ASIAN MENTAL HEALTH AND ADDICTION RESEARCH AGENDA FOR NEW ZEALAND 2008-2012

Te Pou o Te Whakaaro Nui
The NATIONAL CENTRE of MENTAL HEALTH RESEARCH, INFORMATION and WORKFORCE DEVELOPMENT
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RESEARCH
TRANSLATING RESEARCH

Citation: Te Pou. (2008). *Asian Mental Health and Addiction Research Agenda for New Zealand 2008-2012.* Auckland: Te Pou, The National Centre of Mental Health Research, Information and Workforce Development.

Published in December 2008 by Te Pou o Te Whakaaro Nui: The National Centre of Mental Health Research, Information and Workforce Development. PO Box 108 244, Symonds St, Auckland 1150, New Zealand

ISBN 978-0-9582904-3-2

This document is available on the Te Pou website: www.tepou.co.nz.

ACKNOWLEDGEMENTS

Te Pou would like to extend our sincere acknowledgements and thanks to the following people.

- Members of Asian, refugee and migrant communities in New Zealand, and staff from the New Zealand mental health and addiction sector and key support agencies, for sharing their experiences and providing feedback on the research agenda.

- The project reference group for providing ongoing advice, support and peer review for the research agenda:
  - Patrick Au: Asian Mental Health Services Coordinator, Auckland District Health Board
  - Ruth De Souza: Senior Research Fellow, Auckland University of Technology (AUT), and Coordinator of AUT Centre for Asian & Migrant Health Research
  - Gary Poole: Chief Executive of Refugees as Survivors
  - Sue Lim: Manager of Asian Health Support Services, Waitemata DHB
  - Anil Thapliyal: General Manager, Lifeline Aotearoa New Zealand
  - Samson Tse: Associate Professor, The University of Auckland's School of Population Health and Director for Centre of Asian Health Research & Evaluation
  - Ivan Yeo: Like Minds Like Mine Project Worker, Mental Health Foundation.

- Janet Chen for managing the Phase II consultation and supporting research question development.

- Nemu Lallu and Annette Mortensen for technical advice and peer review.
  - Nemu Lallu: Project Manager, Population Health Directorate, Ministry of Health.
  - Annette Mortensen: Project Manager, Auckland Regional Settlement Strategy, Northern DHB Support Agency.

- Ruth DeSouza, Elsie Ho and Samson Tse for peer reviewing the final draft.
  - Elsie Ho: Senior Research Fellow, Migration Research Group, University of Waikato.
  - Ruth De Souza: AUT Senior Research Fellow and Coordinator of AUT Centre for Asian & Migrant Health Research.
  - Samson Tse: Associate Professor, The University of Auckland's School of Population Health and Director for Centre of Asian Health Research & Evaluation.

- Martin Molloy, Te Pou project lead for Asian workforce development, for stakeholder advice and planning assistance.

- WISE Management Services for the administrative and publication support.

- The Ministry of Health for commissioning this project.

The report was written by Jenny Long and Jane Vanderpyl.
December 2008.

CONTENTS

ACKNOWLEDGEMENTS 3

CONTENTS 4

EXECUTIVE SUMMARY 6

- PROJECT BACKGROUND 6
- METHOD 6
- RESEARCH TOPICS IDENTIFIED 6
- RECOMMENDATIONS 7

INTRODUCTION 9

- PROJECT BACKGROUND 9
- NEED FOR THE AGENDA 9
- WHO CAN USE THE AGENDA? 9
- REFUGEE AND MIGRANT RESEARCH AGENDA 10

CONTEXT: ASIAN COMMUNITIES AND MENTAL HEALTH AND ADDICTION 11

- DEFINITION OF 'ASIAN' 11
- POPULATION 11
- POPULATION HETEROGENEITY 11
- NEW ZEALAND SERVICE RESPONSE TO ASIAN MENTAL WELL-BEING 12
- MENTAL HEALTH AND ADDICTION DEFINITIONS 13

DEVELOPING THE RESEARCH AGENDAS 14

- PHASE I 14
- PHASE II 14
- PHASE III (ASIAN SPECIFIC) 15
- FIGURE 1. AGENDA DEVELOPMENT PROCESSASIAN RESEARCH AGENDA 17

ASIAN RESEARCH AGENDA 18

- AGENDA OVERVIEW 18
- THE 'ASIAN' CATEGORY IN RESEARCH 18
- UNDERSTANDING THE CONTEXT 20
  - 1. Prevalence of mental illness and addiction within specific Asian communities in New Zealand 20
  - 2. Understanding risk and protective factors for mental well-being among Asian communities 23
- INTERVENTIONS 26
  - 3. Developing mental health promotion to improve mental well-being among Asian communities 26
  - 4. Improving the service access of Asian communities in New Zealand 30
  - 5. Enhancing New Zealand's primary health responses to mental illness and addiction in Asian communities 34
  - 6. Enhancing the responsiveness of New Zealand's mental health and addiction services for Asian communities 36
- WORKFORCE DEVELOPMENT 39
  - 7. Developing New Zealand's workforce to provide culturally appropriate mental health and addiction care for Asian communities 39

DISCUSSION 42

- RESEARCH AGENDA CONTEXT AND VALUE 42

AGENDA DEVELOPMENT AND KEY RESULTS 42
SOME METHODOLOGICAL CONSIDERATIONS 43
AGENDA IMPLEMENTATION 45
RECOMMENDATIONS 47
CONCLUSION 47
REFERENCES 48
APPENDIX A – ORGANISATIONS AND COMMUNITY GROUPS CONSULTED 54
APPENDIX B – IMPLEMENTATION OF CRITICAL RESEARCH QUESTIONS 56

EXECUTIVE SUMMARY

PROJECT BACKGROUND

Two major government policy documents, namely, *Te Tāhuhu – Improving Mental Health 2005-2015* and *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015* have identified the need to develop a research agenda for mental health and addiction in Asian communities. Te Pou was commissioned by the Ministry of Health to develop a national research agenda that would identify targets or priorities for mental health and addiction research for New Zealand's Asian population in the next three to five years. A separate agenda has been developed by Te Pou to identify priorities for New Zealand's refugee and migrant populations[1]. However, a number of areas in the classification and needs of Asian, refugee and migrant communities overlap.[2]

This agenda is intended as a resource for students, researchers, funders of research, and those interested in mental health and addiction in Asian communities.

METHOD

This Asian mental health and addiction research agenda brought together people representing Ministry of Health, district health boards and primary health organisations, government agencies, government and non-government service providers, Asian, refugee and migrant community representatives, service users, and New Zealand researchers. The different priorities suggested by each group were considered, synthesised and compared with existing literature then revised to form a final set of research questions. The answers to these research questions will provide important information to influence service and policy responses to Asian mental health and addiction needs.

RESEARCH TOPICS IDENTIFIED

Identified research needs are organised in seven topics relating to three broad themes.

Understanding the context

1. Prevalence of mental illness and addiction within specific Asian communities in New Zealand.

Research is needed to address the gaps in knowledge about the prevalence of mental illness for New Zealand's Asian population and specific Asian sub-groups.

2. Understanding risk and protective factors for mental well-being among Asian communities.

Further work is needed to investigate the impact of New Zealand's policies and services to address risk and protective factors, and to identify the most important risk and protective factors for addiction in Asian communities.

1 Te Pou. (2008). *Refugee and migrant mental health and addiction research agenda for New Zealand 2008-2012.* Auckland: Te Pou, The National Centre of Mental Health Research, Information and Workforce Development.

2 For example, a new migrant who arrives in New Zealand may have done so on a refugee status application and may be of Asian origin.

Interventions

3. Developing mental health promotion to improve mental well-being among Asian communities.
Little is known about the impact of either different mainstream or culturally-targeted mental health promotion interventions on mental health and well-being in Asian communities.

4. Improving the service access of Asian communities in New Zealand.
More research could support the development and evaluation of strategies to improve service access for Asian people in New Zealand who experience mental illness.

5. Enhancing New Zealand's primary health responses to mental illness and addiction in Asian communities.
The quality of assessment and treatment of the mental health concerns of Asian clients within primary care services is unknown.

6. Enhancing the responsiveness of New Zealand's mental health and addiction services for Asian communities.
There is a need for research to test what types of mental health services and treatment approaches will be most useful for Asian communities.

Workforce development

7. Developing New Zealand's workforce to provide culturally appropriate mental health and addiction care for Asian communities.
Research is needed to investigate what cultural competencies are most important for improving treatment outcomes, what are the best ways to train and support these competencies in New Zealand's workforce.

Many of the above research topics extend previous research by focusing on measuring the impact of service initiatives on mental health, not just measuring service access or service user satisfaction. By addressing the knowledge gaps outlined in this agenda, researchers and funders can enhance future planning to deliver better and more appropriate services, and support and enhance mental well-being in Asian communities.

RECOMMENDATIONS

The following recommendations are designed to support agenda implementation, the expansion of research and information on Asian mental health and addiction, and translation of this agenda into improved mental well-being for Asian communities.

1. Establish research collaborations among service providers, researchers and members of the Asian community to enhance the knowledge transfer of research findings for providers and the community.
2. Researchers consider differences among Asian sub-groups, use technically and culturally sound research methodologies, and advocate for oversampling of Asian communities in national surveys.
3. Multiple agencies commit to funding the research priorities outlined in this report.

4. Form an on-going stakeholders group to lead the monitoring of the agenda, further prioritisation, and dissemination of research findings.
5. Disseminate research findings widely to service providers and Asian communities.

The strategic and consultative nature of this research agenda acknowledges the importance of developing research that considers public needs. Funding of priorities, dissemination of research findings, and service provider and community engagement are crucial to the translation of research into improved mental well-being of Asian communities in New Zealand.

INTRODUCTION

PROJECT BACKGROUND

Recent Ministry of Health plans have emphasised the need for mental health and addiction services to be responsive to Asian communities. *Te Tāhuhu – Improving Mental Health 2005-2015* challenged the mental health and addiction sector to respond to the "unique needs of special population groups" such as "Asian communities". In *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015,* an Asian mental health and addition research agenda was identified as a specific action to support responsiveness to Asian people (p.31). Furthermore district health boards (DHBs) have a responsibility to "improve, promote and protect the health of the population within their district" under the New Zealand Public Health and Disability Act 2000 (section 22). Addressing the health needs of people of Asian ethnicity is a component of this responsibility.

In this context, Te Pou was commissioned by the Ministry of Health (MOH) to develop an Asian mental health and addiction research agenda that identifies target topics and priorities for research in the next three to five years.[3] The development involved collaboration with key stakeholders, including the MOH, DHBs and primary health organisations (PHOs), other government and non-governmental agencies and service providers, Asian community representatives and service users, and New Zealand researchers. The agenda aims to help support and enhance mental health and well-being for New Zealand's Asian population. It is envisioned that many agencies will support implementation of the research agenda.

NEED FOR THE AGENDA

A variety of information is required to address the mental health and addiction needs of Asian communities. Steps must be taken to identify what the needs of these communities are, understand the causes of mental health and addiction, and test the effectiveness of different service responses in addressing these needs. At present little is known about the prevalence of mental illness and addiction disorders within New Zealand's Asian communities and what services and mental health promotion approaches are most appropriate for different Asian ethnic groups (Ho, Au, Bedford & Cooper, 2002; Kumar, Tse, Fernando & Wong, 2006). This information is vital to influence service developments that will be responsive to the mental health and addiction needs of Asian people living in New Zealand.

WHO CAN USE THE AGENDA?

This agenda can be used by funding agencies, students, DHBs, other service providers and researchers looking to fund and/or undertake research on mental health and addiction needs of Asian communities in New Zealand. The questions address the impact of a range of different agencies, interventions and sectors on mental health. Thus, a range of agencies are expected to be interested in supporting and undertaking questions outlined in this agenda. The research

3 The Asian agenda overlaps with the refugee and migrant research agenda also developed by Te Pou. A Pacific agenda has been developed by Le Va and a Maori research agenda has been mental health and addiction developed by Te Rau Matatini.

questions have been framed broadly so that researchers can design studies which contribute to particular aspects of a question.

REFUGEE AND MIGRANT RESEARCH AGENDA

This Asian mental health and addiction research agenda was developed in parallel with the mental health and addiction research agenda for refugee and migrant communities.[4] More precisely, the initial round of question development and community consultations were conducted in a single process. However, further literature review, consultation and question development were conducted separately for each population.

Areas of overlap in the classification and needs of Asian, refugee and migrant communities complicate the scope of this Asian mental health and addiction research agenda[5], and the refugee and migrant research agenda. Literature, issues and questions that are specific to refugees, or relate to issues around resettlement, are covered in the refugee and migrant research agenda. Issues common to people of Asian ethnicity, which are irrespective of whether they are from a refugee, recent migrant or long-term migrant background, are covered within this Asian agenda.

4 Te Pou. (2008). *Refugee and Migrant Mental Health and Addiction Research Agenda for New Zealand 2008-2012.* Te Pou, The National Centre of Mental Health Research, Information and Workforce Development.

5 For example, a new migrant or refugee may be of Asian origin.

CONTEXT: ASIAN COMMUNITIES AND MENTAL HEALTH AND ADDICTION

DEFINITION OF 'ASIAN'

Asian is used to refer to people originating in the Asian continent, east of and including Afghanistan, and south of and including China (Rasanathan, Craig, & Perkins, 2006a).

This report follows the official Statistics New Zealand (1996) definition of 'Asian' which is paraphrased above. This definition is used by the MOH and within the research community (Rasanthan, et al 2006a; Workshop organising team, 2005). International definitions of 'Asian' differ from New Zealand's definition (Ministry of Health, 2006a; Rasanthan et al., 2006a). For example, the United Kingdom definition refers to people from South Asia but is not used to describe people from East and South-East Asia. In New Zealand 'Asian' refers to self-identified ethnicity and is not necessarily equivalent to race, country of birth or ancestry (Aspinall, 2003; Kumar et al., 2006; Rasanathan et al., 2006a).

POPULATION

Asian is the fastest growing ethnic population in New Zealand. The Asian population is predicted to increase to 790,000 or 16 % of the total population by 2026, from 400,000 at the 2006 census (Statistics New Zealand, 2008). On average, the population is relatively young; in 2006 31 % were between 15 and 29 years and only 5 % were aged over 65 (Statistics New Zealand, 2007).

POPULATION HETEROGENEITY

People classified under the broad Statistics New Zealand category of 'Asian' vary widely in their country of origin, religion, languages, culture and pre-migration experiences (Ho et al., 2002; Kumar et al., 2006; Ministry of Health, 2006a). Thus, categorising or researching Asian communities as a single group is often criticised[6] (e.g. Ho et al., 2002; Kumar et al., 2006; Ministry of Health, 2006a; Rasanthan et al., 2006a; Workshop organising team, 2005).

Asian migrants come from many different nations and identify with a range of ethnicities. The most common ethnic identity is Chinese followed by Indian and Korean (Statistics New Zealand, 2007). The next largest ethnic sub-groups are the Filipino, Japanese, Sri Lankan and Cambodian. Some Asian ethnic sub-groups have grown at particularly fast rates in recent years. The population of Indian, Korean and Filipino people in New Zealand more than doubled between 2001 and 2006 (Statistics New Zealand, 2007).

Each of these groups is unique in terms of settlement histories, cultural affiliations, languages, socioeconomic status, education and health status (Ho et al., 2002; Ministry of Health, 2006a). Within Asian ethnic groups individuals also differ in social and demographic characteristics. Between group and within group differences have important implications for research and health service delivery,

6 For further discussion on the utility of the term 'Asian' please refer to Issues and options paper: *The use of the term 'Asian' in New Zealand and implications for research, policy development and community engagement* (Workshop Organising Team, 2005).

Research has confirmed that mental illness and addiction needs and preferred interventions differ between Asian ethnic groups, and between New Zealand born and foreign born Asian people (Ho et al., 2002). For these reasons, averaging across multiple Asian ethnic groups may produce data that has little relevance to individual Asian ethnic groups (Ministry of Health, 2006a; Yee, 2003).

NEW ZEALAND SERVICE RESPONSE TO ASIAN MENTAL WELL-BEING

A range of services potentially contribute to the mental well-being of Asian communities in New Zealand. These services include: support for post-migration adjustment (such as employment, language, information services, social supports), health promotion services (media, anti-stigma campaigns, education campaigns), primary health services (first point of contact for the population, many involved in referring to the correct agencies, responsible for treating mild to moderate mental illness) and secondary mental health services (respond to acute instances of mental illness).

International students are entitled to free counselling services within their education institutions and free access to acute mental health services whilst they are under the Mental Health Act (DeSouza, 2006). All other services must be covered through their insurance or personal financial resources (DeSouza, 2006).

According to the New Zealand *National Mental Health Sector Standard* mental health service providers in New Zealand have responsibilities to consider cultural needs in their service provision. Responsibilities include being knowledgeable about culture and circumstances of their culturally diverse clients, involving culturally diverse community groups in service planning and monitoring, delivering culturally sensitive services and collaborating with other treatment and support agencies in the community (New Zealand Standards, 2001).

The density of Asian settlement impacts on the resources which are put into developing specific services for Asian communities. Asian health and support services have recently been developed within the wider Auckland region where the large majority (66 %) of Asian people reside (Statistics New Zealand, 2007). The next largest places of settlement are Wellington (10.3 %), followed by Canterbury (8.2 %), Waikato (5.1 %), Bay of Plenty (2.2 %) and Otago (2.2 %). Outside the Auckland region there do not appear to be any Asian mental health or addiction services.[7]

Community supports (such as community groups, church/religious groups, family, friendship and neighbourhood networks) contribute to the mental well-being of these populations. Their role should not be ignored in developing responsive mental health and addiction services.

7 With the exception of Asian staff in the Problem Gambling Foundation.

MENTAL HEALTH AND ADDICTION DEFINITIONS

Definitions about mental well-being and mental health services are presented in the box below.

Mental health
The concept of mental health extends beyond an absence of mental illness. "Mental health can be conceptualised as a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2007, Factsheet 220).

Mental illness
Mental illness refers to "any clinically significant behavioural or psychological syndrome characterised by distressing symptoms or significant impairment affecting a person's ability to function" (Minister of Health, 2006, p.77).

Addiction
"In the context of this plan (Te Kōkiri), addiction relates only to alcohol and other drug use and/or problem gambling. It refers to a maladaptive pattern of substance use, or problem gambling leading to clinically significant impairment or distress. Substance use disorders and pathological gambling disorder are characterised by dyscontrol, tolerance, withdrawal and salience, and are considered chronic relapsing conditions" (Minister of Health, 2006, p.75).

Mental health sector
"The organisations and individuals involved in mental health to any degree and at any level" (Minister of Health, 2006, p.77).

Mental health service provider
"An organisation providing as its core activity assessment, treatment or support to consumers with mental illness and/or alcohol and drug problems" (Minister of Health, 2006, p.77).

DEVELOPING THE RESEARCH AGENDAS

The development of this Asian mental health and addiction research agenda involved three distinct phases of consultation and review. The first two phases were conducted in parallel with the refugee and migrant research agenda. In Phase III, the Asian agenda was developed separately from the refugee and migrant agenda. The subsequent literature review, consultation and question development focused specifically on the needs of Asian populations.

Development actions aimed for transparency by providing opportunities for communities, practitioners and researchers to participate in the 'agenda setting' process. Research topics and questions were developed from an analysis of existing knowledge, key strategy documents, community consultations and gaps in the existing research base. A core goal was to ensure that research recommendations were driven by community needs.

PHASE I

An initial scan of New Zealand and international Asian, refugee and migrant research reviews was undertaken (e.g. Abbott, 1997; Fazel, Wheeler., & Danesh, 2007; Ho et al., 2002; Gray & Elliot, 2001; Keyes, 2000; Lustig, Kia-Keating, Knight, Geltman, Ellis, Kinzie, Terence, & Saxe, 2004; Watters, 2001). A further search of academic journals and websites of New Zealand research institutions was conducted to identify topics addressed by recent research that had not been included in the above literature reviews.

A project reference group comprising two senior New Zealand researchers, a DHB service manager, national non-government organisation (NGO) general manager, refugee service CEO, DHB Asian mental health coordinator and a consumer advocate supported the initial framework and development of core topics and potential research questions. The Delphi technique was used to generate and refine further research questions and topics. The results of the brainstorming session were reviewed by the project reference group and used to produce a list of 32 potential questions, organised within seven research topics.

PHASE II

Sixty people representing consumer, community groups, mental health services, health services, social and settlement support services, researchers and government agencies attended consultation meetings held in Auckland (20 people), Wellington (22), Christchurch (11) and Hamilton (7). Seven people who did not attend the consultation meetings provided written feedback on the initial research questions.

Fifty-six people with an interest in Asian, refugee or migrant mental health and addiction were identified via personal contacts, email networks and the internet. These people were invited to attend the consultation meetings via email and follow up phone calls. A further 20 people were identified through these initial contacts and subsequently invited to attend the meetings. Feedback was requested from PHOs and DHB funders and planners across New Zealand via email. Responses were received from PHOs and funders and planners in Auckland, Wellington, Christchurch and Hamilton only.

Stakeholders provided rankings on the priority of each question for Asian communities. At the same meetings, rankings were produced for refugee and migrant populations. Group discussions provided broader feedback on the research topics, community and sector issues, and further questions of importance. The results of the first consultation round supported the development, elimination and refinement of questions in Phase III.

PHASE III (ASIAN SPECIFIC)

A focused literature search, specific to Asian populations, identified published material pertinent to questions and issues raised by stakeholders during Phase I and Phase II consultations. This involved a search of peer reviewed and non-peer reviewed articles published since the year 2000 using the Google Scholar search engine. The search used terms relating to questions identified through consultation (e.g. prevalence, stigma, mental health promotion, workforce, risk factors, primary health, GPs, screening, intervention, treatment, services, psychiatric, service access) combined with terms relating to mental health (e.g. mental health, addiction, psychiatric, mental well-being, mental illness, psychological, depression) and terms relating to Asian populations (e.g. Asian, Chinese, Cambodian, Vietnamese, Indian, Korean, ethnic and cross-cultural).

Cross-cultural and other ethnic research was only reviewed for questions when relevant Asian specific research could not be located. The reference lists of the latest articles and reviews were also scanned to identify important contributions, which included some articles pre-dating 2000. The standard Google search engine was then used to identify non-peer reviewed literature by government departments, health and immigration agencies in New Zealand and overseas. Similar search terms were applied to this search. It was noted that very little New Zealand research had been conducted specific to Asian populations in many areas of stakeholder interest. Over 100 abstracts and full text articles were reviewed.

The scope of the literature search had a number of limitations. The search aimed to provide an overview of whether stakeholder questions of interest had been covered by existing research, and thus did not seek to identify every piece of published research on each topic. Furthermore, only English language documents were reviewed, and the review focused on documents published in peer review journals and government or health agency websites and little research originating in Asian countries was identifed.

As a result of the literature review, research relating to risk and protective factors and healthcare access were developed as distinct topics. Important questions initially grouped under the topics of 'information and technology' and 'sector and community collaboration' were incorporated into other topics within the research agenda.

A small group presentation and feedback session was held with three service users from the Asian community. Discussions focused on research that would support the development of services that were more responsive to their needs.

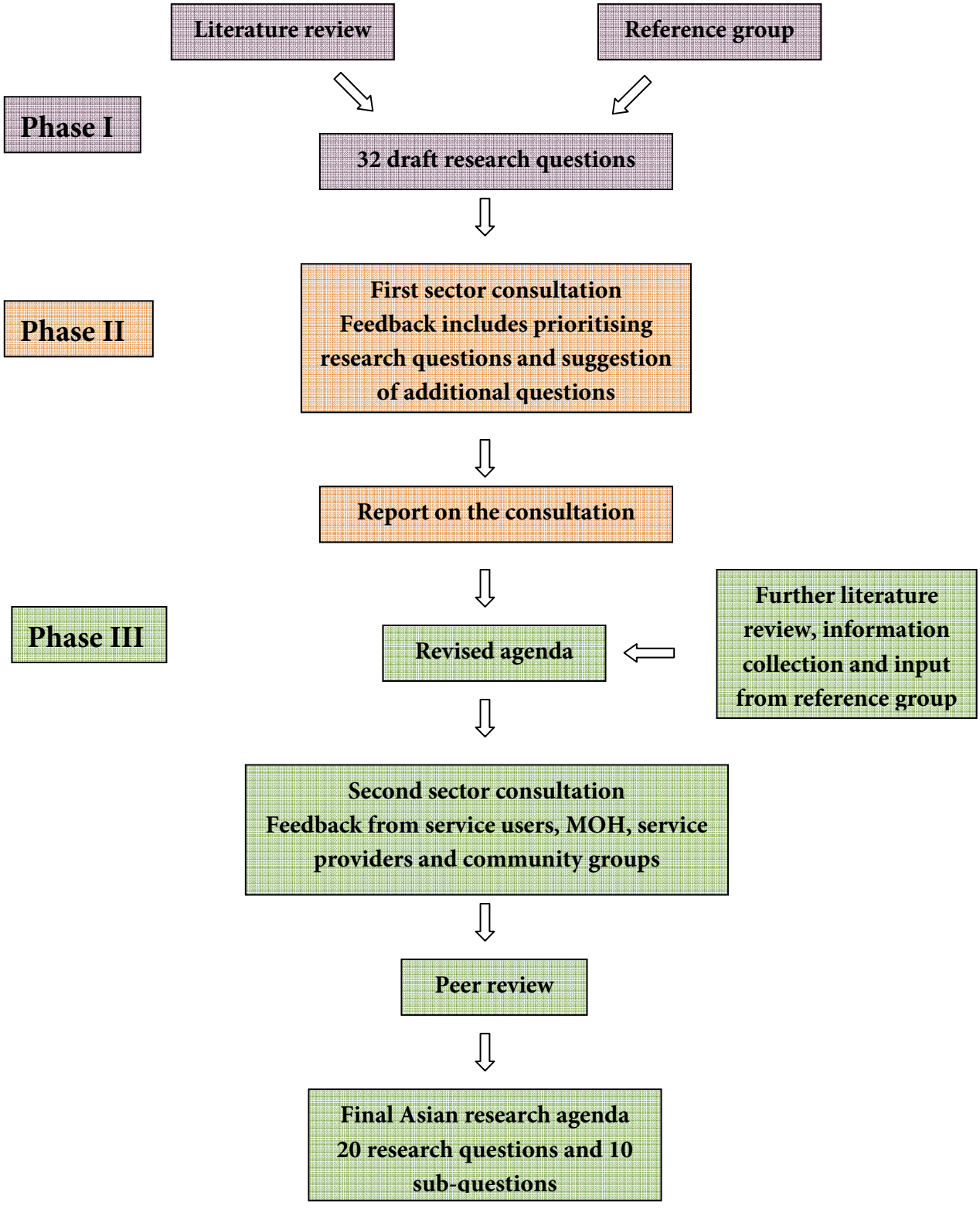
The reference group continued to provide information about health sector developments, barriers to service responsiveness and existing and upcoming research studies throughout Phase III of the research agenda development. Other groups and organisations consulted in Phase I, II and III of the agenda are listed in Appendix A.

Information collected in the consultation, service user feedback, project reference group meetings, targeted phone interviews and the literature review was used to revise the research questions further. Questions were excluded if they could not influence policy, mental health promotion or service delivery for Asian communities, or if they had been well addressed by previous research.[8]

A final round of sector feedback was collected at the 2008 Asian Health Conference and via email survey and phone interviews with representatives from the research community, service users, community groups, NGO service providers, DHBs (including public health units) and government departments. Peer review of the research agendas was conducted prior to publication.

8 Needs assessments, community consultations and stocktakes of services were excluded because DHBs are responsible to MOH for undertaking this work as part of their funding and planning cycles, and regular progress and evaluation of service performance and health outcomes. Problem gambling and family violence were not given priority as specific research questions, because existing research strategies address these issues.

FIGURE 1. AGENDA DEVELOPMENT PROCESS



ASIAN RESEARCH AGENDA

AGENDA OVERVIEW

This Asian mental health and addiction research agenda outlines existing literature, and recommends questions that address service provider, planning and funding and policy responses to the mental health and addiction needs of Asian communities.

Research needs are organised in seven topics relating to three broad themes.

Understanding the context

1. Prevalence of mental illness and addiction within specific Asian communities in New Zealand.
2. Understanding risk and protective factors for mental well-being among Asian communities.

Interventions

3. Developing mental health promotion to improve mental well-being among Asian communities.
4. Improving the service access of Asian communities in New Zealand.
5. Enhancing New Zealand's primary health responses to mental illness and addiction in Asian communities.
6. Enhancing the responsiveness of New Zealand's mental health and addiction services for Asian communities.

Workforce development

7. Developing New Zealand's workforce to provide culturally appropriate mental health and addiction care for Asian communities.

Each topic summarises the relevant international and New Zealand research. At the end of each section the research needs identified by stakeholders are presented, followed by a summary of the knowledge gaps and a list of priority research questions.

Extensive efforts have been made to review sufficient literature to draw conclusions about the existing research base. However, it is certain that some research studies will have been missed. Further analysis of the literature should be undertaken before embarking on a specific research question outlined in this document.

THE 'ASIAN' CATEGORY IN RESEARCH

As discussed in the description on population heterogeneity, much of the existing research on Asian communities has focused on Asian as a single group. Averages for the Asian population as a whole will have limited application for service and policy development as it prevents identification of the various needs within these communities[9] (Ho et al., 2002; Kumar et al.,

9 For further discussion on the utility of the term 'Asian' please refer to Issues and options paper: *The use of the term 'Asian' in New Zealand and implications for research, policy development and community engagement* (Workshop organising team, 2005).

2006; Ministry of Health, 2006a; Rasanthan et al., 2006a; Workshop organising team, 2005). Research has confirmed mental illness and addiction needs and preferred interventions differ between Asian ethnic groups, and between New Zealand born and foreign born Asian people (Ho et al., 2002).

To drive service and policy development to be more responsive to Asian communities, information about the needs and effective responses for broad Asian groupings should be supplemented with information about the differences and specific needs of sub-groups of Asian communities, for example the rapidly growing group of Asian young people (0-14 year old) from mixed ethnic backgrounds (Ho, 2008).

Little is known about the needs of most of the smaller ethnic and religious Asian community groups within New Zealand (Ho et al., 2002). In particular there is little research on which to base the development of service and policy for South Asian communities. The service and policy needs of South Asian communities are predicted be to be distinct from the needs of Chinese and other ethnic Asian groups due to differences in settlement histories, culture, community structures and cultural patterns of responding to stress (A. Mortensen, personal communication, September 11, 2008). There is also a need for more research on other specific Asian sub-groups who are at high risk of mental illness, such as older people, students, women and refugees[10] (Ho et al., 2002; Workshop organising team, 2005).

10 Research and questions about Asian refugee communities is reported in the Refugee and Migrant Mental Health and Addiction Research Agenda.

UNDERSTANDING THE CONTEXT

1. Prevalence of mental illness and addiction within specific Asian communities in New Zealand

Prevalence refers to the proportion of people within a population who experience a condition within a specified period of time[11] (Goldner, Hsu, Waraich & Somers, 2002).

Information about the prevalence of mental illness within Asian communities has important implications for service delivery and policy planning. Prevalence has implications for resource allocation, identification of priority or high risk groups (Kumar et al., 2006), monitoring changes in mental health over time, and determining the level of service support needed to address the level of distress in the population.

Several international studies report on average Asian migrant communities experience lower rates of mental illness and addiction than the host communities (Ho et al., 2002; The WHO World Mental Health Survey Consortium, 2004). For example, a prevalence study found that 7% of Chinese-Americans living in Los Angeles reported experiencing depression at least once in their lifetime, lower than the national United States average of 17 % (Takeuchi, Zane, Hong, Chae, Gong, Gee, Walton, Sue, & Alegría, 2007). However, not all Asian communities have been found to have lower rates of mental illness. Reviews of international research suggest that Asian communities with a refugee background typically experience higher than average rates of mental illness and addiction (Cheung, Nguyen & Yeung; 2004; Ho et al., 2002)[12].

For New Zealand's Asian communities, there is little information on rates of overall or specific mental illness or addiction disorders (Ho et al., 2002; Kumar et al., 2006). The closest existing proxy to prevalence rates is a couple of New Zealand studies which have measured general concepts of well-being (e.g. Ministry of Health, 2006a; Rasanthan et al., 2006). These reports suggest that Asian mental well-being, on average, is similar or better than the general New Zealand population (Ministry of Health, 2006a; Rasanthan et al., 2006).

Most Asian mental health research from New Zealand has provided little data on the many ethnic and regional sub-groups of New Zealand's Asian population. Broad Asian sub-grouping of 'Chinese', 'Indian' and 'Other Asian' were used in the National Health Survey and New Zealand Youth Survey (Ministry of Health, 2006a; Rasanathan et al., 2006). Within each of these sub-groups it is expected that there will be variation in the patterns of mental illness.

Poor mental well-being in particular Asian sub-groups has been identified by the small number of research studies which have looked beyond broad Asian categories. For example, Indian students have reported higher than average symptoms of mental illness (Rasanathan et al., 2006) as have South-East Asian refugees (Cheung & Spears, 1995, as cited in Ho et al., 2002) and Chinese older people (Abbott, Wong, Giles, Wong, Young, & Au, 2003). Students (particularly

11 Typical timeframes used are within the previous year or within a persons lifetime.
12 Research about Asian refugee communities is reported in the Refugee and Migrant Mental Health and Addiction Research Agenda.

secondary)[13], women, and Asian people from isolated ethnic groups may also be at increased risk of mental illness, but prevalence rates do not appear to have been measured for these groups in New Zealand (Abbott et al., 2003; Ho et al., 2002).

Reviews of international research indicate that many, but not all, Asian communities have lower rates of alcohol and drug use than the Western host community (Cheung et al., 2004; Rasanathan, Ameratunga, Chen, Robinson, Young, Wong, Garrett, Watson, 2006b). New Zealand and overseas reports predict that Asian populations had low rates of addiction because they have low rates of access to alcohol, drug and gambling addiction services (Cheung et al., 2004). Service access data is not necessarily a good estimate of the total number of Asian people who experience addiction, because many Asian people experience barriers to accessing such services [14](Cheung et al., 2004; Ho et al., 2002). Research on addiction conducted in New Zealand and overseas has often focused on rates of use, rather than the prevalence of addiction (e.g. Harachi, Catalano, Kim & Choi, 2001: Rasanthan et al 2006). [15]

The small number of Asian people sampled in *Te Rau Hinengaro, The National Mental Health Survey*, limits an examination of the prevalence of mental illness in Asian communities. To date, analysis of the Te Rau Hinengaro data has included Asian people within a larger 'other' group (Oakley Browne, Wells & Scott, 2006). No specific prevalence figures have been calculated for the Asian population. A bigger sample size is needed for epidemiological research to create a meaningful picture of prevalence rates within the heterogeneous Asian community.

A number of authors have questioned the appropriateness of using Western diagnostic tools for measuring distress within Asian and other ethnic communities (e.g. Ho et al., 2002; Summerfield, 1999; Takeuchi et al., 2007). It has been suggested that lower prevalence rates reported for Asian communities may arise from under reporting or a lack of sensitivity of Western diagnostic measures (Ho et al., 2002; Takeuchi et al., 2007). However, there is mixed evidence whether Western measures are less sensitive for measuring mental illness and addiction within Asian populations (Takeuchi et al., 2007). Some researchers in New Zealand and the United States have adapted and validated diagnostic measures for Asian communities (see Ho et al., 2002; Takeuchi, et al, 2007). For example, the General Health Questionnaire was adapted to produce a Chinese Health Questionnaire (Ho et al., 2002).

Whilst existing New Zealand studies give some indication of average mental well-being, these studies do not provide service providers, policy makers or Asian communities with information about the level of need for services, interventions or priorities for policy direction. Furthermore, pockets of poorer mental well-being reported in previous research caution that averaging across a broad Asian group can present an imprecise picture of widespread mental well-being in Asian communities (Ministry of Health, 2006a).

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13 A recent survey of New Zealand international students found that those from China had lower life satisfaction relative to international students from North America, Middle East, Pacific Islands and other parts of Asia (Deloitte, 2008).

14 See topic four on service access for further information.

15 Recent analysis of the 2006/2007 New Zealand health survey suggests that, on average, Asian populations have lower than average rates of problem gambling. Nonetheless, it has been predicted that certain sub-groups within the Asian population have higher-than-average rates of problem gambling which are not revealed by researching Asian communities as a single group. The Ministry of Health plans to commission research to identify these groups as part of its 2007-2010 research strategy.

Knowledge about the prevalence of mental illness in Asian communities can be used to establish priorities for mental health, health and social services (Kumar et al., 2006). It can also be used to assess whether low service access rates represent an underutilisation of services by Asian communities. The Ministry of Health has indicated that collecting knowledge about population service needs is a key task for health providers in New Zealand (Ministry of Health, 2004). Many service providers consulted during Phase II commented that they have little knowledge about the level of mental illness within Asian communities.

Summary

Information about the level of mental illness in New Zealand's Asian communities is needed to guide health policy and service planning. Prevalence rates for specific Asian sub-groups can be used to identify any at risk groups within the Asian population. No representative studies have been conducted on the prevalence of mental illness and addiction disorders within New Zealand's Asian communities.

Research questions

1.1. What are the prevalence rates of common mental illnesses and addiction in Asian communities? Consider mild, moderate and severe levels where possible.

1.2. Examine differences in prevalence rates according to age, gender, ethnic and geographical location.

1.3 How have prevalence rates for mental illness and addiction in Asian communities changed over time?

1.4. What are the culturally appropriate ways to measure prevalence in Asian communities?

UNDERSTANDING THE CONTEXT

2. Understanding risk and protective factors for mental well-being among Asian communities

A risk factor is an experience or demographic feature that correlates with an increased likelihood of mental disorder (Ho et al., 2002; Cheung et al., 2004).

A protective factor is an experience or demographic feature that is associated with positive mental well-being (Cheung et al., 2004).

International research has documented that experiences before and after migration impact on the mental health of Asian migrant populations (Abbott, 1997; Ho et al., 2002). Mental illness is elevated in people exposed to trauma and/or prolonged stress prior to migration (Gray & Elliot, 2001; Kinsie, 2006). Severe migration stress is more common in Asian people from a refugee background (Ho et al., 2002). Nonetheless, non-refugee Asian migrants may also have experienced levels of stress increase risk for mental illnesses such as post-traumatic stress disorder (Kinsie, 2006). The process of migration can itself be stressful, sometimes involving multiple applications, family separation and limited control over one's circumstances. Such migration stressors can also impact on mental well-being (Ho et al., 2002).

Post-migration experiences that relate to mental well-being in migrant and local born Asian communities have also been identified. Positive mental well-being is associated with good English language skills (Abbott, 1997; Gray & Elliot, 2001; Takeuchi et al., 2007) and high income and employment (Takeuchi, et al., 1998). In contrast, discrimination, marginalisation, hostility or a lack of acceptance from the host population is associated with higher rates of mental illness (Abbott, 1997; Gray & Elliot, 2001). Asian people who experience mental illness are likely to face a double dose of discrimination, firstly related to ethnicity and secondly to Asian and general public perceptions of mental illness (Tse, Wong, & Kim, 2004).

Asian children and youth are often more likely to have contact with, and adopt aspects of Western culture, which can conflict with the affiliation to traditional Asian cultural values and practices held by their parents. The resulting cultural differences, expectations and social norms can result in tensions within a family. Family structures are also disrupted by isolation from extended families and changing gender roles (Bhui et al., 2007). Whilst it has been predicted that intergenerational conflict may have a negative impact on mental well-being of children and parents, there appears to be very little research investigating this. Unhealthy and tense family dynamics may also impact on the ability of Asian people to achieve and maintain mental well-being.

A number of New Zealand research studies have looked at pre- and post-migration risk and protective factors for mental illness. Pernice and Brook (1996) documented an association between discrimination by members of the host society and high levels of anxiety and depression in their study of Cambodian refugees to Dunedin. Other New Zealand research has investigated employment, social support and language skills in migrant communities. Because few of the

immigration studies have included measures of mental illness, the relationship between these post-migration experiences and mental illness cannot be examined.

International research suggests that both pre- and post-migration factors also impact on the rates of addiction in Asian communities (Cheung et al., 2004). In New Zealand some research has looked at post-migration experiences of Asian migrants but few studies, if any, have looked at the impact of these experiences on alcohol and drug use (Cheung et al., 2004). Cheung et al., (2004) argue that New Zealand research into alcohol and drug use in Asian communities should focus on risk factors. These can indicate who is most likely to experience drug and alcohol difficulties and what experiences may exacerbate this risk (Cheung et al., 2004). Internationally there appears to be a major research gap around risk and protective factors for addiction in adult Asian populations.

Social support is believed to be the most important protective factor against mental illness (Abbott, 1997; Gray & Elliot, 2001). Research has documented better mental well-being in Asian people who have support and contact with friends and family (Ho et al., 2002). In contrast, being separated, divorced or widowed is associated with higher rates of mental illness (Takeuchi et al., 1998). Research on social contact tends to suggest that mental well-being is best when Asian people have social contact with both host and Asian cultures, rather than one group or the other, however not all studies have found this same result (Jackson, 2006).

Many of the people consulted in Phase II emphasised the importance of understanding how social and environmental factors relate to mental health. Information about risk factors can be used to identify who within the Asian population is most likely to experience mental illness and addictions.[16] This information needs to be incorporated into the design and prioritisation of government and service provider responses to Asian communities. Social and environmental factors may also account for differences in prevalence rates noted between various Asian sub-groups.

Knowledge about risk factors can also assist professionals, service providers and health promotion professionals to develop effective interventions for Asian communities (Harachi et al., 2001; Ho et al., 2002; Hermann Saxena & Moodie, 2005). As noted by people during Phase II of the consultation, various risk factors for mental health have already been identified. Research should focus on which of these risk and protective factors are most important to target in order to improve mental well-being in Asian communities.

Summary

A number of protective factors associated with mental illness have been identified. These include English language competency, employment, lack of discrimination, sufficient income, social support and an absence of pre-migration and migration stressors. Social and immigration services and policy in New Zealand target a number of post-migration stressors, but the impact of these services on mental health does not appear to have been evaluated. Few pieces of research have investigated the risk and protective factors for addiction in Asian communities.

16 Research outlined in a Ministry of Health research programme on problem gambling will investigate what sub-groups of the Asian population are most at risk of problem-gambling related harm.

Research questions

2.1. How well are post-migration risk and protective factors addressed by the range of government policies and services for Asian communities?

2.2. What are the most important risk and protective factors to target in order to reduce addiction in Asian communities?

INTERVENTIONS

3. Developing mental health promotion to improve mental well-being among Asian communities

Mental health promotion builds the innate ability to achieve and maintain good mental health and reduces barriers to good health for individuals and communities (Pollet, 2007).[17]

Mental health promotion and prevention strategies have been implemented and evaluated in many Western countries. The World Health Organization (WHO) identified that a range of programmes, including early childhood interventions, support for children, social support for elderly, mental health promotion activities in schools, interventions at work, community development and housing policies can be cost effective at improving mental health (WHO, 2007).

It has been questioned whether such programmes will be effective for non-European populations (Milat, Carroll, & Taylor, 2005). Few trials have been conducted on the effectiveness of mental health promotion interventions for Asian or other ethnic groups (Milat, Carroll, & Taylor, 2005).

There is a perception among general members of Asian communities and Asians with experience of mental illness that mainstream health and mental health promotion approaches are ineffective for people of their culture (Jackson, Yeo, & Lee, unpublished paper; Milat, Carroll, & Taylor, 2005). For example, ethnic groups in New Zealand and the United States do not report positive views about mental health promotion resources that are not in their native language (Jackson, Yeo, & Lee, unpublished paper; Palinkas, Pickwell, Brandstein, Clark, Hill, Moser, & Osman, 2003). It is also reported that non-Western populations have little enthusiasm for resources that are directly translated from English or 'tag lines' originally designed for Western cultures (Jackson, Yeo, & Lee, unpublished paper; Palinkas et al., 2003).

What constitutes an appropriate mental health promotion strategy is also likely to differ between different Asian ethnic groups. When asked to report on desirable mental health promotion content and sources of health promotion and health information, Asian ethnic groups report different preferences (e.g. Ahmad, Shik, Vanza, Cheung, George, & Stewart, 2004; Phoenix Research, 2005). Asian interviewees also highlight that information sources which are not in their native language are unlikely to be effective (Ahmad et al., 2004). This research suggests that mainstream mental health promotion interventions and media may need to be adapted specifically for different Asian sub-groups to have similar effectiveness with these communities. However, at present there is little quantitative evidence about the efficacy of either mainstream or culturally adapted mental health promotion media sources for Asian communities.

There is also little research into the impact of broader types of mental health promotion strategies for ethnic minority groups (Hermann et al., 2005). Evaluations of mental health promotion programmes for immigrant or ethnic minority groups have not been designed to allow firm conclusions about their efficacy (Milat et al., 2005). Many evaluations have relied on

17 Research into strategies to reduce barriers to healthcare access are discussed in the following section.

consumer satisfaction measures, and when measures of behaviour or knowledge were included, baseline or control measures were not conducted (Milat et al., 2005). The scarcity of rigorous research also means people do not know which particular features of a mental health promotion campaign will drive change in knowledge and behaviours in Asian communities (Milat et al., 2005). This information is important for informing the future development of mental health promotion campaigns for Asian communities,

Social support has been identified as a protective factor that promotes mental well-being in both research and community consultations (Ho et al., 2002). For example, service user and community group stakeholders in this consultation emphasised that community groups, social and peer support were particularly important for the mental well-being of Asian communities. Church, religious groups and other community networks may play a role in supporting mental health and well-being. However, the extent to which these groups impact on mental well-being is unknown. Furthermore, research needs to investigate how traditional family cultures and practices may protect Asian communities from mental illness and how these protective effects are maintained (Rasanthan et al., 2006a).

Campaigns to reduce discrimination by other ethnic groups towards the Asian community have also been proposed as a potential method for improving mental well-being. There is evidence to suggest a link between experience of mental illness and discrimination. Nonetheless it is not known whether anti-discrimination campaigns change how the host community regards Asian communities to the extent that it has a measurable impact on mental well-being (Rychetnik & Todd, 2004). Stigma towards people because of mental illness was also identified as a significant issue for Asian communities, but again, there is little information on the impact of anti-stigma campaigns on mental well-being.

Discrimination and stigma have been identified as a key barrier to help-seeking and mental well-being in Asian communities. Media campaigns are one type of mental health promotion intervention which has been adopted to target this discrimination and stigma. However, limited work has been done in New Zealand or internationally to evaluate the effectiveness of multimedia campaigns or information sources for improving mental well-being in Asian communities. Exceptions include two Australian studies, one evaluating a mental health promotion campaign targeting community awareness[18], and the other evaluating a series of mental health promotion pamphlets and radio screenings for Afghani asylum seekers (Multicultural Mental Health Australia, 2005).

In New Zealand a Chinese version of the Like Minds, Like Mine social marketing campaign called, "Kai Xin Xing Dong" has been developed in New Zealand. The campaign aims to reduce stigma and discrimination and increase the awareness of mental illness within Auckland's Chinese communities (Jackson, Yeo, & Lee, unpublished paper). The first two stages of this campaign involved ethnic community newspapers and Chinese radio as well as training Chinese people who have experienced mental illness to work with their community groups. The impact of the Kai Xin Xing Dong campaign for changing knowledge and behaviour has not been measured (see Jackson, Yeo, & Lee, unpublished paper). There is also no baseline or ongoing monitoring of attitudes and knowledge within Asian communities, such as that collected for

18 The report of this evaluation can be purchased from http://www.shop.nsw.gov.au/pubdetails.jsp?publication=5989 .

mainstream, Maori and Pacific groups as part of the evaluation of the national Like Minds Like Mine campaign (e.g Wyllie, & Mackinlay, 2007).

There are currently no major mental health promotion strategies for Auckland's Asian communities who are not Chinese, or for any Asian community outside the Auckland region (I. Yeo, personal communication, June 25, 2008). Mental health promotion strategies to reduce alcohol and drug use, such as the Alcohol Advisory Council of New Zealand (ALAC) social marketing campaigns and community action projects, have not been adapted for any Asian community. Some ad hoc work has been done to translate information from brochures about the healthcare system and services in New Zealand. Little, if any, work has been done to evaluate the effectiveness of these brochures or other information sources (S. Lim, personal communication, July 9, 2007). Developing campaigns for other Asian ethnic groups is hindered by a lack of existing community based services such as helpline services and service user support groups for these ethnic groups (I. Yeo, personal communication, June 25, 2008).

During the Phase II consultation process mental health promotion research was ranked the most important means to support mental health in Asian communities. Many consultation attendees were interested in finding out what approaches could be used for health promotion in regions where Asian communities are small, with fewer resources and fewer opportunities for social support. As mentioned previously, measures of knowledge and stigmatising behaviour are collected regularly in New Zealand (e.g Wyllie, & Mackinlay, 2007), but data is not analysed for Asian communities (Jackson, Yeo, & Lee, unpublished). Oversampling and independent analysis of Asian communities could provide valuable information about the need for mental health promotion and prevention campaigns, as well as information about the impact of existing New Zealand campaigns.

Summary

Mental health promotion is considered an important method for improving the mental health and well-being of Asian communities. However, little is known about the effectiveness of mainstream or culturally targeted mental health promotion campaigns for Asian populations in New Zealand or overseas. More work is needed to evaluate existing approaches and identify the most effective methods to develop mental health promoting behaviour and knowledge, reduce discrimination and encourage service access in Asian communities.

Research questions

3.1. Test and compare the effectiveness of new and existing methods (such as social marketing and information resources) for promoting mental well-being in Asian communities[19].

3.1a. Consider the cost-effectiveness of each method.

3.2. How and to what extent do religious groups, community groups, community leaders and complementary medicine promote mental health and well-being in Asian communities?

3.3. Test the effectiveness of methods to challenge negative attitudes towards Asian communities, including collaborative interventions to reduce discrimination.

19 This could include measuring the impact on service access, mental health knowledge, attitudes, shame, discrimination and mental-health related behaviour.

INTERVENTIONS

4. Improving the service access of Asian communities in New Zealand

"Service access is a potential service user's ability to obtain the right service when they need it within the appropriate time" (Minister of Health, 2006, p.75).

Low access to health and mental health services can be detrimental to individual and community well-being because failure to gain effective treatment can increase the negative impact of mental illness. Existing research from New Zealand and United States suggests that many Asian communities have low rates of service access compared to the national average in these countries (Abe-Kim, Takeuchi, Hong, Zane, Sue, Spencer, Appel, Nicdao, & Alegria, 2007; DeSouza, 2006). For example, Abe-Kim and associates found only 8.6 % of all Asian-Americans in the sample sought help from any service compared to 17. 9 % of the general population. Use of services by Asian individuals differed according to migrant generation, rates of mental health service use were higher for US born individuals than migrants (Abe-Kim et al., 2007). Research indicates that low rates of service access may be a result of low rates of mental illness, differences in help-seeking behaviours and/or ineffective referrals between services.

Abe-Kim et al (2007) found evidence to suggest that compared with the national US population, a higher proportion of Asian-Americans who experience mental illness do not seek service access. In their study only 34.1 % of Asian-Americans experiencing symptoms of mental illness sought any access to health services, compared with 41 % of a national sample (Abe-Kim et al., 2007).

Other research and reports from service providers suggest that Asian people tend to delay access or avoid treatment unless mental illness symptoms become severe (Ho et al., 2002). For example, an early study of Asian-Americans with symptoms of schizophrenia found this group took much longer (3 years compared to 1.5 years) to access mental health services than people from Caucasian or African American ethnicity who experienced schizophrenic symptoms (Lin, Inui, Kleinman, & Womack, 1982). Delay in help-seeking by Asian New Zealanders does not appear to have been measured. However both service providers and service users in our consultation noted instances where Asian clients delayed treatment until they had very severe symptoms of mental illness.

There are also anecdotal reports that Asian people may experience less effective access through services. For example, once they make first contact access to a health or mental health service they may not receive referrals to ongoing care or more appropriate services.[20]. There is little information about the impact of health-provider actions on treatment access and treatment delay in New Zealand.

Under-utilisation of services is not universal across Asian communities and services (Abe-Kim et al., 2007; Snowden & Hu, 2007). Research has shown higher rates of utilisation when services target minority ethnic groups (Snowden & Hu, 1997) and family members do not experience stigma and discrimination (Okazi, 2000). Rates of utilisation are also higher among longer settled Asian migrants and people who come from Asian countries with similar patterns of

20 These issues are discussed further in the following section on primary care.

access and beliefs (Leong & Lau, 2001; Meyers & Staff, 2006). Snowden and Hu (1997) found that, in one United States district, Asian people with severe mental illness accessed community mental health services at higher rates than severely ill Anglo Americans in the district.

New Zealand data on mental health service use is collected by the National Health Information Service each year. This data reports low rates of use by New Zealand's Asian population.[21] In 2004 2.3% of clients to DHB mental health services were Asian, despite Asian people making up over 6.6 % of New Zealand's population at this time (Ministry of Health, 2004; New Zealand Health Information Service, 2007). Rates of utilisation of child and adolescent mental health services were also much lower for Asian than for New Zealand European children and youth (Bir, Vague, Cargo, Faleafa, Au, Vick, Ramage, 2007). National health surveys have also documented lower than average access to general health services by adults, children and adolescents from the Asian community (Ministry of Health, 2006a; Rasanthan et al., 2006b). Alcohol and drug service data has noted lower than average rates of access to alcohol and drug services by the Asian population (Cheung et al., 2004).

There are many gaps in knowledge about service access by Asian communities in New Zealand. There is little or no information on rates of access to NGO services, primary healthcare services for mental health concerns (e.g depression or drinking problems) or information specific to most Asian sub-groups. Patient information is collected at the Level 2 ethnicity category which does not provide information specific to Asian sub-groups[22], and DHBs report figures at the level of the larger Asian groups (Rasanthan et al., 2006). Most importantly, a lack of knowledge about the prevalence of mental illness means that estimates of unmet need cannot be made from service access data.

Within New Zealand's Asian communities, a number of barriers to service access have been noted. Some of these barriers relate to practical resources, whilst other relate to Asian cultures. Practical barriers noted in Asian communities include poor English language skills and a lack of knowledge about the New Zealand health system and services. Financial and transport issues may be a barrier for some members of Asian communities, particularly Asian international students who are not eligible for publically funded services.

Barriers related to culture include a strong fear of stigma and discrimination in Asian communities and cultural beliefs and attributions of mental illness (Auckland Sustainable Cities Programme, 2006; Department of Labour, 2004; Fraser, 2007; Ngai, Latimer & Cheung, 2001; ho et al., 2002). Differences between the New Zealand health system and health systems in Asian countries may also act as a barrier to service provision. Expectations about service access and the nature of service provision are often based on experience with health services in Asian countries (Ngai et al., 2001). Service users and service providers in this consultation reflected the view that when these expectations were not met, this may discourage Asian people from accessing New Zealand's health services in the future.

Some Asian sub-groups are expected to face more barriers to service access than others. For example, elderly Asian people are likely to have fewer financial and transport resources and

21 Statistical tables of 2004 DHB mental health service utilisation data is available from http://www.nzhis.govt.nz/moh.nsf/pagesns/502/$File/mentalhealth2004.xls

22 Proposals have been made to change ethnicity collection to the Level 4 Statistics New Zealand category by 2011. This would allow an analysis of access for different Asian sub-groups.

experience more cultural and language barriers (Leong & Lau, 2001). Chinese students reported that lack of knowledge about the healthcare system, fear, cost, concerns about confidentiality and not wanting to 'make a fuss' were major obstacles to healthcare access (Rasanathan et al., 2006a).

Research conducted by Berthold et al (2007) on Chinese-Americans suggests that practical barriers (e.g. treatment costs, treatment time, knowledge about services and English language) may be better for predicting service use than measures of cultural barriers (e.g. credibility of treatment, recognition of need and fear of loss of face). There is mixed evidence about how much family support, cultural beliefs and traditions influence service access. For example, American Chinese health service use for psychological distress was predicted by low levels of family conflict (Abe-Kim, Takeuchi, & Hwang, 2002). However, the use of health services was not predicted by the measure of family support (Abe-Kim, Takeuchi, & Hwang, 2002). Whilst many assume that cultural beliefs create a reluctance to access services (Glasgow Anti Stigma Partnership, 2007), a study of US refugees found that those who used alternative medicines were also more likely to use Western services (Berthold, Wong, Schell, Marshall, Elliot, Takeuchi, & Hambarsoomians, 2007).

Potential methods for improving access have been mentioned in various studies in New Zealand. These include improving anti-stigma campaigns[23], information sources, interagency referrals and improving workforce competencies (Ngai, Latimer, & Cheung, 2001; Ho et al., 2002). Research has demonstrated that community health workers and cross-cultural training of mental health staff can result in improved service utilisation by ethnic minority groups (Fortier & Bishop, 2003). Furthermore, one study reported that culturally sensitive health promotion led to improvements in the use of preventative health services, such as mammography screening by ethnic minority groups (Fortier & Bishop, 2003).

Measuring service access in response to mental health concerns is important for assessing how well the mental health and addiction needs of Asian communities are being met. The bulk of the existing research has focused on barriers to service access, rather than investigating factors that encourage help-seeking behaviours and promote effective health service utilisation. Information about barriers and enablers to help-seeking, and evaluations of existing strategies and/or piloting new strategies can be used to decide what types of strategies should be developed and funded.

Summary

New Zealand data shows that Asian communities access health and mental health services at lower rates than the Pakeha New Zealand population. Research has identified a number of barriers to service access, including a lack of knowledge about the health system, language barriers, cultural beliefs and attributions of mental illness, fear of stigma and discrimination. Reducing barriers to service access can improve service responsiveness to Asian communities. There is a need for further research to evaluate what types of approaches are most effective for encouraging service access and to drive the development and funding of such interventions.

23 Further research about workforce, information and education strategies to improve service access are discussed within the workforce and health promotion sections of this research agenda.

Research questions

4.1. What are the help-seeking behaviour patterns and critical decision points in the process of accessing primary and mental health services for Asian children and adults who experience symptoms of psychological distress? How do these differ between New Zealand born and overseas born people of Asian ethnicity?

4.2. Apply knowledge about critical decision points to develop ways to encourage access to services.

4.3. Pilot new methods or test the effectiveness of existing methods that encourage access to primary care and mental health services. Consider the cost-effectiveness of each method.

4.4. What do potential Asian service users expect from the New Zealand health system (e.g in referral protocol, triaging, time waiting for initial consultation/follow up and treatment practices)? To what extent are these expectations met?
4.4a. Do unmet expectations impact on future help-seeking behaviours?

INTERVENTIONS

5. Enhancing New Zealand's primary health responses to mental illness and addiction in Asian communities

Primary healthcare is first contact essential healthcare provided by health practitioners and support workers in the community. It includes health promotion, health screening, illness diagnosis and treatment services (Ministry of Health, 2004).

Primary care settings are an important first point of call for screening and diagnosing mental illness and addiction concerns in Asian communities (Humeniuk, Dennington, & Ali, 2008). In the United States, Cambodian refugees accessed primary health professionals more frequently than they accessed mental health professionals in response to psychological problems (Berthold et al., 2007). Primary care practitioners engage in mental health screening, treatment for mild to moderate mental illness and provide referrals to other health and support agencies. Stakeholders and service users in our consultation noted that primary care practitioners can also play an important role by linking clients with information about the healthcare system.

In the United States and the United Kingdom systematic differences have been noted in the interactions of primary care professionals with Asian relative to the interactions with European clients (van Ryn, Burgess, Malat, & Griffin, 2006). It is uncertain whether differences in interactions relative to majority ethnic clients have a positive or negative impact on treatment outcomes (Snowden, 2003). Further research is needed to assess whether these differences in healthcare practices are a result of misdiagnosis, cultural expectations by the client or undue bias on the part of healthcare practitioners (Snowden, 2003).

Misdiagnosis are underdiagnosis frequently reported as possible concerns for Asian clients (Snowden, 2003). Practitioners in New Zealand and overseas have reported difficulties recognising symptoms of mental illness among Asian clients (Leong & Lau, 2001; Ngai et al, 2001). The equivalence of Western screening and diagnostic practices for Asian clients is unknown (Leong & Lau, 2001). On average, Asian individuals living in the United States report less satisfaction with the time doctors spent with them relative to Black and White racial groups (Saha, Arbelaez & Cooper, 2003). There is no information about the quality of care, effectiveness of referrals, and extent of mental health and addiction misdiagnosis for Asian people who access primary care services in New Zealand and internationally.

Traditional herbal medicine use is also a potential concern for primary health practitioners prescribing medication to Asian clients. Traditional herbal medicines can potentially interact with psychotropic medications and result in negative side effects for the client (Berthold et al., 2007; Ho et al., 2002). For primary practitioners, it can be difficult to establish whether there is risk of interaction with herbal medications for two reasons. Firstly, patients often do not let their practitioners know if they are also using traditional herbal medicines (Berthold et al., 2007; Ho et al., 2002; Fortier & Bishop, 2003; Tse, Tong, Hong & Rasalingam, 2007). Secondly, little is known about which herbal medicines may interact with Western medications and how they interact (Berthold et al., 2007). Limited research has been conducted to investigate the potential benefits and hazards of combining alternative medicine use with the care provided by mainstream health services (Fortier & Bishop, 2003).

Limited data exists on the extent of traditional herbal medicine use in New Zealand's Asian communities (Ho et al., 2002). The Asian Health Chart Book reports that Asian people are less likely to report visiting complementary/alternative health providers than Pakeha New Zealanders (Ministry of Health, 2006a). One Auckland study found that Chinese herbal medicines were the most common type of traditional Chinese medicine used by Chinese, Cambodians, Vietnamese and other Asian migrants (Ho et al., 2002). Few drug trial assessments have been conducted to investigate the potential interactions between traditional herbal medicines and psychotropic drugs. Such trials are likely to be beyond the research and funding capacity available in New Zealand. Whilst New Zealand does not have the capacity to investigate the pharmaceutical consequences of traditional herbal medicine use, it is important that practitioners keep themselves up to date with research in this field.

Primary care can play an important role in early detection and appropriate referrals for mental health and addiction, thus reducing the impact of mental illness on Asian people and Asian communities. Information about the quality of care provided can be used to influence the development of services so that they are more responsive to mental health needs in Asian communities. [24]

Summary

Existing research suggests that primary care services are an important part of mental health support for Asian people. There are concerns that Asian patients may not make the best use of primary health services in New Zealand and their experiences using the services may vary. However there is limited data to substantiate these claims or investigate the impact of primary care use on mental well-being in Asian communities.

Research questions

5.1. How effectively do primary health services in New Zealand address and screen for the mental health and addiction issues and concerns of their local Asian populations?

5.1a. Consider differences in treatments prescribed, the number of referrals to secondary services for Asian and non-Asian clients in New Zealand.

5.1b. How effectively do primary health professionals (for example GPs, GP nurses and pharmacists) and other health providers explain health services to Asian clients?

5.1c. Consider the impact of these factors on the mental well-being of Asian clients.

24 Please refer to the healthcare access and workforce sections for strategies to improve the quality of primary healthcare delivery.

INTERVENTIONS

6. Enhancing the responsiveness of New Zealand's mental health and addiction services for Asian communities

> "Responsive services focus on recovery, reflect relevant cultural models of health, and take into account the clinical and cultural needs of people affected by mental illness and addiction" (Minister of Health, 2006, p.27).

Western models of mental health care may be less effective for Asian people than they are for the New Zealand Pakeha population (Abe-Kim et al., 2007; Ho et al., 2002). Cultural and linguistic characteristics of Asian communities are believed to reduce the effectiveness of Western based mental health services and treatment approaches for these people (Leong & Lau, 2001). Evidence about rates of service utilisation discussed in the previous section is commonly mentioned to argue that mainstream services are not as effective for Asian populations (Ho et al., 2002).

There is little information on what modes of therapy are most effective for Asian communities (Ho et al., 2002; Leong & Lau, 2001; Tseng, Chang & Nishizono, 2005). One randomised trial under way in the United States is comparing the effectiveness of combined cognitive therapy and drug treatment with drug treatment alone for severely depressed Asian-American patients.[25] Little evidence of other randomised controlled trials on therapy approaches was found in this literature review. Traditional relaxation methods, such as breathing exercises, muscular relaxation, meditation and massage, may also be useful for improving mental well-being in Asian clients, but few well designed, controlled studies have investigated their impact on mental well-being outcomes.

A number of specific recommendations about how to work with Indian, Chinese and refugee clients are included in the *New Zealand Guidelines for Care of People at Risk of Suicide* (New Zealand Guidelines Group, 2003). The *New Zealand National Mental Health Sector Standard* (Ministry of Health, 2008) includes recommendations for working with ethnic clients in its outline of responsibilities for the health and disability sector workforce. Due to limitations in the research base, the recommendations in these New Zealand guidelines are often 'good practice' or clinician advice rather than evidence-based recommendations (New Zealand Guidelines Group, 2003). Furthermore many of the mental health guidelines do not have specific recommendations for working with Asian communities.

Ethnic specific services and adaptations to mainstream mental health and addiction services have been developed as models of service delivery in the United States and New Zealand (Cheung et al., 2004; Leong & Lau, 2001). For example, one centre in the United States recruited bilingual practitioners, conducted training on cultural beliefs and symptom expression and created service settings to fit with Asian cultures (Leong & Lau, 2001). It is not known whether adapted or cultural consultancy service models have a more positive impact on mental health than mainstream services (Leong & Lau, 2001; Serafica, 1999). Current evidence is limited to a small number of studies looking at service utilisation in the United States and is inconclusive on whether culturally specific services are more effective for Asian populations (Leong & Lau, 2001). At least two studies have noted that Asian people accessing specialised services were more

25 See http://psychology.ucdavis.edu/aacdr/programs.html for further details.

likely to complete treatment and used a greater number of services than those who used mainstream services (Serafica, 1999). Other research studies looking at specialised services do not report improved access. Further research is needed to test whether these findings of increased use are generalisable to other Asian specific services (Serafica, 1999).

Many practitioners and Asian clients report that family members should be included in healthcare interactions but research has not investigated the impact of family inclusion on patient outcomes or service delivery (Fortier & Bishop, 2003).[26]

Limited work has been done to evaluate the effectiveness of mainstream or Asian specific mental health and addiction services in New Zealand. Asian specific services have been developed in the Auckland region and involve incorporating interpreters and translating services in mainstream DHB services. The impact on rates of utilisation has been measured, but evaluations have not assessed whether these services have a greater benefit on mental health than mainstream services have. There appears to be no published literature about the effectiveness of addiction services for Asian clients in New Zealand.

Outcome measures can be used by services to assess changes in mental health, but Kirmayer et al (2003) argue that these may need to be translated into the patient's language and standardised according to the patient's level of education if they are to provide valid information. Specific Maori and Pacific outcomes measures have been developed in New Zealand due to concerns about the validity of mainstream measures for these populations. For Asian populations, specific outcomes measures have not been developed and there is limited evidence about the validity, reliability or sensitivity to change of existing measures for Asian communities.

During Phase II of the consultation, service providers listed the barriers they faced in providing culturally responsive services to Asian populations. These included limited availability of culture specific mental health services, accessibility and sharing of patient information, and the lack of coordination of services and resources across services and regions. Adapting mainstream services so they can respond effectively to Asian communities is important for many areas in New Zealand where there is insufficient density of Asian populations to justify Asian specific services. Stakeholders in the Phase II consultations noted that community collaborations are needed to identify and address gaps in service responsiveness and address the wider determinants of health, in particular, employment issues.

Summary

Little work has been done internationally to evaluate the effectiveness of culturally specific services or mainstream services in terms of outcomes for service users. There is also limited information about what treatment approaches are best for assisting recovery and mental well-being in Asian populations. This information is needed to influence service development and service funding decisions in New Zealand.

26 The Asian American Centre on Disparities research is undertaking an experimental trial of a family based therapy for patients from South-east Asia . See http://psychology.ucdavis.edu/aacdr/programs.html for further details.

Research questions

6.1. Test the effectiveness of different models of service delivery for the New Zealand Asian population (including one stop shops and tailored treatment delivered in mainstream services).

6.1a. Consider the effectiveness for different Asian sub-groups.[27]

6.2. How effective are the mental health and addiction services that currently serve Asian communities? In particular consider the effectiveness for infants, children, adolescents and their families.

6.2a. What are the immediate and long-term outcomes for people from Asian backgrounds who access specialist mental health services?

6.2b. What needs of these populations are not being met?

6.3. How do mental health services engage with Asian family members in treatment planning?

6.3a. What improvements could be made to current practices to encourage family involvement?

6.4. What are the most culturally appropriate tools to measure mental health, addiction and social outcomes for Asian groups?

6.4a. Measure the effectiveness of the tools currently used in New Zealand.[28]

27 This could include different ethnic and religious communities, child, adult and elderly age-groupings as well as migrant and New Zealand born sub-groupings.

28 Possible things to consider when measuring effectiveness of these tools include the cultural appropriateness and face validity of the tools for clients from different Asian communities, the sensitivity to change following interventions, the utility of the tools to support the delivery of care to individual Asian clients, and the utility of the tools to support funding, planning, monitoring and policy development for services for Asian service users.

WORKFORCE DEVELOPMENT

7. Developing New Zealand's workforce to provide culturally appropriate mental health and addiction care for Asian communities

"The ultimate goal of workforce development in the mental health and addiction sector is to ensure that we have the right mental health and addiction practitioners and staff in the right place, at the right time, to treat, support and care for the users of mental health and addiction services" (Ministry of Health, 2005, p.3).

"Cultural competence means that a practitioner has the attitude, skills and knowledge to work effectively and respectfully with people of other cultural backgrounds" (New Zealand Guidelines Group, 2008, p.20).

Cultural competency has been highlighted as a key need for those involved in delivering health and mental health services to Asian communities. Cultural competency is a requirement of New Zealand's *Health Professional Competency Assurance Act 2003* (DeSouza, 2006). Even so, particularly outside the Auckland region[29], there are few Asian staff working within mental health services (Bir et al., 2007) and few staff who understand Asian languages and cultures. This lack of cultural awareness is considered a barrier to service access for Asian communities (Ho et al., 2002). For example, medical practitioners and nurses working in primary care settings identified that cultural and language differences posed difficulties to service delivery (Ngai et al., 2001). Developing this knowledge in healthcare staff is complicated by the diverse range of languages, cultures, communication styles, religions, and levels of acculturation within Asian communities.

Many authors argue that a wide range of knowledge is necessary for providing culturally appropriate care to Asian clients[30]. Recommended knowledge includes culture specific communication styles (Ho et al., 2002; Jackson, 2006), emotion and symptom expression in Asian cultures (Ho et al., 2002), levels of cultural stigma associated with mental illness (Ho et al., 2002), use of alternative medicine, the importance of working with family (Ho et al., 2002; O'Hagan, 2001) and culture specific beliefs about the causes of mental illness (Ho et al., 2002).

Whilst a number of important cultural considerations have been proposed, there is little research to confirm which behaviours and attitudes have a measurable impact on the delivery of care. Fortier & Bishop (2003) suggest that such research would be a useful starting point before investigating what teaching methods work best to improve behaviours and attitudes. Many of the behaviours and attitudes currently emphasised in cultural competency training are based on practitioner predictions that these behaviours and attitudes are important.

29 An Auckland regional stocktake and training needs analysis for the Asian NGO and DHB workforce is being conducted in 2008 (Sue Lim, personal communication, 9 July 2008).

30 This argument may have tensions with models of cultural safety which argue that self-reflection about one's own cultural beliefs and worldviews and acknowledgment of power relations is of primary importance (Tse et al., 2005). Cultural safety models are part of nursing education and professional development in New Zealand and were originally developed to support Maori-Pakeha biculturalism (Richardson, 2004). This model does not appear to have been specifically applied or tested with Asian clients.

A few cultural competency training programmes have reportedly improved the cultural knowledge, attitudes and skills of health staff, and patient satisfaction (Beach, Price, Gary, Robinson, Gozu, Palacio, Smarth, Jenckes, Feuerstein, Bass, Powe, Cooper, 2005; Fortier & Bishop, 2003; Nayar, Tse, Wong, Wali, Thapliyal, & Bhui, 2007). There is a need for studies to investigate the impact of training on staff behaviour and the treatment outcomes of Asian clients (Fortier & Bishop, 2003).

Training techniques include lectures, discussion groups, case scenarios, cultural immersion, audio and visual presentations, interviewing people from other cultures and role plays (Beach et al., 2002). There is little research that has directly compared what methods of training are most effective (Beach et al., 2005; Nayar & Tse, 2006). Nayar and Tse (2006) argue that multiple methods of training should be used, with an emphasis on incorporating actual problems in the training. They also add that training content should include cultural awareness training, skill development and communication skill development. Different approaches may be useful for different professional groups and different levels of experience (Tse et al., 2005).

Nayar & Tse (2006) argue that post-training support is critical for successful workforce development. To sustain training-gains, there is a need for organisational support and commitment to cultural competencies at the organisational level (Nayar & Tse, 2006). Guidelines and standards of cultural competence and resources including follow up and assessment tools can also help to sustain cultural competencies post-training (Nayar & Tse, 2006). There is a need to investigate what types of support have the greatest impact on sustained cultural competencies and the mental health outcomes of Asian clients.

Another option to improve workforce cultural competencies is to recruit staff from the ethnic group of the client. However, a high degree of ethnic diversity in a particular region can make it difficult to develop ethnic specific practitioners of services for each ethnic group (Brach & Fraser, 2001; De Souza & Garrett, 2005; Fortier & Bishop, 2003; Taylor & Lurie, 2004).[31] There is also little evidence about whether trained practitioners have any benefit beyond improving rates of treatment attendance and access (Brach & Fraser, 2001; De Souza & Garrett, 2005; Fortier & Bishop, 2003; Taylor & Lurie, 2004). There appears to be little, if any, research measuring whether matched clinicians facilitate better mental health and addiction outcomes for Asian clients.

International research has also investigated the value of interpreters for improving care provided to minority ethnic groups. Most of this research has been conducted on Spanish speaking Mexicans living in the United States. Interpreter use is linked to improvements in service utilisation and improvements in perceived understanding of diagnosis and treatment for ethnic minority groups (Fortier & Bishop, 2003). However, research suggests that interpreters are not a complete solution for eliminating ethnic differences in health care. Providing interpreters does not necessarily lead to equivalent levels of follow up care or patient satisfaction for ethnic minority patients, and some interpreters have been known to make errors in medical interpretations (Fortier & Bishop, 2003). Limited work has been done to investigate the impact of interpreters on health outcomes for any minority group. Research in New Zealand and

31 The majority of these studies have been conducted in the United States, on Mexican populations, and have largely focused on general health care (Fortier & Bishop, 2003).

internationally does not appear to have measured the impact of interpreter services on patient satisfaction, treatment adherence or health outcomes (van Ryn, Burgess, Malat, & Griffin, 2006).

Previous and existing New Zealand initiatives to improve the cultural competency of the workforce include computer based training for undergraduate health students and cultural awareness training programmes for mental health professionals. A pilot programme is being conducted by Waitemata DHB and Refugees as Survivors across New Zealand during 2007-2008 to train practitioners in skills for working with refugee and migrant clients, which will include Asian clients. The evaluation of the training will measure its impact on the knowledge, skills and confidence of the workforce (S. Lim, personal communication, 9 July 2007). However, measurements of client satisfaction and changes to mental well-being for Asian clients are not included in the evaluation (S. Lim, personal communication, 12 August 2007).

A sample of Auckland and Wellington health practitioners reported that accessible interpreters are the most useful tool for providing better health services to the Asian population (Ngai et al., 2001). Recruiting Asian health professionals and Asian health support workers were also suggested as ways to improve care of Asian clients (Ngai et al., 2001).[32] Initiatives have been developed in the Auckland region following these recommendations but little formal evaluation of the effectiveness of these programmes has been conducted.

Summary

Many consider improving workforce cultural competencies to be an important way to enhance service provision to Asian communities in New Zealand. Existing research suggests that resources, training and organisational support are required to develop accessible and effective culturally competent staff. However, there is little research into which competencies are most important, the best ways to improve these competencies or whether cultural competencies have benefits for the mental health of Asian clients.

Research questions

7.1 What staff behaviours and attitudes are most important for enhancing recovery outcomes of Asian clients?

7.2. Examine and compare the effectiveness of different methods of training and ongoing support and mentoring to improve the cultural competency of the mental health workforce, particularly in relation to improved recovery outcomes for clients.

32 Improving care by recruiting Asian staff is limited by a number of difficulties recruiting Asian people into New Zealand's mental health positions. Few people within the Asian community hold New Zealand mental health qualifications, work experience and knowledge about mainstream health systems (Affinity Services, 2005).

DISCUSSION

RESEARCH AGENDA CONTEXT AND VALUE

The goal of this research agenda is to contribute to the mental well-being of Asian communities. It aims to do this by guiding research that will support the development of culturally responsive mental health and addiction services and mental health policy. Asian populations in New Zealand are often omitted from health research (DeSouza, 2006). At present, little is known about mental health and addiction needs in New Zealand's various Asian communities and the most effective ways to respond to these needs (Ho et al., 2002). Implementation of this mental health research agenda will be critical in improving the knowledge base amongst professionals, service users and families, and in ensuring that mental health promotion, clinical assessment and treatment is evidence-based and of the most benefit to those we care for.

New Zealand is currently in an excellent position to develop relevant research to support Asian mental well-being. As already identified, Asian people represent a growing proportion of the New Zealand population (Statistics New Zealand, 2007). This research agenda is as a key milestone in Te Kōkiri's leading challenge of responsiveness. The challenge focuses attention on the need "to build responsive services for people who are severely affected by mental illness and/or addiction, with immediate emphasis on improving service responsiveness of services for… Asian peoples and other ethnic communities" (p. 27). This research agenda is one of a series of population specific mental health and addiction research agendas developed over the last year. Emphasising the agenda priorities, in combination with ongoing DHB needs assessments and evaluations is crucial to alleviating knowledge gaps that impede service responsiveness.

It is expected that a number of research activities will be guided by this agenda nationally. This includes Ministry of Health funded research and academic and graduate research. The research agenda is not an end product but a 'process'. Ongoing development, review and revision of this research agenda is required as new knowledge and understanding emerge.

AGENDA DEVELOPMENT AND KEY RESULTS

The development of this research agenda was grounded in literature review and community consultations. A preliminary set of research questions was developed in consultation with the project reference group after an initial literature review. These questions were organised in main questions and sub-questions within seven topics. Amendments were made to these research topics and additional research questions were included and revised following feedback from community consultation and a further literature review.

Community consultation occurred in three rounds to maximise the opportunities for communities, practitioners and researchers to participate in the agenda setting process. Firstly, a project reference group provided an overview and analysis of the key issues. Secondly, a wider group of individuals (government representatives, service providers, researchers, community groups and service users) was approached to provide feedback on the questions. Thirdly, service users, community groups, service providers, planners and funders and government representatives were invited to provide feedback on the near final set of research questions.

Two literature reviews were conducted to investigate whether questions suggested by stakeholders had already been addressed in existing research. Extensive efforts were made to review sufficient literature to draw conclusions about the existing research base. However, it is certain that some literature will have been missed, and new research is constantly being conducted. Further analysis of existing research should be undertaken when embarking on research questions outlined in this document.

The fact that this Asian research agenda was initially developed in parallel with the refugee and migrant research agenda was a concern for some stakeholders during the community consultation. Initial discussions about the priorities for the three groups overlapped, making it difficult to establish whether topics related specifically to Asian, refugee or migrant communities, or all three groups. To address this overlap, further rounds of literature review, question analysis and service user review were conducted independently for the Asian population.

Consultation processes were limited by the small number of responses relative to the number of people approached. Furthermore, it was a challenging task for people without a research or academic background to make judgments about research questions. Stakeholder comments and suggested questions were therefore combined with the written ranking judgments to provide a fuller picture of the perspectives of stakeholders.

The finalised set of questions in this agenda reflect knowledge gaps that limit the ability to provide responsive services to Asian communities. Key knowledge gaps include the prevalence rates of mental health and addiction in New Zealand's Asian communities, the most effective ways to promote mental health and the most effective mental health service provision for Asian communities. Many of the questions extend previous research by focusing on measuring the impact of service initiatives for mental health, not just on service access or patient satisfaction. By addressing the knowledge gaps outlined in this agenda, researchers and research funders can support planning to deliver better and more appropriate services, and enhance mental well-being in Asian communities.

SOME METHODOLOGICAL CONSIDERATIONS

A number of methodological issues need to be considered when developing and implementing research that addresses Asian communities' mental health and addiction needs.

Using Asian as a specific category for sampling and analysis has both advantages and disadvantages. A single Asian category is infinitely better than including Asian people within the category of other or within the New Zealand Pakeha group which has often been done in previous New Zealand surveys. Including Asian within other dissimilar ethnicities prevents the understanding of the specific health needs of Asian people within New Zealand. Understanding the specific needs of Asian communities is important given that Asian people are expected to make up 16 % of the total population by 2026 (Statistics New Zealand, 2008). For national surveys to achieve sufficient power in the data analysis, oversampling of Asian communities and/or Asian sub-groups is required.

In addition to broad level research of people who fit within the 'umbrella' category of Asian (Kumar et al., 2006), differences and specific needs of sub-groups of Asian communities must not be neglected (DeSouza, 2007; Ministry of Health, 2006a). Broad-level data does not allow specific pockets of high-needs groups with Asian communities to be identified or addressed. Due to limitations in sample size, qualitative research may be necessary to gather information on the needs of very small Asian ethnic groups (Ho, 2008). Where possible, all research into Asian populations should consider sub-groups of Asian communities separately or at least clearly acknowledge the makeup of the Asian sample under study.

Research methodology should reflect respect for the cultural knowledge and values of others, as well as recognising the culture bound nature of one's own practices (Kearns & Dyck, 2004, cited in DeSouza, 2007). For example, researchers who are not familiar with Asian culture may incorrectly code or translate comments from Asian participants when cultural norms, beliefs, and languages are not clearly understood (Hunt & Bhopal, 2004). Western measurement tools may also have biases and limitations. Western diagnostic measures of mental health are based on biomedical models, which do not fully acknowledge Asian world views on the causes and cures for mental illness. Furthermore, Western measurement tools typically focus on symptoms of mental illness expressed within Western cultures and may not be sensitive to unique symptoms expressed by Asian communities (Takeuchi et al., 1998).

Engagement of the Asian community throughout the research process is essential for ensuring relevance to New Zealand's Asian community (Cheung et al., 2004; DeSouza, 2007; Rose, Thornicroft, & Slade, 2006). Asian people who experience mental illness are often reluctant to discuss their thoughts and experiences with people they do not already know and trust (Peterson, Barnes, & Duncan, 2008). Supporting and building on existing links between Asian communities and researchers is critical to the development of research which is relevant to, useful for and based on the experiences of Asian people who experience mental illness and/or addiction.

Some of the research questions focus on measuring the impact of service initiatives on the mental health of Asian clients. In doing this, the questions extend previous research focusing on proximal measures, such as service access or patient satisfaction, which are easier to obtain. Nonetheless, challenges exist in measuring the impact of a service or service type on mental health. When measuring the level of change associated with an intervention it is important to consider 'clinical significance' and 'cultural significance', not just whether the level of change meets criteria for 'statistical significance'.

Furthermore randomised, matched or waiting list control groups are important to demonstrate that changes in mental health outcomes are a result of service implementation rather than unrelated events. However, in the real world, it is often not practical or desirable to control other experiences and circumstances which can contribute to mental well-being, or to create control groups which do not experience the same access to services. Large sample sizes will be required when comparing the potential benefits of one type of programme over another. This is particularly important when programmes are likely to have a similar level of impact.
These challenges, and others, have to be taken into consideration so that research results will have sufficient credibility to impact on service responsiveness and service delivery.

AGENDA IMPLEMENTATION

The development of this Asian mental health and addiction research agenda presents a significant step towards a more strategic approach to setting research priorities.

For the agenda to have the desired impact, it will be critical to develop a plan for efficient implementation of research priorities. The large number of questions selected will allow flexibility for researcher creativity, multiple funding sources, and levels of research expertise. The priorities identified have implications for health strategies, primary and secondary NGO and DHB mental health services and training institutions. In particular, the topics of risk and protective factors and mental health promotion have implications for immigration support and community development. It is envisioned that a number of agencies will commit to funding the research questions outlined in this agenda. An implementation strategy outlining major research targets will be available on the Te Pou website.[33] It will be useful to have a central group promote, facilitate, and review the progress of the agenda over the next 3-5 years.

Strategies to enhance research leadership and the recruitment and retention of researchers within the Asian field will support this agenda and long-term research with Asian communities. Research establishments, such as the Centre for Asian Health Research & Evaluation, University of Auckland; the Migration Research Group, University of Waikato; the Centre for Applied Cross-cultural Research, Victoria University of Wellington; the Integration of Immigrants programme run by Massey University and AUT's Centre for Asian & Migrant Health Research, can play a pivotal role in developing this capacity. Collaborations across national and international research establishments and New Zealand government agencies involved in settlement research (Department of Labour, Ministry for Social Development, and the Office of Ethnic Affairs) along with other health research strands are also important for maximising the benefit of research expertise and research funding.

Continued involvement from stakeholder groups (service users, service providers, clinicians, researchers, service funders and policy maker) will be important in undertaking research and implementing the research findings into practice. There is a need to support opportunities for new and experienced researchers, community practitioners, and researchers in related fields, such as the public health research community to exchange ideas around Asian mental health and wellbeing. Asian service users and wider communities also need to be supported to engage in, understand and utilise research. To translate research findings into improved service delivery and health outcomes, it is crucial that information is disseminated to service providers, decision-makers and Asian communities. Dissemination activities must be tailored to their decision areas, interests and levels of existing knowledge of each group. Examples of modes of communication often used to support research translation include guidelines, practice recommendations and skills based training (Kerner, 2006).

This research agenda was developed to address gaps in the knowledge about mental health and addiction needs of Asian communities and the responsiveness of New Zealand mental health and addiction services to these needs. The strategic and consultative nature of this research agenda acknowledges the importance of developing research directed at addressing the needs of people living in New Zealand. Thorough processes of literature review and community

33 It is expected that this implementation strategy will be developed by February 2009.

consultations were central to the development of the research priorities outlined in this document. Funding of priorities, dissemination of research findings, and service provider and community engagement are crucial to the translation of research into improved mental well-being for Asian communities in New Zealand.

RECOMMENDATIONS

The following recommendations are designed to support agenda implementation, the expansion of research and information on Asian mental health and addiction, and translation of this agenda into improved mental well-being for Asian communities.

1. Establish research collaborations among service providers, researchers and members of the Asian community to enhance the knowledge transfer of research findings for providers and the community.
2. Researchers consider differences among Asian sub-groups, use technically and culturally sound research methodologies and advocate for oversampling of Asian communities in national surveys.
3. Multiple agencies commit to funding the research priorities outlined in this report.
4. Form an ongoing stakeholders group to lead the monitoring of the agenda, further prioritisation, and dissemination of research findings.
5. Disseminate research findings widely to service providers and Asian communities.

CONCLUSION

This Asian mental health and addiction research agenda collates research questions that address gaps in knowledge about the mental health and addiction needs of New Zealand's Asian communities and effective ways to respond to these needs. Literature review and community consultations were central to the development of these research priorities. The strategic and consultative nature of this research agenda acknowledges the importance of developing research which directly addresses the needs of people living in New Zealand. Funding of priorities, dissemination of research findings, and service provider and community engagement are crucial to the translation of research into improved mental well-being for Asian communities in New Zealand.

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APPENDIX A – ORGANISATIONS AND COMMUNITY GROUPS CONSULTED ON THIS AGENDA

Stakeholders consulted during the agenda development process represented a number of groups and organisations. Some stakeholders belonged to more than one organisation/community group. Groups and organisations represented are listed below.

Consumer and consumer advocates

- BoAiShe Chinese consumer self help group.
- Canterbury Mental Health Consumers Network (3 people).
- Challenge Trust (Pacific Services).
- Counties Manukau Consumer Leaders & Strategy Group.
- Kites Trust (consumer advocate).
- Independent consumers (2).
- Temp Solutions (2).

Community groups

- Asian Health Foundation.
- Canterbury Indonesia society.
- Chinese Positive Ageing Trust.
- Greek and Cypriot communities.
- Hindu Council of New Zealand.
- Refugee Council of NZ.
- The Asian Network Incorporated.
- Tainui MAPO (Māori Public Health Representative).
- Wellington Somali Council.

Mental health-specific services

- Affinity Services Ltd.
- Auckland DHB Asian Mental Health Services (2).
- Community Alcohol and Drug Services (2).
- Counties Manukau Mental Health and Addiction Network.
- Framework Trust.
- Franklin Bipolar Depression Support Group.
- Lifeline NZ.
- Mental Health Foundation (2).
- Mental Health Service, ADHB.
- Mental Health Service, unspecified.
- Problem Gambling Foundation (5).
- Refugees As Survivors, NZ (2).
- Refugees As Survivors, Wellington.
- Transcultural Service, Cornwall House.
- Waitemata DHB Asian mental health services (2).
- Werry Centre, Christchurch.

Primary care

- Canterbury Community PHO.
- Capital PHO.
- Christchurch PHO - Brief intervention service.
- Independent GP.
- Newtown Union Health Service.
- South-East Community PHO (4).
- Regional Public Health, Wellington.
- Waikato Primary Health.
- Union and Community Health (PHO).

DHB/ NGO health services (unspecified area)

- Auckland Chinese Medical Association.
- Auckland Regional Public Health Service.
- Counties Manukau DHB (2).
- Hutt Valley DHB funding and planning.
- Northern DHB regional advisory committee .
- Waikato DHB.
- Waikato DHB funding and planning.
- Waikato DHB, Population Health.

Social and settlement support services

- Auckland Regional Migrant Services (2).
- ChangeMakers Refugee Forum.
- Chinese New Settlers Services Trust.
- Christchurch Resettlement Services.
- Penina Health Trust.
- Refugee and migrant Services.
- Settlement Support New Zealand.

Researchers

- University of Auckland, School of Population Health (2).
- University of Otago.
- University of Waikato.

Government agencies

- Auckland Regional Settlement Strategy, Migrant and Refugee Health Action Plan.
- Department of Labour (3).
- Ministry of Education.
- Ministry of Health, Auckland.
- Ministry of Health, Wellington (3).
- Ministry of Social Development, Auckland.
- Wellington City Council.

APPENDIX B – IMPLEMENTATION OF CRITICAL RESEARCH QUESTIONS

FURTHER PRIORITISATION

The Asian mental health and addiction research agenda was developed through parallel processes of literature review and consultation. Twenty questions and ten associated sub-questions were identified as important and under-researched by researchers, policy makers, service planners and funders, frontline staff service users and community representatives.

To encourage implementation Te Pou would like to identify a small set of priorities to promote to key funding agencies. Research questions of importance are those which are feasible and most likely to translate into improved outcomes for Asian mental health and well-being. Stakeholder representatives will select agenda questions based on the following criteria relating to topic importance and feasibility.

Mental health importance/applicability

A. Important for improving outcomes for Asian mental health and well-being in New Zealand.
B. Useful to modify services, mental health promotion, or policy.

Research feasibility

C. New Zealand's research capacity is able to generate useful information.
D. Research methodologies and New Zealand data sets can be used to collect this information.

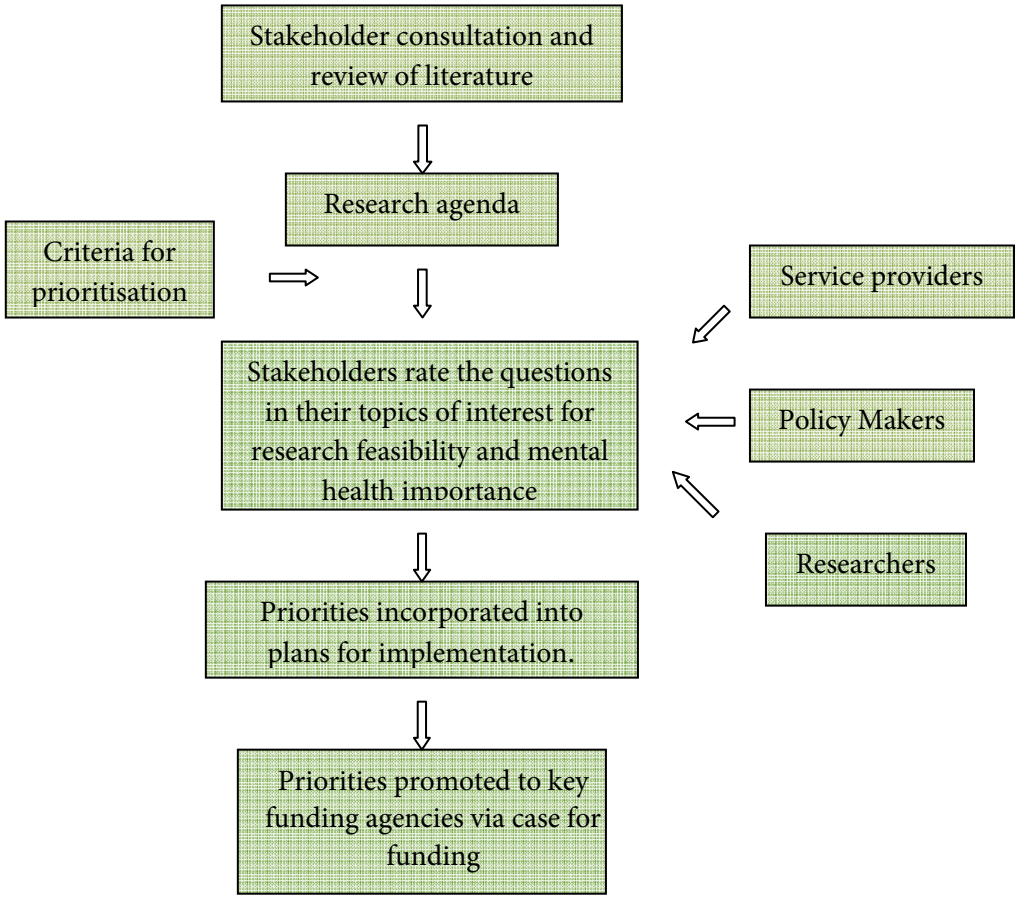
PROMOTING PRIORITY RESEARCH QUESTIONS

The selected priorities will be promoted to key agencies to encourage funding over the next 3-5 years. A case for funding, including indicative costs and estimates of potential service development and mental health impacts, will be developed to support funding decisions.

Funding and undertaking other research questions from the Asian mental health and addiction agenda is also very important. All the questions have been identified as important for improving responsiveness to mental health and addiction by various stakeholders.

A similar process will be used to generate a case for funding for priority research questions from the refugee and migrant and the Pacific mental health and addiction research agenda.

Figure 1B. further prioritisation and promotion process



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