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Engaging service users and carers in health and social care education: challenges and opportunities in the Chinese community

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Abstract

Service users' and carers' involvement in health and social care education has become a mainstream activity in Britain. However, participation of members from black and minority ethnic communities (BME) remains under-represented in this area. In this article, we will take the readers across the globe to explore the difficulties and opportunities of engaging one of the under-represented groups, the Chinese community. The journey will begin in Britain where barriers to engagement of service users and carers from the Chinese community will be discussed. We will then travel to Hong Kong, a cosmopolitan city, where successful engagement in work with Chinese service users and carers will be explored. Throughout the journey, we will highlight the importance of the consideration of cultural factors, particularly Confucian beliefs such as social harmony and collectivism, when working with Chinese people. We will also fully explore the issue of 'trust' as a culturally laden concept in Chinese societies and its significance for successful engagement in work with Chinese service users and carers in different parts of the world.

Key words: Chinese, service users and carers participation, social work and health care education

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Chinese community

Introduction

Service users' and carers' participation in health and social care education has become a mainstream educational activity in Britain. For example, service users and carers have been involved in various aspects of social work education such as selection and recruitment of students, development of curricula, teaching and learning activities, preparation for placement learning and student assessment (Levin, 2004). In recent years, an increasing number of educators from health and social care disciplines have been taking a more proactive role in promoting and supporting service users' and carers' participation in various educational activities at different levels (Allam et al., 2004; Anger et al., 2005; Barnes and Carpenter, 2006; Basset et al., 2006; Forrest et al., 2000). However, the representativeness of their participation has caused some concerns and the General Social Care Council (GSCC) (2004) suggests that there is a need to broaden participation of some under-represented groups. The agenda of widening participation aims to address the issue of tokenism and to avoid consultation of a relatively small number of service users and carers so that they become overused whilst others are overlooked (Brown and Young, 2008; Duffy, 2006). Moreover, service users and carers are not from a homogenous community and efforts should be made to ensure that different experiences and views of a diverse group are heard (Molyneux and Irvine, 2004; Reynolds and Read, 1999).

In Britain, the BME communities are one of the under-represented groups (Yeung and Box, 2008). The first author of this article is of a Chinese ethnic background and has worked as a social worker for the Chinese community in Britain for over 10 years. She has witnessed numerous difficulties that many Chinese families have had to overcome when they access health and social care services in Britain. It is her conviction that students and practitioners can learn a lot from the experience of different marginalized minority ethnic communities. This personal belief was also one of the motivations that drove her to carry out the 'Making a Difference' and 'Learning Together' projects to be discussed below.

This article will discuss two studies the first author undertook as exemplars to illustrate the challenges and opportunities for the engagement of service users and carers from the Chinese community in health and social care education in Britain and Hong Kong. The first study was carried out between 2005 and 2007. It was a two-part project that involved working with service users and carers from BME communities in the areas around Liverpool in Britain (Yeung and Box, 2005, 2007). The researchers successfully engaged a small number of service users and carers of BME backgrounds in the training of social work students. However, there was little success in engaging service users and carers from the Chinese community in the project.

The second study was conducted by the first author, who at the time of writing

was a postgraduate research student at the Centre on Behavioral Health of the University of Hong Kong. She had the opportunity to attend a number of clinical sessions run by the Centre and was inspired by their approach to work with service users and carers in the training and teaching of health and social care students.

This article aims to illuminate different experiences in working with Chinese people in educational activities in different parts of the world. It will first explore some of the obstacles that hinder participation of people from the Chinese community in Britain. Then, it will take the readers to Hong Kong to witness the innovative methods that are used to involve individuals and families of Chinese ethnic origin in the training and teaching of health and social care students. Having learnt from the encouraging story in Hong Kong, it will conclude with some suggestions to overcome the barriers encountered in the UK.

The journey begins

Chinese community profile in Britain

The Chinese first arrived in Britain in the early nineteenth century. The 2001 Census showed that there were 247,403 Chinese living in Britain which made up 0.4% of the total population and 5.3% of all minority ethnic populations (Office for National Statistics, 2002). 29% of the Chinese population was born in Britain, which was the lowest proportion of all main ethnic groups. Another 29% of the Chinese population was born in Hong Kong and the rest came from

different parts of the world such as mainland China (19%), Malaysia (8%), Vietnam (4%), Singapore (3%) and Taiwan (2%). A significant proportion (50%) of the Chinese population worked in the catering related businesses and most of them were born overseas, had limited education and limited English language skills. As the nature of the catering industry discourages the concentration of the Chinese population, the population tends to disperse across the country.

The Home Affairs Committee Report (1985) found that about 70 to 80 % of the first generation of Chinese immigrants did not speak English. Language difference is found to be a major barrier to accessing health and social care services for many Chinese people (Aspinall, 2007; Chu et al. 2000; Li and Logan, 1999; Newcastle Chinese Healthy Living Centre, 2006; Wong, 2006). They also speak different dialects and are of different educational and socio-economic backgrounds. Therefore, the Chinese population in Britain should not be treated as a homogenous group.

UK experience in working with service users and carers from BME communities

In Britain, participation of service users and carers in health and social care education has become 'fashionable' and yet members of BME communities are under-represented in this activity. Taking into consideration of some historical factors such as 'consultation fatigue', fear and lack of trust that might hinder their participation (Begum,2006; Butt and O'Neil, 2004), Yeung and Box (2005)

used the action research approach as a conceptual framework to facilitate and encourage their participation in the 'Making a Difference' project. The underlying belief of this approach is that research participants are not passive recipients but are active agents in the entire research process (Alston and Bowles, 1998; Stringer, 1999). The action research approach was considered well suited to support and facilitate the marginalized BME groups to identify barriers to participation, articulate their concerns and get involved in devising plans to overcome the barriers that they identified.

The researchers contacted 17 agencies that provided social care services for BME communities in the Merseyside area. Two organizations providing support services for people with mental illness and their carers responded positively and the researchers were able to engage a few service users and carers from these organizations in the study. In the meetings, participants voiced their concerns about getting involved; the strongest theme arising out of the dialogue was trust. Some service users were concerned that the project was simply another mandatory exercise to help fill a monitoring form. They had witnessed many small projects aiming at improving services for BME communities blossom and wither away in a short span of time. Participation rendering little or short-lived influence on service development discouraged further involvement. The resounding message is that developing a trusting relationship with service users and carers is fundamental to successful engagement.

Having considered their concerns, the researchers managed to secure further funding and launched the 'Learning Together' project (Yeung and Box, 2007). They re-established contact with those individuals and agencies formerly involved in the 'Making a Difference' project. However, because of budgetary constraints, the researchers had to limit the number of participants. This indeed raised some ethical concerns as it had led to exclusion of some of the hard-to-engage service user and carer groups such as non-English speakers and people with physical disabilities and learning difficulties as their participation would have incurred additional cost for transportation and translation because of their complex needs.

In the 'Learning Together' project, all participants attended a series of training exercises before they delivered teaching sessions to groups of BA Social Work students. Students who attended those teaching sessions remarked that listening to service users and carers in a classroom setting was "an invaluable process" and they were appreciative of their "honesty and openness" in sharing some of their most painful experiences. Students also learnt that active listening is a key to building a trusting relationship with service users and carers.

Although the researchers successfully engaged four members from BME communities in the project, attempts to engage individuals from the Chinese community were unsuccessful.

Difficulties in engaging service users and carers from the Chinese

community in Britain

Worry of disgracing family and losing face

In the early stage of the 'Making a Difference' project, repeated attempts were made to engage Chinese service users who experienced mental distress and their carers. However, it was apparent that family members objected to participation because of the worry that their 'family secret' would become public knowledge in their local Chinese community (Yeung and Box, 2005). Because of the stigma of mental illness and the anticipated discrimination and shunning from friends and the wider social network, many Chinese will choose to hide the family secret (Chang and Horrocks, 2006; Lau and Wong, 2008; Wong, 2000). The National Survey on Chinese Mental Health Needs found that many British Chinese with mental illness experienced discrimination and prejudice in the Chinese community and 21.4% of the research subjects with mental illness did not disclose information about their conditions to their friends (Li and Logan, 1999). 'Aggressive concealment' is a strategy some of them employ to shield the family disgrace (Li, 1991). Although the Chinese population is scattered across the country, they are closely connected through catering networks and their social life is firmly embedded in the local Chinese community. Family members of relatives with mental illness explained that they did not want to hear people from the Chinese community 'gossiping' about their 'family disgrace' while they were having a family meal in a Chinese restaurant.

Moreover, many traditional Chinese families are reluctant to involve 'outsiders' to resolve family difficulties and believe that families are responsible for sorting out their own problems (Sue and McKinney, 1975). To seek outside help is an indication that the family is failing its family members and will reveal the family's weakness (Jim and Pistrang, 2007; Kramer et al., 2002). Family members will lose face in the community and it may bring shame to the family (Kung, 2001). Therefore, people using mental health and other social care services from the Chinese community are very reluctant to get involved in any research related activities in case it may expose their family problems. These factors provided some explanation as to why the Chinese community in Britain is under-represented in many research studies (Department of Health, 2001; Hanley, 2005).

In psychotherapy, it was found that Chinese people had more difficulty than white British and Americans in disclosing personal psychological distress in a group setting (Chen and Mak, 2008; Devan, 2001; Sue and McKinney, 1975). Given this reluctance to disclose personal information, it is easy to understand why we struggled to engage participants from the Chinese community when they might be required to openly discuss their family difficulties in front of a group of students who are strangers to them. Moreover, families might not want to be constantly reminded of their 'family disgrace' which was one of the main reasons they declined to take part in the 'Making a Difference' project.

Traditional Confucian beliefs as a barrier to participation

Service users and carers have articulated the benefits of getting involved in different aspects of health care and social work education. Most found the experience rewarding, energizing and empowering (Frisby, 2001; Hayward et al., 2005; Levin, 2004; Yeung and Box, 2007). The process of getting involved in the 'Learning Together' project was felt to have a 'therapeutic effect' for some participants (Yeung and Box, 2007). Service users also found the teaching sessions to be a positive experience as students listened attentively to their stories. They therefore see their teaching role as an opportunity to shape the attitudes of future professionals and to redress the power imbalance inherent in the professional-client dyad (Hayward et al., 2005; Stevens and Tanner, 2006; Yeung and Box, 2007).

However, concepts such as empowerment, social change and equality are part of western ideology which are 'alien' concepts to many Chinese, who still hold tight to their traditional Confucian philosophy such as social orderliness, stability, responsibility and social harmony (Yip, 2004). As nearly 70% of the Chinese population in Britain are immigrants from different Chinese societies such as Hong Kong and China, many British Chinese retain their traditional Chinese thinking and practices (Chiu and Yu, 2001). Their traditional beliefs and practices also impact on the upbringing of their younger generation in Britain. Empirical evidence demonstrates that, for example, women and young people of Chinese origin in Britain neither abandon their cultural heritage nor uncritically adopt British ways of living (Green et al., 2006; Parker, 1995).

According to the teachings of Confucianism, a society is built on a hierarchical basis which clearly defines one's familial and social role. The most commonly known hierarchical system in Confucian teaching is the *wulun* (Five Relationships). *Wulun* is made up of ruler and minister, father and son, husband and wife, older and younger brother, friend and friend. Apart from the last relationship, the *wulun* is arranged in an order of priority and on a superior / inferior basis. The foundation of this 'moral hierarchy' specifies clearly that some members of society (government officials, father, husband and older brother) are considered to be morally superior to others (citizens, son, wife and younger brother). For example, a father is expected to discipline his son when he misbehaves; a son is expected to be respectful and submissive to his father.

Individuals are expected to fulfil their obligations in accordance with their assigned positions in the familial and social hierarchy (Kramer et al., 2002). If they can observe this rule properly, there will be no conflicts and tensions in the family and society. Social harmony, the collective good, can be achieved and maintained. The strong emphasis on collectivism is a key component of Confucianism and individual rights and personal interests have to be sacrificed for collective good (Ng et al., 2009; Weatherley, 2002). Acceptance of the status quo, non-intervention and inaction are the preferred strategies to confrontations and challenging authority to manage conflicting situations. Therefore, empowering and promoting individual rights may not be a welcome idea in many traditional Chinese communities because it often involves challenging the establishment, inevitably disrupting and damaging social

harmony. Empowering people who are considered to be morally inferior is unhealthy for the collective good. In other words, the underpinning philosophy of Confucianism is one of moral inequality (Weatherley, 2002). These beliefs are incompatible with the social work values advocated in the West. The Hong Kong experience to be discussed later will inform educators how to address the complexity of these cultural issues when planning to engage members from the Chinese community in educational activities.

Language difference as a communication barrier

Last but not least, we need to consider a practical difficulty when involving Chinese service users and carers in educational activities - the language difference. Many Chinese immigrants in Britain cannot speak fluent English and most health and social care students are not of Chinese ethnic background and cannot speak any Chinese dialect. For example, according to the statistical data of the GSCC (2007), between 1st April 06 and 31st March 07, out of 5,470 social work students registered with the GSCC, only 17 of them were of Chinese ethnic origin. Communication difficulty between Chinese service users / carers and educators could become an issue during preparation and teaching sessions. It also makes effective dialogue problematic in the classroom and therefore it is essential to involve an interpreter throughout the entire process. This often demands support and commitment from the educational institution because additional funding is required to pay for the involvement of an interpreter.

In addition, particular attention should be paid to the sensitive issues related to confidentiality when interpreters are required to be involved in the educational activities. The fear that confidentiality may be compromised is a major obstacle for the BME groups when using interpreting services (Fatimilehin and Coleman, 1999; Sainsbury Centre for Mental Health, 2002; Webb-Johnson, 1991).

Chinese research participants have expressed great anxiety about using interpreting services as most interpreters are often recruited from the local Chinese community (Yeung, 2002).

To sum up, some traditional Chinese beliefs and language difference are barriers to engaging and involving the Chinese community in the teaching and training of health and social care students in Britain. More importantly, this journey has highlighted again the importance of developing a 'trusting' relationship with service users and carers from the Chinese community. However, the issue about trust is culturally laden. Because of the concern about losing face and bringing shame to the family, the issue of confidentiality needs to be addressed explicitly at the outset. We need to address this issue and other cultural factors to facilitate the expression of some painful experiences and disclosure of vulnerabilities (Chan and Chan, 2005). Before turning to the possible solutions to overcome these barriers in Britain, we would like to take the readers to witness a successful story in a vibrant city, Hong Kong.

The journey continues

Hong Kong Chinese

Hong Kong, a former British colony, was handed back to Chinese sovereignty in 1997. Hong Kong has since become a Special Administrative Region of China, under the 'one country, two systems principle'. It is estimated that there were around 6,963,100 people living in Hong Kong at the end of 2007 (Information Services Department, 2007). The major Hong Kong immigrant population comes from China and nearly 95% of Hong Kong's population is of Chinese ethnic origin. The rest of the population is made up of other ethnic minority groups coming from other countries such as the Philippines, Indonesia, Thailand, India, the United States and Canada. Most people in Hong Kong speak Cantonese. However, since 1997, a growing number of Mandarin-speaking people are coming to live in Hong Kong.

Under the colonial regime, many western values, beliefs and practices were imported to Hong Kong. However, most of the traditional Chinese customs and practices survive and remain intact. Buddhism and Taoism are the dominant religions in Hong Kong. Confucian beliefs and values play an important role in shaping different aspects of the daily life of Hong Kong people.

Service users' and carers' participation in health and social care education in Hong Kong

Background information

Participation of service users and carers in teaching, training, learning and other educational activities in health and social care education is relatively under-

developed in Hong Kong. Service users and carers play no part in the selection and recruitment of students, direct teaching and curriculum development. There is a total absence of policy guidance and resources to support and promote their participation. The Centre on Behavioral Health (CBH) of the University of Hong Kong is the pioneer in this area in Hong Kong.

The CBH was set up in 2002. It advocates the use of a holistic approach which aims to integrate the physical, cognitive and spiritual aspects of individuals, with a view to building on individuals' resilience and strength in facing adversities (Ng and Chan, 2005). The Centre provides educational programmes including the Master of Social Sciences in Behavioral Health and other training programmes such as arts therapy and eastern body-mind-spirit interventions, practice research opportunities and clinical services for the community.

Students enrolled on the programmes come from various health and social care backgrounds such as social work, counselling, physiotherapy, occupational therapy and nursing. The integration of clinical practice and clinical training is an important component of all educational programmes of the CBH.

Development of counselling services in the CBH

Since 2002, the Centre has adopted the one-way mirror for clinical training. The use of the one-way mirror was seen as a breakthrough in the training of clinical practitioners in the 1980's as it provides excellent learning opportunities for students to witness application of theories to practice. However, it also has

its shortcomings (Ng, 2009). First, there is the issue of power. Although informed consent is sought before a clinical session commences, by and large, individuals involved in the counselling session have no idea who is sitting behind the one-way mirror. Secondly, discussions between clinicians and students normally take place after the counselling session finishes. There is no communication between the observers and those being observed; people using the counselling service are not given the opportunity to clarify any misunderstanding and misinterpretation regarding their difficulties. Finally, during the counselling session, as the trainers / instructors often play the role as clinicians, students are often left to observe without supervision and on-the-spot guidance. This may not be the most conducive learning environment, as misinterpretation cannot be rectified promptly.

Because of these potential shortcomings, in 2004, the CBH made a decisive turn and took a step forward to go beyond the one-way mirror. It allows individuals using the counselling service, the clinical practitioner and up to 30 students to sit in the same room when a counselling session is conducted. The integration of clinical practice and clinical training allows practice, teaching and learning to take place simultaneously. This approach is more transparent and interactive than using the one-way mirror. However, because of the large number of participants, the issue of power imbalance remains unresolved. Individuals may feel intimidated and be reluctant to share their problems in front of a big group. Service users who had been involved in training health care

professionals expressed feelings of anxiety, discomfort and ambiguity about their role in student's learning (Twinn, 1995). Moreover, as the group is made up of participants with varying levels of clinical experiences, some students may say something inappropriate, potentially damaging the well-being of people using the service.

Individuals and families using the counselling services are either self-referred or referred to the Centre by other agencies. **They are of different social, economic and educational backgrounds.** Most of them have long-standing behavioural, psychological or emotional problems and have sought help and advice from different professionals before they approach the Centre. Before the counselling sessions take place, the full implication of using the service is explained to individuals and families, that is; the counselling session will be videoed and may be used as a 'teaching case' for training and teaching purposes; the video may also be used in other clinical sessions; and a group of students of a multi-disciplinary background may take part in the session. If the individuals and families refuse to have any students attend the counselling session, they may then be seen as 'private cases'; they will be receiving counselling services in a traditional setting only with the presence of the clinician.

The counselling session

If treated as a teaching case, the counselling session will take place with the presence of a group of students that come from a range of health and social

care professional backgrounds such as social workers, physiotherapists, clinical counsellors and nurses. The size of the group varies from 10 to 30. Most students taking part in the clinical session are enrolled on the programme of Master of Social Sciences and Behavioral Health.

The clinician normally begins the counselling session by taking the full history of the difficulties service users and / or carers experience. A range of activities including small group sharing, role plays, watching videos and group exercises may be used during the session. Because of the number of students involved in the session, it provides scope for the clinician to manoeuvre and allow different therapeutic interventions to take place. Such an approach provides perfect opportunities for all participants to appreciate differences and diversities; it demonstrates that a problem can be viewed from different perspectives and can be resolved in many different ways.

An experience of participant observation

The discussion of the Hong Kong experience was mainly based on the first author's observation of a number of counselling sessions she attended as a student and the second author's many observations as a clinician in those clinical sessions he conducted (the second author is a clinical practitioner and an assistant professor of CBH). Participant observation is used as a method by means of participating in the activities of the people under study. In this study, covert observations were used to allow the researchers to gather data through

watching and listening to what people do and say (Brewer, 2002; Denscombe, 2003). Covert observations can pose ethical problems for the researchers as 'informed consent' cannot be obtained. In order to minimize disruption to the counselling sessions, the use of such an approach was justified in this study (Denscombe, 2003). Also, other ethical considerations were observed in the study to ensure that no one suffered as a result of the observation and anonymity was maintained in any publication.

The clinical sessions attended by the first author concerned a teenage boy with a presenting problem of school attendance. The parents of the teenager had had concerns about his behavioural problems for about eight years and had consulted different professionals for advice before they approached the Centre. The observed clinical sessions to be discussed in the article only involved the parents of the teenager. The teenager concerned only agreed to be seen as a private case.

Trust to share

Although the clinician had fully explained to the couple the context of the counselling session, entering into a consultation room with about 30 strangers waiting to listen to one's personal and family's problems could be a daunting experience. The couple looked apprehensive when they first arrived. Perhaps they were intimidated by the sheer number of people attending the session. After a brief introduction of the composition and the diverse professional

backgrounds of the participants, the clinician began the session by asking the couple to briefly talk about their difficulties.

As mentioned earlier, Chinese people are reluctant to discuss personal problems in front of strangers. However, the first author was surprised by the couple's willingness and openness to **share** their concern **about** their only child. They asserted their perspectives on the possible causes of their difficulty. The father openly admitted that he was very 'traditional' but realized he was too strict with his son when he was little and he believed that he was partly responsible for causing the problem. This confession informed us that culture is not static and is subject to change (Leung, 2007). Living in a dynamic and vibrant city and being exposed to both Chinese and western culture, the father was applying different cultural frameworks to explain the possible cause of the family's difficulty. He came to realize that he had to abandon his traditional thinking and that he could be responsible for his son's behavioural problems.

Trust the experts

Another inherent feature of Confucianism is that individual behaviours are influenced by their position in the social hierarchy. Confucianism advocates a 'hierarchy of merit'. People such as the intellectuals and academics attain moral excellence by demonstrating that they possess superior personal attributes through their academic achievements. They are therefore allocated a superior position in the social hierarchy. This explains why in many Chinese

societies, intellectuals and academics are awarded high social status and their opinions are often respected and highly valued. Indeed, many Chinese parents place emphasis on education (Chan et al., 2007; Sue and Sue, 1973) and because of that, many Chinese children and young people are under a lot of pressure to excel in their school performances.

Because academics and intellectuals occupy such a high position in the social hierarchy in Chinese societies, the couple respected the opinions of the clinician and students. The words from the clinician, who earned the title of 'Doctor' through his academic achievement, and from the fellow students, who gained their respective social status through their professional titles and academic qualifications, were highly regarded by the couple. There was a tacit expectation from the couple that the experts would find a solution to their problem.

Mindful that the couple might have an unrealistic expectation of the experts, the clinician carefully and tactfully pointed out that there was indeed a fluid boundary between professionals and service users / carers and everyone could easily fall into the other side of this dividing line. By engaging everyone in a range of activities, the clinician pointed out that all participants were learning from each others' experiences and were exploring the problem together.

Trust to get involved

The clinician, because of his relative higher position in the social hierarchy in the consultation room, was perceived by the couple as an authority figure and to be endowed with the specialist knowledge and experience to solve many difficult problems. To the couple, the client-clinician relationship was not seen as a partnership, rather the clinician was perceived as the authority (Kramer et al., 2002). This observation confirms that Chinese service users and carers often perceive clinicians / academics to be authoritative experts. They tend to adopt the role as students in a therapeutic relationship and view the clinicians as teachers (Jim and Pistrang, 2007). As the counselling sessions take place on the premises of the University of Hong Kong, an educational institution, viewing the clinician as an authoritative expert helps the couple settle more readily in a culturally familiar social role (Lin et al., 1995). Since they see themselves playing the role similar to that of students, they expect to follow the expert's 'instruction' and to take part in all activities he suggests.

The clinician was aware of the complexity of the power dynamics and was careful not to reinforce such beliefs. His approach to motivate all participants to take part in different activities was facilitating and encouraging rather than commanding and dogmatic. Also, by appealing to the Chinese collective-oriented thinking, the clinician was able to engage all participants to take part in the activities to resolve a 'shared' problem. From the observation, it was remarkable to witness that the couple was very eager to contribute in the problem-solving process when they heard that some of the students, the

'experts', shared their difficulties.

Lessons learnt from the Hong Kong experience

Although the observation mainly concerned one family, from the second author's clinical experience, most individuals and families seeking help from the CBH were also very willing to share their personal difficulties and ready to take part in different activities. Because most individuals and families who take part in the counselling sessions have had unresolved difficulties for a number of years before they contact the CBH, they are eager to share their difficulties and are highly motivated to take part in the counselling sessions. Moreover, because the counselling sessions take place in an educational setting and are delivered by the academics, participants are keen to get involved in the activities in the hope that the experts can help them find the solutions to their problems. More importantly, the CBH clearly lays down the ground rules such as confidentiality at the outset in order to promote an open forum for all participants to discuss and debate some critical perceptions. All participants taking part in the counselling sessions are required to sign an agreement to ensure that they will follow the terms and regulations and understand the consequences if they breach the rules.

Strategies to develop a trusting relationship with Chinese service users and carers in Britain

Learning from the Hong Kong experience, it is paramount to provide a safe and

comfortable environment for participants to disclose their personal problems. A study involved Chinese people using counselling services in the UK revealed that the provision of such an environment was vital to all participants in a therapeutic relationship so that they felt at ease to ventilate their inner feelings and conflicts (Jim and Pistrang's, 2007). Other studies also show that establishing ground rules is crucial to facilitate and support service users to share and disclose their vulnerabilities in educational settings (Frisby, 2001; Hayward, et al. 2005). It is therefore never too burdensome to emphasize that the rule of confidentiality will be strictly adhered to when working with Chinese service users and carers. This ground rule needs to be spelt out clearly at the outset to address the issues of fear of losing face and disgracing one's family.

Because of the issue of confidentiality, identifying and involving someone they trust at an early stage is vital to work with this hard-to-engage community. Many cross-cultural studies documented the benefits of approaching key insiders such as community leaders to secure access to some of the marginalized communities (Bowes and Sim, 2006; Hesse-Biber, 2007; Hinton et al., 2000; Liamputtong, 2008; Sheridan, 1984). For example, a study aimed at examining the understanding and expectations of 'advocacy' held by BME communities in Glasgow, Scotland illustrated the importance of the use of 'trusted intermediaries' to help identify and engage members from these disadvantaged groups (Bowes and Sim, 2006). This mirrors the first author's working experience with the Chinese community in the UK. It is advisable to

establish links with some bilingual Chinese community workers in the process because they are some of the trusted intermediaries who have already established a good and trusting relationship with the Chinese community.

Advantages of involvement of bilingual community workers

Apart from gaining access to the hard-to-engage community, the involvement of bilingual community workers can serve other purposes. First, as the bilingual workers have already established a trusting relationship with the service users and carers, they can provide them with on-going emotional support throughout the whole process. Secondly, the bilingual workers can act as interpreters, which will help address the issue of communication barrier in the classroom and allow a more meaningful dialogue to take place. Identification and involvement of bilingual workers inevitably demands individual dedication from the educators and commitment from the educational institutions. However, involvement of bilingual workers need not be seen as an additional cost for the educational establishments because of the multiple advantages that a training session may entail.

Gerrish and Papadopoulos (1999) asserted the importance of developing a range of teaching and learning strategies to ensure that health care workers had the necessary knowledge and skills to respond to the needs of a multi-cultural society. Involvement of non-English speaking communities and bilingual workers in educational activities provides excellent learning

opportunities to prepare future practitioners to work with individuals and families of diverse backgrounds. Britain is a multi-cultural society and about 7.9 % of its population is of BME backgrounds (Office for National Statistics, 2002).

Language difference presents one of the major barriers for BME groups to accessing health and social care services (Bowes and Sim, 2006). Many health and social care practitioners have to involve interpreters so that they can carry out assessments and render appropriate services to the non-English speaking communities. Needless to say, professional interpreters require proper training and orientation to permit more meaningful and accurate translation to take place (Lu, 2004). Likewise, utilizing an interpreter effectively requires some clinical skills (Tseng and Streltzer, 2004; Webb-Johnson, 1991). Training for health and social care students / workers is therefore very important so that they can acquire the skills to manage some of the sensitive issues mentioned above.

Moreover, people belonging to a marginalized and disadvantaged sector in the society such as the Maori in New Zealand expressed the view that educators from a health background should have a knowledge base that was firmly grounded in the effects of marginalization and discrimination (Durie, 1994 cited in Wepa, 2003). The non-English speaking communities are mostly made up of the first generation of immigrants, who are also more traditionally oriented and experience the greatest barriers to accessing health and social care services (Kramer et al., 2002). Involvement of non-English speaking service users and carers in health and social care education not only serves to address

issues raised by the widening participation agenda but also better-equips practitioners with the first-hand well-grounded knowledge to work with people from the marginalized communities.

Strategies to address cultural differences

Finally, the Hong Kong experience serves to remind educators in the UK that each BME community is unique and the 'one size fits all' blanket approach should be abandoned when planning to involve different minority ethnic groups in any educational activities. Service users' and carers' participation in health and social care education, in essence, is a 'white' orientated movement. The underpinning ideologies of this movement are the empowerment and promotion of individual rights and an attempt to redress structural inequality. These ideologies, however, are out of tune with some of the traditional Chinese beliefs. Previous debates have highlighted the danger of the application of a Eurocentric ideologies to practice in various social care settings (Bowes and Sim, 2006; Midgley, 2000; Yip, 2004). For example, Yip (2004) asserted his concern that a direct transplantation of a western value based social work practice and education model implied professional imperialism and neglected the diversity of cultural and social contexts in social work practice. Furthermore, a white approach to promote service users' and carers' involvement in social care education may serve to further alienate the marginalized Chinese community and discourage their participation. Educators need to fully recognize the cultural factors discussed in this article and adopt different

strategies when planning to involve members from the Chinese community in health and social care education. Focusing on the promotion of responsibility to ensure collective good rather than the advancement of individual rights is a more appropriate approach to engage them in different educational activities.

Conclusion

The integration of clinical practice and clinical training at the CBH in Hong Kong is an inspiring story. It demonstrates that service users and carers can contribute to health and social care education in different settings. However, such an integrative approach has its limitation of application in Britain because of the lack of Chinese speaking academics and clinical expertise to support participation of members from the Chinese community in this activity. Moreover, the integrative approach has raised some ethical concerns. There is the uncertainty that if individuals seeking counselling services fully understand their commitment so that they can make an informed decision about their involvement. To this end, it would be helpful to seek their views on their role in the teaching and learning process so that they can be adequately supported and make meaningful contributions to the teaching and learning activities.

Given the limited literature related to Chinese service users' and carers' participation in health and social care education, it is hoped that this article will contribute to knowledge building and help educators to develop different ways to engage and involve this under-represented community in educational

activities. The Hong Kong experience nevertheless provides some insightful ideas for UK practice. It highlights that developing a trusting partnership is fundamental when working with people from the Chinese community. It is important to acknowledge the complexity of the issues of power and confidentiality. The cultural issues about shame, losing face and other traditional Chinese beliefs as well as the communication difficulty caused by language difference need to be thought through carefully when planning to involve this marginalized community in health and social care education.

The journey has now come to an end, however, there are many milestones to reach before full participation of service users and carers in health and social care education in Hong Kong becomes a mandatory activity. Mainstreaming service users' and carers' participation in educational activities requires commitment from government and educational institutions which is clearly lacking in Hong Kong. Our work demonstrates that some practices in Hong Kong could be developed in the UK; equally, educators in Hong Kong can learn a lot from the UK experience, further collaborative research may be the way forward to facilitate a mutually beneficial learning experience.

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