

A theory of change for mental health advocacy: a case study

Partners for Health in London, a King's Fund one-year grants programme running in 2005-2010, was designed to produce good quality evidence from community interventions. There were three themes to the programme: mental health advocacy, sexual health and end-of-life care.

Service teams were introduced to a realist evaluation framework¹ and supported to collect and analyse data to answer specified research questions. Realistic evaluation includes the identification of a theory of change at the outset, and the evaluation then tests out whether there is any evidence to suggest that the theory is supported.

The Chinese National Healthy Living Centre (CNHLC) was funded for three years in June 2006, to provide mental health advocacy to Chinese users. There is evidence for under-representation of Chinese people across the NHS, including in mental health services. This could suggest that Chinese people experience better mental health than the general population or that specific barriers to services exist. This project was designed to improve access to services for Chinese people with mental health problems. The evaluation officer, Lucy Tran, segmented the population into three groups: new arrivals, first generation settlers and students. It was thought these groups would respond to the intervention differently, and it would be useful to find out about the differing needs and contexts.

She developed the theory using three categories:

- **C**ontexts
- **M**echanism
- **O**utcomes

Taken together they become CMO configurations and are used to explain why the service provider thinks the project will work.

CMO configurations

- **Contexts** – this includes factors describing the social circumstances of the individual and their situation that may affect the project and the ability of the user to access and use the service
- **Mechanism** – this encompasses the resources that the organisation brings to the problem identified and the reasons why the user would use the service
- **Outcomes** – this indicates the changes that the organisation would expect to see as a result of their work.

¹ Described in Pawson and Tilley (1997) *Realistic Evaluation*, Sage, London.

The evaluator set out her first change theory in the table below:

	Contexts	Mechanisms	Outcomes
First generation settlers	<ul style="list-style-type: none"> • Mainly Cantonese-speakers from Hong Kong • Cultural conflict between generations • Isolation among the elderly • Lack of English 	<ul style="list-style-type: none"> • Need for support identified by family or the community and met by provision of an advocate with Chinese cultural background and language skills 	<ul style="list-style-type: none"> • Improved access to services • Improved communication and understanding between clients and health professionals
New arrivals	<ul style="list-style-type: none"> • Mainly Mandarin-speaking from China • Isolation from family (in homeland) and community • Culture shock • Welfare issues • Lack of knowledge of health and social care system • Lack of English 	<ul style="list-style-type: none"> • Need for support identified by service providers and met by provision of an advocate with Chinese cultural background and language skills, and provision of practical support 	
Overseas students	<ul style="list-style-type: none"> • From China, Hong Kong, Malaysia, Singapore • Initial isolation • Culture shock • Pressures to achieve (cultural and financial) 	<ul style="list-style-type: none"> • Need for support identified by student support services and met by provision of an advocate with Chinese cultural background and language skills 	

This initial theory of change at the start of the project, showed in the table above, was expressed in the following:

Mental health advocacy, delivered by a Chinese advocate with Mandarin and Cantonese language skills, to first generation settlers, new arrivals and students, will improve access to services, and communication and understanding between clients and health professionals.

She decided to ask these three research questions to understand the project better:

1. What issue does the client want to tackle?

Lucy's early assumptions were that clients may not want to admit to having mental health problems and may concentrate on physical symptoms. She wanted to track what they wanted to discuss to see if this happened. She also thought that each group would have slightly different concerns.

2. Does the advocate support the client in discussing illness with the family or community?

Family and community are considered very important to this group and there is a strong notion of 'face', or what is socially acceptable to the group. Mental illness carries a great deal of stigma and Lucy thought that families may present a barrier to clients seeking help. She wanted to find out if the advocate had an educational role within the wider community and with families to enable clients to gain greater access to services.

3. What is the kind of cultural explanation done by the advocate in meetings with the health professional?

Lucy thought that cultural explanation, more than the language skills of the advocate, may play an important part in the advocate's role.

Evaluation methods

There were two components to the evaluation:

1. A quantitative, descriptive component derived from the case notes kept by the advocate: number of clients; client demographics; referral routes.
2. A qualitative case-study component consisting of interviews with clients, clients' relatives and care providers to address the research questions posed by the process evaluation.

Between the start of the project in December 2006 and July 2009 when data was collated, a total of 40 clients accessed the service. For the qualitative component, eight client cases were selected and a total of 14 transcripts were analysed, with the data set consisting of a mixture of interviews with clients, their family members, care providers and an advocate account.

Evaluation findings

Did the project meet its intended outcomes?

Overall, the project was highly successful in providing effective, culturally-sensitive support to its users.² The intended outcomes were:

- Improved communication and understanding between clients and health professionals.
- Improved access to services for clients.

The findings demonstrated a clear role for the Chinese mental health advocate in improving communication and understanding between health professionals and patients – not only in providing linguistic and cultural support during meetings but also in providing an independent, external link through which information could be passed in both directions. Contrary to the conventional role of an advocate in working on behalf of a single client, the advocate on many occasions was also advocating for service providers, for example, in reinforcing their messages.

The project also achieved the second outcome of improving access to services. Through the provision of an advocate of the same cultural and linguistic background, the project hoped to break down any barriers to mainstream services that might be perceived by the Chinese community. Indicators for this might be:

- an increase in self-referral rates and referrals by family members as a measure of change in the perceptions of Chinese community members
- number of referrals made to other services by the advocate.

In the first eight months, only 9 per cent of referrals were made by family or clients themselves. This increased to 60 per cent and 69 per cent in the second and third quarters of the project, perhaps suggesting that members of the community were more willing to seek help, although the increase might also be attributed to increased awareness of the service.

Family or self-referrals were mainly associated with less severe illness and emotional problems. In these cases, the advocate accompanied clients to GPs and made referrals to mental health services and the CNHLC's Chinese-speaking counselling service.

All referrals made to the project by statutory services were for clients with severe diagnoses. In these cases, the advocate improved patient compliance and engagement with mental health services.

For service providers, language support was also highly valued but the advocate added an additional dimension to the role of the interpreter, providing an independent

² The term 'user' here refers to both the statutory service providers and clients who accessed the project.

voice. Service providers often found it difficult to engage with Chinese patients and in these circumstances, the advocate was often working to support the provider. The advocate also acted as a link person, relaying client past history and cultural contexts to the provider and relevant information to the client.

Research question 1: What issues did clients want to tackle?

The evaluation revealed differences between the issues that clients in the first generation and new migrant groups faced. For new migrants, practical issues such as immigration and welfare and language issues were the primary concerns. For first generation settlers, these were also issues but the range of issues was much broader. The differences were not clear cut, but were likely to be associated with length of residence in the UK, circumstances of the migration (with new migrants tending to have migrated under irregular circumstances), immigration status and diagnosis.

For some clients, the benefits of having an advocate were not initially recognised, and they appreciated only the language support provided. The continuity provided by the advocate became valued as the advocate-client relationship progressed and in some cases clients also developed emotional dependence on the advocate.

In the original CMO configurations, isolation from family was a characteristic of the new migrant group and this was borne out in the project findings. Social isolation and lack of support from friends and family was a significant issue among new migrants. The advocate's input was crucial in enabling engagement with mental health services and supporting the basic health and welfare needs of this group. However, the broader support needs of this group were not met.

The evaluation also found that clients who self-referred or were referred by family expressed their difficulties in psychological or emotional terms (rather than focusing purely on physical symptoms). The majority of clients who had clinical diagnoses accepted their diagnosis.

Research question 2: Did the advocate support the client in discussing illness with the family or community?

In posing this question, **assumptions** were made about the stigma of mental illness and its impact on the client's relationship with family members and friends within the context of strong family identity and values.

It has been suggested that the close-knit family structure of the Chinese community offers protection against mental ill health. While the findings of this project neither support nor refute this hypothesis, they show that the family situation and cultural influences sometimes contribute to mental illness. In these cases, the cultural identity of the advocate was an important asset in the mediatory role of the advocate, both between client and family, and between health professionals and family.

Stigma associated with mental illness was not captured in the evaluation. Clients who approached the project themselves or who were referred by family were more likely

to be suffering from common mental disorders or psychological distress which carry less stigma than severe mental disorders.

Research question 3: What is the kind of cultural explanation done by the advocate in meetings with health professionals?

Cultural explanations for client behaviour or reasoning were generally provided to health professionals outside of meetings with clients, with clients' consent. The type of culture-related information that the advocate provided included:

- client history and its cultural context
- client beliefs around medication and the use of Chinese medicine
- Chinese family structures and values.

However, the cultural input of the advocate during meetings was less obvious. The advocate felt that the process of interpretation itself often went beyond the linguistic and carried cultural nuances that were difficult to capture.

For clients, there was not an explicit need for cultural explanation but the cultural identity of the advocate was a crucial factor in enabling them to access the service.

Based on the findings, the conjectured CMO configurations proposed at the start of the project were revised and show the mechanisms and outcomes of the advocacy process for each client group. CMO configurations for health and social care professionals were also created based on the findings.

	Contexts	Mechanisms	Outcomes
First generation settlers	<ul style="list-style-type: none"> • Mainly Cantonese-speakers from Hong Kong • Cultural conflict between generations • Isolation among the elderly • Lack of English • Family issues 	<ul style="list-style-type: none"> • Self- and family referral • Cultural identity and language skills of advocate • Cultural explanation for professionals and language support 	<ul style="list-style-type: none"> • Improved access to services • Improved communication and understanding between clients and health professionals
New arrivals	<ul style="list-style-type: none"> • Mainly Mandarin-speaking from China • Isolation from family (in homeland) and community • Culture shock • Welfare issues • Lack of knowledge of health and social care system • Lack of English 	<ul style="list-style-type: none"> • Service provider referral • Language skills and practical support for the client • Language and advocacy skills to engage clients 	<ul style="list-style-type: none"> • Improved compliance and better engagement with services • Improved communication and understanding between clients and health professionals
Overseas students	<ul style="list-style-type: none"> • From China, Hong Kong, Malaysia, Singapore • Initial isolation • Culture shock • Pressures to achieve (cultural and financial) 	<ul style="list-style-type: none"> • Self, family and service provider referral • Cultural identity and emotional support • Cultural explanation for professionals and language support 	<ul style="list-style-type: none"> • Improved communication and understanding between clients and health professionals

Contexts	Mechanisms	Outcomes
Mental and physical health professionals, eg, psychiatrists, GPs, community psychiatric nurses, social workers	<ul style="list-style-type: none"> • Cultural explanation • Improved quality of interpretation • Continuity • Befriending 	<ul style="list-style-type: none"> • Greater understanding of user • Greater confidence in their impact on user
Social care services, eg, social workers, housing officers Other agencies, eg, benefits agencies, legal services	<ul style="list-style-type: none"> • Interpretation • Continuity • Befriending 	<ul style="list-style-type: none"> • Greater understanding of user • Greater confidence in ability to improve the user's situation

Revised theory of change

As a result of the evaluation, the theory of change can be refined and re-written:

Mental health advocacy, delivered by a Chinese advocate with Mandarin and Cantonese language skills, to first generation settlers, new arrivals and students will improve access to health, social welfare and community services, and improve compliance to medication and understanding of the treatments for service users.

Mental health advocacy, delivered by a Chinese advocate with Mandarin and Cantonese language skills to first generation settlers, new arrivals and students will improve the cultural understanding of this community, strengthen continuity of provision, and increase confidence in the ability to improve the users situation for service providers.

Extracted with permission from the final report to the King's Fund: *Evaluation of a Chinese Mental Health Advocacy and Support Project*, November 2009, by Lucy Tran.

http://www.kingsfund.org.uk/current_projects/partners_for_health_in_london/case_studies/chinese_national.html