenges. The three key ones I would highlight here are:

- Providing services to dispersed communities. We must be able to do this more effectively than we are doing at the moment. We have to think beyond the vertical bounds of how we deliver services, and how we can make the best of relatively scarce clinical and linguistic specialist resources. If we don't achieve that we are going to be reeling off the same points in six years time.
- Cultural and linguistic sensitivity is a critical point of services. We say time and time again about developing services for

people from minority ethnic groups, but I have to say we make slow progress. It is a challenge to think specifically of how we can achieve this for the Chinese community living in the United Kingdom. Let's think specifically and not generally about all of the challenges for all of the minority ethnic groups, and focus on what we can do for one particular community today.

- Linking primary, secondary and tertiary levels of care. Going to see the GP, going to hospital and getting specialist services. The survey was clear that for many people from the Chinese community, there was no link between these at all. It largely stopped at primary care and it often stopped at the GP. One of the biggest challenges to the NHS is in linking these services so that people get fair and reasonable access to specialist services when and where they need them.

I just want to end on a more positive note. There is progress in London, Liverpool and in other cities. There are centres set up and there are studies that have been done. We are more aware of what's necessary. There are specific services that are being set up to move things forward. But that progress is tempered by all the things that I have mentioned. No one would sit back and say we are completely happy. There is a good deal of learning from existing projects, such as the Cantonese leaflet covering mental health problems, and the Chinese Healthy Living Centre in Soho. There are models to learn from, but still a long way to go.

I would just like to end with an appeal. There is a major effort needed. Alan (Yates) already offered the service provider response in Liverpool and hopefully others will elsewhere. They will listen to what comes out of today's conference. There is a major effort needed from all of us to get the strategic health authorities to ensure that investments are going in, that there is equity of access to services, and that they actually understand the needs of dispersed and diverse communities.

The primary care trusts, who are the lynch pin of delivering services, are the ones who will put the money into the services or not. They are the people that we have to get on board in order to be able to move this whole agenda forward. This is a real challenge because they have got a long list of everything else that they have to do, but that does not mean that they should not be focusing equally, and in some ways differentially, on diverse and dispersed communities.

In terms of service providers, I think you have got a head start in Liverpool with a new Trust. It is a different philosophy, as it is a board of a Trust orientated towards diversity, trying to do things that make a



difference. I think that it is a fantastic opportunity and I hope those of you from other parts of the country can have the same experience with your local Trusts.

Finally, there is a real challenge for local authorities around community development. It is not just about clinical services, but it is about housing, community development, education, opportunity, and regeneration. These are critical areas where local authorities have a real opportunity to push this agenda forward.

I will end on a positive note. I think today is a fantastic opportunity to take on and move forward some of the things that I presented as being negative aspects of where we are. The fact that there are many people here today from such diverse backgrounds shows real evidence that things are beginning to move forward.

Let's not lose the opportunity of taking away answers to some of these challenges, and let's make today the start of a further step in this progress.

### **Lord Chan:**

*Could I respond on behalf of the Chinese community. We would like to say to you that all your concerns have been rehearsed amongst the Chinese community every year. This is the first time we have heard a significant response from the National Health Service, so that is good.*

*There are some points which have been mentioned in previous years. For example, how do we achieve coverage for the Chinese communities scattered in small numbers in different parts of the country. It has already been stated in Government documents that we need to be buying services across boundaries and that is very important. It is good to know that local authorities are involved in partnership with NHS Trusts. However, what we would plead for is to speed up this process because one of the difficulties occurs when the NHS Trust hasn't got the bi-lingual professional or the support team. When it tries to buy the services of another team it takes so long to agree that the services are delayed for many months.*

*Secondly, there is no doubt that the cultural and linguistic sensitivity of which we have been asking for the last eight years is now beginning to register in the minds of the decision makers in the NHS. What we ask for is that there is training in cultural sensitivity for all ethnic minority communities as soon as possible. The NHS is still the one of the slowest Government*

Agency in giving opportunities for its staff to learn about other people's cultures and how to respond sensitively. It varies from one part of the country to another, so I hope you don't think that I am being negative. All that I am saying is we want to push it faster. There are different patterns of service provision. Good examples include the Midlands, London and Liverpool, but we need to have better coverage.

## 7. Dr Seng Eng Goh, Consultant Psychiatrist, Service Delivery

### Biography

*Dr Seng Eng Goh has been working in psychiatry for over 20 years and specialises in mental health problems in the elderly.*

We have heard this morning of how the Government is willing to help us. The money is there as Mr Yates says, but he also said you have to make a case for it. This means that we have to go there with a properly researched business plan, outlining what we want to do, how much money we want, and why we want it. As Professor Kane said, how do we provide a service to such a diverse community? How do we link the primary, secondary and tertiary care?

We say "What is the NHS doing for us, what is the health authority doing for us, what is the social service doing for us"? but we forget to say, "What are we doing for ourselves"? What I would like to do is to see if we can organise ourselves better. When Billy organised the first meeting eight years ago in Birmingham, we thought 'well it is just a one off'. Now we are in the eighth meeting, so maybe I should wake up and think of something constructive, because if we don't, we will be embarrassed two years down the line when we are talking about the same thing. So let us get organised. For example, let us look into getting a national organisation and becoming a registered charity. An earlier speaker said 'sometimes people don't know who to contact' so we could get local and regional contacts.

We don't want meeting after meeting having the same theme. We need to be better organised so that we can cover different themes in different years.

We need an National Organisation so we can have information for the public, the statutory bodies and for people to get advice. There are a lot of mental health leaflets from Hong Kong all written in Chinese, don't reinvent the wheel, let us get it from them.

We need to have better trained staff, so that staff can provide counselling, for example, and we should do it at a national level. We have people who can provide training. Billy (Ko) has been going up the country giving informal training for people. If we organise ourselves for larger areas then more people can benefit and there is less work involved in having to duplicate ourselves. If we are established it can be a media and press link, which is important as people like to find out what the Chinese community want.

If we have an organisation we have to collect data and use this data to argue our case better and maybe do research. What I would suggest is that is apart from the national level, let us concentrate on what we can do locally. At the moment some places have mental health workers and some do not. I met someone from Belfast and they don't have anybody, but if you go to London, they have one or two. So I think it is important that all areas ask for local mental health workers. They will be the key. If you can train a mental health worker, they don't have to be a professional, such as a mental health nurse or a social worker. They can be someone who is entrusted in mental health issues. We could train them and they could provide information and advice to the local community.

Interpretation is fairly well established. We need to do counselling and the mental health worker can be sent on counselling courses. We can have our own day centre and drop-in services. A lot of our people may not wish to go to the mainstream mental health day centres because of the language problems. A telephone help-line is important because a lot of our people live far away. The local mental health worker can be the advocacy service and link to social services, housing department, and voluntary services.

When GPs see people, they don't know who to refer them to. They can provide medication, but they are not there to provide long term counselling or other support, such as help with social services or housing benefits. If we have a local mental health worker, the GP can just link up with them and help them.

We can link up with mental health provider, so that the mental health worker will work as a link and advocate with the mental multi-disciplinary team. It could be the psychiatric social worker, who could help the local psychiatric hospital clinics with interpretation and to speak on the patients behalf. We can get mental health professionals to act as volunteers. I did, unsuccessfully, try to get three other psychiatrists to come today, one couldn't come and the other two didn't think it was their cup of tea. If we can persuade them that it is worth helping out, that if enough of us do it then the time as volunteers may not be too much.

So if we can get people involved with mental health background, such as doctors, nurses, social workers or counsellors. A lot of trained counsellors may just need more experience in psychiatric counselling or mental health counselling. These professionals can help to provide support to the mental health worker, including Mental Health Act advice. They can also provide counselling, I know there a lot of other people up and down the country who already provide counselling as well as telephone advice. What we need to do is co-ordinate ourselves and make sure that when we have telephone advice people know where to access you.

So what next? What I would suggest is to have a steering group to form a National Association for Chinese Mental Health. We want regional representatives with everybody involved. We can look into funding at a later date, and all the issues that I discussed earlier. If we can get our act together we can come to the next meeting in Glasgow with a proposed constitution. But what do we do locally? I think that each place should have a local mental community service. If you haven't, then make a case for one by asking the local services, health authorities and social services. I am sure they will be happy to help you prepare a proper business case. You should be integrated with the local base, like the Pagoda here in Liverpool. What we need is a dedicated locally based mental health worker who can provide day care. The advantage of a base is that people know where to come for help. Telephone help-lines are important. People may not want to go twenty miles for help. This ties in with the funding issue. So where do we get the funding from? As I have said there must be a good business case. We have people here today, such as the chairman of the local Chinese community. Let's get him to do fund raising sessions and help out with national agencies. For example, maybe the NHS have some kind of funding. You need to ask for three to five years funding, because it takes time to develop. What you need to do is to collect data so that you can argue for further funding the next time, so that you can justify your existence.

What we can do in the meantime if to get local volunteers to help the mental community worker. Try to get mental health nurses, doctors, psychologists, social workers, psychiatrists or occupational therapists, for example, that might be willing to help out. What I would like to do is to ask people if they can spare some time at the end of the meeting to have a quick discussion about whether we can form a steering group for a National Association for Chinese Mental Health.

## 8. Shun Au, Chinese Mental Health Association

### Biography

*Trained in psychology at City, linguistics and general management at Cambridge Universities, Shun Au is a founder and chairman of Chinese Mental Health Association, a charity specialising in Chinese mental health for the last ten years. Between 1986 and 1998, Shun worked in the voluntary and statutory sectors, which included YWCA, BBC, MIND, Westminster Council, and a number of NHS organisations in senior management. Since 1998, Shun has been a freelance management and project consultant and director of an integrated health care agency. In addition, Shun is non-executive director for Walthamstow, Leyton, Leytonstone NHS Primary Care Trust in London.*

Firstly, I would like to give you some idea of what we have doing for the past ten years. We are based in London, set up about ten years ago, and are still the only charity specialising in Chinese Mental Health in the UK. Although we have been doing a lot of work in London we now have a national project working in partnership with North London, North Birmingham Mental Health Trust.

We do two main things, one is to provide direct services, and the other is to input into policy work. The approach that we take is a collaborative one. When we are working with the statutory sector we like to work in partnership with them. We particularly want to guard against a haphazard approach, which means that when the statutory sector want to work with us, they just elect some things that they want, rather than work as equal partners.

We have been providing a range of direct services. On direct services we have been lucky enough to have a team of associates who don't work full time with us, but are qualified psychiatrists, CPN and mental worker and they would take on cases where there is a need to provide professional medical assessment depending on what sort of services of level of services that people need from us. We are providing some counselling, although that is not funded at the moment. We are running a befriending project, and have also just got money to develop a supported housing scheme. This was a research and development project, carried out between 1996 and 1999, in supported housing needs for Chinese mental patients in London. Based on the research and development work we have identified over

100 people in London who could benefit from a supported housing scheme, and we are working with housing associations, local authorities and mental health trusts to develop a pioneering project providing supported housing.

User groups and user involvement is an important aspect of our work at the moment. We have users sitting on our management committee and also on the steering group on a national project with the North Birmingham Trust. We are pleased about that as we like to see users at the forefront of decision making. We have been providing advocacy and home support in the past, but we haven't any money now to provide it. We would like to apply for funding to carry on with the advocacy work that we have been doing in the past.

We are keen to input into the policy work, but because time is limited it is hard to provide direct services and also impact on policy work at the same time. We are fairly selective in what we can do.

We produced the first book on Chinese mental issues within the UK, published by the Mental Health Foundation in 1997, although the statistics and the quantitative information may be out of date. The qualitative statements are still true. Also, we have been inputting into the national policies committees and working groups such as the National Black and African Mental Health strategy.

Finally, I would like to share our experiences of the past ten years of working in Chinese mental health. We believe that extendibility is the biggest issue when working in the voluntary sector. Funding is a constant battle, trying to get enough money to employ new staff and retain existing staff. It is not just about applying for funds, it is about spending time filling in forms, talking to people, and lobbying. The problem is that most of our work is project based, so it is hard to get someone who is able to act and see things in a proactive way and that has been one of our major problems.

Another area that we want to go into is to monitor and review our services so that we are sure that the quality of our service is high. We are trying our best to do that by employing qualified people, and making sure that they are supervised properly by CPNs and psychiatrists, but it is nothing like having a systematic way of monitoring and reviewing all the services that we are providing. The rapid changes in the statutory sector doesn't help. These actions makes relationship building difficult, especially at a senior level, because people keep changing their jobs. It is difficult to develop policy issues with senior people in NHS and local authorities at a national and local level.



People, at this conference, have spoken about critical mass and diverse community. For example, one of our workers is a mental health manager in the local Acute hospital, and we know we have not got a single Chinese in Acute Trust in an area of about 200 thousand population. Given that we are talking about diverse dispersed communities it is important to think how we actually develop critical mass in order to provide a good service.

Qualified workers in the voluntary sector are few and far between, we need to hold on to them and develop them. Finally, focus is important in order to provide long term services and we are lucky to be focusing on Chinese mental health, rather than a generic Chinese Centre trying to develop mental services, which is laudable, but difficult.

## 9. Lakhvir Rellon, Director, Asian Services Directorate, North Birmingham Mental Health Trust

### Biography

*A Social Worker by background, Lakhvir has extensive experience of service development having worked in Social Services departments, Save the Children Fund and the NSPCC. She joined North Birmingham in 1998 as the Asian Service Development Manager. She has led the development of the multi-award winning Asian Services Directorate which is now recognised as a model of good practice nationally. Lakhvir has recently been appointed as a locality Director at Northern Birmingham and will take up her post at the beginning of July.*

About four years ago we made a commitment to improve the quality of the services that we offer to South Asian communities in North Birmingham. The first reaction from a lot of professional people was that we were going to set up a clinical service, bring together doctors, nurses, social workers and support workers, and meet all the needs of the Asian communities in Birmingham. Those types of services are set up to fail, they are not sustainable, money runs out and people get burnt out quickly.

What we decided to do was to proceed on a process of consultation. The consultation within the community told us some clear things, the challenge for the Trust was to take these on board and act on them. Communities and service users were saying that they wanted power, information, jobs, and involvement in services. This was a real challenge for the Trust, because we were going to be spending our

money differently. We weren't going to be spending the whole budget on employing professional people, what we were going to do was employ people to work in the community, but doing work that wouldn't necessarily be seen as clinical professional work in the remit of mental health workers.

So we have been developing a service which involves advocacy, befriending, support services, and mental health promotion work. We have been held up as a model of good practice nationally. The model that we have developing in North Birmingham is not a model that is exclusive to South Asian communities. The model is around community developments, support for the voluntary sector, empowering service users and carers and community groups and valuing the work that the voluntary sector does. It is about identifying what we can do to strengthen the capacity of the voluntary sector alongside our professional staff.

People say that it takes years to get pieces of work off the ground and to develop proposals. We did it in six months, that is how easy it was. What we can do is have a model of the practice nationally from the statutory sector working in partnership with the National Voluntary Sector organisation. We ask the Voluntary Organisation to tell us what they want to do, in terms of ideas, how they want to do it, how much money they need, where they want to access money from and what are the difficulties that they have in putting projects into practice. The usual reply is, *"We have got the ideas, but we don't know how to put a project proposal together. We have good workers but they need training and supervision around project management. We know about funders, but we need people who are prepared to back us and say this organisation is capable of delivering on this proposal and that your funding will be secure"*

We put a proposal to the Community Fund, and they loved it, but didn't have enough money at that time. We tried several other potential funders and within six months we had two year's funding of nearly 95 thousand pounds. The interesting challenge for us now is to say that this is a national opportunity and I was interested in the presentation that Dr Goh gave. There is a lot happening and perhaps we need to tap into those networks. We need to be talking about the good and bad practices in Chinese mental health, and identifying how it is that we can alter people's mindsets. What is important is how many Chinese people are being sectioned inappropriately, how many Chinese people are being assessed without interpreters, and how equitable are the services that are currently being offered to Chinese communities. We need to do the good stuff, such as the mental health promotion and advocacy, but we also need to see the struggle that the Chinese communities have in receiving the services that are



appropriate to their needs. It is a real challenge and a responsibility for Chinese, Asian or Black people to be working collaboratively with the statutory sector.

## 10. Professor John Ashton, Regional Director of Public Health (North West)

### Biography

*Professor John Ashton CBE, North West Regional Director of Public Health and Regional Medical Officer was born in Liverpool in 1947. Educated at Quarry Bank High School in Liverpool, the University of Newcastle-upon-Tyne Medical School and the London School of Hygiene and Tropical Medicine, he has specialised in psychiatry, general practice, family planning and reproductive medicine and finally public health.*

*He worked in Newcastle and Northumberland, Hampshire and London before returning to Liverpool in 1983. For two years he was a Councillor on Hampshire County Council.*

*John Ashton is well known for his work on planned parenthood and healthy cities and for his personal advocacy for public health. He was a member of the British delegation to Macedonia during the Kosovo emergency and played a prominent role in resolving the fuel dispute.*

*John holds chairs in the Liverpool Medical School, Liverpool John Moores University, the Liverpool School of Tropical Medicine, Manchester Medical School and the Valencia Institute of Public Health in Spain.*

*He is the author of many scientific papers; articles and chapters in books and of several books including "The New Public Health" which is standard textbook on public health.*

*Since 1993 he has held his regional position and has played an active part in developing government policies for public health.*

*He was awarded the CBE in the Millennium New Year's honours list for service to the NHS.*


*John Ashton lives in Liverpool and has three grown sons.*

One of the things that has always frustrated me about mental health is that people always talk about mental health and they mean mental illness. Having trained in psychiatry, moving into primary care as a general practitioner and, then, into public health was a search for prevention and health promotion in mental health. It was difficult to find it in the clinical end of psychiatry and when I was doing my Masters Degree at London School of Hygiene I needed to do a

dissertation. I asked a lot of important psychiatrists as to which topic I should cover, because I wanted to do something which was about mental health. Nobody would come up with a suggestion. It was all about early diagnosis, treatment or access to services, and the sort of big questions that impact on mental health seemed to be too frightening for people to try to address. So in the end I did a piece of work on family planning and abortion services, which I felt to be about mental health. For me the challenge is how do we get to move up stream?

Health care workers are like life savers standing beside a fast flowing river. Every so often somebody comes down the river and somebody jumps in and pulls them out, resuscitates them and just as soon as they finish that there is another one coming down the river. The health care workers are so busy pulling out and resuscitating that they have no time to walk up the river and see who is pushing everybody in. The point about mental health is that we really must get up stream of mental health. We know of the demographics that we face, if you take the illustration of diabetes from physical health. The current situation with maturity onset diabetes in England and Wales is that there are about 1.2 million people with maturity onset diabetes. According to George Alberti, the recent President of the College of Physicians London, if you take together the fact that people are living longer, becoming fatter, and are taking less exercise, then we are looking at more than a doubling to over 2 million, maybe 3 million people with maturity onset diabetes within 10 or 12 years. We could spend the entire NHS budget for services for people with diabetes unless we get to a point where diet and exercise participation changes significantly. If we address that to mental health and apply public health principles, and think about the whole population first, 7 million people in the North West. Secondly, think about people who are at risk for particular conditions. If we are focusing on minority ethnic groups who might have particular risk factors and we know groups who have migrated, they have different characteristics from the people who have stayed behind. There is a huge literature on migration and mental health comparative epidemiology. We need to think about the Chinese in England as a total population, as a group who will have specific risk factors. What we are talking about is people in their environment. What is the interaction between people and their environment? How do we influence that environment to be supportive of mental health? Second to that in a public health perspective is the whole set of hygiene questions. You don't often hear people talk about mental hygiene these days. Let's get into mental hygiene and let's recognise that in developing a contemporary public health approach, we are talking about community development. We need to get to grips with the appalling way in





which this diverse country has failed to embrace the gifts, skills, traditions and intrinsic knowledge that people bring from their own cultures. Why haven't we celebrated and incorporated them and developed a hybrid version of what would make sense for this country. Why don't we do that as part of an approach to mental health? We need to think about the changing dynamic of life here. My father worked for a brewery in Liverpool on the estates management side. Many of the tenants in Pitt Street and Nelson Street in Liverpool were the Chinese community and they were confined to a very small area of central Liverpool during the blitz in 1941. Now, the Chinese in Liverpool and in the North West are distributed, in contrast to Liverpool's Afro-Caribbean population, which remains concentrated and which hasn't moved out into the suburbs. The kids haven't benefited from going to the decent schools and having an educational opportunity. An understanding of the social ecology and geography and what's going on is important in giving us a route map for what we need to do.

In the future, we are looking at big numbers and shifts of population's characteristics. Within this region we are looking at about a 40% increase in the over sixty fives in Cheshire and Lancashire. We are looking at proportionately big increases in the numbers of people within the minority ethnic groups in parts of Manchester and in East Lancashire. I don't know what the dynamic of the demography is of the Chinese population in either Liverpool or Manchester, but I am sure it is interesting and important to get to grips with it in terms of what the future patterns of need are going to be. The regional agenda is giving us a fantastic opportunity to develop an integrated approach to Government policy in a range of areas at the regional and sub- regional level, with particular focus in relation to the primary care trust's responsibilities for promoting health as well as delivering and commissioning services. The vehicle of the local strategic partnerships is one which those who are in Chinese minority ethnic community health is an opportunity. So when we come to looking at how to optimise things, like Sure Start or the New Deal, in terms of opportunities for people from minority ethnic we can begin to get to grips with the new agenda as part of an employment approach and other initiatives.

The mental illness services are important and they have failed people from particular areas and groups in the past. Most improvements in health will come from action from outside the health service. If we are going to improve mental health in this country we need to get upstream. We want to have robust mental health that starts in childhood and that equips people so that they live their 80 or 85 years and don't finish up with mental illness in the last years. The loneliness and depression, which is the fate of about 40% of all

elderly women living on their own, to do with our failure to provide appropriate social networks, infrastructures and support systems, these are the real challenges for the next five, ten and fifteen years. I hope that you will find it within your scope to look at these parallel imperatives side by side, the health service, the public health context and the mental health promotion.

### **Lord Chan:**

*Professor Ashton is always there to give us reminders of the broad picture. You will be pleased to know that in the Merseyside Chinese community there has been a great deal of emphasis on care for the elderly. I think we need to go to the other end of the scale and look at how the young people meet up with new challenges within Britain today. In the Chinese community 25% of our young people have university degrees. I want that section of the Chinese population to think of joining Government services and statutory services. It is easy to make a lot of money on the stock market, now is the time for us to look at joining statutory services, becoming professional people and changing the system for the benefit of everyone.*

## **11. Billy Ko MBE, JP, Chinese Mental Health Project (U.K.)**

### **Biography**

*Chair – Chinese Mental Health Kinhole Project (U.K.)*

*Billy Ko has been working in the mental health field for over 35 years, experiencing the custodian care of the mentally ill in the 1960's to the community care of today. He was the vision and founder of the Chinese Mental Health KINHOLE Project (U.K.) in 1994, with the unique aim to promote mental health understanding to the Chinese Community in U.K. He travels extensively to the Chinese Community in U.K. promoting Mental Health awareness and he operates the first and only Chinese Mental Health Hot Line for the Chinese in U.K. since 1999.*

*He was the Manager of the Northern Birmingham Mental Health NHS Trust, Chinese Mental Health Service and also the Millennium Mental Health Award Winner (Nursing Standard) and a Millennium Awards Fellow of the Millennium Commission.*

*Mr Ko, unfortunately, passed away on 18th November 2002.*

My God there are smiling people. You have come to a mental health conference, not mental illness, so smile.

Being so important I will tell you who I am! I ask senior management from the Department of Health to do a very important job, can you fire?

I don't claim a lot, I am a humble man, a man of few words, I just work, I don't talk, except today. You can see that from 1995 there have been seven conferences, today is the eighth. People say they have never heard of the conferences, blame me, don't blame anybody else. From 1995 we printed the first Chinese booklet in Chinese, and if you have got one in your hand that is original, this will cost you £10,000 pounds!

Culturally speaking, the Chinese elderly are being looked after by the younger generation, so they do have a need. However, as somebody has suggested, it is better for the elderly now to retire back to China because they have a first class service, they can go into care homes, speak their own language, and know their own culture. I wonder whether we can put this forward to the Government? Can we buy in service from China, and get all of these Chinese back to China to be taken care of. There are other suggestions, and we have a lively discussion about how do we improve the mental service? We suggest that the local user groups should go 'Outreach' which, as we all know, we don't stay in. We all have to go outdoors and put that forward.

The Government knows that there is a need and, therefore, we have to publicise our own services. If the services are mainly English-speaking and if you want to involve other ethnic groups, there is a need for interpreting a language. You need to educate the next generation to speak their own language. How do we aim to improve the mental health service for the Chinese service user? We say that group and family therapy is essential because you want to build a good foundation for a start. The next generation will be aware of what is going on and how they are going to look after themselves. We need to bridge the generation gap, as well as the cultural gap. We need to teach the parents parenting skills, so that they can provide a stable and healthy generation in the form of mental health.

Counselling for individuals or groups is essential as well. We are talking about counselling in a way that people can form themselves into a peer group, and this peer group has got to be in the community itself.

## 12. Dr. David Li, Clinical Assistant Professor,

Department of Psychiatry, University of Calgary, Canada

### Biography

*From 1994 to 1997, David was a Consultant in Audit/Community Psychiatry with lead for Black and Ethnic Minority issues, based in inner city Liverpool.*

*From 1994 to 1995, Assistant Clinical Director, Acute Mental Health Directorate, North Mersey Community NHS Trust.*

*From 1997 to 1998, he worked as Locum Consultant Psychiatrist in Whiston Hospital (for 6 months), and Halton Hospital (for 6 months).*

*1998 to 2001 – Office based Specialist Adult Psychiatrist in Medicine Hat, Alberta, Canada.*

*2001 to present – David works as a Staff Psychiatrist in Inpatient and Day programs at Rockyview Hospital, Calgary, Alberta.*

*He is the Clinical Medical Director of the Assertive Community Treatment Program in Calgary, and Clinical Assistant Professor at the Department of Psychiatry, University of Calgary.*

I want to begin by giving a few statistics about Calgary in Canada. Ethnic minorities groups are defined in Canada under the Equity and Employment Act as:

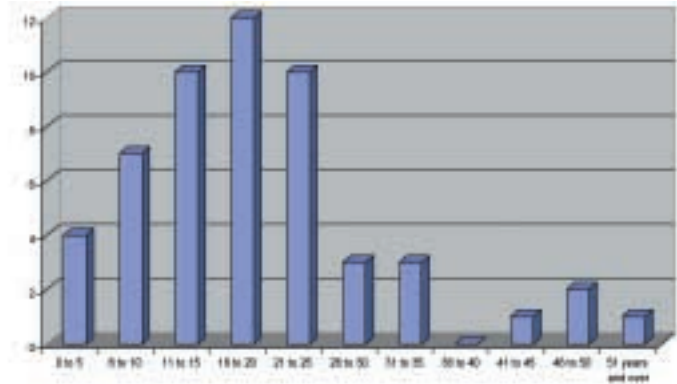
*"...persons, other than Aboriginal peoples, who are non-Caucasian in race, or are non-white in colour."*

In 1996, the population of Canada was 28.5 million and the Chinese population about 3%: In Calgary it was 5.5%. In the last five years there has been an increase in population in Calgary. 10% of the population is Chinese and in Canada as a whole it is 7%. Interestingly, 22% of medical school students are Chinese. Calgary's population has increased about 1000 per week.

I want to move on to a study which is being put together by Dr Zannusi and Dr Twang. Due to the shortage of Chinese psychiatrists in Calgary, over the last four years the family doctors have referred a number of Chinese patients to Dr Twang. They have about 100 patients. The number of males actually outnumbers the number of females slightly, which is unusual for psychiatric clinics. In terms of age distribution, the middle range of 41 to 50 are the highest. What you will see later on is that there is a lot of neurotic problems, like depression, anxiety, schizophrenia and psychotic breakdowns, some of whom are referred from hospital.

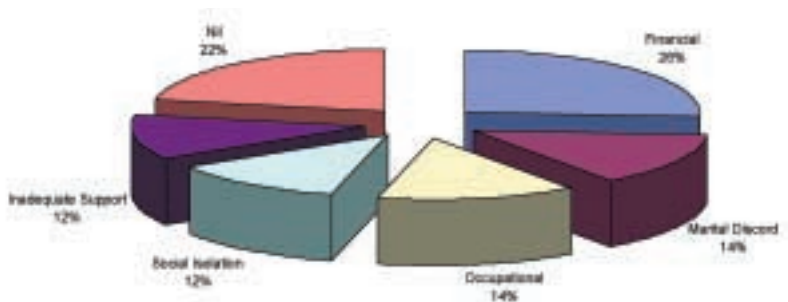
**Figure 1** shows the number of years that people who have been in Canada before they presented for treatment. The system in Alberta is that doctors are paid fees for services, so if you see a patient, you bill for that. The Alberta Mental Health Clinics are a provincial set up where there are three clinics in Calgary and these patients are referred to the central clinic where Dr Twang works. There is a predominance of major depression and adjustment disorder, which is basically a depression of mood or anxiety as a result of an event in someone's life. The number of people with schizophrenia totals about 15% and for the type of practice in Alberta that is fairly typical.

**Figure 1: Number of Years Living in Canada before presenting to Alberta Mental Health**



When looking at the social stresses related to diagnoses (Figure 2), 26% of the diagnoses are financial-related. You expect that amongst Chinese patients there is a lot of shame attached to family or marital problems, so it is probably an underestimation in terms of the problems in those area.

**Figure 2: Main Axis IV Diagnoses in Chinese Patients Presenting to Alberta Mental Health**



The global function measures how severe the patients illness is when they present. The average is 59.1 and that is fairly mild. If you go down to around 30 that is where you have suicidal ideas.

A large variation is seen in the number of sessions that were required before patients were discharged. About 50% had less than two treatment sessions with a therapist, but some needed over 20 sessions. Generally, a therapist and psychiatrist is consulted on a need basis, but in this case Dr Twang actually saw them because of the language difficulties.

I just want to touch on neurasthenia. This diagnosis is quite widespread in China and it is one of the reasons why it was actually included in ICD-10. The symptoms are: fatigue after mental effort, weakness and exhaustion after minimal effort, muscle aches and pains, dizziness, tension headaches, sleep disturbance, inability to relax, irritable, dyspepsia, autonomic anxiety symptoms and depressive symptoms. If you listen to, particularly the first generation Chinese, you won't hear anyone saying, "I am depressed, or I am sad". People say, "I am tired, I have got a headache, I feel dizzy". I think it is important that we rethink the way we diagnose Chinese patients. When it comes to treatment I think that is another issue. I think what we are trying to do is fit the diagnosis, rather than see what is going on and put in an appropriate diagnosis. If you have someone with depressive and anxiety symptoms, some psychiatrists are more prone to diagnosing depression, as in some ways it is easier to treat. Other people will diagnose anxiety. Neurasthenia requires a more holistic approach. It is not just identifying the psychological symptoms, there are also physical symptoms. I think that it is artificial to separate the psychological from the physical because we are whole beings. Research indicates in depression that there are structural changes in the brain, so we need to look at it in the context of Chinese patients. I think the treatment setting is important. I would support that the treatment setting should be primary care, where there is a blending of the physical, psychological and spiritual.

Just one comment about language. We have talked about this in conference after conference and it is still the major problem. Recently I saw a lady in the clinic who had been seeing a psychiatrist for about 4 or 5 years. She had a depressive disorder diagnosed for about 10 years and was on antidepressants. When I went into her history, she actually had a delusional disorder. She thought that every time that her husband was on the phone, there was another woman on the phone and that he was having affairs and she was misinterpreting. She would mishear things and that led to family conflict. They lived in the same house, but divided the house down the middle. They didn't have anything to do with each other. Recently I have started her on

anti psychotic medication and she is improving, so the language aspect is crucial. It leads to the diagnosis, and to the appropriate treatment and intervention. In some cases ECT has been used, because the diagnosis was not accurate or there was lack of information, so the appropriate intervention wasn't made.

I have already mentioned stigma in terms of neurasthenia. In Canada, within the North American population there tends to be less stigma attached to psychological and psychiatric problems. People talk more openly about it and I think that has rubbed off onto the Chinese population. On the whole, the Chinese population are more accepting of psychological issues. We spoke to a Chinese psychologist, who runs workshops about mental health problems in one of the local Chinese churches. I think that is great way of decreasing stigma through education. We have been brought up on a shame based, disciplined basis. I am not challenging our system and culture, but I think we need to have a rethink about this whole thing. I have three patients in the Assertive Community Treatment Programme and these have a very severe sort of schizophrenia. All three are Vietnamese Chinese, and none of them are in contact with the Chinese community. In fact, one or two of them don't even go to Chinese or Vietnamese restaurants to eat because of the stigma. The stigma is isolating them. It is difficult to work with them, because of the language difficulty. One of the patients has a very strong work ethic, she is constantly looking for jobs and every time it gets too stressful she relapses, gets better, and looks for work. I think it is part of our shamed based up bringing, it plays a big role in some of the problems that are caused when some of our patients develop mental illness.

Lastly, these are the resources. In Calgary there are 50 Chinese family physicians, so given the population, this is potentially one Chinese doctor for every two thousand patients, which is about the ratio here. Not all of them can speak Chinese, some of them have been born in Canada, but in terms of the treatment, it is quite good in Calgary. The problem comes from the fact that there are very few counsellors and psychiatric nurses, and there are only five psychiatrists. One of them doesn't want to see Chinese patients, one speaks Mandarin, one doesn't speak any Chinese dialect at all and I speak a little bit of Cantonese. So the resources aren't great there even in a city.

The interpretation services are not very well organised. There are lots of volunteer services based out of churches, but at the main Chinese community association, there is a long wait for appointments. Liverpool, in that respect, has a very good service. I have to give credit to people like Helen Owen, here at the Pagoda, and people who are dedicated to this. Helen originally, thought there was a

better service in Calgary and she wanted me to speak about that as ammunition. In fact the service is very good here compared to Calgary, but there are other resources that we don't have here.

### 13. Albert Persaud, Senior Policy Advisor, Department of Health

#### Biography

*Albert Persaud is a Senior Policy Advisor at the Department of Health. Albert is one of the principal architect of the National Strategy for Black and Ethnic Minority Mental Health, to be launched later this year. He is also a member of the Women's Mental Health Strategy Group, responsible for producing the section on Perinatal Mental Health. Part of the Bill Team on the Reform of the Mental Health Act and other associated legislation. Member of the National Institute for Mental Health in England Core Team with responsibility for Black and Ethnic Minority Issues and Law and Practice. Albert's background in the health service included clinical practice, public health and research. He has published in the areas of mental health and ethnic minority health extensively.*

Later this year we will be launching the National Black and Ethnic Minority Mental Strategy, which addresses the need of the Black and ethnic community in England. When I say Black and ethnic minority, I mean people from South Asia, including Chinese community, Afro Caribbean and Irish. The strategy itself tries to seek solutions. Too often the research base is trying to find out what the problem is. We know what the problem is, we have researched it for 50 years. We had a phase of paralysis by analysis of the many research programmes that have been running, but little research itself has tried to seek ways of trying to improve services and experience of Black and ethnic minority communities. The strategy itself tries to seek solutions to the problem.

The second part of the strategy is aimed with a phrase called 'Inside outside'. By that I mean using current services, trying to adapt services or trying to expand on current policy so that it is specifically addressed to the needs of ethnic minority people. For example, the National Service framework makes a loose reference to the needs of ethnic minority people, but it doesn't go into detail to tell you what sort of standard should be developed, how we should be monitored and how we should be audited. So the Black ethnic minority strategy defines that in more detail, and that is the Inside part of it. The

Outside part of it is involving the communities because it has to be accepted that the NHS alone cannot provide the service and is not the best solution. So the strategy has three main elements:

The first one is about reducing and eliminating ethnic inequalities. We are targeting the experiences of ethnic minority people when they come to the service. We tried to find out the views of service users, in terms of "Did you have a good, bad or an indifferent service?" The experience of the service user is much more important. What happened to them when they got into the service and what happened to them prior to them getting into the service. If you are Black Afro Caribbean and the only way into the service is in the back of a police van on a Section of the Mental Health Act. That is a different experience, but maybe people from the South Asian community tend to arrive in the more conventional way, by their GPs.

The second part of the strategy is aimed at capacity building within the communities. We have many volunteer sectors in this country who provide excellent services in the area of ethnic minority health. Every year there is a struggle to bid for money and when you get the money you start the bidding again for the second year funding and third year funding. Capacity building is about trying to increase the ability of the voluntary sector, so they are better able to provide and respond to the needs of the communities and, secondly, about trying to build the voluntary sector in areas where there is no voluntary sector at all. I live in Devizes in Wiltshire, where I am the only black person in a village. There is no voluntary sector, just an individual, that is me. I am not saying we should develop a voluntary sector in Devizes for one person, but how can we use the nearby Bristol voluntary sector to help support what happens in Devizes and other rural areas where the communities are smaller as a solution.

The third part of strategy is developing a cultural capability within the community. We are advocating the development of a community development worker in the Black and ethnic minority communities. The voluntary sector knows what that is, but the statutory sector don't because they have never pioneered it. It has been developed through the NGO and the voluntary sectors. We are moving those statutory initiatives from the fringes of our society into the middle, i.e. part of the policy map plus the strategy. We talk about developing culturally capable services. What this means is having better collaboration in terms of service provision, the statutory service and the voluntary sector come together to be able to provide service locally. A culturally diverse service does not describe one group of people. If the first language isn't English, how on earth can a doctor do an assessment on a patient who has a problem. I tend to hear sometime that the interpreter is only available at ward rounds. What happens with the

other six days of the week?

I have taken a community development model engaging in enhancing mental health and the development community development worker. It is likely to be a national strategy and so the funding is likely to come with that. The valid thing about capable cultural workforce is that it is okay having the voluntary sector and the services responding to various needs, but we need to have a workforce that is able to provide a service in a fast moving society. The needs are static and therefore the services cannot be static. We need to recruit from the communities themselves. There is no point in having a service if people can't identify themselves and their cultures within that service when they arrive.

As I said a strategy will be launched later this year. This is the first time we have been able to describe it to a conference. I hope that the days of the struggle will soon end and that you will see yourself part of the mainstream policy. It will take a lot of challenges and development, and various groups working together. You do need an association.

This is your eighth Chinese conference. Not many ethnic minority groups can stand up and say that they have had one or two conferences let alone eight, so you are ahead of the game. There are a lot of good things I have seen in this area. I travel the country and I see what happens. What is interesting to me is to hear from those of you who are users and carers in the services and those who respond to the services. What is clear is the whole issue of mental health has different meaning in different cultures. We try to apply mainstream diagnostic tools to peoples of different cultures and it doesn't always work. We get the diagnosis and approach wrong. The key message today is that the whole issue of mental health and mental illness has different interpretation and meaning within cultures and therefore it has different stigma, acceptance and responses. I will take heart from what has been said today and that what we put in the strategy with regards to the consultation is exactly the same song that we are all singing.

## 14. Play

Mrs Wong has been feeling unwell in the past five years since the death of her husband. Her situation became worse in the past few months after she learned that Mary, her daughter, has got a job in London that meant that she would not be living with her. Mrs Wong had difficulty in sleeping, she spent most of her time at home and refused to go out. Mary had to do shopping for her; she has lost her

appetite and lost about a stone in the past two months. Mary had taken her to her GP but could not find out anything wrong with her. Mary was very worried about her health and contacted the Chinese social worker. Social workers visited twice, a joint visit now with the GP was arranged to see Mrs Wong and Mary at home.

**Doctor:**

"We need to explain to Mrs Wong why we are visiting her, why we are coming today".

*Interpreter speaks Cantonese to the mother. Mrs Wong replies.*

**Interpreter:**

"Mrs Wong said that she had not been feeling too well recently, she can't eat, she can't sleep, she just felt her heart is not, not comfortable in her heart."

**Doctor:**

"Well, I did refer Mrs Wong to a specialist at a hospital, who has seen her and sent me a report which I got two days ago. He says there is nothing wrong with her heart. Can you explain that to her?"

*Interpreter translates to Mrs Wong. She still complains that she is not well.*

**Doctor:**

"Right. What about her friends, does she have friends visit?"

*Interpreter translates to Mrs Wong. She replies... she has some friends come to see her every now and then.*

**Doctor:**

"Right. Can you ask Mrs (doctor has trouble with Mrs Wong's name and laughs) If I give her some tablets will she take them?"

*Interpreter translates to Mrs Wong. She replies..... She is not too sure as a lot of Chinese believe that Western medication has a lot of side effects and they don't really like it, but she says that if it helps her to sleep, she will try it.*

**Doctor:**

"Well I can give her some sleeping tablets, I suppose, but only a very small dose, as I wouldn't want her to carry on very long, and we could try it and see how it goes. Mary, would you be able to monitor her medication"?

**Mary:**

"Erm, yes, okay".

*Interpreter translates to Mrs Wong. She replies..... she says she will try.*

**Doctor:**

"Okay. Is there a day centre she could go to? I am worried that when Mary goes to London, she is going to be left very isolated.

**Interpreter:**

"yes, there is a support group in Salisbury Day Centre, there is a Chinese Support Group there, there is a lot of Chinese people with mental health problems, and a lot of their carers go there as well. should we try and ....."

**Doctor:**

"Ask her if she will go to the group"?

*Interpreter translates to Mrs Wong.*

**Interpreter:**

"Well Mrs Wong just said that there would be a lot of Chinese people in the day centre and there is quite a lot of stigma attached to mental health illness and she doesn't want a lot of people to find out, but it is good that Mary says that she will try and come with her and Mrs Wong said that she would try".

**Doctor:**

"Okay. Let's try that".

*Interpreter translates to Mrs Wong. She replies..... Okay, okay.*

**Lord Chan:**

*I hope you found that useful, how to manage in a bi-lingual consultation. I hope that all NHS staff and also local authority staff have got used to hearing two languages at the same time. If you haven't then you will have to get used to this, because we are a multicultural, multiethnic Britain.*

## 15. Carer Account

### Mrs Fung:

I help other people, especially those who have mental health problems. To them, I am their friend and they are my friend as well. Mental illness can occur for a number of reasons due to family, debt and marriages problems. But this might be due to their psychology because they have unhappiness in the family. For me I am a visitor, I know when to see them and I really enjoy seeing them and helping them. When we visit them we have to keep our promise. If I say I will come tomorrow, then I must go. You must be on time as well, because they are waiting for you. If you promise to help them to do things you must keep your promise, because they treat you as a friend.

When I went to see my friend I always have to wear an apron and bring gloves with me for hygiene purpose, because if they are elderly I can clean up the place for them. Because a lot of elderly people don't like fruits I would grate carrots or a plum for her so that she can eat it with her spoon. That's why they are really pleased to see me. Another thing is that some of the family living in the house might want to commit suicide, because they think that their life is not worth living. So I will explain to them that they are doing a lot for society now, and that they have passed on good knowledge to their children, that you have got to be proud of them because they are successful. However, in this way we all have illnesses and eventually leading to death, but we have to have a heart to receive the progressions of our life.

I have been visiting these couples seven to eight years now, one is eighty-four and one is eighty-nine. They call me Goddaughter and I call him a Godfather. They came here from China so that they could have their chip shop. He is elderly and has lost his eyesight, however his Chinese is excellent and my Chinese is not very good, so I could write on his palm to ask him how to pronounce these words. He has a special interest, Chinese Lin Gwins, and he would tell me about who these people are and what they did in Chinese history. He also gave me advice, and so I really enjoy seeing him. When he was young he was a farmer, but because of his situation he came to England and he had to open a chip shop. His English is no good, so therefore he has become very depressed thinking about when he is going to die. My job is to tell him about God. Life and death is like a journey - you need a passport and a visa to go through. So once you get the visa you can go to heaven and you can help people. You also might need

people's help. Not long ago, I had a fall and I hurt my back, so he rang me, and said why haven't you been to see us. *'You come to see me, and I can use the Chinese medication to treat you, especially as you are my Goddaughter'*. So after three or four weeks, he had actually cured my back.

Our friendship has been good, but now he has been dead for two to three years. When I was visiting them, some of the relatives were not very pleased and they resented me because I visited too much. However, since he died the relatives felt bad and they apologised to me about their attitude towards me. So they invited me to the funeral.

Now, what I am doing now is for the person himself, because of his needs. So I am directly in contact with him, but not to his family. I have no regrets at all. Before he died he said a few words that are very helpful to me. *'Whatever you do during your youth time you need to use your youth to help others. When you are helping people, you are not going to ask for rewards, it comes from your inside, so whatever you have done to the people in sincerity then you will get the rewards. When you are visiting the elderly you need to be very punctual, you can't say, "I am a bit late today, because I am too busy and I am not going to come", because the elderly are very anxious, they need to know when you are going to come to see them'*.

## 16. Service User Account

It is sad to say that people do have poor mental health. I have a son who suffers from poor mental health illness. I look up to heaven, and say "how can I live with my son who has got mental health?" I thank God, because as a believer I have faith in him to help me to be a Carer.

When my son had mental health problems, for a long time, I was working. Whenever I went to see my GP, I asked him how can I survive and manage with work and caring for my own son? I have been caring for my son for over twenty-four years and I am now aged over sixty. I have been married for twenty-eight years. Our family has no mental health history. Sometimes, I think that poor mental health does not affect people who live in a better environment, in a wealthy situation. I always feel that when someone has wealth and power that they do not have to face mental health, but because I am poor and a working class person, I feel depressed that I have to care for my son who has got this illness. I have tried to love my son and help him to cope with his mental illness. But when my son lost his temper I always felt very frustrated. All I could do was to phone the police and he

would be sectioned. When he was sectioned, my son told me he had a very bad experience. He would be restrained, restricted and maybe put in a dark room, waiting for someone who was an approved social worker or an appropriate profession to come to advise him. I feel really sorry for him because I know he is a good person, and to see him in this situation, it hurts my heart. After work I went home and saw my son running up and down the stairs losing his temper. It is very easy to get angry and lose control of yourself and end up in a big argument. At the end of the argument my son would go back to sleep. After a while I went back to check if he was alright, again he would open his eyes wide and scream, because he knew he might have to go to hospital to be sectioned again. He said " Don't take me to the hospital, if you could give me the injection I will calm again, I will be back to normal. When I am back to normal I will have a good night's sleep I will be all right. Please don't take me to the hospital". But because I feel that taking him to hospital is the appropriate solution, my son will blame me for taking him to the hospital. He would say, " I am all right, why do you take me to the hospital?", but I am grateful to the services of the mental health staff and other staff workers.

## 17. Panel Questions & Answers

### Panel

Rob Poole, Consultant Psychiatrist, Windsor House  
 Simon Kan, General Practitioner, St James Health Centre  
 Stephen Hawkins, Chair of Mersey Care NHS Trust  
 Czarina Chou, Operational Manager Chinese/Vietnamese Team  
 Ruth Chan, Community Midwife, Liverpool Women's Hospital  
 Andy Kerr, Liverpool Mental Health Consortium  
 Niala Waraich, Building Bridges

### Rob Poole:

In the context of the play, if we go back to psychiatric practice, about twenty years ago, the expectation was that the psychiatrist would tell you what to do and it was sometimes difficult for people to give their perspective about whether it solved problems for them or not. Increasingly in psychiatric practice there is a process of negotiation between the strictly technical medical perspective and the attempt to solve people's problems. One of the difficulties that we confront about dealing with people who are not English-speakers is that the negotiation is badly flawed. There are also cultural issues, which can make it more difficult to get into the ordinary dialogue about what is going to solve problems. One of the issues that I find dealing with

Chinese patients is that they are quite deferential to medical opinion and don't necessarily tell you that they are not happy. You really have to give people the opportunity to express if you are not aware of a different attitude to professionals that is prevalent within the Chinese community.

### **Simon Kan:**

It is important that the interpreter is also an advocate and not just a member of the family, who will just say everything is fine and everybody is happy when that is not the case.

**I represent a number of detained patients at Ashworth hospital and I am wondering how, now that Mersey NHS Care Trust are responsible for the hospital, they are going to seek to meet the cultural diverse needs of the patients there?**

### **Stephen Hawkins:**

Ashworth hospital came into Mersey Care in April and there was already some advocacy work taking place in the hospital. What we are trying to do is take down some of the barriers that exist between elements of health that are provided in Ashworth and elements of health that are provided outside. Dedicated as it is on inclusive values and having advocacy at the centre of everything we do in the Trust, we hope that those permeate through and make sure that a good service and equitable service is provided to all detained patients in Ashworth and in other parts of the Trust. It is going to take a little while. The main thing is that you have got the right values in commitment and our Board is well served by people with those values.

**Bearing in mind the crisis in midwifery at the moment and the fact that it is not widely known within the midwife service that Chinese people stay at home for four weeks after they have had a baby. What effect does that have on the care of postnatal depression?**

### **Ruth Chan:**

In my past experience as a community midwife for twenty years, I was mainly working in the centre of Liverpool, Central West. I come in contact with a lot of bi-lingual speaking ladies, such as Somali, Bangladesh and Chinese.

In particular there were two cases. I was called in on the ward, and they were saying that a woman was behaving very oddly. We knew that language was a barrier, so we did not know why she behaved oddly. Whenever you spoke to her, she would say "Hi, yes". You know it is not in her head it is in the language difficulties. Bi-lingual staff should be used.



About five to six years ago we had a health link worker, who had a link with the patient through language. If they are familiar with the language then the patient is able to tell you how they feel.

As a community midwife when I go to the houses, I don't just see the mother as a patient, but her overall well being. In particular, the Chinese stay in the house for thirty days, and I understand that some cultures stay in the house for forty days. They are very isolated to care for themselves, and the majority of them have businesses to run. So there is nobody there to care, because the support network from extended families does not exist anymore, because you in a different country now. So how do we recognise that postnatal depression is a very serious matter. There is research going on in Liverpool, taking the history of patients who have any mental illness before to then see if a link exists to post natal depression in the future. Nobody, though, has researched the Chinese, Bangladesh or Somali ladies, so at the moment we don't really know what the full situation is. This only depends on the midwife who can go in when the hospital staff recognise this odd behaviour. Is this behaviour cultural or is it because she has a problem? How are we going to address this? We have heard beforehand that we are using a lot of bi-lingual staff and trying to get the link into the community. Now they are building bridges and the programme project here in Liverpool for the Chinese and other ethnic minority groups.

I remember one incident, it was a hot summer day in anti natal clinic. I had just walked into the anti natal clinic and they said to me, "*Ruth, this lady is behaving oddly, she won't answer any questions*". So I went to see her and she said, "*Oh, this is very hot*". She was holding a magazine over her head and when I saw her I realised that there was a mental problem. I tried to point out to people that this lady had a problem, and that she needed to be seen by a psychiatrist. It would take about ten days to be recognised. Postnatal depression is very subtle, it is very difficult to diagnose. You have to think about the ethnic minority group, there is a lot of postnatal depression, depression, or psychotic situation that has never been discovered. This goes unnoticed until the major issue comes around. So before they go to the hospital they have been having treatment. As we have mentioned, GPs are the ones who should be able to recognise the symptoms. The major problem is understanding the culture and the language. This is the first step in eliminating the mental problem amongst pregnant women.

**I just wanted to ask what the Trust is doing to support the young carers of the Chinese community who have got mums, dads, brothers or sisters, who are in the mental health system?**

## Stephen Hawkins:

I think the answer is, probably not enough. Part of engaging in events like this is to not just to look back at what North Mersey or any of our originating Trusts did, and to feel even remotely pleased, but to say *"Look there is a big job to do out there"*.

One of the things I would like to see is the NHS taking down its own barriers to other agencies. There is a lot of talk about partnership these days and people talk about the partnership between the private sector and the public sector and the voluntary sector and so on. The real partnership is between service users and the people who provide services, and if we are adequately providing good services we need to engage those people and have imagination in delivering services that they really need. We want to see Mersey Care being an organisation which reflects the plurality of the community it serves. We will take the messages back from here and the messages that we are constantly given by agencies, like the joint forum and various carers groups, to develop a better service. It is helpful that the governance arrangements for Trusts have changed in recent years. I am from Liverpool and nearly all of our serving board members and non-executive board members are local people. Ten years ago, you could well have been sitting in front of Cheshire who didn't really live or know the local community as well as I do, and some of my non-executive colleagues know it better than me. So, I think we are moving in the right direction and events like this very much help.

## Czarina Chou:

Support to the young carers of parents with mental illness is very limited. In my experience I don't think we have any support from Health Service, with some exceptions. Building Bridges is providing support to families, which will include young carers. Within my work, often the Chinese social workers will deal with, not just the sufferer, but also the carer, and the whole family. So my team will deal with the whole issue.

## Andy Kerr:

I would like to make a broader point which refers back to what we were saying about how you make services culturally acceptable, with particular reference to Ashworth, but it applies across the board as well. There is a misconception that institutionalised services came down with the bricks and mortar of the institutions, and that those institutions live on in the hearts and minds of people who work in them, and with the people who use mental health services. The more complete and total the institution, the less possible it is to make



sensitive the diverse cultural needs of the people who use its services. I would add moreover that while they are not sensitive to the needs of Chinese people, they are not able to meet the diverse needs of white European people either. Although I acknowledge what has been said about the progress made to date regarding the partnerships that the Trusts have set up with service users and carers which are starting to bear fruit, there is still a long way to go. There is also service user involvement that tends to be dominated by white people and you don't get the direct views of Chinese, Black or disabled people. So I would call for a look at not only how services are structurally managed and how you change that, but about how you influence the hearts and minds of people to bring down the institutions that live in people's heads.

**My name is Jeanette Abendstern, I am a social worker based at Mossley Hill hospital. I am concerned to know what the NHS Mersey Care Trust is, and what policies you have at the present time in terms of promoting equal opportunities in employment? This is crucial in promoting a just society and we have duties, not only under the 1976 Race Relations Act, but also in terms of extending a welcoming environment and service to people of Black and ethnic minority groups. It is crucial that we have a workforce that represents the wider populations.**

### **Stephen Hawkins:**

Unemployment, particularly, amongst people with mental health problems, runs at about 85%. You have to try extra hard to get people engaged. The Trust employs over four thousand people so there is a huge opportunity to do that. We recently passed a policy at our board to set targets to engage service users as employees and there are lots of other policies around in terms of Equal Opportunities. But, you have got to do more than just have policies and targets. The way we have gone about the open space network of engaging and listening to people and setting our own targets to respond to those points raised, shows that there is a real intention to do that. I agree with the spirit of everything that you have said and I think we measure ourselves and be measured on it. The Government also has diversity targets that it has given all NHS Trusts and we are signing up to that as well as our local targets.

### **Niala Waraich:**

I think bi-lingual workers are essential to make inroads into communities. Within our service the majority of the workers are bi-lingual and we have much easier access to the Bangladeshi, Pakistani and Indian communities than we would have done otherwise. I am

not saying that the concept of the bi-lingual worker works for all, but it does make a significant impact. We also need to be aware of the Race Relations Amendment Act, but also to think about how public services meet the needs of communities. Some of the solution is based around bi-lingual workers, but that is not the only way to have staff services geared up to work with communities from diverse backgrounds. Some things are mainstreamed as Lord Chan said earlier on. It doesn't just get targeted to specialised services or ethnic minorities exclusively.

**I am a community mental nurse and I only found out about this conference from one of my Chinese clients. How do the panel feel we can improve communications between the different service providers?**

### **Simon Kan:**

We, the Chinese community, have established a lot of voluntary and special sectors for the Chinese community all around the country. Billy (Ko) has been counselling the Chinese community for 37 years. This networking is very important. Our committee need a network to publish all the services available for the Chinese community and to distribute through the NHS network. I think that would improve the communication between the NHS and the Chinese community.

### **Lord Chan:**

Can we ask people who work in the NHS, how did they hear about this conference?

### **Czarina Chou:**

We work closely with the Chinese Community Centre and my team and I have attended most of the past conferences. The Chinese Pagoda informed us about this conference.

The Chinese in Britain Forum have published a directory of all the Chinese organisations in Britain and you can purchase one from them for £5.00.

The Forum has a web site (<http://www.chinese-forum.co.uk>) with the latest news and in a few months' time we will have a menu for non-Chinese professionals to be launched in October – November.

### **Niala Waraich:**

I found out about the conference through the links with the Chinese Pagoda Centre. There isn't a forum where Black and minority ethnic



issues are discussed within Liverpool, and I suppose if senior managers had a forum then information could be cascaded down, but things are kind of haphazard.

### **Rob Poole:**

I found out because I was asked to be on this panel!

With regards to having good communications, it would be nice not to be reorganised all the time, because it does help to have stable structures.

The second point is that we are at a very early point in a very long process in terms of listening to service users, service carers and communities. This didn't happen five years ago in any significant way. We are particularly naïve in how we listen to communities like the Chinese community. We discussed this before, there were three Trust mental health workers, none of whom had found out about the conference through any of the normal channels. I think that reflects the fact that we see communities as out there, but already within the structures that we have got, as well. You have to have a more sophisticated continuous process and not be just doing service user empowerment.

### **Stephen Hawkins:**

Behind the question is something around how teams can talk to each other, as well in the Trust. We have a team briefing system, a web site and we are going to develop that further. There is the spirit about what Rob (Poole) was saying about communicating with the outside world to all the partners, because Mersey Care sees itself as part of a family. Most of the care is provided in families, not in and around the NHS. We know that carers are there for life, so somehow we need to develop sophisticated arrangements for communicating with them. We could start today by everybody signing up to get Trust Matters, which is a new monthly publication, to engage people and actively encourage people to put articles in. Please let us know and we will build a database. The reason I am here is because Helen Owen would not take no for an answer.

### **Ruth Chan:**

Following on from Doctor Poole's suggestion, we are part of the community. I knew about this conference because I work very closely with Helen (Owen) at the Chinese Pagoda.

Networking is very important. In the Liverpool Women's Hospital, we have set up a culture awareness group because a few of us are from

ethnic minority groups. We have become a steering group. I am also involved with a lot of asylum seekers of different ethnic backgrounds. I am there for anyone with a problem. If I can't help then I know that I can find help by networking with my colleagues in other projects, like Building Bridges or the Chinese Carer Project. It is up to us to network.

### **Andy Kerr:**

You can tinker with communication methods as much as you like. I have seen news letters come and go, cascades and team briefs have no impact at all. I think what is important is not how people communicate, but how they relate to each other. You want to know what kind of relationships that people have and what kind of regard people hold one another in. Every conference comes to the conclusion that there is a lack of communication, but unless you change peoples respect for each other, allow them space in their working practice and in the way they pick services to develop relationships, then we will be no further forward in the next five years.

### **Lord Chan:**

The Government certainly wants patient and people involvement. All of us who work in statutory sectors have to be aware of this. We can no longer wait for people to come to us, we have to go to them, we have to have our ears open to the community. Secondly, members of the community can, in fact, expect staff and statutory bodies to actually know about these things and I am glad that when your client or patient told you about it, you came. The kind of response is that we get involved and not say, "*Well, it has nothing to do with me, I didn't get an official invitation*". We need to be out there and people can access us and demand that we know.

## **18. Recommendations**

A number of recommendations have been derived from the conference presentations and the workgroup discussions (see Appendix-Workshop Notes for the transcripts).

- A National Organisation to be set up to provide advice and information for the public, with national links and influence in Government policy. N.B. The U.K. Association for Chinese Mental Health is to be launched in November 2003.
- Mental health staff training needs to be appropriate with an emphasis on encouraging greater understanding with relation to cultural sensitivity. For example, clients can feel intimidated due to language barrier difficulties.
- Service providers should work closely with the community to give

an holistic approach to mental health treatment, and should strive for equitable access to their services.

- Direct support for family and carers of service users was deemed to be lacking. A system of direct counselling to be open to these people in areas such as Government agency support available i.e. benefits; time management and issues relating to their own well-being.
- A requirement for more advocate voices with an awareness of mental health issues for service users and carers.
- Assess the quality and relevance of mental health information leaflets currently available through different health agencies, and provide this information in the desired language for the service users and carers.
- Improved focus on the integration of clients back into voluntary and then full-time employment.
- Confidential and culturally sensitive interpretation services available round-the-clock.
- An evaluation of the mental health support required for asylum seekers.

## 建議(Recommendations)

以下為本年度研討會及工作坊所作出的建議  
[請參考附錄：工作坊記錄]：

- 成立一個與政府有聯系，有影響力的全國性組織以提供各類意見及資料。[注意：英國華人精神健康協會將于二零零三年十一月投入服務。]
- 精神健康服務的護理人應對“感同身受”及“文化差別”加深了解。例如：語言障礙可能對服務使用者有無形的壓力。
- 服務組織應與社區有密切的聯系，以便提供全面的精神健康治療服務。
- 一直以來，給予服務使用者的家人及家居護理人員的援助一向不足，因此，將有一套直接輔導系統專為上述人士而設。可查詢的資料包括各類津貼及個人事務如：如何有效地運用時間。
- 為精神健康服務使用者及有關的護理人員加強提倡有關精神健康問題。

- 邀請不同的健康機構對精神健康小冊子就內容的相關程度及其他各方面的質素作出評估，並將收集的意見用多種語言發表，以方便不同的人士參閱。
- 改善精神康復者回歸社會的配套，加強整合精神康復者由參與義務工作到全職工作的演進過程。
- 加強保密條款及二十四小時翻譯服務。
- 評估政治求庇者對精神健康服務的需求。

## 19. Appendix A – Images from the Conference



Front: Alan Yates, Albert Persaud, Louise Ellman MP, Lord Michael Chan, Richard Lau, Lady Chan, Professor Eddie Kane, Helen Owen  
Back: Dr.Seng Eng Goh, Billy Ko, Lord Mayor of Liverpool Councillor Jack Spriggs, Gideon Ben Tovim, Brian Wong, Professor John Ashton



Lord Michael Chan, Louise Ellman MP, Lord Mayor of Liverpool Councillor Jack Spriggs, Stephen Hawkins



*Lord Michael Chan, Louise Ellman MP*



*Delegates and keynote speakers*



*Question time for the panel members*



*A carer's presentation by Mrs Fung*



*A workshop in action*





*Andrew Wong, Dr. David Li, Albert Persaud, Billy Ko, Helen Owen*

## 20. Appendix B – Workshop Notes

Highlight the mental health needs of the Chinese community.

### ISSUES

- Needs not being addressed
- Communication
- Equality and rights

### OTHER GAPS

- Locality issues – no inter-borough integration
- Finance implication to PCT

### SUGGESTIONS

- Education & training
- Chinese advocate
- Generalised health promotion to increase support for M.H.
- Use natural groups to promote well being 'mental health awareness'
- Start early – Chinese children attending language groups
- NHS Direct – offering telephone line multi-lingual
- 'Developing culturally competence organisation' DOH 2001
- Audit on organisations to see if they reflect the local needs

### ACCESS TO SERVICES

- Impair by language barrier

- Expression could vary influence by culture
- Worried of confidentiality
- Link worker may not be aware of mental health symptoms
- Professionals not involved with link workers?

## SUGGESTIONS

- Various representatives (groups) feed in to the Building Bridges Community Participation Project (increase membership)
- Individualised assessment
- Choice of avenue of access to services needed to be communicated
- CRE – inequality needs to be raised

**Discuss the responsibilities of service providers to meet the needs of Chinese service users and carers.**

1. Definition of services providers e.g. health
2. Needs of services users/carers e.g. health, education, support, employment etc.
3. Responsibilities of service providers:
  - identify/assess service needs/gaps
  - aware of cultural differences and implications
  - information & material in appropriate languages
  - better communication between service providers
  - sensitive towards individual cultures

## SERVICE GAPS

Integration between service providers and community Language barrier

Cultural awareness (on both service providers/ service users)

2nd generation have different experience from the 1st generation

- expectation
- communication

Community not knowing what services are available/ how to access

## RESOURCES

How the M.H. services can be improved transcultural

Involvement of community in planning, implementation and evaluation process

Role model in social care/health background from the community



\* Transcultural training for everyone

\* Innovative way to access/educate the Chinese Community

### **Discuss influence on policy and decision making**

Policy should be informed by frontline issues

Ideas for development should be underpinned by appropriate investment

National org to formulate and promote policy – with brief to support local associations in their efforts

### ***Identify/gap for service for Mental Health***

Low intake of service

Lacking involvement/participation

Interpreting service – recruitment problems

Life style/working hours – service inaccessible

Insufficient out-reach/worker e.g. GP surgery/clinic hours

Qualification to do the job?

Services are not local and culturally diverse e.g. residential home/respice home

Recognise the difference in culture – not stigmatise

Target funding – to recruit ethnic worker e.g. in Sheffield

Gap between service user/service provider

Chinese Home Care Agencies

### **Improve Mental Health**

Stop territory games – service to be across the border. Community people don't see boundary, they need services.

More linking – buy services – other partnership – national association

Health Promotion

- Raise awareness
- Reduce Stigma M.H.
- Family Support

Provide information to make them aware what services are available to them.

Increase access of interpreting service – e.g. available in emergency situation.

Break down services.

More funding to e.g. voluntary sectors & communities.

Sustainable funding.

Raise awareness amongst the Chinese communities on mental health issues and services

### ***Can you identify services and gaps of Chinese Mental Health Services in your area?***

- Suitable accommodation – outside social services – private
- Workers in the main stream as well as in the communities (resources) young recruits
- Bilingual Psychiatrist
- Named counsellor to support the service user to access services
- As a carer it is important to be able to have in hand information to pass on to the service user
- Raise awareness of M.H. problems in the community
- Primary Care/Social workers – information to G.P.
- Education from a young age (communication)
- Information about access to G.P. would help to gain culturally appropriate services
- There are big gaps in Home help/Day centre services; statutory or voluntary organisations
- Resources centre where people can go
- Radio/TV to promote Chinese M.H. issues (before the Chinese Opera) as well as the non-Chinese people to be aware of the needs

### **GAPS**

Mental Health Consortium – No Chinese user

Chinese social service – bridging the gap

How to do 'Out reach' – linking

Don't wait for people to come

Liaison officer

Publicity

TRUST – Relationship

Interpreter

Residential Care – Elderly – National problem

### **IDENTIFICATION OF NEEDS**

Elderly – covering the young at home (culture)

No residential home

Cultural changes – Future – No language

Problem! Younger generation

Home helps

Gap in user group may influence in – policy, decision & need

## IMPROVEMENT

Family therapy – generation, culture gap  
 Preventive – measurement  
 Parenting skill  
 Sure start  
 Linking other users – teenage pregnancy, young offenders  
 Counselling  
 Group therapy  
 Peer group in community

## 21. Appendix C – Delegate List

Surname	First names	Position	Organisation
Abendstern	Jeanette	Social Worker	Liverpool Social Services / Mossley Hill Hospital
Armitage	Marie	MHAZ Co-ordinator	Merseyside Health Action Zone
Ashton	John (Professor)	Regional Director of Public Health	NHS Executive North West
Au	Shun	Chair	Chinese Mental Health Association
Banh	Allen	Social Worker	L.C.C.S. Supported Living (Adults)
Banh	Quyem	Carers' Advice & Breaks Worker	Wandsworth Carers Centre
Barnard	Lysa	Service Manager	Mersey Care NHS
Beirendonck	Lei Van	Community Health Council Officer	Community Health Council
Belfield	Jeanette	Senior Manager Chinese Support Service	Imagine
Ben-Tovim	Gideon	Chair	Central Liverpool NHS Primary Care Trust
Birmingham	David	Mental Health Awareness Worker	Imagine
Bishop	Anna	Housing Services Manager	Pine Court H.A. Ltd.

Surname	First names	Position	Organisation
Brookman	Joan	Liverpool MHAZ Co-ordinator	Central Liverpool PCT
Chan	Anita		Pagoda Chinese Community Centre
Chan	Carmen	Outreach-Worker	Touchstone - Support Centre
Chan	David		
Chan	Irene	Centre Administrator	Wirral Multicultural Organization
Chan	Katherine	Mental Health Worker	Imagine Chinese Support Service
Chan	Lai		
Chan	Lai Ha	Mental Health Support Worker	Kinhon Project
Chan	Lai Kuen	Lecturer	School of Health Studies
Chan	Michael (Lord)		House of Lords
Chan	Patricia	Interpreter	Dundee City Council
Chan	Ruth	Midwife	Liverpool Women's Hospital
Chan	Shing Yan		
Chao	Katy Hsin Chieh		
Chee	Colin	Team Leader	Wirral Multicultural Organisation
Chee	Ivy	Senior Lecturer at Chester College	Wirral Multicultural Organization
Chen	Yue Sheng	Chinese Mental Health Co-ordinator	Lambeth Chinese Community Association
Cheung	Judy		Liverpool Chinese Gospel Church
Chiu	Gibbs Seung Lee	Senior Project Worker	Cherish House
Cho	Nicola	Partner / Solicitor	Jackson & Canter Solicitors



Surname	First names	Position	Organisation
Chou	Czarina	Operational Manager	L.C.C.S. Supported Living (Adults)
Chu	John		
Chung	May	Project Development Officer (Health)	Chinese National Health Living Centre (Midlands)
Church	Elaine	Consultant in Public Health	
Cliff	Elsie	Team Manager	Liverpool Social Services / Mossley Hill Hospital
Connor	Bernadette	Mental Health Awareness Worker	Imagine
Cuthbert	Veronica	Public Health Facilitator	Birkenhead & Wallasey PCT
Darku	Petina		
Dersch	Carmel	Chair	Health and Community Care Forum
Dosman	Maxwell	Functional Service Manager	Mersey Care NHS Trust
Dowell	Antony	Bridge Builder	Imagine
Du	Maggie	Volunteer	Chinese Carers Network
Dunn	Ming Shi		
Dyer	Lindsey	Assistant Director	Central Liverpool PCT
Ellman	Louise (MP)	Labour and Co-operative Member of Parliament	Liverpool Riverside
Eme	Ugo	Member	Liverpool Mental Health Consortium
Evason	Lynn	Approved Social Worker	Liverpool City Council
Fung	Erica	Befriending Co-ordinator	Chinese Mental Health Association

Surname	First names	Position	Organisation
Fung	Teresa		
Garner	Susan	Community Mental Health Nurse	Mersey Care
Gegg	Ann Josephine	Associate Consultant	North West Mental Health Development Centre
Gibb	Andrew	Faith & Culture Bridgebuilder	Mainstream/Imagine
Gilroy	Linda		
Goh	Seng Eng (Dr.)	Consultant Psychiatrist	Dudley Beacon & Castle PCT
Green	Polly		Pagoda Chinese Community Centre
Hassan	Amira	Senior Counsellor	Building Bridge
Hawkins	Stephen	Chairman	Mersey Care NHS Trust
Heng	Lily	Senior Co-ordinator	Imagine Chinese Support Service
Hill	Julia	Transcultural Team Manager	Sheffield Adult Mental Health Services
Holloway	Tara	Researcher	Praxis Care Group
Hoyle	Roger	CEO	Liverpool Housing Authority
Hui	Stanley	Executive Director	The Chinese in Britain Forum
Hui	Wai Lin	Health Promotion Officer	Greater Glasgow NHS Board
Jones	Ben	P.P.D.O.	P.C.T. Central
Jones	Cora		
Jou	Ann	Advanced Neonatal Midwife	Wirral Multicultural Organization
Kan	Simon (Dr.)	General Practitioner	St. James Health Centre
Kane	Eddie (Professor)	Regional Director of Mental Health	NHS Executive North West

Surname	First names	Position	Organisation
Kar	Reba	Transcultural Social Worker	Sheffield Adult Mental Health Services
Kerr	Andy	User & Carer Involvement Worker	Liverpool Mental Health Consortium
Ko	Billy (MBE J.P)	Chair	Chinese Mental Health Project (U.K.)
Kwok	Juanna	Drop-in Worker	Touchstone - Support Centre
Lam	Shirley	Nurse Operations Manager	Chinese Health Information Centre
Lau	Henry	Outreach-Worker	Touchstone - Support Centre
Lau	Mui-Fun	Chinese Health Linkwork	Central Liverpool Primary Care Trust
Lau	Peter		
Lau	Richard	Chair	Pagoda Chinese Community Centre
Law	Alex	Project Worker	Cherish House
Leung	Christine		Pagoda Chinese Community Centre
Li	Chun Heng		
Li	David	Clinical Assistant Professor	Department of Psychiatry
Li	Fat Lin		
Li	Jane	Student	Imagine
Li	Kathleen	Committee Member	Wirral Chinese Association
Li	Kin Wa	Community Development Worker	FRAE FIFE
Li	Koon Shun		
Li	Oi Mei		
Lloyd	Tracy		Manchester Care
Lo	Po Ling	NVQ Assessor & Internal Verifier	Liverpool City Council

Surname	First names	Position	Organisation
Lord	Jo		
Luk	Tony		
Luo	Pei Xuan	Volunteer	Chinese Carers Network
Maguire	Susan	Commissioning Manager	Liverpool Social Services
Man	Jennie	Joint Commissioning	Liverpool NHS Health Authority
Marmion	Robbie	Day Service Manager	Mersey Care Trust
Mealin	Edward P.J.		
Mitchell	Noreen	Home Manager	Manchester Care
Mullitan	Tony		
Ng	Daniel (Pastor)		Liverpool Chinese Gospel Church
Ng	Mary		
Ng	Sarah	Centre Manager	Sheffield Chinese Community Centre
O'Hare	Collette	Mental Health Worker	Imagine
Oosman	Max	Service Manager	Mersey Care NHS Trust
Owen	Helen	Conference Manager	Pagoda Chinese Community Centre
Packwood	Estella	Centre Manager	Oxfordshire Chinese Community Centre
Page	Helen	Mental Health Lead	Central Liverpool Primary Care Trust
Persaud	Albert	Senior Policy Advisor	Department of Health
Pimblett	Julie	Training & Development Officer	Liverpool City Council
Poole	Rob (Dr.)	Consultant Psychiatrist	Mersey Care NHS Trust

Surname	First names	Position	Organisation
Poon	Siu Mui	Editor Marketing Officer	Phoenix Chinese News
Powell	Liz	Chief Officer	Liverpool Central & Southern CHC
Reed	Emma	Network Co-ordinator	Merseyside Healthy Living Centre
Rellon	Lakhvir	Director of Asian Services	North Birmingham Mental Health Trust
Richman	Sheila	Psychotherapist	Self Employed
Riddle	Mary		
Ridley	Joanne	Service Manager	Imagine
Rushton	Lynn	Mental Health Worker	Imagine
Scott	Jean	Executive Manager	Cheshire and Merseyside NHS Health Authority
Sit	Yee Fon	Solicitor	Alexander Harris Solicitors
Snowdon	Gwen		
Soo Chi Chung	Cathy	Administrative Assistant	Pine Court Housing Association
Sowande	Carolyn	Manager	Mary Seacole House
Sparrow	Janet	Mental Health Worker	Imagine
Spriggs	Jack (Councillor)	The Lord Mayor	The City of Liverpool
Su	Xilong		
Su	Xinhong Wang		
Tai	Joyce	Development Officer	Chinese Community Development Partnership
Tan	Margaret	Project Manager	Cherish House
Tang	Cheung		

Surname	First names	Position	Organisation
Teoh	Yanny	Project Worker	Cherish House
Thomas Services	Hilary	Team Manager	Liverpool Social
Thomas	Roger	Audio Engineer	Westminster Sound System
Thompson	Hazel		Social Services Department
Thomson	Margaret	Associate Director, Health	Central Liverpool PCT
Thornton	Heather		Contracts & Purchasing Unit
To	Georina	Elderly Mental Health Worker	Lambeth Chinese Community Association
Tse	Dorothy	Health Link Interpreter	Chinese Community Centre
Tseng	Sam		
Tweddle	Audrey	Employment Support	Leeds Mind Dove Centre
U	Kean Hong		
Wai Lan Clark	Clare	Race Equality Development / Training Officer	The Nugent Care Society
Wan	Shannon	Co-ordinator	Chinese Carers Network
Wang	Zhen Ming	Chinese Employment and Training Officer	Pagoda Chinese Community Centre
Waraich	Niala	Deputy Project Leader	Building Bridges Project
Wilson	Rod	Chair	Liverpool MENCAP
Wong	Albert	Clinical Supervisor	Lambeth Chinese Community Association
Wong	Andrew	Project Worker	Kinhon Project - Sheffield Chinese Community Ctr

Surname	First names	Position	Organisation
Wong	Brian		Liverpool Chinatown Business Association
Wong	Jeffy		
Wong	Selina		Pagoda Chinese Community Centre
Wong	Stephen		
Wong	Stephen	Secretary	MCCDA
Wong	Yuk Ming		
Woo	Arthur	Approved Social Worker	Liverpool City Council
Woo	Pamela		Pagoda Chinese Community Centre
Wu	Cathy	Committee Member	Wirral Chinese Association
Wu	Tong Jian		
Xu	Mian	Editor Marketing Officer	PCNE
Yates	Alan	Chief Executive	Mersey Care NHS Trust
Yeung	Echo	Research Fellow	Merseyside Health Action Zone
Yiu	Fung	Social Worker	L.C.C.S. Supported Living (Adults)
Young	Duncan	Health Promotion Officer	Liverpool Health Promotion
Yu	Jennifer	C D Worker	South & East Belfast Trust
Yuen	Pei Ying		
Yuen	Susan		
Yuen	Yau Fat		
Zack-Williams	Dorothy	Lead for Inherited Blood Disorders	Centre for Inherited Blood Disorders
Zamorski	Mike		Carr-Gomm Society









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