

# FINAL REPORT

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## **Mental Health Services for Migrant and Refugee Communities in Christchurch**

**Prepared for  
The Funding and Planning Office,  
Canterbury District Health Board**

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### **Conflict of Interest Statement**

All members of the research team involved in the present project and production of the Report are employed by The University of Auckland.

The project team declares no conflict of interests to this research project.

### **Disclaimer**

This Report summarises key findings on the topic of the settlement and social inclusion of migrant and refugee youth in New Zealand. Members of the research team have taken all care to accurately capture and interpret the perspectives of research participants while maintaining their privacy and confidentiality. Any view or opinions expressed in this Report are those of the authors and *do not necessarily represent the views of the Canterbury District Health Board.*

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## **Executive Summary**

Christchurch is recognised as one of the main centres for migrant and refugee resettlement in Aotearoa New Zealand. The aims of this project are to: 1) identify mental health problems experienced by migrant and refugee populations; and 2) discuss key issues influencing the health delivery system targeting migrant and refugee communities.

The project started in September 2007 with a debriefing meeting between the CDHB Funding and Planning office and two members of the project team (ST & EH) to finalise the scope of the work. The Project consisted of four phases: review of literature, key informants interviews, preparation of the draft, collection of feedback and preparation of the final report.

Following are the major findings from the review of literature and key informants interviews. On the one hand, the overall mental health status of Asian migrants is seen to be quite good or does not differ significantly from those of the general population. On the other hand, there are pockets of studies both locally and internationally, suggesting mental health issues such as loneliness, depressive symptoms, stress and anxiety are the leading concerns among members of refugee and migrant communities. With regard to refugee mental health, the literature review shows that not only should post-traumatic stress be considered as a major healthcare concern, but post-migration experiences, such as separation from family, under-employment, loneliness and isolation and concerns about the refugee application process are also identified as having a negative impact on mental health. Lastly, both members of the Asian and refugee communities are confronted by barriers in accessing mental health services; the common examples include stigmatisation, language barrier; insufficient understanding of the mainstream health and social system and cultural differences in the assessment and treatment processes.

The recommendations for future development are outlined in the present report: 1) collect better ethnic mental health data to identify trends and pattern of needs, and gaps of mental health services for migrant and refugee communities within the CDH area; 2) build strong links with DHBs, PHOs and community agencies to share experiences and resources to address ethnic mental health issues; 3) strengthen the relationships with local refugee and Asian migrant communities to identify community leaders who are prepared to collaborate with government agencies to meet the mental health needs; 4) increase the workforce cultural competence in order to provide culturally responsive mental health services in the region; and 5) grow the local research capacity in the wider Canterbury region. The last recommendation captures two key issues which require further debate and careful analysis: effective model of service delivery and needs of specific sub-groups within the refugee and migrant communities.

# 1. Background

New Zealand, a country often described as a “land of immigrants”, experienced a sudden increase in the number and ethnic diversity of migrants only from the late 1970’s. The increasingly diverse immigration gained momentum following changes to legislation in 1987 and 1991 which removed a bias in favour of British and West Europeans who were considered “preferred sources” of migrants in New Zealand (Brooking & Rebel, 1995). It is recognised in New Zealand that of every five New Zealanders, one is born overseas and brings skills and resources to contribute to the wider New Zealand society.

The migrant population of Aotearoa New Zealand has increased significantly over recent years. Between 1997 and 2001 the Asian population increased by 140% (Statistics New Zealand, 2000), at that time accounting for 6% of the country’s population. According to the 2006 statistics, Asians<sup>1</sup> make up the fourth largest major ethnic group after European, Maori and Other Ethnicity totalling 354,552 people (9.2%) in 2006. Chinese (46%) and Indians (29%) form the major part of the Asian population which also includes other Asian communities such as Korean, Filipino, Japanese, Sri Lankan, Cambodian and Thai. Many Asians were born overseas (30-40%) and some (15%) do not speak English. There are also a sizeable proportion of older Asian migrants. The growth of the Asian population is not confined to the wider Auckland region.

“Christchurch is recognised as one of the main centres for migrant and refugee resettlement, and in the 2001 census, 6.7% of Canterbury population identified themselves as ‘ethnic’ as opposed to European or Maori. By the 2006 census this had increased to 11%, showing that Christchurch is an *increasingly diverse city*” (Christchurch Resettlement Services, Inc, 2007, p.4, *italic added*).

The migrant population includes refugees who enter New Zealand in three ways (Ministry of Health, 2001): 1) Under the United Nations High Commissioner for Refugees (UNHCR) mandated quota system (‘quota refugees’). On arrival, quota refugees spend a six-week orientation period in the Refugee Resettlement Centre. 2) As part of the New Zealand Immigration Service (NZIS) humanitarian migrant intake or family reunification (‘family reunification refugees’); and 3) As spontaneous refugees (‘asylum seekers’). Asylum seekers usually seek refugee status on arrival at our borders, or when their temporary visa or permit expires.

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<sup>1</sup> For discussion on the use of the term “Asian”, please refer to: Rasanathan, K., Craig, D., & Perkins, R. (2006). The novel use of “Asian” as an ethnic category in the New Zealand health sector. *Ethnicity and Health*, 11, 211–27.

Aspinall, P. J. (2003). Who is Asian? A category that remains contested in population and health research. *Journal of Public Health Medicine*, 25, 91–97.

The ethnic<sup>2</sup> sector includes all people who identify with an ethnic group from Asia, Continental Europe, the Middle East, Africa and Central and South America, and includes people who may also be identified refugees or migrants, as well as people born in New Zealand. By 2021, population forecasts predict that the ethnic sector will account for 18% of the usually resident population (including 13.4% Asian).

New Zealand currently has an “annual quota” of 750 refugee resettlement places. The places are primarily given to refugees considered by the United Health Council Organization to be in the greatest need of physical or legal protection. Since 1944, New Zealand has resettled more than 30,000 former refugees from conflict zones throughout the world that include Cambodia, Laos, Vietnam, Burma, Iraq, Iran, Afghanistan, Ethiopia, Sudan, Somalia, Rwanda, Burundi, and Eritrea (Jackson, 2006). For refugees, pre-migration trauma may include: war, rape, physical injuries, sense of unsafety, fear, imprisonment and torture, family separation and loss, struggle for survival in refugee camps, sense of disempowerment, lack of justice, violence and atrocities, extreme poverty and deprivation. Examples of resettlement challenges in a new host country are: adjusting to a new culture (language, people, religion, traditions), loss of control, separation from loved ones, lack of extended family support, fear of being sent back, feelings of shame, confusion, loss of confidence and dignity, loss of lifestyle and career, and the onset of PTSD symptoms (Poole, 2007).

“In any year an average of 100 refugees find new homes in Christchurch. 2006 census figures for Christchurch show that the four main local refugee groups are (in order of size)- Afghan, Somali, Kurdish and Ethiopian. In the experience of CRS, each person resettling in Christchurch brings *a unique story* with them, and leaves a shared history behind them” (Christchurch Resettlement Services, Inc, 2007, p.9, *italic added*).

Overall, many refugee ethnic groups in New Zealand have a disproportionate number of youth. In 2001, half of the Cambodians were under 24 years of age; of the Vietnamese groups, the proportion of young people aged under 24 years was 48% compared with 36% in the total population (Statistics New Zealand, 2006). Gibbs and Huang (2005) state that at an immediate level, the refugee youth has to maintain the family system in the context of a new cultural system, negotiate educational systems, comprehend the intricacies of migration, and manoeuvre through an impersonal social service system. Underlying all this is the need to master a new language, a new culture, and a new set of behaviours and

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<sup>2</sup> Ethnic is used in a general sense to include groups who share all or some of the following characteristics – a common language, culture, traditions, heritage, customs, beliefs, national, tribal or geographic origins. The ethnic sector is used in government to refer to that proportion of the resident population who identify with an ethnic group that is different from the majority of people in New Zealand, and from Maori and Pacific peoples.

expectations. In addition to these difficulties, refugee youth, like all youth, must also navigate developmental challenges, including adjustment to ongoing life stressors (Newcobm & Drabman, 1995).

## **1.1 Defining terms**

For the purpose of this report, the following definitions have been used:

Migrants:

The term “migrants” denotes “one that moves from one region to another by chance, instinct, or plan” or “an itinerant worker who travels from one area to another in search of work” (Houghton Mifflin Company, 2003). In New Zealand it is used to describe all migrants, permanent or temporary, living in the country. This definition is used in this research.

Refugees:

The term “refugees” refers to those people who have fled their countries because of war, political oppression or religious persecution and have sought refuge in New Zealand. According to the United Nations<sup>3</sup>, “A refugee is: any person who, owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country”.

Ethnic minorities:

Ethnic minorities are defined as those groups whose fundamental cultural values, customs, traditions and characteristics differ from the majority of the New Zealand population. This includes people from well-established ethnic communities, recent migrants, refugees and those people born in New Zealand who identify with their ethnic heritage.

Visible ethnic minorities:

Visible ethnic minorities are defined as those ethnic minorities who are physically different from the majority of the population in New Zealand and easily recognisable as such.

## **1.2 Overall aims of the present project**

This project reviews the existing literature to identify mental health problems experienced by migrant and refugee populations. It also discusses key issues influencing the health delivery system with the aim of engaging migrant and refugee communities effectively in health and resettlement programmes.

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<sup>3</sup> Article 1, United Nations Convention Relating to the Status of Refugees, Geneva: United Nations Conference on the Status of Refugees and Stateless Persons, 1951, cited in the Ministry of Health (2001). *Refugee health care: A handbook for health professionals*. Wellington: Author.

### **1.3 Objectives of the present project**

1. To discuss the specific health issues which emerge as relevant from the critical review of the selected literature. Topics include (not restricted to): delivery of effective mental health services, primary mental health care, access issues, workforce development.
2. To discuss ways in which healthcare services can engage with ethnic communities in health and resettlement activities.

### **1.4 Project design and methods**

#### *Debriefing meeting:*

As principal investigators, Drs Ekramul Hoque and Samson Tse, visited Christchurch on 27<sup>th</sup> September 2007 and met the funder to: 1) finalise the scope of the work and 2) access relevant population data and literature available in the CDHB.

#### *Phase-1: Review of literature*

The project team has identified a need to compare and contrast research or theoretical work in the area of migrant and refugee health and their state of service utilization, which are apparently being influenced by social and cultural practices. The purpose of the literature review as part of the project is twofold: firstly, to identify relevant studies investigating the topic, and secondly, to search for specific topics such as identification of access issues related to uses of primary health care and mental health service

#### *Phase-2: Discussion with health authority on local health issues and review of relevant unpublished data (visited Christchurch on 5<sup>th</sup> & 6<sup>th</sup> May, 2008)*

- Visited the CDHB for discussions with migrant and refugee health units to elucidate local health issues and health initiatives undertaken to address them.
- Made contact with other migrant and refugee health related NGOs to discuss existing health related programmes.
- Discussed health concerns with local migrant and refugee representatives..

#### *Phase-3: Preparation of draft report*

On the basis of the literature review and discussion with local health authority, NGOs and community representatives in phase one and two respectively, this phase concentrated on drafting the report.

- Compiled the information and discussed the outcome of study.
- Prepared the draft report.

#### *Phase-4: Collecting feedback and completion of the final report*

- Feedback was collected from relevant stakeholders on the draft work and adjustments were made for the final report.
- Report was submitted to the funding authority for their approval

## **2 Literature review**

### **2.1 The New Zealand context**

The growth of the refugee and migrant communities in New Zealand has created unique challenges at a scale that has never been seen. The challenges are:

- **Rapidity of the phenomenon:** By any international standard the ethnic sector, or the migrant and refugee population growth is very rapid. This rapid growth may have a unique impact on the host population as well as on the health delivery system because of the suddenness of the phenomenon.
- **Diverse population landscape:** New Zealand is renowned for having a bicultural society that has its root in the Treaty of Waitangi. This has made New Zealand distinctive among the four ‘traditional lands of immigration’ in North America and Australasia (Canada, the United States, Australia and New Zealand) because of the emphasis given to biculturalism within a context of increasing ethnic and cultural diversity (Rata, 2003).
- **Recency of the phenomenon:** The influx of migrants and refugees to New Zealand is still a recent phenomenon. We may be in a unique position to address the effects of migration on the mental health of the first generation “new” New Zealanders arriving in a country that is still culturally very different to their own. In other parts of the world migrants and refugees were there a long time ago and service providers may be more interested in the mental health of second, third or later generation migrants.

### **2.2 Policy environment related to the migrant and refugee population**

This section maps out the migrant and refugee resettlement services against relevant government policies.

#### **Ethnic perspectives led by the Office of Ethnic Affairs**

The role of the Office of Ethnic Affairs (OEA) is to provide advice and information about ethnic sector groups in New Zealand. The ethnic sector<sup>4</sup> refers to the 10% of the usually resident population (from 2001 New Zealand Census) who identify with an ethnic group that is different from the majority population groups and from Maori or Pacific people in New Zealand. The existing document titled *Ethnic Perspectives in Policy* (Office of Ethnic Affairs, 2002a) provides a framework of policy and services considerations and outcomes that public policies and services such as District Health Boards (DHBs) are expected to consider. In particular the government has agreed that

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<sup>4</sup> The ethnic sector is used in government to refer to that proportion of the resident population who identify with an ethnic group that is different from the majority of people in New Zealand, and from Maori and Pacific peoples.

- There should be better information about the ethnic sector
- That policy advice and services should be based on the following values
  - Acceptance, so ethnic communities are celebrated and diversity is valued
  - Participation, so that ethnic people may contribute in all aspects of New Zealand life
  - Accessibility, so barriers to information and services are overcome
  - Responsiveness, to meet the needs of ethnic people
  - Equity, so that ethnic people are treated fairly and experience outcomes no less favourable than other New Zealanders, and
- And, as a priority, policy advice should contribute to outcomes of: valuing diversity, economic participation, education and training, immigration and settlement, health and housing.

It is important to note the government's agreed specific health outcome as follows:

“Achieving good health outcomes requires all ethnic people; including those with disabilities and community care needs, to have access to services that are timely, appropriate and culturally sensitive. It also requires equal access to material resources such as income, education, employment and housing. Services for ethnic people take into account the effect of social networks, culture and language on ethnic peoples’ understanding and access to information or services. Key outcome indicators are:

- Health policies and services are responsive to ethnic peoples’ needs identified in consultation with ethnic communities
- Health services are accessible to all ethnic people (including those with disabilities)
- Each ethnic community has the same opportunity for good health as those experiencing the best health.”

### **Ministry of Health strategies**

Promotion of mental wellness in refugee and migrant populations is a priority for a number of important health strategies in New Zealand including the following:

One of the 10 challenges in the *Te Tāhuhu: Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* (Ministry of Health, 2005) is about “Responsiveness” (the third challenge). The document refers to building responsive services for people, in particular, mentioning: “Pacific peoples, Asian peoples and other ethnic communities, Refugee and migrant communities” (MOH, 2005, p.11). Furthermore, the document states:

“New Zealand’s growing ethnic diversity. Maori make up nearly 15 percent of the population, Pacific peoples nearly 7 percent, and Asian peoples 6.4 percent. Ethnic communities include people who identify with ethnic groups originating from across the world as well as people who may also identify as migrants and refugees. Mental

health services must be able to respond to the unique needs of *all New Zealanders*” (p.2, *italic added*).

“Ethnic communities are a growing part of New Zealand’s population. Language barriers, social isolation, intergenerational and disrupted family and social relationships are among the problems experienced by different ethnic groups, including migrants, refugees and their descendants. Ethnic youth, women and older people are particularly at risk, as are *refugees and migrants from refugee-like circumstances* who have experienced severe trauma” (p.11, *italics added*).

Subsequently in the later Ministry of Health publication titled *Te Kōkiri: The Mental Health and Addiction Action Plan Implementation work programme 2006-2009* (Ministry of health, 2006a), four actions were mentioned making specific reference to the refugee and migrant communities, in particular, people of Asian origin.

Challenge 3: Responsiveness (MOH, 2006, pp. 31-32)

3.11 Increase understanding of the mental health and addiction needs of Asian and ethnic communities

3.12 Develop an Asian mental health and addiction research agenda

3.13 Develop initiatives to increase the Asian mental health workforce

3.14 Increase understanding of the mental health and addiction needs of refugee and migrant communities

Challenge 4: Workforce and Culture for Recovery (MOH, 2006, p.38)

4.5 Strengthen the cultural capability of workers in mainstream services to work effectively with Maori, Pacific, Asian, refugee and migrant populations

## **Development of mental health workforce**

The migrant and refugee population comprises a diverse range of communities and cultures with their unique worldviews that impact on their ways of being. This includes their responses to mental health issues. There are several initiatives being undertaken taken by the Ministry of Health to identify the health needs and issues of the diverse population. However, a key issue facing mental health services is a shortage of appropriately trained specialist workforce (Arthur, 2000). According to the “*Strategic Principles for Workforce Development in New Zealand*” (Health Workforce Advisory Committee, 2006), New Zealand currently relies on overseas practitioners to “ensure the availability of appropriate health services for specific ethnic communities” (p. 8). The report further acknowledges a need for New Zealand to ensure a sustainable supply of practitioners skilled in

addressing cultural factors within the workplace. Access to a highly skilled, culturally competent and effective mental health workforce can; however, only be achieved with the collective participation by a variety of stakeholders such as the funders and planners, the DHBs and education and training organisations.

To address this need and provide more appropriate services, mental health practitioners need to become more knowledgeable about the profound and intrinsic impact of cultural factors on the prevention, presentation and treatment of mental health issues; the aspect of training and psychotherapy (Falender & Shafranske, 2006), and be more skilled in interacting with members of the culturally and linguistically diverse population.

### **2.3 Specific literature**

The following articles were selected and reviewed on the basis that:

- They were peer-reviewed articles and published between 2000 and 2008
- The empirical studies or discussion papers are particularly relevant to New Zealand work
- Their foci were on young people and older people who are often identified as “vulnerable” to experiencing mental health problems.

### **General background**

**DeSouza, R. (2007). Walking a tightrope: Asian health research in New Zealand. *Diversity in Health and Social Care*, 4, 9-20.**

#### ***Main discussion points:***

“Asian” is a term that has differing definitions depending on the geographical context in which it is used. In New Zealand, “Asian” tends to refer to people from South East Asia and there are debates about whether such an umbrella term is useful or strategic or merely disguises disparities within groups.

The Treaty of Waitangi and the social policy principle of biculturalism have become an explicit template for relationships between indigenous Maori and subsequent migrants. The racialising and “othering” of migrant groups, along with past migration policy designed to keep the country white, have implicitly shaped the treatment of migrants.

It is suggested that attempts to address the bicultural/multicultural relationship came about with proposals that biculturalism should take precedence, and subsequent arrivals to Aotearoa needed to negotiate a primary relationship with Maori. Multiculturalism would then be the outcome of a network of completed bicultural negotiations.

Large-scale studies are needed to determine health risks across all major ethnic groups in New Zealand, which will in turn enable development of ethnic-specific data. Even more critical is the need for data concerning ethnic variation in other areas of health, so that effective interventions can be developed and implemented.

***Implications for mental healthcare for migrants and refugees:***

- This work has strong relevance to Asian health research, including collection of mental health data among migrants and refugees. The specific implications include the following<sup>5</sup>:
  - Incorporating sound consultation processes throughout the lifecycle of the data collection process (e.g. needs survey)
  - Identifying “Asian”-appropriate methodologies that position Asian worldviews at the centre, thus providing an opportunity for innovative and culturally appropriate methodologies to emerge
  - Increasing population research to a greater extent than currently occurs
  - Maintaining accountability and integrity by utilising alternative indicators of research quality, such as endorsement and dissemination by Asian advisory groups, communities and media
  - Developing a regional Asian health research strategy that promotes networking and partnership rather than competition for scarce funding, and which works towards minimising gaps and duplication
  - Creating guidelines for developing ethical relationships with Asian communities with regard to conducting health research

## **Refugee mental health**

**Keyes, E. F. (2000). Mental health status in refugees: An integrative review of current research. *Issues in Mental Health Nursing*, 21, 397-410.**

***Main discussion points:***

Cultural bereavement may a more appropriate term for refugees whose “condition may be a sign of normal, even constructive, rehabilitation from devastatingly traumatic experiences”. Cultural bereavement includes what the experience means to the refugee, cultural differences in communicating distress and approaches for dealing with it, and the cultural interpretation of symptoms.

The review of 12 articles on the mental health status of refugees worldwide discovered that negative mental health states were often present in refugees. In those studies, depression was commonly witnessed amongst refugees, with distress presented through physical illness such as headache, backache, and

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<sup>5</sup> Although this article focuses on Asian population, some of the implications can be transferred to the wider migrants and refugee sector.

fatigue. Authors from those studies used instruments that were designed in a more participant-friendly manner in which questions were written in their native language and contained culturally relevant information.

***Implications for mental healthcare for refugees:***

- It is important for researchers, practitioners and managers alike to incorporate culturally sensitive and specific issues and information while they are designing their research tools or services.
- There are varying factors such as host country's social acceptance, peer support and access to health care that influence refugees mental health outcomes.

**Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science & Medicine*, 52, 1709-1718.**

***Main discussion points:***

1. *Refugees' own voice*

It is very common to portray that refugees suffer from PTSD but scant attention is paid to refugees' own perceptions and interpretations of distress and their choices in terms of treatment. Typically when most refugees are asked what would help their situation they are much more likely to point to social and economic factors rather than psychological help. Services rarely provide opportunities for refugee service consumers to identify on a *broader level what they want from mental health and social services*. For example, a survey of mental health services for refugees in Europe carried out in collaboration with the World Federation for Mental Health found that of 18 European countries only 2 had developed mechanisms for listening to the voices of refugee service consumers. Furthermore, the telling of refugees' stories takes place within a clinical arena, which is, in itself, viewed as having a therapeutic effect.

2. *Bio-medical taxonomies*

Bio-medical taxonomies are not merely scientific labels but are mechanisms where resources, be they professional help or financial support, can be directed in accordance with established norms of clinical practice. Those who are critical of bio-medical approaches thus may be faced with a stark choice. Either present the refugees problems in terms that highlight the range of social, political, and economic concerns of the refugee but that may not mobilise any resources to support the refugee, or, alternatively present the refugee as a traumatised victim (concentrating on the bio-medical perspective) and enhance her/his claim for asylum and mobilise support.

3. *Post-migration experience*

*Scant attention* is normally paid to the impact of post-migration experiences on mental health amongst people from refugee background. In a survey of 62 Tamil asylum seekers from Sri Lanka, the negative impact of factors such as fears of

being sent home, interviews with immigration officials, separation from a spouse, threats to family, poverty, and discrimination on mental health was noted. In another study conducted in Australia the impact of post-migration experiences, such as separation from family, under-employment, loneliness and isolation and concerns about the refugee application was identified as having a negative impact on mental health.

#### 4. *Alternative approach*

A three-dimensional approach could be used to achieve an appropriate delivery of mental health care to refugees and asylum seekers.

- (1) *Macro- or institutional level*: a broad legal and policy context in which health and social care purchasers and providers present views about the health needs of particular populations and make decisions about the allocation of resources.
- (2) *Service level*: arrangements are put in place within localities for the deployment of health and social care professionals and arrangements governing the interaction between these professionals.
- (3) *Treatment level*: focuses on the direct interaction between health and social care professionals and their clients/patients.

Resilience to mental health problems are linked to a sense of self-esteem and self-confidence: an ability to deal with change and adaptation; and a repertoire of social problem solving approaches. In order to develop resilience, an individual needs experiences of secure, stable, affectionate responses, and an experience of success and achievement.

#### 5. *Culturally matched workers*

Components of “culturally sensitive” services include the employment of health and social care workers from similar cultural backgrounds to the refugees themselves, the provision of interpreting services, advocacy services and specific training in cultural issues for mental health staff. The development of culturally sensitive services is presented as a means of overcoming barriers between professionals and refugee clients and developing methods of therapeutic intervention, which are meaningful and effective to refugees. However, this has to be approached cautiously. In a study in which a refugee was trained as a bilingual therapist and interviewed people from the same ethnic background, the therapist was instructed to categorise patients according to diagnostic categories of “major depression, schizophrenia” “conduct disorder” and “bipolar disorder”. After listening to the stories of the refugees he felt he needed to translate them in such a way that the material collected could be operationalised as mental illness categories within a medical hierarchy. Thus, while the employment of people from similar ethnic and cultural backgrounds to the refugees themselves may be cited by services as evidence of cultural sensitivity, they may in fact be seen as *agents of de-culturalisation and de-politicisation* in that they transfigure the refugees’ accounts into individualised pathology.

A holistic approach suggests that, rather than impose a dualism which seeks to define whether the client has a physiological or a psychological problem, it may be more appropriate for clinicians to ask refugee patients for their own views regarding the etiology of their conditions. In the context of a holistic approach, clinicians will function less as detectives trying to uncover the “real” causes of the presentation of physical symptoms, but will instead be open and receptive to the explanations given by patients with refugee background as to the causes of their distress.

***Implications for mental healthcare for refugees:***

- Refugees’ needs assessment is the crucial step before any other political or clinical action takes place. If environmental factors allow, prior to their arrival in a new country their needs and health assessment are obtained in order to attune their settlement places according to the result of the assessments.
- It is important that their voices are heard. What they need and want needs to be thoroughly analysed and put into action for better outcomes.
- Also, it is critical to educate the people of the host country to understand and openly accept cultural differences. It is the first step to helping refugees integrate into mainstream society quickly and effectively.

**Beiser, M., & Hou, F. (2006). Ethnic identity, resettlement stress and depressive affect among Southeast Asian refugees in Canada. *Social Science & Medicine*, 63, 137-150.**

***Background:***

Migrants and refugees face a choice between enduring commitment to one’s ethnic identity (a decision which may invoke and perpetuate minority status), abandoning this heritage in the hope of achieving full membership in the receiving society, or creating compromises between the old and the new.

According to the research literature, economic difficulties, discrimination and language difficulties are among the most important resettlement challenges to well-being. Although a number of researchers have found that commitment to an ethnic identity (defined as identification with one’s culture of origin) mitigates the stress of discrimination and the accompanying risk of depressive affect, other studies have found the opposite, that strong commitment to ethnic identity amplified the negative psychological impact of racially based discrimination.

The US literature often argues that Asians have been “racially triangulated.” While acknowledging the economic success of Asian migrants and the intellectual prowess of their children, the mainstream majority simultaneously practices “civic ostracism” by means of a social construction of Asian culture as alien, Asian communities as impenetrable and Asian individuals as inassimilable. Aside from racism, migrants and refugees encounter other resettlement stressors, notably unemployment and language difficulties.

**Study design:**

The study examined both direct and indirect effects of ethnic identity on psychological distress. It was hypothesised that a strongly held ethnic identification would either have no effect on psychological distress, or might, in fact, increase it. 1,348 adults participated in the project between 1981 and 1991. However, only 647 adults' interviews were used in this study.

**Findings:**

Discrimination and unemployment were perceived as stressors forced upon one's ethnic group as a whole, regardless of the degree to which an individual chooses to identify with that ethnic group.

A strong ethnic identity apparently buffered the potentially damaging consequences of failure to acquire the language of the resettlement country. However, in comparison with individuals with a relatively detached attitude towards their ethnic heritage, refugees who were strongly committed to an ethnic identity were more vulnerable to discrimination and unemployment.

Strong identification with the culture of origin appeared to make people vulnerable to discrimination, perhaps because ethnic commitment both increased the likelihood of interpreting experiences involving discrimination as being ethnically based, and because assaults on a strongly salient identity were intolerable.

Although it seemed clear that the achieved level of education is antecedent to employment, linguistic fluency was another important variable. Other studies confirmed that linguistic fluency is a predictor of economic success, particularly for socially disadvantaged refugees. Although Canada does provide language training for newcomers, factors such as gender and the type of work people do creates inequities in access.

During the refugees' first few years in Canada, unemployment jeopardised their mental health, just as it did the mental health of members of native-born Canadians. However, among the refugees, the effects were entirely due to material deprivation, and not, as was the case for the native-born, to feelings of embarrassment, social isolation or inadequacy. In addition to being experienced as evidence of personal shortcoming, unemployment may also have been perceived as failure to uphold one's obligations to the family and to the larger community. The resultant loss of face would have a particularly stressful effect on individuals.

**Implications for mental healthcare for refugees:**

- As part of refugee resettlement process, the provision of the host government's education services to refugees needs to focus on raising their understanding and update basic knowledge of the host country and the

mainstream culture. Its purpose is to help refugees not to lose their own ethnic identity, but at the same time show them how and what to do to survive in a whole new environment where language, custom and societal values and beliefs are hugely different to their own.

- Material deprivation and low socioeconomic status play a relatively major role in deteriorating refugees' mental health during the resettlement phase.
- Refugees learn to live together with people in the mainstream society and cope with cultural differences better than they would without the support service. They will be more likely to adopt the host country's language and integrate with the major ethnic group individuals.
- The objectives of future research studies are to focus on the likely outcomes of effects of the education service provision policy.

**Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7,000 refugees resettled in western countries: A systematic review. *Lancet*, 365, 1309-1314.**

***Background:***

Worldwide, the number of refugees— defined by the refugee convention as individuals who have been forcibly displaced outside their native countries— is estimated to be about 13 million plus a much larger number of former refugees granted citizenship in their new countries. Refugees could be at excess risk of psychiatric morbidity because of forced migration, traumatic events, and resettlement in unfamiliar environments.

This study searched for surveys about common disorders that refugees are likely to experience in their new countries. Twenty surveys provided results for 6,743 adult refugees from 7 countries. There was substantial variation in sampling methods and assessment.

***Study findings:***

The meta-analysis suggested that about one in ten adult refugees in Western countries has post-traumatic stress disorder, about one in 20 has major depression, and about one in 25 has a generalised anxiety overlap in many people.

Refugees based in Western countries could be about ten-times more likely than the age-matched general American population to have post-traumatic stress disorder. This disorder is a potentially disabling condition characterised by traumatic flash-backs, hypervigilance, and emotional numbing that might be a risk factor for substance abuse and suicide.

Data in the present meta-analysis (about two-thirds of which were derived from the US) suggested that roughly 50,000 of about 500,000 current refugees living in the US had post-traumatic stress disorder, with even larger numbers of the 2.5

million former refugees settled there between 1975 and 2002. The exact burden of disability implied by such numbers was; however, unknown because many surveys did not record the functional impairment (or treatment needs) associated with the disorder in refugees. Furthermore, the triggering factors, psychiatric comorbidity, and long-term consequences of non-treatment in refugee communities had been reported to differ from those of other groups with post-traumatic stress.

***Implications for mental healthcare for refugees:***

- Needs assessment is a useful tool to identify what refugees require to adjust themselves in new environments and overcome any unprecedented difficulties. As they are resettling in refugee camps and obtaining information relevant to the new country, the needs assessment can be conducted before they are allowed to live on their own and blend into the host society.
- Based on the findings from post-traumatic psychiatric disorder surveys, health policy makers and health practitioners are in position to develop strategies that are more effectively targeted at reducing the magnitude of the mental disorders among refugees in Western countries. New Zealand is no exception.

**Briggs, L., Talbot, C., & Melvin, K. (2007). Demoralisation and migration experience. *International Review of Modern Sociology*, 33(2), 193-209.**

***Background:***

When the expectations and realities of migration do not match, the individuals involved can experience elevated levels of psychological distress. A sense of helplessness and hopelessness and loss of purpose can prevail which, when coupled with social isolation from extended and friends, can lead to existential distress, low mood and demoralisation. Kissane et al. (2001) identified a core distinction between demoralisation and depression as being a loss of a person's capacity to feel pleasure (i.e. anhedonia), whereas a demoralised person, while being unable to look forward with pleasant anticipation, may laugh and enjoy the present moment.

In brief, to gain an understanding the impact of the migration experience, factors such as the differing cultural understandings of mental illness/health; pre-migration, migration and post-migration experiences (especially in relation to adverse events and trauma); culture 'shock' and its stages need to be taken into account. Other considerations include the rural/urban background of country of origin; individual factors (e.g. role performance, resilience, aspirations); the socioeconomic-political factors of the new country (e.g. level of acceptance of migrants and refugees).

While resettlement for immigrants, refugees, asylum seekers is a complex post-migration process, requiring adjustment to a new environment, involving all aspects of migrants' lives, it also entails change and adjustment from the

receiving host countries. One of the key factors to successful resettlement is having 'family' in the host country; dislocation from significant family members is a major stressor in its own right. Recent studies found that for those separated from family, the time and effort committed to seeking reunification significantly impeded resettlement and impacted negatively on physical and mental health.

**Study design:**

25 Australian participants were recruited through community contacts obtained through a local church and a multicultural health service. In New Zealand, 20 participants were recruited from a Family Mental Health Service and 5 from a local refugee resettlement service.

The data gathered included responses to the following self-report rating scales, all of which have proven psychometric properties: the Becks Depression Inventory (BDI-II) to assess the level of subjective psychological distress; the Becks Hopelessness Scale (BHS) for the measurement of pessimism; the Snaith-Hamilton Pleasure Scale (SAHPS) for the assessment of hedonic tone and Kissane's Demoralisation Scale (DS) to assess the different aspects of demoralisation.

A short questionnaire, specifically designed for the study to collect demographic and some clinical information, was completed by the attending clinician or the researcher involved with the participants.

**Results and implications:**

Overall, the majority of the Australian sample consisted of men, whereas the New Zealand sample mainly consisted of women. Despite the apparent relative success of Australia in absorbing and integrating waves of migration of differing cultural and linguistic groups over a long period of time, the findings showed that the Australian participants seemed to experience similar level of risk of demoralisation as the New Zealand participants in the study.

One of the major protective factors against demoralisation appeared to be having family in the host country. Other factors that might have been a protective factor against adverse outcomes, was participation in the labour market, or social contacts provided through educational participation and an ability to speak English.

**Guerin, B., Guerin, P., Abdi, A., & Diiriye, R. O. (2003). Identity and community: Somali children's adjustment to life in the western world. In J. Gao, R. Le Heron and J. Logie (Eds.), *Windows on a Changing World. Proceedings of the 22<sup>nd</sup> New Zealand Geographical Society Conference*. Auckland: University of Auckland, July 6-11, pp.184-188.**

**Main discussion points:**

Unlike Western children who tend to be influenced by their families and school activities, Somali children are influenced by the Somali community, the Islamic communities, and the extended family. Peers and friends are typically met through the Somali community or through family, and sports are organised by the Somali community rather than through schools. Also, due to various factors or influences, only the children might have access to the cultural practices and customs of the host society, and parents may not have any opportunity to encounter them. Children consequently adopt new customs that are commonly seen in the Western culture, of which Somali parents may not be fully aware.

There are conflicts seen between younger Somali girls and older Somali women as they do not share the common ground for understanding and adopting the Western culture while they are resettling in New Zealand. In addition, boys are also experiencing many difficulties in adjusting their social life to the patterns generally created in the western culture.

***Implications for mental healthcare for refugees:***

- One of the strategies to avoid the above-mentioned inter-generational conflict is to find schools that Somali do well at and documenting their strategies for achieving this.
- Somali communities are empowered and are given the strategies to solve their problems.
- It is necessary to customise intervention strategies for different target populations. As Somali people likely face different types of problems in the process of their resettlement in New Zealand, it is crucial to conduct a systematic needs survey and utilise tailored strategies to solve their problems.

**Guerin, B., Abdi, A., & Guerin, P. (2003). Experiences with the medical and health systems for Somali refugees living in Hamilton. *New Zealand Journal of Psychology*, 32(1), 27-32.**

***Background:***

While there are physical and mental health issues resulting from their previous experiences in war and camps, other health-related problems in New Zealand arise from unemployment, separation from family, poor proficiency in English, changes in food and diet, and changes in daily exercise patterns. Barriers in preventing refugees accessing healthcare services include: issues of language proficiency, transportation, different views of health between refugees and health professionals, lack of childcare, and lack of suitably written health information.

The major objective of the study is to find out the reported health status and barriers to health service utilisation of Somali refugees in Hamilton. The focus is on how they conceive good and bad health, what they like or do not like about medical personnel, and problems they have utilising health services.

**Study design:**

54 participants were interviewed, 29 females and 25 males from different households. Their average stay in New Zealand had been 37.9 months. The method of interviewing was to 'talk around' the topics rather than ask sequentially fixed questions. Interviews were conducted by the interviewer writing notes on a printed questionnaire since participants in general preferred not to use tape-recorders. It was conducted in a mixture of Somali and English.

**Findings:**

Overall, the sample from the Somali community in Hamilton reported themselves as being in good health with few special health problems. The main problems relate only indirectly to health, but are perhaps just as important for that reason and are therefore of specific concern to health and social services. The major concern is the impact that lack of English proficiency has upon all aspects of utilising health services.

**Implications for mental healthcare for refugees:**

English classes need to be offered and easily accessible by the refugee communities, as the main finding of the study discovered that the impact of lack of English proficiency affects all aspects of refugees' lifestyle in New Zealand.

**Migrant mental health**

DeSouza, R. (2006). *Sailing in a new direction: multicultural mental health in New Zealand. Australian e-Journal for the Advancement of Mental Health, 5(2)* <http://www.auseinet.com/journal/vol5iss2/desouza.pdf>.

**Main discussion points:**

## 1. Health and mental health status

To date, no epidemiological studies have been conducted to address the mental health needs of the migrant and refugee population in New Zealand.

The Asian Health Chartbook (2006) revealed that Asians under-utilise health services:

- Asian people were less likely than other New Zealanders, Maori and Pacific people to have visited a health practitioner (or service) when they were first unwell.
- Asian people were less likely than other Europeans to visit a health practitioner about a chronic disease (doctor, specialist, nurse or complementary healer).
- Asian women were less likely than other New Zealand women to have had a mammogram or cervical screening test in the last three years.
- Asians were less likely than all New Zealanders to use any type of telephone helpline in the last 12 months.

- Asians also only wanted to see their general practitioner for a short term illness or a routine check up rather than visiting for an injury, poisoning, or for mental or emotional health reasons.
- Factors such as unemployment or underemployment, having experienced discrimination in New Zealand, not having close friends, being unemployed and spending most time with one's own ethnic group were predictors for poor adjustment among migrant groups.

## 2. Barriers in accessing mental healthcare

It was found that barriers to accessing services for Chinese people included lack of language proficiency of respondents, lack of knowledge about civil rights and problems accessing general practitioners.

An epidemiological analysis of migrants conducted by McDonald & Steel in New South Wales, Australia, highlighted that “the lowest rates of hospitalisation for mental disorders were for people from Northeast Asia followed by Southeast Asia and Southern Asia”. Ho et al (2003) identified that the barriers to accessing mental health services for Asian clients included: stigmatisation, perceiving mental disorders as shameful as punishment for previous wrong doings; language barrier; insufficient understanding of the mainstream health and social system and cultural differences in the assessment and treatment methods.

## 3. International students' mental health

The arrival of primarily Asian fee-paying students has had an impact on the education system, a greater importance to the national economy in terms of providing increased funding to educational institutions. Most international students are not entitled to access publicly funded (mental) health services while in New Zealand and are liable for the full costs of treatment unless they are sectioned under the Mental Health Act, and then only for the duration of that process.

## 4. Young Asians' mental health

The Youth 2000 Survey revealed that a significant number of Asian High School students in Auckland reported high levels of anxiety and depressive symptoms, and suicidal thoughts.

As the New Zealand Government is opening our education system to overseas students, there is a simultaneous increase in the number of Asian non-residents. This group of “sojourner” students is usually mobile and transient; they are however of a significant number that should not be overlooked by policy makers and service providers.

Because of the cultural stigma and a lack of understanding of the health system and mental health problems presented by the Asian young people and their families, work is yet to be done to improve their access to service. Workforce

development should therefore include education and upskilling of the current workforce who can help to identify the “at risk” Asian young people early.

#### 5. Government documents and policy framework

Asian researchers have outlined the legislative and policy frameworks that support culturally sensitive mental health service provision. These include The Health and Disability Commissioner Act 1995 and the Health and Disability Code of Rights 1996 which require that services acknowledge the needs of people from a range of cultures and provide for these needs while also protecting culturally diverse people from coercion, discrimination and exploitation.

#### 6. Other relevant health policy environment:

Te Tahuu– Improving Mental Health 2005-1015: The Second New Zealand Mental Health and Addiction Plan. Te Tahuu acknowledges that “there is no national strategy or policy to address the mental health issues of the full range of ethnic groups living in New Zealand. Building stronger relationships with people from *diverse cultures and ethnic groups* will be essential as we work towards developing strategies to address their particular needs” (italics added). Te Tahuu became the first Ministry document which highlighted that there is a need to improve the responsiveness of services for Asians.

The New Zealand Health Strategy (NZHS) guides the development and provision of new services in the health and disability sector to improve the health of New Zealanders. It aims to reduce inequalities in health status for Maori, Pacific peoples and people from lower socio-economic groups.

The Northern Region Mental Health and Addictions Strategic Direction 2005-2010 has two foci for its vision. 1) A specific focus on “equal opportunity to access quality services delivered in a culturally appropriate manner for refugee and recent Asian migrant clients and families” and 2) refugees and migrant clients with experience of mental illness and their families can access to professionally trained and qualified interpreting services to meet their needs.

#### 7. Professional interpreters

There was a need for the development of professional interpreter services as well as increasing the mainstream providers’ awareness of Asian cultural issues.

For instance, the Northern District initiated a number of projects aimed at improving and enhancing mental health services to meet the needs of Asians. Providing training to Asian interpreters and clinicians was identified as their priority.

#### 8. Workforce development

Reasons why it is more difficult to recruit Asian staff members in mental health services:

- Within the tertiary training systems, the easiest access to clinical training

is through nursing, social work, occupational therapy and psychotherapy. Hence the Asian workforce is mainly found in these four disciplines. Other professional teams including clinical psychology and medicine appear to have stricter entrance and selection criteria and limited spaces are also factors. It is only recently that one of the training tertiary institutions introduced Asian Mental Health in their undergraduate professional training.

- Increases in the attrition rate due to better pay overseas.
- Traditionally, due to cultural taboos, mental health is not the Asian people's preferred work of choice.
- Although not trained clinically, some members of Asian communities are very academically and culturally proficient to provide cultural bridging work between clinical teams and Asian communities.

#### 9. Effective use of the current Asian workforce

While it is ideal to recruit more Asian workers, it is envisaged that it will take some time to develop a new and fully matured Asian workforce. In the immediate future, efficient use of the existing workforce would provide both the resources needed for consultation and liaison and also provide the critical mass to incubate workforce development.

#### 10. Where to from here:

Large-scale studies are needed to determine mental health risk across all major ethnic groups in New Zealand, which will in turn enable development of ethnic-specific data. Even more critical is the need for data concerning ethnic variation in other areas of health (e.g. diabetes, accidents and injuries) so that effective interventions can be developed and implemented.

A more strategic response to New Zealand's changing demographics is required as until now the majority of developments have been ad hoc, reactive and operational, based on lobbying from ethnic community groups and non-governmental organisations such that responses are geared to our current situation rather than our future. It is necessary to address the place of the Treaty of Waitangi in the context of how multiculturalism is to be accommodated.

**Abe-Kim, J., Takeuchi, D., Hong, S., Zane, N., Sue, S., Spencer, S., Appel, H., Nicado & Alegria, M. (2007). Use of mental health-related services among immigrant and US-born Asian Americans: Results from the National Latino and Asian American study. *American Journal of Public Health, 97, 91-97.***

#### **Background:**

Asian migrants may have unique patterns of help-seeking and may receive a different quality of care from mental health service providers than do their US-born counterparts.

Empirical findings on the association between immigration-related variables and mental health service use are somewhat mixed, although they suggest that US-born Asian Americans may be more likely to use mental health services than Asians who have immigrated to the United States. Information regarding Asian Americans' satisfaction with mental health care is scarce.

Levels of mental health service need and corresponding rates of service use may vary across different Asian American groups, as well as being affected by the availability of culturally responsive services.

***Study design:***

Data were derived from the National Latino and Asian American Study (NLAAS, 2002-2003). A total of 2,095 Asian Americans were recruited between May 2002 and November 2003 as part of the larger NLAAS survey. Face-to-face interviews were conducted with participants in the core and high-density samples, unless the respondent specifically requested a telephone interview, or if face-to-face interviewing was not feasible. As a measure of quality control, a random sample of participants who had completed interviews was re-contacted to validate the data. Use of services, treatment ratings, quality of diagnosis, subjective satisfaction and perceived helpfulness were measured.

***Findings:***

Findings in the present study indicate that, overall, Asian Americans appeared to have lower rates of mental health-related service use compared with the general population; only 8.6% of Asian Americans sought help from any service versus 17.9% of the general population.

Differences in rates of help seeking persisted among individuals who had a demonstrated need for services: 34.1% of all Asian Americans who had a probable DSM-IV diagnosis during a 12-month period sought any services compared with 41.1% of all individuals who had a DSM-IV diagnosis during a 12-month period.

Use of services differed according to nativity status: US-born individuals used mental health services at higher rates than did migrants. Second-generation individuals were more similar to migrants in their use of services than to third-generation individuals. Third generation individuals were more similar in their pattern of service use to the general population sampled.

Perceived helpfulness of care varied by immigration-related characteristics: US-born Asian Americans, particularly third-generation or later, gave higher helpfulness ratings for any services. Ratings of subjective satisfaction, however, did not differ by immigration-related characteristics. These findings probably reflected the fact that ratings of "highly satisfied" and "satisfied" were combined, so that a large majority of the sample endorsed being satisfied with care.

The finding that second-generation Asian Americans were similar to migrants in their patterns of service use, along with treatment ratings of perceived helpfulness, suggested that more general factors, or even cultural factors (such as stigma or loss of face), might act as constraints on service use, beyond such migrant-specific barriers as language or knowledge of services.

The data also indicated that migrants require the most intensive outreach efforts to facilitate service use.

***Implications for mental healthcare for migrants:***

- The US experience showed that the first and second-generation individuals are struggling to blend into the mainstream society and overcome the cultural differences in the process of their resettlement in a new country and seeking professional help for mental health problems.
- It is paramount to identify specific barriers preventing migrants from accessing mental health services.

**Wong, D., Chau, P., Kwok, A., & Kwan J. (2007). Cognitive behavioural treatment groups for people with chronic physical illness in Hong Kong: reflections on a culturally attuned model. *International Journal of Group Psychotherapy*, 57(3), 367-385.**

***Background:***

Cognitive-behavioural treatments (CBTs) aim at modifying negative automatic thoughts and the dysfunctional rules underlying these thoughts, and enhancing adaptive coping skills. Clinical interventions using CBT groups have demonstrated their usefulness in enhancing the rehabilitation of persons with a variety of chronic physical illnesses. In particular, CBT groups help persons with chronic physical illness to develop better psychological adjustment and more adaptive coping behaviours.

A literature review of the therapy processes with Asians suggested that Asians (including Chinese people) tend to have less tolerance for ambiguity and prefer structured therapy sessions with practical and immediate solutions to their problems. Furthermore, Chinese clients are not used to expressing their emotions openly and in a free-flowing manner, and may require a more structured and focused format in order for them to express their feelings.

Group exercises, worksheets, simple readings, and homework assignments are often used to help members to examine their negative automatic thoughts and dysfunctional rules, and to learn strategies to change their dysfunctional cognitive process.

***Study design:***

73 participants were recruited through the Community Rehabilitation Network, a non-governmental organisation. They were randomly allocated to experimental

groups and waitlist control groups. All participants completed a self-administered questionnaire at the beginning of and end of the treatment. Members of the experimental condition participated in CBT groups between the times of measurement, whereas those in the control condition were placed on a waiting list.

***Findings:***

This study found no significant difference in coping skills between experimental and control groups at posttest. It might be that there was not enough time for the members in the CBT groups to practice the cognitive and behavioural skills learned during the group sessions. CBT strategies such as self-debating, thought stopping, positive self-talk, and self-reward required a great deal of practice and feedback from others in order for the individuals to use them effectively to deal with their emotions.

During the study, group members expected the group leaders to provide a group structure for discussion and to actively facilitate such a discussion. However, once the group members had gotten used to such an open atmosphere, they were able to discuss issues freely among themselves, and the group leaders could gradually facilitate the members to take more control of the group processes. Once a supportive atmosphere was established in the group, the members were able to confront and be confronted by one another.

***Implications for mental healthcare for migrants:***

- The findings of this study suggested that this CBT group was able to help members to make improvements in their mental health and reduce cognitive distortions and negative emotions.
- When delivering CBT in group format, the group leader has to actively create a supportive and cohesive group atmosphere that endorses and encourages the expression of constructive criticism.
- Group leaders may need to use themselves as a model to teach members to accept and express criticism.
- The group leader should facilitate members to gently confront one another by learning to raise questions such as “Is it worth holding rigidly onto such a belief?” or “Does your rule lead you to expect too much of yourself or others?”
- Within community settings, CBT education sessions should be held to help community members realise the importance of adopting new behaviours that will lead to positive mental health outcomes when chronic physical illness is found among family members.
- For more effective delivery of CBT to multicultural communities, it is necessary for CBT providers to bear in mind a possibility of confrontation of cultural differences and difficulties of discerning the way to overcome those barriers. Hence, it is also required for CBT practitioners to obtain a base knowledge of the culture from which a majority of community members come, and have a good sense of the particular ethnic group’s characteristics.

**Eyou, M., Adair, V., & Dixon, R. (2000). Cultural identity and psychological adjustment of adolescent Chinese immigrants in New Zealand. *Journal of Adolescence*, 23, 531-543.**

***Background:***

There is growing evidence from international research that in addition to normative issues of adolescence concerning biological, cognitive, psychological, and social development, ethnic minority adolescents face stressors arising from their minority status in society. Studies of ethnic identity development and acculturation suggest that the impact of these stressors on the psychological adjustment of ethnic minority adolescents may be mediated by the strength of their identification with their own ethnic group and with the mainstream society. Within the acculturation theory, it is suggested that:

- (1) Integrated individuals have strong identification with both their own ethnic group and the mainstream society
- (2) Assimilated individuals have strong identification with the mainstream society but weak ties with their own ethnic group
- (3) Separated individuals have strong identification with their own ethnic group but weak ties with the mainstream society
- (4) Marginalised individuals have weak identification with both groups

Numerous studies have reported that some ethnic minorities can identify with both their own ethnic group and with the mainstream society without evidence of conflict between the two identifications. However, other ethnic minority individuals and groups are unable to integrate as they find identifications with ethnic and mainstream cultures to be incompatible and conflicting.

Assimilation into the mainstream society alienates these individuals from their own ethnic group, while separation alienates them from the mainstream culture. This incompatibility in behaviour, attitudes, and values between the two cultures may cause psychological distress.

Integration has been found to be associated with psychological well-being, while marginalisation was associated with poor mental health. It may be the ability to identify with and live as part of both cultures without being alienated from or rejected by either that contributes to the psychological well-being of integrated individuals.

The extent to which these different findings are due to contextual factors, such as the status of the particular ethnic group and its relationship with the mainstream society, could not be determined due to differences in the methodology of these studies.

***Study design:***

A self-report questionnaire was used among participants in order to identify their background information, ethnic identity scale, European Kiwi identity scale, and

psychological adjustment. The questionnaire was developed in both English and Chinese as to eliminate language barriers. Psychological adjustment was assessed by three scales: Negative self-image scale, Depressive tendencies scale, Psychosomatic symptoms scale.

***Findings:***

Integrated adolescents were found to have significantly higher self-esteem than their separated or marginalised peers.

However, no significant differences were found across cultural identity groups in terms of depressive tendencies, although marginalised adolescents were found to have significantly less psychosomatic symptoms than their assimilated peers. It means that the nature of the relationship between each indicator and cultural identity appears to differ.

Among adolescents who were integrated and marginalised, ethnic identity and European Kiwi identity scores were found to be uncorrelated, suggesting that these two identities (i.e. own ethnic identity & European Kiwi identity) were not conflicting but were on independent dimensions.

Among adolescents who were separated, the strength of ethnic identity was found to be negatively correlated with the strength of European Kiwi identity. This suggested that these adolescents found identification with their own ethnic group to be incompatible and conflicting with identification with the mainstream society. It might be the stress from the incompatibility in behaviour, attitudes, and values between the two cultures that contributes to their low self-esteem.

The finding that strong ethnic identity was not necessarily associated with psychological well-being, as it depended on the strength of identification with the majority culture, highlighting the importance of examining both identification with one's own ethnic group as well as with the majority group.

Furthermore, the attitude, behaviour and identity exploration components of cultural identity were found to be significantly inter-related, and the Ethnic Identity and European Kiwi identity scales were found to have high internal reliabilities.

***Implications for mental healthcare for migrants:***

- The relationship between ethnic identification and status of psychological well-being was more complicated than what the acculturation theory might imply.
- A nationwide mental health policy is needed to attain the overall societal goal of keeping everyone mentally healthy regardless of their gender, ethnicity, age, and social status.
- With limited resource, it should mainly focus on the mental health status of those who are socially disadvantaged or marginalised. Its prior target population should include refugees, migrants, and those with deprivation of

social support, financial aid, and other help for their everyday activities.

**Abbott, M., Wong, S., Giles, L., Wong, S., Young, W., & Au, M. (2003). Depression in older Chinese migrants to Auckland. *Australian and New Zealand Journal of Psychiatry*, 37, 445-451.**

***Background:***

Depression is the major psychological problem that affects older people and is the risk factor most often associated with suicide. In the US, older foreign-born Chinese have much higher suicide rates than their US-born counterparts and other older Americans. This suggests that older Chinese migrants have elevated rates of depression. Research with older people generally has shown that they are more likely to be depressed if they are female, have poor self-rated health, live alone and have low social support.

The expression of depressive symptoms is also influenced by cultural factors and in some studies Chinese people have been shown to differ from European in this regard. Somatic features have been considered more important among Chinese, although some recent studies have challenged this. These considerations are important in the study of depression among older Chinese. They may also result in low detection rates by health professionals who are not familiar with older Chinese patients. A Singapore study identified that high rates of depression were found and risk factors included low socioeconomic status, poor physical health, functional disability, strained social relationships and isolation. Female gender and advanced age were additional risk factors in some studies. Family and social support may be particularly important in reducing the risk for depression among older Chinese.

***Study design:***

Face-to-face interviews were conducted among 162 Chinese people aged 55 or more attending general practice clinics. Questions regarding demographic information, social relationships, health and service utilisation, cultural orientation, and stressors were asked.

***Findings:***

In this study, over a quarter of participants were identified as showing symptoms of depression. If a half of those assessed as symptomatic were clinically depressed, older Chinese migrants were likely to have an elevated risk for depressive disorders relative to older New Zealanders generally.

It could not be determined whether the participants in the present study had depressive symptoms prior to their migration to New Zealand. However, the finding of no cases of depressive symptoms among participants resident less than 12 months suggested that pre-migration rates of depressive symptoms might be low and that post-migration factors were more likely responsible for symptoms of depression.

Although very few of the respondents reported serious arguments with a spouse or problems with relatives or friends, considerable variation was apparent with respect to receipt or tangible support from others, emotional support and satisfaction with social support.

Over a third of respondents reported having difficulty accessing health services and this group had significantly higher rates of depressive symptoms. A recent survey of the healthcare needs of Asian people in Auckland has highlighted concerns in this area. Common complaints noted were the high cost of general practitioner and private health care, a lack of information and understanding of the health care system, and language and cultural barriers.

Given the 26% prevalence of depressive symptoms among older people in the present study, it is of particular concern that a disproportionate number had experienced considerable difficulty in obtaining health care.

***Implications for mental healthcare for migrants:***

- As it has been shown in many other studies, migrants are experiencing strong barriers to access to health care services. It may be due to language difficulties, geographical inaccessibility to health care settings, or lack of financial support.
- It has also been demonstrated that these barriers can be removed by establishing community support. Interpreters can be sought and allocated to clinical practices to provide additional support for clients from diverse linguistic background.
- Post-migration depression is mainly caused by difficulty to blend into the mainstream society. In many research studies, cultural, linguistic and perspective differences are found to result in elevated rates of suicide, depression, and poor mental and physical health status among new settlers.
- A large number of strategies have been suggested, but they have not been so successful in regard to examining the outcome of the implementation of such strategies. Future studies need to focus largely on practical ways of improving the overall status of those who come to live in a new country.

**Grossman, J., & Liang, B. (2008). Discrimination distress among Chinese American adolescents. *Journal of Youth Adolescence*, 37, 1-11.**

***Background:***

Asian American adolescents experience higher levels of peer discrimination than teens from other minority groups, and that distress from this unrecognised discrimination bears significant ramifications for their emotional development. However a contradiction lies in the discrepancy between research documenting discrimination against Asian American adolescents, and a broadly held belief that Asian Americans are a successful or “model” minority. The “model minority” puts pressure on Asian American students to fulfil stereotypical academic

expectations. Discrimination against Asian Americans is closely linked with stereotypes that portray them as perpetually foreign and lacking in social skills and competence in social relationships, particularly in peer contexts. These issues are not widely discussed, yet salient challenges for Asian American youth.

A previous study found that among Chinese American college students, racial discrimination negatively predicted a sense of coherence across life domains. Peer stereotypes of Asian Americans as socially awkward and unable to communicate, and racial teasing and exclusion by peers directly challenge Asian American teens. It is hypothesized that individuals internalise racial messages about their group, and suggested that collectivist aspects of Asian American cultures may make this theory particularly applicable to this group. That is, Chinese cultural values that emphasise interdependence and attunement to others' expectations can heighten the impact of external appraisals for Chinese American adolescents.

While research provides preliminary evidence for the protective role of overall social support for Asian Americans, only a few studies investigate stress-buffering effects of peer support specifically among Asian American adolescents. For example, a qualitative study of Japanese migrant youth in the US found that participants tended to seek peer support to cope with difficulties such as racism, language barriers, and identity and values conflict.

***Study design:***

158 Chinese American middle school-aged youth from the greater Boston area participated. A relationship between discrimination related stress and social emotional health was examined, and the latter was measured by two different indicators of mental health and social competence.

***Findings:***

Significant relationships were found in this study between discrimination and distresses, and both depressive symptoms and cooperation were consistent with the premise of symbolic interaction theory that individuals internalise race-related appraisals, increasing the adolescents' vulnerability to external, negative social feedback.

Negative experiences with the majority culture may impede the process of navigating dual cultures, and adapting to White American cultural norms at school. Distress due to treatment from peers and teachers that was perceived as negative or unfair might reduce youths' motivation to cooperate and adhere to social expectations of classroom contexts.

Findings from this study indicated that with greater peer support, the negative relationship between discrimination distress and cooperation was reduced. Furthermore youth who reported higher levels of cooperation may possess the

social skills necessary to make and retain a close friend, who in turn provides support.

***Implications for mental healthcare for migrants:***

- The lack of recognition of discrimination and its consequences decrease the likelihood that Chinese American adolescents will access needed external supports. Recognition is the critical initial step.
- The internalisation of “model minority” stereotypes, along with traditional Chinese cultural values that may inhibit institutional help-seeking behaviour, further decreased the likelihood that youth will access needed support services at school.
- A helpline needs to be developed and made accessible. It needs to be better advertised among ethnic minority students at institutional settings, and more strictly enhanced laws to regulate the discriminatory behaviour of those from the majority culture should be reinforced at institutional settings.
- Teachers and parents need to listen more carefully and frequently to those from minor ethnic groups. Young teenagers are less likely to seek help themselves on their own; hence, it is crucial to identify their primary needs and causes of emotional distress.

**Abbott, M. W., Wong, S., Williams, M. M., Au, M. K., & Young, W. (2000). Recent Chinese migrants health adjustment to life in New Zealand and primary health care utilisation. *Journal of Disability & Rehabilitation*, 22(1-2), 43-56.**

***Background:***

The Model of Acculturative Stress more explicitly considers the adaptation process of migrants from the point of view of psychological stress. It postulates that serious adjustment and health problems are not inevitable but depend on the nature of the new society (e.g. monocultural or multicultural ideology), the type of acculturating group (e.g. refugee or migrant), mode of acculturation and individual and group coping abilities.

Major risk factors for mental disorders in the migrant population include pre-migratory trauma and stress, separation from family or community, isolation from people of similar ethnic background, inability to speak the language of the host country, unemployment or underemployment, negative public attitudes and rejection, being a child without parents, being adolescent or of advanced age at the time of migration and being a woman from a culture in which gender roles and values differ from the host country.

One member of the study team (SW) examined psychiatric hospital and community mental health centre admissions for South Auckland. He found that both hospital and community utilisation rates for Chinese were approximately a quarter of those of the remainder of the population. The community rate for another major recent migrant group, Pacific Islanders, was also substantially

lower than those for European and Maori, but doubled the Chinese rate in South Auckland.

***Study design:***

The multivariate model of migrant adaptation took into consideration pre-migration conditions, socio-demographic characteristics of individuals, length of residence in the new country and post-migration factors. Post migration variables were considered to be the most potent. They included societal risk factors or stressors such as prejudice and discrimination and protective or buffering factors such as the size of the migrant community. Stressors and buffers at the individual level included language ability, employment/unemployment and the presence/absence of family and social support networks.

***Findings:***

Migration involves losses, disruption to families and life patterns and exposure to multiple stressors, new experiences and challenges. These are all magnified when, as in the situation examined here, migrants relocate in a very different culture and become members of a visible ethnic minority.

In addition to many living in households with an absent spouse/parent, significant numbers experienced unemployment or underemployment, a variety of problems including difficulty with language and communication, a lack of prior information about life in New Zealand and ambivalent reactions from locals in terms of acceptance and rejection.

In the case of experiencing major post-migration problems, being aged 26-35 years, perceiving rejection or a mixture of acceptance and rejection on the part of locals and low levels of English proficiency appeared to be most important. There was no difference between recent and earlier arrivals with respect to frequency of problems encountered, suggesting consistency over time in terms of migrant exposure to major problems.

The finding that adults aged 26-35 years experienced significantly more problems than other age groups appeared to contradict the consensus in the refugee and migrant mental health literature that adolescents and older people were at greater risk. The 26-35 year group also reported poorer adjustment. Perhaps there were particular pressures on people in this age group arising from establishing new careers and having young families, often without the support of parents and extended family. Long separations of spouses during the resettlement phase might also be an important factor.

***Implications for mental healthcare for migrants:***

- It is essential to meet needs of migrants and refugees by providing full assistance so that they are more enabled to adjust themselves in a new environment. This would be likely to reduce their adjustment difficulties in the process of migration.

- More surveys or studies need to be conducted to assist health practitioners or government officials to take appropriate action for migrants as well as refugees to resettle in New Zealand.

**Ho, J., Yeh, M., McCabe, K., & Hough, R. (2007). Parental cultural affiliation and youth mental health service use. *Journal of Youth and Adolescence*, 36, 529-542.**

***Background:***

Research shows that African American, Asian/Pacific Islanders and Latino youth have a much higher rate of unmet mental health needs compared to non-Hispanic White youth.

Adding to the urgency of addressing these racial/ethnic disparities is the rapid diversification of the U.S. population. Minority youth will continue to experience more rapid growth than non-minority youth, and it is estimated that in about 20 years, 48% of American youth will be from ethnic minority backgrounds.

Researchers have hypothesised that certain cultural attitudes, values, beliefs, and /or behaviours may act as barriers to mental health services use for these populations and help explain differential use.

The potential role of cultural attitudes, values, and beliefs in disproportionate service utilisation can be illustrated by the examples of coping styles, stigma associated with mental illness and mental health treatment, and mistrust of mental health professionals and services.

Acculturation refers to the psychosocial adaptation of persons from their culture of origin to a new or host cultural environment, and can include relearning language, incorporating new values, expectations, and beliefs, and altering behaviours. The current study examined the extent to which acculturation affects the youth's mental health service use.

***Study design:***

Participants were a subsample of 1,364 youth from a large survey study, entitled the "Patterns of Youth Mental Health Care in Public Service Systems". Data were collected on demographic characteristics, emotional/behavioural problems, parental acculturation level, and mental health service utilisation through primary caregiver and youth interviews.

Socio-economic status in the study was assessed through family income and highest level of parental education. Socio-demographic variables included age, gender, ethnicity of adolescents and primary caregivers. A valid and reliable measure of child's emotional/behavioural problems, the Child Behaviour Checklist (CBCL) was used to assess child emotional/behavioural problems. Parent acculturation was measured by the PAN Acculturation Scale. Use of

mental health services at two-year follow-up was assessed by the National Institute of Mental Health Service Assessment of Children and Adolescents, which has demonstrated adequate reliability and validity.

***Findings:***

Results indicated that parental acculturation level as measured by affinity to an alternative culture was indeed a partial mediator in the relationship between ethnicity and mental health service use for Asian/Pacific Islander and Latino youth, even when youth gender, youth age, youth symptomatology, household income, parent education level, and parent gender were held constant in analyses.

The results of the study showed that acculturation, as a way of measuring adherence to culture-specific attitudes, values, beliefs, and/or behaviours, was significantly related to disparities in the current mental health care system. The findings suggested that minority parents who reported high affinity to an alternative culture may subscribe to cultural values that discouraged help-seeking in the mental health sector, reduced the likelihood of seeking outside help, held negative views of the mental health services sector due to unfamiliarity with Western mental health services, and mistrust of clinicians.

***Implications for mental healthcare for migrants:***

- In order to remove these cultural barriers to youth mental health service utilisation, it is important to raise public awareness of mental health services including treatment and prevention services and issues that concern the overall health status of ethnic minority groups.
- It is important to support ethnic minority groups to overcome the barriers in accessing mental health services.
- Also, health professionals need to take up training to: 1) increase their awareness of different mental health needs of diverse population groups, 2) be able to provide culturally responsive services.

**Clarke, D., Tse, S., Abbott, M., Townsend, S., Kingi, P., & Manaia, W. (2006). Key indicators of the transition from social to problem gambling. *International Journal of Mental Health Addiction*, 4, 247-264.**

***Background:***

The 1991 New Zealand National Gambling Prevalence Survey found that initial problem gambling severity, preference for track betting and co-morbid excessive alcohol use predicted future problems. Also, it was found that a significant number of people with problem gambling who no longer reported gambling problems engaged in excessive or problematic alcohol use. Many of the non-problem gamblers participated weekly or more frequently in continuous gambling activities, and few subsequently developed gambling problems. Existing research also shows that: (1) there is higher exposure to gambling, particularly gaming machines, in low incomes areas; (2) Maori women are the fastest growing

population presenting to treatment services; and (3) residents of less affluent areas participate in gambling activities at a higher level than those in more affluent areas. Some studies found that emotional stress, loneliness and social factors were significantly associated with problem gambling at the 12 month assessment. Unfortunately, these factors were only measured at follow-up, not prospectively. Consequently, it is not known whether negative emotions preceded and played a role in the transition to problem gambling or were a consequence of problem gambling.

This study aims to examine the determinants of the problem gambling behaviour. It seeks to identify predictors of initial problem onset in a cross-cultural context.

***Study design:***

Two phases were developed.

Phase One: The first stage of the phase one is a systematic literature review to identify studies relevant to the shift between social and problem gambling. The second stage of the phase is individual interviews with problem gamblers, and professionals working with problem gamblers and family members affected by problem gambling. The third stage involved the development of a methodology in the form of a questionnaire to assess the determinants of the transition from starting gambling to continuing gambling at the individual, social and environmental levels, based on the findings obtained from the first two stages.

Phase Two: In phase two, the questionnaire was administered to a convenience sample of gamblers who were recruited from a variety of sources including training/education institutions, cultural groups, social service agencies, sports groups and clubs, and through individual networks in the South Auckland area.

***Findings:***

Low economic status, reduction of negative affect, loss of control, conducive environments, glamorous advertising and social inducements are relevant to the development of problem gambling and substance abuse. Alcohol and substance abuse are clearly specific risk factors for the development of problem gambling.

Social, cultural, situational and environmental reasons seemed to be more important than personal reasons for starting gambling, while personal reasons were proportionately greater for continuing gambling. Personal reasons that predominated were emotional stress and loneliness.

There are differences in determinants of the problem gambling behaviour among ethnic groups. Asians were less likely to start gambling to solve money problems and to continue gambling to cover losses than the other ethnic groups. Pacific Islanders gamble to escape from stress, troubles and loneliness. Like Maori, needing money for family and obligations was more relevant for Samoans and Tongans than for the other Pacific Island groups. They, though, began gambling

as a social activity which was much less a reason for continuing regular gambling.

***Implications for mental healthcare for migrants and refugees:***

- Be aware around the advertising of gambling products- whether certain at-risk groups (e.g. Asian young people, like international students) have been purposely targeted at a disproportionate level. Gambling products or activities need to be fairly and accurately advertised that it contains addictive elements and causes potential harms.
- Also, the distribution and allocation of gambling machines need to be strictly controlled and monitored. From the findings of the study, a large number of participants commented that they have easy access to gaming activities and money machines.
- Future studies should focus on practical factors that may cause the problem gambling behaviour such as unemployment (or under-employment), mental distress and financial insecurity for instance among people from migrant and refugee backgrounds.

**Kumar, S., Tse, S., Fernando, A., & Wong, S. (2006). Epidemiological studies on mental health needs of Asian population in New Zealand. *International Journal of Social Psychiatry*, 52(5), 408-412.**

***Main discussion points:***

Compared with the UK and US, where such migration has happened over several decades, New Zealand's experience has been so rapid that it has not allowed time for acclimatisation to the host population or the health care system.

Asian migrants have a different or delayed pattern of seeking help, have a lesser probability of being referred to specialist services by their GPs and face barriers because of language difficulties, reliance on family resources, failure to detect psychiatric symptoms and reluctance in seeking help from primary care workers.

Asians in New Zealand are a very heterogeneous group culturally and linguistically. This makes data collection of diverse Asian ethnic groups challenging, but there might also be some similarities between them. Socially or self-assigned ethnicity may be preferred for data collection because of the ongoing debate on what constitutes race as opposed to ethnicity. Priority will need to be given to the main Asian sub-groups in New Zealand, with focus on first-generation migrants and apparent high-risk groups (e.g. international Asian students, older people, women, members from small Asian communities). Effective implementation of the strategy requires accurate information, which is lacking in psychiatric morbidity among Asians. Lack of coordination of various social and health services across government and non-government sectors is a major problem in addressing Asian mental health needs.

***Implications for mental healthcare for migrants:***

- There have been quite a number of studies that have investigated the health status of Asian migrants in New Zealand. However, there has not been much attention to their needs assessment. It is necessary for government officials to probe into Asian migrants' needs via surveys or interviews, which will in turn enhance migrants' ability to integrate into the new environment more successfully.
- Future studies may be more strategically designed to identify the needs of Asian migrants, bearing in mind that there will be cultural differences within the Asian population as they distinguish themselves from others. Therefore, needs assessments should be formulated in such a manner in which cultural perspectives are uniquely formatted for *different ethnic groups*.

**Trauer, T., Eager, K., & Mellso, G. (2006). Ethnicity, deprivation and mental health outcomes. *Australian Health Review*, 30(3), 310-321.**

***Main discussion points:***

1. Ethnic differences

Evidence of ethnic differences at the care level exists. An overseas study found African-American mental health service consumers were more likely to be prescribed older antipsychotic medications, but the level of contact they received was no less than non-African-Americans. Another study found lower neuroleptic doses in white inpatients than in African-American inpatients; certain other differences disappeared after socio-economic status and diagnosis were controlled for, but others did not.

2. Casemix study

In this study, the Mental Health Classification and Outcomes Study commissioned by the New Zealand Health Research Council was included. Its main purpose was to develop the first version of a national casemix classification for specialist mental health services and to trial the introduction of outcome measurement into routine clinical practice. Three broad "blocks" of data were collected: service utilisation data; financial data; and service user characteristics. Data collection was governed by the key concept of an "episode of care". An episode of care is the whole or part of a period of illness during which there is contact between a consumer and a health care provider or team of providers, is delivered in one setting (eg, hospital, clinic), and where there is no major change in the goal of the intervention. Users were rated on the instruments at the start and end of each episode or, for ongoing episodes, at intervals of 90 days. Episode start data were collected on all consumers under care at the beginning of the study and those who entered during the study period. Similarly, episode end data were collected at episode closure or at the end of the 6-month study.

3. New Zealand findings

The finding of higher levels of severity and lower levels of functioning in Maori and Pacific Island patients is consistent with higher severities in non-psychiatric disorders, for example asthma and dental problems.

Maori and Pacific Island consumers may be entering the service later in their episode of illness than non-Maori and non-Pacific Island consumers and their higher severity and lower functioning could be a result of longer periods of untreated illness.

A major finding is that, despite often large pre-existing ethnic differences in severity levels in both inpatient and community settings, the amount of improvement over the course of an episode of care, defined as the percentage change from the initial level, was roughly equal for all three groups. It may be that socio-cultural factors affected the circumstances by which consumers came into contact with services, but once in care there were similar processes toward improvement and recovery. Another, non-exclusive, possibility was that differences in pathways of access to care (i.e., when help is sought, when help is offered, and when people are accepted into health care) might occur differently across ethnicity and socio-economic status groupings.

Accessibility and acceptability of mental health services have been implicated in ethnic differences in utilisation. Failure to identify problems early may be one result, resulting in consumers not seeking or being accepted into treatment until later in their illness.

Another possibility is a form of selection bias, whereby Maori and Pacific Island consumers with milder conditions and higher incomes may be more likely to access services not included in this study, such as private therapists and alternative treatments.

Another possible reason may be social and cultural dislocation. Maori and Pacific Island people living in areas of relative social advantage like city, urban living, may experience more social and cultural dislocation in the sense of less connectedness with family networks and community supports.

***Implications for mental healthcare for migrants and refugees:***

- Some of the findings on Maori and Pacific Island people might be applicable to migrants and refugees as well, for example, low and delayed presentation to mental health services.
- Future studies need to aim to discover the factors that prevent Maori and Pacific Islanders, and migrants and refugees from accessing mental health care services.

## **2.4 What do we know about the current mental health status of the migrant and refugee population?**

### **The good and the not so good**

On the one hand, the overall mental health status of Asian migrants is seen to be quite good or does not differ significantly from those of the general population (DeSouza, 2006; Ho, Au, Bedford & Cooper, 2002). A natural selection might have occurred during the process of migration to exclude those with more severe pathological problems (McDonald & Steel, 1997; Rasanathan et al., 2006). This may be further explained by the generally young and middle age structure and being recent migrants who have to have a good health status to be accepted for immigration (Ho et al., 2002). One may even argue that migrants on the whole are more resilient to adversarial events and stress (McDonald & Steel, 1997). On the other hand, migrants are exposed to stresses during the settlement phase and are therefore predisposed to psychological morbidity (Chu, 2006; Lin, Tsang, & Yeh, 1995).

Examples of post-immigration adjustment difficulties include finding suitable employment<sup>6</sup>, language difficulties, social isolation and cultural shock. There are examples of New Zealand studies supporting this view. A higher rate of psychiatric morbidity was found among Cambodian refugees and Chinese women in Dunedin who were less acculturated. The elevated mental health needs were found to be related to inadequate language skill, lack of acculturation and feelings of being discriminated against, little social support, coming to New Zealand to follow the lead of the family (Cheung & Spears, 1992; 1995a & b). Another recent study found that migrants' mental health levels (people from Peoples' Republic of China, India & South Africa) were low, and were independent of their number of months residence in New Zealand, employment status and regardless of the participants' proficiency in English language (Pernice, Trlin, Henderson & North, 2000).

Although Abbott and associates (1999) in Auckland found a GHQ score of the Chinese migrants comparable to those of the host population, closer scrutiny of the scores has shown that those whose GHQ scores are above the level of "caseness", have ratings much higher than the threshold and indicating more severe psychopathology. Abbott and associates (2002) also found that up to 26% of Chinese respondents aged above 55 years were classified as "clinically depressed" and this was attributed to factors like post-retirement adjustment compounded by immigration effects, isolation, inter-generation gap, transportation, language and communication difficulties. A United Kingdom review concluded that the suicide rate of young Indian migrant women was consistently higher than their male counterparts and women of their host

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<sup>6</sup> 21% of the Asian and Middle-Eastern ethnic group had a tertiary degree or qualification, twice as many as those in the total New Zealand population. This high education background is inconsistent with employment rates and associated income level. Source: Office of Ethnic Affairs (2002b).

countries. Suicide rates among older Indian migrants appeared low, however use of violent methods was common and a disproportionately higher number of migrant Hindus committed suicide, and mental illness was rarely cited as a cause. The review concluded that affective disorders might be under-diagnosed in this population (Patel & Gaw, 1996).

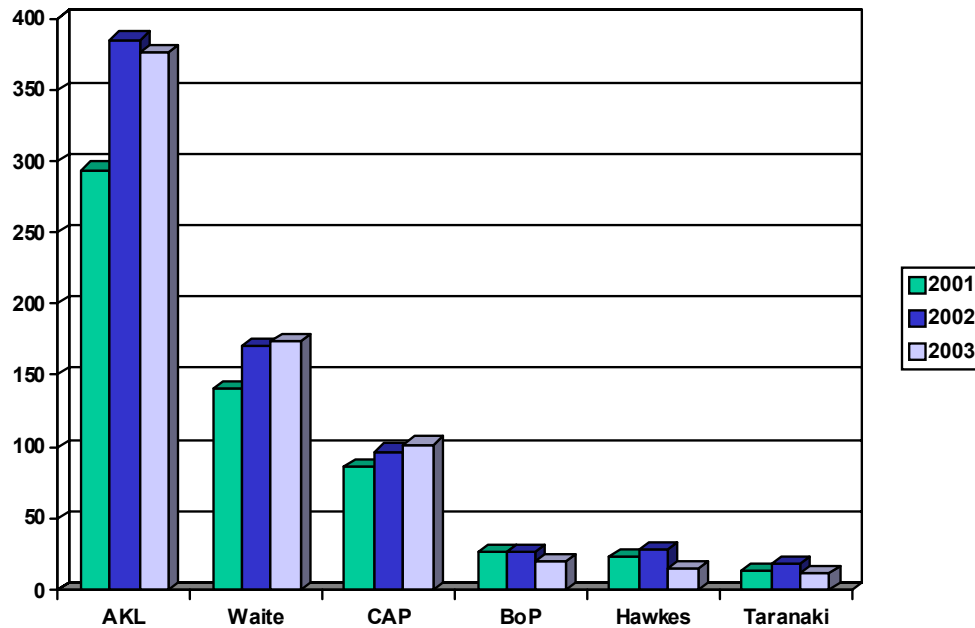
Furthermore, the New Zealand Mental Health Commission's Report on Asian mental health (Ho et al., 2002) mentioned several high-risk groups for further investigation:

- Women and foreign fee-paying students from Asian countries;
- Refugees because of pre-migration traumas and post-migration stressors of adapting to a new culture;
- The high mental health needs of women and refugees from small ethnic communities for example Vietnamese, Indonesian, Sri Lankan;
- Problems (e.g., depression, very limited emotional support, loneliness and isolation, apparent lack of respect from adult children and grandchildren) and mental health needs of older people within the Asian population.

### **Mental health services utilisation data: Insights and implications**

Since there is no systematic Asian mental health epidemiology data in New Zealand, the alternative is to examine service utilisation statistics. Three important trends emerge when we review Asian people's rates of utilisation of mental health services. Firstly, there has been a general increase in utilisation rates of mental health services amongst Asian people in some selected DHBs (Figure 1, data between 2001 and 2003). Secondly, the rate is still much lower than other population groups and is disproportionately lower than the population statistics (e.g. the Asian population accounted for 6.6% of the total population in 2001). This highlights concerns that there might be a substantial proportion of the population not accessing the help required. Thirdly, the changes in utilisation rates among Asian people accessing mental health services might be explained by the fluctuation of Asian population size (e.g. Asian international students) and improved accessibility of services for Asian people.

Figure 1. Number of Asian people accessing inpatient and community mental health services in selected DHBs (2001- 2003) Source: *The Mental Health Information National Collection, Ministry of Health.*



While service utilisation statistics may appear reassuring, they have to be interpreted with caution due to the following reasons.

Firstly, migrants and refugees in a new host country have a different or delayed pattern of seeking help. Based on the United States data, Asian migrants tend not to use mental health services, or when they do utilise the services, they exhibit more severe mental symptoms than their American counterparts (Sue, Fujion, Hu, Takeuchi & Zane, 1991). In an international study of the pathways to care of 1,554 patients newly referred to the mental health services in 11 countries, one quarter were referred by hospital doctors, a third were self referred and 11-17% were referred by religious healers. This referral trend was in sharp contrast to European countries where 63-80% were referred by their GPs (Gater, de Almeida, & Barrientos et al., 1991). In other words, migrants' and refugees' choice or first port of call for mental health problems varies immensely based on their ethnicity.

Secondly, as a recent study by Chung and associates (2003) suggested, although ethnic people appeared to have similar depressive symptom rates as local people, these were detected less by primary care physicians. There is a possibility that this situation may also occur in New Zealand where mental illness among migrants and refugees in comparison with other population groups might not be picked up by physicians. In the Sydney survey (McDonald & Steel, 1997), it was concluded that there was no evidence to suggest that the low rate of utilisation by non-English speaking people was related to lower prevalence of

psychiatric problems. The authors postulated several reasons for a low utilisation rate including cultural barriers such as language, reliance on family resources in the management of psychiatric disturbances, failure to detect psychiatric symptoms and reluctance in seeking help from a primary healthcare worker.

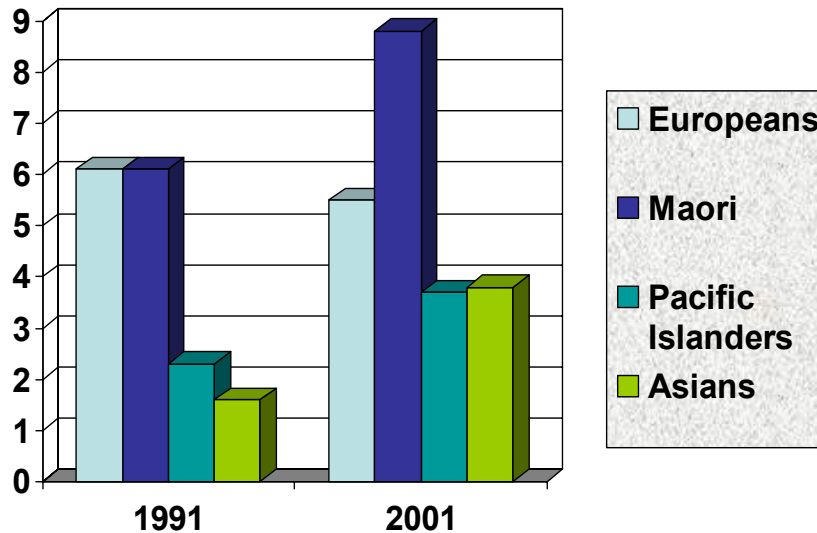
In a mental health context the ethnic sector groups will have worldviews quite different from the mainstream (Kleinman, 2002). This will affect a range of factors such as the validity of assumptions being made about attitudes to mental illness or wellbeing, mental health services, treatments and health professionals, the causes of illness, how symptoms are presented and how to access or use services. It will also have implications for training of professionals. The risks and issues posed to people from the ethnic sector include: accessibility of information, appeals or complaints procedures, how informed consent is obtained, how diversity is accommodated in the design of the proposal, and cultural safety. Anecdotal evidence suggests the language risks and worldviews of ethnic groups are often overlooked.

Thirdly, “visible ethnic” (please refer to Chapter One, 1.1 defining terms) migrants and refugees are likely to experience prejudice and discrimination through being “the visible minorities” (Greif 1995; Harris, Tobias, Jeffreys, Waldergrave, Karisen & Nazroo, 2006; Pernice & Brook 1994); unemployment; separation from family; social isolation and low socioeconomic status (Abbott, 1997). All these factors are associated with greater mental morbidity (Jones, 2000). And yet, surprisingly enough, both hospital and community mental health service utilisation studies seem to suggest a much better mental health status for Asian migrants compared to the local population.

Fourthly, utilisation figures are not meaningfully representative of the prevalence rate and are likely to be influenced by cultural barriers to accessing mental health services. In some cases, a number of Asian migrants do not access the services, are reliant on medication sent from overseas and are more disabled when they finally access help. Even if migrants represent a healthier group by natural selection, or are protected by a hardiness personality trait, it seems unlikely that a low morbidity rate would account for a low utilisation rate of community mental health services compared with other population groups (see Figure 2). The paradoxical findings are:

- Excessively low utilisation rates among Asian migrants relative to the national population statistics,
- Excessively low utilisation rates among Asian migrants compared with other New Zealand population groups, yet migrants *are confronted* by a whole array of settlement issues.

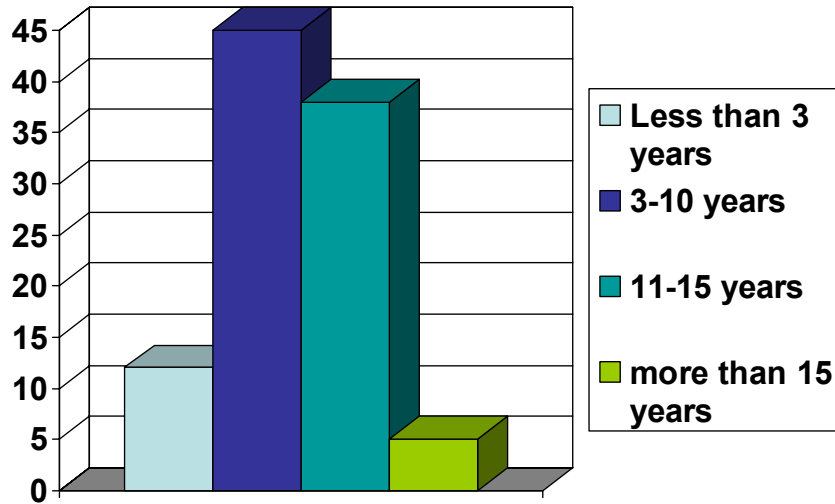
Figure 2. Utilisation rates (over 1,000 people) of community mental health services in South Auckland from 1991 to 2001.



### Diversity matters

Figure 3 also shows the majority of the total Asian people resided in the country for less than 10 years. This suggests migrants might have limited knowledge about the New Zealand mental healthcare services and experience difficulties in navigating through the system. Diversity amongst the ethnic sector of the population (see Figure 4 and 5 using the Asian population as an example) also has implications for communication, mental health promotion and prevention strategies and results in a need for interpreters or translation of information in key ethnic languages. There is also an emerging need for better understanding of the impact of different worldviews on accessing mental health services, and an understanding of ethnic specific intergenerational and cross cultural determinants of mental health, and the importance of family and community in the provision of care (Leff, 2002; van Os & McKenzie, 2002; Tse, 2004; Tse, Lloyd, & McKenna, 2006). A basic requirement for effective services is for consumers to have their needs assessed and understood as appropriate to their cultural or ethnic background and the intercultural environment, in both specialist and primary health care settings (Bhui, Mohamud, Warfa, Craig, & Stansfeld, 2003; Yee, 2003).

Figure 3. New Zealand Asian population: Duration of residency.



New Zealand Asians: Years of residency (Statistics, 2001)

Figure 4. Asians by birthplaces (1991 & 2001). Source: Ho E. (2005) "Asian peoples in Aotearoa/ New Zealand: Birthplace, ethnic self-identification, language & religion" Paper presented at the Workshop on Defining term "Asian" on 29<sup>th</sup> July.

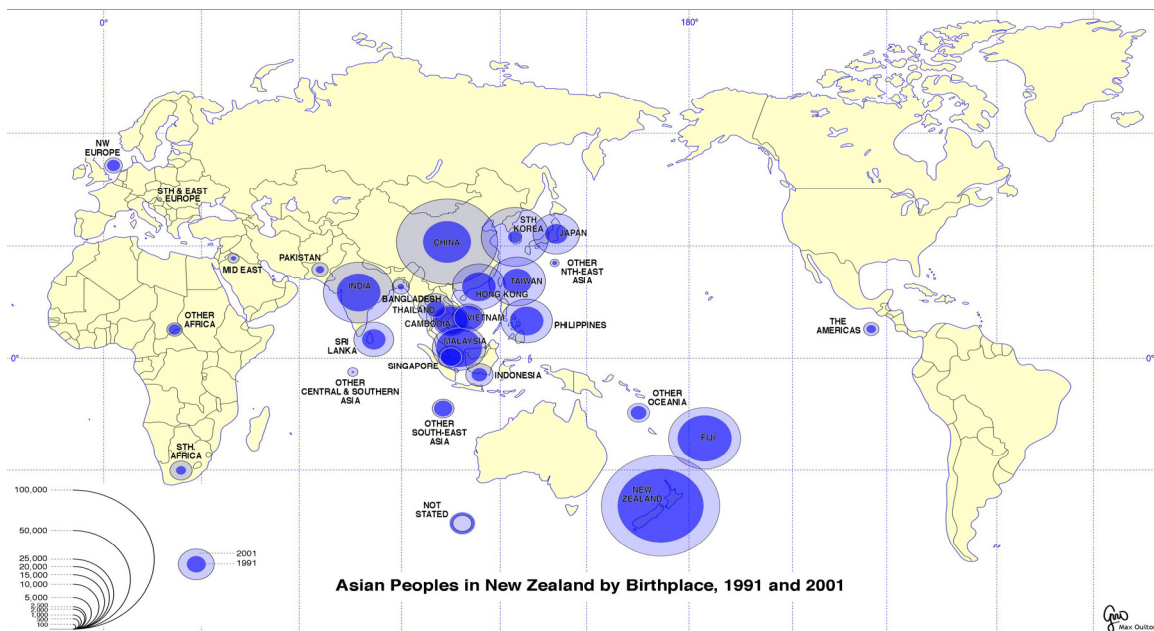
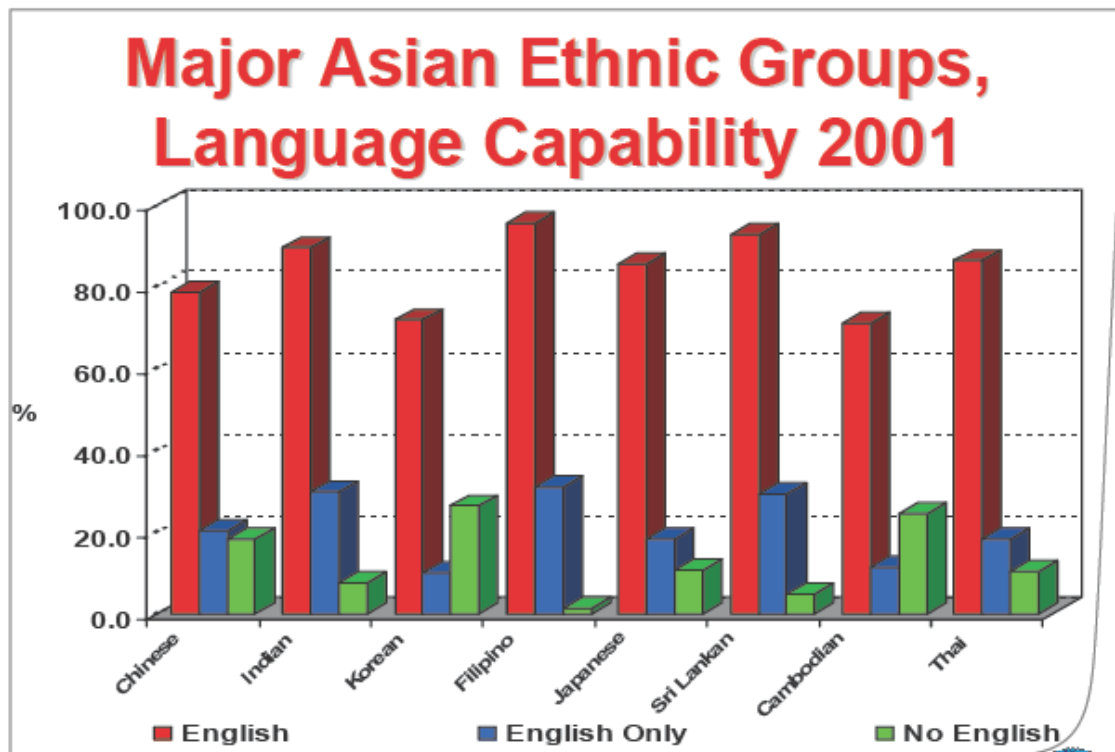


Figure 5. Language capability among Asians. Source: Ho E. (2005) "Asian peoples in Aotearoa/ New Zealand: Birthplace, ethnic self-identification, language & religion" Paper presented at the Workshop on Defining term "Asian" on 29<sup>th</sup> July.



### Review summary: Current mental health status among refugees and Asian migrants

- Community consultations and existing documents (prepared by community groups [e.g. The Asian Network Incorporated], Mental Health Commission [e.g. the literature review by Ho and associates 2002] and Ministry of Health (e.g. the *Asian Health Chartbook*, 2006]) show that there is a need for both social and mental health services to be more responsive and sensitive to the needs of different ethnic groups.
- The lack of information (e.g. the extent, context, who has most difficulty) about mental health epidemiology and service accessibility is a significant gap across all ethnic sector groups. It is also noted that presently, administrative data tend not to record ethnicity information.
- There are only a few studies about mental health status or needs of Asian people and refugees in New Zealand; most of the existing work has major limitations of either small sample size or relying on convenience sampling methods.
- Mental health issues affect long term and New Zealand born generations as well as new migrants and refugees, particularly those associated with discrimination, identity and adjustment issues.

- While there is a range of ethnic diversity, qualitatively there is a degree of similarity of experiences across ethnic sector groups.

## ***2.5 What are the benefits of addressing the mental health needs of migrants and refugees now?***

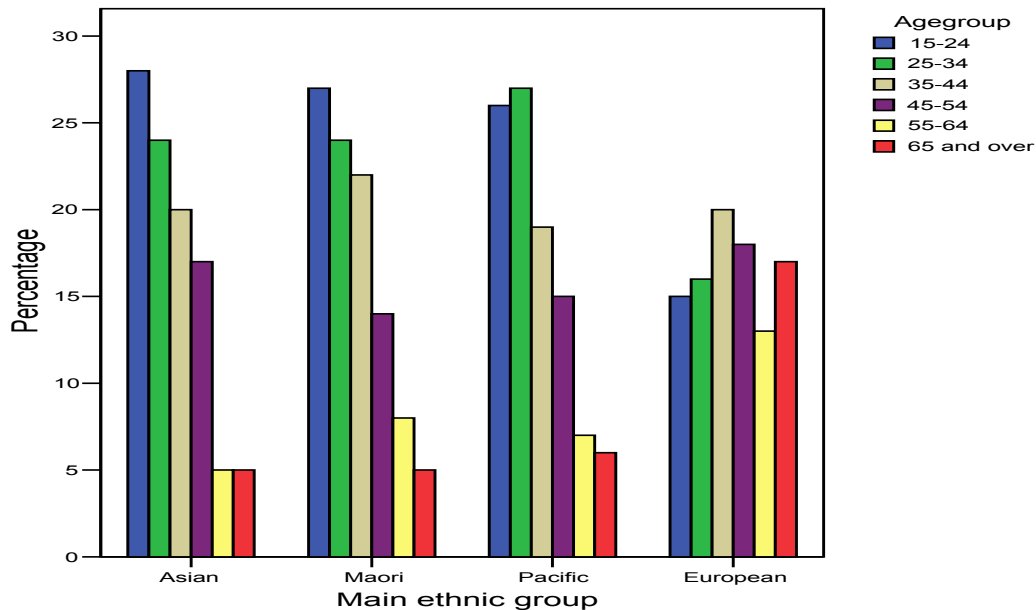
There are assumptions that migrant communities on the whole are doing well, but the present report presents a different view. It is felt that migrants and refugees are quiet about their problems because of fear of discrimination, or lack of knowledge in terms of where they can seek help (de Jong, 2001). With regard to the refugee communities, “Although they are not inherently less healthy, refugees and their families coming to New Zealand face a range of physical, mental and social health problems where public health interventions can be beneficial, including: 1) Communicable diseases, such as tuberculosis, schistosomiasis, HIV/AIDS, viral hepatitis, 2) Mental health, including post-traumatic stress disorders and adjustment difficulties ...” (Ministry of Health, fact sheet<sup>7</sup>). There are three main reasons why it is important for the Canterbury DHB to act proactively to foster the mental health status of New Zealand migrants and refugees.

Firstly, in 2006, 27% of the Asian population was in the 15-24 years age group, compared with 14% of the total New Zealand population (see Figure 6, Statistics New Zealand, 2006). This is especially relevant given that serious mental illness tends to occur in early adulthood, between 20 and 30 years of age. In 2001, half of the Cambodians were under 24 years of age; of the Vietnamese groups, the proportion of young people aged under 24 years was 48% compared with 36% in the total population. The young age profile of the migrant and refugee communities will reach the “at risk” age over the next few years.

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<sup>7</sup> Ministry of Health: Refugees and Asylum Seeker Health. Retrieved June 16, 2008 from <http://www.immigration.govt.nz/NR/rdonlyres/4ED5FBBF-DCEE-40CC-B4D4-C15E437C2CED/0/MinistryofHealthRefugeeServicesOutline.pdf>

Figure 6. Four population groups and age distribution (Statistics New Zealand, 2001).



Secondly, within the Asian communities, mental health problems are identified as the “number one” health issue concerning the Asian communities in New Zealand (Asian Public Health Project Team [APHPT], 2003). A recent study on young Asians found that more Chinese students reported significant depressive symptoms when compared with New Zealand European students. 5.5% of male Chinese students and 14% of females reported having carried out a suicide attempt in the past year (Rasanathan, Ameratunga, Chen et al., 2006). Using the method of community consultation meetings and accessing key informants, other relevant health issues were identified (APHPT, 2003, pp. 63-66). They are the issues of difficulties in accessing the health system, diet and lifestyles, heart disease, diabetes and stroke, sexual and reproductive health, respiratory disease/allergies/asthma, infectious disease, excessive use of alcohol, gambling, smoking, dental services, safe environments/allergies, food safety, gastric problems, arthritis and other health issues like domestic violence and use of illicit drugs. Noticeably some of these health problems (e.g. excessive consumption of alcohol, use of illicit drugs, gambling, are closely linked to mental distress) (Tse & Liew, 2004).

For further details on Asians’ health status, see the following three recent reports:

- *Asian Health in Aotearoa: an Analysis of the 2002–2003 New Zealand Health Survey* (The Asian Network Inc.);
- *A Health Profile of Young Asian New Zealanders who attend Secondary School: Findings from Youth2000* (The Youth2000 project at the University of Auckland);

- *Asian Health Chart Book 2006* (Ministry of Health, 2006)

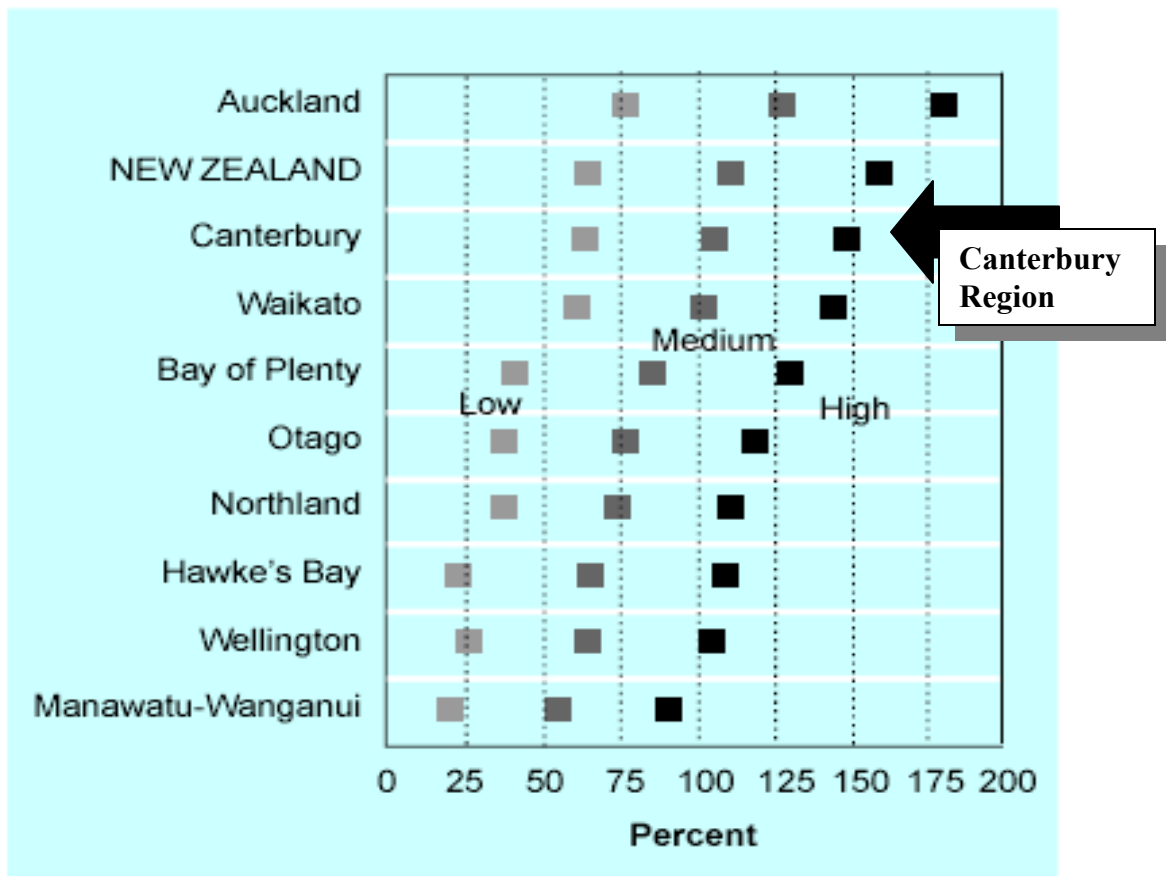
Rasanathan, Ameratunga, & Tse (2006) provided a useful summary and commentaries on the topic of Asian health in the New Zealand context.

Thirdly, it is about population growth and projection.

- It is worth noting that New Zealand is now more ethnically diverse than 10 years ago and this is projected to continue well into the 21<sup>st</sup> century.
- The ethnic sector is projected to grow in size over the next twenty years to 18% of the population by 2021.
- Most of the recent growth has been from non-English speaking regions, particularly Asia.
- In addition to migrants and refugees, other vulnerable ethnic sector groups are ethnic youth, women and older people, including NZ born generations.

One has to ask: “What will be the cost of not acting now?”

Figure 7. Projection of Asian population growth.



## **2.6 Recommendation: Where to start?**

This chapter highlights an urgent need to collect credible information (e.g. ethnicity data, health needs) on which to plan and provide adequate and culturally responsive mental health services within the Canterbury District Health Board catchment area.

The ethnic minority sector (including migrants and refugees) in New Zealand is a very heterogeneous group culturally and linguistically. It is not meaningful and perhaps counterproductive to combine the information of the diverse ethnic groups and draw conclusions about rates of disorders, level of severity, type of services required and associated risk and protective factors. There have been different viewpoints on which ethnic population sub-group's mental health needs should be addressed first. The main considerations are:

- Population size (e.g. Chinese, Middle-Eastern people or Koreans)
- Rate of growth (e.g. overseas born Japanese)
- Specific mental health problems related to significant migration/refugee backgrounds<sup>8</sup> (e.g. business/ skilled category immigration vs. refugee background)
- Apparent high risk groups (e.g. international Asian students, older people, women, members from smaller communities)
- Years of residency in New Zealand (e.g. recent migrants in their first five years of residency in New Zealand)
- English language proficiency

Lastly, funders and planners should not feel they have to reinvent the wheel to develop culturally responsive migrant and refugee mental health services. There is a great deal of knowledge and experience that we can access from DHBs, and from overseas migrant and refugee studies. Furthermore, let us not underestimate what can be learnt from the Maori and Pacific Island people's experiences in New Zealand.

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<sup>8</sup> It is often suggested that the business/skilled category migrants and migrants with a refugee status might experience different mental problems for example (generally speaking), anxiety, depression for the migrants; post-traumatic stress disorders, substance abuse for refugees.

### **3. Discussion with key informants**

#### **3.1 Background**

The following people were interviewed between the 5<sup>th</sup> and 6<sup>th</sup> May, 2008:

**Dr Lynne Briggs**

Clinical Leader, Refugee Mental Health Service  
Senior Lecturer, University of Otago

**Associate Professor Phil Brinded**

Chief of Psychiatry and Director of Area Mental Health  
Specialist Mental Health Service

**Mr Doug Wells**

Service Manager, Specialist Mental Health Services

**Dr Steve Duffy**

Clinical Director, Adult Community Services

**Mr Vince Barry**

General Manager, Specialist Mental Health Services

**Ms Rose Henderson**

Allied Health Professional Leader and Project Manager

**Mr Vinod Kozhissery**

Integrated Care Co-ordinator, Specialist Mental Health Services

**Mr Stu Bigwood**

Director of Nursing, Specialist Mental Health Service

**Ms Gail Moore**

Senior Social Worker, Christchurch Resettlement Services

On average, each interview spanned over an hour except one interview which lasted for one and half hour. All interviews were conducted individually in the key informant's office except one small group discussion which took place in a café. The guideline for the semi-structured interview covered four main areas:

1. The utilisation of mental health services (in your particular area) by Asian people and individuals with refugee background  
(Prompts: Any particular trends, common profile of consumers, changes over time, say the last five and seven years)
2. What seems to help or hinder individuals in accessing mental healthcare services in the Canterbury area?  
(Prompts: Environmental [e.g. transport difficulty, prevailing cultural values], organisational [e.g. staff attitude and skills] and individual factors [e.g. language skills, knowledge of services available])

3. What are the specific initiatives, programmes to enhance migrant and refugee mental health in the region? Please elaborate.  
(Prompts: Range from clinical, crisis interventions to community based mental health promotion initiatives)
4. What are your visions for migrant and refugee mental health services in the CDHB? What would be your recommendations for things that have to be in place?  
(Prompts: Anything urgent, as a matter of priority)

### **3.2 Main themes of findings**

This section summarises the findings under four headings:

- Migrants and refugees using mental health services in the CDHB catchment area
- Barriers and facilitators in accessing mental health services
- Specific mental health programmes targetting migrant and refugee communities
- Visions and goals for the next three to five years
- Recommendations for future development

#### **Migrants and refugees using mental health services in the CDHB catchment area**

- Underutilisation of mental health services. One of the interviewees' common responses suggested that members of ethnic visible minority groups were under-represented in the local mental health services. One interviewee commented: *"Virtually no Asian clients using mental health services"*.
- Migrant issues. The following summarises the key challenges faced by members of migrant communities:
  - Accessing information and health education material
  - Migrants have different ways of approaching their health problems, different interpretation of what constitutes health and treatments
  - Difficult to enter and navigate through the mental health system
  - Most of the information is in English which may not be easily accessed by migrants with English as additional language
  - Families find it hard to liaise with healthcare professionals
  - Older people- isolated, language barriers and transport problems
  - Lose of status when migrating to another country
- Refugees issues. The following summarises the key challenges faced by members of refugees communities:
  - Complex needs, not easily met by one single service

- Identity problems for young people (for example 12-20 years old) with refugee background, when they had spent so much time in the refugee camp, confused about which cultural identity they would adopt/relate to
- Forced migration
- Trauma of resettling; one key informant said “they were confronted by the reality of living in New Zealand”
- Social isolation
- Away from family
- Not speaking the language
- Lack of confidence
- Not having the means e.g. financial hardship

### **Barriers and facilitators in accessing mental health services**

- Barriers- environmental
  - Stigma and discrimination associated with mental illness, for example, affecting adversely the person’s eligibility for marriage. One respondent elaborated: “it (family with loved one affected by mental illness) is not a good family to get married, they have bad things happen in their family (mentioned ‘bad genes’)...”
  - Transport and geographical barrier, being away from the city centre (e.g. Refugee and Migrant Mental Health Service)
- Barriers- organisational
  - Service providers have limited understanding of the concept of mental health in migrant and refugee communities
  - Service providers have limited understanding of the whole range of mental health concerns faced by refugee and migrant communities. Interviewee added: “...the concerns range from mild form of depression/anxiety to serious, persistent mental illness, for example psychosis, schizophrenia”
  - Difficult to organise interpreters. The two reasons mentioned by interviewees were: a) some of the refugee and migrant communities are small in Christchurch (i.e. people know each other and do not trust someone of their community to act as interpreter), b) no qualified or approved person is available from certain small refugee or migrant groups.
  - Some individuals affected by mental health problems may present to mental health services with a bodily/ somatic complaint which has not been picked up by health professionals
  - Very few psychiatrists or mental health professionals who know the refugee and migrant culture; the CDHB mental health workforce does not mirror the population demographics in the region
  - Limited staff and resources within the existing refugee mental health service which makes it difficult to be embedded within the whole mental health system

- There is a lack of core-competence training among staff in relation to culture-based theories and knowledge about mental health
- Lack of resources (e.g. different language pamphlets to introduce mental health services) to support staff
- Barriers- personal/ individual
  - Sheer isolation. Interviewee explained: "...in some cases, to the extent that individuals and families have very little knowledge about the services available to provide care and support in time of need"
  - People have unpleasant experience in using mental health services in their home country prior to living in New Zealand
  - General distrust of the mental health system in New Zealand or western countries
  - Language barriers
  - Lack of information
  - Individuals worry about issues associated with confidentiality and privacy
- Strengths and resources (migrants and refugees). The present interview did not wish to dwell on only the negatives. The following strengths were highlighted by some interviewees:
  - Problem solving skills
  - Being very task focused
  - Willingness to work together
  - Peer support, looking after each other
  - Creative in finding solutions
  - Resilience among refugees and migrants as they have overcome many hurdles before moving to resettle in another country
  - Financial resources (in some cases)

### **Specific mental health programmes targeting migrant and refugee communities**

Most of the interviewees were not able to mention any specific programme targeting the refugee and migrant communities. A few informants said there were limited number of initiatives of that nature. The following highlights the major grouping of services catering for the ethnic communities in Christchurch.

- Clinical services (e.g. mainstream, Refugee and Migrant Mental Health Service) and an outreach service within the Christchurch migrant and refugee communities (e.g. Christchurch Resettlement Services, other relevant NGOs)
- Clinical services: Providing social work and clinical services, screening and making referrals for comprehensive assessment and interventions
- Community-based interventions seek to:
  - Support people to access mainstream and refugee and migrant mental health service

- Provide advocacy- work alongside members from the migrant and refugee communities
- Provide information and knowledge
- Deliver mental health promotion activities

### **Visions and goals for the next three to five years**

The “visions and goals” mentioned by interviewees grouped into: 1) concerning Canterbury DHB and 2) concerning the inter-face between DHB and relevant communities

- Canterbury District Health Board
  - Equitable services for every New Zealander within the CDHB catchment area
  - Keep pace with the changing population demographics
  - A culturally responsive mental health service
  - Better uptake of mental health services by members of the refugee and migrant communities when needs arise
  - Deal with mental health issues (e.g. demoralization, clinical depression) affecting the refugee and migrant communities at social, psychological and political level, for example, one interviewee described, “...to provide English language training, make full utilization of refugees’ and migrants’ skills and talents by recognising their qualifications or providing them with up-skilling opportunity”
  - Emphasis on the whole context of settlement, not only mental health related issues
  - Set up “Asian Health Services Canterbury”
  - Continue to make the refugee and migrant mental health services accessible and visible within the wider mental health services community (i.e. not working in a silo, not marginalised)
  - Address stigma and discrimination among staff towards visible ethnic minority individuals
  - Multi-disciplinary treatment approach to foster improved health in the refugee and migrant communities
  - Work with families and significant others
  
- Migrant and refugee communities
  - Strengthen inter-agency collaboration
  - Be proactive in fostering stronger links between primary health organisations and specialist mental health services within the CDHB
  - Strengthen the referral process, an interviewee pointed out, “it is about relationships and people *not paper*” (italic denotes the respondent’s emphasis).
  - Partner with the ethnic communities in Christchurch. An interviewee put it succinctly, “Raise new knowledge leaders in Christchurch who can champion the development of culturally responsive mental health services...”

- Address stigma and discrimination associated with mental illness within the migrant and refugee communities
- Users and family members voices are critical

### **Recommendations for future development**

The following recommendations were mentioned by the interviewees. One interviewee in particular commented that the Funding and Planning Office has a pivotal role in reviewing the recommendations.

#### ***Establish baseline: identify where and what the needs are***

- Evidence: Collect better ethnic mental health data such as:
  - Migrant and refugee current utilization of mental health services
  - Data collected from PHOs, community leaders, consumers and their families. An interviewee emphasised, "...different voices or opinions from different communities...but 'what are the relevant questions?' 'where and how to ask those questions?'"
  - Community forums or advisory groups (e.g. the work by Mr Vinod Kozhissery, Integrated Care Co-ordinator)
  - Consult mental health staff- what resources, training and support needs are for staff
- Analyse existing data within the CDHB mental health services, for example, the acute in-patient beds information: ethnic distribution, years of residency in the country, having mental health problems before or prior to arriving at New Zealand, trends over the last 10 years, clinical presentations and subsequent care and support, outcomes

#### ***Build links with DHBs, PHOs and community agencies***

- Share resources and experiences with the 21 DHBs
- Strengthen the links between PHOs and the CDHB mental health services, for example,
  - Through the "Accessing Canterbury" forum to identify mental health needs in refugee and migrant communities
  - Provision of ongoing care and support for refugee and migrant clients by PHOs, yet they can re-assess tertiary mental healthcare if needs arise
- Build stronger partnership with University Student Health Centre, and Christchurch Resettlement Services
- Increase level of financial support for relevant services or specific programmes

#### ***Strengthen the ties with local communities***

- Identify community leaders- "Who are the leaders?" and "Who are prepared to take up the challenges?"
- More coordination among services e.g. working party to look at services for older people in Christchurch

- Community development. An interviewee elaborated, “make use of local knowledge, target vulnerable groups, for example, older people- who are isolated, build strong links with existing community groups...”
- Continue the effort to bring health messages and healthcare services to the “difficult to reach” groups; the strategies include: providing transport support, reaching out through peer support and word of mouth, recruiting bilingual workers, taking referrals from GPs, using a positive approach to encourage participation (e.g. running generic parenting course instead of programme carrying negative labels like “family violence”, “gambling” or “depression”)

### ***Grow workforce cultural competence- training, recruitment and retention***

- Mobilise existing practitioners who are familiar with migrant and refugee backgrounds within the CDHB to address the needs of refugee and migrant communities
- Recruit and retain, train, develop existing staff with migrant background
- Increase number of bilingual workers
- Do not only have approved interpreter services, but also someone who can provide cultural inputs to mental health teams
- In-service training (e.g. raising awareness of issues concerning refugee and migrant communities, promoting best practice in working with individuals from culturally and linguistically diverse background)
- Provide training on cultural competence (e.g. in a form of tool kits): increase staff capability to work with culturally and linguistically diverse populations
- Support ethnic interest groups within disciplines (e.g. Chinese Social Work Interest Group)

### ***Grow research capacity***

- Explore research opportunity as part of training and completion of qualifications for post-graduate students. An interviewee suggested, “an important area for research is which model of service delivery works and does not work...”

### ***Issues that require further debate***

- Model of service delivery for refugee and migrant mental health:
  - Specialised refugee and migrant services exist *alongside* mainstream mental health services
  - Specialised refugee and migrant services *are embedded and integrated* within mainstream mental health services
  - Specialised refugee and migrant services *are contracted out to NGOs* who can provide competent services
- There are multiple sub-groups within the migrant and refugee communities. The challenges are:
  - Are there groups more at risk than others?

- What would be an appropriate way to group several communities together for cost-effective intervention, if applicable? One interviewee mentioned perhaps in some cases, “shared religious beliefs” is a meaningful grouping.

## 4. Conclusion

Apparently, mental health issues such as loneliness, depressive symptoms, stress and anxiety are the leading concerns among members of refugee and migrant communities. Mental health problems are associated with a reduced quality of life and even excess mortality, if untreated. A spiral of resettlement difficulties leading to depression leading to further adjustment problems has been identified as a consequence of both poor settlement outcomes and mood problems. More interventions are needed to reduce the burden of mental health problems from difficulties associated with post-migration adjustment (including forced migrations). This exploratory report addresses this issue in one often neglected population; those who are migrants or refugees and have arrived in Christchurch recently, or any part of New Zealand for this matter. For culturally responsive mental health services to be evidence-based and of benefit to those we care for, rigorous studies (including comprehensive needs assessment and baseline measure) need to be conducted to demonstrate effectiveness.

The present authors offer a number of observations based on the review of literature and information collected during the visit to Christchurch in early May:

1. The Christchurch mental health sector is aware that more attention is required to identify and meet the needs of migrant and refugee communities
2. There is not enough data available on the needs of refugees and migrants; more data are required (e.g. demographics, needs) if effective services are to be provided
3. It is felt that the first step is to improve the quality of ethnic data within the sector in order to identify where and what the needs are
4. Capacity building: It is paramount to identify groups or individuals locally who are prepared to champion the development of culturally responsive mental health services in the wider Christchurch area
5. Further development needs to be built on strong networks with migrant and refugee communities; consultation with them about service provision and involvement of them; giving them a voice to ensure that appropriate services are provided for them
6. It demands an inter-agency approach to deal with the wide range of issues pertaining to resettlement. Isolated programmes do not work
7. It is necessary to educate New Zealanders, including government officials and the media, about migrants and refugees and their contributions to the area, and on the (re)settlement process- a two-way process in which everyone (members of the host community and individuals from refugee and migrant backgrounds) has to play a part
8. There is a great deal of knowledge and experience that the CDHB can access from other parts of the country
9. In order to achieve improved health for the refugee and migrant communities, increased level of resource allocation (e.g. funding, staff FTEs) is required

10. The following recommendations are made for future research into migrant and refugee issues.

- Conduct research that gives migrants and refugees a voice and that is contextually grounded
- Evaluate migrant and refugee settlement programmes for success.

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