Scoping exercise with Black and minority ethnic groups on perceptions of mental wellbeing in Scotland

Final Report
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The opinions expressed in this publication are those of the author/s and do not necessarily reflect those of Health Scotland.
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## Abbreviations

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<th>Abbreviation</th>
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<tr>
<td>BME</td>
<td>Black and minority ethnic</td>
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<td>CHI</td>
<td>Chinese Happiness Inventory</td>
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<td>GHQ</td>
<td>General Health Questionnaire</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NIMHE</td>
<td>National Institute for Mental Health England</td>
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<td>NRCEMH</td>
<td>National Resource Centre for Ethnic Minority Health</td>
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<td>NSF</td>
<td>National Service Framework</td>
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<td>OHI</td>
<td>Oxford Happiness Inventory</td>
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<td>PAR</td>
<td>Participatory Action Research</td>
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<tr>
<td>SCIE</td>
<td>Social Care Institute for Excellence</td>
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<td>SWB</td>
<td>Subjective Wellbeing</td>
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<td>UCLan</td>
<td>University of Central Lancashire</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>US and USA</td>
<td>United States of America</td>
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<td>WEMWBS</td>
<td>Warwick-Edinburgh Mental Wellbeing Scale</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Executive Summary

Background

1. The Scottish Government has made a commitment to improving public mental health as part of a wider agenda on health improvement. This includes work on promoting mental wellbeing in addition to work on the prevention of mental health problems and recovery.

2. This project was commissioned by NHS Health Scotland to add to the knowledge base in relation to the conceptualisations of mental wellbeing by Black and minority ethnic communities (BME) in order, ultimately, to provide mental health improvement guidance in relation to BME communities. The project has focused on Chinese and Pakistani communities, the largest BME communities in Scotland.

3. This report provides an overview of the method and the main findings of this scoping exercise, which forms phase one of a project. The theoretical, methodological, policy and practice implications are explored and recommendations are made for future work in this area.

Method

4. The broad research question that guided this project asked how do Chinese and Pakistani communities living in Scotland conceptualise mental wellbeing and what are the implications of this for mental health promotion strategies?

5. The scoping exercise involved:
   - reviewing the literature on mental wellbeing and Chinese and Pakistani communities
   - interviews with key informants from community organisations working with Chinese and Pakistani communities in Scotland. Nearly all the people interviewed were also from these communities
   - a brief review of the literature to identify the methods for undertaking research in this area of inquiry with Chinese and Pakistani communities.

Findings

6. In total over 5,000 papers were initially identified for the literature review but only 140 were found to be relevant to this area of inquiry. This included 32 from the UK and 108 from China, Pakistan, USA, Canada, Australia, New Zealand and Europe. Just over half of the non-UK papers came from China and the majority of the material from non-UK English speaking countries related to Chinese communities, with only 5% from Pakistan. However there were more papers relating to Pakistani communities in the UK and they made up 50% of the total UK papers compared with 28% for
Chinese communities; the remainder relating to Asian or BME communities in general but inclusive of Chinese and Pakistani communities.

7. None of the UK papers directly answered the research question in any depth. By contrast the wealth of material from China provided rich insights into conceptualisations of mental wellbeing in different parts of China. This material included cross-sectional and longitudinal surveys that explored a broad range of factors and their relationship to mental wellbeing. These studies used measures of mental wellbeing, often validated on US populations and developed for use with Chinese populations. A small number of theoretical papers provided a useful exploration of philosophical influences, particularly Confucianism and Taoism, on conceptualisations of mental wellbeing and happiness. Papers relating to Pakistani Muslim communities, mainly from the UK, highlighted the central role of Islam in understanding and contributing to maintaining mental wellbeing.

8. From the interviews and the literature review, happiness emerges as the most widely used term to describe mental wellbeing for Chinese communities and the concept of a peaceful mind seemed to be most widely used within Pakistani communities. It was also apparent that these conceptualisations of mental wellbeing are rooted in philosophical and religious values, often described by community informants as cultural values. For Chinese communities, Confucianism and Taoism were identified, particularly in the literature from China, as major and not necessarily complementary influences. For Pakistani communities, the importance of faith was confirmed by community informants.

9. For both communities, conceptualisations of wellbeing have a number of dimensions, which appear to be inextricably linked – family wellbeing, spiritual wellbeing and material wellbeing with both communities placing an emphasis on social roles and connectedness. Further the way in which mental illness was conceptualised by both communities has an influence on how mental wellbeing was conceptualised. In general community informants viewed mental wellbeing as incompatible with mental illness, with mental illness defined in terms of severe mental illness and with more common mental health problems viewed as part of life.

10. Philosophical and religious beliefs emerge as the most significant influence on conceptualisations of mental wellbeing, even for younger people who have received a Western education. However age, generation, ethnic identity, cultural orientation and context were also important. There was a hint from both the literature review and the interviews that people may hold more than one frame of reference for conceptualising mental wellbeing.

11. There were relatively few papers in the literature review that related to specific strategies used by Chinese and Pakistani communities to maintain mental wellbeing and prevent mental illness although a number of papers relating to policy, or good practice in mental health promotion for these
communities were identified. The interviews with the community informants identified the role of religion and faith, activity and social networks and the importance of awareness raising in relation to mental health problems.

12. Whilst no direct comparisons could be drawn between Chinese and Pakistani communities and the majority community in Scotland, it was evident from studies elsewhere that the conceptualisations of mental wellbeing may differ fundamentally from those developed with majority populations. In particular it is suggested that terms and concepts used in mental wellbeing research in the West may not be as relevant or have a profoundly different meaning in these communities.

13. The indication from a rapid review of the literature is that participatory action research using qualitative methods provides the most promising way of developing a richer understanding of the meaning of mental wellbeing for Black and minority ethnic communities. Participatory action research aims to address inequalities between researchers and participants found in a traditional model of research and is well suited to identifying practical action that needs to be taken.

Recommendations

14. A wealth of data has been generated through this scoping exercise and further analysis of the literature and the interview data is recommended. The focus of this should be a more in-depth analysis of the factors influencing conceptualisations of mental wellbeing and the points of convergence and divergence within Chinese and Pakistani and with majority communities in Scotland and other English-speaking countries.

15. As the literature review identified a significant gap in the knowledge base in terms of qualitative studies exploring meaning of mental wellbeing within Chinese and Pakistani communities it is recommended that this should be a priority for further research. Strategies for sampling and methods for facilitating discussion of the issues are discussed in the report.

16. This scoping phase also identified that tremendous potential exists within Chinese and Pakistani community organisations to build on this initial scoping exercise. The authors recommend investment in Black and minority ethnic organisations in Scotland to support capacity building, providing them with the training and resources to take this agenda forward.
1. Introduction

The strategic emphasis on public mental health forms part of Scottish Government’s wider agenda for a Healthier Scotland, with the “goal of less ill-health and higher levels of wellbeing and fitness across the nation and social spectrum” (Scottish Executive, 1998, Ch 4). There is a clear recognition that if the public mental health agenda is to be thoroughly pursued this needs to include a focus on mental wellbeing. This project has been commissioned by NHS Health Scotland as a means of extending the knowledge base about mental wellbeing in Black and minority ethnic (BME) communities in order, ultimately, to provide mental health improvement guidance in relation to BME communities.

It is self-evident that mental wellbeing is likely to be understood differently by diverse communities. This project has scoped the conceptualisations of mental wellbeing by Chinese and Pakistani communities, i.e. the majority BME communities, living in Scotland. It is intended as Phase 1 of a more comprehensive piece of work and has involved a rapid appraisal of the literature and initial fieldwork with community workers in Scotland undertaken between November 2007 and February 2008. The implications for subsequent research are drawn out in the final section.

The work has been undertaken by the Institute for Philosophy, Diversity and Mental Health in the Centre for Ethnicity and Health at the University of Central Lancashire (UCLan). The Centre has an established national and international reputation for engaging service users, carers and communities as equal partners in research and service development.

1.1 A note on terminology

The concept of mental wellbeing is complex, interpreted differently and continues to be debated (Friedli, 2006) and Section 3 provides a discussion of the term. The term positive mental health is also used to refer to the concept of mental wellbeing by other authors and both terms “encompass more than the absence of mental health problems and cover both experience and functioning” (Parkinson 2007, p.15). The starting point for this review has been a broad and inclusive approach to definition so as not to preclude important aspects of the concept. The term mental wellbeing is therefore used within this report to refer to a subjective sense of emotional, psychological, social and/or spiritual wellbeing and includes life satisfaction, positive relationships with others and a purpose in life (Parkinson, 2007). As well as positive mental health, the terms subjective wellbeing, psychological wellbeing and emotional wellbeing are also used but tend to be used to refer to specific elements of the overall concept of mental wellbeing, as discussed in Section 3. The term mental health is used in this report as an umbrella term to refer to mental health problems, diagnosable mental illness and mental wellbeing (i.e. positive mental health) whilst the term wellbeing is also used as an umbrella term to refer to physical wellbeing and mental wellbeing.
The term mental health improvement is used to refer to any action to increase mental health amongst individuals and populations. This includes action to strengthen mental wellbeing and/or action to prevent mental illness. A fuller exploration of the terms mental health, mental wellbeing, mental health improvement and mental illness is provided by Friedli (2006).

The other terminology that is debated and can be misleading relates to the definition of ethnicity. Where possible the descriptors Chinese or Pakistani have been used and generic terms avoided. However this had not always been possible and it is therefore worth noting that the term Asian is used differently in US and Australian contexts (likely to refer to people from China or East Asia) and the UK where it is used to refer to people from Pakistan, India or Bangladesh (i.e. South Asia). The terms Western and Eastern have been used, again reflecting their use in the literature and in particular used to distinguish belief systems and values and their origin.

2. Background

2.1 Policy background
The current strategic direction for mental health improvement or public mental health has evolved from a number of policy areas including: mental health, public health, social justice and social inclusion, education, enterprise and lifelong learning and arts, sports and culture. Public health policy in Scotland has increasingly identified mental health as an integral part of the wider agenda for health improvement (Scottish Executive, 1998). It forms part of the Scottish Government’s ambitions for wider health and wellbeing and is integral to addressing health and social inequalities (Scottish Government, 2008a). Forty-five national indicators have been developed to enable the Government to identify the extent to which its overall strategic objectives are being achieved. One of these indicators is concerned with improving the mental wellbeing of the Scottish population by 2011 (Scottish Government, 2008b).

Scottish Government policy on mental health integrates mental health improvement (i.e. promotion, prevention and support) and care and treatment (i.e. implementation of mental health legislation and mental health services) within the Scottish Government Health and Wellbeing portfolio. In 2000 a framework for further improvements in health and health services was established and included a commitment to a national anti-stigma campaign, the promotion of positive mental health and a national framework to reduce suicides in Scotland (Scottish Executive, 2000a). Further emphasis on the importance of continuing efforts in these areas was given in 2003 (Scottish Executive, 2003a) and a subsequent framework for action for health improvement in Scotland included a commitment to establishing a 3 year action plan for the National Programme for Improving Mental Health and Wellbeing between 2003-2006 (Scottish Executive, 2003b). This was extended into a second phase (2006-2008) with underpinning resources from the Scottish Executive Health Improvement Fund. Further information on the Scottish Government’s mental health improvement work can be found at www.wellscotland.info.
The discussion document, *Towards a Mentally Flourishing Scotland*, was published for consultation in October 2007, outlining a proposed future direction for mental health improvement and population mental health for 2008-2011 (Scottish Government, 2007). This discussion document draws attention to the debate about defining mental health and wellbeing, the underlying causes of mental health problems and the best ways of maintaining and improving mental health and wellbeing. It frames mental wellbeing in terms of three dimensions - emotional, social and psychological wellbeing, which includes:

“our ability to cope with life’s problems and make the most of life’s opportunities, to cope in the face of adversity and to flourish in all our environments; to feel good and function well, both individually and collectively.”

(Scottish Government, 2007, p.2)

The model underpinning this and outlined in the discussion document is the dual continua model, discussed in Section 3 of the current report. The document proposes taking forward action on three themes:

- promoting and improving mental health through a focus on increasing key protective factors and reducing key risk factors
- preventing mental health problems, mental illness, co-morbidity and suicide with a focus on key risk factors and protective factors
- supporting improvements in the quality of life, social inclusion, health, equality and recovery of people who experience mental illness.

It proposes that targeted groups for local and national action could include amongst others, people without access to key assets and resources and people and groups who experience discrimination, including racism. This is a clear reference to people from Scotland’s diverse BME communities and the analysis of the consultation responses confirms the need for a targeted approach to mental health improvement with these communities (Griesback, 2008).

In Scotland, the framework for race equality across health services is driven by the Race Relations Amendment Act of 2000, the Equalities Strategy (Scottish Executive, 2000) and the subsequent Fair for All policy driver (Scottish Executive, 2001) and subsequent guidance (Scottish Executive, 2002) directing the NHS in Scotland. The legislation and policy provides a baseline on race equality practice and clear guidance to NHS boards on mainstreaming race equality. These policies directly led to the establishment of the National Resource Centre for Ethnic Minority Health (NRCEMH) in 2002. The National Programme for the Improvement of Mental Health and

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1 In April 2008 NRCEMH along with the other organisations representing the equality ‘strands’ identified by the Fair for All policy driver joined together to form a single Equalities and Planning Directorate within NHS Health Scotland. The mental health and race equality programme formerly hosted by NRCEMH is now also part of the Equalities and Planning Directorate.
Wellbeing funded a specific mental health programme within NRCEMH which sought to strategically influence and improve the mental health and wellbeing of BME communities (Meller, 2007). This research brief clearly relates to this programme of work as part of a broader portfolio of mental health improvement work within NHS Health Scotland.

2.2 Background to the development of the project
The development of this scoping exercise looking at perceptions of mental wellbeing in Black and minority ethnic (BME) communities developed in response to a number of key issues.

There is growing international recognition of the benefits of addressing mental wellbeing and its role in protecting and promoting mental health as part of a comprehensive approach to mental health improvement, as evidenced in The Helsinki Declaration signed by member states in Europe in 2005 (WHO, 2005). In line with this, national policy in mental health improvement in Scotland places a strong emphasis on promoting mental wellbeing in addition to the work on prevention of mental health problems and recovery.

The national work on mental health amongst BME communities in Scotland, developed by NRCEMH has a strong focus on service delivery and recovery and recognised that there was a gap in the research and practice in relation to mental wellbeing. NHS Health Scotland also identified a clear need for guidance for practitioners on promoting mental wellbeing within BME communities.

Given the lack of research on perceptions of mental wellbeing amongst BME communities generally and more specifically in Scotland, NHS Health Scotland’s NRCEMH and Mental Health improvement Programme, agreed that there was a need to develop a research programme to increase the knowledge base in this area. Due to the complexity of the area, any research needed to generate a good quality, meaningful output which was of practical value to stakeholders.

The first stage in the process was commissioning a scoping project which would provide an overview of the current level of knowledge and understanding about mental wellbeing in BME communities in Scotland. This research project forms part of a portfolio of mental health improvement work. It was anticipated that this scoping exercise would help inform the development of more substantive research addressing relevant questions around mental wellbeing amongst BME communities in Scotland and ultimately informing culturally sensitive mental health improvement work to be carried out in Scotland.

2.3 Chinese and Pakistani communities in Scotland
Analysis of the 2001 census data indicates that the minority ethnic population compromises just over 100,000, or 2% of the population (Scottish Executive, 2004). This is likely to be an underestimate as there has since been continued
arrival of refugees, asylum seekers and migrant workers from the European Union. Based on the 2001 Census figures, the Pakistani community is the largest BME group in Scotland, followed by Chinese, Indians and those of mixed backgrounds. In 2001, 31% of the Scottish BME population lived in Glasgow making up 5.5% of Glasgow’s total population, 4% in Edinburgh, 3.9% in Renfrewshire, 3.5% in Dundee and just fewer than 3% in Aberdeen and East Dunbartonshire. In general, BME communities have a younger population profile than the majority community with 60% of Pakistani communities and 52% of Chinese communities under the age of 29 compared with 12% and 15% over the age of 50 respectively (Scottish Executive, 2004). Information from the Census also indicates that in most urban areas the largest ethnic minority is Pakistani, but that in rural areas such as Ayrshire and Arran, the Borders, Grampian and Dumfries and Galloway, the Chinese community is larger. The majority of people from Pakistani communities were either born in Scotland (47.4%) or Pakistan (36.7%) whilst the majority of people from Chinese communities were born in the Far East, excluding China (44.9%) or Scotland (29.7%) compared with 18% born in China.

2.3.1 Chinese communities in Scotland
Chinese people living in Scotland are a heterogeneous community and include people born in Britain (British Born Chinese-BBC), Hong Kong, Taiwan and mainland China and speak different languages including Cantonese, Mandarin and Hakka (Dobbie & Lee, 2004). The first Chinese people arrived in Scotland as a result of Scotland’s colonial activities in China. Chinese seamen hired as cheap labour became stranded in Scottish ports and they became part of the Lascar communities, which developed in dock areas throughout Scotland.² Dorothy Neoh (2005) provides a useful overview of the migration of Chinese people to Scotland and their experience. The first settled Chinese community developed in Glasgow in 1960. The collapse of the agricultural economy in the People’s Republic in China in 1949, coupled with economic prosperity in Britain in the 1950s led to the first major wave of immigration from Hong Kong and the rural New Territories. The catering business developed and expanded and people from urban areas of Hong Kong and the nearby island of Apu Chau followed. Further migration occurred in the 1990s as Hong Kong reverted to Chinese control in 1997. Education has also been a driver for migration, particularly as China’s market economy has expanded and created a need for education and training overseas. There has also been migration from Taiwan with the opening of the Taiwanese manufacturing plants in Renfrewshire, South Lanarkshire and West Lothian. Marriage to Scottish men has been part of the pattern of settlement for Chinese women. The asylum dispersal system has led to Chinese men from Canton and Fijian seeking employment in the catering and retail sectors in Glasgow and Edinburgh.

Neoh (2005) describes how the notion of ‘family’ supported the survival of Chinese migrants in their chosen place of settlement. Family reunion and business opportunities, which were mainly family run, have led to Chinese communities being spread across Scotland. The lack of concentration of

these communities, particularly in rural areas has contributed to social incohesion and exclusion (Neoh, 2005). Social exclusion has further been compounded by language, culture, racism and social isolation. This is particularly the case for early migrants who came from rural areas such as the New Territories compared with later migrants who had a better education and therefore found it easier to integrate and learn about the host community (Neoh, 2005). Neoh writes that the process of integration is not an easy one and identifies the conflict between Chinese values of family, respect for authority, harmony, dependency and conservatism and those derived from a Western education, including individuality, independent thinking, equality, justice and liberalism as a source of intergenerational conflict and confusion in terms of identity for Scottish-born Chinese people. She goes on to describe the multi-layered and evolving identity for Chinese people in Scotland, particularly second and third generations who face challenges associated with experience of tensions between majority and minority cultures.

In contrast with the Pakistani community, Chinese people in Scotland do not have a single shared religion but do ascribe to Confucian ideals and principles, which Neoh indicates could be seen as part of the Chinese cultural identity. As well as Confucianism, Taoism and Buddhism are followed by Chinese people and there is a revival of interest in religious practices among the older generation following the establishment of small Buddhist and Taoist temples that have connections with religious communities in Manchester and London (Neoh, 2005). Furthermore, Christianity is also followed and there are now several Chinese Christian churches in Scotland, which are attended by Chinese people of different generations.

2.3.2 Pakistani communities in Scotland
The majority of people from Pakistan migrated to Scotland after 1945. However migration from India to Scotland began during the 18th century also as a consequence of Scotland’s colonial involvement. These early migrants formed the Lascar colonies and went on to develop the social structures that subsequently assisted later migrants. By 1920, people had begun to settle and small communities developed initially in Glasgow and Edinburgh, with the majority of these people coming from the area of India that formed Pakistan in 1948. These communities developed further in the 1950s and 60s, particularly as industries faced labour shortages and Pakistani migrants were employed often in low paid jobs in factories, mills and in public transport. However the experience of racism in the labour force led many to establish small scale retail businesses, particularly small shops involving working long hours.

Pakistani people are predominantly Muslim and form the largest Muslim community in Scotland. The first Muslim organisation was established in Glasgow in 1940. For Muslims, their faith is a way of life; it provides the main

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3 www.scotlandagainstracism
4 ibid
5 ibid
basis for group cohesiveness; it sustains and advances their ethnic identity and helps establish social networks (Anwar, 1994). Muslims in general face significant educational and economic disadvantage and experience racism and Islamophobia, which has heightened since 9/11 and the London bombings. Racism has been identified as a major issue affecting mental health and wellbeing for Muslims in Scotland and police data indicates that it has increased (Grant, 2007). The experience of conflict between cultural values, issues in relation to citizenship and defining identity have been identified as key issues for Pakistani Muslims with two main influences on identity being faith and national identity as Scottish

3. Conceptualising mental wellbeing

There are many different and debated definitions of mental wellbeing leading Ryan and Deci (2001) to conclude that mental wellbeing is a multidimensional and complex concept. Three key ideas emerge from the general literature on the concept of mental wellbeing. First the relationship between mental wellbeing and mental illness; second the elements of mental wellbeing and in particular the distinction between hedonic (subjective) and eudaimonic (psychological) wellbeing. Third the idea that mental wellbeing can be enhanced and is therefore an appropriate focus for understanding and intervention and consequently measurement.

3.1 The relationship between mental wellbeing and mental illness

Mental health is a confusing term and can be merely seen as a euphemism for mental illness as observed by Herron & Mortimer, 1999. They go on to identify two models for the relationship between positive mental health, i.e. mental wellbeing and mental illness. The bipolar or single continuum model reflects the view that mental wellbeing (positive mental health) exists at the opposing end of the same continuum as mental illness. The existence or degree of one is dependent on the existence, absence or degree of the other and mental wellbeing is therefore seen in terms of the absence or reduction of mental illness (Herron & Trent, 2000). Mental wellbeing has therefore been described as a secondary concept to mental illness; requiring prior knowledge of mental illness to be understood and inevitably viewed through ‘the lens of mental illness’ (Herron & Trent, 2000, p.30).

The alternative model is the two or dual continua model, which suggest that mental health consists of two dimensions; mental health problems or mental illness and mental wellbeing (positive mental health) (Tudor, 1996; Keyes 2007). Separating the definition of mental wellbeing from mental illness means that it is possible to focus on strengths rather than deficiencies; capacity rather than loss and growth rather than remediation (Herron & Trent, 2000). Mental wellbeing is thus more than the absence of mental illness and is a state “in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2004, p.12 as

7 ibid

cited in Keyes, 2007). There is emerging evidence to support the dual continua model – for example the data drawn from the Midlife in the United States (MIDUS) Survey, undertaken with English-speaking populations only. This model is increasingly being used to underpin public mental health in Scotland (Scottish Government, 2007) and the Scottish Indicators of Mental Health programme has established mental health indicators to encompass both mental health problems and positive mental health (Parkinson, 2007).

3.2 Elements of mental wellbeing

From a review of research on mental wellbeing, Ryan and Deci (2001) identify two broad traditions - hedonic wellbeing and eudaimonic wellbeing. Hedonic wellbeing often refers to the subjective sense of wellbeing, notably happiness and life satisfaction and is most usually termed subjective wellbeing (SWB). Eudaimonic wellbeing relates to the realisation of human potential and includes meaning, self-realisation and functioning in life and is usually referred to as psychological wellbeing. Although these two concepts overlap, they are derived from two distinct traditions, both arising from Western philosophy - hedonism and eudaimonism. They differ fundamentally in terms of their views of what constitutes a good society and a good life (Ryan & Deci, 2001). This has had implications for the questions asked about how developmental and social processes relate to wellbeing and to the approach to undertaking research and Ryan & Deci’s review outlines this in some detail. They describe how research within the hedonic paradigm has used the assessment of subjective wellbeing as its focus. SWB includes three components life satisfaction, positive mood and the absence of negative mood, which together are often summarised as happiness. Ryan & Deci argue that much of the research on SWB fits with the expectancy-value approach; in other words, that wellbeing is a function of expecting to attain (and ultimately attaining) the outcomes or values, whatever these might be. The goals through which SWB is enhanced can therefore be highly idiosyncratic and culturally specific.

Eudaimonic wellbeing, also referred to as psychological wellbeing, positive mental health or positive functioning consists of an individual’s evaluation of their psychological wellbeing (Keyes, 2006). It has been operationalised by Ryff who identified six aspects of functioning – autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self-acceptance (Ryff, 1989). Ryff has developed these into various scales of psychological wellbeing, which have been predominantly tested on US populations.

Keyes (2006) has commented on the relative lack of focus on the social dimensions of an individual’s functioning in life within the eudaimonic tradition of research. He has thus developed the concept of social well-being and proposed five dimensions - social coherence (whether a social life is seen as meaningful); social actualization (whether society is seen as possessing potential for growth; social integration (a sense of belonging and acceptance by their communities; social acceptance (feel they accept other people) and social contribution (sense of having something worthwhile to contribute) (Keyes 2006, p.5).
3.3 Enhancing mental wellbeing
Keyes (2006) contends that mental wellbeing\(^9\) (hedonic and eudaimonic) is a valuable asset at both an individual and a social level. In a conference presentation in Glasgow in autumn 2007\(^{10}\), he thus argued that governments needed to focus on enhancing mental wellbeing as well as reducing mental illness. This emphasis is increasingly reflected in national government policy not just in Scotland but across the UK (DH, 2005) and internationally. The development of national mental health indicators in Scotland will enable changes in Scotland’s mental health (both mental wellbeing/positive mental health and mental health problems) to be monitored (Parkinson, 2007) and could provide a mechanism for evaluating the impact of public policy on the mental wellbeing of Scotland’s population.

3.4 Cultural and ethnic differences in the conceptualisation of mental wellbeing
The importance of cultural context in shaping health beliefs (Gervais & Jochemovitch, 1998) and in wellbeing research is recognised (Keyes, Schmotkin & Ryff, 2002). In particular attention has been drawn to the integration of physical, spiritual and emotional aspects of health and illness in sharp contrast with mind-body dualism of Western philosophies impacting upon how mental distress is perceived Belippa (1991). In drawing comparisons between subjective and psychological wellbeing (Keyes, Schmotkin & Ryff, 2002) suggest that both traditions may reflect Western, and possibly middle and upper-class definitions of what it means to live a full and satisfying life. They suggest that Eastern perspectives may emphasise connection to others; meeting obligations and achieving fulfillment through carefully managed social ties.

This points to the importance of exploring mental wellbeing in different cultural contexts. However the discussion above raises a fundamental methodological issue about whether the constructs are equally applicable across different populations. Cheng & Chan (2004) note that this issue has been relatively unexplored. Two key concepts have thus influenced our thinking and approach, both derived from cross-cultural work in relation to the meaning of mental illness and stigma (Glasgow Anti-stigma Partnership, 2007). The first is the concept of categorical fallacy from Kleinman (1977) who sounds a note of caution in the search for conceptual equivalence in relation to the definition of mental illness. Kleinman uses the term to refer to the adoption of a disease classification developed for a particular cultural group and then applying it to another cultural group for whom it lacks coherence and for whom its validity has not been established (Kleinman, 1987, p. 452). The second related concept is the distinction drawn between etic and emic approaches, Again these concepts have been developed in the context of cross-cultural research with etic referring to the outsider view to research developed in the positivist tradition that emphasises independence, objectivity and universalism and

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\(^9\) Although Keyes typically uses the term mental health to refer to mental wellbeing.
\(^{10}\) http://www.wellscotland.info/mentally-flourishing-scotland-interactive.html.
emic referring to the insider view, and to research in the constructionist tradition that is qualitative and focuses on developing an understanding and meaning from the communities’ perspective, often involving narrative accounts of individual experience.

4. Method

4.1 Aims and objectives of the scoping exercise
This scoping exercise forms phase one of a project, whose ultimate aims are to increase the understanding of: conceptualisations of mental health and wellbeing among BME groups; strategies used to promote mental wellbeing and prevent the development of mental health problems; and the extent to which these conceptualisations and strategies complement or diverge from current mental health improvement strategies. This scoping exercise is being undertaken to inform the scope, aims, methodology and focus of the subsequent research phase.

The aim of the scoping exercise is therefore to develop recommendations to inform the next research phase, focusing on the two largest established BME communities in Scotland, the Pakistani and Chinese communities. It is important to understand that these communities are not homogenous and that there is considerable diversity in terms of age, generation of migration, gender, religious beliefs and geographical location. Specific objectives for this scoping exercise are:

- to scope and explore existing literature relating to the conceptualisations of mental wellbeing amongst Chinese and Pakistani communities and the strategies used by these communities to promote wellbeing within these communities and prevent mental health problems
- to gather expert opinion within Scotland regarding the extent that these conceptualisations and strategies are used by these two communities and the degree to which they complement or diverge from the majority population
- to explore priorities for further research in relation to promoting mental wellbeing and preventing mental health problems within the two communities
- to explore methodology literature in order to identify appropriate methodology for the subsequent research phase, with consideration of issues such as skills and experience required of researchers carrying out the project.

4.2 Involving stakeholders
It was recognised by NHS Health Scotland early on in the development process that the project required external expertise in the form of a steering
group. NRCEMH made use of its national contacts across the BME mental health sector to approach individuals who would bring such expertise to the steering group. Many of the individuals approached were already part of NRCEMH’s Mental Health Strategic Advisory Panel. Although ultimately the steering group was small it did achieve representation from the BME mental health voluntary sector, mental health improvement specialists (with experience in BME work), specialist research and NRCEMH’s race equality and mental health programme.

The Steering Group has been directly involved in developing the research brief, monitoring and reviewing the progress of the work, informing the search strategy and defining the search terms for the literature review, identifying individuals and organisations to be interviewed and finalising this report.

4.3 Methodology
There are three elements to the scoping exercise – a literature review of conceptualisations and strategies for mental wellbeing; consultation with community informants to explore the use of these conceptualisations within a Scottish context; and, an exploration of the methodology literature, to identify the key issues for the subsequent phase of research.

4.3.1 Literature review
The literature review provides an appraisal of a diverse and wide range of literature to identify conceptualisations of mental wellbeing and strategies to promote mental wellbeing and prevent mental health problems within Chinese and Pakistani communities living within the UK and their parent countries. It is not a systematic review but is a scoping exercise and therefore deliberately wide ranging in order to establish the breadth of the literature. It has been undertaken in accordance with Social Care Institute for Excellence (SCIE) guidelines (Coren & Fisher, 2006). A protocol was developed for the review, and circulated for comment to the Project Steering Group. This protocol outlined in full the review question, search strategies, parameters for the review, analysis and quality appraisal methods. The technical detail is available in Appendix 1.

Review questions

- What are the main ways of conceptualising mental wellbeing by Chinese and Pakistani communities?
- What strategies do Chinese and Pakistani communities living in Scotland use to maintain their mental wellbeing?
- What strategies do Chinese and Pakistani communities living in Scotland use to prevent mental health problems?
- To what extent do these conceptualisations and strategies differ from majority populations living in Scotland?
- What methodologies have been used to ascertain conceptualisations of mental wellbeing in Chinese and Pakistani communities?
- What are the implications of this for further research to inform mental health improvement?
Searching
This review aimed to establish the extent of the literature and identify the implications for further searching for the next phase of the research. The materials were identified by using bibliographic databases and web-based sources, communication with experts in the field and contacting relevant organisations in the UK. A full list is provided in Appendix 1. The search terms used were mental wellbeing; emotional wellbeing; psychological wellbeing; subjective wellbeing; happiness; positive mental health; self-esteem; psychological resilience or adaptation or mental health beliefs or mental health concepts or mental health promotion or mental illness prevention and Chinese or Pakistani or Muslim or Asian or Black and minority ethnic (BME). The material searched for was limited to that published in English between 1988 and 2007, as an earlier review in relation to stigma and BME communities in Scotland had identified little material before this date.

Criteria for inclusion and exclusion
The criteria for inclusion was material concerned with knowledge, attitudes, concepts and beliefs of Chinese and Pakistani communities in relation to mental wellbeing and mental health and strategies for mental health promotion and/or prevention of mental illness. Both UK and international papers were included and non-English material was excluded, as it was not possible within the timescale and resources of the review to undertake translation.

Inclusion criteria
Papers were included if they met criteria in the following areas:

- **Participants:** Pakistani, Chinese; Asian; South Asian; Muslim of all ages and both men and women. Material that covered Muslim or South Asian or Asian communities was only included if there was clear reference to Chinese or Pakistani communities and it was possible to extract relevant data.

- **Definition of mental wellbeing:** As this is the focus of the review and given the conceptual issues raised earlier, the definition aimed to be as inclusive as possible and included beliefs, attitudes, personal experiences, self-expression, social relationships and behaviours that convey a positive sense of wellbeing and/or freedom from mental illness. The search terms used included mental wellbeing, emotional wellbeing, psychological wellbeing, subjective wellbeing, resilience, happiness and self-esteem.

- **Interventions:** Material relating to mental health promotion activities used by Chinese and Pakistani communities was searched for using the terms mental health promotion, positive mental health and prevention of mental illness.

- **Contexts:** Scotland; UK; China; Pakistan; English-speaking non-UK countries, Europe.

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12 And various spellings of wellbeing i.e. well being and well-being
• Literature. The search was limited to literature published from 1988 to the present day. The search was limited to material published in English.

Exclusion criteria

Papers were excluded if:

- published in languages other than English
- relating to other BME communities
- solely concerned with substance abuse, drug misuse and alcohol abuse, or learning disabilities

Two reviewers applied the inclusion and exclusion criteria to all titles and abstracts and then to the majority of hard copies. Papers identified were coded for inclusion, and all relevant or potentially relevant papers were retrieved, within an 8 week period. Theses, although details were kept were not retrieved at this stage.

Analysis

The analysis that was undertaken was as follows:

Mapping of available material

All the material that met the inclusion criteria was systematically mapped in order to describe the extent of the available material, identify gaps in the knowledge base and to identify areas for future work. A keywording strategy for classifying the material was used (see Appendix 1) with the following categories:

- participants (i.e. Chinese or Pakistani, age, generation, gender)
- location (China, Pakistan, US and Canada, Australia and New Zealand, Other European)
- type of material (theoretical, study and type of study, instrument design, policy, commentary)
- focus (mental wellbeing, quality of life, subjective wellbeing, happiness, mental health symptomatology, mental health improvement, prevention of mental illness).

In depth analysis of the material

The material was organised into four categories, reflecting the country that the material related to: UK, considered primary data; China or Pakistan, English speaking Non-UK countries and Europe, which were all considered as secondary data sources.

1. Material from the UK

An in-depth analysis, including a quality appraisal, was undertaken on this material as this was considered to be primary data. The categories for data extraction of content were:

- participants (Chinese or Pakistani, age, generation, gender)
• location (Scotland; rest of UK)
• language and key terms used to describe mental wellbeing
• conceptualisation of mental wellbeing
• factors identified influencing conceptualisations of mental wellbeing
• details of strategies to promote mental wellbeing and/or prevent mental health problems
• outcomes of strategies used, including service user views
• comparisons with other populations.

In addition, details were extracted relating to the evidence:

• evidence type and main details of design e.g. aim, sample, data collection method
• quality criteria relevant to the evidence type/study design.

There was limited but consistent quality appraisal of included material using a brief version of TAPUPAS (Pawson, Boaz, Grayson et al., 2003). The form for this is included in Appendix 1 and the criteria include strength of design, centrality of perspectives of Chinese and Pakistani communities; transparency; quality and reporting of analysis; utility; propriety; accessibility and generalisability. No material was excluded from the review on the basis of quality, but quality issues influencing the interpretation of results and the strength of the evidence are included in Section 5.2.

2. Secondary data
A thematic analysis was undertaken on the material from China and Pakistan, defined by participants’ location, rather than author location. A more limited analysis was undertaken and the following categories for data extraction were used:

• language and key terms used to describe mental wellbeing
• conceptualisation of mental wellbeing
• factors identified influencing conceptualisations of mental wellbeing
• details of strategies to promote mental wellbeing and/or prevent mental health problems
• outcomes of strategies used, including service user views
• comparisons with other populations.

This material from English speaking, non-UK countries or Europe was read and the key theoretical points extracted.

The results from the mapping the literature is are provided in Section 5, the more detailed analysis in Sections 6 and 7, where it is considered in relation to Chinese and Pakistani communities respectively, and an overview of the search results and details of the papers and data extracted available in Appendices 4-7.

4.3.2 Consultation with community informants
A qualitative approach was used to collect in-depth data using either one to one or group interviews with 47 community development workers with
Chinese and Pakistani communities in Scotland. The aim of these interviews was to explore:

- conceptualisations and strategies used by Chinese and Pakistani communities within the Scottish context
- the similarities and differences for these communities and the majority populations
- priorities for future work in relation to mental health promotion and/or the prevention of mental illness in Chinese and Pakistani communities;
- key issues in relation to the methodology for the next phase.

The individuals were selected for this initial stage because of their roles, which gave them a working knowledge and overview of the issues in relation to these communities. Individuals were only interviewed as a group when more than one member of the community worked in the same organisation and hence the participants would have an existing working relationship. Table 1 details the total number of participants (N = 47) together with the breakdown of participants and method used.

### Sampling and recruitment strategies

As the timescale for this first phase was tight, it was necessary to adopt a degree of pragmatism to recruit participants. Nineteen key organisations or individuals were identified by NRCEMH. Four initial scoping interviews were undertaken with this sample to identify other potential interviewees and snowballing was subsequently used to identify other key informants. Information about the research was sent to the identified individuals and groups (see Appendix 2). This was followed by a personal approach by telephone to provide further information, answer questions and arrange a date either for an individual interview or focus group discussion.

### Participants

Forty-seven interviews were undertaken with people who had relevant knowledge of either Chinese or Pakistani communities in Scotland. The majority were community workers mainly in the voluntary sector with a small number in professional roles e.g. social work, health promotion. All of the people working with Chinese communities were Chinese and 81% of those working with the Pakistani community were Pakistani with the remainder being South Asian.

### Table 1: Details of participants and methods used

<table>
<thead>
<tr>
<th>Method</th>
<th>Chinese</th>
<th>Pakistani</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to one interviews</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Culturally specific focus group (i.e. Chinese or Pakistani)</td>
<td>12 (4 groups)</td>
<td>2 (1 group)</td>
</tr>
<tr>
<td>Culturally mixed</td>
<td>2 (2 groups)</td>
<td>4 (2 groups)</td>
</tr>
<tr>
<td>Totals</td>
<td>(4 male, 21 female)</td>
<td>22 (3 male, 18 female)</td>
</tr>
<tr>
<td></td>
<td>All Chinese</td>
<td>18 Pakistani, 4 South Asian</td>
</tr>
</tbody>
</table>
The majority of interviewees were drawn from the urban belt between the main centres of population and interviews were undertaken in Edinburgh or Glasgow. The number of men in the final sample was relatively small (15%) and this is likely to reflect the recruitment strategy of targeting community workers in the voluntary sector, which is female dominated.

In addition, four telephone interviews were undertaken with key informants who could provide a national picture of developments in relation to mental health policy, mental wellbeing and/or BME communities in Scotland.

**Data collection**
Data was collected through interviews or small group interview as appropriate. The majority (96%) of interviews with the key community informants were face to face with the remainder being telephone interviews. All but one of the interviews were undertaken mainly in English, with the other being conducted in Urdu. However the language skills of the researcher enabled definitions or terms to be explored in Urdu or Punjabi as appropriate.

**Lines of inquiry**
The topic guide used to ascertain the views of the participants is provided in Appendix 3. These interviews were in-depth and open ended to encourage interviewees to explore the issues from their perspective. The areas covered were:

- language and terms used to describe mental wellbeing, mental health and mental illness
- preferred conceptualisations of mental wellbeing
- factors influencing the conceptualisation of mental wellbeing including spirituality, family and community factors etc
- perceived differences between the conceptualisation of wellbeing and that of the majority population
- the range of strategies for promoting and maintaining mental wellbeing and frequency of use by different community members
- the range of strategies for preventing mental health problems and frequency of use by different community members
- priorities for future research on promoting and preventing mental health problems in Chinese and Pakistani communities
- key issues in relation to the methodology for the next phase e.g. preferred methods for community engagement.

The topic guide was only that – a guide. It showed what needed to be covered and expected responses to vary according to the individual. The language on the guide – formal academic language was substituted with everyday wording during the interview. The questions were not asked in any particular order and the questions were supplemented with follow on questions to answers given by participants. In a way the guide was a checklist and used as a prompt for information. All interviews with community informants were tape recorded and 60% transcribed for analysis reflecting the available time and resource constraints of the project, although saturation was reached fairly early on. The remaining tapes were all listened to and coded.
Analysis
The review questions were used as the main focal points of analysis for the data and the interview data was analysed using a systematic thematic analysis method. An initial coding frame was developed from the categories used for the literature review to enable comparison and synthesis of the interview data with that from the review. Each interview transcript was coded and summary notes and memos made in the margins. This was carried out for all the transcribed data (60% of total data set). The remaining taped data was then listened to and data extracted in relation to the identified codes and themes.

4.3.3 Synthesis
Findings from the literature review and the consultation with community informants were drawn together to provide a description of the language and terms used to describe mental wellbeing by Chinese and Pakistani communities, the conceptualisations of mental wellbeing, the factors influencing these conceptualisations, the strategies used by these communities to maintain and promote mental wellbeing or prevent mental illness, comparisons with the majority population and the implications for further research. The information has been organised to answer the review questions above (see Sections 6 and 7). A glossary of terms used by informants can be found in Appendix 7).

4.3.4 Ethical considerations
As the project involved consultation with community workers rather than NHS patients, it was not necessary to obtain NHS Ethical Committee Approval but approval was applied for and given by the University’s Faculty of Health Ethics Committee. Information about the study was given or sent to key informants and community organisations and this laid out:

- the aims of the study and purpose of the interview
- the areas that the consultation group or interview will cover
- consent and the right to refuse
- confidentiality
- what will happen to the information that is collected.

Participants were asked if they have any questions about their involvement before the interview commenced and were asked to give written consent at the beginning of the interview for the interview to be recorded.

Confidentiality was stressed both in the written information circulated prior to and at the beginning of the interview. All information given during the course of the interviews will be treated confidentially and the anonymity of all participants in the study was assured.

4.4 Exploration of the relevant methodology literature
A rapid review was undertaken to identify key publications and reviews of methodologies for research with Black and minority ethnic communities from 1990. The search strategy focused on web-based sources that were known to
the authors to have specific expertise in this area or be undertaking research on BME communities and included:

- Scottish Government, Department of Health, Department of Communities and Local Government and Care Services Improvement Partnership (CSIP), non-government organisations such as the Civis Trust, the Mental Health Foundation and the Scottish Development Centre and Universities known to be undertaking relevant mental health-related research with Black and minority ethnic communities

- Examination of national databases specifically the Kings Fund; the CSIP library database, CRE, Joseph Rowntree Foundation, Social Care Online.

In addition a basic search of two bibliographic databases (Medline and Cambridge Web of Knowledge) was also undertaken. The search terms used were research methods, participatory research, community engagement and Black and minority ethnic and the search was not restricted to health or mental health. Strict inclusion criteria were not applied as this was essentially an exploratory exercise to scope what was readily accessible.

The results of the rapid appraisal and from the methodology literature review have been used to build an annotated bibliography for use in the second phase of the study (Appendix 8). The results of this are included in Section 9 together with the methodological issues identified during the course of the review and observations from interviewees about methods for future research. Information about methods for undertaking research on mental wellbeing with Chinese and Pakistani communities was extracted from the material that had met the study inclusion criteria for the literature review on conceptualisations of mental wellbeing and from interview data, where interviewees had explored methodological issues. The results of this have been combined and are reported in Section 10.

4.5 Limitations
There are five main limitations to this scoping exercise, the first two reflecting that this is a scoping review. First, the search for grey literature was limited and given the relative shortage of published material it is important to extend the search in the next phase. Whether this will lead to the identification of a significant amount of additional material may be unlikely, given the feedback from experts in this area. Second, the depth of the analysis in all elements is limited as the aim has been to provide an overview of the key issues. However data capture, particularly in the fieldwork element has been good and consideration should be paid to undertaking further analysis of existing data as part of the next phase of this project. Third the majority of fieldwork was undertaken by an English-speaking researcher who was also fluent in Urdu and Punjabi and supported in the analysis by a colleague, also fluent in both languages. However, the research team did not have the same capacity in relation to Chinese languages and this is a major weakness as English was the second language for a number of participants. Fourth there was a significant gender imbalance in the sample with the ratio of women: men being 5.6:1. This reflected the sampling strategy of recruiting via community organisations where there are more women workers in community worker
roles. This is a potential source of bias and will be taken into account in the interpretation of the results from the fieldwork data.

Finally, the extent of involvement of people from Chinese and Pakistani communities in the research design and process has been limited. Involvement of people from these communities has the potential to increase the validity and quality of research (Beresford, 2005) and therefore needs consideration in any subsequent work.

5. Review of the literature

This section provides the results from the literature review element of the scoping exercise. 5.1 provides an overview of the material that was identified and the following sub-sections a summary by country of origin. The main themes from this material are summarised in Sections 6, 7 and 8 together with the findings from the interviews with the community informants.

5.1 Overview of the material identified

A total of 5,264 papers were identified, with a significant number of duplicates. Once these were removed 4,006 papers were filtered and those that did not meet the inclusion criteria were excluded either on the basis of date, the paper’s scope, the population considered or if it was clear that it was not available in English. This left 508 papers and of these it was possible to retrieve 461 papers (90.7%). These were subsequently filtered again and 140 papers that met the criteria for inclusion as either a primary or secondary source were left. Appendix 4 provides an overview of the results from each stage of the review and Appendix 5 a bibliography of papers classified by country.

5.1.1 Breakdown by country

The majority of the material identified that met the inclusion criteria related to Chinese populations, with the majority coming from China. Figure 1 provides an overview of the material identified by country and Figure 2 a breakdown by country and ethnicity.
5.1.2 Participants
As Figure 2 indicates, not only is there a significant amount of material from China but Chinese communities have been a focus of interest in a broad range of countries, reflecting their mobility and patterns of migration. The relatively small number of papers relating to Pakistani communities (12) come from Pakistan or the UK, with one paper from Europe. In the UK there are nearly twice as many papers relating to Pakistani communities as to Chinese communities (1.7:1) when papers focused on South Asian communities in general, but inclusive of Pakistani communities, are taken into account. Papers from Scotland all considered BME communities in general, inclusive of Pakistani and Chinese communities.

Excluding theoretical papers and commentary, Figure 3 indicates that the papers from Scotland, the rest of the UK and other English-speaking countries mainly relate to adults of working age. Of the five papers identified from Scotland, one related to promoting mental health and wellbeing in later life (Grant, 2007). In contrast China has a spread of interest and young people are particularly well represented. It is likely that this reflects cultural values as the importance of both children and older people underpinned by a concept of filial piety was referred to in some of the literature (see Davis, Tang & Ko, 2002 for example). It also reflects the work of one particular researcher Daniel Shek, whose work accounts for 76% of the Chinese papers on children and adolescents, some of which also include parents. The material from the US and Canada that focused on children and adolescents tended to be authored by Chinese Americans. The analysis also indicates a general bias towards young people, as a substantial number of studies in China and Non-UK English speaking countries have looked at University undergraduates.
It needs to be noted that the age bands used here are indicative only as the definition of adulthood and older age differs across ethnic groups and studies. Broadly speaking, the under 18 group refers to children and adolescents, 18-50 adults of working age as the studies of both communities tended to define people over 50 as elderly. Age emerges as a complex and relative concept in both communities. It is based on cultural expectations of being looked after in relation to the Chinese community and on the ages of their children and thus their traditional roles within the household rather than chronological age for the Pakistani community (Hussain, 2006).

5.1.3 Type of material
Using the keywording strategy the material was classified according to its primary focus as outlined in Table 2. The type of material retrieved is depicted in Figure 4. As can be seen the majority of this material relates to cross-sectional and longitudinal surveys. Again this reflects the extent of research undertaken by Daniel Shek and mainly refers to research on Chinese communities in China. Of note is the relatively small number of qualitative studies (i.e. emic) compared with the substantial number of cross-sectional and longitudinal surveys using validated measures (i.e. etic). Three papers relating to intervention studies were identified; one from Pakistan (Gater & Rehman, 2001) and two from China (Lee & Loke, 2005; Shek & Chow, 2006).
Table 2: Keywording scheme for type of papers

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical</td>
<td>Description or development of a theoretical perspective</td>
</tr>
<tr>
<td>Literature review</td>
<td>Review of literature</td>
</tr>
<tr>
<td>Service description</td>
<td>Description of a project or a service</td>
</tr>
<tr>
<td>Needs analysis</td>
<td>Assessment and analysis of needs, usually in relation to mental illness</td>
</tr>
<tr>
<td>Surveys</td>
<td>Cross-sectional or longitudinal surveys, usually of factors influencing mental wellbeing</td>
</tr>
<tr>
<td>Intervention study</td>
<td>An investigation of the outcomes of an intervention, namely a mental health improvement intervention</td>
</tr>
<tr>
<td>Instrument validation</td>
<td>Validation of the psychometric properties of a rating scale or other instrument with a Chinese or Pakistani population</td>
</tr>
<tr>
<td>Qualitative studies</td>
<td>In-depth studies, involving narratives, in depth interviews and focus groups</td>
</tr>
<tr>
<td>Policy</td>
<td>Statement of policy, usually related to prevention of mental illness</td>
</tr>
<tr>
<td>Commentary</td>
<td>Relevant opinion or observations but not directly derived from a theoretical or empirical analysis</td>
</tr>
<tr>
<td>Other</td>
<td>Material not fitting any of the above categories</td>
</tr>
</tbody>
</table>

Figure 4: Analysis of material by focus (N = 140)

5.2 UK material
124 papers from the UK were filtered and 32 identified as meeting the criteria for inclusion, with 2 papers relating to the same study and 3 to guidance on mental health promotion with BME communities published by National
Institute for Mental Health England (NIMHE). The majority of papers (84%) related to Chinese and Pakistani communities in England with 5 papers relating to the Scottish context. As can be seen from Table 3, the focus of the material is diverse with the majority relating to needs assessments, access to services or conceptualisations of mental illness (41%) or mental health promotion policy, guidance or initiatives with BME communities, inclusive of Chinese and Pakistani communities (25%).

The majority of the material is focused on working age adults although a number of studies also included a small number of older people. Two papers were identified that specifically focused on older people (Chan, Ho, Jung et al., 2007; Grant, 2007) and one on children and young people (Bashford, Kaur, Winters et al., 2006). 4 papers related to women and two to men.

There were no papers that clearly addressed the review question in relation to conceptualisations of mental wellbeing in any depth, although one paper did explore lay accounts in relation to general health (Prior, Chun & Huat, 2000). The relevant information was often embedded in studies relating to an assessment of mental health needs or access to services. This in part reflects the inclusion of grey material from the Centre for Ethnicity and Health at UCLan and 8 reports from the community engagement programme. These studies included questions relating to how communities identified mental health or wellbeing and strategies used by these communities to maintain their mental health or prevent mental health problems but did not probe the issues in any depth.

A small number of papers were included because they provided significant detail on conceptions of the aetiology of mental illness and it is possible to draw out the implications from these papers for the conceptualisation of wellbeing as possible hypotheses for further exploration. Table 3 provides a summary of the focus of the UK material and Appendix 6 the detail of the papers relating to empirical studies. One paper provides a comparison between British Pakistanis, British Europeans living in the UK and people living in Pakistan (Sheikh & Furnham, 2000) and two papers compare people from different generations (Furnham & Li, 1993; Sonuga-Barke & Mistry, 2000).
Table 3: Focus of UK material by ethnic group

<table>
<thead>
<tr>
<th>Focus of paper</th>
<th>Ethnic focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay beliefs of wellbeing or happiness</td>
<td>1 Chinese</td>
</tr>
<tr>
<td></td>
<td>2 Pakistani</td>
</tr>
<tr>
<td></td>
<td>1 Muslim</td>
</tr>
<tr>
<td></td>
<td>2 Asian</td>
</tr>
<tr>
<td></td>
<td>2 BME</td>
</tr>
<tr>
<td>Factors affecting mental health or wellbeing</td>
<td>1 Prior, Chun &amp; Huat (2000)</td>
</tr>
<tr>
<td></td>
<td>1 Sonuga-Barke &amp; Mistry (2000)</td>
</tr>
<tr>
<td>Mental health needs assessment and service use</td>
<td>2 Li &amp; Logan, (1999) Chan, Ho, Jung et al. (2007)</td>
</tr>
<tr>
<td></td>
<td>1 Saeed, Sarwar, Younas, Yunis, (2006)</td>
</tr>
<tr>
<td>Conceptualisation of mental health problems and/or mental illness</td>
<td>1 Hussain (2006)</td>
</tr>
<tr>
<td>Meaning of and/or tackling stigma</td>
<td>1 Glasgow Anti-Stigma Partnership (2007)</td>
</tr>
<tr>
<td>Awareness raising/training materials</td>
<td>1 Yeung (2002)</td>
</tr>
<tr>
<td>Mental health improvement</td>
<td>2 CMHA, (2007) NIMHE (2004a) also NIMHE (2004c)</td>
</tr>
<tr>
<td></td>
<td>3 Carpenter, Imitiaz and Noguer, 2003 NIMHE (2004b) also NIMHE (2004c)</td>
</tr>
<tr>
<td>Treatment of mental health problems through non-Western means</td>
<td>1 Macioca (1994)</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>7</td>
</tr>
</tbody>
</table>
5.3 Material from China

Just over half of the material identified for inclusion is from China (51%). Figure 5 provides a map of the different types of material using the classification described in Table 2. The largest category is cross-sectional and longitudinal studies using validated measures (n = 54). These have explored the contribution of a broad range of factors, including parental characteristics (e.g. Shek, 1999; Shek, 2007), coping styles (e.g. Wong, Leung & so, 2001; life events (e.g. Boey & Chi, 1998), living situations including inter-generational support(Chen & Silverstein, 2000; Zhang & Liu, 2007; C) socio-economic status (e.g. Davis & Tang, 2002) and their relationship to mental wellbeing, which is usually termed psychological wellbeing or happiness. A small number of papers have considered generational differences and in contrast with the material from the UK, the Chinese material covers the whole age range. There is a significant amount of material on adolescents, reflecting Shek’s work at the Chinese University of Hong Kong and 18 of his papers are included (e.g. Shek, 1999; 2003; 2007). The populations considered are also diverse in terms of socio-economic status and area of residence, with the majority of papers referring to Hong Kong although there is a significant amount of material relating to Taiwan (e.g. Luo, 1995, 2005) and Mainland China (e.g. Liu, 2006).

Figure 1: Map of the material from China

A smaller number of theoretical papers (n=10) provide a useful exploration of the philosophical influences, particularly of Confucianism and Taoism on
conceptualisations psychological wellbeing and happiness with several authored or co-authored by Lu (e.g. Lu & Shih, 1997; Lu, 2001; Chan, Ho & Chow, 2001; Pan, 2003). These include comparisons between Eastern and Western approaches to conceptualising mental wellbeing (e.g. Lu, Gilmour & Kao, 2001).

This material appears to be the most relevant and comprehensive in relation to the review question. However there are very few qualitative in-depth studies or narratives in relation to mental wellbeing. The utility of some of the material, particularly the cross-sectional surveys where measures developed on non-Chinese populations is questionable. The extent to which the findings from this material can be applied to Chinese communities in Scotland is obviously debatable.

5.4 Material from Pakistan
Seven papers were identified, three of which related to policy or service developments in Pakistan. Two were included for their reference to a School mental health programme, a mental health promotion initiative (Gater & Rehman, 2001; Goldberg, Malik, Mubbashar et al., 2000) and the third for outlining strategies for prevention, which in fact focused on improving access to service provision (Nishtar, Minhas, Ahmed et al., 2004). The remaining four papers relate to cross-sectional surveys, two relating to women (Stewart, Bond, Zaman et al., 1999; Ali & Haq, 2006), one to medical students and their coping strategies (Shaikh, Kahloon, Kazmi et al. 2004) and the final paper to a study of emotional literacy (Suhail, 2005).

5.5 Non-UK English speaking countries
5.5.1 United States and Canada
Twenty three papers were identified from USA and Canada with the majority from the US (91%) focusing on Chinese-Americans. Many of these papers related to ethnic identity and its relationship to wellbeing, acculturation or cultural orientation (see for example Lieber, Chin, Nihira et al., 2001) and factors influencing wellbeing with a small number concerned with coping strategies. All of the empirical studies were either cross-sectional or longitudinal survey using validated measures. There were several papers that drew comparisons with other populations, particularly other ethnic groups, for example, African Americans and native Americans within the US.

5.5.2 Australia and New Zealand
Four papers, three from Australia and one from New Zealand met the criteria for inclusion but did not answer the review question directly. All papers related to Chinese people and three of the papers also included people from Singapore, Indonesia, Korea, Vietnam, Macau and the Philippines (Fan, 1999, Leung, 2001, Neill, & Proeve, 2000) with the results aggregated for all Asian ethnic groups in two papers. Two of the papers were concerned with the psychological adaptation and adjustment to life in New Zealand (Abbott, Wong, Williams et al, 1999) or Australia (Leung, 2001); one a comparison of self-esteem and coping styles analysed in terms of gender and ethnicity (Neill & Proeve, 2000) and one a
comparison of attitudes towards mental illness and knowledge of mental health services between Australian and Asian students (Fan, 1999). All studies looked at young adults, three focusing on undergraduate students and one on older secondary school students (Neill & Proeve, 2000). The contribution of this material to the overall review is weak although the papers are interesting and helpful theoretical points, particularly in relation to acculturation and migration.

5.6 Other European countries
Two English language papers were identified from Europe: one from Norway relating to Pakistani youth (Sam, 2000) and one from the Netherlands relating to Chinese youth (Verkuyten & Kwa, 1994). Both papers were concerned with psychological adaptation and wellbeing of adolescents as a minority. As with the papers from Australia and New Zealand their contribution to the overall evidence is weak but they are useful in highlighting issues in relation to acculturation and wellbeing.

5.7 Cross-cultural comparisons
No papers were identified that systematically compared conceptualisations of mental wellbeing by Chinese and Pakistani communities, with either the majority population in Scotland or in the wider UK. Thirteen papers reported studies comparing aspects of mental wellbeing across different ethnic groups as summarised in Table 4. The majority (69%) of these, including all four papers involving UK populations, were cross-country comparisons. The remaining papers compared populations of different ethnic origin within the same country.

In addition a small number of other papers, predominantly from the US and not included here, have provided comparisons within the same cultural group but with different ethnic identities. For example Yip and Cross (2004) recruited 100 young people of Chinese descent and then divided them into four groups depending on their cultural orientation (Chinese, American, bicultural or other) to examine the relationship between cultural orientation and patterns of mental health and community involvement.
<table>
<thead>
<tr>
<th>Publication details</th>
<th>Populations compared</th>
<th>Focus of comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comparison with UK populations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lu, L., Gilmour, R., &amp; Kao, S. F. 2001, &quot;Cultural values and happiness: An East-West dialogue.&quot;</td>
<td>University students from UK and Taiwan</td>
<td>Relationship between cultural values and subjective wellbeing across East-West cultures</td>
</tr>
<tr>
<td>Sheikh, S. &amp; Furnham, A. 2000, &quot;A cross-cultural study of mental health beliefs and attitudes towards seeking professional help&quot;</td>
<td>British Asians (incl. Pakistani); White Westerners (English &amp; European) and Pakistani residents in Karachi</td>
<td>Relationship between cultural beliefs and causes of mental distress and attitudes associated with seeking professional help</td>
</tr>
<tr>
<td>Furnham, A. &amp; Cheng, H. 1999, &quot;Personality as predictor of mental health and happiness in the East and West&quot;</td>
<td>University students from UK, Japan and Hong Kong</td>
<td>Personality correlates of happiness</td>
</tr>
<tr>
<td><strong>Comparison with North American populations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lu, L. &amp; Gilmour, R. 2004, &quot;Culture and conceptions of Happiness: Individual Oriented and Social oriented SWB&quot;</td>
<td>White Caucasian undergraduate students in the US. Results compared with results from an earlier study of Chinese students.</td>
<td>Conceptions of happiness</td>
</tr>
<tr>
<td>Shaw, W. S., Patterson, T. L., Semple, S. J., Grant, I., Yu, E. S., Zhang, M., He, Y. Y., &amp; Wu, W. Y. 1997, &quot;A cross-cultural validation of coping strategies and their associations with caregiving distress&quot;</td>
<td>Caregivers of patients with Alzheimer’s disease in Shanghai, China and San Diego, US.</td>
<td>Coping strategies and relationship to mental health</td>
</tr>
<tr>
<td><strong>Comparison with Australian populations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fan, C. 1999, &quot;A comparison of attitudes towards mental illness and knowledge of mental health services between Australian and Asian students&quot;</td>
<td>Asian, including Chinese, and Australian students</td>
<td>Attitudes towards mental illness and knowledge of mental health services</td>
</tr>
<tr>
<td>Lu, L. &amp; Shih, J. B. 1997, &quot;Sources of happiness: A qualitative approach&quot;,</td>
<td>Adults living in Taiwan-responses compared to Western responses to happiness on Oxford Happiness Inventory (OHI)</td>
<td>Perceived sources of happiness</td>
</tr>
</tbody>
</table>
5. 8 Qualitative studies

Seven qualitative, or emic studies, whose main focus was exploring understandings or beliefs relevant to mental wellbeing were identified as summarised in Table 5. They used a variety of methods to obtain rich descriptions of the meanings of health-related concepts or cultural beliefs. It is worth noting that qualitative methods were widely used within needs assessment studies but have not been included here because their primary focus was understanding needs, often related to mental health problems.

Table 5: Papers identified using qualitative methods to explore meanings of health and mental health

<table>
<thead>
<tr>
<th>Publication details</th>
<th>Participants</th>
<th>Country</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chan, E. A., Cheung, K., Mok, E., Cheung, S., &amp; Tong, E. 2006, &quot;A narrative inquiry into the Hong Kong Chinese adults' concepts of health through their cultural stories.&quot;</td>
<td>5 Chinese adults in Hong Kong</td>
<td>China</td>
<td>Unstructured interviews to explore how Hong Kong Chinese adults understand the meaning of health and the ways by which they construct and express these meanings in their lives.</td>
</tr>
<tr>
<td>Saeed, Sarwar, Younas et al., 2006, &quot;Report of the Community Led Research Project Focussing on Self Defined Mental Health Needs of the Muslim Community&quot;</td>
<td>Muslim men and women aged 16-40 years</td>
<td>UK</td>
<td>Participatory research involving 6 focus groups and 10-15 interviews.</td>
</tr>
<tr>
<td>Gilbert, P., Gilbert, J., &amp; Sanghera, J. 2004, &quot;A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby.&quot;</td>
<td>South Asian women</td>
<td>UK</td>
<td>Focus groups to explore the views on the processes of izzat, shame, subordination and their impact on mental health.</td>
</tr>
<tr>
<td>Hussain, N. 2006, &quot;Culturally determined care goals and the efficacy of statutory services.&quot;</td>
<td>Older Pakistani-Punjabi immigrants, statutory healthcare service providers and traditional Pakistani healers</td>
<td>UK</td>
<td>Qualitative interviews using interviews to generate personal narratives to explore how culturally determined understandings of good mental health and distress of, and of how these impact on the help-seeking process.</td>
</tr>
<tr>
<td>Lu, L. &amp; Shih, J. B. 1997, &quot;Sources of happiness: A qualitative approach&quot;,</td>
<td>Adults living in Kaohsiung, Taiwan</td>
<td>China</td>
<td>Open ended interviews to identify sources of happiness</td>
</tr>
<tr>
<td>Prior, L., Chun, P. L., &amp; Huat, S. B. 2000, &quot;Beliefs and accounts of illness. Views from two Cantonese-speaking communities in England&quot;</td>
<td>Cantonese-speaking Chinese adults living in two urban areas, one in North and one in South of England</td>
<td>UK</td>
<td>To examine lay accounts of illness and health using focus groups with vignettes to stimulate discussion.</td>
</tr>
</tbody>
</table>
6. Chinese communities

In this section the key findings in relation to Chinese communities are discussed. Information is drawn from the literature review on conceptualizations of mental wellbeing and the key informant interviews.

6.1 Language and key terms used to describe mental wellbeing

6.1.1 Findings from the literature review

The mental health section of British Chinese Community website, Dim Sum\textsuperscript{13}, heads the section on mental health: ‘Mental health Happiness, Prosperity and Peace’ apparently linking mental health and wellbeing to material and spiritual wellbeing. Happiness emerges as the most widely used term and Lu & Shih (1997) identify \textit{Fu or fu qi} as the closest equivalent Chinese terms with Lu (2005) providing an overview of the origin and development of the term. \textit{Kualie} in Cantonese (Prior, Chun & Huat, 2000) and \textit{fa lok} are also mentioned (Yip 2005). Other Chinese terms used include \textit{wor} (harmony), \textit{sim on} (an internal sense of security) and \textit{tin yu} (relaxed) (Yip, 2005). As is explored in 6.2 these terms do not necessarily refer to the same concepts as in the Euro-American tradition (Lu, 2005).

Psychological wellbeing, subjective wellbeing and happiness are also found extensively throughout the Chinese literature with the first two to most often found in papers describing surveys that are using adapted Western measures. The terms mental health and mental wellbeing are also used, predominantly in the research literature but Chan, Ho, Hun et al., (2007) observed that they may have less meaning within Chinese communities.

6.1.2 Findings from interviews with community informants

When the term mental wellbeing was introduced interviewees tend to initially think of mental health problems and negatively associated it with mental illness. The terms depression or sadness were used as generic terms for mental health problems and viewed as being more socially acceptable than other terms that might denote mental illness. The terms happy and not happy, feeling OK and Chinese words (e.g. \textit{jing sun}) were mentioned to capture a sense of mental wellbeing.

6.2 Conceptualisations of mental wellbeing

6.2.1 Findings from the literature review

Happiness emerges as the main construct but has a fuller meaning than positive mood and the absence of negative mood as typically found in literature following the US school of thought (Ryan & Deci, 2001).

Lu and Shih (1997) describe the Chinese conception of happiness in folk wisdom as including material abundance, physical health, virtuous and peaceful life and

\textsuperscript{13} \url{http://www.dimsum.co.uk/}
relief from death anxiety. Older people in Manchester used the term happiness and defined it in terms of being content with life, absence of worry, family welfare, social connections and freedom from physical illness (Chan, Ho, Hun et al., 2007). Prior, Chun & Huat found strong agreement that a healthy life was to be achieved through happiness, contentment and an inner sense of balance, which is echoed in the recent mental health needs assessment undertaken in Glasgow (GAMH, 2006).

In a qualitative study of sources of perceived happiness Lu and Shih (1997) interviewed community residents at a large square in the centre of Kaohsing, Taiwan. From these interviews they developed a nine-category classification:

- gratification of need for respect
- harmony of interpersonal relationships
- satisfaction of material needs
- achievement at work
- being at ease with life
- taking pleasure at other’s expense
- sense of control and self-actualization
- pleasure and positive affect
- physical health.

Lu (2005) subsequently identified the following defining aspects of Chinese conceptualisations of happiness:

- happiness as a dynamic process of being in harmony with oneself and others - “a harmonious homoeostasis within the individual as well as between the individual and his surroundings” (Lu, 2005, p. 103)
- an emphasis on spiritual enrichment over hedonistic satisfaction and therefore happiness is more than a reflection of objective reality
- a dialectical view where “happiness and unhappiness are viewed as locked in a never-ending relationship of interdependence: each depends on the other for contrast and meaning” (Lu, 2005, p. 102)

In general, concepts of health and wellbeing are associated with values relating to role obligation, harmonious social relationship and priority afforded to the collective, as opposed to individual good (Chan, Cheung, Mok et al., 2006). Liu, Tein, Zhao (2004) observe that traditional Chinese values stress collectivism, cooperation, modesty, courtesy, academic achievement, in-group harmony and hierarchical relationships. They contrast this with Western culture, with its emphasis on individualism, competition, independence and equality of relationships. In relation to mental health, Yip (2005, p. 395) observes:

“Traditional Chinese concepts of mental health encourage Chinese people to restrain emotion, avoid interpersonal conflict and suppress individual rights so as to maintain harmony with others and the law of nature”.

31
Four main influences were identified that shape these traditional cultural beliefs, particularly evident in the material from China: Chinese folk beliefs such as Ancestor worship, Confucianism, Taoism and Buddhism. There is most literature relating to Confucianism and Taoism, both of which are viewed as having a powerful influence on traditional Chinese values.

**Confucianism**
Confucianism is described by Lu and Shih (1997) as the dominant value system, which has shaped Chinese culture and beliefs for many centuries. Their 1997 paper provides a useful description of the key elements of the Confucian belief system which influence Chinese people’s conception of happiness. These are:

> “An emphasis on social interaction and collective welfare, placing the family at the centre of one’s life so that “contributing to society is the ultimate happiness, whereas hedonistic striving for happiness is regarded as unworthy or even shameful”

(Lu and Shih, 1997, p. 184).

Confucianism advocates that one should strive to expand and preserve the vitality of one’s family. To achieve this goal, one must work hard and be frugal to accumulate material resources, obtain respectable social status, suppress selfish desires, lead a virtuous life and fulfill one’s social duties. The emphasis on social interaction found in Confucianism provides a basis for understanding the Chinese conception of happiness (Lu and Shih, 1997). Confucianism stresses the hierarchical and ordered nature of the world which has a place for every person, with duties appropriate to that position. As Rybak et al (2002, p. 46) observe this means that “a psychologically healthy state is achieved by living in wise accord with the order of the world, with an emphasis on social order and active living.” Yip (2005) describes the internal and external requirements for an individual to maintain his/her mental health that arise from Confucianism:

> “In Confucianism, internally a mentally healthy individual is a self-cultivated individual with a purified mind, a well disciplined manner and mild expressions of emotion. Externally s/he is humane, righteous, faithful and forgiving in interaction with others. S/he is fully aware of his/her rights and responsibilities in his/her social status.”

(Yip, 2005, p.394)

**Taoism**
In comparison with Confucianism, which focuses on worldly matters and obligations, Taoism concentrates on the transcendence and mystical aspects of the world (Rybak et. al, 2002). Taoism emphasises non-action (wu-wei), tranquility brings clarity. Three papers by Kam-shing Yip provide a helpful overview of the influence of Taoism on Chinese concepts of mental health. Yip (2005) identifies Taoism as the most influential religion in China and in Taoism, mental health is described as “an ultimate peace of mind and absolute happiness in relating to the universe” (Yip, 2005, p.394).
Key concepts within Taoism are transcendence from self and secularity; dynamic revertism referring to everything in the world being relative to its complement; integration with the law of nature and high level transformation and transcendence. Yip (2004, 2005) compares the Taoist concept of mental health with the Western concept of mental health as summarised in Table 6. Traditional Chinese Medicine (TCM) drawing on Taoism defines mental health as the balance of yin and yang and an equilibrium of the five elements – metal, wood, water, fire and earth (Chan, Ho & Chow, 2001).

Table 6: Analysis of Taoist concepts of mental health adapted from Yip (2005, p.39)

<table>
<thead>
<tr>
<th>Taoist concept of mental health</th>
<th>Western concept of mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-transcendence versus self-development</td>
<td>Realising individual potential, feelings of self worth and positive self image</td>
</tr>
<tr>
<td>Meaning of values of self transcends the standards and perceptions of others</td>
<td></td>
</tr>
<tr>
<td>Law of nature versus social attainment</td>
<td></td>
</tr>
<tr>
<td>Social attainment is untrustworthy and temporary and all personal endeavours are in vain; blessing and suffering are relative and one should transcend beyond social attainment to the law of nature</td>
<td>Social attainment in the form of social functioning, social adjustment and achievement is crucial to positive mental health</td>
</tr>
<tr>
<td>Inaction versus progressive endeavour</td>
<td></td>
</tr>
<tr>
<td>All personal efforts are in vain and to be integrated into the law of nature, a ‘state of natural silence’ should be kept by the individual</td>
<td>Self-competence and assertiveness to pursue personal goals are valued.</td>
</tr>
<tr>
<td>Infinite frame of reference versus personal interpretation</td>
<td></td>
</tr>
<tr>
<td>An infinite frame of reference encouraged and instead of being confined by human limitation should transcend beyond life and death and pursue eternity.</td>
<td>Subjective feelings of wellness or wellbeing</td>
</tr>
</tbody>
</table>

**Strategies of being**

Wong and Tsang (2004) are critical of the adoption of classical philosophical systems being used as distinctive features of a cultural group and this is explored in more detail below. In their Canadian study of Asian women, which included Chinese women from Hong Kong and mainland China, they did not find evidence for the emphasis placed on Confucianism. Rather mental health is experienced in a very broad way, it has multiple articulations and demands that the uniqueness of individual experience is recognised and that individual women will privilege different ideas in representing their views and experience. They therefore conclude by arguing for a conceptual shift from mental health to strategies of being.
**Operationalising mental wellbeing**

Mental wellbeing has been extensively operationalised and is typically measured either by multi-dimensional inventories, which include questions on subjective satisfaction as well as objective dimensions and symptoms of distress (Zhang & Liu, 2006) or by the use of a battery of inventories measuring different dimensions. In the studies by Shek identified for inclusion in the review, for example, he uses the same measures across several different studies to measure psychological wellbeing and these include measure of life satisfaction, self esteem, mastery and symptom rating scales. Examples of some of the main measures identified are provided in Table 7. Many of these studies use measures of mental health status that are designed to detect mental health problems, particularly the General Health Questionnaire (GHQ), which has been adapted for use with Chinese populations.

**Table 7: Example of measures for operationally defining mental wellbeing identified in Chinese papers**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Scale</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Geriatric Depression Rating Scale (Chinese version)</td>
<td>Lam &amp; Boey. (2005) &quot;The psychological well-being of the Chinese elderly living in old urban areas of Hong Kong: A social perspective&quot;.</td>
</tr>
<tr>
<td>Coping</td>
<td>Coping Strategies scale</td>
<td>Wong, Leung &amp; So - see above.</td>
</tr>
<tr>
<td></td>
<td>Coping Style Questionnaire</td>
<td>Liu et al. (2006) - see above.</td>
</tr>
</tbody>
</table>
6.2.2 Findings from interviews with community informants

It was evident that the concept of mental wellbeing is inextricably linked to other fundamental aspects of life, notably material wellbeing, physical wellbeing and family wellbeing:

“Chinese people define mental wellbeing [as] wrapped up in material wellbeing. Like [having] your basic needs met but basic also includes your children getting a good marriage and knowing that your children are doing well, if they are at school, they are concentrating on their studies and that they are [Chinese word meaning obedient] actually, doing what they are supposed to. So that would all be part of the package deal. You couldn’t have your own personal mental wellbeing if your whole family unit and your extended family weren’t also, didn’t have all those conditions.”

(Community worker with Chinese communities)

It was suggested that if someone had these elements of their life in place they would be unaware of the concept of mental wellbeing. Echoing the literature, the concepts of balance and harmony were also referred to but were far from being recurrent themes:

“It’s about balance isn’t it when you talk about yin and yang and harmony. If there is harmony in the family then everyone wins. You are sharing the happiness. Conflicts are submerged. Families have to live together in harmony. In some ways I see goodness mental health as good community wellbeing as a harmonious community and with that comes good health and prosperity.”

(Community worker with Chinese communities)

Participants also indicated that mental wellbeing was commonly conceptualised in relation to the absence of mental illness, particularly for the older generation. Mild mental health problems are viewed as normal and not part of a continuum whereas mental illness is seen as distinct and separate:

“I think for Chinese people they don’t intend to let people know if they have some…for example not very serious mental problem, for example they have pressure and very stressful these kinds of things. They have some kind of
behaviour and they will not think this is something relating to the mental health problem, they just take it, they treat it as normal.”

(Community worker with Chinese communities)

6.3 Factors influencing conceptualisations of mental wellbeing

6.3.1 Findings from the literature review

The main factor influencing conceptualisations of mental wellbeing identified, particularly from the Chinese literature is adherence to beliefs that are Confucianism or Taoist in origin. However Wong & Tsang (2004, p.3) sound a cautionary note arguing that “when traditional or classic philosophical systems are heralded as distinctive cultural features of a given group, it perpetuates the homogeneity assumption and increases the risk of stereotyping”. They point to the way in which Confucianism is assumed to be a powerful force but the impact of communism on Chinese communities is neglected.

The diversity in the Chinese population is stressed throughout the material that was reviewed. The material from non-UK English-speaking countries was largely concerned with the adaptation or adjustment of people from minority ethnic communities. This process of adaptation to the new cultural environment is often referred to as acculturation. The concept of acculturation refers to the process of reconciling cultural differences in terms of values, beliefs, practices and behaviour between an individual's country of origin and their adopted country (Lieber, Chin, Nihira et al., 2001). Lieber, Chin, Nihira et al., (2001, p.248) go on to define ethnic identity as “the degree to which immigrants identify with and derive aspects of his or her self-concept from knowledge about, participation with, and attachment to one’s ethnic group.” Several studies were identified that examined the relationship between affiliation to ethnic identity and measures of psychological wellbeing. These studies are noteworthy because they describe the diversity within Chinese communities in terms of the strength of their ethnic identity (i.e. Chinese, Scottish, Bicultural or other?) and the degree to which people are assimilated within the majority culture. Yip (2005) suggests that Chinese people living in a multicultural country, such as Scotland, may internalise two or more cultural frames for interpreting meaning.

The way in which mental illness is conceptualised was also identified as relevant to the conceptualisation of mental wellbeing as they can be viewed as inextricably linked, reflecting the influence of Taoist philosophy. Further mental illness is construed as either or and the term mental health taken to refer to serious mental illness whereas feelings of anxiety or depression, which are viewed as common mental health problems in the West, are seen as part of everyday life (Prior, Chun & Huat, 2000; Li & Logan, 1999).

Finally age appears to have a bearing on the way in which mental wellbeing is conceptualised by Chinese people. Lu (1995) found age related differences in subjective wellbeing in Taiwan identified that older people were more likely to hold fatalistic beliefs in other words an acceptance that situations cannot be
changed; an approach which is seen as having its roots in Taoist philosophy (Wong, Leung & So, 2001).

6.3.2 Findings from interviews with community informants

There were two aspects to factors influencing conceptualisations of mental wellbeing. First whether the concept of mental wellbeing was identified and second if it was, how it was conceptualised.

Identification of mental wellbeing as a distinct concept

Two overlapping factors emerged in relation to the identification of the concept. The first of these was personal experience of stress or other mental health problems:

“They’ve got the awareness either because they had suffered from mental health problems or they had suffered in life then they knew it was important to keep mentally well. But I think the average person probably doesn’t really think about those things.”

(Community worker with Chinese communities)

The second was generational and exposure to Western models of mental health and wellbeing through education in Scotland:

“My daughter’s generation its different know a lot, talk about from media, professional even for the way we [raise] our children so important looking after yourself not only physically but mental health emphasis important.”

(Community worker with Chinese communities)

The reasons for the relative absence of a concept of mental wellbeing were explored and the following developed through analysis:

Conceptualisation of self

Interviewees referred to a concept of self as defined in relation to others: a social and interdependent self as opposed to an individual and independent self. The themes of connectedness and the role played within the family and the community were recurrent.

Influence of cultural values

An emphasis on practical action as opposed to self reflection as suggested by this interviewee’s response could be interpreted as reflecting the Confucian values identified in the literature:

“I think to a large extent many people don’t have time to consider their unhappiness if you want to use a better term, they just don’t have time because it is more in their cultural practices to be just practical, to just get on with things. It’s an indulgence to have people just hanging around telling each other how sad they are.”

(Community worker with Chinese communities)
**Economic realities of migration**
Alongside cultural values the reasons for and realities of migration also define priorities, mental wellbeing was not viewed as essential compared with meeting basic needs and improving your situation through working hard and making money:

“I think if you look at any new immigrant or new person who has come to a community it takes maybe a generation and they use the Maslow’s hierarchy of need and most people we work with are at the lowest end of the hierarchy in terms of basic needs so they won’t start to address spirituality or religion or anything like that until they’ve got the kind of basic stuff sorted.”

(Community worker with Chinese communities)

**Stigma**
Interviewees identified the stigma associated with mental illness and powerful social taboo about discussing mental health issues particularly the sense of shame in disclosing that there are mental health problems within your family, which will reflect negatively on the family’s reputation:

“People will be more understanding if you said “oh I’m depressed, I’m sad” or things like that, but if you mention that you’ve got a sort of mental condition then people “uh oh, I’d better keep my distance because this person may be dangerous or, you know, violent.”

(Community worker with Chinese communities)

“And also it is a common thing that if you think that people know that they are ill and then they will also … the family will also be blamed, you know, and even the family will be affected.”

(Community worker with Chinese communities)

This partly reflected beliefs held about possession and spirits and as the term mental wellbeing is not common currency, acts as a further disincentive to talking about how you are coping or your mental wellbeing:

“If not well then you are possessed by evil, and tradition where someone comes to cleanse soul, so have evil, possessed evil spirit”.

(Community worker with Chinese communities)

There was also a sense that this is changing and that these beliefs and attitudes are particularly marked in older generations, particularly those who do not speak English.

“But with older people they don’t understand all those terms and if they understand they will not accept. They won’t know because once they accept they’ve got this sort of illness which means they will be an outcast within their community. They won’t be accepted by anyone and they will lose their respect.”

(Community worker with Chinese communities)
The impact of the Mosaics of Meaning work (Glasgow Anti-Stigma Partnership, 2007) and other initiatives to raise awareness as to the meaning of mental health or wellbeing attracted positive comments.

**Factors influencing how mental wellbeing is conceptualised**

Age, generation and education emerged as important determinants of beliefs in relation to mental wellbeing. Associated with age and generational issues are issues in relation to ethnic identity and exposure to Western concepts of mental wellbeing through education in this country:

“I think the younger generation like myself who are educated see it more as… it’s not so much a work to live culture as much as one enjoying themselves so they have a better understanding of their own mental health as in whether they feel depressed as whereas the older generation would say what you’ve got to be depressed for.”

(Community worker with Chinese communities)

**Economic factors**

A person’s wealth is seen as influencing the conceptualisation of mental wellbeing because of the assumption that material wellbeing means happiness because you have no worries:

“I think with the Chinese culture there’s that kind of emphasis like chasing the American dream, that kind of sense that you are going to make it, make money. And that belief that once you have that financial kind of gain you will be happy.”

(Community worker with Chinese communities)

### 6.4 Factors influencing mental wellbeing

#### 6.4.1 Findings from the literature review

Many of the longitudinal and cross-sectional surveys, described predominantly in the Chinese literature, are concerned with examining the associations between a range of different factors and mental wellbeing. They include the impact of life events; social support; social factors such as experiencing economic adversity; parenting characteristics and family environment; living arrangements; personality traits and coping styles. A systematic review of this literature and the contribution of these different factors to mental wellbeing is out with the terms of reference for the current review.

Of particular note is the contribution of the philosophical traditions described above to coping styles and approaches to problem solving. Direct action is viewed by Wong, Leung & So (2001) as reflecting Confucian beliefs of hard work to overcome life’s difficulties whereas acceptance strategies are associated with Taoist philosophy of doing nothing and waiting patiently in times of difficulty (Wong, Leung & So, 2001). However overgeneralisations from this need to be avoided as Wong, Leung & So observed; the choice of strategies may be situation-specific and for example avoidance strategies used in relation to
interpersonal conflicts in order to maintain social harmony (Wong, Leung & So, 2001). Shek (2005) has examined the relationship between cultural beliefs regarding adversity and mental wellbeing. He divides cultural beliefs about adversity into two categories: positive and negative beliefs. Positive beliefs are shaped by Confucian philosophy where strengths and virtues such as perseverance and tolerance are sternly maintained as reflected in the sayings:

“You zhi zhe shi jing cheng”
(Where there is a will there is a way)
Shek (2005)

On the other hand negative beliefs emphasises people’s inability to change adversity and reliance and a belief in fate as illustrated by the saying:

“Hao ming sheng ching”
(Whether a life is good or bad depends on fate)
Shek (2005)

Shek (2005) found an association between positive beliefs and mental wellbeing. He draws out the implications for interventions, notably that there should be an emphasis on promoting positive cultural beliefs and debating negative beliefs about adversity. Shek also suggests that not only might such beliefs have an impact on mental wellbeing but that mental wellbeing may shape cultural beliefs about adversity.

6.4.2 Findings from interviews with community informants

Reasons for and experiences of migration

Consistent themes related to the reasons for migration and life in Scotland coupled with a sense of filial duty, family honour and of being here on behalf of your community:

“I think that’s filial stuff you know, if you get sent overseas as a student or an immigrant worker you have that golden opportunity to better yourself and therefore either reunite with your family or send money home. And I think that duty to provide for your family and your family will support you to do that. Some of it is obviously misguided. We’ve seen stories of the cockle pickers etc that they would do that is heartbreaking and the reason that they do that is because the hardship they experience in China is worth that sacrifice. I sometimes think it’s so misguided it really it is, the little villages that club together all their life savings to send that one golden boy or girl abroad and families are broken up as a result but these are desperate people because the need to repay. They get themselves into a debt situation and it’s not just money debt, it’s debt to people, families, uncles and aunties and richer people so that debt is like an honour thing.”

(Community worker with Chinese communities)

The difference in expectations between the generations was seen as playing a role with the expectations of the older generation being strongly shaped by these
economic realities and experiences of migration. This pattern, described as one of hard work and unrealised ambitions was seen as being repeated by the new group of migrant workers.

Issues in relation to ethnic identity, language and conflict between the generations because of the perceived erosion of traditional cultural values were also identified. Families are central and are viewed as both a source of support but also a stressor with poor family relations or children who do not conform being viewed as a cause of health problems:

“I suppose an important thing to mention in the context of framing mental wellbeing in Chinese culture traditionally, if your children disobey you - not bothering at school, rebelling you know - that would be number one cause for your poor mental health so disobedience.”

(Community worker with Chinese communities)

“Having very good family relationship is very important. Lots of family here, the parents don’t even communicate with children [be]cause of language. Children live in culture and society here and parent’s expectation on kids very different so [it] creates [an] atmosphere, conflict, unhapp[iness]. So even in family structure [there can be] no dialogue, language and cultural expectation different, children want to stay out all night with friends parents don’t. [Be]cause of this kids don’t open up to parents so they don’t understand. [It] creates tension and tough, parents suffer emotionally and children suffer.”

(Community worker with Chinese communities)

The impact of these generational differences and difficulty accepting them and the potential loss of the support of your children in your old age was identified as having a significant impact on mental wellbeing, particularly of middle-aged women.

**Gender**

The issue of the imbalance of power between men and women was raised, particularly for women who are newly arrived in this country and who may face restrictions being placed on them by a partner. It was also suggested that there are pressures on men to ‘keep face’ and appear strong, thus influencing their willingness to discuss mental wellbeing and related issues.

**Language barriers**

Being unable to speak English was identified as contributing to isolation, lowering confidence; compromising integration into Scottish society and making it harder to understand unfamiliar concepts such as mental wellbeing.

**Isolation**

This was identified as a particular issue for Chinese people living in rural communities, who are isolated both from the majority community and also the Chinese community and where there is a lack of resources for Chinese people. This was seen as having a significant negative impact on mental wellbeing.
6.5 Improving mental wellbeing

6.5.1 Findings from the literature review
There is a relatively extensive literature, much of which has looked at coping styles and cultural values, relevant to maintaining mental wellbeing. For example, Yeung (2002) writes that Chinese people do not like to confront or challenge people in case it causes disharmony in social relationships and that traditional values of moderation and avoidance of excesses of emotion were designed as preventative measure against disruption of a balanced bodily function (Yeung 2002).

Scant material was identified that focused on strategies developed by Chinese communities in Scotland or the rest of the UK to promote mental wellbeing and prevent mental illness. The need for raising mental health awareness, namely knowledge of mental illness and for social activities was highlighted. Two papers that described specific initiatives were identified and are essentially concerned with improving access to services either through improving awareness of mental health issues in the Chinese community or by raising awareness of staff working in mental health services of the cultural heritage of Chinese communities. The first of these initiatives is the Multimedia Mental Health Project developed by the Chinese Mental Health Association and is targeted at reducing stigma and increasing awareness of mental health issues using a range of media formats, TV, user-led newsletter and translated information. A recent evaluation concluded that it had contributed to raising awareness and improving access to mental health services (CMHA, 2006). The second initiative, Endurance, is a training and resource pack for mental health professionals (Yeung, 2002).

Guidance has also been developed by the National Institute for Mental Health England (NIMHE) for mental health promotion specifically with Chinese communities and generally with BME communities. This guidance makes it clear that the definition of mental health will be influenced by culture, background, beliefs and spirituality and draws a comparison between Eastern and Western thought in relation to mental health. The guidance goes on to outline the risk factors for Chinese communities. It stresses the importance of engaging and working with Chinese and BME communities to design and develop appropriate interventions. Potential interventions include raising awareness, staff training, increasing access to employment and training opportunities, supporting mental health service user groups and carers, promoting holistic approaches, tackling stigma and discrimination, promoting social support and reducing isolation and tackling racism and discrimination.

6.5.2 Findings from interviews with community informants
The strategies mentioned by interviewees were:

Religion
Although the number of people who follow a religion was seen as variable, there
was strong agreement that the importance of religion for these communities is growing in Scotland. A diversity of religious beliefs was mentioned; Christianity, reflecting the missionary influence in China and being the majority religion in Scotland, Confucianism, Buddhism and Ancestor worship. The way in which they help people maintain their mental health, seems to be similar in terms of prayer, providing spiritual comfort and a social network.

Education
The importance of demystifying mental health issues and addressing stigma was repeatedly stressed but its role in terms of increasing self-awareness and reflexivity was also highlighted.

“We’re finding education quite useful here, public health awareness, public education, any sort of education creates an opportunity for someone to start thinking for themselves and to look at themselves and to look at their own awareness and say “I think I might need to talk to somebody. I think I might need to go out and even expose myself out of my family and to tell someone outside my family that I’m not coping”.”

(Community worker with Chinese communities)

Examples of well known people from the Chinese community who have had a mental illness and can share their story of recovery are being sought to help change attitudes. Such educational activities are predominantly focused on raising awareness of mental illness but there was evidence that this was being developed to introduce a broader concept of mental wellbeing.

Activities
The importance of activities, such as dancing and Tai Chi classes, developing hobbies and sharing mutual interests with friends was seen as particularly important for older people.

Opportunities to link with identity and culture
The internet, Chinese TV channels, Chinese news channels, Chinese music, films and opportunities to link back with the home county and with family, friends and Chinese people in Scotland were identified as important. They serve to strengthen identity and a personal sense of who you are. The importance of having choices in relation to your identity was also stressed:

“At the end of the day I think it’s about going through that journey and being able to choose. I think in the past people didn’t have those choices of who they were or how they wanted to identify in terms of ethnic(ity) or how you would define yourself. A lot of it is like self identification but we challenge people who don’t have a choice but we might have lived here all our lives but the perception of other people of us is that where are you from? Explain yourself”.

(Community worker with Chinese communities)
Reference was made to the positive impact of awareness raising campaigns and projects such as Kim Hong (Good Health) in Birmingham, and initiatives that had taken place in Glasgow, particularly the Mosaics of Meaning project (Glasgow Anti-Stigma Partnership, 2007). The importance of sustaining these efforts was highlighted if the sense of shame and stigma is going to be tackled effectively.

**Recommendations for good practice in relation to mental health promotion strategies**

The following recommendations for the development of mental health promotion for Chinese communities in Scotland were made by participants:

- All strategies need to take into account that the Chinese community in Scotland is small. The issue of trust, reflecting the concerns about confidentiality and ultimately an avoidance of shame need to be a fundamental consideration. Maintaining a positive reputation within the community is highly important.

- The need for information and resources and the importance of education, which is interactive and tailored to the needs of the Chinese community, was highlighted. The suggestion of linking to physical health was made, as people are more willing to consider physical health issues.

- Strategies to promote mental health need to occur within a context where significant changes to improve access to appropriate mental health care for Chinese people are also taking place.

**7. Pakistani communities**

In this section the key findings in relation to Pakistani communities are discussed. Information is drawn from the literature review on conceptualisations of mental wellbeing and the key informant interviews.

**7.1 Language and key terms used to describe mental wellbeing**

7.1.1 Findings from the literature review

Khan, Choudry, Khurshid et al., (2007) identified the terms ‘dimaghi sehat’ and ‘zehini bemari’ being used by the Pakistani community in Birmingham to refer to mental health. ‘Peace of mind’ was identified as the term to capture mental wellbeing identified by Chopra, Farouk, Haq et al, (2007) and Hussain (2006). Chopra, Farouk, Haq et al, (2007) in their study of women who had experienced domestic violence also used the term ‘feeling good about yourself’ to describe positive mental health. The term happiness was used in a study in Pakistan to examine whether specific indicators of autonomy were related to women’s subjective assessment of happiness using responses to a direct question about current degree of happiness (Ali & Haq, 2006). Finally one study examining the relationship between parenting styles and psychosocial adjustment in Pakistan
(Stewart, Bond, Zaman et al., 1999) used the Current Perceived Health Scale, Satisfaction with Life Scale, Rosenberg Self-esteem Scale and Interpersonal Relationship Harmony Inventory to assess wellbeing and psychosocial adjustment.

7.1.2 Findings from interviews with community informants

Some interviewees used the available English terms which denote milder forms of mental illness, particularly depression, as generic terms to describe emotional or mental health issues:

“I think it’s like anything, you pick one buzz word and you think that’s going to describe my experience. I was thinking if you think about it we all do that, all do it. I would say to someone I was really depressed last week without even thinking of the whole meaning of the word.”

(Community worker with Pakistani communities)

Others labelled anything to do with mental health in a negative way, using term ‘phagal’, which refers to mental illness:

“Depression [is] used more as a term as people understand this better. They don’t understand wellbeing, only use words ‘stress’ and ‘depression’.”

(Community worker with Pakistani communities)

“It’s psychological behaviour, don’t know if there’s softer word. Mental means ‘phagal’ and need to move away from it, even if we say ‘zehni health’ which [means] mental conditions?”

(Community worker with Pakistani communities)

Some thought that there were no terms used on a day to day basis to refer to mental wellbeing, if anything people try not to consider mental health as it is only seen in terms of the negative – illness and due to its stigma there is a need to escape from it:

“[I] don’t think community use any terms – try to escape from that word. If a problem in family or someone in community we’d be the first to abuse that word [be]cause of the way community are. We like to make fun of other people and say someone is going through mental health conditions or got mental wellbeing issue in the family and community stigma and people make fun of other people and when it’s in your family you try and hide it - runaway and tell people all sorts of things”.

(Community worker with Pakistani communities)

Acceptable alternatives are everyday words like ‘feeling happiness’ or content, peace, serenity and good existence’:

“So it’s mindful peace. Rather than translating it into mental it would be better to say mind peace because it gives you a positive word compared to a negative one”

(Community worker with Pakistani communities)
7.2 Conceptualisations of mental wellbeing

7.2.1 Findings from the literature review
Mental health was typically defined in terms of mental illness and/or negative spiritual concepts such as Jinns or black magic, particularly by members of the older generation (Aziz, Hasham, Patel et al., 2007). Hussain (2006) suggests that the term mental health is problematic with ‘mental’ suggestive of ‘madness’, which was viewed as punishment for sins and the concept of mental health is not congruent with the Western concept. Hussain describes a broad concept of spiritual wellbeing termed ‘peace of mind’, which requires optimism, an ability to carry out religious duties and fulfill gender roles. He identifies four key concepts that are critical regarding health and distress- kismet, sabr, purdah and izzat. Family structure, good izzat, with each member observing purdah, and with blessing of God are considered necessary to have peace of mind. Reestablishing family structure, prayer and sabr are ways of rewriting kismet and therefore addressing mental ill-health. Enduring distress without complaint and observing gender roles piously can entice God to ameliorate distress and rewrite kismet (Hussain, 2006).

Ali & Haq (2006) also observe that Islam teaches people to be patient and content in life. This is consistent with the findings from Anand & Cochrane (2005) who found that conceptions of mental health are embedded in a religious, holistic and relational context for Pakistani Muslims. Saeed, Sarwar, Younas et al., (2006) explored the understanding of the relationship between faith, and personal identity and how this impinges on their emotional wellbeing by Muslim people in Bradford. They describe the Islamic way of life as concerned with developing human potential by creating ‘a state of balance to live healthily and rewarding lives’ (Saeed, Sarwar, Younas et al., 2006, p.14). They go on to write:

“The Islamic view of health and wellbeing is holistic and encompasses the whole and is a state of ‘being Muslim’ literally translates as ‘one who submits’. Therefore mental health or wellbeing in Islam is seen as part of the daily practical life and also the observance of religious duties.”

Saeed, Sarwar, Younas et al., (2006, p.14)

Bashford, Kaur, Winters et al. (2006) in their study of children and adolescents also in Bradford, found that young people had a well developed understanding of the term. They saw mental health as being grouped into seven domains; ability, identity, physical health, attributes, feelings, mental ability and behaviour with the majority of responses relating to physical attributes and mental ability.

7.2.2 Findings from the interviews with community informants
The term mental wellbeing was clearly unfamiliar and it clearly has multiple meanings with diversity particularly marked across different generations. Throughout nearly all the interviews it was associated with mental illness and before positive conceptions were explored, the negative aspects were highlighted:
“Mental wellbeing means different things to different people. The word mental is not very friendly. Mental health breaks down and someone who has mental conditions we never specifically think about wellbeing or mental health. The word isn’t something which fits into [our] society. “

(Community worker with Pakistani communities)

And in relation to younger people:

“They accept the language more then parents as talked about at schools youth clubs so familiar and more understanding need for mental wellbeing and keep self safe. They’re familiar with term but don’t know where to go for support advice for their own wellbeing. Understanding the term doesn’t necessarily mean you understand the problems behind it.”

(Community worker with Pakistani communities)

Interviewees explored the reasons why this might be the case and four themes were evident:

**Interconnection with physical health**

There is a greater emphasis placed on physical problems because of their visibility and this is compounded by the absence of everyday language to describe mental health. More fundamentally interviewees talked about physical and emotional experiences not being separate:

“Wellbeing is related to health, they wouldn’t think it’s psychological/mental thing, probably more to do with diabetes, health problems, arthritis, a more physical thing as we don’t really understand emotional psychological factors in our community.”

(Community worker with Pakistani communities)

“I think people automatically think of their physical health before they think of their mental health and I think that’s how the community sees it as well. But again if you asked them to define what mental health or wellbeing is for them….. then obviously to be healthy, to be worry free and all that comes into it.”

(Community worker with Pakistani communities)

**Connection and contribution of cultural beliefs and faith**

Faith and religion were also discussed, both the teachings of Islam in relation to mental wellbeing and the role that faith plays in promoting mental wellbeing:

“For some it is an important part and if religious leaders can take a lead on it they can have a big impact. And they have that control or whatever you call it. They have a role, it teaches you to look after your spiritual wellbeing but [you can do] other things or people can help you alongside with your prayers. You can do both, it’s acceptable and if you keep a positive mind and your spirituality, along with your other things, you recover quicker.”

(Community worker with Pakistani communities)
Stigma related to mental illness
The stigma related to mental illness was a dominant theme and has a profound impact on the way people conceptualise wellbeing:

“The term mental wellbeing has a negative impact on people because of the word 'mental' People don’t wait to see what follows the word, automatically think of illness or negativity and don’t want to talk about it.”

(Community worker with Pakistani communities)

A lack of information and difficulties accessing services
Although a relatively minor theme, this also appears to play a role in inhibiting discussion about mental health related issues.

7.3 Factors influencing conceptualisations of mental wellbeing
7.3.1 Findings from the literature review
The overall picture is that adherence to religious beliefs and cultural values are integral to the way in which mental wellbeing is conceptualised. Age, generation, ethnic identity, cultural orientation, context all appear to have a bearing on adherence to religious beliefs and cultural values and thus conceptualisations of mental wellbeing. In Pakistan Suhail (2005) has identified a relationship between overall literacy and mental health awareness in relation to awareness of symptoms of mental illness. Suhail draws attention to the lack of information, in English, particularly in rural communities in Pakistan reflecting educational provision and communication networks.

7.3.2 Findings from interviews with community informants
The main factor that was identified during the course of the interviews was generation and whether you had been educated in this country, with fluency in English and more familiarity with Western ideas influencing conceptualisations. However it was suggested that the traditional ideas in relation to mental illness are pervasive and younger people are still likely to hold negative attitudes to mental illness:

“With education you are more likely to understand mental wellbeing but still coming from another culture you have that cultural perspective as well and that may shape how you see things (e.g. if you put it down to nazar or possession as a cause compared to say medical problem).”

(Community worker with Pakistani communities)

7.4 Factors influencing mental wellbeing
7.4.1 Findings from the literature review
A number of factors that influenced mental wellbeing were identified from UK papers. The impact of physical health on mental wellbeing (Khan, Choudry, Khurshid, et al., 2007), the experience of racism specifically in Scotland (Grant, 2006; Renfrewshire Association for Mental Health, 2000) and elsewhere in the UK (Saeed, Sarwar, Younas et al., 2006) and the impact of domestic violence for women (Chopra, Farouk, Haq et al., 2007) were all mentioned. The stress on
young people in relation to achievement and to uphold family and cultural traditions were also identified (Khan, Choudry, Khurshid et al, 2007).

Two studies from the UK examined the relationship between specific factors and mental wellbeing. The first by Quraishi & Evangeli (2007) considered whether cultural identity was associated with mental wellbeing (operationally defined by the GHQ, Symptom Checklist 90R and the Positive Feelings Facet of the World Health Organisation’s Quality of Life assessment) for British Asian female university students. Their results did not indicate a relationship between British identity or Asian identity to measures of mental wellbeing. The second study confirmed a relationship between family structure and mental health, using the Hospital Anxiety and Depression Scale as a measurement of psychological wellbeing in adults and the Rutter B2 Children’s Behaviour Scale to assess children’s adjustment (Sonuga-Barke & Mistry, 2000). This study focused on women and Hussain and Cochrane (2004) highlight the need to be aware of the complexity of disentangling gender-specific issues from culture-specific issues in the context of depression and South Asian women.

Two studies were identified, both from Pakistan that had used positive measures of mental wellbeing to identify the contribution of different factors. Ali & Haq (2006) examined indicators of autonomy and their relationship to women’s happiness. They found that education, decision-making and possession of assets were associated with higher levels of happiness. However they also found that not all indicators of autonomy, using data from the Pakistan Socio-economic Survey, were associated with happiness concluding that the concept of autonomy and its relationship with happiness is different in Pakistani society than other societies, particularly Western societies. Stewart, Bond, Zaman et al., (1999) found that parental warmth and training correlated positively with measures of psychological adjustment including measures of life satisfaction and wellbeing.

7.4.2 Findings from interviews with community informants

Gender

The interconnection with family and community was perceived as potentially having a negative impact on wellbeing for women:

“Women haven’t looked after themselves: they think kids, husband, household and have never looked out for themselves to eat properly, do exercise or [have] freedom, go out and socialise – sometimes they do go and get clothes but not too much, some don’t at all.”

(Community worker with Pakistani communities)

Cultural expectations in relation to roles and family living arrangements were viewed as potentially having a detrimental effect on women’s wellbeing, not least because of the demands on time. Isolation, particularly in relation to women with a lack of fluency in English (especially older women and young women recently arrived to marry) is identified as a contributory factor.
Issues for men were also identified in terms of expectations regarding employment, being able to raise sufficient income to support their family and to ensure their children have an education. It was suggested that although men may socialise more than women, they may find it harder to share their difficulties although it was unclear whether the support of social networks was a protective factor in maintaining women’s mental wellbeing. It was however implicit in the way in which the way of life in this country was contrasted with life in Pakistan:

“It’s more community back home if you have children you are visited and all are equally concerned if something goes wrong. And here everyone has own life, its very much individualistic whereas Pakistan community – this individualistic way makes them feel more isolated – they don’t have anyone popping in to say hello how are you, live by themselves, then children are busy, everyone busy they’re all alone.”

(Community worker with Pakistani communities)

**Generational issues**

Cultural issues were highlighted in relation to the integration of second and third generations into Scotland and being able to balance Eastern and Western approaches. For parents, there is concern that children are not maintaining their ethnic identity and for their children concerns about isolation from their Western peers by not being able to join in with their social activities e.g. going out and drinking alcohol. Facilitating communication around these issues might prove a helpful strategy in terms of mental wellbeing.

“The younger have pressures from the Western community given that they are raised here. They feel they have to juggle both cultures in terms [of] language use at home and school, costumes and general social pressures such as drugs, drinking, unemployment, so they’re under pressure to fuse both cultures. Of course this would have an impact on their mental wellbeing. On the other hand first generation Pakistani’s have different pressures including language barriers. They are not so familiar with the British culture and so tend to seek solace within their own family network as this forms their comfort zone”

(Community worker with Pakistani communities)

Further there was a view that the young generation are more likely to look after themselves and their mental wellbeing.

**Socio-economic status**

In particular, the type of employment you have is seen as having a bearing on mental wellbeing. The conditions for shopkeepers are viewed as particularly arduous partly because of their self employed status, which means working long hours, not being able to take a break for holidays or periods of illness, and also the isolation form their networks that can result from this working pattern. By contrast those in professional roles are able to take time off at the weekends and get annual leave.
Language
As noted above language is a barrier to communication and therefore understanding of different ways of framing issues. It can directly affect mental wellbeing by isolating the individual from mainstream society. However it was also identified as protecting against the impact of racism:

“If I’m going along and somebody says any racial abuse words or something I do get upset I do answer them back. Where [as] I can’t imagine my mother-in-law, her English is not that good so she wouldn’t be able to answer back. And that’s why she feels more accepted.”

(Community worker with Pakistani communities)

Racism
Racism clearly has an impact on mental wellbeing:

“Racism – this is important. The media is always portraying something. It's ongoing and as result if people see us wearing shalwar kameez or hijaab get called “paki” and that's not nice and you can’t do anything. That really hurts you sometimes. This affects your mental wellbeing as you feel depressed by this as you haven't done anything. Sometimes people get scared as feel they can be attacked at any time.”

(Community worker with Pakistani communities)

Isolation
Isolation was mentioned in a variety of contexts and was seen as a consequence of language difficulties, intergenerational differences and racism. It was identified as having major impact on mental wellbeing, particularly for older people:

“In this country elderly people very much isolated have a very much generation gap. Young people here speak very good Scottish they don’t speak Punjabi’ Urdu and grandparents have poor knowledge of English and feel isolated - have nothing else to think or worry which leads to depression.

(Community worker with Pakistani communities)

7.5 Improving mental wellbeing
7.5.1 Findings from the literature review
As with Chinese communities, the literature on strategies developed by Pakistani communities to promote mental wellbeing is sparse, with the majority of it in the form of policy guidance or initiatives either in a UK context or from Pakistan.

In the UK, Aziz, Hasham, Patel & Ramzan (2007) identified that carers acknowledged that to maintain their health it was necessary to stay both physically health and mentally well through being active, not experiencing tension, looking after yourself and participating socially but do not provide detail on strategies adopted. The contribution of culture and family traditions to mental wellbeing were identified (Hussain, 2006; Khan, Choudry, Khurshid, et al., 2007). The importance of religious beliefs emerge as central for Pakistani Muslims (Saeed, Sarwar, Younas et al., 2006; Bector, Randhawa, Mehan et al., 2006)
with faith leaders (particularly Alims) identified as playing an important role in making Islamic teachings relevant to people’s experience including their mental health (Saeed, Sarwar, Younas et al., (2006).

The importance of working with and in partnership with BME communities is a recurrent theme from the NIMHE guidance on mental health promotion with Chinese, South Asian and BME communities (DH, 2004). This includes:

- designing and delivering mental health promotion programmes in partnership with BME communities and the organisations that work with them
- building partnerships and identifying adequate and sustained funding for local groups.

In addition the importance of enabling people from different communities to develop a positive cultural identity; raising awareness about mental health issues including mental health literacy within these communities; promoting employment opportunities; training staff; challenging racism and discrimination in service provision and promoting mental health within services is emphasised. Details of seven initiatives targeted at Asian communities are described and six are aimed at women who may be particularly vulnerable, either younger women at risk of self harm or older women experiencing social isolation. A detailed description of a mental health promotion project targeted at Asian people living in Coventry is described by Carpenter, Imitaz and Noguera (2003), who stress the importance of adopting a holistic approach and translate this into service delivery through the provision of complementary therapies; home remedies and workshops that focus on the emotional feelings and anxieties associated with physical health problems. Two papers were also identified where views of Pakistani and Chinese, and other BME communities, had been specifically sought on mental health promotion initiatives, which had been designed for the whole population (Grant, 2007; Meller, 2007).

A number of papers refer to action necessary to improve the level of mental health awareness and the importance of ensuring that these are focused on the information needs of the community (Nishtar, Minhas, Ahmed et al. 2004). A WHO mental health initiative, the School Mental Health programme in Pakistan is referred to. This initiative aimed to improve the understanding of mental health in two rural communities in Pakistan. The evaluation of this programme indicated positive outcomes in terms of increased awareness of mental health and points to the role of school children and teachers as effective change agents to help destigmatise mental health issues in the community (Goldberg, Mubbashar & Mubbashar, 2000). The theme of harnessing traditional wisdom alongside modern advances in mental health was also suggested by the literature from Pakistan and in particular the value of educating faith leaders about mental health (Gater & Rehman, 2001).
Finally, a study from Pakistan (Shaikh, Kahloun, Kazmi et al., 2004) identifies coping strategies for medical students. These included spending time with friends, sleeping, music, sport, study and isolation with women preferring sleep and study and men spending time with their friends. The generalisability of these findings to the broader population is doubtful.

7.5.2 Findings from interviews with community informants

Religion
Religion is central and was identified as one of the main ways of maintaining mental wellbeing, as it is a way of relieving pressure:

“Our religion, praying makes huge difference, personal hygiene, keep yourselves clean – knowing have to pray read Quran makes you feel relaxed and it prevents bad thoughts – you know what to do and that you shouldn’t do this as it’s a sin – religion keeps you on the right path, shouldn’t do wrong things like alcohol, if on right track you don’t do anything wrong and don’t think wrongly like going [night]clubs. If you don’t have awareness of religion then you will think why can’t we go clubbing drinking but when you know it’s wrong it doesn’t bother you then.”

(Community worker with Pakistani communities)

In addition the mosque, which is the main social network for Pakistani community, particularly for men, provides a place to discuss issues and their wellbeing.

However the difficulty of people going to religious leaders as the first port of call when experiencing mental health problems was also identified as a potential problem, as it may reinforce beliefs about possession or black magic and thereby detract from people seeking help from their GP. This is providing a focus for intervention for some of the community workers:

“I think it's less, if I'm right, from what you found in the research. It's less in other communities than in Pakistani community or they do go to their religious teachers to say they fear something. We are trying to do work with their prayer leaders now, to rid them of the fact of the whole issue. If these people [are] going to these religious leaders, then they [the leaders] need to have understanding.”

(Community worker with Pakistani communities)

Family
The family is seen as the support system for maintenance and recovery if there is an illness. However the extended family is also seen as one of the main causes of stress for women. The extended family is maintained even when children move into their own homes, separation is not viewed as total and the older generation are still seen as a support system for grandchildren and children as a support system for elderly.
Acceptance
The belief in fate and accepting what befalls you was also identified as a strategy for coping with difficulties:

“I think Kismet helps them overcome (acceptance) rather than dealing with it, cope with it.”

(Community worker with Pakistani communities)

Community development
The community workers also described interventions that they used to raise awareness within the community. These included:

- building language skills as enabling people to speak English helped by improving their access to help if needed and addressing isolation
- raising awareness of existing information and resources and the potential impact of not looking after your mental wellbeing on your children and family
- developing accessible methods to create a dialogue around mental health issues:

The impact, particularly of community development work, was described in terms of increasing attention to personal wellbeing, particularly for women:

“Now there is some awareness that they should look out for themselves and this has an impact on their house[hold] life. I get feedback from women that their husbands have noticed a change in them since they have been coming to the groups and this had a positive impact on their family life. When they’re getting ready to go to the group their husbands acknowledge and when sometimes they feel like not coming there husbands encourage them, as their wives are happier now.”

(Community worker with Pakistani communities)

Recommendations for good practice in relation to mental health promotion strategies
Some interviewees were aware of mental health promotion initiatives but felt that there was little targeted at the Pakistani community despite the need for them. Given the earlier discussion about the tendency to frame mental wellbeing as mental illness and the stigma related to this, it was apparent that mental health promotion strategies would need to take into account that the Pakistani community is relatively small and that there may be issues regarding trust. Further they made the following recommendations about the development of mental health promotion:

- The need for an approach that builds on what people already know, challenges and develops their understanding, and crucially, in the appropriate languages emerged as a good starting point for several interviewees:
“As long as people are building on what’s already there and learning from it instead of saying ‘oh but we want to find out from another organisation’. Don’t do that because if you already know there is an issue of isolation, there is an issue of shame, there is an issue of not understanding the word itself, there is the issue of black magic that people believe in and then where they go for help and advice. So make sure that you’ve built on that rather than totally going to find out ourselves. Because communities get fed up too by keep going back to them asking the same kind of question and that’s why we did those workshops to promote positive mental health and recovery because that’s what people like.”

(Community worker with Pakistani communities)

Interviewees appreciated material designed to raise mental health awareness that is available in different formats (websites, DVDs etc), in different languages. It is important that the language used is accessible and appropriate in lay rather than professional terms. There was support for further research to identify best practice both in this area and in relation to therapeutic interventions for the community.

A range of issues were raised about mainstream services and the difficulties in accessing appropriate help as early as possible in order to prevent mental health problems developing were identified. In particular there are issues about:

- the lack of understanding about the culture, background and religion
- confidentiality if help is accessed via a community organisation or using interpreters from the same community
- targeting women without working with men to enable them to address the issues.

The needs for accessible, culturally specific services with workers, who speak appropriate languages and that build social networks were stressed.

8. Comparison with the majority populations living in Scotland

8.1 Literature review

No literature was found that systematically compared conceptualisations of mental wellbeing of Chinese and/or Pakistani communities with those of the majority population in Scotland. One UK paper was identified that compared beliefs about mental illness and attitudes towards seeking professional help of British Asians with White Westerners and Pakistani residents in Karachi and significant differences between the three groups were identified in their attributions of mental illness (Sheikh & Furnham, 2000). Three other UK papers compared university students from the UK and China to draw out differences between East and West cultures. Furnham, Cheng & Shirasu (2001) through factor analysis of lay theories of happiness found that Chinese students rated independence, maturity and willpower, extraversion, stability and social skills higher than British and Japanese students. The authors suggest that this
difference reflects philosophical beliefs (Taoism, Zen and Buddhism) that emphasise internal strength as an important path to happiness (Furnham, Cheng & Shirasu 2001).

Lou Lu, from Fu-Jen Catholic University, Taiwan, is a major contributor to this area and has written several papers comparing happiness for Chinese communities across cultures, identifying the distinctive nature of Eastern conceptions of happiness compared with Western approaches. This work is referred to in 6.2.1. Lu (2005) summarises this difference with Western approaches, described as originating within the Euro-American tradition, of being individual-oriented with two distinct characteristics: personal accountability and explicit pursuit. In contrast Eastern approaches, specifically East Asian, are social-oriented in conception and are composed of two distinct characteristics: role obligations and dialectical balance.

Material relating to the psychometric properties of scales for wellbeing goes some way to illuminating the differences between populations in terms of their conceptualisations of wellbeing. Echoing Kleinman (1977), Byrne & Watkins, (2003) observed that constructs and their measurements are not entirely equivalent across cultures. From their development of a psychological wellbeing scale based on the Ryff scale with a Chinese population in Hong Kong, Cheng and Chan (2005) found that some terms were semantically problematic for Chinese people. These related to purpose in life, personal growth and self-acceptance and items relating to autonomy also proved to have low internal consistency. Cheng and Chan suggest that this may reflect that these concepts are not unidimensional within Chinese culture. They refer to how it may be more difficult to assess autonomy for Chinese men because they are subject to two influences- to be autonomous by virtue of their gender role but at the same time living within a collectivist culture, emphasising harmony in personal relationships. This lack of unidimensionality was also reflected on the scales relating to self-acceptance, particularly for older Chinese people. These scales relate to two aspects: liking for oneself and what one has achieved; and, accepting one’s life history, despite ups and downs.

Lu & Shih (1997) have developed the Oxford Happiness Inventory for use with a Chinese population after they observed that the Chinese concept of happiness has some different features. These new items covered harmony of interpersonal relationships with family members and friends; gratification of need for others' respect; satisfaction of material needs; achievement at work; taking pleasure at others’ expenses and being at ease with life.

8.2 Findings from interviews with community informants
For both the communities, the comparison with the majority community was made in terms of priorities and focus of attention. Working hard and getting on with it is seen as important and the quote below captures a sense of resilience and resourcefulness:
“Our approach is, once we do we do, once we think, we want to do this we think we are able to do it, we do it with heart and soul and everything. But here people have their mind if they’re in between they feel they’re tired they should have a rest and they, then they stop it and things like that but we are energetic.”

(Community worker with Pakistani communities)

The value placed on individualism by the majority population as opposed to conformity was raised by one Chinese interviewee, with obvious links to the issue of stigma:

“Western culture respects people’s difference, you know treat everyone individual, but in China we used to try to treat people, everyone as the same so if there is one people there the difference is very, very different from the others”

(Community worker with Chinese communities)

The other area of comparison was that the majority community are seen as better informed about mental health issues although there was also recognition that everyone has difficulties defining mental illness, mental health and mental wellbeing and particularly find the term mental health confusing because it can refer to mental illness as well as mental wellbeing.

9. Synthesis

9.1 Conceptualisations of mental wellbeing

From the literature and from the consultation with community informants it is evident that mental wellbeing is not a familiar concept within Chinese and Pakistani communities and the term ‘mental’ carries negative connotations. Little material from the UK was identified that focused explicitly on lay conceptions of mental wellbeing. Where the concept was explored it was typically defined initially in relation to mental illness or in Western terms for mental distress, notably stress or depression.

One of the key questions that emerged early on was whether or not there is a discourse about mental wellbeing within these communities and whether the data from key informants reflects their work and knowledge which may be different to that of the communities. Indeed at one stage we were reminded of Kleinman’s concept of category fallacy in relation to the use of research in a particular group failing to identify the same issues in a different group because it lacks any meaning in that culture. Hussain and Cochrane (2004) argue that this concept is fundamental to understanding culturally different models of mental health/illness and that there is a problem in assuming that all concepts have relevance or are meaningful across all cultures.

This seemed particularly to fit some members of the Pakistani community where attempting to isolate the concept of mental wellbeing from other aspects of life,
physical health, family, community and faith felt somewhat contrived. The need to find an appropriate vocabulary for future research was evident. This study established from the interviews and from the literature that a broad range of terms are being used within Chinese communities. Appendix 7 provides a summary of terms and phrases identified during the course of the review from both the literature and the interviews.

Relatedness and connectivity emerge as central constructs for both Chinese and Pakistani communities and had a number of dimensions including role obligations and social harmony.

For Pakistani communities, faith emerged as central; both as a way of conceptualising wellbeing so mental wellbeing is conceptualised in terms of adherence to religious teachings and as a strategy for maintaining mental wellbeing include prayer. For Chinese communities, although little explicit reference was made to Confucianism during the fieldwork, the emphasis on hard work and material wellbeing would appear to reflect its influence. At the level of analysis that has been undertaken, less evidence of Taoist beliefs on Scottish Chinese communities’ conceptualisations of mental wellbeing in the literature was identified. This may well reflect the fact that these populations include a majority of economic migrants and this may mean that first they are self-selecting and comprise people willing and able to make a go of it in another country and second their economic circumstances and reasons for being here dictate that they work hard. Although scant literature was identified in relation to Christianity, this was identified as becoming increasingly important for the Chinese community in Scotland. There was the suggestion both from the literature and the community informants that religion and faith are important strategies for maintaining mental wellbeing. Religion and faith serve to shape beliefs about life’s adversities and coping strategies that can be used. Further they also provide access to a social network, which may be able to mobiles further support and resources for coping.

One conclusion that could be drawn from this scoping exercise is that mental wellbeing is being conceptualised in terms of the absence of mental illness. However it was clear that mental wellbeing means much more than this. The conceptualisation of mental wellbeing that has emerged from this initial analysis has three critical dimensions - interconnection with physical health; interconnection with social and family wellbeing and interconnection with spiritual wellbeing.

9.2 Factors influencing conceptualisations of mental wellbeing

From the literature review philosophical and religious beliefs emerge as the most significant influence on conceptualisations of mental wellbeing. This was echoed by the interviews with community informants in relation to Pakistani communities and it is suggested that the Islam faith plays a central role in conceptualisations of mental wellbeing for these communities, even for younger people who have received a Western education. Whilst the academic literature emphasises the
importance of philosophical and religious beliefs, particularly Confucianism and Taoism in Chinese conceptualisations of mental wellbeing this emphasis was more muted in the interviews with Chinese community informants.

It is also evident that the overlapping factors of generation, ethnic identity, age, educational history, cultural orientation and context play a critical role suggesting that there are indeed multiple meanings in relation to mental wellbeing within these communities. There is the suggestion that people may hold more than one frame of reference for conceptualising wellbeing and this is worthy of further investigation both for Chinese and Pakistani communities, the majority and other minority communities in Scotland.

9.3 Promoting mental wellbeing

Little material was identified from the literature review that described specific strategies that the communities in Scotland used to strengthen and maintain their mental health. Initiatives that were mentioned, particularly during the course of the interviews were focused on raising awareness of mental health symptoms and targeted at addressing stigma. A range of mental health promotion initiatives that have been undertaken with the community, sometimes in consultation with them were described. These also reflected an emphasis on improving an understanding of mental health issues, symptoms of mental illness and initiatives to tackle stigma. On occasion they had been evaluated in terms of outcomes (Goldberg, Mubbashar & Mubbashar, 2000). The recent evaluation of Scotland’s Mental Health First Aid Training Programme highlights the need from feedback from BME participants, to think carefully about the language and cultural concepts and to include people from those communities in its delivery (Meller, 2007).

Specific strategies aside, there was a general theme that beliefs about life and about the meaning and experience of adversity may well influence the way in which individuals, families and communities respond to circumstances and events that may negatively impact upon their mental wellbeing. For example the papers mainly from China, have described the role of beliefs about adversity, derived from different cultural traditions, namely Confucianism and Taoism, and their influence on mental wellbeing. This theme was also evident in some of the papers and in the interviews for the Pakistani community where it was clear that a belief in Islam provides a frame of reference also influencing attributions and coping strategies for life circumstances and events.

Further the implications of viewing self in relation to others in family and community and the importance of social networks for prompting mental wellbeing deserves further exploration. It suggests that mental wellbeing is maintained by having other things in place as opposed to action to be taken by the individual.
10. Methods for future research

10.1 Methodological issues in relation to this review
This section provides an overview of the methodological issues that were identified in the course of undertaking the review.

10.1.1 Issues arising from the literature review
Five key issues were identified. First the relative absence of directly relevant material meant that a considerable amount of time was spent searching, which inevitably generated a significant number of papers for screening. This detracted from time for extensive hand-searching and systematically contacting organisations across the UK to identify grey literature. It is recommended that this is done in the next phase, although it may actually produce little additional material.

Second, the wealth of Chinese material has meant that the issues relating to Chinese communities have been explored in more depth. In part this reflects the number and range of empirical studies, the development of theoretical ideas and the systematic investigation of comparisons with Western populations in both theoretical and empirical papers. It clearly highlights a gap in the knowledge base in relation to Pakistani communities. However this review also suggests that the definitions of mental wellbeing that have been used in the review may have disadvantaged Pakistani communities given that the term ‘mental wellbeing’ appeared to have less currency with these communities but that concepts relating to spiritual wellbeing and peace of mind emerged as important. It is therefore recommended that additional searching using these search terms and others developed in discussion with Pakistani communities in Scotland is undertaken.

Third, the absence of definitions of mental wellbeing and related terms in the available material and the diverse ways in which they were used raises issues about conceptual equivalence. The material identified covered the terms happiness, psychological wellbeing, emotional wellbeing, subjective wellbeing, quality of life and life satisfaction and the review has explored some of the different ways in which these concepts are used. It is evident that there is a lack of conceptual equivalence, not only across papers, but crucially across those in the Euro-American tradition and Chinese and Pakistani communities. This raises a question mark over the inclusion and interpretation of those studies that have uncritically adopted Western concepts and their operational definitions to examine these concepts in non-Western populations. A further stage of analysis to explore the issue of conceptual equivalence in more depth would be useful and could involve developing a framework of key concepts from the general literature on mental wellbeing and to systematically searching for the points of convergence and divergence in the material identified during this review. Further research that explores lay conceptualisations of mental wellbeing in these
communities is also suggested by the relative lack of qualitative studies that have explored meanings of wellbeing, particularly within Pakistani communities.

Fourth, the categorisation by ethnicity or religion is a fundamental methodological issue. At the most basic level the categorisations used were not uniform and this is most clearly seen in the way that the term Asian is used differently in UK, US and Canada and Australia and New Zealand. Papers from US, Canada, Australia and New Zealand which did not clearly identify the populations covered, were in general excluded but this may have been at the expense of theoretical insights. A more profound but related issues is the risk of ethnic categorisation reifying ethnic origin thus masking the diversity within these categories and negating the existence of multiple fluid identities (Gunaratnam, 2003). Indeed if culture is viewed as operating at different levels (individual and social), within-culture variance may be as large or larger than between culture variance in relation to subjective wellbeing research (Lu, 2006).

Finally, there may be a difference in lay meanings of mental wellbeing and conceptualisations of mental wellbeing found in an academic discourse. This point is well made by Lu and Shih (1997) who found both areas of convergence and divergence when comparing the experience of happiness of Taiwan residents with the conceptual framework provided by Confucianism.

10.1.2 Issues arising from the fieldwork
The following issues were identified:

**Language and terminology**
The term mental wellbeing had little immediate currency with the interviewees and in many instances it was only possible to get to a discussion of mental wellbeing through a discussion of mental illness. Initially we thought this was because mental wellbeing was being framed in terms of the absence of mental illness, and whilst this is partly true it became evident that the term did not facilitate an exploration of the concept. It is also possible that as much of the previous engagement with these communities has been in relation to the discourse of mental illness (e.g. Mosaic of Meaning project) that this had shaped both expectations and understanding of the agenda. The researcher consequently adopted a more directive approach and had to actively lead the discussion away from mental illness, having given the interviewee the opportunity to explore views about mental illness and its perception in the community. This involved approaching the concept of mental wellbeing from different angles; using the terms and building on concepts that the interviewee was using. Consequently the lack of a co-researcher fluent in Hakka, Cantonese or Mandarin will have influenced the quality of the data collected for Chinese communities and a researcher fluent in these languages will be essential for the next phase if community members are to be interviewed. Further work also needs to be done on developing the vocabulary in relation to research on mental wellbeing with Pakistani, and to a lesser extent Chinese communities.
Characteristics of participants
Nearly the entire sample consisted of individuals who worked with Chinese or Pakistani communities, either in a voluntary or paid capacity. There was a bias towards women, which may be reflected in the results and in particular in the emphasis on family wellbeing with relatively little mention made of employment. The sample of people interviewed was also mainly drawn from the urban belt between Glasgow and Edinburgh and did not represent people living in more rural and isolated areas. The importance of extending the sample to include people from these areas became apparent as interviewees raised issues in relation to the isolation faced by Chinese people living in these areas. The next phase of the research must directly target members of these communities and use stratified sampling to ensure that the contribution of gender, age, cultural orientation and geographical location to conceptualisations of mental wellbeing and the strategies used to maintain positive mental health are further explored.

The organisations that were approached to participate in this research welcomed the opportunity to be part of this research. All the interviewees were working with the communities, many were part of the communities concerned, and they expressed an interest in the focus on mental health. From our experience of community engagement, we concluded that tremendous potential to build on this initial scoping exercise exists. We would recommend investment in these organisations to support capacity building, providing them with the training and resources to take this agenda forward.

Researcher characteristics
The majority of the interviews were undertaken by Dr Manjit Bola, who is from a BME community and fluent in Urdu and Punjabi. Although there is significant and important debate about ethnic matching (Gunaratnam, 2003) it was clear to us that Manjit’s ethnic background was enormously helpful. With members of the Pakistani community, there was a shared language and understanding of each others culture, facilitating reflections on shared understandings of key concepts. This is both an advantage and disadvantage – the advantage being that interviewees are more likely to share information because they can be certain of a shared language and understanding. Indeed on one occasion the interview was held in Urdu and on other occasions where there were no equivalent words in English, this allowed for part of the conversation to be in Urdu. A clear disadvantage is that the interviewer may not probe deep enough because understanding is assumed. In terms of Chinese participants, as the interviewer was not of Chinese origin or fluent in Chinese, there was an assumption of no prior knowledge making it possible to obtained detailed descriptions of cultural issues and explore differences and similarities in perspectives. However this issue is debatable as it was also possible that participants were selective in their description of issues and choose those that they thought might be most readily understood by a non-Chinese interviewer. Further on one occasion the interview, whilst in English, would have benefited from being in Chinese as the person’s ability to speak in English was very limited. We cannot tell how much richer data
would have been if the researcher was able to speak in Chinese and had a shared understanding of the Chinese cultures but we would recommend a researcher fluent in the relevant Chinese languages for the next phase.

**Research method**
The sensitivity and complexity of the issues being discussed needs to be recognised. The issues relating to stigma raised by interviewees from both communities, namely shame and reputation, have implications for the way research with these communities is undertaken. A couple of interviewees talked about ‘having been put on the spot’ and the literature on Chinese communities in relation to maintaining social harmony suggesting a potential response bias in individual interview situations, led us to reflect on whether one-off interviews (either individual or group) are the best method for collecting this type of data. Further saturation was reached fairly early on in the interview process because of the similarity between the key informants in terms of role and gender and we thought that there would be much to be gained by conducting repeat interviews to allow further exploration and more probing questions to be explored.

The use of group interviews and individual interviews had some real advantages over the use of individual interviews only and allowed points of convergence and divergence to be explored, particularly when there was a mix of Chinese and Pakistani participants. The group interviews all took place within the same organisation and so participants knew each other and issues relating to the organisation of the group interviews proved less problematic than with organising a focus group for a wider group of participants. However, as would be expected there was less depth compared with the individual interviews. Focus groups would be a useful method for the next phase of research to explicitly explore variations within and between BME communities as well as the majority populations and individual in-depth interviews to explore and probe understandings and experiences.

**Research process**
We started out with the ambition of using an iterative research process so that the emergent findings from the literature review could inform and develop the lines of inquiry for the interviews and that the emergent findings from the interviews could refine the search terms for the literature review. However the timescale allowed for the project meant that this was not particularly feasible and therefore the two activities were undertaken simultaneously.

**10.2 Methods identified from the literature review**
A range of methods were identified during the course of the review, particularly from the Chinese literature. A brief overview of the relative strengths and weaknesses of the different approaches that have been used are summarised in Table 8.
A couple of approaches stood out. The first in the study by Lu & Shih (1997) where they sampled 54 community residents in Taiwan through undertaking interviews at a large square in the centre of town, a popular location for leisure pursuits. They used two relatively simple questions:

- What is happiness?
- What sort of things will make you happy?

Interestingly 54 respondents generated 180 sources of happiness that they then developed into a nine category typology, as described earlier.

Table 8: Comparison of methods identified during the review

<table>
<thead>
<tr>
<th>Method</th>
<th>Strengths</th>
<th>Weakness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-sectional survey using standardised measures</td>
<td>Possible to sample large numbers and make comparisons with other populations. Factors influencing mental wellbeing or preferred strategies for promoting mental health can be systematically explored and compared across populations.</td>
<td>Measures may not accurately reflect lay conceptualisations of mental wellbeing and miss important detail on the strategies used to maintain mental wellbeing. Initial development of measures may have been undertaken on Western populations. Do not provide an in-depth understanding</td>
</tr>
<tr>
<td>Longitudinal survey using standardised measures</td>
<td>Possible to sample large numbers and make comparisons with other populations. Provide a picture over time.</td>
<td>Measures may not accurately reflect lay conceptualisations of wellbeing and miss important detail on the strategies used to maintain mental health</td>
</tr>
<tr>
<td>Narrative inquiry</td>
<td>In depth inquiry into the experience of mental wellbeing. Generates understanding form the individual's perspective</td>
<td>Time intensive and so sample size will be small.</td>
</tr>
<tr>
<td>Focus group sometimes using scenarios or visual methods to stimulate discussion</td>
<td>As above Opportunity to explore points of divergence and convergence</td>
<td>Concerns about confidentiality may act as a barrier for some people</td>
</tr>
<tr>
<td>Diary keeping</td>
<td>Insight into daily variations in wellbeing. Provides learning opportunity through introspection and reflection.</td>
<td>Requires a high level of motivation and literacy, which may limit key groups</td>
</tr>
<tr>
<td>Participatory action research using peer researchers</td>
<td>Quality of data improved by researchers having in-depth knowledge of cultural issues Potential for capacity building.</td>
<td>Participants may have concerns about confidentiality Time intensive in terms of capacity building</td>
</tr>
</tbody>
</table>
The second approach used in a number of qualitative studies was that of using scenarios or vignettes to stimulate the exploration of meaning, usually in relation to health or mental illness. A good example of this is the study by Gilbert, Gilbert & Sanghera (2004) who used focus groups to explore the potentially sensitive issues of izzat, shame, subordination, entrapment and mental health with South Asian women. As it was felt that it would be too threatening to discuss these issues directly, more impersonal scenarios were generated by a project working with the community. This approach could enable culture-specific meanings to be explored and comparisons in relation to the same concepts across populations, although members of these communities would need to be actively involved in developing the scenarios.

In terms of quantitative methods, scales do exist that allow for assessment of mental wellbeing particularly in Chinese populations (e.g.: Chinese Happiness Inventory) but no evidence was identified that they have been validated in the Scottish or UK context.

Finally it was evident that the diversity within these communities will also need to influence the choice of methods. Whilst some studies identified that the concepts of mental health, and by implication mental wellbeing, did not appear to exist for older first generation members of Pakistani communities particularly if they did not speak English, one study identified a complex and rich understanding of the term mental health by Pakistani children and adolescents (Bashford, Kaur, Winters et al., 2006).

10.3 Rapid appraisal of methods literature
The rapid review of methods for undertaking research with BME communities in this specific area of inquiry provided a limited amount of material although the depth of searching was limited by the time available. An annotated bibliography is available at Appendix 8. Three main methodological issues were identified all of which relate to the theme of power and knowledge. First there is a consistent concern within this material that people from BME communities may be ‘the objects’ of research rather than potential participants. It is evident that some communities have been over-researched and consequently frustrated by the lack of change whilst other communities, such as Chinese or newly arrived communities have been under-researched (Hanley, 2005). Good practice pointers from the review by the Toronto Group (which includes SCIE, the Joseph Rowntree Foundation, INVOLVE, the Race Equality Unit and Centre for Citizen Participation) (Hanley, 2005) are the need to ensure:

- the active involvement of people from Black and minority ethnic communities as partners throughout the research process
- that the research addresses questions that the communities agree are important to their lives
- that people from these communities are themselves researchers or co-researchers
that there is a commitment from everyone to use the research to bring about change and to feedback what has happened.

This theme of involvement is echoed in the report from consultations with BME communities in Glasgow (Weaver 2003), which reports that the most salient point is people wanted to be empowered and equipped to be involved. However the debate goes beyond involvement to reframing the relationship between the researcher and the researched. The issues of power relations within research, the validity of knowledge, the utility of its outcomes are identified by Alam and Husband (2006) as key elements of an alternative model of research that they developed to understand the experiences of British Pakistani men in Bradford.

Gunaratnam (2003) provides a general resource on researching race and ethnicity and she explores the association between power and knowledge with a detailed discussion of ethnicity. She also provides a useful discussion of the ambiguities, tensions and complexities of engaging researchers of a similar ethnicity. Several papers were identified that explored the influence of commonality and difference between researcher and participants and concerns expressed about the strategy of ethnic matching masking class, gender and generational differences (Culley, Hudson & Rapport, 2007; Sin, 2007). These authors point to a second methodological issue, that of defining people in terms of their ethnicity or viewing culture as a fixed entity, which leads to an assumption of BME communities as homogenous or failing to recognise the fluidity of identity and changing nature of cultures (Fenton & Sadiq-Sangster, 1996).

The third issue relates to the contribution of lay knowledge to understanding the complexity and diversity of human experience in relation to health and health promotion. Millburn (1996) for instance argues that lay theorising is an essential prerequisite for developing relevant theories and effective practice in health promotion.

The indication then is that participatory action research using qualitative methods provide the most promising methodology to develop a richer understanding of the conceptualisations of mental wellbeing by Black and minority ethnic communities. Participatory Action Research (PAR) starts with the recognition of the inequalities between researchers and participants in a traditional model of research. PAR seeks to empower participants in the research process and thus moderate inequalities by developing their capacity (Liu, Gao & Pusari, 2006). The adoption of PAR as a method is strengthened by the concerns about conceptual equivalence of key terms and of the validity of measure developed on Western populations for BME communities, identified by the literature review.

One example of using PAR as a method to identify general health promotion issues for disadvantaged elders in the Shaanxi Province, China was identified (Liu, Gao & Pusari, 2006). In this study, sharing power and decision-making with participants were the starting point. This approach is also the hallmark of the
community engagement model developed by UCLan to undertake research with a diverse range of minority groups (Fountain, Patel & Buffin, 1997). This model aims to build capacity and therefore sustainability in BME communities. It is the most widely used model for research with BME communities within the UK and has been evaluated.

11. Discussion

The paucity of literature from the UK, identified by the methods used in this review, indicates that this has not been an area for research endeavour and highlights the innovative nature of the work being undertaken by NHS Health Scotland. Both elements of this scoping review have illustrated the heterogeneity of Chinese and Pakistani communities in terms of their conceptualisations of mental wellbeing. They have also pointed to a rich cultural heritage for both communities, which have a profound influence on how mental wellbeing is conceptualised. It is difficult to distil as its reduction risks simplification and potentially misinterpretation. Further this has been a scoping review and has lacked the depth of analysis necessary to convey a richer and more extensive understanding of the issues. This section explores the theoretical, methodological and policy implications of the findings.

11.1 Theoretical implications
Four theoretical issues will be explored here – the dual continua model, cultural beliefs and mental wellbeing, conceptual equivalence and the heterogeneity within Chinese and Pakistani communities.

11.1.1 Relationship between mental wellbeing and mental health problems/illness
The dual continua model, as described earlier has two dimensions – a continuum of mental wellbeing, typically termed positive mental health, ranging from a low level to a high level and a continuum of mental health problems from mild to severe and clinically diagnosable symptoms (Parkinson, 2007). Whilst the terms found in this current study may be different, the review suggests the conceptualisation of two different dimensions: positive mental wellbeing - happiness and peace of mind was viewed by interviewees and within the literature reviews as distinct and qualitatively different from the experience of mental illness. Both communities appeared to define mental health problems in terms of serious mental illness. However it is unclear whether common mental health problems are viewed as existing on the same continuum as mental illness or whether they are viewed as part of life with mental wellbeing defined therefore in terms of the absence of serious mental illness.

11.1.2 Cultural beliefs and wellbeing
Shek (2005) provides a theoretical basis for how cultural beliefs may influence psychological wellbeing. First, people from different cultures may hold different cultural beliefs about events, for example in terms of attributions for success, reasons for children behaving badly and indeed mental illness. Second, cultural beliefs may shape the coping resources and therefore the behaviour of the
person concerned, for example the value and priority accorded to seeking help or the importance placed on disclosing personal problems. Third, Skek proposes that cultural beliefs may constitute stressors that influence adjustment or coping strategies. Watkins, Dong & Xia (1997) have also identified several major papers that have pointed to variations in the way that people from different cultures tend to think about themselves (For example, Markus & Kitayama, 1991; Triandis, 1989). These indicate that people from Western cultures tend to have an individualistic self-concept, with the emphasis on individual characteristics and achievement in contrast to people from non-Western cultures who describe a concept of self in relation to other people, termed a collectivistic self-conception (Watkins, Dong & Xia, 1997, p. 375).

11.1.3 Conceptual equivalence
It is clear that similar terms lack conceptual equivalence and this must sound a warning for mental health improvement initiatives in Scotland adopting terms identified within this review uncritically. There are two aspects to this. First the assumption that the same term has the same meaning in different cultural contexts. The clearest example is the word happiness, used extensively in research on subjective wellbeing in the US and in other countries developed from that tradition and also used extensively in Chinese research. However it is evident that the term is being used differently and crudely put may be used in Western research to describe a state of wellbeing (positive affect and absence of negative affect) but within Chinese communities is referring to beliefs relating to wellbeing. The second danger is translating other cultural values or beliefs into Western concepts and Shek (2003) warns against this in relation to the risk of translating Confucian values into Western values of mastery and autonomy. Further work is clearly needed to explore meanings in different cultural contexts.

What is apparent however is that for both Chinese and Pakistani communities the concept of mental wellbeing is embedded and integral to their lives and reflects family, community, physical, material and spiritual wellbeing, with both communities placing a strong emphasis on family welfare and on role obligations. It is suggested in some of the material identified that this reflects the organisation and values of these communities and it is contrasted with the conceptualisations of mental wellbeing in the Anglo-American context that place an emphasis on mastery and autonomy (see for example Lu, 2005). This difference has been construed in terms of the characteristics of individualistic and collectivistic cultures. Triandis (1989, 1995) outlines in detail this distinction. There are three defining characteristics of collectivists:

- definition of self in terms of the group as opposed to independence and autonomy
- a concern with the goals of the social group and enjoyment derived form doing what is right from the group perspective as opposed to the pursuit and achievement of individual goals
- carry out obligations and perform what is expected of them.
Keyes and Ryff (2003) identify a number of features of collectivist cultures that may impact on the definition of wellbeing:

- high degree of consensus about appropriate behaviors in specific situations
- fewer behavioural options and greater pressure and sanction to respond
- decisions are highly contextual and based on an appraisal of an individual’s social rank and ties
- relationships are interdependent and an individual’s achievement and self worth are inseparable from the quality and nature of their social relationships.

Whilst a critical analysis of this is out with the terms of reference for this review it does have implications for the work in Scotland particularly that of the adult mental health and wellbeing indicators and their underpinning constructs. It is likely that the relationship between some of the indicators identified and the underlying constructs will be stronger in some cultural contexts that others (See Keyes and Ryff, 2003, for example).

11.1.4 Diversity of Chinese and Pakistani communities

In using ethnic categories for defining communities in Triandis’ terms as the way of representing people from Chinese and Pakistani communities, there is a danger of assuming that such characteristics define all people from those communities. This is often referred to as an essentialist discourse. Uncritical adoption of such classifications risks masking diversity and intra-group differences. Indeed discourse analyses of racism have emphasised that problems of racism are largely problems of essentialism (Verkuyten, 2003).

The diversity of Chinese and Pakistani communities was clear from the fieldwork that was undertaken and from the literature review. The material from non-UK English-speaking countries in particular point to the impact of migration, the processes of acculturation and experiences within the host country on identity formation, which will influence how individuals and communities conceptualise mental wellbeing. This echoes Cowan (2001) who, writing in relation to mental health and Chinese communities in Britain, cautions against over-generalisation because of the cultural social diversity and variations in the degree of identification with the dominant culture. The body of literature that explores cultural orientation, ethnic identity and its relationship to wellbeing, mainly from the US (for example: Ying, 19995; Yip, 2005), is worth further exploration to identify theoretical ideas that may be relevant and useful to the UK context.

11.2 Methodological implications

Whilst a substantial number of studies were identified, over half were from China and in particular reflected the efforts of one researcher and his team, notably Daniel Shek. Many of these studies are etic in nature involving cross-sectional surveys. These studies, particularly those that have used measures developed on Western populations, are open to criticism for not taking into account the
different nature of relationships, cultural values, philosophy and religion within Chinese communities, all of which will influence conceptualisations of wellbeing. The absence of qualitative studies that have explored narratives across generations in relation to mental wellbeing is evident and there is a clear need for research that addresses this gap. The theoretical case for focusing on narrative identity is made by Bauer, McAdams and Pals (2008) in relation to eudaimonic wellbeing and they outline how it is possible from narrative accounts to develop a richer and broader understanding of mental wellbeing. We believe that the way in which this research is undertaken is crucial and that participatory action research is the necessary paradigm, consistent with good practice in this field, for both developing a rich and detailed understanding and successfully engaging these communities with this agenda.

For further qualitative research to be fruitful, the development of a vocabulary of language and terms, the development of scenarios and the use of researchers with appropriate languages would facilitate the process of inquiry. The influence of generation and age on the conceptualisations of mental wellbeing in Scotland was evident from the interviews and cultural orientation and ethnic identity from the literature review. Gender may also be important and a bias may be reflected in the themes identified from the interviews with a predominantly female sample. Sampling strategies that explicitly recognise these sources of diversity need to be developed for the next phase of research.

From the fieldwork, it has emerged that the concept of mental wellbeing and the term mental carries a negative connotation and is confusing for people of all ages. This may be similar in the majority community in Scotland (Pavis, Masters and Cunningham-Burley, 1996; Scott Porter, 2000), which points to the need for research on both the majority and BME communities in terms of the key questions.

11.3 Implications for policy and practice
The following implications are obviously tentative given the nature of this scoping review and will need to be developed in the light of further evidence. Four key issues emerged. First the way in which this agenda is framed is important and needs consideration given that the term mental wellbeing has little currency and carries negative connotations within these communities and that the relationship between mental health and illness may be construed differently. The second arises from the theoretical implications considered in the earlier section of this report; that is the need to develop policy and practice based on a broad conception of mental wellbeing that includes the dimensions of family wellbeing, faith and spiritual wellbeing, social role and standing and material wellbeing. For example, the development of mental health indicators should be considered in the context of this review. Third, the age structure of BME populations in Scotland should be considered; the emphasis on family and the cultural values of filial piety within Chinese communities coupled with the evidence from the mental health promotion literature about the importance of strategies targeted at young people and parents indicate that the focus on the whole population across the life
course needs to be strengthened. The fieldwork for example, highlighted the isolation faced by older people who do not speak English in both communities. This is clearly a concern and is likely to increase their vulnerability to depression in the elderly. Fourth the issues raised during the interviews indicate significant concern about mental health problems in the Pakistani and Chinese communities in Scotland and a need to continue efforts to improve access to appropriate provision and for initiatives to raise awareness of mental health issues and tackle the stigma related to mental illness within these communities.

In conclusion, perhaps the most far-reaching implication for policy and practice development is how to ensure that the mechanisms are in place to mainstream the understanding, strategies and related issues for BME communities at the beginning and throughout the process of policy and practice development.

12. Implications for Phase 2

The difficulties with conceptual equivalence and the relative absence of qualitative studies exploring the meaning of mental wellbeing and strategies for promoting mental wellbeing point to a significant gap in the knowledge base. This supports the need for further qualitative work (i.e. emic) to explore these issues in depth. This first phase of the research has provided a basis to be built upon and it is recommended from this that the following specific actions are taken:

1. Exploring the vocabulary for describing mental wellbeing with Pakistani, Chinese, and other BME communities in Scotland to use in further research and enable a stronger focus on lay perceptions
2. Extending the search for grey literature by contacting Chinese and Pakistani mental health organisations across the UK
3. Extending the search using the search terms ‘spiritual wellbeing’ and ‘peace of mind’.
4. Undertaking further analysis of the literature to explore the issue of conceptual equivalence in more depth
5. Undertaking more detailed analysis of the interview data already collected.

In addition the following recommendations are made for the second phase of the research:

1. Given the identified gap in the knowledge base the next phase of research should focus on exploring narratives in relation to the broad conceptions of mental wellbeing identified by this review.
2. Building on this work to extend data collection to community members, which should be undertaken using participatory research methods to involve communities in the design of the research and as co-researchers. From our experience this will require investment in capacity-building to enable and equip people from the target communities to be actively involved in the next phase of research.
3. A deliberate approach to exploring the diversity within BME communities using stratified sampling to extend data collection to isolated communities in rural areas and to ensure a balanced representation of men, people of different ages and generations in the sample.

4. Using focus groups to explore points of convergence and divergence and to include cultural orientation and identity as lines of inquiry.

5. Using scenarios or vignettes to stimulate discussion and enable the discussion to avoid, if possible, mental wellbeing being viewed through the lens of mental illness.

6. Ensuring that the research team have the appropriate language skills.

13. Conclusion

As Delivering for Mental Health makes clear, ‘good mental health is important to everyone living in Scotland’ (Scottish Executive, 2006, p. vi). This scoping exercise has demonstrated that what constitutes good mental health i.e. mental wellbeing is different across different communities and across different generations of people living and working in Scotland. If the ambition to promote mental health for all of Scotland’s population is to be realised, further work with Scotland’s’ diverse communities on exploring the different conceptualisations and their implications for mental health improvement interventions is supported by this review. The way in which this work is undertaken needs to ensure that equal weight is given to different conceptualisations of mental wellbeing and that particular approaches preferred by the majority community are not uncritically transposed on to other communities. Both this moral imperative and the review of methodological approaches point to working in genuine partnership with Black and minority ethnic communities in Scotland to define, design and develop research and interventions that reflect these different world views.
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[http://www.scotland.gov.uk/About/scotPerforms/outcomes](http://www.scotland.gov.uk/About/scotPerforms/outcomes)


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Appendix 1: Technical appendix for literature review

1.1 Search strategy

1.1.1 Bibliographic databases searched

Table 9: Bibliographic databases searched

<table>
<thead>
<tr>
<th>Database Type</th>
<th>Sources</th>
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</thead>
<tbody>
<tr>
<td>Health related databases</td>
<td>Cochrane, Medline, EMBASE, Cinahl, PsychInfo</td>
</tr>
<tr>
<td>Health related unpublished research sources</td>
<td>NRR, Refer</td>
</tr>
<tr>
<td>Social science/care databases</td>
<td>Wilson Social Science Abstracts, CSA, Social science abstracts, ASSIA, Web of Knowledge, IBSS, Social Care Online, Social Work abstracts</td>
</tr>
<tr>
<td>Anthropological databases</td>
<td>The Anthropological Index of the Royal Anthropological Institute, Anthropology Review Database</td>
</tr>
<tr>
<td>Health and social care management</td>
<td>HMIC, Kings Fund</td>
</tr>
<tr>
<td>Grey literature databases</td>
<td>Open SIGLEC</td>
</tr>
<tr>
<td>Mail lists</td>
<td>JISC mail</td>
</tr>
<tr>
<td>Health promotion</td>
<td>HealthPromis, HDA Evidence Base (NICE)</td>
</tr>
<tr>
<td>Newspaper coverage</td>
<td>Lexis</td>
</tr>
<tr>
<td>Research review or subject specific sources</td>
<td>EPPI Centre, Campbell SPECTR, CEEHD (UK Centre for Ethnicity, Health and Diversity), CRER Database, Information for Practice, NRCEMH, SLEH, SOURCE International Information and Support Centre, Chinese Mental Health Association, Dim Sum Care Services Improvement Partnership</td>
</tr>
<tr>
<td>Internet sources</td>
<td>Google, Google Scholar, BUBL</td>
</tr>
</tbody>
</table>

1.1.2 Hand searching
Reports from the Centre for Ethnicity and Health Community Engagement Project projects were searched by hand.

1.1.3 Citation tracking
Citation tracking was undertaken and this was limited to theoretical papers and qualitative studies, as the latter in particular was identified as a gap in the knowledge base.

1.1.4 Expert opinion
A limited number of experts were consulted. These were identified either by NHS Health Scotland or colleagues within the Institute for Philosophy, Diversity and Mental Health.
1.2 Search terms
The search terms used were:
(Mental wellbeing) or (Emotional wellbeing) or Happiness or Self-esteem or (Psychological wellbeing) or (Subjective Wellbeing) or (Psychological resilience/adaptation) or (Mental health beliefs) or (Mental health concepts) or (Mental health promotion) or (Mental illness prevention) or (Positive mental health Promotion) and Chinese or Pakistani or Muslim or Asian or BME.

MeSH terms used for mental wellbeing were mental health; mental disorder; mental health services; health status; health promotion; quality of life; personal satisfaction; adaptation; psychological; models; psychological; self efficacy; motivation and for Chinese and Pakistani Asian Continental Ancestry Group.

English Language only

1.3 Sample search strategy
Table 10: Sample search strategy using Ovid Medline (R) January 1988 to November 2007

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<td>12 and 25</td>
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<td>37</td>
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82
1.4 Inclusion and exclusion criteria

**Inclusion criteria**

- **Participants:** Pakistani, Chinese; Asian; South Asian; Muslim of all ages and both men and women.
- **Definition of mental wellbeing:** As this is the focus of the review and given the conceptual issues raised earlier, the definition aimed to be as inclusive as possible and included beliefs, attitudes, personal experiences, self-expression, social relationships and behaviours that convey a positive sense of wellbeing and/or freedom from mental illness. The search terms used included mental wellbeing\(^{14}\), emotional wellbeing, psychological wellbeing, subjective wellbeing, resilience, happiness and self-esteem.
- **Interventions:** Material relating to mental health promotion activities used by Chinese and Pakistani communities was searched for using the terms mental health promotion, positive mental health and prevention of mental illness.
- **Contexts:** Scotland; UK; China; Pakistan; English-speaking non-UK countries, Europe
- **Literature.** The search will be limited to literature published from 1988 to the present day, as little of note has been published in this area before then. The search will be limited to material published in English.

**Exclusion criteria**

- Papers published in languages other than English.
- Papers relating to other BME communities.
- Papers solely concerned with substance abuse, drug misuse and alcohol abuse, or learning disabilities.

\(^{14}\) And various spellings of wellbeing i.e. well being and well-being
1.5 Data Filtration
Form A was used to filter all material meeting the inclusion criteria on the basis of title and abstract.

**Form A: Data filtration form**

<table>
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<tr>
<td>Title of paper (first few words)</td>
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<tr>
<td>Reference Manager Number</td>
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</table>

Only select papers in English, published after 1.1.1988 for filtration.

**PRIMARY FILTRATION CRITERIA**

<table>
<thead>
<tr>
<th>Does the paper relate to one of:</th>
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<td>Chinese communities</td>
<td></td>
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<tr>
<td>Pakistani</td>
<td></td>
</tr>
<tr>
<td>Asian or South Asian</td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td></td>
</tr>
<tr>
<td><strong>AND</strong></td>
<td><strong>-</strong></td>
</tr>
<tr>
<td>Mental wellbeing</td>
<td></td>
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<tr>
<td><strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td>Mental health promotion</td>
<td></td>
</tr>
<tr>
<td>Prevention of mental illness</td>
<td></td>
</tr>
<tr>
<td><strong>AND</strong></td>
<td><strong>-</strong></td>
</tr>
<tr>
<td>UK context</td>
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**IF YES - ADD TO DATABASE AND PROGRESS TO DATA EXTRACTION**

If the paper does not directly relate to the above:

**SECONDARY FILTRATION CRITERIA**

<table>
<thead>
<tr>
<th>Does the paper relate to mental wellbeing/mental health promotion of Chinese or Pakistani communities in China Hong Kong or Pakistan?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Does it relate to mental wellbeing/mental health promotion of Chinese or Pakistani communities in English-speaking non-UK countries?</td>
<td></td>
</tr>
<tr>
<td>Does it relate to the conceptualisation of mental health needs for Chinese or Pakistani or Asian communities?</td>
<td></td>
</tr>
<tr>
<td>Does it relate to mental wellbeing/mental health promotion and BME communities?</td>
<td></td>
</tr>
</tbody>
</table>

Reviewer 1      Reviewer 2:

**IF YES – ADD TO DATABASE AND LABEL USING KEYWORDING STRATEGY**
1.6 Data extraction

Forms B and c were used to extract data from all material meeting criteria for inclusion as a primary source i.e. UK material.

**Form B: Empirical studies**

**1. Publication Details**

| Name of author(s)         |  
| Date of publication      |  
| Title of paper           |  
| Reference ID             |  

**2. Classification**

| Document type |  
| What is the stated purpose of the document? |  

**3. Nature of the study**

| Aims of the study |  
| Any further research questions |  
| Study type and design |  
| Study date and duration |  
| Research tools used |  
| Analysis used |  
| Location (Scotland; UK; China, Hong Kong or Pakistan; Other) |  
| Study sites (setting and key characteristics) |  
| Participants (ethnicity, age, gender, faith ) |  
| Sampling/recruitment procedures |  
| Number of participants |  
| Characteristics of participants |  
| Details of any theory referred to or conceptual models |  

85
4. Findings

<table>
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<th>Language and key terms used to describe mental wellbeing</th>
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<tr>
<td>Conceptualisations of mental wellbeing</td>
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<td>Factors influencing mental wellbeing</td>
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<td>Comparisons with other communities</td>
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<td>Strategies to promote mental wellbeing</td>
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<td>Strategies to prevent mental illness</td>
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<td>Outcomes including community views</td>
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<tr>
<td>Recommendations or good practice in relation to mental health promotion strategies</td>
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5. Other observations
# Form C: Descriptive papers and commentary

## 1. Publication Details

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## 2. Classification

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<td>Population (ethnicity, age, gender, faith)</td>
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<tr>
<td>Location (Scotland, UK, China, Hong Kong or Pakistan, Other)</td>
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## 3. Content

| Language and key terms used to describe mental wellbeing |  |
| Conceptualisations of mental wellbeing |  |
| Details of any theory referred to or conceptual models |  |
| Factors influencing mental wellbeing |  |
| Comparisons with other communities |  |
| Strategies to promote mental wellbeing |  |
| Strategies to prevent mental illness |  |
| Outcomes including community views |  |
| Recommendations or good practice in relation to mental health promotion strategies |  |
1.7 TAPUPAS: Quality Appraisal Tool

For each item rate low, medium or high

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<td><strong>A.6.3 Religion</strong></td>
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Appendix 2: Briefing Sheet

Scoping exercise with Black and minority ethnic groups on perceptions of mental wellbeing in Scotland

Background
Public mental health and a focus on mental wellbeing forms part of the wider agenda in Scotland for health improvement. There are many different ways of understanding mental wellbeing and mental health. It is clear that age, class, gender, cultural and religious beliefs as well as personal experiences and expectations are likely to be an influence. This will impact upon the strategies used by individuals and communities to promote mental health and prevent mental illness. However little work on these has been undertaken in the UK to explore this in relation to Black and minority ethnic communities. Against this background, Health Scotland has commissioned the Centre for Ethnicity and Health at the University of Central Lancashire to undertake a scoping exercise of the definitions and understanding of mental wellbeing in Chinese and Pakistani communities in Scotland and the strategies used by these communities to promote mental health and prevent mental health problems.

What are the main aims of the project?
The aims of this project are to develop an increased understanding of:

1. Definitions of mental health and wellbeing among Chinese and Pakistani communities;
2. The extent to which definitions and understandings of mental wellbeing differ from the majority communities within Scotland and;
3. How these impact on strategies used by the communities to maintain mental wellbeing and prevent mental health problems.

This will provide a greater understanding of the degree to which definitions and practices complement and diverge from current approaches to mental health improvement in Scotland.

How will this be achieved?
The scoping exercise involves:

- Reviewing the currently available literature to investigate what is already known about definitions and understanding of mental wellbeing within Chinese and Pakistani communities and the strategies used to promote wellbeing and prevent mental health problems within these communities;
- Consulting with community workers, leaders and other key people who have knowledge of Chinese and Pakistani communities within Scotland. The focus of this consultation will be the definitions of mental wellbeing and strategies
used by these communities and the degree to which they are similar or
different to those of the majority community in Scotland;

- To identify implications and priorities for further research.

In practical terms this will involve interviews or focus groups with community
workers and leaders. The interviews and focus groups will be arranged at a
convenient location and additional information about the project will be given prior
to these.

**Outputs**
A report of the findings will be produced for Health Scotland and a brief summary
that will be sent to all those who participate in the scoping exercise.

**Timescale**
The project started in November 2007 and is scheduled for completion in March
2008.

**Project Team**
The Project lead is Karen Newbigging, with Professor Ajit Shah and Dr. Manjit
Bola. All members of the project team are experienced in undertaking systematic
literature reviews and are well versed in the range of issues relating to mental
health and inequalities for a diverse range of BME communities. The literature
review is being undertaken by Karen Newbigging and Professor Ajit Shah and
the interviews and focus groups will mainly be undertaken by Dr. Manjit Bola and
Karen Newbigging.

**Further Information**

**Contact:**
- Karen Newbigging (Project lead-Centre for Ethnicity and Health, UCLAN) on k.newbigging@uclan.ac.uk or ring 07974-929367
- Manjit Bola (to arrange an interview) on mbola@uclan.ac.uk or ring 07906-724206
- Joanna Teuton (Public Health Adviser – Mental Health and Wellbeing) on Joanna.teuton@health.scot.nhs.uk or ring 0141 300 1048
- Dale Meller (Programme Manager Mental Health - NRCEMH) on dale.meller@health.scot.nhs.uk or ring 0141 354 2933
Appendix 3: Topic guide for individual and group interviews

The following are the lines of inquiry for the in-depth interviews.

1. Role of organisation and nature of work with Pakistani/Chinese communities in Scotland?

2. Profile of interviewee
   - Ethnicity and country of origin
   - Languages spoken

3. Concepts of mental wellbeing and/or mental health used by members from Pakistani/Chinese communities community
   - Meaning and relevance of concepts
   - Specific terminology used

4. Factors influencing members conceptualisations of mental wellbeing
   - Age
   - Class
   - Geographical location (in Scotland and country of origin)
   - Gender
   - Cultural traditions
   - Religious beliefs
   - Personal experiences
   - Personal expectations
   - Other factors

5. Strategies used by Pakistani/Chinese communities to maintain mental wellbeing, promote positive mental health and/or prevent mental illness

6. Comparison with Westernised conceptualisations and other ethnic minority communities including factors such as
   - Eastern philosophy of mind/body link
   - Cultural traditions and their maintenance (e.g. family honour/duty; role of outside influences – having spells or curses put upon you; kismet)
   - family/social structures – extended family

7. Comparison with strategies used by members of the majority community living in Scotland including:
   - Use of statutory services
   - Community events
   - Family relationships
   - Social relationships
- Personal beliefs

8. Main issues affecting mental wellbeing for the Pakistani/Chinese community.


10. Other services, if any, required by the community

11. Reflections on research process and interview.
Appendix 4: Overview of search results

Searches of electronic database, internet searching, recommended by experts
N = 5264
After duplicates removed
N = 4006

Abstracts and titles screened
N = 4006

Papers excluded
N = 3549

- Exclude date
  N = 8

- Exclude scope
  N = 3398

- Exclude population
  N = 132

- Exclude language
  N = 11

Papers meeting inclusion criteria and filtered
N = 508 (UK = 124, Non-UK = 384)

- Papers excluded
  N = 318

  - Exclude scope
    N = 302

  - Exclude population
    N = 16

  - Could not retrieve = 50
    (7 UK, 3 possibly primary, 43 non-UK)

Primary sources (UK)
N = 32

Secondary (Non-UK)
N = 108
Appendix 5: Bibliography of results of literature review

UK material


Aziz, I., Hasham, I., Patel, K., & Ramzan, P. 2007, *Exploring the needs and views and experiences of South Asian mental health carers in Blackburn with Darwen*, Blackburn with Darwen Community Links Limited, Blackburn with Darwen.


National Institute for Mental Health England 2004a, Celebrating our cultures: guidelines for mental health promotion with the Chinese community, Department of Health, London.

National Institute for Mental Health England 2004b, Celebrating our cultures: guidelines for mental health promotion with the South Asian community, Department of Health, London.

National Institute for Mental Health England 2004c, Celebrating our cultures: guidelines for mental health promotion with black and minority communities, Department of Health, London.


Renfrewshire Association for Mental Health 2000, Changing Minds: Ascertain the mental health needs of Black and minority ethnic People, Renfrewshire Association for Mental Health.


Material from China


Silverstein, M., Cong, Z., & Li, S. 2006, "Intergenerational transfers and living arrangements of older people in rural China: Consequences for psychological well-being", *Journals of Gerontology - Series B Psychological Sciences and Social Sciences*.61(5) pp S256-S266.


Material from Pakistan


Material from US and Canada


Material from Australia and New Zealand


Material from Europe

### Appendix 6: Summary of UK material- systematic inquiry

#### 1. Chinese communities

<table>
<thead>
<tr>
<th>Publication Details</th>
<th>Population and Location</th>
<th>Type of Paper</th>
<th>Study Aim</th>
<th>Study Design</th>
<th>Relevant Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chan, Ho, Ho, et al, 2007, The needs of Chinese older people with dementia and their carers.</td>
<td>People aged 50+ with 75% born in HK and none in UK. Majority Cantonese speakers with 14% fluent in English. Living in Greater Manchester, England.</td>
<td>Unpublished report</td>
<td>To explore the needs of Chinese older people with dementia and their carers</td>
<td>Semi-structured questionnaire with 72 responses and a focus group.</td>
<td>1. Happiness used as main construct with following identified - able to join activities, being content with circumstances and not worrying too much and religious faith, being together with family, having friends or visitors to talk too, children being settled and keeping oneself healthy or being free from illness or pain. 2. 26% did not know what mental health meant. 28% defined it in terms of being content with personal circumstances and not worrying too much and 17% referred to mental health as a “balanced mind” so that the person is able to think positively and 14% to being in good health, both physically and mentally. 3. 51% thought dementia could be prevented and identified the following – making friends 80%, outdoor activities 77%, playing Ma jiang 72%, Tai Chi 54%, singing such as Chinese opera 57%, card games 58%, dancing 47%.</td>
</tr>
<tr>
<td>Huang &amp; Spurgeon, 2006, The mental health of Chinese immigrants in Birmingham, UK,</td>
<td>113 Chinese people in Birmingham, aged 21-60+ with the majority (90%) having lived in Birmingham for more than 3 years.</td>
<td>Peer-reviewed journal article</td>
<td>To describe the life experiences associated with migration to the UK and to explore in-depth information about the processes of life adjustment to migration and mental health of Chinese immigrants in a large city area.</td>
<td>A cross-sectional quantitative survey using a questionnaire to investigate demographic factors, life experiences associated with migration, proficiency in English and mental health status. In depth interviews were used with a sample to explore these factors further.</td>
<td>1. Mental wellbeing defined in terms of life adjustment following migration. GHQ used to determine mental health status and indicated that 62% had mild or moderate mental health problems. 2. Adjustment heavily dependent of family relationships and for those in the catering industry psychological adjustment heavily dependent on strong ties with the Chinese community as there was minimal contact with the host society. 3. Those in professional roles, experienced conflict as a result of perceived need for integration alongside recognition of the problems associated with this. The role of family relationships emphasised as mental health status of the majority was poor.</td>
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<tr>
<td>PUBLICATION DETAILS</td>
<td>POPULATION AND LOCATION</td>
<td>TYPE OF PAPER</td>
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<tr>
<td>Prior, Chun, &amp; Huat, 2000, Beliefs and accounts of illness. Views from two Cantonese-speaking communities in England</td>
<td>64 Cantonese-speaking Chinese people, aged 18-60+ living in two urban areas, one in North and one in South of England.</td>
<td>Peer-reviewed journal article</td>
<td>To examine lay accounts of illness and health of two Cantonese-speaking communities in England</td>
<td>Qualitative study with eight focus groups using vignettes as stimulants for discussion</td>
<td>1. There was a strong agreement that a healthy life was to be achieved through happiness, contentment and an inner sense of balance and this was particularly the case for women, who mentioned it more than twice as often as men. 2. Concept of health extends beyond happiness and the physical body health to the social body. 3. A wide variety of agents used to account for illness but much more limited in relation to health. 4. Serious mental illness is stigmatised but less serious illnesses, recognised by professionals as symptoms appear to be framed as problems of living.</td>
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<tr>
<td>Li &amp; Logan, 1999, The mental health needs of Chinese people in England</td>
<td>401 Chinese people living in London, Leeds, Birmingham, Liverpool, and Nottingham</td>
<td>Report</td>
<td>To examine the barriers encountered by Chinese people with mental health needs in England, which hinder obtaining appropriate help form the NHS</td>
<td>Cross sectional survey using questionnaire plus targeted interviews with Chinese people plus postal questionnaires to community workers, GPs, commissioning managers and psychiatrists.</td>
<td>1. Mental illnesses viewed as serious and incurable conditions. 2. Steps to prevent mental illnesses, predominantly identified by professionals included: • promotion of a more caring society • provision of social activities to reduce isolation • raising the communities’ awareness of mental health • making information available • early detection of problems • access to Chinese mental health workers</td>
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<tr>
<td>Furnham &amp; Li, 1993. The psychological adjustment of the Chinese community in Britain: A study of two generations.</td>
<td>43 first-generation and 27 second generation Chinese immigrants to the UK living in London, Edinburgh and the Midlands.</td>
<td>Peer-reviewed Journal article</td>
<td>To examine the psychological health and adjustment to life in Britain of first and second generation immigrants to Britain.</td>
<td>Cross-sectional study using a questionnaire to collect data on personal details; four main independent variables-proficiency in the English language; strength of Chinese values held; access to social support and personal expectations concerning life in Britain; and measures of psychological health (Langner-22 and Beck Depression Inventory)</td>
<td>1. Evidence for language problems and unfulfilled expectations being linked to mental health in the second generation. 2. Findings suggest complex differences between generations in terms of adjustment to host culture and adherence to core cultural values.</td>
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## 2. Pakistani, Muslim and South Asian communities

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<th>STUDY AIM</th>
<th>STUDY DESIGN</th>
<th>RELEVANT FINDINGS</th>
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<tbody>
<tr>
<td>Aziz, Hasham, Patel, &amp; et al, 2007, Exploring the needs and views and experiences of South Asian mental health carers in Blackburn with Darwen</td>
<td>71 South Asian carers living in Blackburn with Darwen, aged 19 – 50+, 80% identified as Muslims and majority were women</td>
<td>Unpublished report</td>
<td>To explore the needs, views and experiences, including perceptions of mental health of South Asian mental health carers</td>
<td>Needs assessment using community engagement model with community researchers. Data collection through focus groups or individual interviews.</td>
<td>1. In general, there was little knowledge of mental health and when asked to define mental health they repeatedly associated it with ill-health and negative spiritual concepts. This was particularly the case for the older generation. 2. Highlighted that mental health was being able to look after yourself, be active, exercise, having a healthy mind and being able to converse socially was a key element.</td>
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<tr>
<td>Chopra, Farouk, Haq, et al, 2007, &quot;Domestic violence and mental health: experiences of South Asian women in Manchester&quot;</td>
<td>South Asian women Aged 18+, predominantly Muslim, experiencing domestic violence and their children living in Manchester</td>
<td>Unpublished report</td>
<td>To explore understandings and links between domestic violence and mental health; to assess needs of the women and their children and their experience of services.</td>
<td>Needs assessment using community engagement model with community researchers. Data collection through individual semi-structured interviews.</td>
<td>1. Mental wellbeing defined as peace of mind and feeling good about yourself. 2. Women consistently attributed wellbeing and mental health to the absence of inhibiting factors namely stress, fear, violence and abuse and to positive factors like confidence, self esteem and ‘feeling relaxed’ in your own home. 3. Understanding of mental health interpreted as reflecting experience of domestic violence and its impact upon self-esteem, self worth and ability to live independently and experience freedom in everyday life and decision-making.</td>
</tr>
<tr>
<td>Khan, Choudry, Khurshid, et al, 2007, The mental health views, concerns and needs of the Pakistani community in Small Heath, Birmingham. See also see Aap Ki Awaaz project (2007).</td>
<td>Pakistani Muslims aged 16 + living in Birmingham</td>
<td>Unpublished report and published summary report</td>
<td>To learn about perceptions of mental health and illness To explore mental health needs To understand how mental health services are viewed.</td>
<td>Questionnaire (152 completed) plus two specific groups and a focus group with service providers using the UCLan community engagement model.</td>
<td>1. Less than half of the sample (43%) responded to the question asking what mental health meant. 2. Mental health termed dimaghi sehat and seen as linked to everything and specifically to physical health. 3. 57% linked mental health to mental illness and it was also linked to religion. 4. 74% thought culture and family traditions impact upon perceptions of wellbeing, particularly those born in Britain, and 61% to media publicity of Muslims. 5. Religion was identified as a strategy for maintaining mental health.</td>
</tr>
<tr>
<td>PUBLICATION DETAILS</td>
<td>POPULATION AND LOCATION</td>
<td>TYPE OF PAPER</td>
<td>STUDY AIM</td>
<td>STUDY DESIGN</td>
<td>RELEVANT FINDINGS</td>
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<tr>
<td>Quraishi, S. &amp; Evangeli, M. (2007). An investigation of psychological well-being and cultural identity in British Asian female University students*.</td>
<td>British women of Asian descent aged 18-29 in London</td>
<td>Peer reviewed Journal article</td>
<td>To assess if cultural identity relates to psychological wellbeing in British women of Asian descent</td>
<td>Cross-sectional study using measures in three areas-cultural identity; psychological wellbeing (GHQ 12, Positive feelings facet of the WHO Quality of Life assessment, Symptom Checklist 90R) and Family Environment</td>
<td>1. Results were not disaggregated by ethnic group but findings revealed that identity status (construed as a possible source of cultural conflict) had minimal overall impact on psychological wellbeing.</td>
</tr>
<tr>
<td>Bashford, Kaur, Winters, et al., 2006, Healthy minds; A child and adolescent mental health research project*</td>
<td>50 children and young people aged 11-18 attending secondary schools in Bradford and Keighley</td>
<td>Unpublished report</td>
<td>To determine the mental health needs of Bradford’s Pakistani Muslim children and young people</td>
<td>Focused literature review, interviews with professionals, managers and commissioners of CAMHS services and 7 focus groups with children and young people</td>
<td>1. Response to questions relating to what they saw as being mentally health grouped into seven domains-views of others, ability, identity, physical health and attributes, feelings, mental ability and behaviour. The majority of responses related to physical attributes and mental ability, reflecting concerns about academic performance and aspirations to achieve. 2. Authors conclude that young people able to articulate a sophisticated description of what constitutes mental health in contrast with professionals’ view that they were likely to be relatively unaware of mental health issues.</td>
</tr>
<tr>
<td>Bector, Randhawa, Mehan et al., 2006, Asian men's mental health needs assessment</td>
<td>40 Asian men, aged 19-83, with mental health problems living in Wolverhampton</td>
<td>Unpublished report</td>
<td>To explore how well mental health services are meeting the needs of Asian men in Wolverhampton</td>
<td>Needs assessment using community engagement model with community researchers. Data collection through questionnaires.</td>
<td>1. Limited understanding of mental illness and broader concept of mental health. 2. Faith, talking to someone, keeping busy, music, family members, medication, drinking and smoking, work all identified as helping them to cope with daily life.</td>
</tr>
<tr>
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| Hussain, N. 2006,   | 33 first-generation Punjabi immigrants from Pakistan,      | Peer reviewed journal      | To explore why first-generation Punjabi immigrants had one of the         | Qualitative study using interviews to generate personal narratives             | 1. Concept of mental health not congruent with the Western concept-term mental health problematic with 'mental' suggestive of 'madness', which was viewed as punishment for sins.  
2. Four key concepts critical regarding health and distress-kismet, sabr, purdah and izzat.  
3. Broad concept of spiritual wellbeing termed 'peace of mind', which requires optimism, an ability to carry out religious duties and fulfill gender roles.  
4. Family structure, good izzat, with each member observing purdah, and with blessing of God considered necessary to have peace of mind.  
5. Reestablishing family structure, prayer and sabr are ways of rewriting kismet and therefore addressing mental ill-health.  
6. Enduring distress without complaint and observing gender roles piously can entice God to ameliorate distress and rewrite kismet. |
| Culturally determined care goals and the efficacy of statutory services. | aged 55+ experiencing mental distress living in Northern England | article | of the lowest uptakes rates of statutory mental health care, despite being on one of the largest BME groups in that region. |                                                                                                                                     |                                                                                                                                                                                                                       |
| Saeed, Sarwar, Younas et al., 2006, Report of the community led research project focussing on self defined mental health needs of the Muslim community” | Muslim men and women aged 16-40 years living in Bradford, England. | Unpublished report | To explore the relationship between faith, personal identity and cultural and political context. To provide a description of factors and relationships that impinge on mental wellbeing and/or mental health. To identify how the above influences choice of support. | Participatory research involving 6 focus groups and 10-15 interviews. | 1. Faith central to defining identity.  
2. Role of faith in maintaining wellbeing.  
3. Stigma identified in relation to services being culturally unaware of faith and religious beliefs of service users  
4. Impact of discrimination and identity as a Muslim impacting upon mental health  
5. Need for gender specific and age specific services  
6. Stigma identified in relation to services being culturally unaware of faith and religious beliefs of service users |
<table>
<thead>
<tr>
<th>Publication Details</th>
<th>Population and Location</th>
<th>Type of Paper</th>
<th>Study Aim</th>
<th>Study Design</th>
<th>Relevant Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anand, &amp; Cochrane, 2005, The mental health status of South Asian women in Britain: A review of the UK literature.</td>
<td>South Asian women in Britain</td>
<td>Peer reviewed journal article</td>
<td>To review research studies that describe cultural influences on conceptualisations and expressions of distress, help seeking behaviours and alternative coping strategies.</td>
<td>Review of the UK literature on the mental health status of South Asian women living in Britain.</td>
<td>1. Conceptions of mental health embedded in a religious, holistic and relational context orientated in religious (Muslim and Hindu) belief systems. 2. Relationship between acculturation and mental health mediated by capacity to experience shame. Value of shame as an intervening variable to regulate behaviours that are important in maintaining group identity (community and family ties). 3. Role of prayer as a coping strategy.</td>
</tr>
<tr>
<td>Gilbert, Gilbert, &amp; Sanghera, 2004, A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby.</td>
<td>South Asian women of different ages living in Derby.</td>
<td>Peer reviewed journal article</td>
<td>To examine South Asian women’s views of the processes of shame, subordination and entrapment and how they impact upon their lives.</td>
<td>Focus groups to explore the views on the processes of izzat, shame, subordination and their impact on mental health.</td>
<td>1. Key themes to emerge suggest that mental health is linked to the themes of izzat (family honour, shame, subordination; with a distinction drawn between compromising and giving in) and entrapment. 2. Fear of bringing shame to others was linked to socially defined rules and prescriptions for maintaining reputation via culturally transmitted systems of izzat.</td>
</tr>
<tr>
<td>Sheikh, S. &amp; Furnham, A. 2000, A cross-cultural study of mental health beliefs and attitudes towards seeking professional help</td>
<td>287 adults from three groups-British Asian, Western European and Pakistani in London and Karachi</td>
<td>Peer-reviewed Journal article</td>
<td>To examine the relationship between cultural beliefs about the causes of mental distress and attitude associated with seeking professional help for a psychological problem.</td>
<td>Participants completed two questionnaires: Orientations to seeking Professional help and the Mental Distress Explanatory Questionnaire</td>
<td>1. Significant differences between three groups in terms of causal attributions of mental illness. Culture found to be a predictor for all four categories of causal beliefs- stress; Western physiological causes; supernatural causes and non-Western physiological causes. Pakistanis had higher scores for all 4 thought to reflect medically pluralistic context in Pakistan in which all 4 etiologies exist. 2. Muslims had highest scores for belief in ‘supernatural’ causes of mental distress.</td>
</tr>
<tr>
<td>Sonuga-Barke, E. J. S. &amp; Mistry, M. 2000, The effect of extended family living on the mental health of three generations within two Asian communities.</td>
<td>44 Muslim and 42 Hindu families whose children attended one of four primary schools in east London</td>
<td>Peer-reviewed journal article</td>
<td>To explore the impact of nuclear and extended family living on the mental health of three generations in British Muslim and Hindu communities.</td>
<td>Cross-sectional study using rating scales to compare two populations in terms of wellbeing (Hospital Anxiety and depression Scale), children’s adjustment and an acculturation index.</td>
<td>1. Negative mental health conceptualised by study authors in Western terms of loss of sense of agency and feelings of helplessness. 2. Draws out generational differences in terms of Muslim women living in more traditional family structures, having more restricted roles, less likely to be in paid employment or to come from acculturated families. However indices of traditionality not found to be correlated with mental health.</td>
</tr>
<tr>
<td>Tabassum, Macaskill, &amp; Ahmad, 2000, Attitudes towards mental health in an urban Pakistani community in the United Kingdom</td>
<td>29 first and 23 second generation women and 22 male heads of Households in Sheffield</td>
<td>Peer-reviewed journal article</td>
<td>To investigate the attitudes of Pakistani families living in an urban area of the UK towards mental health issues; to identify the emic models and compare them with the etic model, predominant in Western medicine.</td>
<td>Interviews using a schedule relating to various aspects of mental health including questions about aetiology of psychiatric illnesses and factors related to health and help-seeking</td>
<td>1. Results indicate a reasonable level of psychological symptomatology and entire sample had knowledge of at least one person experiencing mental illness. 2. Main emphasis placed on physical symptoms. 3. Also emphasis on aggressive behaviour as unacceptable</td>
</tr>
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### 3. Summary of UK material - systematic inquiry – Black and minority ethnic communities in Scotland

<table>
<thead>
<tr>
<th>PUBLICATION DETAILS</th>
<th>POPULATION AND LOCATION</th>
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<th>STUDY DESIGN</th>
<th>RELEVANT FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow Anti-Stigma Partnership 2007, “Mosaics of Meaning”</td>
<td>Pakistani, Chinese, Indian and African Caribbean communities in Glasgow</td>
<td>Published report</td>
<td>To explore stigma for people with mental health problems from 4 Black and minority ethnic communities (Pakistani, Chinese, Indian and African Caribbean) in Glasgow</td>
<td>Brief literature review of published evidence of attitudes towards mental health within the 4 target communities and action research involving focus groups to explore the issues of stigma in these communities in Glasgow.</td>
<td>1. Identified a shared conception of mental health as a sense of harmony; of being in balance and of peace underpinned by a concept of community harmony and belonging. 2. Mental health initially associated by Muslim communities with negative terms relating to serious mental illness (‘pagal’), including learning disability and in Chinese communities to more common and milder mental health problems with few generational differences. 3. Religion plays a major part for Muslim communities in perceptions of mental health and is used as a source of potential support. In Chinese communities, there is no single religion but spiritual and religious beliefs are also important. 4. Mental illness is construed as a single illness at the severe end of the continuum. 5. A consensus that changing attitudes to mental health issues would be difficult and the main barriers identified were fixed views, lack of interest, lack of understanding and language.</td>
</tr>
<tr>
<td>Renfrewshire Association for Mental Health, 2000, “Changing Minds: Ascertaining the mental health needs of Black and minority ethnic People”</td>
<td>29 people, (service users and non-service users) from BME communities in East Renfrewshire/South of Glasgow. Mainly from Pakistani communities, but also Chinese, and other communities.</td>
<td>Unpublished report</td>
<td>To ascertain the mental health needs of people from BME communities and to make recommendations for service delivery</td>
<td>Needs assessment using semi-structured interviews, focus groups with people from BME communities and also interviews with service providers and visits to outreach centres.</td>
<td>1. Concepts of health and wellbeing varied considerably between service users and non-users with service users recognising the importance of a holistic concept of mental health. Non-service users had difficulty understanding the term mental health and often associated it with ‘pagal’ or mad. 2. Respondents gave accounts of situations that adversely affect their mental health, such as racism and positive wellbeing was associated as not experiencing racism and not experiencing stress. The majority of service users explained positive wellbeing in terms of self esteem, confidence and access to learning.</td>
</tr>
<tr>
<td>GAMH Ethnic Minority Project 1995, “Promoting awareness: Perceptions of mental health needs of Black and Ethnic Minority Communities in Glasgow”</td>
<td>60 people including 25 users and potential users of mental health services and carers in Glasgow with 55% from Pakistani and 33% from Chinese communities</td>
<td>Unpublished report</td>
<td>To assess the mental health needs of selected ethnic minorities (Including Chinese and Pakistani) in Glasgow and their perception of existing mental health services</td>
<td>Needs assessment involving individual interviews using a questionnaire</td>
<td>1. Majority of Chinese people defined being healthy in physical terms with a minority making reference to mental aspects—having no worries or being happy within self. 3. Pakistani respondents focused on the ability to cope with everyday life, the lack of worries, anxieties or stress or the ability to undertake daily chores without assistance. They also referred to having no worries, peace of mind and the absence of disease, not just physical but mental and spiritual.</td>
</tr>
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### Appendix 7: Language and terms used

#### Chinese Communities

<table>
<thead>
<tr>
<th>Phrase or word</th>
<th>Meaning</th>
<th>Source</th>
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<tbody>
<tr>
<td>Endurance</td>
<td>Anything positive and good in life, roughly translates to happiness</td>
<td>Yeung 2002</td>
</tr>
<tr>
<td>Fu or fu qi</td>
<td>Happiness</td>
<td>Lu &amp; Shih, 1997</td>
</tr>
<tr>
<td>Fa lok</td>
<td>Happiness</td>
<td>Yip 2005</td>
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<tr>
<td>Wor</td>
<td>Harmony</td>
<td>Yip 2005</td>
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<tr>
<td>Sim on</td>
<td>Internal sense of security</td>
<td>Yip 2005</td>
</tr>
<tr>
<td>Tin yu</td>
<td>Relaxed</td>
<td>Yip 2005</td>
</tr>
<tr>
<td>Jing shum geen hong</td>
<td>Mental health</td>
<td>Yip 2005</td>
</tr>
<tr>
<td>Keng hong (Cantonese)</td>
<td>Healthy</td>
<td>Interviews</td>
</tr>
<tr>
<td>Kinhon</td>
<td>Health</td>
<td>Kinhon Project, Sheffield</td>
</tr>
<tr>
<td>Kualie (Cantonese)</td>
<td>Being happy</td>
<td>Prior, Chuan &amp; Huat, 2000</td>
</tr>
<tr>
<td>Xing fu (Cantonese)</td>
<td>Happiness</td>
<td>Prior, Chuan &amp; Huat, 2000</td>
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#### Pakistani Communities

<table>
<thead>
<tr>
<th>Phrase or word</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>Dimaghi sehat</td>
<td>Mental health</td>
<td>Khan, Choudry, Kurshid &amp; Shuaib (2007)</td>
</tr>
<tr>
<td>Zehni bemari</td>
<td>Mental health</td>
<td>Khan, Choudry, Kurshid &amp; Shuaib (2007)</td>
</tr>
<tr>
<td>‘Kushi’</td>
<td>Happiness</td>
<td>Interviews</td>
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<tr>
<td>‘Peace of mind’</td>
<td>Spiritual wellbeing</td>
<td>Hussain, 2006</td>
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<tr>
<td>Alim “”</td>
<td>A scholar of Islamic studies</td>
<td>Interviews</td>
</tr>
<tr>
<td>Izzat</td>
<td>Honour</td>
<td>Interviews</td>
</tr>
<tr>
<td>Kismet</td>
<td>Destiny/fate</td>
<td>Interviews</td>
</tr>
<tr>
<td>Phagal</td>
<td>Madness</td>
<td>Interviews</td>
</tr>
<tr>
<td>Purdah</td>
<td>To be modest or modesty</td>
<td>Interviews</td>
</tr>
<tr>
<td>Sabr</td>
<td>Patience</td>
<td>Interviews</td>
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</tbody>
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15 The definitions for Alim, Izzat, Kismet, Phagal, Purdah and Sabr are not definitive but provide an indication of how these words were used in the context of the key informant interviews.
Appendix 8: Annotated bibliography of methodological literature


Provide a discussion of the qualitative methodology used to explore the experience of British Pakistani men living in Bradford. Identify issues relating to power, knowledge, validity and their impact upon research design and process.


Discusses the use of focus groups as a method with South Asian communities. Discusses the contribution and role of community facilitators, issues regarding access and recruitment and reciprocity in research relations.


Provides a review of involvement of service users in research, summarising discussion that took place at series of UK seminars to discuss a variety of issues related to involvement, including involving people from BME communities in research.


Provide an analysis of the ways in which culture may be viewed as a problematic term. Outline a methodology of how Asian women might view health, illness and consultations with their doctor. Describe two studies-one involving structured interviews and the second qualitative interviews.


Provides a brief overview of the UCLan community engagement models and its key components.


Provides an exploration of methodological issues, production of knowledge and the politics of research on race, ethnicity and intersection with other forms of social difference -gender, age and disability.


This study used focus groups to explore conceptions of mental health. The focus groups started with participants being given a few minutes at the beginning to write down words, draw pictures or choose colours that they would associate with a person who is mentally healthy.