Health provider perspectives on mental health service provision for Chinese people living in Christchurch, New Zealand

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Background: Migration imposes stress and may contribute to the incidence of mental illness among natives of mainland China living overseas. Both cultural norms and service inadequacies may act as barriers to accessing needed mental health services.

Objective: Assess New Zealand health providers’ perspectives on the utilization of mental health services by immigrants from mainland China.

Methods: A qualitative study in Christchurch, New Zealand involved in-depth interviews with nine mental health professionals with experience in providing services to Chinese clients. The interviews were transcribed and thematically analysed.

Results: Four main themes emerged from the interviews: (1) specific mental health concerns of Chinese migrants; (2) subgroups of migrants most likely to manifest mental health problems; (3) barriers to accessing services; and (4) the centrality of social support networks to the mental health of Chinese migrants.

Conclusions: Qualitative research with health providers in high-income countries who provide mental health services to the growing numbers of migrants from mainland China can identify areas where improved cultural sensitivity could increase both the utilization of mental health services by Chinese immigrants and the effectiveness of these services.

1. Introduction

New Zealand is a multicultural nation of approximately 4.5 million people in which the Asian population, including people from China, has grown rapidly in recent years.¹ According to the 2006 census, 147,570 Chinese people are now living in New Zealand. This represents about 3.6% of the total population, and makes Chinese one of the largest minority ethnic groups. According to DeSouza and Garrett,² many Chinese migrants experience difficulties integrating into their new lives in New Zealand, primarily due to social isolation, language obstacles and differences in cultural expectations. These difficulties may directly affect their employment, income and quality of life – problems that can contribute to increased rates of mental illness.³

Chinese people have a culturally-patterned model for conceptualizing mental health problems that includes ideas about the definition of what does and does not constitute a mental illness, about the appropriate method of seeking help for these types of problems, about the effectiveness of different types of treatment, about re-integration into the community after an episode of illness, and about the social stigma associated with mental illnesses.⁴⁻⁸ For example, the highly influential ancient Chinese medical treatise, the Yellow Emperor’s Inner Canon (or Huang Di Nei Jing), describes the conditions ‘Kuang’ and ‘Dian’ which assemble the manic and depressive episodes in bipolar disorder.⁹ ‘Kuang’ and ‘Dian’ are considered two separate conditions in Traditional Chinese Medicine, whereas they are considered two cycling components of a single disease in modern psychiatry.¹⁰ Highlighting the ongoing relevance of these traditional cultural views in the modern world, a survey in New Zealand found that Chinese respondents’ beliefs about what constituted normal versus abnormal behaviour differed greatly from those of western mental health professionals, differences that pose a major challenge when diagnosing and treating mental illnesses in Chinese migrants.¹¹ Mental illnesses in Asian cultures are strongly associated with loss of

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face, stigma and discrimination, so there is an over-
riding imperative for patients and their family members
to ‘keep it in the family’ rather than seek professional help.

Despite an increase in research on Asian people’s
health over the last decade, there is a lack of population-
based evidence in immigrants. Data from New
Zealand demonstrated that Chinese people are less
likely to use health services, especially mental health
services. The underutilization of mental health care by
Chinese immigrants may indicate that the mental health
needs of Chinese people are neither fully understood
nor provided for by current mental health service
providers. The aim of this study was to identify mental
health providers’ perspectives on issues affecting both
the mental health of their Chinese patients and their
provision of care to Chinese migrants.

2. Method
2.1 Setting
This study was conducted in Christchurch, New Zealand,
which has a population of 348,435 individuals, among
whom 7.8% are Asian. Like all other locations in
New Zealand, health care services in Christchurch are
funded and coordinated by the local district health
board. Chinese migrants have access, as does the entire
population, to mental health care through primary care
services and, on referral, to publicly funded specialist
mental health services, predominantly outpatient
care. They may also seek help from private providers
including practitioners of Traditional Chinese Medicine
(TCM).

2.2 Participant recruitment
Eligible participants were health providers that offered
mental health services and were experienced in
the care of Chinese patients. Potential participants
were identified by the research team from personal
knowledge, through consultation with other informants,
or by contacting organisations that assist Chinese
people with mental health problems. Moreover, as part
of the research interview, participants were asked to
recommend other interviewees who might be suitable
(i.e., snowball sampling). The final set of participants
included individuals from a range of service settings,
including primary and secondary health providers, non-
government organisations and individual practitioners
in Christchurch.

As shown in Figure 1, over the three-month period
from November 2010 to January 2011, twelve potential
participants were contacted by email, either directly or via
a provider organisation; this e-mail provided information
about the study and invited them to participate. One
of these 12 individuals did not respond to the initial
e-mail and two declined to participate. The remaining
9 individuals who provided preliminary consent were
contacted directly but, after the initial contact, the
researcher decided that one of them was not suitable
due to his limited experience of Chinese people’s
mental health problems. However, this individual
recommended another mental health provider who was
suitable. In the end, nine participants were recruited
into the study and completed the in-depth interview.

2.3 Interviews
Face-to-face interviews were completed by the first
author (QZ) with individual health providers from
November 2010 to January 2011. Interviews were semi-
structured and based on five key topics: participants’
experiences with their Chinese clients; the presenting
mental health concerns of Chinese clients; the provision
of treatment and social support to Chinese clients;
providers’ perceptions of the barriers to receiving needed
treatment and support among Chinese clients; and
respondents’ assessment of the availability of mental
health information and services in the Chinese language.
The interview guide was developed based on the
literature on Chinese migrants’ use of services.

The interviews were completed in 45-60 minutes.
Seven interviews were audiotaped and detailed
handwritten notes were taken during the other two
interviews. Post-interview, further questions were asked
by email or phone to clarify participants’ responses.
Eight interviews were conducted in English and one
interview (with a TCM provider) was conducted in
Mandarin – this was subsequently translated and
transcribed by the first author. In this report, interviewee’s
names were replaced with pseudonyms to maintain
confidentiality.

Figure 1. Flowchart of the study

12 potential interviewees were contacted by email
from November 2010 to January 2011

3 did not participate:
- 1 no response after multiple attempts
- 2 refused

9 health professionals agreed to participate

1 excluded because of his lack of
experience in treating Chinese
people’s mental health problems

1 additional respondent
recommended by interviewee

9 health professionals completed the interview
2.4 Data analyses
Analyses of transcripts and handwritten data were guided by a systematic process described by Morse[17] which includes comprehending, synthesising, theorising and recontextualizing.

The transcripts were closely read and re-read by the first author until she was thoroughly familiar with the content. An initial framework of the content organized by themes and subthemes was generated by the first author and then discussed with the other two authors. Based on their comments the framework was revised and the text data were searched to identify content relevant to each theme or subtheme; these passages were then coded accordingly using NVivo 8 software.[18] This process of re-categorizing the data resulted in the emergence of new themes and subthemes; these were again discussed between all three authors to generate a further revision of the framework for conceptualizing the information. This iterative process was repeated until no new themes or sub-themes could be identified.

2.5 Trustworthiness
In qualitative research assessing the ‘trustworthiness’ of a study is the most common approach for assessing the methodological rigor of the study. It includes four components: credibility, transferability, dependability and confirmability.[19] The current study has addressed these issues in the following manner.

Credibility: The initial e-mail contact and subsequent face-to-face interview allowed the researcher to establish a trusting relationship with the interviewees – an essential component of obtaining credible information from informants in an interview situation. Audiotaping of most of the interviews ensured that the credibility of the information provided in the interview could be checked if considered necessary.

Transferability: Participants were purposively sampled from a wide range of health services. Relatively few health professionals provide mental health services to Chinese clients in Christchurch, so the sample of nine respondents was considered sufficient to identify most of the opinions of these types of providers about the mental health of Chinese clients and about the services they receive.

Dependability: During the research, the three authors met after the completion of each interview and at every stage of the text analysis. This process ensured that there was a clear and consistent approach taken to the collection and analysis of the qualitative data.

Confirmability: During the interviews, the interviewer avoided leading questions to ensure that the information obtained was not biased by the researcher’s point of view. When the interview record contained any ambiguity, the information was validated by a follow-up telephone call with the interviewee.

2.6 Ethical approval
Ethical approval was attained from the University of Canterbury Human Ethics Committee prior to recruitment and data collection. All participants signed the written consent form that was approved by this Committee.

3. Results
3.1 Demographic profiles of participants:
Of the nine health providers, four were male and five were female. They were of various ages: 3 were in their thirties, 1 in her forties, 2 in their fifties, and 3 in their sixties. Five of the health providers identified themselves as Chinese, two were British European, and two were European New Zealanders. They included general physicians, psychiatrists, nurses, counsellors, social workers, nutritionists, and health promotion professionals. Eight worked in the mainstream health care system and one was a TCM provider who was trained in TCM in China and currently works in Christchurch.

3.2 Themes
Four key themes emerged from the interviews.

3.2.1 Theme 1: Presenting mental health concerns
Participants reported a variety of mental health concerns among their Chinese patients, including stress, relationship problems, addiction problems (mainly smoking and gambling), anxiety, eating disorders, depression, suicide and psychosis. Among these, stress, gambling, and depression were the most commonly reported. For example:

(Andrew) The usual thing is stress, caused by a variety of serious problems. Under these pressures, a few of them get into gambling, thinking that gambling could make fast money and that they could get rich quickly.

(Betty) But from my personal knowledge, I know Chinese people do have mental health issues, such as gambling, addiction to alcohol, and being socially withdrawn. And depression is a big problem.

(Ian) Some people get divorced or beat their children, or go gambling.

(Frank) We know that smoking, alcohol use, drug use and gambling are all issues among Asian people. All lead to mental health issues: worry, concern, fear, and isolation. Suicide is a problem.

Migration-related stressors were perceived to have a particularly strong impact on Chinese people’s mental health. These included stressors related to
language barriers, an unfamiliar social environment, and unemployment or under-employment. Even small things in their daily life could be stressful, for example, different eating or cooking styles. In addition, some participants indicated that Chinese migrants had high expectations of a good quality lifestyle in New Zealand and when these expectations were not met, their mental health would likely suffer.

(Frank) It is not meeting their goal of a better life…. If you are working as a cleaner, you might feel ashamed to tell the family, and if the family wants to come over to visit you, you will feel embarrassed.

Nearly all health providers indicated that unfamiliarity with New Zealand’s health system was particularly stressful for Chinese people seeking health support. Frank commented further:

(Frank) Every country is different. Asian countries have different health systems than what exists in New Zealand. We have a primary health and secondary health system. But in a country like China, you do not have this. You go to hospital straight away. You do not have family doctors.

Some participants also made the link between physical health and mental health, indicating that physical health and mental health are likely to influence each other.

(Gay) I think physical health and mental health are interrelated. If they do not eat well, then their general health status will deteriorate, and this will impact their mental health as well. When you feel bad, you do not want to cook, and have no energy at all. You do not have enthusiasm to do nice things for yourself or other people. And then if you do not eat well, you have less energy, and do not want to try new things or socialize. And then it becomes a vicious circle.

3.2.2 Theme 2: Particular groups with mental health problems

Participants expressed concerns about the mental health of specific groups among Chinese people including Chinese elders, Chinese students, ‘people in between’, people who were socially isolated, and migrants arriving from China who were already unwell. Chinese elders were identified as a high-risk group because they were likely to delay seeking mental health care due to difficulties of communication and a lack of transportation. While Chinese students experienced the expected resettlement issues, they were also seen to experience extra pressures from their academic studies, from high family expectations for success, and from a lack of financial resources. The ‘people in-between’ appeared to belong to neither western culture nor Chinese culture; they struggled between two cultures, unable to adapt fully to the New Zealand way of life whilst also feeling alienated from traditional Chinese culture either in New Zealand or in China.

(Ella) But what happens to these people, they do not belong to the New Zealand culture, and they do not belong to Chinese culture either. So they are stuck in the middle. So it is very hard for them to get support.

(Betty) She could not adapt to the New Zealand life so she went back to her home country, but when she got there she could not adapt to life there either.

Another group, described as ‘quiet’ or ‘isolated’ Chinese people, chose not to go out and connect with local people or social groups, or with the Chinese community. They might be busy with their study or work, or they may lack confidence to make friends in a different cultural environment. This group includes Chinese elders who were considered less likely to go out socializing because of language and transportation obstacles. Due to their isolated lifestyle, these individuals might be neglected in their new environment. If they experience difficulties during the adaptation process, they might not know where to go for help or how to get help.

(Gay) Probably the people who have not got a chance to work with a group, need more help. They are quite isolated, they do not go to any groups, maybe because of language and transportation problems.

(Betty) I know a lady that because she could not communicate well in English, she became socially isolated, lacked energy, motivation and then had depression with hallucinations. She stayed at home most of the time.

The final group of Chinese at high-risk of developing mental health problems were people from China who were mentally ill prior to migrating to New Zealand. Their families expected (or hoped) that their recovery from mental illness would be enhanced by being in a new and ‘beautiful environment’. However, if these individuals had difficulties adapting to significant environmental and cultural differences, they typically became increasingly isolated and, thus, less likely to get needed support for their mental health problems.

(Ella) What a terrible thing to do to somebody. Watching somebody become unwell and then sending them off to another country. The family doesn’t even know what’s happening. It is not a common situation but when it happens it is a scary situation for everybody.

3.2.3 Theme 3: Barriers to accessing or receiving help

Participants reported that poor language skills, shame, lack of knowledge and awareness of mental health and mental health services, high cost of services, lack of information in the Chinese language, and lack of
acceptance from mainstream health providers may be barriers that prevent Chinese people from using mental health services. All participants recognized the importance of increasing health professionals’ awareness of the needs of Chinese patients and of their methods of expressing psychological distress. For example, respondents reported that Chinese patients are more guarded about their mental health problems, often veiling them by presentations of physical complaints.

(Ella) A lot of people present with physical symptoms. But often their physical symptoms are really the symptoms of depression. And a lot of people come with problems of sleep; it is the most common presentation. You know when you get depressed, you cannot sleep well.

One way to meet the needs of some Chinese patients is to practice traditional Chinese medicine (TCM). But many western practitioners lack knowledge about the practices of TCM and, moreover, have ‘concerns about the quality and safety’ of TCM.

(Chris) If somebody sees it in a culturally different way or has a different point of view on what we call alternative medications, I cannot provide any information on that, because I just do not know. My knowledge is solidly based on western treatments. If somebody with depression wants to be treated with traditional Chinese medicine, which is probably just as effective as western treatments, I cannot do that here, because there are no resources, there is nobody to ask.

Even practitioners who were trained in China have concerns about TCM.

(Gay) For TCM my concerns are about toxic side effects. When you use it, so many things get put together in a prescription. I think you need to know it really well to be able to use it safely. If I was in China and I really needed TCM, I would go to the hospital. But here, I am not quite sure what kind of standards they need to meet, or whether or not they have registration, probably not. I think they just run their businesses. Whether their knowledge or skills meet the standards in China, I am not quite sure. In China, we have big hospitals, and the monitoring in place can ensure it is safe.

Participants also reported that lack of policy and funding supports in health services prohibit the establishment of cultural and linguistic resources to support Chinese people’s mental health needs.

(Andrew) The most important thing is there are no specific services. If there was more funding we would start Asian-specific services. We could employ people who fit the job. We need more professional people involved as regular employees; they cannot keep doing volunteer work.

(Gay) There are quite a lot of people who make the decisions, high up there. They are not really aware of health or mental health-related issues among Asian people or among Chinese people. I think quite a lot of them think that Chinese people are healthy because they do not go to general practitioners, that they are all fine.

(Frank) The problem is that we get a certain amount of funding for refugees but we get no funding for migrants. The Canterbury Region [where Christchurch is the main city] is one of a few regions in New Zealand that does not get funding for this, because the District Health Board just doesn’t believe that Asian people have health needs. They believe Asians are healthy and wealthy, which is wrong.

Participants reported that Chinese people with mental health problems are less likely to access ‘mainstream’ (i.e. western) mental health services. They tend to hide their mental health problems and are reluctant to seek help, and many choose to go back to China to be treated. Participants pointed out that Chinese people’s decision-making reveals a passive help-seeking model.

3.2.4 Theme 4: Support factors

Participants outlined a variety of mental health services that are available to Chinese people living in Christchurch, ranging from mental health services in primary health care settings to specialized psychiatric services, including mental health services from both government and non-government organizations. In these mainstream mental health services a strong multi-disciplinary team provides a comprehensive set of support services to those in need.

(Betty) We always work as a group of professionals. In the hospital, patients can get medications, and professional health providers surround the patients. Psychiatrists, psychologists, counsellors, and physiotherapists are all around the patients to support them. A social worker will help patients to deal with finance or housing problems. Also, the hospitals have a discharge plan that includes informing their primary care physician, identifying community support services and, for some, arranging rehabilitation programs.

(Andrew) Usually I do counseling and refer clients to other organizations or agencies for other services they may need such as employment, financial support, food, housing, and general medical care. Other agencies refer clients to us for psychological services.

When prompted to discuss how they support their Chinese patients in their particular agencies, participants suggested that the ease of access to services and the flexibility of the services helped to increase Chinese clients’ comfort with using the services. They believed
that producing more information materials in Chinese and including more Chinese professionals at the agencies would reduce communication barriers and make it easier for Chinese people to access services. Several of the interviewees reported that some general practice groups of physicians in Christchurch had many more Chinese enrollees than other practices groups; one important reason cited was that these practices had Chinese-speaking staff who could readily assist Chinese patients.

Some participants reported that their own life and work experiences are particularly helpful in understanding Chinese people and their mental health issues.

(Ella) Our experience helps. I have seen many Chinese students talking about all sorts of difficulties with their relationships with their parents at home. So that alerts me to an issue that may be important for other Chinese students. So the counseling experience helps. It’s a kind of heads up into what might be happening. Some experience also comes from my New Zealand culture, such as my experience as a daughter and as a mother.

Participants also acknowledged the importance of support from family members, and other social groups. For example, several participants reported that local churches helped Chinese people access mental health services.

4. Discussion

4.1 Main findings

This qualitative project provides new insights into the problems involved in providing mental health services to Chinese people in Christchurch from the health providers’ perspectives. It identified important mental health problems among the Chinese population, such as depression and addictions. Several groups of Chinese people perceived to be at high risk of mental health problems were identified. Our findings confirm previous studies which report that elder Chinese migrants in high-income countries have difficulties with communication and transportation that may be associated with delays in seeking needed mental health services. The participants in this current study also identified other high-risk groups of Chinese migrants that have not been clearly delineated in prior research: Chinese students, Chinese migrants who are ‘people in between’ two cultures, migrants who are socially isolated, and people who had significant mental health problems prior to migration.

Some prior studies, such as the New Zealand Mental Health Survey, did not subdivide the various Asian ethnic groups, so it may have failed to identify important ethnic group-specific mental health issues. Several prior studies have reported that Chinese individuals use mental health services less than other groups, but there is virtually no work on understanding how Chinese migrants perceive and manage mental health problems or on the factors that promote or inhibit their use of professional mental health services. This study also found that Chinese migrants in need of mental health care did not seek or access mental health services; respondents in our study felt that the lack of culturally sensitive services and, particularly, the lack of Chinese-language based services were among the most important barriers to service utilization.

This reluctance to seek professional help has led to a negative cycle. Chinese migrants do not often present to mental health services, so little is known about their mental health needs and concerns. Thus, Chinese people’s mental health and their underutilization of services do not get attention from policy makers, and their needs are not considered. Because of this, there is little funding and policy support to improve the cultural appropriateness of current services. Breaking up this negative cycle and establishing a positive cycle is a priority for improving the mental health of Chinese migrants.

Health providers’ awareness of cultural differences is very important in offering quality care to individuals who are not members of the mainstream cultural group of a community. Our findings parallel those of Ran and colleagues who reported that Chinese individuals in need of mental health services would, instead, often seek medical help for associated physical problems. According to our respondents, Chinese health providers tend to have a better understanding of these issues and of the migration background of clients, particularly if they personally experienced migration and resettlement. But Chinese are under-represented among mental health professions in New Zealand (and, possibly, in other high-income countries). Decreasing this gap in the ethnic distribution of mental health providers is probably the best long-term solution to minimizing the barriers that are limiting the utilization of mental health services by Chinese migrants in New Zealand and elsewhere.

As an integral part of Chinese culture, traditional Chinese medicine (TCM) has helped address its people’s health problems for thousands of years. However, in the current health system in New Zealand, Chinese people are likely to find it difficult to access TCM services. Expanding access to standardized, high-quality TCM services in high-income countries and increasing their integration with mainstream western health services will be politically and administratively difficult, but this would be one option for increasing Chinese migrants’ use of health services and, possibly, could provide benefits to non-Chinese community members as well.

4.2 Strengths and limitations

This descriptive study of health providers’ perspectives on mental health services provided to Chinese immigrants
offered some new perspectives on Chinese people’s mental health and service use in Christchurch, New Zealand. The generalizability of the findings to other communities of Chinese immigrants is unknown, though we expect that the identified themes would be present to a greater or lesser extent in most communities of Chinese migrants in high-income countries.

This study also only considered one side of the provider-client dyad. Understanding how best to alter a system requires information from both the supply side (i.e., providers of mental health services) and from the demand side (i.e., the consumers of mental health services). This work needs to be complemented with surveys of users – Chinese community members, Chinese mental health patients, and family members of Chinese patients – before attempting to implement the recommendations.

4.3 Implications

Finding ways to assist migrants from China overcome the challenges of language, culture, and employment is vital to help them relieve stress, and to reduce the occurrence of mental health problems during the process of relocation. Moreover, once Chinese individuals develop mental health problems, there is a need to help them overcome barriers that may prevent them from accessing needed mental health services.

This study identified some opportunities that could lead to improvements in the overall mental well-being of the growing number of Chinese migrants: improved education of non-Chinese providers about culture-specific issues, recruitment of more people of Chinese origin into the health professions, increased awareness on the part of the Chinese community of mental health service options, and the development of additional community support alternatives. While needing the resources and support of health authorities, such alternatives will need to be initiated by the Chinese community itself.

This study also identified several areas relevant to the Chinese population in New Zealand — and, perhaps, to Chinese in other high-income countries — that require further research. Addictive behaviors are common but largely unstudied in Chinese immigrants. A subgroup of migrants who find themselves unable to acclimatize to either culture (the ‘in between’ group) have been identified, but little is known about them or about how to help them reduce their psychological distress. Finally, periodic quantitative studies are needed to monitor the changing mental health needs of successive generations of Chinese migrants (and their locally born offspring) so that policies and services can be altered in ways that will promote the mental health of this increasingly important population subgroup.

Conflict of interest

The authors report no conflict of interest.

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References

1. Statistics New Zealand. Census 2006 [Internet]. Wellington: Statistics New Zealand; 2007 [cited 2010 Apr 26]. Available from: http://www.stats.govt.nz/Census/2006CensusHomePage.aspx.

2. DeSouza R, Garrett N. Access issues for Chinese people in New Zealand. Final report. Wellington: Accident Compensation Corporation (ACC); 2005 [cited 2013 Oct 25]. Available from: http://www.asianhealth.govt.nz/Publications/Access_Issues_for_Chinese_people_in_NZ.pdf

3. Wang J. Highlighting two gaps in existing New Zealand social services: settlement programmes and Asian services — identifying problems and issues arising for Chinese immigrants during the settlement process. Proceedings of Aotearoa New Zealand Association of Social Workers, Biennial Conference; 2000; Auckland, New Zealand.

4. Ngai MMY, Latimer S, Cheung VYM. Final report on healthcare needs of Asian people: survey of Asian people and health professionals in the North and West Auckland [Internet]. Auckland (New Zealand): Waitemata District Health Boards; 2001 [cited 2013 Oct 30]. Available from: http://asianhealthservices.co.nz/documents/Publications/Healthcare%20Needs%20of%20Asian%20People%200301.pdf

5. Lin K. Traditional Chinese medical beliefs and their relevance for mental illness and psychiatry. In: Kleinman A., Lin T, editors. Normal and Abnormal Behaviour in Chinese Culture. Dordrecht (Netherlands): D. Reidel; 1981. p. 95-114.

6. Ng E. Heartache of the state, enemy of the self: bipolar disorder and cultural change in urban China. Cult Med Psychiatry 2009; 33(3): 421-450.

7. Ng J. Steven Young & Associates Limited [Internet]. [updated 2003 Jul 24, cited 2010 Nov 2]. Characteristics of Chinese culture and aspects of health care; [about 6 screens]. Available from: http://www.stevenyoung.co.nz/the-chinese-in-new-zealand/History-of-Chinese-in-NewZealand-Characteristics-of-Chinese-culture-and-aspects-of-health-care.html

8. Peterson D, Barnes A, Duncan C. Fighting shadows: self-stigma and mental illness [Internet]. Auckland: Mental Health Foundation of New Zealand; 2008 [cited 2013 Oct 30]. Available from: http://www.mentalhealth.org.nz/file/Policy-Advocacy-etc/PDFs/Fighting-Shadows-doc-20-06-08.pdf

9. Lu HC, editor. A Complete Translation of The Yellow Emperor’s Classic of Internal Medicine and the Difficult Classic. Academy of Oriental Heritage. Vancouver (Canada): Academy of Oriental Heritage; 1978.

10. Kumar S, Tse S, Fernando A, Wong S. Epidemiological studies on mental health needs of Asian population in New Zealand. Int J Soc Psychiatry 2006; 52(5): 408-412.

11. Oakley Browne MA, Wells JE, Scott KM, editors. The New Zealand mental health survey. Summary [Internet]. Wellington: Ministry of Health; 2006 [cited 2013 Oct 30]. Available from: http://www.health.govt.nz/publication/te-rau-hinengaro-new-zealand-mental-health-survey-summary.
Qiuhong Zhang has been working as a psychiatrist in China for more than 10 years. She graduated from Tianjin Medical University with a bachelor’s degree. Since then, she has been working in Tianjin Anding Hospital. In 2011, she obtained a master’s degree in health sciences at the University of Canterbury, New Zealand. During her stay in New Zealand, she volunteered at the Problem Gambling Foundation. While in New Zealand, she also had a placement at a psychiatric service-based hospital, where she participated in team activities, attended clinical meetings, visited wards for patients with dementia and depression, and observed different types of treatment sessions such as physiotherapy, occupational therapy and electroconvulsive therapy. Currently, she is working as an attending doctor in the Psychological Unit of the Science and Education Department within the Tianjin Anding Hospital. She has a wide range of research interests centered on improving clinical practice by enhancing understanding of health providers’ and service users’ perspectives on mental disorders and mental health services.
医疗人员对居住在新西兰克赖斯特彻奇的中国人的精神卫生服务状况的观点

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背景：移民事件会给当事人带来压力，可能提高海外华人居民精神疾病的患病率。文化习俗的差异和对华人精神卫生服务的缺乏也可能阻碍其寻求所需的服务。

目的：评估新西兰医疗服务人员关于华人对精神卫生服务使用状况的观点。

方法：本研究为定性研究。对新西兰克赖斯特彻奇九名曾为华人服务的医疗服务人员进行深入访谈，并笔录及分析访谈内容。

结果：访谈内容包括四个主题：(1) 中国大陆移民特殊的精神健康问题；(2) 其中出现精神健康问题的最易感人群；(3) 妨碍其获得精神卫生服务的因素；(4) 社会支持网络对其精神健康的重要性。

结论：通过对高收入国家中为数目日益增长的华人提供精神健康服务的专业人员的定性研究，找出需要提高文化敏感度的地方，以此促进中国大陆移民接受精神卫生服务，提高服务的效率。