Building evidence for better practice in support of Asian mental wellbeing: An exploratory study




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Building evidence for better practice in support of Asian mental wellbeing:
An exploratory study

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Executive summary

The Asian immigrant population has grown considerably in the past decade, and there is empirical and anecdotal data which suggests that this population may be experiencing mental health difficulties in New Zealand. This has significant implications for the mental health workforce in New Zealand, one of which is how to respond in culturally appropriate ways, for example by taking into consideration cultural understandings of concepts, to the diverse Asian clientele that may access their services.

In response to this, an exploratory study was undertaken to evaluate specific recovery-relevant components of the Wellness Recovery Action Plan® (WRAP) (Copeland 1997), the training programme most widely used with Asian clients in the Waitemata District Health Board, and the Re-covery Model (RCM) (Randal, Stewart et al. 2009), and their impact on staff knowledge, skills, attitudes and behaviours about recovery. The study also identifies gaps that may exist in the training programme of Asian staff, recommends modifications for enhancing the use of the models for this cultural group, and finally produces a suggested model of delivery and toolkit that could be tested further with Asian practitioners and service users.

Eleven Asian mental health support staff participated in the study, which was comprised of two workshops, a focus group discussion, two case studies, and pre- and post-training evaluations. The two workshops consisted of a full-day programme each, and included training in the use of RCM and WRAP. The RCM and WRAP were integrated, and tested for their impact on and appropriateness for Asian mental health cultural support staff working with Asian consumers. The Recovery Knowledge Inventory (RKI) (Bedregal, O'Connell et al. 2006) was used to assess the staff's recovery knowledge and attitudes before and after the workshops.

Analysis of quantitative and qualitative data suggests a positive impact of the workshops on staff knowledge, attitudes and understanding of recovery. This data showed that participants found most aspects of the WRAP and RCM appropriate for working with Asian mental health service users, and that the training utilising both models increased their knowledge and improved attitudes and behaviours about recovery and the application of recovery principles, e.g. staff members felt more confident about their work practice and felt more hopeful in assisting their clients in their recovery. Qualitative feedback from staff indicated opportunities to modify the use of the models to improve their impact on and appropriateness for Asian mental health staff and consumers.

The significant findings of the study are:

- Asian staff are aware of their role as providers and are providing culturally appropriate care at the client's pace
- understandings of recovery are different for Asians: recovery usually means being symptom and medication-free.
- many Asians are unfamiliar with Western models of recovery and prefer Asian models that emphasise spirituality, balance, and overall health and well-being.
- Asians have a hierarchical social structure that respects authority; hence, clients often expect to be prescribed to by providers and may not actively participate in their recovery
- Asian societies are collective; hence, family is important and should be included in treatment and recovery processes
- there is intense stigma attached to mental illness; hence, mental illness is often concealed, and the notion of living normally again after having mental illness is still not accepted

- most Asians avoid risk-taking, e.g. changing to new medication, which may impact on the clinician and client relationships, and treatment and recovery plans
- overall, the staff's recovery-orientation increased after the workshop training using the WRAP and the RCM
- the WRAP and the RCM appear to be appropriate for Asians, but some aspects could be adapted to be more culturally and contextually appropriate, e.g. considering the cultural context; including culturally appropriate tools; and considering the impact of the migration experience on mental health.

Practical application of the models would depend on the recovery stages of the consumer, and would need to factor in Asian cultural concepts of recovery, for both staff and mental health consumers. Recommendations include continuing the use of the WRAP and adding the RCM to the training package; including cultural competency training for all practitioners that work with Asian clients; having family involvement in treatment processes; recognising the individual as a cultural being; building trust; dealing with practical needs; recognising the migration experience as a major source or trigger; and applying Asian models of health and cultural meanings of recovery.

A suggested model of delivery for Asian mental health and a toolkit, which take into account these recommendations, have been developed, but need to be tested further.

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Glossary of terms and abbreviations

Asians: the broad group of people in New Zealand from Afghanistan in the west, to Japan in the east, and China in the north, to Indonesia in the south.

Consumer or client: a user of mental health services. Consumer and client are used interchangeably in this report.

Clinical team: a multidisciplinary group of professionals that are involved with the client's treatment and care plan.

Immigrants: people from abroad who have settled in New Zealand, including Asians.

RCM: Re-covery Model (Randal et al., 2009).

Recovery in mental health: "is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony 1993).

RKI: Recovery Knowledge Inventory (Bedregal, O'Connell et al. 2006).

Significant other: a person considered important to the consumer, other than family.

WRAP: Wellness Recovery Action Plan® (Copeland 1995-2009©).

1 Introduction and background

1.1 Asians in New Zealand

New Zealand has been experiencing a rapid increase in its immigrant population over recent decades, with one in five New Zealanders born overseas (Merwood 2007). More recently, increasing numbers of immigrants have been entering New Zealand from non-traditional source countries[1] such as Asia and Africa. Statistics New Zealand (2006) estimates that 9.5 per cent of New Zealand's current population is Asian, and projections estimate that Asian ethnic groups will account for almost 15 per cent of the total population in New Zealand by 2021 and 16 per cent by 2026 (Statistics New Zealand 2006). Asian immigrants have become the fastest growing population in New Zealand and make up the fourth largest ethnic group in New Zealand after European, Māori and 'Other' ethnicity (Statistics New Zealand 2006). About one-fifth of all Asians in the 2006 Census were born in New Zealand. Of the Asians born overseas, the majority come from Northeast Asia, including China, Japan and Korea, followed by India and the Philippines (Ho and Bedford 2008). Approximately 66 per cent of Asians live in the Auckland region (Statistics New Zealand 2006).

Settling into a new country brings both opportunities and challenges for immigrants. Many factors are known to impact on the well-being of Asian immigrant families. There is some anecdotal and empirical evidence that suggests that the needs of these families are poorly understood, and that many are not receiving the necessary levels of support, especially for work-related issues (e.g., Ho, Bedford et al. 1999; Trlin, Henderson et al. 2004; Dixon, Tse et al. 2009; Spoonley and Meares 2009). Consequently, many Asian immigrant families are experiencing a number of settlement difficulties, and are exposed to risk factors associated with migration, which may be impacting on their general well-being. There is increasing evidence that migration issues may be important for the mental and physical well-being of Asian immigrants, such as those relating to employment and level of income (Tse and Hoque 2006; Dixon, Tse et al. 2009; Sobrun-Maharaj, Rossen et al. 2010).

1.2 Mental health recovery in New Zealand

Mental health recovery is described as "the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination" (Andresen, Caputi et al. 2006). Anthony (1993) sees this as recovery from the psychological trauma of the illness, where a cure, or the absence of symptoms, is not as important as the recovery experience. He defines recovery as a continuous, totally personal, individual effort that leads to growth and discovery, in which attitudes, values, goals and roles may be changed. Furthermore, Allot, Loganathan, and Fulford (2002) suggest that recovery does not equal the absence of medication and being restored to pre-illness condition. Rather, recovery is about developing coping mechanisms, building on one's personal strengths, accentuating self-esteem, discerning identity, and finding a meaningful role in society.

Asian understandings of recovery in mental health may be different from Western understandings. This could have important consequences for mental health service provision. The

[1] Traditional source countries for immigrants have been the United Kingdom, North America, Europe and Australia, and more recently, the micro-states of the South Pacific (see e.g. APMRN and Bedford, 2003).

increasing number of Asians in the country, coupled with the settlement difficulties and consequences they experience, has significant implications for the mental health workforce in New Zealand. One of these is how to respond in culturally appropriate ways to the diverse Asian clientele that may access services.

There is some information available on the mental health recovery process for the general population (Anthony 1993). However, there is very little Asian-specific data available. The few Asian service models that have recently been developed have not been systematically evaluated and their efficacy tested. There is also limited research to support which actual staff behaviours or attitudes have a measureable impact on recovery outcomes for Asian clients (Fortier and Bishop 2003). Research data (Tarrier and Barrowclough 2003) suggest that interpersonal interactions and therapeutic relationships between consumers and mental health professionals could significantly affect the consumer's recovery. However, there is no information on the extent to which the application and practice of recovery-oriented principles by mental health professionals could be influenced by their cultural beliefs, values and attitudes about recovery.

In order to provide culturally appropriate mental health services to Asian clients, data on Asian service models and the role of culture on staff behaviours, attitudes and subsequent client outcomes is needed. To support translation of such knowledge into practice, appropriate tools and models that take into consideration these factors also need to be developed for use with this community.

1.3 Aims and objectives

In order to attempt to fill these gaps, this exploratory study was commissioned by Te Pou, the National Centre of Mental Health Research, Information and Workforce Development. The study evaluates specific recovery-relevant components of two mental health recovery models. These are: the Wellness Recovery Action Plan® (WRAP) (Copeland 1995-2009©), the mental health recovery training programme most widely used with Asian clients in the Waitemata District Health Board; and the Re-covery Model (RCM) (Randal, Stewart et al. 2009), which is a mental health recovery pathway.

The specific objectives of the study are:

- to assess Waitemata District Health Board Asian Health Support Service staff's knowledge, skills, attitudes and behaviours that support or impede implementation of recovery principles
- to examine how Asian staff's cultural beliefs and practice influence implementation of recovery principles with Asian clients
- to test the appropriateness and impact of WRAP and RCM[2] on the Asian Health Support Service team's knowledge, attitudes and behaviours about recovery and their ability to improve recovery outcomes for Asian clients.
- to adapt the training packages for use by Asian mental health staff in order to enhance their work with Asian clientele.

This evaluation will provide mental health service providers with information on the knowledge, skills, attitudes and behaviours, and cultural beliefs and practices that influence implementation of recovery principles, and a model of delivery that can be used when working with Asian clients.

[2] The WRAP and the RCM are described in detail with reference to other research that has utilised the models, in Chapter 3, Methodology and Methods, p. 37.

A training package, including a toolkit, has also been developed, which could be tested further with Asian practitioners for use with Asian clients.

2 Literature review

There is extensive literature on mental health recovery. For the purposes of this study, we examine four bodies of literature that pertain to mental health and recovery (as understood in Western societies): Asian concepts of mental health and recovery; the impact of migration on mental health; service provision and the role of mental health providers for Asian mental health consumers in Western host countries.

2.1 Western concepts of recovery in mental health

There has been a paradigm shift over the decades, whereby traditional treatment modalities in mental health have advanced from a traditional illness or stabilization model, to community or rehabilitation models, and in the present day, to a focus on recovery incorporating consumers' perspectives (Piat, Sabetti et al. 2009). The current meanings of recovery (in mental health or substance abuse) are no longer limited to medical (symptoms management) or rehabilitation (restoring functional ability) ones. Often, current definitions of recovery include psychological recovery processes, for example, hopefulness, personal growth, and a meaningful life (Crowe , Deane et al. 2006). This understanding of recovery is what Andresen, Oades, and Caputi (2003) define as psychological recovery.

The recurrent themes emerging from the discussions of authors on recovery (e.g. Andresen et al., (e.g., Anderson et al., 2006) are: awareness of the illness and recognition of the opportunity for change; managing the illness and developing recovery skills; self-empowerment and interconnectedness with others to provide support and self-help, and to live a full and meaningful life.

The importance of recovery goals, as opposed to treatment goals, has also been emphasised. Treatment goals, such as avoiding risks of relapses and hospitalisation, are often set by the clinical team. Recovery goals, on the other hand, are about the consumer's dreams and aspirations. They are "idiosyncratic", strengths-based, and oriented towards developing a positive identity and valued social roles (Slade 2009). Consumers emphasise the importance of recovery goals, and assert that it is crucial to develop a personhood that is separate to the illness (for example, see Deegan 1997). Mead and Copeland (2000) have identified hope, personal responsibility, self-advocacy, wellness, education, and peer support as key elements in one's recovery. Other aspects important to one's recovery journey highlighted by consumers are acceptance (Spaniol 1997), empowerment (Ahern and Fisher 2001), self-determination (Frese and Davis 1997), symptom control (Deegan 2003), a supportive clinical team and relationship (McGrath and Jarrett 2004), the pursuit of happiness and peace (Schiff 2004), and healing (Walsh 1996).

Over and above this, social support and inclusion has been recognised as an important factor in recovery. Slade (2009) states that: "…improving social inclusion is central, because hope without opportunity dies" . This is of particular significance to immigrant mental health consumers settling into a new country.

2.2 Asian concepts of mental health and recovery

Most Asian cultures across greater Asia, from Afghanistan in the west to Japan in the east, view physical and mental health and illness holistically, as an equilibrium model. Explanatory models may include mystical, personal, or naturalistic causes (McBride 1996). The basic logic of health

and illness consists of prevention (avoiding inappropriate behaviour that leads to imbalance) and curing (restoring balance). It is a system oriented to moderation.

Rather than talking about mental illness, such as depression, Asians often talk about balance and harmony in health, e.g. yin, yang and qi in China, yoga in India, timbang in the Philippines, and kwan in Thailand (Burnard, Naiyapatana et al. 2006). If balance is maintained, then a disease-free state of mind and body can also be maintained. Hence, Asians integrate the entire body, mind, and relations with family and society in the treatment of mental health disorders (Tarnovetskaia and Cook 2008). This treatment relates to maintaining a balance of the forces in the mind and body. Studies have shown that having the capacity to practice one's faith can be a measure of wellness (Valencia-Go, 1989 as cited in McBride 1996). Using prayer and spiritual counselling can be a part of a treatment plan, with assistance from a traditional healer or a clergy. Some elders and their families consider physical or emotional pain as a challenge to one's spirituality (McBride 1996).

Parallel to this holistic belief system is the understanding of modern medicine, with its own basic logic and principles that treat certain types of diseases. These two systems co-exist, and Asians often use a dual system of health care (McBride 1996).

Most Asian cultures appear to view mental illness negatively. In India, for example, mental health is bound by traditional religious and cultural beliefs, and mental illness is viewed as a stigma for the family involved. Similarly, the Chinese and Japanese tend to look down upon the mentally ill. Mental illness is also regarded as a shameful thing in the Vietnamese culture. Because of this shame, mental illness is often feared or denied, and those who are ill are hidden away by their families, until the family can no longer care for them. In Vietnam, for example, the mentally ill may be taken to hospitals and abandoned (McBride 1996).

Hence, many Asian (and other non-Western) cultures do not appear to recognise the concepts of depression, schizophrenia, and other major mental disorders (see Lehti, Hammarström et al. 2009's study). O'Hare (2004) says that depression is an obviously uncommon illness in China. Chinese and other non-Western patients do not report the same symptoms of depressed mood, feelings of worthlessness and guilt, and general lethargy that Westerners do. Researchers theorise that this is because Chinese, like other Asians, are less likely to make a distinction between mind and body, and attach a greater stigma to mental illness (O'Hare, 2004). However, Norman (2004) states that depression has been observed in most countries of the world, and although the word depression might not exist, it should not be assumed that the disorder does not exist. Hence, variable language and culture-specific symptomatology must be examined to obtain an accurate diagnosis of depression, which would lead to appropriate and needed intervention. Psycho-education for the consumer and family is also important, so that they can participate in treatment decisions.

Instead, researchers (Lippson, Dibble, & Minarik, 1996) suggest that Asians who are less Westernised more commonly show signs of culture-bound syndromes. This may be because older Chinese immigrants, for example, who believe in Chinese alternative medicine, and younger Chinese immigrants combine both Chinese medicine and Western medicine together (Lippson et al., 1996). In Southeast and East Asian countries, culture-bound syndromes are found that have characteristics of schizophrenia, which include *amok*, which is marked by a sudden rampage, usually including homicide and suicide, ending with exhaustion and amnesia, and *latah*, which is marked by an automatic obedience reaction with echopraxia and echolalia (Kaplan, Sadock, & Grebb, 1994).

The Mental Health Foundation in the United Kingdom reports that, in general, Asian people may be one-and-a-half times more likely to have a diagnosis of schizophrenia, compared with other ethnic groups, although this may vary across age groups. However, the evidence is inconsistent, and most studies have found that there is very little difference in the rates for schizophrenia. Asian people are also reported to have better rates of recovery from schizophrenia, which may be linked to the level of family support.

Research has suggested that Western approaches to mental health treatment are often found to be unsuitable and culturally inappropriate to the needs of Asian communities who tend to view the individual in a holistic way, as a physical, emotional, mental and spiritual being (Mental Health Foundation United Kingdom 2010).

2.2.1 Cultural patterns of illness

In the mental health context, somatisation is the term used when a client manifests mental health symptoms as physical symptoms. Tseng, Asai, Liu, Wibulswasdi, Suryani, Wen, Brennan, and Heiby (1990) report that many Asians tend to somatise and will avoid referrals to mental health clinics. This may be partly due to, or exacerbated by, the stigmatisation of mental illness in most Asian cultures. Studies show that the symptoms Asians present may not always link directly to mental health, but may instead be linked to other issues, such as migration issues, language barriers, etc. (Masuda, Lin et al. 1980; Cheung and Lau 1982). In such cases, practical help is asked for more than psychological help.

Culture-bond syndromes have also been associated with Asian cultures, including syndromes such as neurasthenia (nervous break-down). It has been documented that clinicians may prefer to diagnosis many Asian clients as having neurasthenia, rather than schizophrenia, to minimise the stigma attached to mental illness (Kleinman 1982; Lin 1989; Lin and Cheung 1999).

Somatisation and cultural-bound syndromes are important cultural factors shaping symptom manifestation and constellation. Lin and Cheung (1999) state that it is important for the clinician to be aware that the overall well-being of the consumer is important, hence clinicians should not focus predominantly on the psychological side of the consumer's suffering. It is also important for clinicians to be able to formulate a compatible approach, which the consumer is comfortable with. The cultural competency of the clinician will enable this.

2.2.2 Importance of family

In most Asian cultures, as collective societies, family is traditionally seen as of primary importance, and plays a significant role in all aspects of life. This is seen especially in terms of providing support and guidance through traditional values, such as filial piety, saving face, and maintaining harmonious relationships with others (Kuo and Kavanagh 1994; Chan, Levy et al. 2002). This is a recurring theme in studies of all Asian groups. Several studies have been undertaken with Chinese families, which underline this theme. For example, Hsiao, Klimidis, Minas, and Tan's (2006) qualitative study of Chinese families, which investigated the cultural attribution of mental health suffering in Chinese societies through interviews with both consumers and their caregivers, revealed that the family is an important source of social support to individuals in Chinese societies. To understand the Chinese lived experience, as with all other Asian groups, it is important to examine them not only at an individual level, but at a family level as well (Lin, Tseng et al. 1995). These authors have attempted to understand mental health and

mental illness from the perspective of the patients and their family caregivers. They underline the importance of appreciating patients' and their families' cultural values, and understanding how these values shape their reaction to mental illness and help-seeking behaviour, if health-care providers wish to provide culturally sensitive care.

However, families can also sometimes have adverse effects on family members. Although the family is an important source of social support, it can also be a burden and source of unhappiness (Chan, Levy et al. 2002). Lin et al. (1995) analysed more than 20 studies relating to the cultural aspect of mental health in the Chinese population, and found that the family has diphasic effects – providing a source of support and, at the same time, creating stress. Hsiao et al.'s (2006) study confirmed that family members could be a source of stress for consumers. These characteristics also apply to most other Asian groups. Such families may need particular help to deal with their family dynamics.

Asians, being collectivists, talk about family as social units. This includes the community as well, as it also contributes to one's mental well-being, and indeed "social integration buffers stressors and contributes to more positive mental health status" (Mirowsky and Ross as cited in Tarnovetskaia and Cook 2008). Family and community support are crucial for people undergoing great changes in their lives, such as immigrants. Social support is positively associated with psychological well-being (Tofi, Flett et al. 1996). Social supports are intended to prevent or reduce stressors, by changing the situation and managing the symptoms of stress (Pearlin and Aneshensel 1989). Inadequate social support for immigrants has been found to have an adverse effect on psychological well-being (Tofi, Flett et al. 1996). Lack of social support, due to separation from own culture as a side-effect of immigration, has been associated with high rates of depression among the Aboriginal people of Canada (Kirmayer, Brass et al. 2000). Such effects are still seen in studies of Asian immigrants in New Zealand (e.g., Ward 2006; Dixon, Tse et al. 2009). Involvement of the family and community in the client's mental health promotion may be a preventative intervention to some mental health problems. The prevention and treatment of mental health problems, as well as health promotion, must then include not just the consumer, but the family and community in order to be successful (Tarnovetskaia & Cook as cited in Kirmayer, Simpson et al. 2003).

Furthermore, strong gender and family roles are respected amongst Asians and adherence to these roles is considered to be central to well-being. For example, Chinese place great emphasis on interpersonal dynamics in the family and, by treating a Chinese consumer without the whole family, treatment may not be so successful (Hsiao, Klimidis et al. 2006). Similarly, for Indians, the support of family and community for a consumer is imperative, to the extent that it is sometimes not just encouraged, but is often a prerequisite of seeking help for a psychiatric illness (Stanhope 2002).

To a large extent, the Western client-centred mental health system neglects the fact that a person is always a member of a social group. Family involvement might be seen as intrusive (Falloon 1985). Concerns with confidentiality have also limited family input (Lin and Cheung 1999). This individualistic emphasis is still strong today. Where treatment of Asians is concerned, the system needs to be more flexible and consider the well-being of the individual as part of the family unit, as well as the family.

2.2.3 Help-seeking behaviours amongst Asian people

Because collectivists consider the family as the basic unit of society, when a family member is ill, it is automatically assumed that the other family members will take responsibility for the ill person. Help-seeking becomes a joint venture, rather than an isolated decision by the consumer. The ability to have social support and connections is crucial to recovery. These support systems could also act as a preventative foundation. However, lack of access and unwillingness to seek help could also hinder the effects of social support.

Studies show that many Asians do not seek help for their mental health problems, as they feel that their problems are insufficient to warrant seeking formal help, which they perceive as reserved only for seriously unwell people (see Chiu's 2004 study with Chinese women). This becomes a limitation, in terms of the resources the consumer and family can access, leading to self-reliance (Chiu 2004). Furthermore, as stated above, stigma and shame is attached to seeking help from outsiders for personal problems. These limitations can sometimes impede the consumer and the family's willingness to seek professional psychiatric help, or even to admit that a problem may be present that requires formal support.

2.2.4 Alternative treatments

Many Asians are known to seek alternative forms of treatment for mental health issues, as this is often considered more culturally appropriate and helpful. This is evident in Yeung and Kam's (2005) study on Chinese Americans, which found that seeking psychiatric help was least frequent amongst this group (3.5 per cent). Instead, help was sought more from alternative sources, such as lay help (62 per cent), alternative treatment from others (55 per cent), spiritual treatment (14 per cent), and alternative self-treatment (10.5 per cent). O'Mahony and Donnelly (2007) found that in the South Asian culture, many turn to spiritual forms of treatment, as they believe that some mental health issues are caused by *najar* (or *majar*), which is like an evil eye. The family might turn to rituals to remove the najar from the person. Consumers and their families might perform "something like that before they would even turn to the system or mental health services" (O'Mahony and Donnelly 2007).

These Asian views have implications for mental health, including how it is perceived, health beliefs, help-seeking behaviours, stigma against people with mental illness, who holds control, and who influences changes, amongst other things.

2.2.5 Attitudes towards medication in recovery

Western and Asian attitudes toward medication in recovery may differ to some extent. Swedish consumers were found to favour taking medication, as they could function normally again, despite the side-effects. Complying with medication was understood as a vital part of recovery in this sample (Svedberg, Backenroth-Ohsako et al. 2003). The authors described medication as a safety net and protection for consumers, preventing them from relapses and being re-admitted to hospital. Conversely, more than half the sample in an Australian study (Tooth, Kalyanasundaram et al. 2003) on individuals with schizophrenia considered side-effects of medication as a big hindrance to one's recovery. On the other hand, all Chinese consumers in a study of long-term individuals with schizophrenia in a rehabilitation facility based in Hong Kong (Ng, Pearson et al. 2008) acknowledged that taking medication is important, but most of them would not consider taking it themselves. Some consumers were of the view that being off medication means recovery.

An explanation offered for why some Asians prefer alternative forms of treatment to Western medication is that, for both genetic and environmental reasons, Asians who are treated with psychotropic medications may differ from Caucasians in their dosage requirements and side-effect profiles (Lin, Cheung et al. 1997). While this needs to be further tested and evaluated, these findings could imply that current treatment methods may not be as suitable for Asians as clinicians believe.

Piat, Sabetti, and Bloon's study (2009) brings three new insights from their research that could inform the development of appropriate mental health services for Asian consumers: (1) the consumer's and provider's values or levels of confidence in medication should be explored, (2) consumers need to be educated to look beyond medication and take control of their lives, and (3) medication needs to be explained well through good communication, which also depends on a strong therapeutic relationship between the consumers and provider.

Recovery is not just about medication. As Lunt (2002) states, "the biochemical solution does not bring with it a dream, a goal, a journey, a direction, an inspiration, a faith, or a hope. These are what are sought in recovery" . Consumers, practitioners, and mental health providers need to be made aware that medication is only one of the many components for reducing psychiatric symptoms (Mead and Copeland 2000). Although complying with treatment is important to one's recovery, the traditional biomedical model, where adherence to medication is prescribed, could undermine consumer choice, empowerment and determination (Mead and Copeland 2000; Deegan and Drake 2006). Non-adherence may not always reflect psychosis or a lack of insight on the part of the consumer (Roe and Swarbrick 2007). It could instead be a personal choice in alternative treatment methods, where meaning and purpose is found.

2.2.6 Asian mental health in New Zealand

There appears to be a pervading view in New Zealand that Asian immigrants are healthy. However, some seminal work published in New Zealand by the Mental Health Commission (Ho, Au et al. 2002) and the Ministry of Health (Ministry of Health 2003; Ministry of Health 2006) shows results that may not align with this view, or with previous research suggesting a relatively healthy Asian community in New Zealand.

The literature review of mental health issues for Asians in New Zealand by Ho et al. (2002) identified two themes that have dominated recent mental health-related research on Asians in New Zealand. The first theme focuses on the adaptation experiences, mental health status, and factors that contribute to, or hinder, Asian immigrants' successful adaptation and mental health. The second theme concerns the utilisation of mental health services by Asians, particularly the barriers to the access of these services. The recommendations the review makes for promoting mental health in Asian communities include: (1) increasing public support for cultural diversity, (2) providing extensive information before and after migration, (3) improving access to English language education, and (4) encouraging and supporting the development of community support programmes. Recommendations are also made for improving cultural responsiveness in mental health services by: (1) promoting the development of educational materials and professional interpreter services, and (2) increasing service providers' awareness of Asian cultural issues. Further research for high-risk groups (i.e., women, students, refugees and older people) is also recommended (Ho, Au et al. 2002). These themes and recommendations suggest that Asian immigrants may be experiencing issues such as lack of cultural support; lack of settlement information; limited access to English language education, and lack of cultural responsiveness in mental health services.

The *Asian Public Health Project Report* (Ministry of Health 2003) reported research on recent Chinese immigrants to New Zealand in the late 1990s, which may not align with previous research that suggested a relatively healthy Asian community in New Zealand. Although Asian immigrants' levels of mental health problems were reported to be similar to the levels of the population as a whole, Asians experienced mental health problems due to factors such as rejection by locals and having low English proficiency (Abbott, Wong et al. 1999). This is supported by findings of a study in Auckland by Wang (2000), which identified that crisis, safety, cultural shock, being scared about being unaccepted by their peers, loss of personal and cultural identity are some of the key issues Chinese adolescent immigrants are challenged with. These factors can contribute to poor mental health status.

Findings in the *Asian Health Chart Book* (Ministry of Health 2006) also show comparatively good levels of mental health for Asians. For example, the vitality scores in the SF-36 scale (a measure of psychological distress[3] tapping positive mental well-being) were higher among all the Asian ethnic groups than the total population, and the mental health and social functioning mean scale scores were similar to the total population for all Asian ethnic groups[4]. Chinese and Other Asian males had age-standardised suicide mortality rates of approximately half that of the total New Zealand population. Despite this, the Ministry of Health (2006) identified culturally appropriate mental health services as a concern for recent migrants.

Although this report suggests that the mental health status of some Asians has improved over recent years, the concerns of the Ministry of Health and other recent research (Trlin, Henderson et al. 2004; Tse and Hoque 2006; Dixon, Tse et al. 2009; Spoonley and Meares 2009; Sobrun-Maharaj, Rossen et al. 2010), as well as anecdotal data suggest that this may not be the case. Such data suggests that some Asians, immigrants in particular, may be experiencing higher levels of mental illness than is reported, and that the migration experience may contribute to this to varying degrees, as shown in the earlier research quoted above.

2.3 The migration experience

While the migration experience is a positive one for many Asian immigrants, it is generally agreed that immigration to Western countries results in dramatic changes in language, social system, education system, lifestyle and work (e.g., Hsiao, Klimidis et al. 2006). Such changes may result in a difficult and stressful time for many immigrants (Berry 2001; Harker 2001; Sonderegger and Barrett 2004; Sonderegger, Barrett et al. 2004; Ward, Masgoret et al. 2004; Ward 2006). Because of the many settlement issues immigrants experience, such as unemployment and social non-acceptance, many immigrants are known to experience psycho-social issues, such as poor acculturation and identity confusion, which have been associated with lower self-esteem, increased levels of anxiety, and poor mental health (Sonderegger, Barrett et al. 2004).

When studying Asian families who have immigrated to another country, both the traditional culture and what is changed need careful evaluation (Hsiao, Klimidis et al. 2006). Hsiao et al. (2006), in their study of Chinese families in Australia, have suggested that cultural issues that could be further investigated include: an examination of how family relations are changing along with changes in family structure after immigration; what kinds of stress and conflict are faced by

[3] A standardised health status instrument included in the 2002/03 New Zealand Health Survey.
[4] Ethnic groups included in the *Asian Health Chart Book* included Chinese, Indian and other Asians: Koreans, Japanese, Vietnamese, Filipinos, Bangladeshis, Pakistanis and Afghanis, among others.

the contemporary family; and how the family in Australia utilises resources to cope with problems. These are issues that also impact on Asian immigrants in New Zealand.

2.3.1 Employment issues

Unemployment, underemployment and misemployment (i.e. engaging in a lesser job that has nothing to do with a person's qualifications, e.g. a doctor driving a taxi) are reported to be some of the major problems faced by Asian immigrants in New Zealand (Ministry of Social Development 2008; Sobrun-Maharaj, Rossen et al. 2010). *The New Zealand General Social Survey 2008* (Statistics New Zealand 2008) found that Asian people (together with Māori) were two-to-three times more likely to report employment discrimination than Europeans. Perceived discrimination has been associated with various dimensions of psychological health (e.g.,Finch, Kolody et al. 2000), and life satisfaction (e.g., Brown 2001), as well as with physical health (Karlsen and Nazroo 2002).

Psychological research conducted by Akhavan, Bildt, Franzén, and Wamala (2004) has shown that adverse socioeconomic circumstances start psychological, behavioural, and biological reaction patterns, which have a negative impact on both mental and physical health. This is supported by numerous other psychosocial studies, which have consistently shown psychological distress, depression and anxiety, reduced happiness, lowered self-esteem, death by suicide, admissions to psychiatric hospitals, and risk of substance abuse and criminality as among the most salient outcomes associated with unemployment or problems in gaining meaningful employment commensurate with qualifications (e.g., Banks and Ullah 1988; Hammarstrom 1994; Goldsmith, Veum et al. 1996; Oswald 1997; Kokko, Pulkkinen et al. 2000; Rodriguez, Frongillo et al. 2001).

Akhavan et al. (2004) state that the theory of conditioned helplessness implies that people who want to work, but cannot find a job, may experience passivity, negative self-perception, bad self-confidence, and depression. This is endorsed by Goldsmith et al. (1996) who found that both past unemployment and past inactivity reduce current self-esteem, and Warr and Jackson (1987) and Clark, Georgellis, and Sanfey (2001) whose research suggests that unemployed individuals become resigned to their state, reducing the value they attach to paid employment, and causing them to withdraw from job-search activity, and becoming passive and lethargic.

It is clear from this that employment issues need to be explored when working with Asian immigrant clients presenting at mental health services.

2.3.2 Coping with stress

When faced with the migration issues discussed above, families under stress often adopt dysfunctional ways of coping with their situations. This is exacerbated in youth who are not mature enough to deal with adversity in a positive way (Gance-Cleveland 2004). Developmental changes in adolescence can give rise to emotional complexities of fear, horror, isolation, pain and hurt, which are often experienced as anger and transformed into aggressive actions (Silverstein and Rashbaum 1994). On the other hand, older people within immigrant and refugee families may face problems like depression, very limited emotional support, loneliness, isolation, and apparent lack of respect from adult children and grandchildren. Ho, Au, Bedford and Cooper (2002) state that the levels of stress endured by older immigrants should not be underestimated. Furthermore, inability to participate satisfactorily in the new society can lead to loss of status and

self-esteem in individual family members, which can in turn lead to poor mental and physical health (Pernice, Trlin et al. 2000).

2.4 Service provision for Asian mental health consumers in New Zealand

2.4.1 Incommensurability between Western and Asian systems

A significant factor impacting on recovery, rehabilitation and relapse amongst Asian clients is the apparent incommensurability between Western and Asian health systems (Kozuki and Kennedy 2004). As stated above, Asian cultures differ in certain respects from the Western culture of New Zealand, and this difference is reflected in understandings of health and recovery, and in treatment preferences, amongst other matters. Furthermore, how mental illnesses are manifested is, to a large extent, shaped by culture, so differences in culture could logically result in differences in disease presentation (Chin and Kameoka 2005). All of these can lead to misfit and misunderstanding between systems, providers and clients. For example, Kozuki and Kennedy (2004) examined the cultural incommensurability between clients of Japanese ancestry and Western therapists. The authors found that: only observable data was valued for diagnosis and treatment; cultural stereotypes hampered treatment; individuation and separation occurred within a social web of norms in Japanese culture; key concepts in mental health, such as death and dying and rape were interpreted by clients within a Japanese cultural framework, resulting in unique psychological reactions and behaviours, which had not been recognised by Western therapists; psychological effects of immigration were minimised or ignored by Western therapists who showed ethnocentric biases regarding the effects of immigration; and culturally unfamiliar behaviours were "pathologised" by Western therapists. These findings suggest that incommensurable elements could include result in misdiagnoses and inappropriate treatment plans, which could significantly affect the client's recovery journey (Kozuki and Kennedy 2004). This highlights the importance of the cultural appropriateness of mental health services, and of cultural competency and trust within the therapeutic relationship.

2.4.2 Cultural competency

Cultural competency is a "therapist's awareness of assumptions about human behaviour, values, biases, preconceived notions, personal limitations; understanding the worldview of the culturally different client without negative judgments; and developing and practicing appropriate, relevant and sensitive intervention strategies and skills in working with culturally different clients" (Falender and Shafranske 2006). Cross (as cited in Saldana 2001), defines cultural competency as the acceptance and respect for difference, a continuous self-assessment regarding culture, an attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations.

The cultural appropriateness of mental health services may be the most important factor in the accessibility of services for people of different ethnicities. By developing culturally sensitive practices, barriers can be reduced, leading to more effective treatment and utilisation of services. Being culturally competent includes being culturally aware, which refers to acknowledging and appreciating the different values, beliefs, behaviours, and rituals of a particular culture (Cavaiola and Colford 2006). This is important to better equip mental health professionals to work with culturally diverse clientele, to ensure that clients are understood and feel confident that they will have their needs met, and to enable culturally appropriate service provision.

Building rapport is a critical component of competency development. Building trust with the client and their significant others will facilitate and enhance the client's participation in treatment.

2.5 Role of mental health providers

Providers of mental health services are considered an important environmental factor that can either support or hamper recovery. It has been demonstrated by Tarrier and Barrowclough (2003) that interpersonal interactions, including those with mental health professionals, significantly affect individuals with psychological or psychiatric disorders.

Crowe et al. (2006) emphasise that the extent to which mental health professionals embrace recovery-oriented principles and practices could predispose their attitudes and hopefulness concerning their client's prospects in recovery. Haddow and Milne (1995) say "attitudes have been regarded as providing a 'mental readiness' or learned 'predisposition', influencing how we react to things" . Therefore, applying this to the mental health workforce context, Rickwood (2004) says that attitude shifts towards recovery (orientation) for mental health service providers are needed in order to implement practices that support and maximise the well-being of the consumer. Understanding the factors that impact on recovery, rehabilitation and relapse is also essential (Rickwood 2004). However, there is uncertainty about whether recovery-based training programs for mental health professionals will enhance staff attitudes and hopefulness about recovery (Crowe , Deane et al. 2006).

Chung, Nguyen, and Gany (2002) state that many Asian consumers are deeply concerned about the nature of chart documentation and the importance of privacy in discussions related to mental health conditions. At the same time, some consumers ask that family members be involved in treatment planning. To enhance client participation, they suggest some practical steps for assessing Asians in mental health contexts and for reassuring them. These include telling the patient that all discussions with them are confidential; explaining that chart documentation can be limited to descriptions of symptoms and treatment, and sparing in its details of psychosocial difficulties; and involving a family member whom the patient trusts to increase the therapeutic alliance between health professional and patient. Other steps include asking the patient for consent to do this, and reserving some time at each encounter with the patient to speak privately about any confidential matters.

As the New Zealand population grows and changes, the shifts in ethnic diversity will increasingly require new approaches to be considered in service delivery to address cultural differences among mental health service users.

2.5.1 Relationship between the consumer and service provider in recovery

The service provider plays a significant role in the client's recovery. Corin, Gautheir, and Rousseau (as cited in Piat, Sabetti et al. 2009) have reported that the relationship between the consumer and service provider is therapeutic, and that communication and trust in a therapeutic relationship are important. Deegan and Drake (2006) have underlined the importance of client and provider collaboration in this relationship. Other researchers (Malins, Oades et al. 2006; Happell, Manias et al. 2008) have reported that the therapeutic relationship between consumer and mental health providers has influence on the consumer's medication adherence. For example, it offers a forum for the consumer to decide on their personal meanings for their medication, and provides an opportunity for negotiation of medication usage (Corin, Gauthier et al. 2007).

Slade (2009) emphasises that a journey of change could also be possible for mental health service providers. This is supported by Borg and Kristiansen (2004) who say that mental health professionals improve in self-management when they support clients in crisis situations.. New training for service providers needs to include training in promoting well-being and coping strategies of service users. The challenge lies in the understanding or sharing of values.

Summary

This chapter reviewed the literature on Asian mental health. It focussed on: understandings of mental health and recovery from a Western perspective; Asian concepts of health and recovery, including the significance of family in the process of recovery and help-seeking behaviours; the impacts of migration on the mental health of Asian immigrants; and the treatment of Asian mental health. This last section included the role of the practitioner in recovery and the importance of cultural competency for practitioners. The literature shows that there is a difference in Western and Asian understandings of health and recovery, which need to be considered in the treatment of Asian clients, and that the migration experience can have a significant effect on the mental health of Asian immigrants.

3 Methodology and methods

This chapter outlines the methodology and methods employed in this study, and the research questions that guided the study.

3.1 Methodology

This research adopted an ecological approach to studying and understanding the mental health and recovery experiences of Asian immigrants through their service providers. An ecological approach (e.g., Bronfenbrenner 1979) acknowledges the contextual framework in which individuals live and operate. The utilisation of an ecological framework within the context of this research means that individuals have been viewed as members of families, who are situated within communities, and that these in turn are part of wider society, all of which impact on the individual.

The study also utilised an acculturation framework to analyse and understand the mental health and recovery experiences of Asian immigrants. An acculturation framework posits that highly variable cultural and psychological outcomes follow from intergroup contact. For example, integration results in the maintenance of existing cultures and behaviours; separation results in cultural and psychological maintenance, while avoiding interaction; and marginalisation results in cultural and psychological loss, particularly among non-dominant populations, along with their exclusion from full and equitable participation in the larger society (Berry 2005). Studies with Asian immigrants in New Zealand (e.g., Tse, Sobrun-Maharaj et al. 2006; Sobrun-Maharaj, Tse S. et al. 2009) suggest that these communities may be caught within different stages of acculturation, and that some may be experiencing high degrees of marginalisation, which may have mental health consequences.

3.2 Research questions

The key research questions that the study attempted to answer were as follows.

1. What are the Waitemata District Health Board Asian Health Support Service staff's knowledge, skills, attitudes and behaviours that support or impede implementation of recovery principles?
2. What are the Asian cultural beliefs and practices regarding mental health and recovery, and how and to what extent do Asian staff's cultural beliefs and practices influence implementation of recovery principles with Asian clients?
3. How appropriate are Dr Mary Ellen Copeland's Wellness Recovery Action Plan® (WRAP) and Dr Patte Randal's Re-covery Model (RCM) for working with Asian mental health clients, and what is the impact of these on the Asian Health Support Service team's knowledge, attitudes and behaviours about recovery?
4. Can the training packages used by Asian mental health staff be modified to enhance their work with Asian clientele?

3.3 Methods

A mixed-methods design was used in this research, which produced both quantitative and qualitative data, and contributed to triangulation of the data. The quantitative survey enabled a multidimensional assessment and understanding of the key behaviours and attitudes of support staff that support or impede recovery outcomes for Asian clients, while the qualitative data (focus groups and case studies) provided in-depth information from the key informants on relevant contextual issues. The study consisted of seven phases, as seen in Figure 1 below.

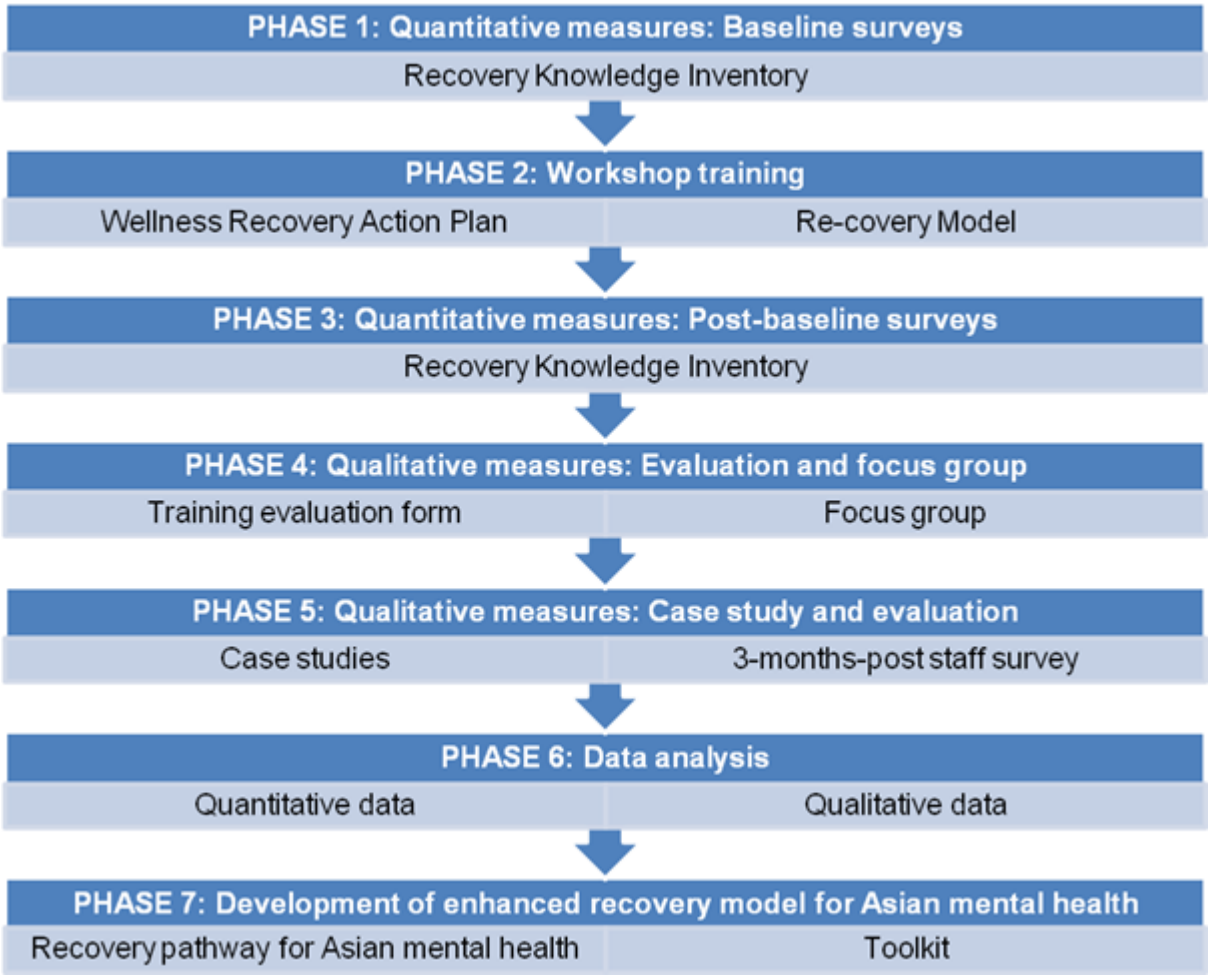


Figure 1: Outline of phases one to seven in the project

3.3.1 Recruitment and sample

The sample for this study was recruited from the Waitemata District Health Board Asian Mental Health Cultural Support and Coordination Service team, and consisted of 11 participants out of a total of 21 core (six) and bureau staff (15). Of these 11, six were core staff members (the whole core staff team) and five were bureau staff members who were part-time employees. There were no selection criteria for participants, other than that they were all staff on the Waitemata District Health Board Asian Mental Health Cultural Support and Coordination Service team and that they volunteered to participate in the project.

Participants were recruited by sending out information sheets about the project to the Asian Mental Health Cultural Support and Coordination Service team. These sheets provided detailed information about the project and the benefits of engaging in it (available on request). The research team also met with the Asian Mental Health Cultural Support and Coordination Service team at the team's workplace to introduce the project's aims and objectives, methodology, methods and expected outcomes, and to answer queries.

3.3.2 Data collection tools and procedures for each phase

Phase one: Baseline survey (Recovery Knowledge Inventory [RKI])

Data collection commenced by administering the Recovery Knowledge Inventory (RKI) (Bedregal, O'Connell et al. 2006) (available on request) to all 11 participants on the day of the workshop training. This measurement tool was used to gather quantitative data before the training began.

The RKI is a self-report questionnaire that assesses the attitudes and beliefs about recovery held by mental health staff (available on request). Factor analysis resulted in 20 items being retained on the original RKI scale. The 20 items fell into four factors: (1) roles and responsibilities in recovery; (2) non-linearity of the recovery process; (3) the roles of self-definition and peers in recovery; and (4) expectations regarding recovery (Bedregal, O'Connell et al. 2006).

Bedregal et al. (2006) determined the validity and reliability of the RKI through measures of internal consistency (Cronbach's alpha) and internal structure (principle components analysis). Reliability analysis estimates (Cronbach's alphas) for the four components (roles and responsibilities in recovery, nonlinearity of the recovery process, role of self-definition and peers in recovery, expectations regarding recovery) were .81, .70, .63, and .47, respectively. The RKI is a considered to be a useful tool for monitoring and training mental health staff (Johnson 2009).

The scale contains 20 items on a Likert-type format ranging from 1 (strongly disagree) to 5 (strongly agree). A more consistent recovery orientation is indicated by a higher score on the instrument (Bedregal, O'Connell et al. 2006).

The scale also contains reversed items that need to be reverted prior to data analysis. For these items, responses range from 1 (strongly agree) to 5 (strongly disagree). Hence a lower score indicates more consistency towards recovery orientation. However, in the study, responses ranged from 1 (strongly disagree) to 5 (strongly agree), that is a low score on the instrument indicated a more consistent recovery orientation.

Phase two: Training workshops (WRAP and RCM)

Two training workshops were conducted over 2 days and consisted of 1 full day of training for each workshop. All 11 participants attended these workshops, which were held 1 week apart.

The workshops involved the use of the WRAP and the RCM. The WRAP is the training package currently being utilised by the Waitemata District Health Board Asian Mental Health Cultural Support and Coordination Service team, and the RCM was introduced to the team during the workshops. A description of the two models follows.

The Wellness Recovery Action Plan® (WRAP)

WRAP is a mental health wellness tool to assist with planning recovery. In the United States, The Vermont Recovery Education Project conducted 23 cycles of the WRAP training, involving 435 participants, from 1997 to 1999. With a response rate of 44 per cent, significant increases were found in consumers' self-reported knowledge of early warning signs of psychosis, tools and skills for coping with symptoms, and various sections in the WRAP workbook. Results also showed that there were significant increases in consumers' self-rated ability to create crisis plans, and to create plans that expressed their needs and wishes. Furthermore, consumers reported being more comfortable asking questions and obtaining information about community services, and engaging in self-advocacy (Vermont Psychiatric Survivors Inc. and The Vermont Department of Developmental and Mental Health Services n.d.).

Evaluation of workshops conducted by Doughty, Tse, Duncan, and McIntyre (2008).determined that the workshops changed participants' attitudes and knowledge about recovery. There was a significant change in total attitudes and knowledge about recovery ($p<0.001$) in the expected direction, with no differences between consumers and health professionals who attended the workshops. The majority of participants found the workshops useful, and the majority of comments were positive (Doughty, Tse et al. 2008).

Zhang, Li, Yeh, Wong, and Zhao (n.d.) affirmed that the WRAP programme has played a significant role in recovery for many Chinese consumers. They suggested some areas (e.g. use of more simple language, introducing more Chinese-style wellness tools) that need to be customised to become culturally appropriate for Chinese.

The Re-covery Model (RCM)

The RCM is a mental health recovery pathway to facilitate shared understanding and action between clients, clinicians and significant others (Randal, Stewart et al. 2009). Some of the core concepts of the Re-covery Model, and the therapeutic framework and multimodal skills training approach that it uses, can be explained by some of the diagrams that form part of the model, e.g. the Map of the Journey of Re-covery, which forms a basis for explaining the recovery programme, and the figure for explaining the Building a Bridge of Trust concept to clients, significant others, family members, and clinicians (see Toolkit). These diagrams can be used in teaching the RCM concepts to mental health professionals of all disciplines, mental health clients, and significant others.

The RCM has been used at inpatient mental health rehabilitation centres with consumers that have a chronic mental health condition. It has also been used in a forensic unit to assist changes to clinical situations. The model has been taught to mental health consumers, family members and peer support workers in non-government organisation sectors. In the workforce, undergraduate and postgraduate nurses, psychiatry registrars and psychiatrists are also being trained to utilise the model. Chaplains have also been taught the model to help them understand mental health, spirituality and recovery better (Randal, Stewart et al. 2009).

The RCM underpins key worker training, and provides a philosophical foundation for community health services like the Acute Home-Based Treatment Service and Hearing Voices Groups and Beliefs Group in New Zealand. Feedback from users of this model indicated that the model offered "an optimistic and credible framework that counteracts the pessimistic perspective people

have often received previously" . The model appears to help people to sustain their mental well-being and strive towards their own goals in life. It has been reported that clients are more capable of reframing crisis situations into opportunities, increasing their strengths and reducing their vulnerabilities. The RCM has also received positive feedback at several national and international conferences (Randal, Stewart et al. 2009).

Trainers are advised to attend the training coached by Dr Patte Randal and Dr Deborah Proverbs to fully comprehend the RCM concepts.

In the workshops conducted during this study, the RCM was facilitated by Dr Patte Randal and the WRAP by Ms Wenli Zhang. The Waitemata District Health Board Asian Mental Health Cultural Support and Coordination Service team utilises the WRAP in their service provision, hence this model was incorporated into the workshops. The workshops covered key elements of the RCM and WRAP through PowerPoint presentations and group exercises (see Appendix A: Toolkit for details), and showed how the models could be integrated for enhanced service provision. As the participants had already been trained in the use of the WRAP model, they were able to relate to using the RCM when integrated with the WRAP.

Phase three: Post-baseline survey (RKI)

The RKI that was administered in phase one was administered again after the workshops to measure the impact of the workshops on participants, i.e. the extent of change in knowledge, attitudes and behaviours.

Phase four: Training evaluation and focus group discussion

The qualitative data was gathered through the training evaluation survey and the focus group discussion. The training evaluation form was administered at the end of the 2-day workshop training. The focus group was held after the workshop to gain more qualitative information on the training, and on staff's cultural beliefs, practices and attitudes. and the influences of these on recovery principles. The focus group was audio-recorded with participant consent.

The training evaluation and focus group questions were developed by the researchers, with input from the collaborator and the cultural advisory group. The training evaluation survey provided qualitative data on the relevance, usefulness, ease of use, and impact of the training workshops. The training evaluation form is available on request.

The focus group questions covered the cultural beliefs and practices of Asian staff, and the influences of these on recovery. Questions regarding the relevance, usefulness, ease of use, and impact of workshop training were also asked again to gain more in-depth information. Focus group questions are available on request. All 11 participants participated in the evaluation survey and the focus group discussion.

Phase five: Case studies and 3-month post-workshop survey

With quantitative measures put in place, a case study method was also chosen to gain more in-depth and specific qualitative information on matters such as which recovery principles were applied most or least during these 3 months, and to what extent the sort cards were useful.

Case studies

Two core staff in the Asian Mental Health Cultural Support and Coordination Service team volunteered to participate in the case studies, which involved carrying out peer observations, writing self-reflection reports on their engagement with a client, and engaging in discussions with the project coordinator and investigator about the use of workshop training content with their clients. The case studies took place approximately 1 and 3 months after the workshop training. The clients with whom the staff engaged during the case studies remained the same for consistency.

Peer observations

Two core staff in the Asian Mental Health Cultural Support and Coordination Service team observed each other's application of recovery skills and knowledge when they met with their clients. The team felt that consumers might feel uncomfortable if a third person was to do the observations at their meeting, hence peer-observation was chosen as a method. For convenience, the contents of the workshop training were broken down into recovery principles, which were listed in a table for staff to tick if the recovery principle was observed. For the process to be fair, this table was completed by the observer and the person being observede. A column for the recovery principle that was applied on a previous occasion with the client was also added (the case study peer-observation table is available on request). The case study procedures and risk issues were explained by the project manager before the case studies took place. The case study risk management protocol form outlined protocols that the case study staff could follow if they were feeling uncomfortable, anxious, worried, hurt, or upset in regards to the process of the case studies (available on request).

Self-reflection reports

The self-reflection report was designed by the researchers, with input from the collaborator and the cultural advisory group, to gain more in-depth information, which would supplement data from the case study peer observations. Questions covered such matters as how well the staff thought they did in terms of applying what they learnt at the workshop, whether there was enough time and space (appropriate context, appropriate pace of client and staff) in their meeting to apply what they learnt at the workshop, what recovery aspects they would focus on the next time they work with their client, and what areas of improvement they could make in terms of applying recovery principles in their work (the self-reflection report questions are available on request). Filling this report also enabled the two case-study staff to reflect on their knowledge, cultural beliefs, attitudes and behaviours, and provided a learning experience for them.

Discussions

Discussions involved case-study staff engaging with the project coordinator and investigator about the use of workshop training content with their clients. Questions were open-ended and based on those used in the observations and self-reflection reports. The purpose of these discussions was to provide staff with the opportunity to ask further questions and expand on and clarify their previous responses.

Three-month post-workshop questionnaire

The 3-month post-workshop questionnaire was designed to measure the impact of training on all participants after 3 months, and was administered 3 months after the workshops were conducted. The measures were administered by the research team. The questionnaire covered topics such as the relevance, usefulness, ease of use, and impact of workshop training. The purpose of this phase was to gain more in-depth and specific information on the skills and knowledge that were applied 3 months after the training. The 3-month post-workshop questionnaire is available on request.

Phase six: Data analysis

The Statistical Package for Social Science (SPSS) version 14 was used to do statistical analyses for the quantitative data. A power analysis with G*Power 3.1.2 (Faul, Erdfelder et al. 2009) was done on sampling size, aiming at a 90 per cent chance of detecting medium size difference between the groups at 0.05 significance levels in the normal distribution. In order to detect an effect size (r = 0.8), a sample size of 27 was needed. Due to the low sample size (n = 11), inferential testing was not performed. Rather, we focussed on the visual inspection of the data, and highlighted the trends and patterns that emerged from factors and individual items.

The qualitative analysis was conducted using a general inductive approach (Thomas 2006) that enables the identification of themes, clusters and categories relevant to the project objectives. The following process was used.

1. Data obtained from the focus group discussion was transcribed as early as possible to ensure that nuances were not missed and that these were paired with the research team's thoughts and interpretations. Transcripts, including notes from the interview, were read and reread, and initial ideas were recorded.
2. The second part of the analysis involved coding any interesting features identified within the data in a systematic fashion across the data set acquired. Data relevant to each code was recorded.
3. Data relevant to each potential theme was collated.
4. The themes were then reviewed and checked to see whether they worked in relation to the coded extracts and the entire data set. This helped to create a thematic framework of the analysis.
5. Further analysis was conducted to refine the specifics of each theme and the overall narration of the analysis reports. This helped to generate clear definitions and labels for each theme.
6. After all the analyses, compelling extracts from the data set were analysed again to relate it back to the research aims and literature.

The research team came together for weekly meetings throughout this process, in which they compared their analyses and interpretations of the data, and noted the presence of common or recurring themes.

Phase seven: Development of an Asian mental health model of delivery and toolkit

A suggested Asian mental health delivery model was developed, which was informed by the quantitative and qualitative data gathered from participants, and feedback from the workshops

(see Chapter 5). A toolkit was also developed for use by Asian mental health support workers (see Appendix A). Both the model and toolkit need to be tested for further use.

3.4 Ethics and quality control

The University of Auckland Human Participants Ethics Committee approved the study outlined in this report on 3 December 2009 (Reference 2009 / 516).

Written consent was arranged with an explanation on the importance of protecting the identity of the participants. The participants' written consent forms with each participant's signature and name is stored separately from the data in a locked file cabinet. Data and research findings have number coding only (i.e. no identifying details are recorded in the findings or data set).

3.5 Cultural advisory group

A cultural advisory group was convened by the research team at the commencement of the research project. The group consisted of six members who are specialists in the field of mental health amongst Asian communities, and who broadly represent the Asian ethnic groups. These included Chinese, Indian and Malaysian. The members of the group also have knowledge and experience with regard to mental health and practices in the New Zealand workforce.

The advisory group met on three occasions during the research project. The group provided expert cultural advice and guidance on issues such as the data collection measures and procedures, commented on the preliminary findings, and aided with the interpretation and contextualisation of the resulting data.

3.6 Research team

The study team comprised of researchers from different ethnic backgrounds who are active in community activities, are aware of cultural sensitivities in a range of ethnic communities, and brought to the project a wealth of knowledge and expertise. The principal investigator, Dr Amritha Sobrun-Maharaj, is an overseas-born Indian psychologist with expertise in the field of Asian health. The project coordinator and investigator, Ms Anita Wong, is a Chinese Master's graduate in Psychology. The local advisor of the project, Ms Chaykham Choummanivong, is a South-east Asian clinical psychologist, and the international advisor, Associate Professor Samson Tse, is a Chinese mental health expert.

4 Results and discussion

This chapter presents the results related to the first three major objectives of the study and a discussion of the outcomes. The results are presented under the themes arising from each objective. These include quantitative data from the RKI and qualitative data from the focus group discussions and case-studies. Please note that because of the small sample size (n = 11), no inferential testing was performed on the quantitative data, and the focus of discussion is on the trends and difference in mean scores.

4.1 Objective 1: Knowledge, skills, attitudes and behaviours of the Waitemata District Health Board Asian Health Support Service staff that support or impede implementation of recovery principles

4.1.1 Recovery Knowledge Inventory (RKI)

The RKI scale was a Likert-style scale ranging from 1 to 5, where 1 = strongly agree, 2 = agree, 3

= neutral, 4 = disagree, and 5 = strongly disagree. Hence, a decrease in mean indicates an increase

in recovery orientation after the workshop training. The participant's means and standard Table 1 (page 24).
deviation scores on the RKI across the four factors pre- and post-workshop are shown on

The data from the RKI showed that there was a decrease in mean scores from pre- to post-test on

Factor 1 (roles and responsibilities). This may indicate that the staff appeared to be aware of their

role as a provider, and that they are providing culturally appropriate care to their clients at the Table 1).
client's pace, e.g. meeting practical needs first, then exploring recovery goals (see
Factor 2 (nonlinearity of the recovery process) on the RKI indicates whether a person has understanding about the nature of the recovery process being non-linear, having multiple pathways by which people can recover that go beyond formal treatments and rehabilitation settings, and that illness and symptom management can not only precede recovery, but also be part of it. The pre and post mean scores sit on neutral on the Likert scale (3.23 and 3.48), suggesting that staff may still be unsure about the multiple pathways of recovery that clients can take, especially in relation to being symptom-free. The qualitative data suggests that, because clients struggle to believe that they have recovered when symptoms persist, staff may also struggle with this concept.

There were similar results in relation to Factor 3 (role of self-definition and peers in recovery), on the RKI. This indicates whether the staff member has understanding of how to develop realistic, yet hopeful, expectations of their clients with respect to their participation in their own recovery and in their lives in general.

The mean score appeared to have increased, which indicates a decrease in recovery orientation in relation to this factor. This may be explained by some of the qualitative data. The qualitative data reveals that participants felt that self-identity is not as emphasised in Asian cultures, due to their

collectivist and hierarchical natures where collectivist identity is emphasised more. Being able to live normally again after experiencing mental health issues is still not accepted, due to the stigma attached.

Again the pre and post mean scores (3.14 and 3.05 on the Likert scale) on Factor 4 (expectations regarding recovery) suggested ongoing uncertainty of staff in relation to expectations regarding recovery. The qualitative data showed that participants feel frustration in terms of what to expect from clients when they are not responding to treatment or support, or are not actively participating in their own recovery.

Table 1: Participants' means and standard deviation scores on the Recovery Knowledge Inventory (RKI) across the four factors pre- and post-workshop

Factor	All staff (n = 11) Pre-test Mean	Pre-test SD	All Staff (n = 11)* Post-test mean	Post-test SD
Factor 1 (roles and responsibilities in recovery)	2.16	.53	1.68	.42
Factor 2 (nonlinearity of the recovery process)	3.23	.48	3.48	.69
Factor 3 (role of self-definition and peers in recovery)	2.18	.32	3.87	.86
Factor 4 (expectations regarding recovery)	3.14	.67	3.05	.96

* One staff member did not attend the second day workshop, but still completed the post test.

4.2 Objective 2: Asian staff cultural beliefs and practices that influence implementation of recovery principles with Asian clients

The following significant cultural beliefs and practices emerged as influencing the implementation of recovery principles with Asian *c*lients.

4.2.1 Asian understandings of the concept of recovery in mental health

Participants identified differences in concepts of recovery as a significant factor influencing the implementation of recovery principles by Asian mental health support staff. They suggested that the term recovery (in mental health), and terms related to recovery, e.g. empowerment, are relatively new concepts for the Asian population. Participants felt that the understanding or meaning of recovery for Asians, including Asian staff, could differ from the Western one. For example:

We need to find out the new concept of the empowerment of the patient…and for the family of the patient...What empowerment means for Asians...it could be different. (Participant 1)

We believe recovery is total recovery. (Participant 2)

The data and literature (see Davidson and Roe 2007; Piat, Sabetti et al. 2009) show that many Asians still find it hard to accept the fact that they are recovering or recovered when symptoms persist or they are still on medication. This is reflected in the participants' own views of recovery:

When I am off medication, that's when I've recovered. (Participant 3)

This view is in line with biomedical traditional views of consumers and clinicians on recovery as being free from symptoms and back to normal functionality (see Davidson and Roe 2007; Piat, Sabetti et al. 2009).

4.2.3 The importance of family involvement

A significant characteristic of collectivistic Asian cultures is the importance placed on family (Hofstede 2001). Participants perceived family as a very important component of the recovery process and suggested that they should be more involved in the client's treatment and rehabilitation process:

We need family involved in process and treatment, including making judgements. (Participant 4)

*My worldview for recovery in my culture...it's a family thing…and in the family I say, the whole village is responsible for someone who has mental illness so if he goes on the high road...you call this person, settle him down in the house, and my uncles and aunties will do that, so that was the recovery path for that person...when it happened to someone, and giving him food, shelter and listening to him, this is what our community, my parents were doing when someone was like this. (*Participant 5)

When we practice, I feel we need family involved in the process for treatment, like Maori. (Participant 4)

As Asians are collectivists, family can be involved in goal setting. Slade uses the term "idiosyncratic" in setting recovery goals and, because this may be seen as selfish in the Asian culture, staff perceive having family involvement as a good idea. They suggested that the wellness of the whole family is also important, hence it is important to work with the family and assist with any dysfunctional coping strategies:

*I think we should consider the wellness of the whole family – what problems they all experience and what resources are available to them. (*Participant 3)

In many case[s] we meet our client, and [find that] other family members are more sick, so…the client is…the sacrifice for all family…We find more serious problems in the family…we help the client and they listen to the home and then

> *they [relapse]. So it's important that we join [the family]…naturally together…to share… consider the wellness of the whole family.* (Participant 2)

Participants stressed the importance of including the family in the process and making sure that everyone has the same understanding within the family. This will help to avoid conflict in recovery goals, and with having the family accept and admit to the problem or the mental health issue that has arisen:

> *She was in hospital and she came out to stay at home. She became more assertive, more empowered....but her husband….her husband was very set in his values, he's not responding to her recovery at all. He thinks that she is over-reacting. So he's so set in his values and perception of what recovery should be for her, so it's even harder for her. So there is friction and just a matter of time until she has another relapse….the wife is starting to like the empowerment model but the husband hasn't moved… he's actually being excluded [in the process]*. (Participant 6)

> *I think…as part of recovery…probably family members and the client should be…in training…so that they…understand what recovery, what empowerment [means]*. (Participant 1)

Furthermore, it was extremely important to involve the family in the client's process of recovery, as family dynamics would affect the journey of recovery for the client, as well as the family.

4.2.4 Hierarchical social structure

As Asian societies are hierarchical, staff stated that it is difficult when a younger support worker engages with an older Asian client. When the support worker tries to suggest recovery messages to an older client, it would seem like a youngster trying to teach an elderly person. This would be considered disrespectful and would impact on the way in which the support worker would interact with the client. Similarly, staff in the case study considered the sort cards in the RCM to be inappropriate for some clients, such as the more educated, who could perceive the activity as childish and insulting to their intelligence:

> *It's already hard when the support worker is younger than the client and the worker is trying to get recovery messages across to the client (like teaching the client) and that is not the norm in Asian cultures, let alone using the cards – this will seem like playing card games.* (Participant 10)

4.2.5 Respect for authority

Respecting authority or the elderly (who are seen as having authority) is an important value and belief that Asians traditionally hold. This could impact on both the service provider and the client alike, as the Asian service provider who understands this has to take this into consideration when working with the client, as suggested by this participant:

> *Doctors in the past have been seen like "Gods", world-savers. It is normal for Asians to listen to doctors and professionals as this is respect in their culture. But this could become a conflict when the professional does not realise this and uses a client-centred approach like asking what the client wants to do about*

> *certain things. The client may feel that the professional does not know what they're doing. (Participant 6)*

Generally, participants felt that Asian clients were accustomed to professionals being prescriptive about treatment and methods, so they may feel uncomfortable at the beginning about client-centred approaches, e.g. informed consent.

4.2.6 Saving face

The need to save face is generally recognised and acknowledged by most Asians as an important characteristic of their cultures, as the participants of this study did. For this reason, they do not like to discuss their problems with outsiders. They have a strong tendency to keep things within the family and present a "good face":

> *Asians in general tend to internalise emotions, they don't express it to a service provider like us, they don't open up, bottle them up in order to give a good face, and become depressed.* (Participant 7)

Consequently, they tend to internalise their emotions and avoid seeking help from professionals, which in turn impacts on the ability of support workers to assist clients adequately.

4.2.7 Stigma

Stigma was identified by participants as a major issue with regard to mental health amongst Asians, especially recent immigrants, who attach a great deal of stigma to those who are afflicted. People with mental illness consequently avoid being identified as such, especially the elderly and those who are more educated who, participants reported, appear to experience more internal stigma. The case study staff suggested that clients who are highly educated sometimes feel that they are useless because they cannot solve issues themselves and require support. They feel that because they are highly educated they should be able to solve issues themselves and not need any assistance. This impacted on their willingness to seek outside help for such a condition:

> *Of course stigma is there when it comes to cultural get-togethers, big functions...this person goes to the back and doesn't come in front. It's a shame for the family; they do not want any mishaps you know, so someone will take care of him at the back.* (Participant 6)

> *The mental health issue is a crazy issue, so it is dangerous, so when I grew up...they should be in hospital. The hospital should treat them and then they discharge these people when the psychiatrist says it's okay, otherwise, you know, we feel a little bit dangerous.* (Participant 4)

This was also shown by the quantitative data from the RKI (Factor 2: willingness to ask for help) and endorsed by the literature (Stanhope 2002).

Consequently, mental health issues are concealed by individuals. It is often the family who recognise the problem and encourage presentation to mental health services:

> *When they realise they are imbalanced they go 'oh my god what's wrong with me' and shut the door...Soon family members recognise this... oh what happened with you*. (Participant 4)

This is evident in referrals, where many Asian consumers are reported to present to mental health services at a crisis level:

> *Almost 90 percent of referrals come from crisis.* (Participant 8)

Psychiatric services are usually seen as the last resort. Hence, many clients present to the service provider at a crisis point, and this may lead to extra time spent in treatment and extra support required by support workers to assist clients in their recovery.

For these reasons, acceptance of the mental health issue was identified by participants as an important initial step to make in the client's recovery journey:

> *Recovery models are based on client's beliefs…or…insights – if they have a mental problem or not…My experience is my client's don't have insights…or they don't even acknowledge it…say I'm fine.* (Participant 9)

> *Once you admit to the problem…I think…all recovery models [will] work with the client…Actually most of my job previously was to help them to accept they are a patient.* (Participant 10)

4.2.8 Spirituality

Spirituality was highlighted by many participants as an important aspect of recovery that many Asians turned to for help, for example:

> *I think the spiritual aspect is important and it's important to have this connection as we will end up there in the end and we have all come from there, there should be a balance of things…Then it comes to spirituality within that person's recovery – it's very important for us...prayers…and not only once, many number of times visits to the temple and taking this person along for the holy cleansing and all those things that can happen*. (Participant 6)

All participants suggested that it was important to acknowledge spirituality, if this aspect was important to the client and family. This view is also held by Randal and Argyle (2005) who state that the concept of spirituality is now being recognised as an important component of mental health and recovery. Consumers in a study by Fallot (2001) have also said that spirituality plays an imperative role for them in bringing hope, empowerment, identity, a sense of purpose and meaning, which are all vital for a consumer's recovery journey (Fallot 2001).

4.2.9 Balance and overall well-being

All participants felt that a balance in all areas of life and overall happiness was important for all Asian clients. Participants felt that this could be the focus when working with them, instead of focusing on mental health. This would help reduce stigma and labelling, for example:

> *I think we should promote overall wellness and not just focus on mental health, since there is still stigma attached and setting up mental health services automatically labels a person when they want to access our services.* (Participant 3)

> *We need a different label…for our organisation rather than showing them mental health…like recreational centre, group activity group…* (Participant 4)

This is in keeping with the recovery goals versus treatment goals discussed by Slade (2009). For this, where appropriate, alternative treatments that are meaningful and helpful to the clients could be considered. This will help reduce the anxieties clients reportedly experience about having to take a "life-long pill". However, it is important that alternative treatment options are discussed with the client's clinical team, as risk issues could be involved in stopping or reducing current medication or treatment.

Participants also said that the client's overall wellness and mental health can be achieved by setting life goals that make them happy. This is supported by the literature (e.g., Schiff 2004; Slade 2009), which has emphasised pursuit of happiness as important to recovery. Participants suggested that, generally, clients will be happy if they are financially stable, have a consistent job, and have good relationships with others, and this would help with recovery:

> *Overall, I think clients would [be happy if they were] financially stable, have a consistent job, have good relationships. That will keep them happy in life.* (Participant 9)

Many Asian clients often have quite a different understanding of mental illness and recovery, with overall wellness and happiness being considered a significant outcome of recovery. Staff suggested that there needs to be a step in the recovery process that accommodates helping clients to identify what happiness means for them, what makes them happy and how they may achieve this state. Understanding this would ensure that recovery goals of the client are achieved:

> *We need a final step in the model that helps clients to find out what happiness means for them…what makes them happy…then help them to achieve this outcome.* (Participant 10)

Furthermore, recognising Asian specific patterns of thoughts, feelings and behaviours related to the problem are an important part of the process. This would contribute to converting clients' dysfunctional coping strategies to functional coping strategies, and vulnerabilities to strengths. This would in turn facilitate treatment with the use of models like the WRAP and RCM, and other tools and models appropriate for Asian clients.

4.2.10 The collective rather than the individual

Participants suggested that Asian clients often find it difficult to express their thoughts, feelings, body sensations and actions, and avoid focussing on the self and using "I statements". Instead, most Asians find it easier to speak about themselves in a third person context, e.g. "My mother thinks I'm…", rather than "I think I am...". Also, most Asian clients usually answer questions in a non-directive way, for example, instead of saying, "I thought I was useless in...(situation)", they will express it in a non-directive way such as, "There was nothing to do then". This may stem

from the collectivistic nature of Asian cultures, where the collective is the focus rather than the individual.

4.2.11 Avoidance of risk-taking

Asians in general are also known to avoid taking risks unnecessarily. This is evident in the item on the RKI that involved risk-taking, where only three of the 11 participants agreed with the statement: "All professionals should encourage clients to take risks in the pursuit of recovery". Clearly, this would impact on support workers' ability to encourage such behaviour in their clients.

4.2.12 Preference for dealing with practical needs

Participants reported that many of their Asian clients prefer to solve current issues, and to receive support around practical needs, rather than having a "therapy session" about "recovery". The main practical need that emerged was help with finding employment and overcoming financial difficulties:

> *Reality is important, if the client finds a job, then he doesn't need any more recovery [treatment]; he is fine.* (Participant 10)

Case-study staff reported that, generally, at the first few meetings with new clients, practical solutions in helping the client address immediate stresses are explored, e.g. making a referral to Work and Income New Zealand. Having immediate and practical needs dealt with first will enable the client to feel more comfortable with progressing to the next stage of talking in depth about aspects of recovery.

4.2.13 Unfamiliarity with Western models

Participants talked about the Western models of health that are currently being used with Asian clients who are generally unfamiliar with these models. They suggested that these models do not always work with Asians and need to be adapted to include Asian concepts, as seen in the following quotations:

> *Models provide Western concepts – we need to adapt these to Asian concepts.* (Participant 4)

> *Adapt the model to suit specific Asian needs, for specific clients. We need to include what needs to be done with Asians – effective ways to work with them.* (Participant 2)

Western models of doing things, such as giving informed consent and giving options to the client and family, were identified as being new concepts for many Asians, especially recent immigrants. Traditionally, Asians are accustomed to being prescribed to by authorities, e.g. doctors and the elderly. Asian staff interviewed suggested that this may take more time for clients and families to understand, for example:

We are educated in our own country, so most of the migrants living in New Zealand are usually familiar with the structured way rather than the creative kind of way. (Participant 3)

They are definitely overwhelmed by the Western approach...when working with an Asian client, when I offer many options, ask him to choose, which activity you are interested in…he is overwhelmed by what he should do. [We need to] practically provide...what about this, this is really good for you, what do you think about it? Just one or two options [are] good, but if you choose something from a lot of things, it's quite hard for the client. (Participant 4)

The informed choice model, they are not used to it. Informing them, giving them choices can overwhelm people….A lot of migrants from Asian countries are treatment-based, all treatment focused, so rehab is not something that is very common, so recovery, empowerment…these are very new things. (Participant 1)

4.2.14 Acculturation

Participants suggested that familiarity with Western models increases with time, and that the more acculturated the client is to the New Zealand system, the more comfortable they feel towards client-centred tools. They felt that being aware of the client's stage of acculturation was important, as this would mean using different approaches to meet their recovery needs, for example:

Training can then be tailored to individual family context in terms of migration, assimilation, life events and afflictions. (Participant 10)

This awareness would also be useful in terms of understanding which recovery tools are appropriate for the client, e.g. sort cards, WRAP workbook.

4.3 Objective 3: Appropriateness and impact of the WRAP and RCM on staff knowledge, attitudes and behaviours about recovery

4.3.1 Appropriateness of the training for providers and their service

Overall, participants felt that the training with the WRAP and the RCM was appropriate for Asian mental health service providers, as reflected in the following comments:

RCM & WRAP – The training may have facilitated Asian clients to be motivated by knowing their own strengths that is caused from hopeful and confident thoughts [in] recovery, with self-reliance and self-trust. (Participant 2)

RCM & WRAP – I would say the material has been stunning and enlightened us, in terms of paradigm shift that is more likely to impact on fundamental thought about mental illness and recovery. (Participant 3)

RCM – Helping the client to identify his/her thoughts, feelings, body reactions and behaviours in various contexts is important. Identifying the timeline of his/her life might give the client an overview of his/her life. (Participant 5)

In particular, 10 participants felt that the training was culturally appropriate to their work with Asian clientele, and that the models could be adapted to include Asian cultural components:

> *I think this will be really useful for working with Asian clients. And also we could put the cultural assessment [component] into the map of the journey [in the Re-covery model]*. (Participant 8)

> *It's a really comprehensive model to use in [mental health] (referring to the training with both models). And for Asians we could add more cultural components into the Re-covery model, so it's easy for clients to understand the whole picture and also reduce the stigma*. (Participant 1)

The RCM component in the training did not address particular cultural ways of working with Asian people when utilising the RCM. However, the WRAP trainer gave personal experiences of using the WRAP with Chinese communities. The Korean participants also mentioned utilising the WRAP in a Korean support group they manage.

More importantly, participants appreciated the fact that the migration context could be accommodated within the models used, which recognised the impact of migration on the mental health of Asians:

> *It was specific for migrant clients, especially Asian migrants. Past trainings and knowledge was in the mainstream context.* (Participant 11)

> *It helps clients to recover in an Asian migration context, especially if there are conflicts in value.* (Participant 10)

On the other hand, one participant was still hesitant about whether the recovery models and content were suitable or adequate for working with the Asian community in their present form. Participant 4 expressed the following view:

> *I still doubt that the training is quite relevant to Asians, because generally it provides the recovery concept from the Western perspective. We are educated here, that's why we feel it's effective; however, the programme doesn't provide any specific, you know, effective way for Asian clients*. (Participant 4)

Participant 5 felt the RCM needed more emphasis on the Asian population and their needs, and that the tools in the model may only be appropriate for some Asian clients:

> *Generally, it is appropriate and useful; however, the training is not specifically relevant to Asian clients because it does not mention cultural consideration aspects in terms of Asian culture.* (Participant 5)

Participants 3 and 4 felt that the RCM is "a good model", but expressed some reservations about its effectiveness and applicability to Asians as reflected by their comments below:

> *I don't know, that's what I mean, you need to show us the proof that it will work with Asian clients or not. I only used it once [using the sort cards]*. (Participant 3)

> *Hard to see if the client is going to recover – victorious cycle or vicious cycle.* (Participant 3)

> *We shared our knowledge, our experience, that's good. However, the training doesn't include anything specific on Asians…We want to hear what effective way there is for Asians, rather than we just bring our own experience and interpret it as training.* (Participant 4)

Furthermore, participant 5 felt that the approach offered by the RCM might not be accepted by people who are used to the biomedical model and approaches:

> *The training defines the general framework of recovery which is important for any professional mental health worker. The approach away from the Biomedical Model is most crucial yet it might not be accepted by all professionals and clients.* (Participant 5)

4.3.2 Usefulness of training

The qualitative data from the training evaluation survey showed that most participants considered the training for using the WRAP and RCM together to be highly useful for working with their clients, as seen in the following comments:

> *It's useful and easy tool to use with clients.* (Participant 1)

> *I can use this with my client's plan, then support plans.* (Participant 6)

> *Practically, it'll be useful to my work.* (Participant 5)

> *Useful for making me knowledgeable in the various ways of dealing with mental health [clients]*. (Participant 3)

> *I think the things I learned about how to identify client's wellness and strength from workshop are very helpful for me.* (Participant 2)

A few participants stated that the training was "validating" and relevant to what they were already applying with their clients, and that it made them reflect on themselves and feel more confident about their role as a support worker, for example:

> *I think every client [and staff] needs to learn this model, so they will understand their life better and also knowing and be aware of what's going on with their life.* (Participant 8)

> *I have been practising some of them and this training validated that it is useful [to] use WRAP and recovery models together.* (Participant 2)

> *Application to self before practised on others [would bring more self-reflection]*. (Participant 1)

> *[The RCM was] validating, [and the WRAP emphasises] taking personal responsibility.* (Participant 3)

[The training] empowers me and my client. [It focuses on] collaborative work. (Participant 7)

We are already practising it [the recovery concepts], even if she [Dr Patte Randal] didn't provide us training, we are doing it already. Her model [RCM] is just more thorough...you know from the beginning…so we can think about the cycle since we were born. (Participant 4)

Moreover, the training was easy to apply in work practice:

Practically, I can apply these models. (Participant 2)

I can use the training to apply to my present client who has some stressful situations, to help him manage them. (Participant 3)

We can use this model any time we need [it]. (Participant 7)

[It is] easy to explain to clients with charts [in the models]. (Participant 9)

[I can] apply [the models] to every part of my work. (Participant 1)

The illustrations made the application of the tools easy to understand and implement. (Participant 5)

It's really easy to apply to the daily practice for our service. (Participant 10)

The case study staff also expressed motivation, in terms of using the training materials with clients, and set goals and aims for trying out the new methods and tools (e.g. sort cards) with their clients at future meetings:

As my client is quite analytical, I like to use 5-part model for her stressful situations. (Participant 9*)*

[I am now] more focused on the present and future of the clients with their potentialities. (Participant 10)

4.3.4 Increase in recovery orientation

Both the quantitative and qualitative data showed increased recovery orientation on the RKI for 8 out of 11 participants. This was evident in the qualitative data from the evaluation after the workshops, the focus group discussions and case study discussion, where participants talked about increased recovery orientation, for example:

I was able to sell them my strong belief in hope for their recovery with defining the term of recovery and the way to maintain their wellness by looking at their own strengths rather than the negative side of the illnesses. In validating their feelings and moods which are sometimes passive and even lower, attempt to build trust relationships with clients and their family by giving empathy in their feeling and matters, so that we may be able to identify the problems or the reasons for them, and then work together with clients to resolve the issues...Again, concentrating on their successful moments step by step and

> *praising them for even their small success and attempts at coping with their matters, in terms of empowering and strengthening.* (Participant 2)

> *The term of recovery (about which it is hard to be sure sometimes) may upset the clients and their families. However, we can assure them they can be confident that such illnesses can be controlled. By doing so, surely they can enjoy their lives despite illness still being there, aligning with de-traumatising re such illnesses.* (Participant 5)

The quantitative data from the RKI factors showed that the training increased staff's knowledge, and also improved attitudes and behaviours about recovery and the application of recovery principles after the training. For example, staff members felt more confident about their work practice and felt more hopeful in assisting their clients in their recovery. There were no major differences between core and bureau staff in the sample.

The quantitative data from the RKI pre- and post-test scores for Factor 1 (roles and responsibilities in recovery) and Factor 4 (expectations regarding recovery) indicated an increase in recovery orientation after the workshop training.

Staff showed better understanding of the importance of differentiating the roles and responsibilities of each party (i.e. provider and client) in the treatment and rehabilitation process. They also had more knowledge of how to develop realistic, yet hopeful, expectations of their clients, with respect to participation levels in the client's recovery and lives in general.

Before the workshops, more than half of the sample disagreed with narrative items in the RKI relating to redefining self (i.e. defining who one is, apart from his or her illness or condition, is an essential component of recovery), incorporating illness (i.e. professionals can help a person recover even if he or she is not ready to accept his or her illness or condition or need for treatment), and managing symptoms (i.e. symptom reduction is not the only essential component of recovery). However, after the workshop training, less than half the sample (four, two, and five people respectively) disagreed with these items.

There were also increases in agreements with items relating to recovery-readiness (i.e. everyone is capable of actively participating in the recovery process), self-determination (i.e. everyone should be involved in making decisions about their care), citizenship (i.e. everyone should be involved with the responsibilities of their everyday life), involvement in meaningful activities and having supportive others.

4.3.5 Participants' growth in knowledge and skills from training

Participants reported gaining much from the workshops in terms of new knowledge and skills, as well as personal growth. For example:

> *[I gained] skills and knowledge in believing in recovery model and wrap when dealing with clients and their families to sell such belief in recovery.* (Participant 1)

> *The training allows me to reflect more especially with the current questions that are being asked. Implementation, however, is harder to achieve.* (Participant 5)

> *The training gave me and peers the opportunity in terms of personal growth to be confident in hopefulness for our clients' improvement. As such, I desire to practice the model with clients by facilitating them to clarify and be mindful of recovery and to identify individual ways to maintain their wellness, on top of validating them, their feelings and personal rationale that may have undermined their life.* (Participant 2)

> *Refreshing skills and experiences that I have been applying, also learning something different that I can do to make a difference in one's life.* (Participant 8)

Participants felt the training was "enlightening" for them. The workshop provided them with additional confidence in their work practice, for example:

> *We feel more confident…enlightened.* (Participant 1)

> *I have become more confident to engage with my clients in hopeful belief and attempts of facilitating them to believe in their own strength and potential capacity also, and to dig out such abilities, believing they have rights to their life including illness as well as wellness.* (Participant 2)

> *I can get more confident and…more hope you know…when I see my client again…I can empower them in some way.* (Participant 3)

This is consistent with Borg and Kristiansen's (2004) findings about staff being able to improve on self-management and coaching following training.

One month after the workshops, the two case study staff had built a certain level of trust with the client, and had a plan for what steps to take next in engaging the client in the process of their recovery:

> *Wellness Recovery Action Plan [workbook] is the focus for next meeting.* (Participant 9)

> *I would try to use the 5-part model with my client next time I meet with her*. (Participant 10)

Three months after the workshop, the case study staff had a clearer pathway on what was appropriate to do next in terms of applying what they learnt at the workshop:

> *Worked on the WRAP more and introduced the 5-part model to the client: More on WRAP (Chinese) version. 5-part models are introduction to give an overview.* (Participant 9)

> *[I will be] doing the Advance Directives with clients the next time*. (Participant 10)

The two case study staff were able to acknowledge the stages of recovery the client has been through, and identify which tools in the training seemed more helpful to the client, for example:

> *As client has actually experienced recovery, client is able to appreciate the 5-part model more.* (Participant 10)

A case study participant felt that they could improve on building the client's strengths and acknowledging their rights at the next meeting:

> *Helping the client to identify own strengths and using them for recovering...Acknowledge clients rights and empowering them…I applied some strategies in my session…identify the triggers of the client's mental [health] problems.* (Participant 9)

Feedback received from peers endorsed participants' views on their learning, as illustrated by the following quotation:

> *My manager told me that my assessment is creative and my approach to each client is appropriate in consideration with the client's working preference in term of Client Pathway. Clients mentioned that using different ways such as 5 part model (cards) and Pizza for Need Assessment was fun. My colleague told me that using 5 part model seemed to be effective.* (Participant 4)

4.3.6 Usefulness of the WRAP and RCM

All participants felt that the WRAP is more practical and easier to comprehend, while the RCM requires more analytic skills to apply with clients. However, they felt that both models were useful for working with clients.

They considered the tools presented in the RCM and WRAP to be useful aids in their work practice:

> *It was very useful [training]. It would be very helpful to use [sort] cards because it can help many clients to get some clue and information to communicate. Many of them find it difficult to find out their problems and express and feelings.* (Participant 2)

> *[The] physical materials, e.g. the flash cards (sort cards) by Dr Patte Randal in particular, are highly relevant and helpful to practice the model. Those visual cards, in terms of communication with clients, allow us to identify not only clients' symptoms and issues, but also help both the care coordinators/ care-givers and clients feel comfortable to implement, and then get familiar with the model.* (Participant 3)

> *[The sort cards] encourage us to feel safe to implement the model, in addition to clarifying clients' symptoms and reasons for them in 5[-part] model, encourage us to develop the plans to replace [eliminate]ongoing problems/ dysfunctional cycles.* (Participant 10)

Participants who found time to use the tools in the recovery models, found they helped clients to manage their health:

> *She [client] can get self-awareness, she had some trouble and the trigger in her situation and she used the WRAP plan.* (Participant 9)
>
> *Knowing the possibility of transition of thought pattern which determines either vicious cycle or victorious cycle of our life, may be a bottom line for Asian clients to understand it and be motivated by it and be assured about manageable mental health, at least*. (Participant 1)
>
> *It is also important for mental health clients to know that adhering to medication is not the only thing needed for recovery, but that self-responsibility for the recovery may be more important*. (Participant 3)
>
> *Clients can be the owner of their matters. Clients and their families may identify their affairs well, including the nature of their illness, and other issues such as some social issues which may be risk factors, as well as their identified strengths that may have given them resilience and kept them well. So, clients and their family can be confident with their current matters with mental illness, with hopefulness rather than helpless*. (Participant 10)

One participant in the focus group discussion said that they found the sort cards from the RCM to be effective after trying them on a client, and found that they helped the client find ways to express himself:

> *The [sort] card is effective in verbally discussing [symptoms]…I use the trigger card and early warning sign because he is my new client. I tried to use it [and found] how effective it is. The first time I used it on him, he said:…'oh I'm not a child'…He's elderly, but actually, it's like going back to childhood…At first, he felt it is kind of like…kids' stuff; thought...kiddy game. Now [he finds it is]useful to express his own idea[s]. So it can be good.* (Participant 4)

Three months after the workshop, a case study staff member reported that the five-part model and the diagrams were welcomed by the client, who liked it and found it useful. The staff member involved felt that the client was more insightful into their own recovery journey, and was able to reflect on the good and bad aspects of the recovery journey or cycle, and cherished the gains they had got from it.

On the other hand, the case study staff member found the sort cards hard to use, as they were not in the client's language, and it was hard to translate each sort card on the spot. They reported that there are also many idioms in Asian languages that clients may use to express themselves, and these cannot be prepared in the sort cards. One case study staff member said she probably would not use the cards on most of her clients. This was because most were elderly clients and using the cards could seem disrespectful to the elderly. It may appear to the client that the support worker is trying to teach them how to recognise themselves or their own problems, and highly educated clients may find their use insulting and offensive. This relates to cultural characteristics of Asians, such as respect for the elderly, the hierarchical societal structure, and their need to save face.

However, the positive experience with sort cards related above suggests that adapting the cards for Asian clients and persevering with their use could have beneficial outcomes.

4.3.7 Adaptations to the RCM and WRAP

The following adaptations to the RCM and WRAP were suggested by participants.

The RCM

First stage: Maternal environment and genetics or temperament

Participants suggested that, when using the RCM with Asian mental health clients, staff may not need to go back as far as the first stage, the maternal environment, which requires talking about childhood experiences. This is because nearly all clients are immigrants and, in most cases, it is the migration experience that has triggered the mental health condition. Hence, delving into triggers that have arisen from the migration experience is more appropriate for these clients. This view is supported by other studies conducted in New Zealand with Asian immigrants, which show clearly that some Asian immigrants experience mental health problems that arise from the difficulties they encounter in trying to settle into New Zealand (e.g., Trlin, Henderson et al. 2004; Tse, Sobrun-Maharaj et al. 2006; Sobrun-Maharaj, Tse S. et al. 2009; Henderson, Jackson et al. 2010). International studies with Asian and other immigrants also support this view (e.g., Finch, Kolody et al. 2000; Aroian and Norris 2003)Avcan & Berry, 1996). However, it is acknowledged that how immigrants cope with settlement adversities would be determined by individual characteristics that stem from the maternal environment.

Furthermore, Asian clients clearly prefer to have their practical needs met and current issues dealt with first. Talking about childhood trauma and pre-migration problems, for example, may seem out of context to them. These practical needs usually involve dealing with employment and language issues, as well as other social issues, such as discrimination, which impact on their ability to settle well, which in turn impacts on their mental well-being. The impact of discrimination and unemployment on mental health has been documented by researchers in New Zealand and Australia ; New Zealand Immigration Service, 2003; Basnayake, 1999; Department of Internal Affairs, 1996), as discussed in the literature review in Chapter 2. Hence, participants consider that having clients' employment and language needs met, and discrimination issues dealt, with first is an important step in the recovery pathway.

Sort cards in the RCM

Staff identified both advantages and disadvantages to using sort cards. While these cards could be useful prompts in helping some Asian clients to express themselves, they could be inappropriate for others, such as the more educated or the elderly, who could regard their use as unproductive and even disrespectful. This is also associated with the Asian value of respect for the elderly and the educated, and for their wisdom. How amenable clients are to the use of sort cards could depend on their degree of acculturation to the New Zealand culture. Issues of allowing time for the cards' use, and of translating cards into the language and idiom of the client, were also raised. Participants suggested that their use be discretionary, based on the characteristics and needs of the client.

Five-part model in the RCM

The five-part model in the RCM is adapted from Padesky and Moonie (1990). The model helps to understand how a situation can affect one's thoughts, feelings, actions (behaviours) and sensations. It is understood that all these components (presented in Figure 2) can affect one another. Clients have found the five-part model a simple model, interesting, and often a relief to

use, because it allows them to see that their issues are interconnected and that small changes could make a difference (Padesky and Mooney 1990).

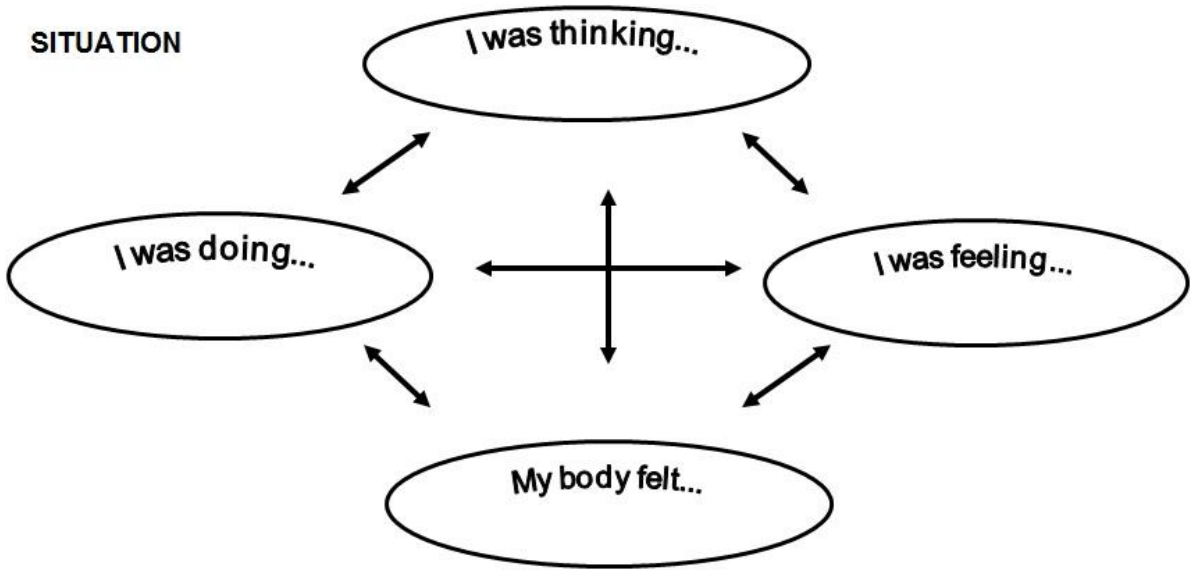


Figure 2. The 5-part model adapted from Padesky and Moonie (1990) in the Re-covery Model (Randal, Stewart et al. 2009)

Most Asians do not tend to talk about their own thoughts, feelings and body sensations, and tend to speak in the third person instead, i.e. about how others feel about them. Research has linked this practice to the collectivistic culture of Asians, where often groups are described, instead of the individual (Bigby 2003). Hence, participants felt the use of this tool should also be discretionary, and based on the level of acculturation and needs of the client.

This feedback is summarised in Table 2 below.

Table 2: Suggestions for the use of various components in the Re-covery Model

Component	Relevance and reasons	Suggestions
RCM – maternal environment and genetics or temperament	This does not appear to be the primary issue for Asian immigrants, as many mental health issues arise from the migration experience. Most Asians also prefer practical needs to be met and current issues to be dealt with first. Talking about childhood trauma or pre-migration problems may seem out of context.	Nearly all clients are immigrants, and migration experiences have usually triggered symptoms. These practical issues need to be dealt with, e.g. help given with employment and settlement issues.
Sort cards in RCM	Useful for some.	Staff can use the cards as prompts for clients to express feelings, thoughts, body sensations and actions related to the stressful situation.
	Using the cards may seem unproductive and disrespectful for the elderly and some educated clients. May seem like	Staff need to use their discretion. Clients who have been in New Zealand longer and are more

	playing card games.	acculturated may be more responsive to the method.
	Cards are not in client's language or idiom.	Cards can be translated into the client's language. The staff will have to know the client well to prompt the client with other things that are not on the sort cards, e.g. idioms. Other cards can be included, which detail immigration issues, such as work, happiness, etc.
Five-part model in RCM	Most Asians do not tend to talk about their own thoughts, feelings and body sensations, and tend instead to speak in the third person	The use of this tool should be discretionary and based on the level of acculturation and needs of the client.

The WRAP

The WRAP workbook

Staff reported that Asian clients do not use the WRAP workbook fully, but usually just talk about the contents, e.g. triggers, early-warning signs, crisis, post-crisis. They seldom write these things up in the workbook. This is reportedly because many Asian clients are reluctant to record this, as it gives permanence to the situation (see Hsiao, Klimidis et al. 2006). Also, because most Asians are private about mental health issues, recording things may risk breaching privacy.

The case study staff also reported that they usually do not have sufficient time to go through the workbook with clients. Instead they invite the client to fill out the workbook, which is usually seen as the client's homework before their next meeting. It may be that, if more time is allocated to specifically go through sections of the WRAP workbook with clients, clients will understand its usefulness and use the workbook more.

At the same time, clinicians in the project's cultural advisory group reported that they have clients who enjoy using the workbook and utilise it fully. This may be due to the hierarchical structure of Asian cultures and respect for authority, where clients are more likely to engage or do their homework when an authoritative figure, like a clinician, has initiated it. Support workers may not be seen as authoritative figures by some clients, but some may perceive themselves as authoritative in terms of their relationship with the client. This may be reflected in some of their interactions with their clients. Adopting an empathetic and egalitarian approach may help break down barriers that may exist and encourage clients to use the workbook.

Despite these issues, participants felt that the workbook is a useful tool, the use of which should be encouraged.

Advance directive in the WRAP

Participants reported that the advance directive is not sufficiently utilised by Asian clients. This is because most Asians prefer to depend on family when unwell, and believe that their family will provide the best support, decisions and options for them. Setting up an advance directive could conflict with this norm, or exclude some members of the family and break the trust within the

family. At present, staff are using the advance directive section more like an emergency contact list for the client. They tend to spend more time on this section with elderly clients, and feel that younger clients might be offended by introducing the advance directive, as they feel that it is only for people who are older and have terminal illnesses.

However, some young Asian clients are apparently beginning to see the value of this tool and staff are being encouraged to use it with them:

> *We encourage staff to utilise this section more often as it could provide very useful information for clinical teams during crisis situations or when the client is unable to make decisions for themselves.* (Participant 8)

This is summarised in Table 3 below.

Table 3: Suggestions for the use of various components in the Wellness Recovery Action Plan®

Component	Relevance and reasons	Suggestions
WRAP workbook	Useful, but insufficiently used. Clients usually just talk about the contents of the WRAP workbook and seldom write things up or use the workbook. Reluctance to record this, as it gives permanence to the situation. Could also be the effect of attitudes towards support workers who may not be seen as authoritative figures.	Support workers may need to adopt an empathetic and egalitarian approach to ensure equality and inclusion between support workers and clients, and spend more time on the workbook with the client to have them use the workbooks fully.
WRAP advance directive	Useful, but insufficiently used. Most Asians prefer to depend on family when unwell, and trust their support and decisions. Setting up an advance directive could conflict with this norm, or exclude family and break trust within the family.	Explain value of the advance directive to clients and families to avoid conflict and encourage setting up this tool. The tool is beginning to gain acceptance amongst Asians who understand its usefulness.

4.3.8 Cultural context

Participants emphasised the importance of cultural considerations when working with Asian mental health clients. These included the following.

Culture of the client

All participants strongly believed that taking into consideration the culture of the client is an extremely important step in the recovery pathway for Asian immigrants. This includes recognising that clients are cultural beings, with their own values and beliefs, which may not necessarily match those of the practitioner.

In terms of working with clients, staff recognised that being culturally competent and aware of one's own cultural values, beliefs and practices are important, in order to ensure that they do not impose their own values onto the client and cause conflict:

> *Staff have to be culturally competent first when using this integrated model (WRAP and RCM together) or else they can impose their cultural values and beliefs onto the client which might come into conflict with theirs.* (Participant 5)

Participants recognised the need for self-reflection to enable staff to understand themselves, which will in turn help them to develop understanding and empathy for others:

> *The first step of the new model needs to include cultural competency and self-reflection for service providers, we need more time for this*. (Participant 2)

Bigby (2003) says that self-awareness of one's own culture, biases and beliefs is a necessary step in developing cultural competence. The hierarchical structure of Asian cultures needs also to be understood by staff as this can have an impact on Asian staff relationships, which can impact on service provision. Breaking down such barriers that may exist between clinical and support staff would enhance service provision.

Culture-specific meanings of mental illness and recovery

Of particular significance to mental health recovery is the understanding of the concepts of mental illness and recovery by Asian clients. Both these concepts may not exist, or may be repressed or understood differently by the different Asian cultures, as shown in the literature (e.g., Lehti, Hammarström et al. 2009). These authors emphasise the need to understand these concepts, and to be able to examine variable language and culture-specific symptomatology to obtain an accurate diagnosis, and provide appropriate and effective intervention.

For most Asian clients, recovery equates with the absence of medication (Ng, Pearson et al. 2008). Hence, most Asians prefer to avoid medication (a "life-long pill") and would rather focus on overall wellness. Culturally appropriate forms of treatment, such as spiritual treatment, yoga and meditation, tai chi, Chinese and Ayurvedic treatments, and focussing on the enhancement of well-being, could assist the recovery process.

Significance of family

As collective societies, family is of primary importance to all Asians. As shown in other New Zealand studies (e.g., Tse and Hoque 2006; Dixon, Tse et al. 2009; Sobrun-Maharaj, Rossen et al. 2010), all members of the nuclear and extended family are usually included in decision-making, which impacts on the help-seeking strategies employed by most Asian clients. Hence, it is important to include the family in the recovery process, and work around issues of privacy and confidentiality.

Including the family will empower the whole family, rather than the individual, as suggested in the following quotations:

> *Training emphasising on empowerment of the whole family will be more helpful than self-empowerment of the individual Asian client.* (Participant 3)

> *Training can encompass family's empowerment as mentioned before. However, family dynamics and issues might have to be addressed first or as part of the recovery process.* (Participant 4)

This is consistent with the literature (e.g., Stanhope 2002; Hsiao, Klimidis et al. 2006) that stresses the importance of having family involvement. It is important that not only the individual (consumer) is empowered, but also the family. Clients and family may need time to understand the various practices in the mental health system, for example, informed consent.

Understanding the consumer's family structure within their culture could assist the mental health professional in determining what approaches to take, in terms of inclusion of family in the consumer's recovery process. This could lead to more effective treatment and appropriate services being provided.

Children were also mentioned as important members of the family that should be included, as they have an influence on a parent's or family member's recovery:

> *When you talk about family, children get neglected…children connect with the parents much better. Any parent, being a parent myself, when your child tells you something is wrong, you need to see a doctor, the parent will listen. Like if my mother tells me to see a doctor, I won't. So there's one channel being listened to more, so should be included more.* (Participant 6)

In Asian communities, the client's family (or significant other) is usually involved with the client's care, and often has a strong connection with the client or to the client's social network. When the family (or significant other) is provided with the right information and resources, they can contribute significantly to the client's well-being.

For example, families or significant others of the client can: provide baseline information about presenting symptoms and mental health history; give information about other relevant behaviours (e.g. substance abuse, legal history); assist in engaging the family's support in medication and treatment compliance; yield information about other key social supports and consumer resources; help maintain or develop support for the consumer through his or her involvement; and enhance treatment outcomes through family education and support activities. However, involving family should be based on the discretion of the service provider, who would need to take into consideration issues of privacy and confidentiality.

Help-seeking strategies

The concept of saving face plays a significant role in the lives of most Asians. Hence, Asians prefer to deal with their problems themselves, or keep them within the family and not discuss them with strangers. Consequently, they present to service providers at a late stage when the mental health problem has exacerbated, and are reluctant to engage fully even after presentation. Because family is paramount to Asians, involving family in discussions and decision-making would alleviate this problem, and assist, and perhaps expedite, recovery.

Hierarchical relationships within Asian cultures may impact on help-seeking strategies. As discussed earlier, elderly and more educated Asians may avoid seeking help, as some may not wish to be "taught" by others when they are faced with problems, and some may not feel

comfortable with taking instructions from strangers, particularly those younger than themselves. An empathetic approach could be adopted by service providers, rather than a hierarchical one.

These cultural considerations are summarised in Table 4 below.

Table 4: Summary of cultural context important to Asian consumers in recovery

Component	Implications and reasons	Suggestions
Culture of client	Values, beliefs and understandings may be different from the practitioner's and could cause conflict.	Be aware of own culture and gain cultural competence to facilitate understanding and empathy.
The meaning of recovery and mental illness	Absence of medication as recovery.	Utilise Asian models of health, including alternative, culturally appropriate treatments, such as spiritual treatments, yoga and meditation, and tai chi to enhance overall well-being, and Chinese and Ayurvedic treatments to combat the side-effects of Western medicine. These could reduce anxieties about taking a "life-long pill".
	Stigma attached to mental illness, hence most Asians prefer to talk about overall well-being, rather than focus on mental health.	Sharing their recovery experiences would empower consumers. Overall well-being needs to be emphasised, e.g. psycho-education on recovery, and focusing on other areas of life for well-being, such as stress management and decreasing stigma.
Significance of family	Family is of primary importance in collective societies, hence it needs to be included in recovery programmes.	Involve family in the recovery process by inviting family to participate. They need to be included in the recovery process from the beginning when trust and rapport is being established.
Help-seeking strategies of Asian people	Asians are generally private people and prefer to deal with problems themselves or keep them within the family.	Involve family in discussions and decision-making.

Summary

This chapter has discussed the knowledge, skills, attitudes and behaviours of the Waitemata District Health Board Asian Health Support Service staff that support or impede implementation of recovery principles. It has also discussed the Asian staff's cultural beliefs and practices that influence implementation of recovery principles with Asian clients, and the appropriateness and impact of the WRAP and RCM on staff knowledge, attitudes and behaviours about recovery. The significant findings are:

- Asian staff are aware of their role as a provider, and are providing culturally appropriate care at the client's pace
- understandings of recovery are different for Asians: recovery usually means being symptom and medication free
- many Asians are unfamiliar with Western models of recovery and prefer Asian models that emphasise spirituality, balance, and overall health and well-being
- Asians have a hierarchical social structure that respects authority. Hence, clients often expect to be prescribed to by providers and may not actively participate in their recovery
- Asian societies are collective, hence family is important and should be included in treatment and recovery processes
- there is intense stigma attached to mental illness. Hence, mental illness is often concealed, and the notion of living normally again after having mental illness is still not accepted
- most Asians avoid risk-taking, e.g. changing medication, which may impact on the clinician and client relationships, and treatment and recovery plans
- overall, the staff's recovery-orientation increased after the workshop training using the WRAP and the RCM
- the WRAP and the RCM appear to be appropriate for Asians, but some aspects could be adapted to be more culturally and contextually appropriate, e.g. considering the cultural context, including culturally appropriate tools, and considering the impact of the migration experience on mental health.

5 Conclusion

This chapter presents a response to the fourth objective of the study, which is to adapt the training packages applied during the course of the study, i.e. the WRAP and the RCM, for use by Asian mental health cultural support staff. It draws together the purpose and value of the study, and makes recommendations for the adaptation of the training package. A culturally appropriate model of delivery is presented, which has been developed for Asian mental health cultural support staff. This needs to be tested further. The model utilises components of the WRAP and the RCM, and adds other components that have emerged from the data as appropriate for Asian immigrant mental health consumers. The chapter also discusses implications for providers and policy makers.

5.1 Purpose and value of the study

The purpose of this study was to evaluate mental health recovery training for Asian staff of the Asian Health Support Service at the Waitemata District Health Board and to assess the staff's knowledge, skills, attitudes and behaviours that support or impede implementation of recovery principles. The study conducted workshops, during which a refresher WRAP course was provided, which is the usual training procedure for the Asian Health Support Service's staff, and the RCM was introduced as an additional model that could enhance their knowledge. These two models were evaluated through pre- and post-tests, which evaluated change in knowledge and behaviours, and through qualitative data acquired from participants.

The timeframe of this study was short, allowing only limited time for working with the RCM, which requires much more time for optimal outcomes. Despite this limitation, the findings presented in Chapter 4 show that additional training using the WRAP together with the RCM increased the staff's recovery orientation. This suggests that more work with this integrated and adapted model may have potential for further increases in recovery orientation amongst Asian staff.

The study has provided valuable information about Asian cultural concepts, and Asian staff's beliefs and practices, which has informed the development of a model of delivery based on the adaptation and integration of the WRAP and the RCM. This suggested model could be used by Asian staff with Asian service users after further testing. The study, therefore, has value in its potential to inform the adaptation of the WRAP training and the RCM training and to influence recovery training for all staff across New Zealand who work with Asian service users. The information provided by the study will also help to develop an appropriate and responsive clinical service for Asians that works towards the goal of reducing mental health problems and disorders in the New Zealand community.

5.2 Recommendations for adaptation of the training package for Asian staff working with Asian mental health clients

The WRAP and the RCM have proved to be useful models for training Asian mental health cultural support workers. However, the study has revealed some gaps and inadequacies in the models in the context of Asian immigrant mental health. Modifications to these models would enhance them for use with Asian support workers working with Asian immigrants. The following recommendations are made for the adaptation of the RCM and the WRAP, and of the training package, for Asian staff. These recommendations are derived from suggestions made by

participants, based on their experience of working with Asian mental health clients and the training they received at the workshops conducted during this study.

5.2.1 Adaptation of the models

The following adaptations to the RCM are recommended.

- The migration experience is explored for triggers when working with Asian immigrant clients, rather than the maternal environment, which may not be the primary issue for some clients whose mental health concerns appear to arise from the migration experience. However, it is acknowledged that how immigrants cope with settlement adversities would be determined by individual characteristics that stem from the maternal environment.
- Use of sort cards in the RCM is discretionary, based on the characteristics and needs of the client. For example, the elderly and the more educated appear to find their use unproductive. Sort cards could be modified to be contextually and culturally appropriate, e.g. include immigration triggers in appropriate languages.
- Use of the five-part model in the RCM should also be discretionary. Because Asians are collectivistic, they generally do not focus on the individual. Hence, some have difficulty focussing on personal feelings, and would rather talk in terms of the third person. They also prefer to answer questions in a non-directive way, referring to a third party rather than themselves.

The following recommendations are made for the use of the WRAP.

- The use of the workbook should be encouraged by using more culturally appropriate approaches, for example, working with family, and introducing Asian models, such as tai chi and yoga in the wellness toolbox.
- Staff are encouraged to use the advance directive as appropriate.

5.2.2 Adaptation of the training package

Based on the data presented in Chapter 4, the following recommendations are made for the adaptation of the training package for Asian staff working with Asian immigrant mental health clients.

- The WRAP continues to be utilised, with the emphases recommended above, as its tools are useful for Asian clients.
- The RCM is introduced into the training package, with the adaptations recommended above, as it increased the knowledge and understanding of staff during the workshops, and has some useful tools that can be used with Asian clients, e.g. the Building a Bridge of Trust and the Feelometer.
- The migration experience is included as a significant component in the delivery model used for treatment, as it is reported to be a major source or trigger of mental health problems for Asian immigrant clients.
- Culture should be emphasised in training, as it is a significant component. Cultural competency training should be compulsory for all core and bureau staff, with ongoing refresher courses to ensure that staff understand and appreciate the impact of culture on clients, staff and service provision. Cultural competency is also necessary at an organisational level and not only at an individual level.

- Self-reflection is included and emphasised as a component of cultural competency training, to enable empathy and improve service provision.
- The family should be a significant component of the recovery process, to form a triadic relationship, rather than a dyad between service provider and individual client.
- Practical needs of clients should be worked with first, especially those associated with the migration experience, as this can alleviate or eliminate some mental health problems.

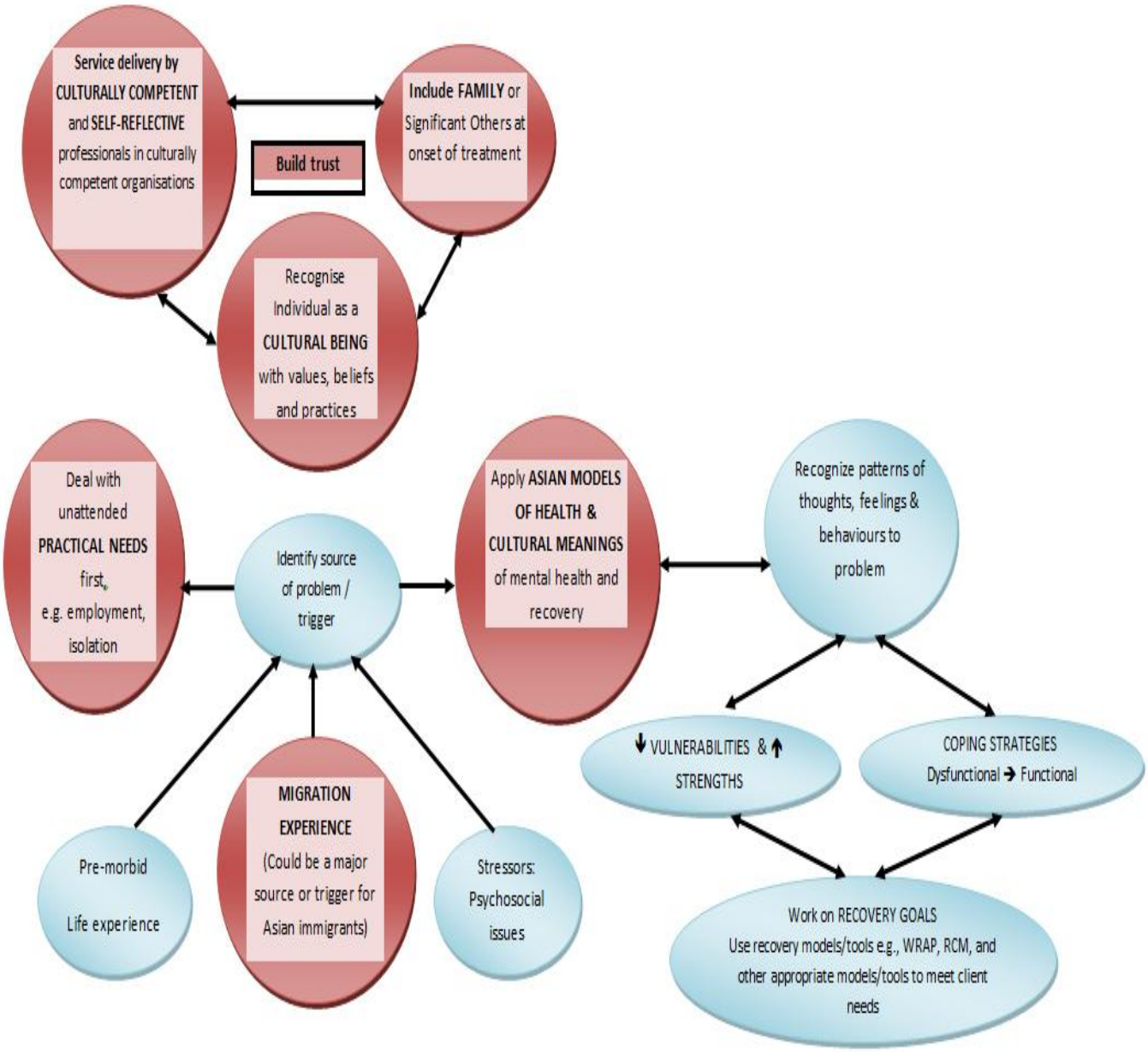
These recommendations have been incorporated into the WRAP and RCM to create a suggested model of delivery for Asian mental health clients. The following significant components have been included: cultural competency and self-reflection for staff; inclusion of family in client care; building trust; recognition of individual as a cultural being; dealing with practical needs; recognising the migration experience as a major source or trigger; and applying Asian models of health and cultural meanings of recovery. These components, and examples of where and how they could be used, are shown in Table 5.

Table 5: Components to be included in model of delivery

Component	How and when it could be included
Cultural competency and self-reflection for staff	Cultural competency training should be provided to all mental health workers prior to working with clients. This should include self-reflection to create awareness about one's own culture, beliefs and practices, and their implications for service delivery. The organisation should also be culturally competent, not just the individual.
Include family in client care	It is important for the support worker to include family in the treatment process from the onset of treatment, and to work within this triadic relationship rather than a dyad.
Build trust	Build trust with the client at the beginning of the treatment process by including family and recognising the cultural context of the client.
Recognition of individual as a cultural being	Determine the cultural context of the client at the beginning to ensure understanding and empathy – the client is a cultural being with values, beliefs and practices that impact on treatment.
Deal with practical needs	Asian immigrant clients usually have practical issues associated with settlement that need to be resolved first, e.g. employment, isolation. This needs to be determined and worked with, before delving into other mental health issues.
Recognise the migration experience as a major source or trigger	The migration experience is usually a major source of mental health issues for Asian clients or a trigger for dormant issues. This needs to be considered at the onset and these issues dealt with first, as they may eliminate or alleviate mental health problems.
Apply Asian models of health and cultural meanings of recovery	Utilise Asian models of health where possible and appropriate, such as Chinese and Ayurvedic models, and consider cultural meanings of recovery for each client and how this may impact on treatment.

This proposed model of delivery is depicted in Figure 3. The components in pink represent aspects that are significant for Asian clients and need to be emphasised in delivery. Some of these components, e.g. working with family and building trust, are already included in the WRAP and RCM, but need further emphasis. The components in blue are taken from the WRAP and the RCM.

Figure 3: Model of delivery for Asian mental health showing significant components for Asian clients in pink, and WRAP and RCM components in blue



5.3 Implications for policy-makers

Information from the study indicates that policy-makers would need to accommodate the following to enhance service provision for Asian mental health clients.

5.3.1 Provide cultural competency training for Asian service providers

Cultural competency training for Asian mental health service providers was unanimously identified by participants as a prerequisite for working with Asian mental health clients. This is supported by other authors who state that to provide more appropriate services, mental health practitioners must become more skilled in interacting with Asian people, and more knowledgeable about the profound and intrinsic impact of cultural factors on the prevention, presentation and treatment of mental health issues, and on every aspect of training and psychotherapy (Falender and Shafranske 2006). Although Asian cultures have many commonalities, they also have significant differences, which need to be understood by both Asian and non-Asian service providers.

The WRAP and RCM provide some opportunities for consideration of culture. However, participants felt that more robust training in cultural competency is needed to ensure effective and culturally appropriate services. It is important that cultural competency is achieved at an organisational level and not only at an individual level. Proponents of the cultural competency training could build on the strengths of earlier concepts such as cultural awareness and self-reflection, and extend them further to facilitate changes in other dimensions of practice, at the level of the health professional, as well as at the organisation and system level (The Lewin Group Inc., Linkins et al. 2002).

5.3.2 Develop specific guidelines for cultural assessment of clients

A gap identified by participants of the study is that there are no specific guidelines for cultural assessment of clients. At present, the Asian Mental Health Cultural Support and Coordination Service team's cultural assessment involves questions about the client's cultural background, e.g. how long has the client been living in New Zealand? These questions were developed by Dr Sai Woh Wong, a Chinese cultural psychiatrist in the mental health field. The staff and Dr Wong are in the process of developing a more specific cultural assessment tool. Assessments of the client's cultural issues need to be done regularly, as they change as the client acculturates to New Zealand culture. Participants suggested that update prompts for cultural information should be in the system, so that all staff can easily update information about the client.

5.3.3 Utilise Asian models of health where possible

Participants felt strongly that Asian models of health should be utilised where possible, as current health models used are based on Western concepts of illness and recovery, which are not always compatible with Asian concepts of health.

This is summarised in Table 6 below.

Table 6: Summary of policy implications

Component	Reasons and justifications	Implications for policy-makers
Cultural competency for Asian service providers	All staff supporting mental health consumers need to be culturally competent, that is, be aware of their own cultural values, beliefs, practices, attitudes, behaviours, and those of others, and of how these could influence their professional practice when supporting the client in recovery. Currently cultural competency training is not a prerequisite for staff.	Cultural competency training should be provided to all mental health workers prior to working with clients.
Guidelines for cultural assessment of clients	There are no specific guidelines for cultural assessment of clients. Assessments of the client's cultural issues need to be done regularly, as they change as the client acculturates to New Zealand culture.	Develop and regularly update guidelines for assessment of clients.
Asian models of health	Current health models used are based on Western concepts of illness and recovery, which are not always compatible with Asian concepts of health.	Utilise Asian models where possible and appropriate, such as Chinese and Ayurvedic models.

5.4 Implications for providers

Information from participants suggests that providers would need to accommodate the following steps in the recovery process when working with Asian immigrant clients.

5.4.1 *Build trust*

The Asian cultural characteristics, attitudes and behaviours discussed in previous chapters underline the importance of building trust with the client and their family. Trust building is a crucial and initial step health professionals need to take with Asian clients, who generally do not like disclosing information to outsiders. Developing trust between the professional and the client and their family will facilitate the recovery process. The Building a Bridge of Trust and the Feelometer in the RCM are good tools to use with clients and their families to build trust initially. The Bridge of Trust is illustrated below.

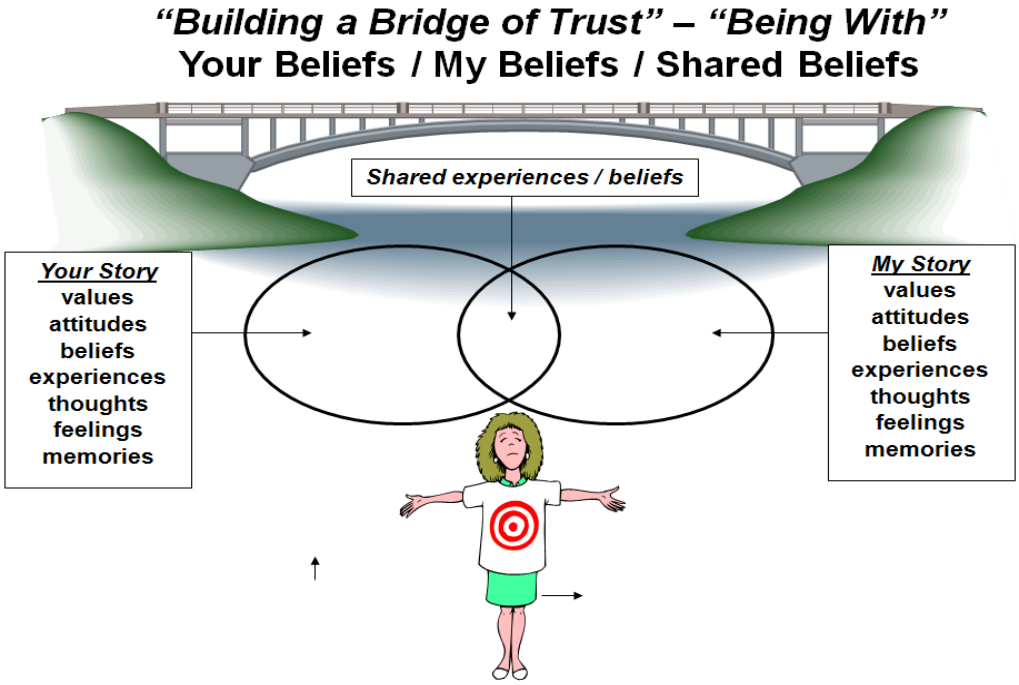


Figure 4. The Bridge of Trust diagram presented in the Re-covery Model (Randal, Stewart et al. 2009)

5.4.2 Work with practical needs

Reports suggest that Asian clients prefer to have their practical needs met first, such as finding employment. Often taking care of these issues alleviates mental health problems. However, staff are not expected to deliver such services and training does not include preparation for this, but some choose to assist with this where possible, as staff believe this benefits recovery. To do this, staff need to be aware of available community resources, in order to make appropriate referrals and to support the client fully in other areas of their life that will affect their mental health. As recovery is not a linear journey, the client will have different needs at different times. It is also important to work at the client's pace, hence, more time may be required with clients.

5.4.3 Recognise the impact of the migration experience on mental health

The migration experience is clearly significant for mental health amongst Asian immigrants. The migration experience could either be a cause of mental health problems, or a trigger for previous mental health issues. Hence, this component needs to be focussed on with most Asian immigrant clients. The consumer and family may face barriers, such as inadequate English language skills, lack of social support, unemployment and financial problems, racism, discrimination, acculturation and cultural conflict, isolation and loneliness, and other psycho-social issues, or, if prior mental health issues existed, these may be triggered by the migration experience. Also, coping strategies employed in the country of origin may no longer work in the New Zealand environment. In such cases, eliminating or alleviating stresses associated with the migration experience could have a positive impact on clients' mental health, and in some cases, may eliminate the problem. The focus on the migration experience brings issues that are present into context, and it may also initiate discussion of pre-migration issues with the support worker.

These implications of the migration experience are summarised in Table 7 below.

Table 7: Summary for providers of implications of the migration experience important to Asian consumers in recovery

Component	Reasons and justifications	Implications/suggestions
Work with family and build trust with client	This is accommodated in the WRAP and the RCM, but needs more emphasis. Asian immigrants are collectivistic. It is important for the support worker to include family, in order to build trust with the client and to fully support them.	The Bridge of Trust and the Feelometer in the RCM are useful tools for this.
Work with practical needs	This is not expected of support workers. Asian clients prefer to solve current issues first and be provided with the practical means to move on. This will enable the client to progress to the next stage of talking in depth about recovery aspects.	Staff need knowledge of available community resources to assist with practical needs. They also need to work at the client's pace.
Focus on the migration experience	Current training does not focus on the migration experience and its impact on mental health. The migration experience could either be a cause of mental health problems or a trigger for previous mental health issues.	Help client to solve practical settlement problems. Coping strategies can be outlined that suit the client's cultural background.

5.5 Limitations of the study

The study has some limitations, which are acknowledged below.

- The time-frame of the project was short, which did not allow sufficient time: between pre- and post-measures; between the workshop and post-measures; for case studies; and to test the suggested model of delivery. Within the short timeframe, the workshop enabled introduction to the RCM, but not in-depth uptake. This requires further work.
- The sample size was small (N=11), due to the small team of support workers in the Waitemata District Health Board Asian Mental Health Cultural Support and Coordination Service (N=21). Hence, findings cannot be generalised. While all core staff of this team participated in the project, it was difficult to recruit all of the bureau staff who are part-time employees.

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