Late Presentations by Asian People to WDHB Mental Health Inpatient Services Project Report

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1. Executive Summary

This report provides the findings of the study of the accessibility of mental health services for Asian people who are first time users who present to an inpatient mental health service. The Waitemata District Health Board (WDHB) mental health inpatient data verifies that Asian clients have a higher rate per 1000 first referrals as inpatients compared to other groups, such as Pacific, Maori and other. A review of the literature confirms that Asian people are most likely to delay seeking help for mental illness until they are very unwell (Burnard et al., 2006; Chan et al, 2002; Lu et al, 2014; McLaughlin, 2004; Tarnovetskaya & Cook, 2008). The literature also identified the barriers they experience when wanting to access mental health services and the models services used to overcome these (Dong et al, 2014; Hampton & Sharp, 2013; Ho et al, 2003; Ko, 2013).

The participants in the study were referred by Waitemata DHB's Mental Health inpatient services. The criteria for the study were Asian people who were first time attenders as inpatients. The project methodology included the collection of service user, families/caregivers and attending clinicians' information. The survey was conducted from September 2014 to May 2015. The study findings have limitations due to the small number of participants. Therefore, the findings of the study may not be generalisable to other Asian mental health users in WDHB or service providers in other DHBs.

Importantly, as this is an under-served population of mental health service users, the participant interviews uncovered some previously unrecognised concerns about why Asian clients present late to mental health services. In this respect, the study achieved the main goal which was to describe holistically and in detail the experiences of Asian first-time users of Mental Health Inpatient services. The results highlight the need for more culturally appropriate mental health awareness programmes in Asian communities disseminated through language appropriate ethnic media including as well as the internet and ethnic TV channels; magazines and newspapers. The study offers some key recommendations for improving mental health service awareness in Asian communities in the Auckland Region.

2. Project Background

The purpose of this project is to investigate the causes of the late presentations by Asian people to inpatient mental health services within 24 hours of first referral and to recommend approaches to improve access.

The term 'Asian' in this project refers to people with origins in the Asian continent, from China in the north to Indonesia in the south and from Afghanistan in the west to Japan in the east. This definition of 'Asian' excludes people originating from the Middle East, Central Asia (except Afghanistan) and Asian Russia (Mehta, 2012).

2.1 Rationale

The investigation is requested by the General Manager and Clinical Director of Mental Health Services because the Waitemata District Health Board (WDHB) mental health inpatient data shows that Asian clients are more likely to have their first presentation to mental health services as an inpatient. This is a quality improvement project.

2.2 Late Presentation Data

The following table shows the Asian groups have the highest rate per 1000 of first referrals to Mental Health Services as an inpatient, compared with other groups, based on the four financial years 2011-12, 2012-13, 2013-14 and 2014-15.

Table 1: First MH Referral to Inpatient Service - Rate per 1000 of First Referrals

Year and Ethnic Group

Row Labels	First Referral	First referrals with presentation to IP	First MH Referral to IP rate per 1000 first referrals
FY11-12	**10056**	**87**	8.65
Asian	684	9	13.16
Maori	2025	13	6.42
Other	6002	58	9.66
Pacific Island	1345	7	5.20
FY12-13	**10080**	**84**	8.33
Asian	705	10	14.18
Maori	2036	7	3.44
Other	5914	60	10.15
Pacific Island	1425	7	4.91
FY13-14	**4744**	**46**	9.70
Asian	366	7	19.13
Maori	960	10	10.42
Other	2824	24	8.50
Pacific Island	594	5	8.42
FY14-15	**7720**	**73**	9.46
Asian	590	9	15.25
Maori	1626	7	4.31
Other	4481	49	10.94
Pacific Island	1023	8	7.82
Grand Total	**32600**	**290**	8.90

NB: FY14 -15 only includes data up to March 15

IP = Inpatient

Admission within 24 hours of presentation

Source: Jane Yang (Mar 2015) PIMS

The following table shows a summary of Asian first presentations to inpatient services for the 40 month period from FY11 to FY 15 (Jul11 to Dec 13 and July 14 to April 15), by Asian sub-group. Other Asian groups, 15 (33%), Chinese, 12 (26%) and Indian, 11 (24%) have high numbers of first referrals to inpatient services, compared with other groups.

Table 2: Summary of Asian first presentations to inpatient services by Asian sub group for the 40 month period from Jul 11 to April 15

Asian-sub group	**Sum of First Pres IP**	**Sum of First Pres IP**
Asian not further defined	5	11%
Chinese	12	26%
Indian	11	24%
Other Asian	15	33%
South East Asian	3	7%
Grand Total	**46**	**100%**

Table 3 shows a summary of Asian first presentations to inpatient services for the 40 month period from FY11 to FY 15 (Jul 11 to Dec 13 and July 14 to April 15), Asian sub-groups by diagnosis. Unspecified Non-organic Psychosis (7) and Bipolar Affective Disorder (3); are the top two diagnoses from the first referrals presented to inpatient services for the reporting period. *Only 1 of the presentations for this reporting period had a diagnosis of suicidal ideation.*

Table 3: Summary Asian first presentation to inpatient services by Asian sub group by Diagnosis for the 40 month period from Jul 11 to April 15

Diagnosis	**Chinese**	**Asian NFD**	**Indian**	**Other Asian**	**Total**
Acute and transient psychotic disorder, unspecified, without mention of associated acute stress	1				1
Adjustment disorders with low mood	1		1		2
Bipolar affective disorder, unspecified	1	1	1		3
Bipolar affective disorder, current episode manic with psychotic symptoms				1	1
Bip I Dis(PPO)Most Recent Epi Manic Severe with psychotic feature				1	1
Bipolar I Disorder, Most Recent Episode Manic, Moderate				2	2
Depressive Disorder non specified	1				1
Depressive episode, unspecified, not specified as arising in the postnatal period	1				1
Diagnosis Deferred on Axis I or II				1	1
Major Depressive Disorder, Recurrent, Severe Without Psychotic Features				1	1
Major Depressive Disorder, Recurrent, Severe With Psychotic Features				1	1
Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, psycho				1	1

Diagnosis	Chinese	Asian NFD	Indian	Other Asian	Total
No Diagnosis not assessed		1		1	2
Null	1	4	1	4	10
Psychosis NOS	1			2	
Psychotic disorder NOS	2				2
Schizoaffective disorder, manic type		1			1
Schizoaffective disorder, unspecified	1				1
Schizophrenia, Paranoid Type			2		2
Schizophrenia, unspecified				1	1
Severe depressive episode with psychotic symptoms, not specified as arising in the postnatal period	1				1
Suicidal ideation	1				1
Unspecified nonorganic psychosis	2		1	4	7
Unspecified Mental Disorder (nonpsychotic)				2	2
Total (Jul11-Dec13) FY11-FY14	**14**	**7**	**6**	**22**	**46**

NB: See Appendix 2 for additional data comparing Asian first time referrals to inpatient services with overall Asian first MH referrals, by diagnosis and by Asian sub group.

2.3 Project Tasks

The following are key tasks:

(a) Conducted a literature review to inform potential barriers, solutions, and successful models
(b) Designed surveys to gather views from Asian service users, families and attending clinicians
(c) Agreed methodology and timeframe with Asian mental health and addiction governance group
(d) Implemented the survey as per agreed methodology
(e) Finalised the project report and recommendations with input from the Asian mental health and addiction governance group

2.4 Summary of Literature Review

A Literature review was completed in Phase 1 of the project. The review of the literature was undertaken by undergraduate nursing students from the School of Nursing, University of Auckland with guidance and support from Sue Lim and Dr Annette Mortensen.

The purpose of the literature review was to gather evidence as to (a) why Asian people delay seeking help for mental illness until they are very unwell; (b) what are the barriers they experience when wanting to access mental health services; and (c) what models do other services use to overcome these?

Findings

Demographics

Asian in this literature refers to anyone identifying themselves as of an Asian ethnic group. Asian groups in New Zealand represent a diverse range of religions, cultures and values (Beford & Ho, 2008). Depending on length of time in New Zealand and acculturation to New Zealand society, cultural and religious backgrounds may have a strong influence on health seeking behaviours.

In 2013, in the Auckland Region 23% of the population was Asian. The five largest Asian ethnic groups in Auckland were: Chinese (38.5%); Indian (34.6%), Korean (7.2%), Filipino (7.0%) and Sri Lankan (6.7%) (Gomez et al., 2014). 13.4% of the Asian population spoke no English. The top three languages spoken by the Asian population other than English were Hindi, Mandarin and Cantonese. Between 2006 and 2013, in the Auckland Region, the Asian population grew by 71,064 (31.2%) (Gomez et al, 2014).

The proportion of the Auckland Asian resident population born overseas is 78%. Almost a quarter of Asian people have lived in New Zealand less than 5 years. Waitemata DHB has the highest proportion of people living in New Zealand for less than five years at 45%.

Potential Barriers

The main barriers to accessing mental health services include:

- Stigma
- Cultural barriers
- Language
- Use of alternative therapies
- Distrust of mainstream services
- Immigration
- Lack of awareness of services
- Unfamiliarity with the structure of health care services

Models that are used to overcome these barriers

The international literature identifies a number of models which have been shown to successfully reduce the impact of access barriers to Mental Health Services for Asian patients and families. These include the following:

- The Community Health Worker (CHW) model which allows the delivery of care in homes and community settings. In addition to reducing barriers such as transport, limited appointment times and fears of entering a mental health service; CHW's reduced client's social isolation.

- A free/low cost access model aims to provide either low cost or free of charge access to health services (CBG Health Research Ltd, 2005, 2003). This service while beneficial for the service users requires a lot of funding and only minimally addresses barriers to access.

- An evaluation of the Reducing Inequalities Contingency Fund (RICF) project highlighted the following strategies as successful in increasing access to primary health care for targeted populations. These included: the reduction or removal of the fees barrier; knowing the characteristics of their target population, employing staff who belong to the same community or who speak the same language; the use of personal engagement to build trust through home visits and frequent consultations; a friendly approach to service delivery and flexibility in service arrangements (Walton, 2007). Task shifting is a redistribution method which has been applied to mental health services to strengthen and expand the health workforce (Kazdin & Rabbitt, 2013). In terms of improving Asian mental health outcomes, task shifting could be applied in a New Zealand context by utilizing Asian health care assistants or caregivers who are working in the community to act as navigators or Asian service users.

- The disruptive innovation theory approach is a novel mental health service delivery model designed to reduce barriers (Kazdin & Rabbitt, 2013). The application of technological aids in the provision of mental health care for example, the use of smartphones, tablets, the internet, and video conferencing offer convenient, user-friendly and immediate ways to provide mental health treatment and care. A study by Lu et al. (2013) identified internet based cognitive behavioural therapy (iCBT) as an innovation which would improve access to mental services for Chinese-speaking international students in Australia. In New Zealand, a programme like iCBT could deliver a series of highly structured online lessons that include information and skills that are similar to those taught in face-to-face CBT. However, while this approach may be effective for individuals competent with using technology, it may not suit isolated populations, particularly elderly Asian migrants, that do not have access to technology and online resources.

- The final model focuses on expanding interventions into unconventional settings. This approach has been illustrated by mental health programmes in Thailand (Ng et al., 2013). By developing care beyond the traditional setting and into everyday settings, individuals who may need the services but are not receiving them can gain access to care (Kazdin & Rabbitt, 2013; Walton, 2007). For example, mental health services could be promoted at local clubs such as Tai-Chi, badminton, table tennis or karate, and schools or religious organisations attended by Asian families .

Summary of findings

- There is evidence that the Asian population is delaying seeking mental health services until they are acutely unwell.
- Research indicates that there are multiple factors contributing to the late presentation of the Asian population to health services.
- These barriers occur at an individual, community and societal level impeding the ability of Asian people to engage with mental health services.
- There is evidence of multiple services nationally and internationally that have addressed these issues.
- The practical interventions utilized by services to address access issues include services that are multi-lingual, culturally sensitive and community focused.
- No single model can successfully overcome all of the access barriers that exist, most of the models focus on diminishing the impact of specific barriers.

Addressing the factors outlined above to improve access to mental health services will reduce the inequities that exist for the Asian populations compared to other populations in regards to utilising

mental health services. Ultimately increasing access to health services will enhance Asian health outcomes and reduce inequalities

The findings from the literature were used to inform the design of the survey questions.

2.5 Methodology

- Forms *(See Appendix 1)*
  - Referral Form:
    - This was created to collect service user's information from the referring service (Waiatarau or Taharoto).
    - It was also for recording whether the referral had led to any participation from the service user/family/caregiver/attending clinician
  - The survey questions were informed by the findings from the literature. Three survey forms were designed to collect views from:
    - Survey Form 1: Service users
    - Survey Form 2: Families/ caregivers
    - Survey Form 3: Attending clinicians
  - Three participant information sheets were designed for the interviewer to explain the reason for the survey to the participants
    - PIS Form 1: Service users
    - PIS Form 2: Families / caregivers
    - PIS Form 3: Attending Clinicians

- Participation
  - Participants (service user, family/caregiver, clinician) were given explanations about the reason for the survey)
  - Participants were informed that participation was voluntary

- Survey Timeframe
  - The survey started on 1 September 2014
  - The survey was completed on 30 May 2015.

- Survey Forms and Participant Information Sheets were not translated (an interpreter was provided to assist the interviewer to interview non-English speakers)

- Use of Interpreters
  - Participant Information was explained in the client's language or with the help of an interpreter or in English
  - Survey Interviews were conducted in the client's own language with the help of an interpreter or in English

- Survey Referral Process:
  - Taharoto and Waiatarau notified the Asian mental health service (AMHS) Team Leader (TL) (Hannah Lee) by email when an Asian service user was identified who met the referral criteria
  - Referral criteria: An Asian service user who is admitted and attended by either the Taharoto or Waiatarau unit and was a first time referral
  - Referral notifications must be sent to AMHS TL within 48 hours of service user's admission

- The AMHS Team Leader completed the referral form (Form 1) from the referral notification information and from the HCC system
- The AMHS TL referenced the NHI number to the Survey Forms 2, 3, and 4 for the interviewer

- Survey Process
  - The Team Leader coordinated the survey interview
  - The interviewer arranged to meet and discuss the Participant Information with the service users, family/support/caregiver, and the responsible clinician to encourage participation
  - The survey was conducted for each case referred based on voluntary participation
  - An interpreter for interviews with service user/family/caregiver was organised as and when required
  - All interview notes were written in English

- Sample size
  - Table 1 shows that on average only 10 Asian service users per year are admitted to inpatient services as first time referrals, therefore, the sample size is expected to be small
  - The target was to achieve a minimum of 12 responses from service users, family members/caregivers, clinicians from a minimum of 7 case referrals within the survey period

  NB: The case referral here refers to a specific /unique service user.

- Inclusion

  The survey was inclusive of:
  - All Asian first time referrals admitted and attended to by either the Taharoto or Waiatarau unit
  - All families /support persons /caregivers of referred service users
  - Attending clinicians of referred service users

- Exclusion
  - The survey excluded non-Asian first time referrals to the Taharoto or Waiatarau unit.

3. Survey Findings

Table 4: Summary of results from the survey conducted between September 2014 and May 2015 (9 month period)

Late Presentation by Asian People to WDHB Mental Health Inpatient Services - Survey Project

Referral From - Survey on the accessibility of mental health services for Asian people

A. Referral Information				B. Patient Information									
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	
23/10/2014	1	Waiatrau			Waitarau	22/10/2014	F	45-64	Korean	Albany	Korean	risk to self-thoughts of suicide	Service user	
01/10/2014	2	Waiatrau			Waitarau	09/09/2014	F	25-44	Chinese	WT	Mandarin	Post-Natal Depression	Service user	Husband
11/04/2014	3				Taharoto	11/04/2014	F	25-44	Korean	North	Korean/Hindi	Depression	Service user	Husband
23/10/2014	4	Waiatrau			Waitarau	19/10/2014	M	25-44	Vietname	North	Vietnamese	Adjustment Disorder - risk of suicide	Service user	

Survey Form 1 - SERVICE USER SURVEY FORM

Survey on the accessibility of mental health services for Asian people

Q1	Q2	Q3	Q4	Q5	Q6		Q7
11+	NS Crisis team nurse other family member/husband	Yes	Yes	a,b,c,d,e,f,g, h,I,j,k,l,m,n, o,	Yes	mother, friend, Korean counsellor	information about depression in Korean version/Public Advertisement in Korean(magazine and newspapers)
0-2	and other family member/husband	Yes	Yes	b, j	no		Nil
11+	and	No	Yes	a,b,c,d,e,f,g, h,I,j,k,l,m,n, o,	Yes	The GP and Oriental medicine	more mental health promotion in community media, including Korean newspapers and magazines because computer (internet) is not available for some
6-10	doctor	yes	no	a,b,	no		nil

Table 4 above provides a snapshot of the late presentation by Asian people to Waitemata DHB Mental Health Inpatient services' results from the survey conducted between September 2014 and May 2015 (9 month period). The next section outlines the summary of findings.

3.1 Summary of findings

The survey was conducted between 1st September 2014 to 30 May 2015. During this period there were five (5) service users who matched the criteria for referral but one (1) was not referred because the person in charge or the referring process was on annual leave. Only four (4) referrals were received for the survey.

All four referred service users; family members and responsible clinicians were approached for participation.

We had 100% (4) referred service users responded to the survey voluntarily and completed the survey Form (1). We had 50% (2) of the referred family members complete the survey Form (2). Unfortunately, due to lack of awareness of the survey project, 0% (0), that is, none of the referred responsible clinicians participated in the survey project.

Referred service users who participated in the survey were aged between 25 to 62. Two of the referred service users identified themselves as Korean, one as Chinese and one as Vietnamese.

All the referred service users and family members were able to speak basic functional English besides speaking their own first language.
Two service users identified they had lived in New Zealand for over 11 years; one between 6 and 10 years and one lived between 0 and 2 years.

Three out of four service users identified they had enrolled with a family doctor.

The participating service users' diagnoses included the risk of self-thoughts of suicide; post-natal depression; and depression and adjustment disorders.

Both of the service users who had identified as "lived in New Zealand for over 11 years" stated that they had not accessed mental health services earlier because they:

- did not know mental health care services existed
- did not know how to access services
- believed the problem was not severe enough
- accessed other support instead of mainstream services (e.g. traditional healer, alternative therapies and spiritual and religious help)
- believed services were not culturally appropriate
- had language issues or concerns
- cost of service was a concern
- had issues with transportation
- risk of stigma from the community was a concern
- had fears of personal shame and embarrassment
- had fears of being segregated or rejected
- the family did not support them accessing mainstream health care
- had concerns about their residency status
- had concerns about how accessing mental health services would impact on their future endeavours (e.g. education, employment and marital status)

Both of the service users who had "lived in New Zealand for over 11 years" indicated that they had discussed their health concerns with either health professionals or a person in New Zealand prior to their admission. The group of people whom they discussed their mental health concerns with were identified in the survey as: mother; friend; Korean counsellor; general practitioners and oriental medicine person.

Feedback from the Korean service users included the need to:

- improve access to mental health services
- increase mental health promotion in community media, for example having information about depression available and using ethnic media (eg Korean magazines and newspapers), because not every household has access to the internet or a computer.

4. Discussion

This study was limited by the small number of participants. Further, there are limitations in the study design as the participants were not randomly selected but were purposefully selected according to pre-determined criteria and as the opportunity to approach participants arose. Therefore, to what degree the views of study participants; and their families/caregivers are representative of the broader Asian mental health population, is unknown. Another limitation includes the diagnostic categories of participants in the study. Compared to participants who had a diagnosis of depression, those who present with psychosis may present late because they do not believe that they are experiencing mental health issues. It is less likely in the latter case that not presenting to a mental health service is a result of not knowing how to access a mental health service. Due to the restricted time and resources available, it was not possible to enrol more participants in the study. On average only 10 Asian service users per year are admitted to inpatient services as first-time referrals, despite Asian groups having the highest rate per 1000 first referrals as Mental Health inpatient. There were five service users who met the criteria for the study during the survey period September 2014 to May 2015. However due to one referrer being on annual leave; we did not receive one of the referrals. The findings of this study may not be generalisable to other Asian mental health users in WDHB or to mental health services in other DHBs. Importantly, as this is an under-served population of mental health service users, the participant interviews uncovered some previously unrecognised concerns about why Asian clients present late to mental health services. In this respect, the study achieved the main goal which was to describe holistically and in detail the experiences of Asian first-time users of Mental Health Inpatient services. The results highlight the need for more culturally appropriate mental health awareness programmes in Asian communities disseminated through language appropriate ethnic media including, as well as the internet and ethnic TV channels, magazines and newspapers. The lack of participation of clinicians was a result of insufficient promotion of the survey to the clinicians. Therefore, further research is needed which includes clinician's views on the reasons for late presentation. The recommendations in the next section offer guidance on improving mental health service awareness in Asian communities in the Auckland region.

5. Conclusion & Recommendations

The Waitemata DHB's mental health inpatient data shows that Asian clients have a higher rate per 1000 first referrals as inpatients compared to other groups, such as Pacific, Maori and other. According to the four financial years of first referrals, it was found that Asians have a higher rate per 1000 of first referrals. Asians represent 13%, 14.18%, 19.13% and 15.25% compared to the mean of 8.65%, 8.33%, 9.7% and 9.46% respectively in 2011-12, 2012-13, 2013-14 and 2014-15 years.

The data from July 11 to Dec 13 and July 14 to April 15 (40 month) shows that other Asian groups (33%), Chinese (26%) and Indian (24%) have the higher number of first referrals to inpatient services. Unspecified Non-organic Psychosis (7), Bipolar Affective Disorder are the top two diagnoses from the first referrals presented to inpatient services for the same period. Other common diagnoses also include adjustment disorders with low mood, bipolar 1 disorder, most recent episode manic, moderate, psychotic disorder NOS, Schizophrenia, Paranoid type and unspecified mental disorder (nonpsychotic).

A literature review conducted by the undergraduate nursing students from the School of Nursing, University of Auckland identified stigma, cultural barriers, language, use of alternative therapies, distrust of mainstream services, immigration, lack of awareness of services and the unfamiliar structure of health care services as the potential main barriers to using mental health services. Models that are used to overcome these barriers include the community health worker (CHW) model; A free/ low-cost access model aims to provide either low cost or free of charge access to health services; an evaluation of the reducing inequalities contingency fund (RICF); the disruptive innovation theory approach such as use of smartphones, tablets, the internet user-friendly and immediate ways to provide mental health treatment and care and the final model focuses on expanding interventions into unconventional settings, such as homes and community settings. The literature findings were used to inform the design of the survey questions.

A survey was conducted from September 2014 to May 2015 with four Asian service users whose first referral to a mental health services was as to inpatient mental health service. The survey confirmed Rountree, Rooke and Rogers, (2014) findings of the barriers which contribute to Asian people's later presentation to mental health services compared to other groups. The findings tell us that service users would like to see changes in increasing mental health promotion in the community media through ethnic newspapers or magazines.

A significant finding of the survey was the fact that Asian service users who have lived in New Zealand 11 years or more have discussed their health concerns prior to their admission. The group of people includes friends, Korean counsellor, GP, Oriental medicine person and next of kin. It also informs us that these two migrants who have lived in New Zealand for over 11 years are still not familiar with mental health care services and how to access services. Additionally their late presentations are exacerbated by their preferred help seeking behaviours; believing mental health services are not culturally appropriate; language issues, cost of service; stigma, shame, concerns about residency status and other factors.

Below are key recommendations for Waitemata DHB mental health services for consideration to respond to the findings of the literature review and the survey.

- A clearer road map or information line for Asian communities to enable them to access information about mental health services and service access criteria
- Service information is easy and simple to understand.
- Encourage early help seeking behaviour in order to avoid late presentation issues in inpatient mental health service.
- Addressing stigma and discrimination associated with mental illness, i.e. programme such as Like Minds, Like Mine Chinese Media Campaign, Kai Xin Xing Dong.
- Psychoeducational information available to the general public in Asians languages (Chinese & Korean) to start with since these two are the largest non-English speaking Asian population in the Waitemata district
- Increasing the emphasis on cultural sensitivity of mental health services are available and able to meet the need of individual, i.e., eCALD™ training
- Promoting the use of interpreter services for primary health and secondary services

- Establishing an Asian Mental Health Community Awareness Working Group to develop a strategy that
  a) connects with Asian communities to address issues relating to stigma and discrimination in mental health through inter-sectoral links.
  b) raise awareness of mental health services which will result in an early engagement with services and improve mental health literacy.

Appendix 1: FORMS

REFERRAL FORM

Survey on the accessibility of mental health services for Asian people

A. Referrer Information

1. Referral Date: _____/_____/_____ (dd/mm/year)

2. Referred by (name): _____

3. Referring Service:
   - ☐ Taharoto
   - ☐ Waiatarau

4. Attending Clinician (name): _____

B. Patient Information

1. NHI Number: _____

2. Inpatient Service:
   - ☐ Taharoto
   - ☐ Waiatarau

3. Admission Date: _____/_____/_____ (dd/mm/year)

4. Gender
   - ☐ Male
   - ☐ Female

5. Age
   - ☐ 0 – 14
   - ☐ 15 – 24
   - ☐ 25 - 44
   - ☐ 45 - 64
   - ☐ 65 - 74
   - ☐ 75+

6. Ethnicity
   - ☐ Chinese
   - ☐ Indian
   - ☐ Korean
   - ☐ Filipino
   - ☐ Other Asian, please specify _____

7. Residing in
   - ☐ North
   - ☐ West
   - ☐ Central
   - ☐ East
   - ☐ South
   - ☐ Other, please specify_____

REFERRAL FORM, continue…

8. Language spoken
   - ☐ Mandarin
   - ☐ Cantonese
   - ☐ Korean
   - ☐ Hindi
   - ☐ Other, please specify _____

9. Diagnosis _____

Please record this after service users have agreed to participate or the interview has been conducted:

10. For this referral, who participated in the survey?
    - ☐ Service User
    - ☐ Parent
    - ☐ Sibling
    - ☐ Other family member
    - ☐ Friend
    - ☐ Attending clinician
    - ☐ Other, please specify _____
    - ☐ No one

Waitemata
District Health Board
Best Care for Everyone

SURVEY FORM 1

SERVICE USER SURVEY FORM

Survey on the accessibility of mental health services for Asian people

1. How long have you lived in New Zealand for?
   - ☐ 0 – 2 years
   - ☐ 3 – 5 years
   - ☐ 6 – 10 years
   - ☐ 11 years +

2. Who did you come into hospital with?
   - ☐ Parent
   - ☐ Sibling
   - ☐ Other family member
   - ☐ Friend
   - ☐ Alone
   - ☐ Other, please specify _____

3. Do you speak English?
   - ☐ Yes
   - ☐ No

4. Are you enrolled with a family doctor?
   - ☐ Yes
   - ☐ No

5. Which of the following factors deterred you from accessing mental health services earlier?
   - ☐ You did not know mental health care services existed
   - ☐ You did not know how to access services
   - ☐ You believed the problem was not severe enough
   - ☐ You accessed other support instead of mainstream services (e.g. traditional healer, alternative therapies and spiritual and religious help)
   - ☐ You believed services are not culturally appropriate
   - ☐ You had language issues or concerns
   - ☐ Cost of service was a concern for you
   - ☐ You had issues with transportation
   - ☐ Risk of stigma from the community was a concern for you
   - ☐ You had fears of personal shame and embarrassment
   - ☐ You had fears of being segregated or rejected
   - ☐ Your family does not support you accessing mainstream healthcare
   - ☐ You had concerns about your residency status
   - ☐ You had concerns about how accessing mental health services would impact on your future endeavors (e.g. education, employment and marriage status)
   - ☐ Other, please specify

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SERVICE USER SURVEY FORM, continue….

6. Did you discuss your health concerns with any health professional or person in New Zealand or overseas, prior to this admission?

☐ Yes
☐ No

If Yes, who did you discuss your concerns with? : _____

7. What needs to change to improve access to mental health services?

Thank you for completing this survey!

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SURVEY FORM 2

FAMILY/CAREGIVER SURVEY FORM

Survey on the accessibility of mental health services for Asian people

1 How long has your family member lived in New Zealand for?
- ☐ 0 2 years
- ☐ 3 5 years
- ☐ 6 10 years
- ☐ 11 years +

2. Who accompanied your family member to hospital?
- ☐ Parent
- ☐ Sibling
- ☐ Other family member
- ☐ Friend
- ☐ No one
- ☐ Other, please specify _____

3. Does your family member speak English?
- ☐ Yes
- ☐ No

4. Is your family member enrolled with a family doctor?
- ☐ Yes
- ☐ No

5. Which of the following factors do you believe deterred your family member from accessing mental health services earlier?
- ☐ He/she did not know mental health care services existed
- ☐ He/she did not know how to access services
- ☐ He/she believed the problem was not severe enough
- ☐ He/she chose to access other support instead of mainstream services (e.g. traditional healer, alternative therapies and spiritual and religious help)
- ☐ He/she believed the services are not culturally appropriate
- ☐ He/she had language issues or concerns
- ☐ Cost of services was a concern for him/her
- ☐ He/she had issues with transportation
- ☐ Risk of stigma from the community was a concern for him/her
- ☐ He/she had fears of personal shame and embarrassment
- ☐ He/she had fears of being segregated or rejected
- ☐ He/she feels they were not supported by family to access mental health care
- ☐ He/she had concerns about their residency status
- ☐ He/she had concerns about how accessing mental health services would impact on their future endeavors (e.g. education, employment and marriage status)
- ☐ Other, please specify

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FAMILY/CAREGIVER SURVEY FORM, continue…

6. Did you or your family member discuss his/her health concerns with any health professional or person in New Zealand or overseas, prior to this admission?
   - ☐ Yes
   - ☐ No

   If Yes, who did you discuss your concerns with? : _____

7. What needs to change to improve access to mental health services?

Thank you for completing this survey!

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SURVEY FORM 3

CLINICIAN SURVEY FORM

Survey on the accessibility of mental health services for Asian people

NOTE to clinician: This could be information gathered from the patients or family members.

1. From your assessment of the patient and family member(s), what factors do you believe influenced his/her late presentation to WDHB mental health services?

   ☐ Patient did not know mental health care services existed
   ☐ Patient did not know how to access services
   ☐ Believed the problem was not severe enough
   ☐ Accessed other support instead of mainstream services (e.g. traditional healer, alternative therapies and spiritual and religious help)
   ☐ Believed services are not culturally appropriate
   ☐ Language issues or concerns
   ☐ Cost of service was a concern
   ☐ Issues with transportation
   ☐ Risk of stigma from the community
   ☐ Fear of personal shame and embarrassment
   ☐ Fear of being segregated or rejected
   ☐ Family did not support them accessing mainstream healthcare
   ☐ Concerns about residency status
   ☐ Patient had concerns about how accessing mental health services would impact on your future endeavors (e.g. education, employment and marriage status)
   ☐ Other, please specify_____
   _____

2. Did the patient or family member(s) discuss his/her health concerns with any health professional or person in New Zealand or overseas, prior to this admission?

   ☐ Yes
   ☐ No

   If Yes, who? _____

Thank you for completing this survey!

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PIS FORM 1

SERVICE USER Participant Information Sheet

Project title
Identifying the causes of late presentations by Asian people to WDHB mental health inpatient services.

Reason for the survey
The overall aim of this quality improvement survey project is to improve access to WDHB mental health services by the Asian population. The purpose of this project is to investigate the causes of the late presentations by Asian people to inpatient mental health services within 24 hours of first referral and to recommend approaches to improve access.

Participation in the survey
Participation in this survey is completely voluntary. The project requires completion of a one-off survey that will be kept confidential. There are no consequences if you choose not to participate. If you do choose to participate, in no way will the answers you provide impact on the care you receive.

Confidentiality and Data Storage
Any information that identifies you personally will be treated confidentially. Your identity will not be disclosed in any discussion or report of the research. All of the information gathered from this survey will be stored safely.

Use of the data
It is intended that the results from this research will be used to inform the management of WDHB district mental health service to consider the recommendations for improvement.

For any enquiries regarding this survey project you may contact Sue Lim, Operations Manager Asian Health Support Services, Phone: 09 4423239

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PIS FORM 2

FAMILY/CRAEGIVER Participant Information Sheet

Project title
Identifying the causes of late presentations by Asian people to WDHB mental health inpatient services.

Reason for the survey
The overall aim of this quality improvement survey project is to improve access to WDHB mental health services by the Asian population. The purpose of this project is to investigate the causes of the late presentations by Asian people to inpatient mental health services within 24 hours of first referral and to recommend approaches to improve access.

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PIS FORM 3

CLINICIAN Participant Information Sheet

Project title
Identifying the causes of late presentations by Asian people to WDHB mental health inpatient services.

Reason for the survey
The overall aim of this quality improvement survey project is to improve access to WDHB mental health services by the Asian population. The purpose of this project is to investigate the causes of the late presentations by Asian people to inpatient mental health services within 24 hours of first referral and to recommend approaches to improve access.

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For any enquiries regarding this survey project you may contact Sue Lim, Operations Manager Asian Health Support Services, Phone: 09 4423239 or sue.lim@waitematadhb.govt.nz

Appendix 2: Additional Data

The following table provides data of all Asian first presentation to inpatient services compared with overall Asian first MH referrals for the 40 month period FY11 – FY15 (Jul 11 to Dec 13 and July 14 to April 15), by diagnosis and by Asian sub group.

Table 5: Asian first presentation to inpatient services compared with overall Asian first MH referrals for the 40 month period (Jul 11 to April 15), by Asian sub-group by diagnosis.

Ethnicity	FirstPrincipalDiag	Sum of FirstPresIP	First referrals with presentation to IP
Asian not further defined	Alcohol Abuse	0	17
	Alcohol Abuse, Cannabis Abuse	0	1
	Alcohol Abuse, Cannabis Dependence	0	1
	Alcohol Abuse, Major Depressive Disorder (PPO) Single Episode Moderate	0	1
	Alcohol Abuse, Nicotine Dependence	0	4
	Alcohol Dependence	0	2
	Amphetamine Abuse	0	1
	Cannabis Abuse	0	2
	Cannabis Dependence	0	1
	Cannabis Dependence, Diagnosis deferred	0	1
	Diagnosis deferred	0	3
	Diagnosis Deferred on Axis I or II	0	6
	Dysthymic Disorder	0	1
	Major Depressive Disorder (PPO) Single Episode Moderate	0	1
	Major Depressive Disorder, Single Episode, Moderate	0	1
	No diagnosis - Client not assessed	0	1
	No Diagnosis - not assessed	1	5
	NULL	4	64
	Other (or Unknown) Substance Dependence	0	1
	Psychotic Disorder NOS	0	1
	Relational Problem NOS	0	1
Asian not further defined Total		**5**	**116**
Chinese	[X] Psychosis NOS	1	1
	[X] Psychosis: [unspecified nonorganic] or [NOS], Depression	0	1
	ADHD	0	1
	ADHD - Combined hyperactive impulsive	0	2

Ethnicity	FirstPrincipalDiag	Sum of FirstPresIP	First referrals with presentation to IP
	ADHD - Predominantly Inattentive	0	1
	Adjustment Disorder With Depressed Mood	0	2
	Adjustment Disorder With Mixed Anxiety and Depressed Mood	0	1
	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	0	1
	Alcohol Abuse	0	99
	Alcohol Abuse, Cannabis Abuse	0	1
	Alcohol Abuse, Nicotine Dependence	0	15
	Alcohol Abuse, Nicotine Dependence, Pathological Gambling	0	2
	Alcohol Abuse, Pathological Gambling	0	1
	Alcohol and other drug assessment	0	7
	Alcohol Dependence	0	6
	Alcohol Disorder Abuse	0	1
	Alcohol Intoxication	0	1
	Amphetamine Abuse	0	3
	Amphetamine Dependence	0	3
	Anorexia Nervosa - restricting type	0	1
	Anxiety Dis - Generalized Anxiety	0	1
	Anxiety Dis - NOS	0	2
	Anxiety Dis - Panic Disorder with Agoraphobia	0	1
	Anxiety Disorder NOS	0	1
	Anxiety, Depression	0	1
	Autistic Disorder	0	1
	Axis II Borderline Personality Disorder, Major Depressive Disorder, Recurrent, In Partial Remission, Posttraumatic Stress Disorder	0	1
	Bipolar I Disorder, Most Recent Episode Hypomanic	0	1
	Borderline Personality Disorder	0	1
	Cannabis Abuse	0	2
	Cannabis Abuse, Nicotine Dependence	0	1
	Cannabis Abuse, Other Substance Abuse	0	1
	Cannabis Dependence, Nicotine Dependence	0	1
	Cognitive Disorder NOS	0	3
	Cognitive Disorder NOS, Major Depressive Disorder, Recurrent, Moderate	0	1
	Cognitive Disorder NOS, Psychotic Disorder NOS	0	1
	Conversion Disorder	0	1

Ethnicity	FirstPrincipalDiag	Sum of FirstPresIP	First referrals with presentation to IP
	Delirium Due to...[Indicate the General Medical Condition]	0	1
	Dementia Alzheimers type - late onset Uncomplicated	0	1
	Dementia Due to General Med Condition	0	1
	Dementia NOS or Amnestic Disorder NOS	0	5
	Dementia NOS or Amnestic Disorder NOS BPSD	0	1
	Dementia NOS or Amnestic Disorder NOS, Major Depressive Disorder, Recurrent, Moderate	0	1
	Depression	0	1
	Depressive Disorder NOS	0	1
	Diagnosis deferred	0	27
	Diagnosis Deferred on Axis I or II	0	56
	Diagnosis Deferred on Axis I or II, Nicotine Dependence	0	1
	Dissociative Disorder NOS, Dissociative Identity Disorder	0	1
	Eating Disorder NOS	0	1
	Major Depr Dis (PPO) Single Episode In partial remission	0	1
	Major Depr Dis(PPO)Single Epi Severe with psychotic features	0	2
	Major Depre Dis (PPO) Recurrent In partial remission	0	1
	Major Depress Dis Severe with psychotic features	0	2
	Major Depressive Disorder - Non specified	1	1
	Major Depressive Disorder (PPO) Recurrent Moderate	0	1
	Major Depressive Disorder (PPO) Single Episode Moderate	0	1
	Major Depressive Disorder, Recurrent, Mild	0	1
	Major Depressive Disorder, Recurrent, Moderate	0	1
	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features	0	1
	Major Depressive Disorder, Single Episode, Severe With Psychotic Features	0	1
	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features	0	2
	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features, Posttraumatic Stress Disorder	0	1

Ethnicity	FirstPrincipalDiag	Sum of FirstPresIP	First referrals with presentation to IP
	Mood Disorder Due to...[Indicate the General Medical Condition]	0	1
	No diagnosis - Client not assessed	0	5
	No Diagnosis - not assessed	0	18
	No Diagnosis or Condition on Axis I or Axis II	0	7
	No mental illness	0	2
	NULL	8	326
	Obsessive-Compulsive Personality Disorder	0	1
	Opioid Dependence	0	1
	Oppositional Defiant Disorder	0	1
	Other (or Unknown) Substance Dependence	0	1
	Other Autistic Disorder	0	1
	Other conduct disorders	0	1
	Other Substance Abuse	0	2
	Pathalogical Gambling - ICDNE	0	3
	Pathological Gambling	0	14
	Postnatal depression	0	1
	Psychosis NOS	0	2
	Psychotic Disorder Due to...[Indicate the General Medical Condition], With Hallucinations	0	1
	Psychotic Disorder NOS	2	4
	Rel Prob Parent-Child	0	2
	Relational Problem NOS	0	23
	Schizophrenia, Paranoid Type	0	1
	Substance Abuse	0	2
	Substance Dependence	0	1
	Vascular Dementia Uncomplicated	0	1
Chinese Total		**12**	**707**
Indian	ADHD	0	1
	ADHD - Combined hyperactive impulsive	0	2
	Adjustment Disorder Unspecified	0	1
	Adjustment Disorder With Depressed Mood	0	5
	Adjustment Disorder With Mixed Anxiety and Depressed Mood	0	2
	Alcohol Abuse	0	188
	Alcohol Abuse, Amphetamine Abuse, Cannabis Dependence, Nicotine Dependence	0	2
	Alcohol Abuse, Amphetamine Dependence, Cannabis Abuse, Cannabis Dependence	0	1

Ethnicity	FirstPrincipalDiag	Sum of FirstPresIP	First referrals with presentation to IP
	Alcohol Abuse, Amphetamine Dependence, Cannabis Dependence, Nicotine Dependence	0	1
	Alcohol Abuse, Cannabis Abuse	0	7
	Alcohol Abuse, Cannabis Abuse, Nicotine Dependence	0	2
	Alcohol Abuse, Cannabis Dependence	0	7
	Alcohol Abuse, Cannabis Dependence, Nicotine Dependence	0	1
	Alcohol Abuse, Cannabis Dependence, Nicotine Dependence, Other (or Unknown) Substance Dependence	0	1
	Alcohol Abuse, Cannabis Dependence, Nicotine Dependence, Synthetic Cannaboid	0	1
	Alcohol Abuse, Diagnosis deferred	0	1
	Alcohol Abuse, Nicotine Dependence	0	20
	Alcohol Abuse, Opioid Dependence	0	1
	Alcohol Abuse, Other Substance Abuse	0	1
	Alcohol Abuse, Solvent Abuse	0	1
	Alcohol and other drug assessment	0	1
	Alcohol Dependence	0	44
	Alcohol Dependence, Cannabis Abuse	0	1
	Alcohol Dependence, Cannabis Dependence	0	2
	Alcohol Dependence, Cannabis Dependence, Nicotine Dependence	0	2
	Alcohol Dependence, Nicotine Dependence	0	7
	Alcohol Disorder Abuse	0	3
	Amphetamine Abuse	0	3
	Amphetamine Abuse, Cannabis Abuse, Nicotine Dependence	0	2
	Amphetamine Abuse, Cannabis Abuse, Relational Problem NOS	0	1
	Amphetamine Abuse, Cannabis Dependence	0	2
	Amphetamine Abuse, Cannabis Dependence, Nicotine Dependence	0	1
	Amphetamine Abuse, Nicotine Dependence	0	2
	Amphetamine Abuse, Synthetic Cannabinoid Use	0	1
	Amphetamine Dependence	0	5
	Amphetamine Dependence, Cannabis Abuse	0	1
	Anorexia Nervosa - restricting type	0	1
	Anxiety	0	2

Ethnicity	FirstPrincipalDiag	Sum of FirstPresIP	First referrals with presentation to IP
	Anxiety Dis - Generalized Anxiety	0	2
	Anxiety Dis - Obsessive-Compulsive Disorder	0	1
	Anxiety Dis - Separation Anxiety	0	1
	Autism	0	3
	Bereavement	0	1
	Cannabis Abuse	0	17
	Cannabis Abuse, Nicotine Dependence	0	2
	Cannabis Abuse, Other Substance Abuse	0	1
	Cannabis Dependence	0	8
	Cannabis Dependence, Nicotine Dependence	0	3
	Cocaine Abuse	0	1
	Delusional Disorder	0	2
	Dementia NOS or Amnestic Disorder NOS	0	4
	Depr Disorder - Major - Single Episode	0	1
	Depression	0	2
	Depressive Disorder NOS	0	1
	Diagnosis deferred	0	19
	Diagnosis Deferred - Axis II	0	1
	Diagnosis Deferred - Axis II, Diagnosis Deferred on Axis I or II, Nicotine Dependence	0	1
	Diagnosis Deferred on Axis I or II	0	34
	Diagnosis Deferred on Axis I or II, Rel Prob Parent-Child	0	1
	Disruptive Behavior Disorder NOS	0	1
	Generalized Anxiety Disorder, Major Depressive Disorder, Recurrent, Moderate	0	1
	Major Depressive Dis Single/Severe - psychotic features	0	1
	Major Depressive Disorder (PPO) Single Episode Moderate	0	1
	Major Depressive Disorder, Recurrent, Moderate	0	2
	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features	0	2
	Major Depressive Disorder, Recurrent, Unspecified	0	1
	Major Depressive Disorder, Single Episode, Moderate	0	1
	Major Depressive Disorder, Single Episode, Severe Without Psychotic Features	0	3
	Nicotine Dependence	0	2
	Nicotine Dependence, Opioid Dependence	0	1

Ethnicity	FirstPrincipalDiag	Sum of FirstPresIP	First referrals with presentation to IP
	No diagnosis - Client not assessed	0	8
	No Diagnosis - not assessed	0	15
	No Diagnosis on another Axis	0	6
	No Diagnosis or Condition on Axis I or Axis II	0	9
	NULL	10	490
	Opioid Abuse	0	1
	Opioid Dependence	0	2
	Other (or Unknown) Substance Dependence	0	2
	Other Autistic Disorder	0	1
	Other Substance Abuse	0	1
	Postnatal depression	0	1
	Posttraumatic Stress Disorder	0	1
	Psychosis NOS	0	1
	Rel Prob Parent-Child	0	4
	Relational Problem NOS	0	38
	Relationship issue	0	2
	Schizophrenia, Paranoid Type	1	1
	Sedative, Hypnotic, or Anxiolytic Dependence	0	1
	Selective Mutism	0	1
	Solvent Dependence	0	1
	Substance Abuse	0	1
	Substance Dependence - Other	0	1
	Vascular Dementia Uncomplicated	0	1
Indian Total		**11**	**1038**
Other Asian	ADHD - Combined hyperactive impulsive	0	4
	ADHD - Predominantly Inattentive	0	1
	Adjustment Disorder Unspecified	0	3
	Adjustment Disorder With Anxiety	0	1
	Adjustment Disorder With Depressed Mood	0	1
	Adjustment Disorder With Mixed Anxiety and Depressed Mood	0	2
	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	0	2
	Alcohol Abuse	0	75
	Alcohol Abuse, Amphetamine Abuse	0	2
	Alcohol Abuse, Amphetamine Abuse, Cannabis Abuse, Nicotine Dependence	0	1
	Alcohol Abuse, Cannabis Abuse	0	2
	Alcohol Abuse, Cannabis Dependence	0	2
	Alcohol Abuse, Nicotine Dependence	0	7

Ethnicity	FirstPrincipalDiag	Sum of FirstPresIP	First referrals with presentation to IP
	Alcohol Abuse, Other Substance Abuse	0	1
	Alcohol Abuse, Relational Problem NOS	0	1
	Alcohol and other drug assessment	0	2
	Alcohol Dependence	0	20
	Alcohol Dependence, Cannabis Dependence, Nicotine Dependence	0	1
	Alcohol Dependence, Nicotine Dependence	0	2
	Alcohol Disorder Abuse	0	3
	Amphetamine Abuse	0	3
	Amphetamine Abuse, Cannabis Abuse, Nicotine Dependence	0	1
	Amphetamine Abuse, Nicotine Dependence	0	1
	Amphetamine Abuse, Nicotine Dependence, Pathological Gambling	0	1
	Amphetamine Dependence	0	1
	Amphetamine Dependence, Cannabis Dependence, Nicotine Dependence	0	2
	Amphetamine Dependence, Nicotine Dependence	0	2
	Anxiety	0	1
	Anxiety Dis - Generalized Anxiety	0	1
	Anxiety Dis - NOS	0	1
	Anxiety Dis - Social Phobia, Generalized Anxiety Disorder	0	1
	Anxiety Dis - Specific Phobia	0	1
	Anxiety Disorder NOS	0	1
	Autism	0	1
	Autistic Disorder	0	1
	Bipolar Disorder NOS	0	1
	Bipolar I Disorder, Most Recent Episode Manic, Moderate	1	1
	Cannabis Abuse	0	5
	Cannabis Abuse, Nicotine Dependence	0	1
	Cannabis Abuse, Solvent Abuse	0	1
	Cannabis Dependence	0	2
	Cognitive Disorder NOS, Major Depressive Disorder, Recurrent, Moderate	0	1
	Cognitive Disorder NOS, Psychotic Disorder Due to...[Indicate the General Medical Condition], With Hallucinations	0	1
	Conversion Disorder	0	1

Ethnicity	FirstPrincipalDiag	Sum of FirstPresIP	First referrals with presentation to IP
	Cyclothymic Disorder	0	1
	Delirium Due to...[Indicate the General Medical Condition]	0	1
	Delusional/paranoid psychosis	0	1
	Dementia NOS or Amnestic Disorder NOS	0	2
	Dementia NOS or Amnestic Disorder NOS BPSD	0	2
	Dementia NOS or Amnestic Disorder NOS, Psychotic Disorder NOS	0	1
	Depr Disorder - Major - Single Episode	0	1
	Diagnosis deferred	0	10
	Diagnosis Deferred - Axis II	0	1
	Diagnosis Deferred on Axis I or II	1	55
	Dysthymic Disorder	0	1
	Eating Disorder NOS	0	2
	Grief reaction	0	1
	Major depression - not manic depression	0	1
	Major Depressive Dis Single/Severe no psychotic features	0	1
	Major Depressive Disorder - Non specified	0	2
	Major Depressive Disorder (PPO) Recurrent Mild	0	2
	Major Depressive Disorder (PPO) Recurrent Moderate	0	1
	Major Depressive Disorder (PPO) Single Episode Moderate	0	3
	Major Depressive Disorder, Recurrent, Severe With Psychotic Features	1	1
	Major Depressive Disorder, Single Episode, In Full Remission	0	1
	Mental Disorder NOS Due to...[Indicate the General Medical Condition], Sleep Disorder Due to...[Indicate the General Medical Condition], Insomnia Type	0	1
	Mood Disorder Due to...[Indicate the General Medical Condition]	0	1
	Nicotine Dependence	0	3
	No diagnosis - Client not assessed	0	10
	No Diagnosis - not assessed	1	7
	No Diagnosis on another Axis	0	1
	No Diagnosis or Condition on Axis I or Axis II	0	5
	NULL	8	357
	Opioid Dependence	0	1

Ethnicity	FirstPrincipalDiag	Sum of FirstPresIP	First referrals with presentation to IP
	Other (or Unknown) Substance Dependence	0	1
	Other Substance Abuse, Substance Dependence - Other, Synthetic Cannabinoid Use	0	1
	Panic Disorder	0	1
	Pervasive Developmental Disorder NOS	0	1
	Postnatal depression	0	2
	Psychosis NOS	2	3
	Psychotic Disorder NOS	0	2
	Rel Prob Parent-Child	0	3
	Relational Problem NOS	0	10
	Substance-Induced Psychotic Disorder, With Delusions	0	1
	Unspecified Mental Disorder (nonpsychotic)	1	1
	Vascular Dementia Uncomplicated	0	1
Other Asian Total		**15**	**670**
South East Asian	ADHD - Combined hyperactive impulsive	0	1
	ADHD - Predominantly Inattentive	0	2
	Adjustment Disorder Unspecified	0	1
	Adjustment Disorder With Depressed Mood	0	1
	Alcohol Abuse	0	24
	Alcohol Abuse, Amphetamine Abuse	0	1
	Alcohol Abuse, Amphetamine Abuse, Cannabis Abuse, Nicotine Dependence	0	1
	Alcohol Abuse, Cannabis Abuse	0	1
	Alcohol Abuse, Nicotine Dependence	0	2
	Alcohol Abuse, Other Substance Abuse	0	1
	Alcohol and other drug assessment	0	1
	Alcohol Dependence	0	2
	Alcohol Dependence, Nicotine Dependence	0	1
	Alcohol Disorder Abuse, Cannabis Abuse, Nicotine Dependence	0	1
	Amphetamine Abuse, Cannabis Abuse, Nicotine Dependence	0	1
	Amphetamine Dependence	0	1
	Anxiety	0	1
	Anxiety Dis - Generalized Anxiety	0	1
	Anxiety Disorder Due to General Medical Condition	0	1
	Autism	0	1
	Cannabis Dependence, Other Substance Abuse	0	1

Ethnicity	FirstPrincipalDiag	Sum of FirstPresIP	First referrals with presentation to IP
	Depression	0	1
	Diagnosis deferred	0	6
	Diagnosis Deferred on Axis I or II	0	16
	Major Depr Dis (PPO) Single Episode In partial remission	0	1
	Major Depressive Disorder, Recurrent, Severe With Psychotic Features	0	1
	No diagnosis - Client not assessed	0	2
	No Diagnosis - not assessed	0	4
	No Diagnosis on another Axis	0	1
	NULL	3	120
	Other Substance Abuse	0	1
	Pathological Gambling	0	2
	Psychotic Disorder NOS	0	1
	Relational Problem NOS	0	2
	Schizophrenia, Undifferentiated Type	0	1
	Substance Abuse	0	1
	TIC -Tourette's	0	1
	Vascular Dementia Uncomplicated	0	1
South East Asian Total		**3**	**209**
Grand Total		**46**	**2740**

Appendix 3: Literature Review

Compiled by: Kayla Rountree, Jen Rooke and Julia Rogers (Nursing Students)
Supervisor: Michelle LL Honey RN, PhD, FCNA (NZ) Senior Lecturer, School of Nursing, The University of Auckland
Support: Sue Lim and Dr Annette Mortensen

The underuse of health services has been highlighted as a concern for the Asian population throughout the literature (Ho, 2013; Lim & Mortensen, 2013; Lu, Dear, Johnston, Wootton & Titov, 2014; MoH, 2006). Research has found that Asians were significantly less likely to have seen health professionals over a 12-month period in comparison to other ethnic groups (Ho, 2013; MoH, 2006). Furthermore, mental health facilities have been identified as services with particularly low access rates from Asian people (Mehta, 2012). There are no reliable estimates available on the prevalence of psychiatric morbidity in the Asian population of New Zealand (MoH, 2006). Consequently, it is unclear whether the proportion of Asian people accessing mental health services reliably represents all of the Asian population with mental health issues. An Australian study, which investigated the emotional health of Chinese students, found that 54% of the students admitted to experiencing psychological distress, yet only 9% had attempted to seek help. These findings suggest that although mental health issues are prevalent within the Asian population, only a minority of Asians seek help.

It has been recognised that the Asian population present late to mental health services (Lim & Mortensen, 2013; Mehta, 2012; Sobrun-Maharaj & Wong, 2010). Research has found that the majority of Asian consumers will only access services once they have reached a crisis point. This is concerning as a delay in accessing treatment can lead to the experience of more severe and prolonged illnesses (Ho, 2013; McLaughlin, 2004). A recent New Zealand study analysed the experience and views of Asian people using mental health services. The study found that 68.4% of service users had faced difficulties accessing the service. This finding suggests that the late and often critical presentation observed in the Asian population may be attributed to access barriers (Dong et al., 2014).

This literature review identifies the potential barriers that are causing the Asian population to present later to mental health services. After identifying potential barriers, we then investigated how similar services within New Zealand and internationally are implementing initiatives to improve access to mental health care. Finally, models that have been successful at reducing access barriers will be analysed and critiqued.

For this literature review, several online databases were searched: Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, MEDLINE (Ovid), ScienceDirect and Google Scholar. The initial search used the following key words: Asian mental health, mental health barriers, accessibility, migrant populations and traditional medicine. The constraints of the search included limiting the date from 2002-2014, full text, and English language. Retrieved articles were then checked for relevance and their reference lists were used to find other useful studies. From the retrieved articles several themes became apparent, relating to; stigma, culture, language, lack of awareness of services/unfamiliarity of health structure, use of alternative therapies/distrust of mainstream services, cost, transport and immigration status. Each theme is analysed and discussed in detail below.

Stigma

Stigma and shame have consistently been identified as barriers to the use of mental health services for the Asian population (Hampton & Sharp, 2013; Ho, Au, Bedford & Ho, 2003; Ho, 2013; Lu et al., 2014; Sobrun-Maharaj & Wong, 2010; Te Pou, 2010; Zhang, Gage & Barnett, 2013). The burden of this barrier has been

illustrated by Counties Manukau Health who found that 17% of service users identified shame related to seeking help as a barrier to accessing care (Dong et al., 2014). In many Asian cultures mental illness is viewed negatively and is often perceived as a curse or punishment for wrongdoings (Ho et al, 2013; Sobrun-Maharaj & Wong, 2010). Both Te Pou (2010) and Sobrun-Maharaj & Wong (2010) reported that within Asian communities it is common for those with a mental illness to be segregated, rejected, and looked down upon. It has also been observed that some families will hide those who are unwell from the rest of society due to the shame associated with mental illness. Consequently, it is not surprising that Hampton & Sharp's (2013) study investigating shame toward mental health problems, found that Asian patients experienced a high level of anxiety about the stigma and embarrassment related to their mental illness. Thus, it appears that the impact of stigma may be a critical factor in the reluctance and delay in accessing services among the Asian population (Lim & Mortensen, 2013).

Cultural barriers

Asian cultures tend to view health in a holistic manner encompassing both physical and mental health (Sobrun-Maharaj & Wong, 2010). Health and illness are often viewed as equilibrium and Asians often talk about balance and harmony in health. For example, yin, yang and qi in China, yoga in India, timbang in the Philippines, and kwan in Thailand (Burnard, Naiyapatana, & Lloyd, 2006). When balance is maintained, the individual exhibits a disease free state of mind and body. Consequently, the Asian approach is to integrate the body, mind, family, and societal relations in the treatment of mental illnesses (Tarnovetskaia & Cook, 2008). The collectivist culture embedded in the Asian population mean that family, particularly mothers, are closely involved in the care of the distressed family member. This is positive as the family may identify the issue early and seek appropriate help (Chan, Levy, Chung, & Lee, 2002). However the involvement of family can also have adverse effects on the distressed family member. Literature has demonstrated that family can prevent members from accessing mental health services as they may have negative perceptions of mental illness or a fear of damaging societal views. Culture has also been shown to hinder Asians engagement with mental health services, as they feel their problems are insufficient to warrant seeking formal help. Asian people often perceive health services as being reserved for critically unwell people and therefore only access the service when they feel they fit this criteria (Sobrun-Maharaj & Wong, 2010; Dong et al., 2014). This may decrease the service user and family's willingness to access mental health services, or even to admit that a problem may be present that requires formal support (Sobrun-Maharaj & Wong, 2010).

Language

Language is one of the most commonly encountered barriers to the use of health care services for the Asian population (Ho et al., 2003; Lu et al., 2014; Mehta, 2012; Zhang et al., 2013). Research was conducted by Mehta (2012) to help understand the needs of Asian communities. All interviewees who participated in the study singled out difficulties with language as a key determinant preventing Asian service users from accessing appropriate health care. Despite the majority of Asian people speaking English (Indians ~90%, Chinese ~78%, other Asian ~80%) the literature provides evidence that issues with language remain a significant access barrier (Ho et al., 2003; Lu et al., 2014; Mehta, 2012; MoH, 2006; Zhang et al., 2013). Asian mental health service users reported that it was easier for them to express their feelings and emotions in their native language. Thus there is a need for interpretation services. While interpreters are available for free within Auckland health facilities, a study by Dong et al. (2014) revealed only half of service users were aware of this service. Despite interpreters helping to improve communication with Asian service users, the use of interpreters will not solve all language barriers that exist. For example, documents or health information written in English are of no use to Asian service users that cannot read the language. Consequently, language difficulties may prevent them from understanding information and could hinder their ability to book appointments or contact services (Ho, 2013; Mehta, 2012; Zhang et al., 2013). The impact of language as a barrier to health services is evident and may be responsible for the late presentations of the Asian population to health care facilities.

Lack of awareness of services/Unfamiliar structure of health care services

Literature suggests that a lack of knowledge and awareness of existing mental health services is a considerable access barrier to health care for the Asian population (Ho, 2013; Ho et al, 2003; Victoria State Government 2006). Lu et al. (2014) carried out a qualitative study which surveyed 65 Asian international school students who were experiencing high levels of psychological distress. The study showed that 66% of the students were not aware of any mental health services in their local area and therefore did not seek any help. These findings are consistent with New Zealand literature. The literature suggests there is a critical lack of awareness among many Asian people about mainstream and Asian-targeted mental health services that are available in the Auckland region (Mehta, 2012).

A qualitative study conducted in Christchurch aimed to determine the most influential factor causing a knowledge and awareness deficit among the Asian population. The study assessed New Zealand health providers' perspectives on the utilisation of mental health services by immigrants from mainland China. Nearly all health providers who took part in the study indicated that unfamiliarity with New Zealand's health system was particularly stressful for Chinese people seeking health support. The reason Chinese immigrants struggled to understand the New Zealand health system was due to the multiple levels of primary, secondary and tertiary care. Chinese immigrants were unaccustomed to this system as it is a striking contrast to the way the Chinese health system is structured. In China it is expected that if you are unwell you will seek medical treatment at a hospital (Zhang et al., 2013). Furthermore there are very few primary health care clinics or community mental health services available in most of China compared to hospital services, despite the national health reform (Wannian & Chan, 2004). It appears that this difference in health care structure and lack of awareness is acting as a barrier and a contributing factor to the late presentation of Asian service users (Mehta, 2012). It also provides an explanation about why Asian peoples in New Zealand have higher hospital inpatient admission rates.

Use of alternative therapy/distrust of mainstream services

Ho et al. (2003) identified the use of traditional healers and therapies as a potential barrier to accessing mainstream services. According to the literature, Asian people believe traditional therapies are beneficial and legitimate treatments for mental illness. Asian people commonly seek these alternative therapies despite limited scientific evidence on their effectiveness (Mehta, 2012; Te Pou, 2010). Although we do not know a great deal about the use of traditional therapies by Asian people living in New Zealand, studies outside of New Zealand have looked at the rates of Asian people using traditional therapies in comparison to western-based mainstream health services (Ho et al., 2003). Yeung and Kam (2005) investigated the health-seeking behaviours of depressed Chinese-American patients in a primary care setting. They reported that more service users had turned to alternative sources of help such as spiritual treatment (14%), and self-administered alternative treatments (10%), compared with service users that had accessed mental health services (3.5%). Similarly, a study conducted by Lu et al. (2014) observed Chinese participants seeking traditional spiritual healers (16%) more often than mainstream mental health professionals (11%). Despite a higher proportion of participants seeking help from traditional healers, it was revealed that only 39% of participants perceived them as helpful, and 15% believed they were harmful. In comparison, 69% of participants perceived mainstream mental health professionals as helpful, while only 7% believed they were harmful. This illustrated that despite perceiving mainstream treatments as more helpful and less harmful, the Asian participants were still seeking traditional help more frequently.

Within the literature it appears that feelings of a lack of acceptance from mainstream health providers may also be deterring the Asian population from accessing mental health services (Zhang et al., 2013). Ho (2013) demonstrates that Asian people often do not trust, and sometimes even fear, mainstream services. This distrust may be due to the Asian populations' unfamiliarity with western models of recovery (Sobrun-Maharaj & Wong, 2010). Furthermore, research has indicated that a mainstream approach to the treatment of mental health problems is often not suitable or culturally appropriate for the needs of the Asian

population (Mental Health Foundation United Kingdom, 2010; Sobrun-Maharaj & Wong, 2010). Thus, the lack of acceptance of mainstream services coupled with the preference for traditional therapies by the Asian population appears to explain the late presentation of Asian people to health care services.

Cost and transportation

Approximately two-thirds of Chinese and other Asian people have an annual income less than $20,000 compared to half in the total population (Ministry of Health, 2006). This income disparity has significant consequences for the Asian population, including reduced access to health care and mental health services. In particular, Asian students and elderly Asian migrants are more likely to have difficulties with transportation and fears about health-related costs (Zhang et al., 2013). Lu et al. (2013) found that 79% of Asian international high school students suffering from severe psychological distress stated that they were concerned treatment would be too costly and therefore did not seek help. This is not uncommon and Asian people are often unaware of their eligibility for publicly funded health and disability services. Despite New Zealand's public funding, primary health care is often perceived by the Asian population as expensive and overvalued in comparison to services in their country of origin (S. Lim, personal communication, May 2, 2014). It is evident that issues with cost and transportation are potential factors impeding on access to mental health services.

Immigration

Fears exist among the Asian population that having a mental health issue will jeopardise ones citizenship status. There is limited research into this issue, however, it has been suggested that these fears are linked to delays in using mainstream health services for Asian people (Ho et al., 2002). Furthermore, an American study identified immigration status as a factor that influenced an immigrant's vulnerability to inadequate health care (Derose, Escarce & Lurie, 2014). Kelly Feng, a team leader for Asian Mental Health Cultural Support Coordination Service has provided anecdotal information about the fears that exist among her clients that mental problems could impact on their residency status (K. Feng, personal communication, 5th May, 2014). Kelly described an experience with one specific Asian client who presented late and in a critical state to her service. It was discovered that the reason the client had not accessed mental health services earlier was because she was in the process of applying for permanent residency and believed the use of mental health services would affect her application. Despite the limited research on this potential barrier, this example indicates that concerns for residency may be related to the late presentation to mental health services of Asian people.

Services addressing access issues

The expansion of the Asian population has altered the demography and ethnic distribution of New Zealand. It is therefore important that the New Zealand health system reacts to these changes and is responsive to the increasing language and cultural differences amongst the Asian people utilising health services (Tse, 2004). *The New Zealand Health Strategy*, the *New Zealand Settlement Strategy*, and the *Auckland Regional Settlement Strategy*, have produced policy directives to guide the development of services that enhance the accessibility and responsiveness of services for the Asian population (Ho, 2013). Consequently, a number of initiatives have been developed by various services in New Zealand to address the barriers causing the under-utilisation and late presentation to health care services by Asian people. In addition to national services, there are multiple international interventions, which successfully reduced barriers to care.

A key barrier to accessing and engaging with health services by the Asian population is the issue of language. In response, initiatives have been created in the Auckland region to try to improve the communication and acceptability of health services. This includes the translation of health information into numerous Asian languages and the provision of free interpreters for all health and disability services (Ho, 2013). Furthermore, The Auckland District Health Boards have produced culturally and linguistically

appropriate mental health support services (Ko, 2013; Lim, Mortensen, Feng, Ryu & Cui, 2012; Wong & Au, 2006). These services aim to improve accessibility and the care provided to Asian people with mental health issues. This has been accomplished by providing cultural input and advice, assisting with treatment planning, organising access to resources, and promoting the health and well-being of Asian people in New Zealand (The Asian Network Incorporated, 2013).

To counteract access barriers to health services, a Cultural Competency Training Programme was developed. The aim of this programme was to improve the cultural skills of health practitioners when interacting with CALD service users and their families from the Asian culture (Lim & Mortensen, 2010, 2012). Hofstede's (2001) model of cultural dimensions is used to enhance participants' understanding of the differences in values between various cultural groups. It is free for all primary and secondary health care workers in Auckland and has received positive feedback. Significant improvements in cultural competency were observed in the health practitioners who completed the course. In addition, participants reported that the programme had improved their interactions with service users of Asian ethnicity and helped them to develop better rapport (Lim & Mortensen, 2012).

Multiple health promotion projects have been developed to address access barriers and some of these projects target specific groups within the Asian population. Kai Xin Xing Dong (KXXD) is an example of this. Its aim is to reduce stigma and discrimination related to mental illness within the Chinese community (KXXD, 2014). This project stemmed from the 'Like Minds, Like Mine' campaign, which was a national strategy developed to counter mental health stigma and discrimination. However, due to language barriers the strategy was not effectively reaching Chinese communities. As a result, KXXD was created to get the same ideas across but in a more culturally appropriate way. KXXD is a public education programme that raises awareness of mental illness within the Chinese community by providing information through multiple media. Part of this education is focused on increasing knowledge of mental illnesses and breaking down stereotypes. The service also provides information on New Zealand mental health services and organisations that are available. This project addresses significant access barriers for the Asian population that have been identified in the research (Ho, 2013; Te Pou, 2010).

While most of the studies and new programmes in New Zealand have focused on changing attitudes and access by working through the health care systems, efforts internationally have taken a broader cultural approach to addressing barriers to mental health treatment for Asians.

There are many noteworthy international health care programmes working closely with the community to improve accessibility and awareness of mental health services. One such organisation is the Asia-Pacific Community Mental Health Development Project, which was established to document successful partnership interventions in community mental health care. The project's aim is consistent with the WHO Mental Health Global Action Programme, which strives to scale up services for mental, neurological and substance use disorders and remove access barriers in 17 countries across Asia and the Pacific (Ng, Frazer, Goding, Paroissien & Ryan, 2013). Successful interventions are community-focused and address the access barriers identified from the literature, for vulnerable populations. International examples have been summarised below.

In Korea the public mental health sector is partnering with local art festivals in the Gyeonggi Province. Mental health awareness and understanding of mental illness is being successfully promoted through performing and visual arts. All 31 provincial mental health centres in the region took part and initiated cultural activities related to mental health at the province's three major festivals. As a result of the service's promotion, psychiatric stigma was reduced through enhanced public education (Ng et al., 2013).

Singapore has initiated an early clinical intervention to reduce the prevalence of child psychiatric conditions. To achieve this, child and adolescent mental health services have partnered with education services

including schools, counsellers, and the Minister of Education to improve correspondence between the services. Singapore's school-centered programme has involved nearly 400 schools and has trained 386 school counsellers. Since 2007, over 400 cases have been identified that otherwise may have never been assessed. Improved clinical outcomes were seen six months after the intervention was initiated (Ng et al., 2013).

Thailand has begun an effective mental health programme that works in partnership with local religious organisations such as Buddhist temples. The Buddhist teaching approach strengthens mental illness prevention and rehabilitation, and mental health promotion. Psycho-spiritual and life skills programmes are taught at the temples, which help to support individuals in the community. The benefits of this intervention included; increased community engagement in mental health, a reduction of psychiatric admissions into hospital, and the sharing of information between the temple, community, and hospital (Ng et al., 2013).

In Malaysia, families and carers are working closely with the government and regional psychiatric service providers to provide family support groups. These family support groups are provided with courses on psychoeducation to increase the carers' knowledge, support networks, and coping skills. Malaysia has seen the growth of family support groups in all states nationally. This growth has resulted in psychoeducation being translated into multiple local languages to remove critical language barriers. Families in Malaysia are now caring for distressed individuals at home and taking the lead by organising family training and public forums (Ng et al., 2013).

While it is evident that access barriers exist, the literature identifies national and international services that have implemented successful interventions to improve the Asian population's engagement with mental health services.

Models to reduce access barriers

Access issues to health care services in New Zealand exist for the Asian population as well as other minority ethnic groups. As a consequence, New Zealand models have been developed to reduce the impact of access barriers. The *New Zealand Health Strategy* identified an increase in access to primary health care and the reduction of health inequalities as key objectives to be met (King, 2000). In response, the New Zealand government created the Reducing Inequalities Contingency Fund (RICF). The RICF's purpose was to improve access and enhance health care services that were aimed at reducing health inequalities (CBG Health Research Ltd, 2005, 2003). Health care providers that attended to deprived groups with low health status and high-unmet health needs were selected to receive funding. Multiple barriers to accessing care were identified, such as; language, ethnicity, age, transport, clinical setting, work hours, transport, dignity, pride, fear of being identified, cost and debts. No single model can address all the barriers that exist thus a range of service delivery models were developed to target different access barriers. These included the community health worker model and the free/low cost access to service model. In addition to New Zealand's RICF model there have been international delivery models, which have shown to improve the affordability and accessibility of mental health care (Kazdin & Rabbitt, 2013). These included the task shifting, disruptive innovation theory and expansion of interventions to the unconventional setting.

The Community Health Worker (CHW) model involved staff visiting service users outside of the clinic, either in their homes or the community, to deliver health care. The purpose of this model is to improve health service delivery within the community (CBG Health Research Ltd, 2005, 2003). The provision of home visits helps to overcome a range of access barriers. These include issues with transport, limited appointment times, fears of the clinic setting, and pride and dignity preventing service users from accessing services. Furthermore, the ability of CHW's to engage with service users at a non-clinical level helped them to successfully address more complex barriers such as the social isolation of service users.

A free/low cost access model aims to provide either low cost or free of charge access to health services (CBG Health Research Ltd, 2005, 2003). This addresses the barrier of cost and debt that often prevents access to services. In addition, concerns for pride and dignity related to financial difficulties can be overcome by using this model, as money worries related to health care becomes a lesser issue. While this is beneficial for the service users, this model requires a lot of funding to be put into place and only addresses minimal barriers.

An evaluation of the RICF project revealed that funding of the chosen services and the respective delivery models were successful in addressing barriers and increasing access to primary health care for the targeted populations. From the models there appeared to be certain strategies that made them successful. These included the reduction or removal of the fees barrier, knowing the characteristics of their target population, employing staff who belong to the same community or speak the same language, the use of personal engagement to build trust through home visits and frequent consultations, a friendly approach to service delivery and flexibility in service arrangements (Walton, 2007). The models used were not flawless and barriers did remain for some people. However, they did illustrate different approaches that have been successful in reducing barriers. Although the Asian population in New Zealand differs from the targeted population of the RICF project similar principles could be applied to developing specific models focusing on reducing barriers to health care services for the Asian population.

Task shifting is a method of strengthening and expanding the healthcare workforce. This is executed by redistributing the tasks of service delivery to a broad range of individuals with less training and fewer qualifications than traditional health care workers (Kazdin & Rabbitt, 2013). This redistribution method was extended to mental health services. This is due to the model's ability to provide services to individuals who otherwise did not have access to care. Another strength of the model is its adaptability to diverse countries, cultures, and conditions. In terms of improving Asian mental health outcomes, task shifting could be applied by involving Asian health care assistants or caregivers who are working in the community. By providing them with some education and increasing their awareness of mental health, they could help to reduce the access barriers and help Asian people navigate the health system.

Another model to make mental health services more accessible is the disruptive innovation theory. This theory refers to the process by which services that are complicated and expensive, move to novel delivery models to reduce these barriers. (Kazdin & Rabbitt, 2013). Technology is an optimal example of disruptive innovations. Numerous interventions have already extended to mental health care through the use of smartphones, tablets, the internet, and video conferencing. Research has demonstrated that technology and online services have allowed individuals to access services in convenient, user-friendly and immediate ways, free from the usual barriers that can impede seeking or participating in treatment. A study by Lu et al. (2013) identified internet based cognitive behavioural therapy (iCBT) as an innovation which would improve access to mental services for Chinese-speaking international students in Australia. In New Zealand, a programme like iCBT could deliver a series of highly structured online lessons that include information and skills that are similar to those taught in face-to-face CBT. The programme could be taught in the comfort of the individual's home at a time that best suited them. While this approach may be effective for individuals competent with using technology, it may not suit isolated populations, particularly elderly Asian migrants, who do not have access to technology and online resources.

The final model focuses on expanding interventions into unconventional settings. This approach has been illustrated by mental health programmes in Thailand (Ng et al., 2013). By developing care beyond the traditional setting and into everyday settings, individuals who may need the services but are not receiving them can gain access to care (Kazdin & Rabbitt, 2013; Walton, 2007). The choice of setting can also be used to target special populations. One way that this could be applied to the Asian population is to have mental health services promoted by immigration centres. In this way Asian migrants who are coming to live in New

Zealand will be aware of the mental health services available to them and common interventions used to help individuals with mental health conditions. Mental health services could also be promoted at local clubs such as Tai-Chi, badminton, table tennis or karate, and schools or religious organisations with a high prevalence of Asian people. By promoting care and treatment to the individual, this reduces access barriers and makes services easier to approach and better recognised in the community.

Conclusion

From this literature review it is evident that the Asian population is delaying seeking mental health services until they are acutely unwell. Thorough research has indicated there are multiple debilitating factors contributing to the late presentation of the Asian population to health services. These barriers occur at an individual, community and societal level impeding on the ability of Asian people to engage with mental health services. Although there are significant access barriers for the Asian population there have been multiple services nationally and internationally that have addressed these issues. Practical interventions utilized by services were multi-lingual, culturally sensitive and community focused. Furthermore, the literature identified various models that were effective in reducing access barriers and improving minority group's engagement with services. No single model can successfully overcome all of the access barriers that exist, thus, these models focused on diminishing the impact of specific barriers. By addressing certain factors this helps to improve access and consequently reduce the inequities that exist for the Asian population with regards to utilising health services. Ultimately increasing access to health services will enhance Asian health outcomes and make New Zealand a more equitable nation.

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