

Mental Health Issues for Asians in New Zealand: A Literature Review

**Prepared for
Mental Health Commission**

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FOREWORD

This review of the literature represents the Mental Health Commission's first Asian-focused document. It emerged in response to the fast-changing shape of the New Zealand population over the last 15 years. To date, Asian people and their mental health concerns have not received much attention, yet this population comprises a significant and growing proportion of New Zealand society. Asian people are not merely 'immigrants', sojourners or refugees, but New Zealanders making significant contributions, with the same wants, needs and desires as everyone else.

The Mental Health Commission acknowledges the principles of Te Tiriti o Waitangi and the importance of the Health sector's obligations to Maori. This report does not detract from these obligations but rather identifies many similarities between Maori and Asian peoples. Moreover, this look at Asian mental health follows similar reports on Pacific peoples and is an acknowledgement of New Zealand's growing ethnic diversity.

The report highlights the importance of improving the responsiveness of mental health services to the needs of Asian people. Equally important it identifies risk factors and seeks a more collaborative approach between agencies if these risks are to be minimised. The report also confirms that eliminating discrimination and removing barriers to participation are fundamental to positive well-being.

This report is the first component of a larger Asian project by the Mental Health Commission. It represents the completion of Phase One. Phase Two will involve discussion with Asian communities and relevant government agencies. These responses will be disseminated in an occasional paper on Asian mental health to be released in due course.

The Mental Health Commission welcomes comments and further discussion on this report.



Jan Dowland
Chair
Mental Health Commission

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EXECUTIVE SUMMARY

Purpose of the Research

In April 2002 the Mental Health Commission commissioned a review of literature to identify mental health issues for Asian people in New Zealand. The review was to cover literature published since 1990 on Asian immigrants, refugees and foreign fee-paying (FFP) students in New Zealand, and address five main topic areas relevant to the Mental Health Commission's specified areas of interest:

1. What are the major problems and difficulties experienced by Asian recent immigrants, refugees and fee-paying students in New Zealand?
2. What is the prevalence of mental illness and mental health problems amongst Asians?
3. What are the factors associated with increased risk of mental illness amongst immigrants and refugees? What are the factors that protect against the development of mental illness?
4. What barriers are preventing the usage of mental health services by Asian service users and their families?
5. How widespread is the use of traditional healing practices among Asians in New Zealand?

Definition of Terms

Mental illness refers collectively to all mental disorders, which are health conditions characterised by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress and/or impaired functioning (US Department of Health and Human Services, 2001, p.7).

Mental health problems refer to signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder (US Department of Health and Human Services, 2001, p.7). Most people have experienced mental health problems at some point in their life. The experience of feeling low and dispirited in the face of a stressful job is a familiar example.

Immigrants are people who were born overseas and entered New Zealand under an immigration programme. Currently, New Zealand's immigration programme comprises three main streams: Skilled/Business, Family Sponsored, and International/Humanitarian. The General Skills Category is a points based system which rates prospective immigrants on their qualifications, work experience, age and settlement factors. The Business Category is focused on the attraction of experienced and successful business people to develop new business opportunities in New Zealand. Under the Family Category, New Zealand citizens or residents living permanently in New Zealand can sponsor their close family members to apply for residence in New Zealand. The Humanitarian Category enables family members of New Zealanders to be granted residence where serious humanitarian circumstances exist.

New Zealand's definition of **refugee** is based on the 1951 United Nations Convention and the 1967 Protocol Relating to the Status of Refugees (Report from the refugee NGO Groups, 2000, p.1). A refugee is "any person who, owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country".

Foreign fee-paying students (FFP) are people who are studying in New Zealand on a student visa or permit and are meeting the tuition costs themselves or from funds provided by a sponsor other than the New Zealand Ministry of Foreign Affairs and Trade (Ministry of Education, 1995).

Integration refers to the process through which newcomers contribute to the dominant society's social and economic well-being while retaining their own cultural identity. It is a two-way process involving the participation and cooperation of both newcomers and members of the dominant receiving culture.

In this report, **Asians** are studied from the point of view of ethnicity. The New Zealand census data provide information on over 30 Asian ethnic groups living in New Zealand (Statistics New Zealand, 2001). Due to limited time and resources, this report focuses on five groups: Chinese, Indian, Korean, Cambodian and Vietnamese. At times, the term **Asians** is used to refer to the collective set of Asian ethnic groups. The use of this term, however, is in no way meant to imply that these groups or communities are homogeneous in nature. In fact, it will become apparent in this report that although many Asian groups share certain value orientations, they are very diverse in language, migration experiences, and with respect to mental health problems and needs.

Statistical Profile and Trends

To set the context for a discussion of the research findings, a brief demographic profile of Asian immigrants, refugees and fee-paying students in New Zealand is provided below.

Growth of the Asian Population

Asians make up the fastest-growing ethnic population in New Zealand today. In the decade between 1991 and 2001, the number of people identifying with cultural groups linked to countries in Asia more than doubled to almost 240,000, or 6.4% of the total population. Chinese is the largest ethnic group within the Asian population, followed by Indian and Korean. Other ethnic groups that make up the Asian population include Thai, Filipino, Japanese, Sri Lankan, Malay, Cambodian and Vietnamese. Due to limited time and resources, the statistical analyses in this report focus on five groups: Chinese, Indian, Korean, Cambodian and Vietnamese.

Recent immigrants comprise an increasing proportion of the ethnic groups within the Asian population. Recent immigrants refer to people who were born overseas and have been resident in New Zealand for less than 10 years. At the 2001 census, recent immigrants comprised 87% of the total Korean population and 52% of the total Chinese population. The proportions of recent immigrants in the Vietnamese, Indian and Cambodian populations were 44%, 42% and 38% respectively.

A majority of the Chinese, Indian and Korean recent immigrants came to New Zealand following a fundamental change in New Zealand immigration policy in 1986, which aimed at attracting immigrants with professional skills and capital for investment, irrespective of race and country of origin. In the case of Cambodians and Vietnamese, large numbers came to New Zealand as refugees between 1977 and 1992. In recent years, Cambodians and Vietnamese have entered New Zealand as asylum seekers, or as immigrants sponsored by family members under the Family or Humanitarian category.

In 2001, nearly three-quarters of the Chinese and Indian recent immigrants lived in the Auckland Main Urban Area (MUA), compared with 65% in their total populations. The proportions of Koreans, Vietnamese and Cambodians living in the Auckland MUA were 70%, 69% and 50% respectively.

Other than immigrants and refugees, the mental health issues confronting Asian fee-paying students are also explored in this report. There has been a substantive growth of Asian fee-paying students in New Zealand in recent years. For the year ending 30 June 2001, there were 52,700 foreign fee-paying students studying in New Zealand; 84% of them came from the Asian region. The leading source countries of all Asian fee-paying students are China, Japan, South Korea, Taiwan and Thailand. Although Asian fee-paying students are not long-term residents in New Zealand, they experience a range of difficulties common to immigrants, such as loneliness, and insufficient cultural and linguistic skills.

Socioeconomic Profile¹

Asians in New Zealand are very diverse in religion, culture, language, education and socio-economic experiences. In 2001, half of the Chinese people said they had no religion, one-quarter were Christians and nearly 1 in 7 were Buddhists. Within the Indian population, Hinduism is the most common religion whereas amongst Koreans, a majority said their religion was Christianity. In the case of Cambodians and Vietnamese, Buddhism is the most common religion.

Lack of English language proficiency is a fundamental problem facing recent Asian immigrants. Within the Cambodian and Vietnamese groups, one in three men who had been resident in New Zealand for under 10 years could not speak English or Maori, while the proportions amongst women were even higher (47% and 38% respectively). In the case of Chinese and Korean recent immigrants, between 22% and 28% could not speak English or Maori. Across ethnic groups, Indians had the lowest proportion of recent immigrants with no English or Maori (8% for males and 14% for females).

There is considerable variation in education within the Asian population. Across ethnic groups, Indian recent immigrants were the most well-qualified, with 30% of men and 26% of women reporting that they had a university degree and/or higher qualifications in 2001. The incidence of university qualifications amongst Chinese and Korean recent immigrants ranged between 13% and 23%. In the case of Cambodian and Vietnamese recent immigrants, only very small proportions (between 0% and 5%) had a university qualification.

¹ Information in this section was taken from unpublished data files prepared by the Customer Services Division of Statistics New Zealand from the 2001 Census of Population and Dwellings.

Although Asian recent immigrants as a whole were twice as likely as all New Zealanders to have a university qualification, there are considerable barriers to their employment in the labour market. Their unemployment rates (17% for males and 18% for females) were more than double those of the total population (7% and 8% respectively) in 2001. Across ethnic groups, unemployment levels amongst the Chinese, Cambodian and Vietnamese recent immigrants were higher (between 20% and 24%) than the Indian and Korean groups (between 13% and 18%).

In terms of income, a majority of Asian recent immigrants earned less than \$30,000 per annum. Between 35% and 45% of Cambodian and Vietnamese recent immigrants received some form of income support. Amongst Chinese, Indian and Korean recent immigrants, about one in five received income support payments.

Overall, many Asian ethnic groups in New Zealand have youthful age structures. In 2001, half of all Koreans and Cambodians were under 24 years of age. Of the Chinese, Indian and Vietnamese groups, the proportions of young people aged under 24 years were 45%, 43% and 48% respectively, compared with 36% in the total population. Coping with cultural differences is a major challenge faced by many Asian young migrants upon immigration to a new country. The issue of unemployment is an additional obstacle they encounter. In 2001, one in three Koreans and one in five Indians in the 15-24 year age group were unemployed. In the Chinese, Cambodian and Vietnamese groups, one in four in the 15-24 year age group were unemployed.

Despite the youthful structure of the Asian population, the proportions of people aged 65 years and over amongst many Asian ethnic groups are increasingly rapidly. Older Asian immigrants face the most difficulties in participating in the activities of their new society. Their inability to communicate effectively in English and their dependence on their family members to provide transport for them are the main obstacles. For example, for Chinese recent immigrants aged 65 years and over, 77% of men and 85% of women could not speak English or Maori.

Finally, the socio-economic experiences of Asian migrant women in New Zealand are very diverse. There are those women in 'astronaut' family structures whose husbands have returned to their country of origin to work. There are women who were in professional jobs prior to migration who have experienced considerable downward occupational mobility upon immigration to New Zealand. There are also women from traditional religious backgrounds and with limited English language ability who have to cope with considerable social and cultural isolation in their new country. These experiences of Asian migrant women have implications for their own mental health, as well as for the mental health of their families.

New Zealand Literature Overview

The review focuses primarily on "New Zealand" literature, including mental health-related research on Asians in New Zealand published locally, as well as in non-New Zealand journals. This also includes multi-country research that includes New Zealand data. In addition, a limited review of literature published in the United States, Canada and Australia has been undertaken to provide a wider context within which the mental health issues for Asians in New Zealand can be discussed.

A considerable amount of the New Zealand research on Asians published since 1990 has focused on recent immigrants, and addressed a wide range of issues from adaptation problems and difficulties, to mental health status and the utilisation of mainstream mental health services and alternative healing practices. Most of the research has involved Chinese, and to a less extent, Koreans and Indians. A few ethnographic studies on smaller communities such as Japanese, Filipinos and Indonesians have also been found.

Most of the research into mental health issues for Asian refugees in New Zealand was conducted during the 1980s and early 1990s. These studies have been focused mainly on Cambodian refugees. The smaller communities of Vietnamese and Lao have tended to be overlooked, and have often been studied as part of a general investigation into Indo-Chinese or Southeast Asian refugees. Few studies exist on the mental health needs of smaller refugee groups such as the Sri Lankans.

With the phenomenal growth in the number of Asian students in New Zealand, there has been a corresponding increase in the demand for research to provide information to improve our understanding of the needs and adjustments of these students. Most of the available research has focused on tertiary students; only limited studies have been carried out on secondary school students. In general, the available research has addressed a range of topics such as language problems, teaching and learning styles, cultural identity issues, homestay experiences, and intercultural contact between Asian students and New Zealand students. More recently, concerns have been raised regarding the high rates of abortion among Asian women, as well as other issues such as driving and gambling problems. However, there has been very little substantive research addressing these concerns.

Adaptation Problems and Difficulties

Language Difficulties

The inability to communicate effectively with the host population has been identified as an important factor influencing the psychological well-being of new immigrants, refugees and student sojourners. A lack of English proficiency affects all aspects of a newcomer's life and exacerbates virtually every problem he/she faces.

Learning a new language is particularly difficult for women, older immigrants and refugees. Research has shown that many Asian women and older migrants who have limited English language ability tend to rely on their children or grandchildren for interpretation and translation. However, when these children leave home, they may suffer from intense isolation as a result of their inability to speak adequate English and their dependence on their family members to provide transport for them. In the case of refugees who are usually under severe financial pressure on arrival to New Zealand, finding employment tends to be given higher priority than learning English. However, because of their lack of English proficiency, many end up doing unskilled jobs that give them few opportunities for improving their English.

Employment Problems

Even if the language barrier is overcome, many Asian refugees and new immigrants have faced serious problems finding a job because the qualifications they have gained in their country of

origin are not accepted in New Zealand. Lack of local work experience, and the older age of many migrants and refugees, are additional employment barriers.

Contemporary research has demonstrated that unemployment heightens the risk of depression and increases the likelihood of poor adjustment. This is because the problem of unemployment is associated not only with financial strain, but also with loss of status and self esteem, as well as restriction of social contact.

Under-employment may also create a mental health risk. Overseas research has found that because under-employment is associated with real or perceived status loss, it is likely to result in personal frustration and family stress. However, the mental health implications of under-employment among new immigrants in New Zealand have been under-researched.

Disruption of Family and Social Support Networks

The disruption of family and social support networks have been identified as critical factors in the adjustment of refugees during resettlement. A majority of Indo-Chinese refugees often experience a profound sense of loss because they leave home out of fear and not by choice. They may be socially isolated due to a lack of social support, particularly if the ethnic community is not well established.

Within the immigrant population, a number of Asian families also have to cope with the psychological consequences of family separation. 'Astronaut' Asian families are those in which one or more members return to their country of origin to work, while the rest of the family remains in the country of destination. Research results have suggested that such split family arrangements can cause strain in family relationships, and may result in marital discord, parent-child conflict and behavioural problems. However, unlike refugees, immigrants have the opportunity to maintain contact with their homeland. This may help to protect their sense of well-being.

Loneliness has been cited as a common problem experienced by student sojourners. For many of them, it may be the first time that they have left their own families. As temporary immigrants, however, student sojourners tend to have less social support in their new place of residence than those permanent residents who are more settled and established. Research has suggested that although student sojourners expect and desire contact with members of the host society, the amount of interaction with the host community is low. In particular, many Asian students have found their homestay experiences the source of significant distress.

Older migrants, women and unaccompanied children have been identified as groups having greater problems in building up supportive connections in their new place of residence.

Acculturation Attitudes

Acculturation refers to changes in behaviour, attitudes, values and identity that occur when individuals from one cultural group are in continuous contact with people from another cultural group. Research on acculturation attitudes among immigrants has suggested that as immigrants become more acculturated to their host society and adopt the host society's behaviours and attitudes, they may increasingly identify with the new culture. However, their ethnic identity and attachment to their home culture can also remain strong. This acculturation attitude is called

integration (i.e. taking on host society's culture and values while retaining one's own cultural identity). Other acculturation attitudes include: assimilation (adopting aspects of the host society's culture and relinquishing one's own cultural identity); separation (maintaining one's own ethnic culture and identity and rejecting the host society's culture) and marginalisation (rejecting both the host society and one's traditional culture).

Consistent with contemporary international literature, research conducted among Asians in New Zealand has demonstrated that integration is a predictor of more positive mental health among immigrants. Asian immigrants who are integrated have higher self-esteem than their peers who are separated or marginalised. On the other hand, marginalisation is associated with the poorest mental health. Asian new immigrants who are poorly equipped to deal with the conflicting demands of their dual cultural environment are prone to marginalisation.

Traumatic Experiences Prior to Migration

Many Indo-Chinese refugees have suffered severe trauma and torture prior to resettlement. These pre-migration problems continue to have adverse effects on the mental health of refugees during resettlement, and the effects can be very long-lasting. Mental disorders such as post-traumatic stress disorder (PTSD), depression, and psychosomatic problems are common among those who have experienced torture and trauma.

Prevalence Studies

Only very few community-based studies of the prevalence of mental illness among Asian ethnic groups have been carried out in New Zealand, and none of these studies has claimed to have a representative sample. Because the population of the Asian ethnic groups is relatively small, and the demographic characteristics of these groups are changing, researchers have had difficulties finding adequate representative samples with which to conduct studies. Besides, lack of funding for research on Asian ethnic groups has also hindered a more precise determination of prevalence rates among this population.

Although it has been difficult to specify prevalence rates, the limited research findings have suggested that the mental health levels among Asians do not differ significantly from those of the general population. Studies have also indicated high rates of depression among Chinese older migrants. Amongst Cambodian refugees, many are at risk for post-traumatic stress disorder (PTSD).

Aside from determining the rates and distribution of mental disorders, contemporary overseas studies have also focused attention on identifying the specific ways that social and cultural factors influence the manifestation of mental disorders among Asians. The available research findings have demonstrated that somatisation, the physical expression of psychological distress, is more common among Asians than people in Western societies. In New Zealand, very little is known about how sociocultural factors influence the experience of, and explanations for, mental health and illness among Asian ethnic groups.

Risk and Protective Factors

Contrary to the popular belief that migration creates stress which inevitably results in mental health problems, contemporary research suggests that it is not the stress of migration alone, but the context in which it occurs that ultimately determines the impact on mental health. Factors that have been identified as associated with increased risk of mental disorder among immigrants and refugees include:

- drop in personal socio-economic status following migration;
- inability to speak the language of the host country;
- separation from family;
- lack of friendly reception by surrounding host population;
- isolation from persons of similar cultural background;
- traumatic experience or prolonged stress prior to migration; and
- adolescent or senior age at time of migration.

Social support is a major protective factor. Research with Asian immigrants, refugees and student sojourners in New Zealand has generally shown that social support can help newcomers cope better with the stress of migration and reduce the risk of emotional disorders. In addition, factors such as host society policies and public attitudes towards immigrants and immigration can strongly affect the newcomers' successful settlement and mental health.

Barriers to Mental Health Service Utilisation

Mental illness is highly stigmatising in many Asian cultures. In these societies, some forms of mental illness such as schizophrenia or organic brain disorder are conceived of as supernatural punishments for wrong-doings, and as such entail intense shame and stigma. Consequently, many Asians are reluctant to use mental health care, or would delay seeking care until disturbed members become unmanageable. Among Asian recent immigrants, a lack of English proficiency, inadequate knowledge and awareness of existing services, and cultural differences in the assessment and treatment of mental illness, are additional barriers to their use of the mental health care system. All these issues draw attention to the need for more responsiveness to the needs of Asian service users and their families in the mental health system.

Use of Traditional Healing Practices

Limited studies are available on the use of traditional health practices by Asian migrants. The scant literature suggests that simultaneous use of both Western and traditional health practices is very common among Asian immigrants. However, because patients often do not volunteer the information that they are using alternative treatment, mental health professionals are generally unaware of the extent to which traditional healing practices are used in different ethnic communities, and the extent to which these practices might interact with the Western mental health care system. This is a critical research issue in New Zealand as growing population

diversity raises concerns for increased sensitivity to and respect for differences in beliefs and cultural practices.

Conclusion and Recommendations

Until recently, the mental health of Asians in New Zealand has received very little public and professional attention. A popular belief has been that Asians are extremely well adjusted, as reflected in their low rates of crime and divorce as well as high educational and occupational attainment. This brief literature review challenges the stereotypes of extraordinary well-being and mental health amongst Asians.

Two themes dominate recent mental health-related research on Asians in New Zealand. One focuses on their adaptational problems, mental health status, and factors contributing to or hindering their successful adaptation and mental health. The second theme concerns the utilisation of mental health services by Asians, especially the barriers preventing their access to services. Based on the findings from the research review, the following recommendations are developed to promote mental health in Asian communities and improve cultural responsiveness in mental health services. In addition, four groups that experience a high risk of developing mental health difficulties are identified for further research.

Recommendations for Promoting Mental Health in Asian Communities

- Increase public support for cultural diversity
Among the many factors determining whether migration will be a negative or positive experience, host societies' receptivity towards newcomers and their tolerance for cultural diversity are among the most important. Public education is useful to improve receptivity by increasing awareness of the benefits of cultural diversity and the contributions of people from different ethnic and cultural backgrounds to New Zealand society. Public support for cultural diversity can be promoted in school and university curricula, in work settings as well as in the media.
- Provide extensive information before and after migration
Access to information and support networks is a vital part of the settlement process. Providing information to increase the newcomers' knowledge of the resources and opportunities in the host society before and after migration will help them have a more realistic outlook and expectation, which in turn will improve their participation in New Zealand society. Topics addressed should include employment, housing, schooling, language training, and social and cultural relations.
- Improve access to English language education
Inability to speak the language of the host country is a major factor affecting the mental health of newcomers. Besides the isolation and loneliness it imposes, a lack of proficiency in the English language is also a barrier to utilisation of mainstream services in various areas. Mastering a local language and understanding native ways of life through language courses translate into empowerment for the newcomers. They will be more confident and find life as more comprehensible, manageable and meaningful. It will also enhance their opportunities in

employment and higher education, thereby facilitating their full and equal participation in the New Zealand society.

- Encourage and support the development of community support programmes
Social isolation is a taxing problem for newcomers. The provision of practical assistance in housing, transportation and employment at the time of arrival will have long lasting effects on their mental well-being. Community support programmes should also be developed to help those with less potential to participate in the host society (such as women, youth and older people) to have contacts with people from the same culture, thereby forming a supportive subculture for better social interaction and mutual support. In addition, ethnic communities are important sources of social support for newcomers. They help members maintain pride and cultural identity, which can also facilitate their integration with the dominant society.

In view of the lack of local research regarding the particular needs of Asian ethnic groups, ethnic organisations and community services agencies that have daily contacts with Asian migrants should be encouraged to assist in research to provide relevant information to policy makers and service providers to improve understanding of the needs and problems of particular migrant/ethnic groups.

Recommendations for Improving Cultural Responsiveness in Mental Health Services

- Promote the development of educational materials and professional interpreter services
Stigma is a major obstacle preventing Asians from using mainstream mental health services. Public education is one way to promote the appropriate use of mental health services by Asians. Because language is a major barrier confronting Asian people, translations of culturally appropriate materials are necessary to increase understanding of mental disorders and mental health problems, to help counter traditionally held feelings of shame and guilt about mental illness in the family, and to promote earlier help seeking. Ethnic press, radio and television outlets, as well as the church and other valued agencies in ethnic communities, should be used to disseminate information.

There is also a need to improve professional interpreter services. It is necessary to train interpreters for each ethnic group. The interpreters should have an adequate awareness and understanding of the cultural backgrounds and mental health situation in their communities.

- Increase service providers' awareness of Asian cultural issues
It is essential that the formal mental health care system becomes more responsive to the needs of the Asian communities. Health care providers can deal with their clients more competently if they are knowledgeable of their clients' cultural beliefs, their interpretation of mental illness and mental well being, their help seeking patterns and choice of traditional alternative health practices.

High-Risk Groups for Further Research

- Women
Studies of Asian immigrant and refugee women in New Zealand are very limited. However, in the international literature, many immigrant and refugee women are found to be in high-risk situations. While learning the skills of housekeeping and child-rearing in a new cultural system is already a demanding task, many immigrant and refugee women are also forced to

seek jobs in order to help support the family financially. For many, lack of English language proficiency creates problems when seeking employment. This often results in women accepting unskilled jobs at the lowest level of the labour market which, in turn, limits the development of their English skills. There is also a need to assess the mental health needs of women from smaller ethnic communities. Many are likely to suffer intense social isolation because migration has cut up their traditional sources of support and the lack of English language ability has deepened their dependence on children and relatives. In addition, lack of a local ethnic community delays opportunities for them to develop support networks.

- Students

Research to establish the extent of mental health needs among immigrant and fee-paying students from Asian countries is much needed. The various stressors faced by Asian students, such as language barriers, acculturative stress and the lack of social support networks, place them at risk for emotional and behavioural problems. There is a need for further research, in particular, into the social and cultural integration issues Asian students face outside the classroom. This kind of research will provide information that can assist with the development of programmes to promote better understanding, participation and cooperation of both newcomers and members of the dominant society.

- Older people

There has been very little local research conducted on older migrants and refugees, their mental health needs and utilisation of mental health services. There is however evidence in the international literature that depression is a major psychological problem that affects older people. Elderly Asians are particularly vulnerable because of their poor English language skills, small emotional support networks and limited involvement outside the home. Many have often experienced loneliness, isolation, anxiety, and a feeling of being marginalised by the host society. Some also feel distressed by their adult children's and grandchildren's rapid acculturation to the new society, and apparent lack of respect. With the growth of the aged population in Asian ethnic groups, there is a need to pay special attention to the problems and mental health needs of older people within the Asian population. Many elderly Asians encounter great difficulties gaining access to mental health services. Research which can provide information to remove barriers to access and make services more effective should receive priority attention.

- Refugees

Studies have consistently shown that refugees are at particular risk for depression and post-traumatic stress disorder, because of pre-migration traumas and the post-migration stressors of adapting and living in a new culture. Refugee youth is a special needs group within this high-risk group. In the international literature, it has been suggested that refugee youth experience elevated mental health risk because of language difficulties, identity conflict, racism, and rejection by the labour market. Recently, a report from the refugee NGO groups also drew special attention to the vulnerability of this group, and their special needs for services.

Refugees from smaller ethnic groups are also vulnerable. To date, New Zealand research on Asian refugees has been focused on the Cambodians, and to a lesser extent, Vietnamese and Laotians. Those from smaller communities of Sri Lanka, Myanmar, and Indonesia are not

represented in the literature. Refugees from smaller ethnic groups often experience added difficulties in the resettlement process, as they do not have as much access to their own community support networks and are therefore subject to higher degrees of isolation.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	iii
EXECUTIVE SUMMARY	iv
TABLE OF CONTENTS	xvi
LIST OF TABLES	xviii
1. INTRODUCTION	
1.1 Scope of the literature review	1
1.2 Structure of the report	2
2. STATISTICAL PROFILE AND TRENDS	
2.1 Growth of the Asian population	3
2.2 Geographical distribution.....	6
2.3 Age and sex structure	7
2.4 Religious affiliations	9
2.5 Languages.....	11
2.6 Education and qualifications	13
2.7 Unemployment	15
2.8 Income	16
2.9 Income Support	18
2.10 Discussion of main findings	20
3. NEW ZEALAND LITERATURE OVERVIEW	
3.1 Overview of research on Asian recent immigrants	22
3.2 Overview of research on Indo-Chinese refugees	23
3.3 Overview of research on Asian students	23

4. ADAPTATION PROBLEMS AND DIFFICULTIES	
4.1 Language difficulties.....	25
4.2 Employment problems	26
4.3 Disruption of family and social support network	28
4.4 Acculturation attitudes	29
4.5 Traumatic experiences prior to migration	29
5. PREVALENCE STUDIES	
5.1 Hospital studies	31
5.2 Community surveys.....	31
5.3 Sociocultural factors that relate to mental health	34
6. RISK AND PROTECTIVE FACTORS	
6.1 Risk factors.....	35
6.2 Protective factors.....	35
7. BARRIERS TO MENTAL HEALTH SERVICE UTILISATION	
7.1 Accessibility of mental health services	37
7.2 Appropriateness of mental health services.....	38
7.3 Availability of mental health services	39
8. USE OF TRADITIONAL HEALING PRACTICES	
8.1 Patterns of use	40
8.2 Implications for mental health professionals	41
9. CONCLUSION AND RECOMMENDATIONS	
9.1 Recommendations for promoting mental health in Asian communities	42
9.2 Recommendations for improving cultural responsiveness in mental health services	43
9.3 High-risk groups for further research	44
10. BIBLIOGRAPHY	46

LIST OF TABLES

	Page
1 Population change 1991-2001, Asian population by selected ethnic groups	3
2 Number of Asian immigrants by selected ethnic groups and years of residence in New Zealand, 2001	4
3 Top 10 source countries of FFP students in secondary schools, tertiary institutions and English language schools, for the year ending 30 June 2001	5
4a Distribution of Asian population by selected ethnic groups in five Main Urban Areas (MUAs), 2001	6
4b Distribution of Asian recent immigrants by selected ethnic groups in five Main Urban Areas (MUAs), 2001	7
5 Asian population by selected ethnic groups and age groups, 2001	7
6 Age distribution of Asian population by selected ethnic groups, 1991 and 2001	8
7 Sex ratios of Asian population by selected ethnic groups and age groups, 2001	9
8a Selected religious affiliations of the Asian population by ethnic groups and gender, 2001	10
8b Selected religious affiliations of the Asian recent immigrants by ethnic groups and gender, 2001	10
9a Percentages of the Asian population aged 15 years and over who speak other languages but not English or Maori, by selected ethnic groups, age groups and gender, 2001	11
9b Percentages of Asian recent immigrants aged 15 years and over who speak other languages but not English or Maori, by selected ethnic groups, age groups and gender, 2001	12
10 Percentages of the Asian population aged 15 years and over with no qualifications, by selected ethnic groups, age groups and gender, 2001	13
11a Incidence of university qualifications in the Asian population aged 15 years and over, by selected ethnic groups, age groups and gender, 2001	14
11b Incidence of university qualifications among Asian recent immigrants aged 15 years and over, by selected ethnic groups, age groups and gender, 2001	14

12a	Unemployment rates in the Asian population aged 15 years and over, by selected ethnic groups, age groups and gender, 2001	15
12b	Unemployment rates among Asian recent immigrants aged 15 years and over, by selected ethnic groups, age groups and gender, 2001	16
13a	Income distribution in the Asian population, by selected ethnic groups and gender, 2001	17
13b	Income distribution among Asian recent immigrants, by selected ethnic groups and gender, 2001	18
14	Percentages of the Asian total population and Asian recent immigrants aged 15 years and over, with one or more sources of income support, by selected ethnic groups and gender, 2001	18
15a	Sources of income support among Asians aged 15 years and over, by selected ethnic groups and gender, 2001	19
15b	Sources of income support among Asian recent immigrants aged 15 years and over, by selected ethnic groups and gender, 2001	20

INTRODUCTION

1.1 Scope of the Literature Review

This review was commissioned by the Mental Health Commission to identify mental health issues for Asian people in New Zealand. It covers literature published since 1990 on Asian recent immigrants, refugees and foreign fee-paying (FFP) students in New Zealand, and addresses a range of issues relevant to the Mental Health Commission's specified areas of interest. The questions addressed in this report are as follows:

1. What are the major problems and difficulties experienced by Asian recent immigrants, refugees and fee-paying students in New Zealand?
2. What is the prevalence of mental illness and mental health problems amongst Asians?
3. What are the factors associated with increased risk of mental illness amongst immigrants and refugees? What are the factors that protect against the development of mental illness?
4. What barriers are preventing the usage of mental health services by Asian service users and their families?
5. How widespread is the use of traditional healing practices among Asians in New Zealand?

The report also presents a brief demographic profile of Asian immigrants, refugees and fee-paying students in New Zealand, that sets the context for discussion of research findings.

As the timeframe for the production of this report was 12 weeks, this review focused primarily on New Zealand literature, including mental health-related research on Asians in New Zealand published locally, as well as in non-New Zealand journals. This also includes multi-country research that includes New Zealand data.

Over 120 documents were located using computer searches such as the New Zealand University catalogues (with a particular emphasis on Masters and PhD theses), Te Puna Bibliographic database, New Zealand National Library bibliographic database and journal index, as well as subscription databases such as Ingenta, Ebsco, Proquest, and National Library of Medicine. The bibliographies prepared by Trlin & Spoonley (1997) and Bedford, Spragg & Goodwin (1998) on international migration were also used to locate relevant items. The research results were reviewed and discussed under the five main topic areas specified above. An overview of the segments of the Asian population studied (such as ethnicity, age and gender), the cities where the research was conducted, and the research methods used was also made.

In addition, a limited review of literature published in the United States, Canada and Australia was undertaken. The international literature review began with a few major national studies on immigrant mental health issues, such as the U.S. Department of Health and Human Services' (2001) *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General*; Lin & Cheung's (1999) *Mental Health Issues for Asian Americans*; Health Canada's (1999) *Canadian Research on Immigration and Health: An Overview*; as well as Jayasuriya, Sang & Fielding's (1994) *Ethnicity, Immigration and Mental Illness. A Critical Review*

of Australian Research. This was followed by a database search including Medline and PsychINFO to locate relevant papers cited in the bibliographies of these reports, and to search other recent articles. A total of 60 documents were scanned. Due to limited time and resources, the findings of the overseas literature were not reviewed in depth. These studies were simply scanned to identify the range of issues addressed by the literature, and the general directions of findings. The purpose of the international literature scan was to provide a wider context within which the mental health issues for Asians in New Zealand can be discussed. Full literature reviews and syntheses on particular topics may be undertaken as follow-up projects.

Structure of the Report

The substantive part of this report is divided into nine sections. The next section presents a brief statistical profile of Asian immigrants, refugees and foreign fee-paying students in New Zealand. Section 3 gives an overview of the New Zealand literature reviewed in this project. Sections 4 to 8 review research findings under five main topic areas: adaptation problems and difficulties; prevalence studies; risk and protective factors; barriers to mental health service utilisation; and traditional healing practices. In Section 9, some recommendations that arise from these findings are made. The full list of the local and international literature reviewed and scanned is presented in the final section of the report.

2. STATISTICAL PROFILE AND TRENDS

2.1 Growth of the Asian Population

Asians make up the fastest-growing ethnic community in New Zealand today. Between 1991 and 2001, the number of people identifying as Asians more than doubled to almost 240,000, or 6.4% of the total population (Table 1). The largest numerical increase occurred within the Chinese ethnic group. The Chinese population increase of about 60,270 people accounted for nearly half of the Asian population increase between 1991 and 2001. During this period the Indian population also increased by 31,580 people, accounting for 23% of the Asian population increase. The fastest growing Asian community in percentage terms was the Koreans. In 1991 the Korean population in New Zealand was less than 1,000, and by 2001 it was 20 times as large as it had been a decade earlier. The Korean group, at 18,100 in 2001, became the third largest Asian group, after Chinese and Indian.

Table 1 Population change 1991-2001, Asian population by selected ethnic groups

Ethnic Group ¹	Census			Change between 1991-2001	
	1991	1996	2001	Number	Percent
Chinese	44,793	81,309	105,057	60,264	134.5
Indian	30,606	42,408	62,190	31,584	103.2
Korean	927	12,753	19,026	18,099	1952.4
Cambodian	4,317	4,407	5,265	948	22.0
Vietnamese	2,676	2,883	3,462	786	29.4
Total Asian	99,576	173,502	238,176	138,600	139.2
Total NZ	3,373,926	3,618,303	3,737,280	363,354	10.8

¹ Where a person reported more than one ethnic group, they have been counted in each applicable group but are included in the total Asian population only once.

Source: Ho *et al.*, 1998; Unpublished data files prepared by the Customer Services Division of Statistics New Zealand from the 2001 Census of Population and Dwellings.

Immigrants comprise an increasing proportion of the ethnic groups within New Zealand's Asian populations. In this report, the immigrant population is described in terms of **total immigrants** (people who were born overseas) and **recent immigrants** (people born overseas and arrived in New Zealand in the last 10 years). Table 2 gives the total number of immigrants by years of residence in New Zealand for the Chinese, Indian, Korean, Cambodian and Vietnamese ethnic groups, and the total Asian population in 2001.

In 2001, immigrants comprised 75% of the total Chinese population, 71% of the Indian population and 94% of the Korean population. A majority of them came to New Zealand following a fundamental change in New Zealand's immigration policy (Burke, 1986). Since 1986, changes in policy have been aimed at attracting immigrants with professional skills and capital for investment, irrespective of race and country of origin (Bedford, Ho & Lidgard, 2001; Trlin, 1992, 1997).

Table 2 Number of Asian immigrants by selected ethnic groups and years of residence in New Zealand, 2001

Ethnic Group	Years in NZ						Total Immigrants
	Under 10 years		10 Years or More		Not Specified		
	Number	Percent	Number	Percent	Number	Percent	
Chinese	54,624	70	20,502	26	3,444	4	78,570
Indian	25,941	59	15,672	36	2,361	5	43,974
Korean	16,479	92	645	4	786	4	17,910
Cambodian	1,986	47	2,022	47	255	6	4,263
Vietnamese	1,518	54	1,095	39	201	7	2,814
Total Asian	125,079	68	48,504	26	10,026	6	183,609

Source: Unpublished data files prepared by the Customer Services Division of Statistics New Zealand from the 2001 Census of Population and Dwellings.

The total number of Asian immigrants in 2001 was 183,609 (Table 2). Ninety-two percent of the Korean immigrants, 70% of Chinese immigrants and 59% of Indian immigrants had been resident in New Zealand for less than 10 years. Although this report did not study the immigrant population on the basis of birthplace, it is important to note that recent Asian immigrants entered New Zealand from a wide variety of countries. For example, 53% of the recent Chinese immigrants were born in China, 18% were born in Taiwan and 14% were born in Hong Kong. Among recent Indian immigrants, 48% were born in India and 38% were born in Fiji. However, 99% of the Korean recent immigrants were born in the Republic of Korea.

Other than immigrants, over 10,000 refugees from Indo-China came to New Zealand between 1977 and 1992. The largest group was Cambodian (5,071), followed by Vietnamese (4,221) (North, 1995). In addition, many Cambodians and Vietnamese also entered New Zealand as asylum seekers (people who seek refugee status on arrival at our borders or prior/subsequent to the expiry of a temporary visa or permit), or as part of the normal immigration programme (that is, sponsored by family members under the Family or Humanitarian category). Between 1991 and 2001, 2,530 Cambodians and 2,159 Vietnamese were granted residence under the Family or Humanitarian category (New Zealand Immigration Service, 2001). Only 6 Cambodians and 50 Vietnamese were granted residence under the Skilled or Business Category during this period.

At the 2001 Census, there were 5,265 Cambodians and 3,462 Vietnamese living in New Zealand (Table 1). A majority were immigrants. The proportions of Cambodian immigrants resident in New Zealand for under 10 years and those resident for over 10 years were the same (47%). Within the Vietnamese immigrant population, 54% had been resident in this country for under 10 years and 39% for over 10 years (Table 2).

In recent years, the growth of Asian fee-paying students in New Zealand has been phenomenal. According to the Ministry of Education (2001a), the number of Asian fee-paying students in primary and secondary schools increased from 4,367 in 1996 to 6,506 in 2000. In the public tertiary sector, the number of Asian fee-paying students almost tripled between 1994 (3,322) and 2000 (9,100).

For the year ending 30 June 2001, there were 52,700 foreign fee-paying (FFP) students studying in New Zealand (Education New Zealand, 2002). Half of these students (26,203) were attending private English language schools. A further 10,555 were enrolled in secondary schools, 12,653 in public tertiary institutions and 3,289 in private tertiary courses. Eighty-four percent of all fee-paying students came from the Asian region. Table 3 shows the top ten source countries.

Table 3 Top 10 source countries of FFP students in secondary schools, tertiary institutions and English language schools, for the year ending 30 June 2001

Country	Secondary		Public Tertiary		Private Tertiary		English Language		Total
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
China	3,554	24	5,237	35	1,206	8	5,056	33	15,053
Japan	1,422	12	766	7	421	4	9,025	77	11,634
South Korea	2,602	34	753	10	504	6	3,837	50	7,696
Taiwan	430	17	417	16	185	7	1,500	60	2,512
Thailand	628	26	409	17	103	4	1,304	53	2,444
Germany	141	10	101	7	40	3	1,132	80	1,414
Switzerland	6	0.4	17	1	20	1	1,349	97	1,392
Malaysia	139	11	1,126	84	29	2	43	3	1,337
Hong Kong	390	32	465	38	42	3	331	27	1,228
Brazil	194	26	22	3	19	3	499	68	734

Source: Education New Zealand, 2002.

The leading source countries of FFP students are China (15,053), Japan (11,634), South Korea (7,696), Taiwan (2,512) and Thailand (2,444). Germany is the largest non-Asian source, followed by Switzerland (Table 3). Across education sectors, the ranking of source countries differs. In the public tertiary sector, China is the biggest source, followed by Malaysia. Japan, however, is the largest source of students for the English language sector, then China and South Korea. In the secondary sector, China, then South Korea and Japan make up a majority of the total fee-paying student roll.

The distribution of FFP students throughout New Zealand is uneven. According to Education New Zealand's estimates, 46% of FFP students in the year ending June 2001 were in the Auckland/Northland regions and 21% in the Canterbury region (Education New Zealand, 2002). The proportions of FFP students in the other regions were: Waikato (8%), Wellington (8%), Otago/Southland (7%), Manawatu/Wanganui (7%), Bay of Plenty (1%), Hawkes Bay (1%) and Nelson/Malborough (1%).

The dramatic increase in Asian students has drawn considerable public and media attention in recent years (Philip, 2001; Shephard, 2002). Although fee-paying students are not long-term residents in New Zealand, they experience a range of difficulties common to immigrants, such as loneliness, and insufficient cultural and linguistic skills. The mental health issues confronting Asian fee-paying students are explored in this report, along with a review of the substantive literature on Asian recent immigrants and refugees.

The rest of this section gives a brief demographic profile of the total Asian population, as well as five Asian ethnic groups in New Zealand. They are the Chinese, Indians, Koreans, Cambodians and Vietnamese. Unless otherwise stated, information in the remaining part of this section was taken from unpublished data files prepared by the Customer Services Division of Statistics New Zealand from the 2001 Census of Population and Dwellings.

2.2 Geographical Distribution

In 2001, 88% of Asians lived in the North Island, compared with 76% of all New Zealanders. Across different ethnic groups, Indians and Cambodians were the most likely to live in the North Island (95% and 92% of their populations respectively). The proportions of Chinese, Koreans and Vietnamese living in the North Island were 88%, 81% and 88% respectively.

A majority (87%) of Asians lived in five main urban areas (MUAs) with population of 30,000 or over, compared with 54% of all New Zealanders (Table 4a). Nearly two-third of all Chinese, Indians and Vietnamese lived in the Auckland MUA and another 10-13% in the Wellington MUA. Across the five ethnic groups, Cambodians had higher proportions living in the Wellington MUA (24%) and in the Hamilton MUA (12%), and lower proportions living in the Auckland MUA (48%). Koreans were the most likely to live in the Auckland MUA (69% of their population) and in the Christchurch MUA (15%).

Table 4a Distribution of Asian population by selected ethnic groups in five Main Urban Areas (MUAs), 2001

Ethnic Group	Auckland MUA %	Hamilton MUA %	Wellington MUA %	Christchurch MUA %	Dunedin MUA %	Elsewhere NZ %	Total %
Chinese	65	4	10	8	2	11	100
Indian	65	4	13	3	1	14	100
Korean	69	3	3	15	2	8	100
Cambodian	48	12	24	4	2	10	100
Vietnamese	65	2	13	8	1	11	100
Total Asian	63	4	11	7	2	13	100
Total NZ	29	4	9	9	3	46	100

Source: Unpublished data files prepared by the Customer Services Division of Statistics New Zealand from the 2001 Census of Population and Dwellings.

Compared with the total population as a whole, higher proportions of recent immigrants lived in the Auckland MUA (Tables 4a and 4b). For example, nearly three-quarters of the Chinese and Indian recent immigrants lived in the Auckland MUA, compared with 65% in their total populations. Overall, the Auckland MUA was home to 58% of all recent immigrants in the country, although only 29% of all New Zealanders lived there (Tables 4a and 4b).

Table 4b Distribution of Asian recent immigrants by selected ethnic groups in five Main Urban Areas, 2001

Ethnic Group	Auckland	Hamilton	Wellington	Christchurch	Dunedin	Elsewhere	Total
	MUA	MUA	MUA	MUA	MUA	NZ	
	%	%	%	%	%	%	%
Chinese	73	4	5	9	2	7	100
Indian	74	3	9	2	1	11	100
Korean	70	3	3	15	2	7	100
Cambodian	50	11	21	5	2	11	100
Vietnamese	69	2	12	5	1	11	100
Total Asian recent immigrants	69	4	7	8	2	10	100
Total NZ Recent immigrants	58	4	9	8	2	19	100

Source: Unpublished data files prepared by the Customer Services Division of Statistics New Zealand from the 2001 Census of Population and Dwellings.

2.3 Age and Sex Structure

At the 2001 Census, the proportions of Asian children (those aged under 15 years) and youth (aged 15-24) were higher than those in New Zealand's total population (Table 5). Half of all Koreans and Cambodians were under 24 years of age. Of the Chinese, Indian and Vietnamese groups, the proportions of young people aged under 24 years were 45%, 43% and 48% respectively, compared with 36% in the total population. In addition, 12% of all New Zealanders in 2001 were aged 65 and over, and another 30% aged 40-64 years. In comparison, Asians had lower percentages of older people (4%), and those in the older working age groups (25%).

Table 5 Asian population by selected ethnic groups and age groups, 2001

Ethnic Group	Age Group (Years)					Total
	Under 15	15-24	25-39	40-64	65+	
	%	%	%	%	%	%
Chinese	21	24	23	26	6	100
Indian	26	17	27	26	4	100
Korean	26	24	22	26	2	100
Cambodian	25	25	23	23	4	100
Vietnamese	22	26	27	22	3	100
Total Asian	24	22	25	25	4	100
Total NZ	23	13	22	30	12	100

Migration has a major impact on the age structure of the Asian groups in New Zealand. As the migration of families from many Asian countries was predominantly motivated by perceived better educational opportunities for their children and a better lifestyle (Pe-Pua *et al.*, 1996; Ho & Chen, 1997a), it is not surprising that many Asian groups have a younger age structure. Besides, because older people can usually only gain entry to New Zealand under a family reunion scheme or on compassionate grounds, it is also not unexpected that older people make up only a small percentage of all Asian immigrants to New Zealand (Statistics New Zealand, 1995).

Between 1991 and 2001, however, the proportion of children in the Asian populations dropped whereas those of older people (those aged 65 years and over), and people aged 15-64 years increased (Table 6). For example, the Cambodian and Vietnamese groups, which had the highest proportion of children in their populations in 1991, have age structures in 2001 which reflect an ageing process. Ageing is also evident in the other Asian groups. In 2001 the Chinese, which has the longest settlement history in New Zealand, have the highest proportion of older people (6%) in its population.

Table 6 Age distribution of Asian population by selected ethnic groups, 1991 and 2001

Ethnic Group	Age Group (Years)					
	0-14		15-64		65+	
	1991	2001	1991	2001	1991	2001
	%	%	%	%	%	%
Chinese	26	21	70	73	4	6
Indian	29	26	69	70	2	4
Korean	29	26	70	72	--	2
Cambodian	36	25	61	71	3	4
Vietnamese	34	22	64	75	2	3
Total Asian	27	24	70	72	3	4
Total NZ	23	23	66	65	11	12

-- Percentages not given when numbers are very small.

Source: Statistics New Zealand, 1995; Unpublished data files prepared by the Customer Services Division of Statistics New Zealand from the 2001 Census of Population and Dwellings.

Table 7 shows that there are considerable variations in sex ratios within the Asian population. Of the five ethnic groups under study, Indians had the most balanced sex ratio in 2001. Amongst the Cambodians and Vietnamese, there were 97 men per 100 women. Amongst the Chinese and Koreans, there were 92 men per 100 women. For the Asian population as a whole, the sex ratio was even lower (90 per 100).

The sex ratio of Asians also differs across age groups (Table 7). For children under 15 years of age, there were more males than females, except the Vietnamese group. Amongst young people aged 15-24 years, there were more males than females for the Chinese, Cambodian and Vietnamese groups, but the reverse was the case for the Indian and Korean groups. For people in the younger working age groups (those aged 25-39 years), there were considerably fewer men than women amongst the

Chinese (78 per 100) and the Koreans (71 per 100), but sex ratios were more balanced for the Cambodian and the Vietnamese groups. The strong dominance of females in the 25-39 years age groups found amongst the Chinese and the Korean populations was suggestive of the ‘astronaut’ phenomenon: large numbers of female-headed households established in New Zealand with the males returning to their country of origin to work (Ho, Bedford & Goodwin, 1997c). The psychological impact of the ‘astronaut’ arrangement on family members will be further explored in Section 4.1.

Table 7 Sex ratios of Asian population by selected ethnic groups and age groups, 2001

Ethnic Group	Age Group (years)					Total Males per 100 females
	Under 15 Males per 100 females	15-24 Males per 100 females	25-39 Males per 100 females	40-64 Males per 100 females	65+ Males per 100 females	
Chinese	105	105	78	82	92	92
Indian	103	95	96	108	90	100
Korean	110	94	71	95	77	92
Cambodian	110	103	99	81	--	97
Vietnamese	87	106	101	91	--	97
Total Asian	104	99	78	85	87	90
Total NZ	105	101	91	96	78	95

-- Percentages not given when numbers are very small.

For both the Asian population and New Zealand’s total population as a whole, there were fewer men than women amongst those aged 40 years and over (Table 7). The only exception was Indians in the older working age groups (those aged 40-64 years), where there were more men than women.

2.4 Religious Affiliations

Asians in New Zealand are very diverse in their religious affiliation (Table 7a). In 2001, half of the Chinese people said that they had no religion, one-quarter were Christians and nearly 1 in 7 were Buddhists. Within the Indian population, Hinduism is the most common religion (53%), followed by Christianity and Muslim. Only 6% have no religion.

Seven in ten Koreans in New Zealand were Christians, and 5% were Buddhists. Nearly one in five said they had no religion.

71% of Cambodians and nearly half of Vietnamese said their religion was Buddhism. The proportions saying they were Christians were 9% and 26% respectively. One in ten Cambodians and nearly 1 in 5 Vietnamese had no religion (Table 8a).

Table 8a Selected religious affiliations of the Asian population by ethnic groups and gender, 2001

Ethnic Group	No Religion		Buddhist		Christian		Hindu		Muslim	
	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%
Chinese	52	48	13	15	23	26	0	0	0	0
Indian	6	6	0	0	15	16	53	53	11	11
Korean	19	17	5	6	67	69	0	0	0	0
Cambodian	11	10	71	71	8	9	0	0	2	1
Vietnamese	18	16	43	47	25	26	0	0	0	0
Total Asian	29	27	12	13	26	30	16	14	5	4
Total NZ	30	25	1	1	51	58	1	1	1	1

Compared with their total populations, larger proportions of Chinese recent immigrants said they had no religion, whereas lower proportions of Indian, Cambodian and Vietnamese recent immigrants had no religion (Table 8b). In the Chinese group, there were higher percentages of Christians in its population than among recent immigrants. For the Indian group, there were lower percentages of Hindus in its population than among recent immigrants. Both the Cambodian and Vietnamese groups had lower proportions of Buddhists in their population than amongst their recent immigrants (Tables 8a and 8b).

Table 8b Selected religious affiliations of Asian recent immigrants by ethnic groups and gender, 2001

Ethnic Group	No Religion		Buddhist		Christian		Hindu		Muslim	
	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%
Chinese	57	52	13	16	19	22	0	0	0	0
Indian	1	1	0	0	14	15	58	57	12	12
Korean	19	16	6	6	68	70	0	0	0	0
Cambodian	6	5	79	79	7	6	0	0	1	1
Vietnamese	17	14	46	53	24	21	0	0	0	0
Total Asian recent immigrants	30	29	13	15	27	30	14	12	5	4
Total NZ recent immigrants	25	23	6	7	47	50	6	6	5	4

2.5 Languages

The Asians in New Zealand are also very diverse in the languages they speak. In 2001, one in seven Asians aged 15 years and over could speak other language(s) but not English or Maori, compared with just 1% of all New Zealanders (Table 9a). Across ethnic groups, the Indian group had the lowest proportion of their population with no English or Maori, then the Chinese. In the Cambodian, Vietnamese and Korean groups, one in five men aged 15 years and over could not speak English or Maori, while the proportions amongst women were even higher.

Table 9a Percentages of the Asian population aged 15 years and over who speak other languages but not English or Maori, by selected ethnic groups, age groups and gender, 2001

Ethnic Group	Age Group (Years)								Total, 15+	
	15-24		25-39		40-64		65+			
	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%
Chinese	7	7	14	15	25	31	52	62	18	21
Indian	3	5	5	6	7	14	19	46	6	10
Korean	14	11	21	29	27	37	--	--	21	27
Cambodian	11	17	18	29	31	47	--	--	22	35
Vietnamese	10	14	25	31	33	41	--	--	23	31
Total Asian	7	7	11	12	17	23	41	54	13	17
Total NZ	1	1	1	2	2	2	2	2	1	2

-- Percentages not given when numbers are very small.

In all five Asian ethnic groups, the proportions of their adult populations who could not speak English or Maori increase with age. For example in the Chinese group, 7% of those aged 15-24 years had no English or Maori, rising to 14% in the 25-39 year age group, and then to 25% for males and 31% for females in the 40-64 year age group. Amongst older people aged 65 years and over, 52% of Chinese men and 62% of Chinese women could not speak English or Maori.

Compared with their total populations, higher proportions of recent immigrants could not speak English or Maori (Table 9b). The age and gender differentials are also clear. Amongst the Chinese and Indian groups, the proportions of recent immigrants aged under 40 years who had no English or Maori were higher than those in their total populations by not more than four percent, but in the older working age group (those aged 40-64 years), the proportions with no English or Maori were considerably higher amongst recent immigrants, particularly women. For those aged 65 and over, 77% of Chinese men and 85% of Chinese women, as well as 29% of Indian men and 56% of Indian women, could speak other languages but not English or Moari.

In the case of Koreans, because a majority had been resident in this country for less than ten years in 2001 (see Table 2), the percentages of recent Korean immigrants who could speak no English or Maori were only slightly higher than those in its total population.

Table 9b Percentages of Asian recent immigrants aged 15 years and over who speak other languages but not English or Maori, by selected ethnic groups, age groups and gender, 2001

Ethnic Group	Age Group (Years)								Total, 15+	
	15-24		25-39		40-64		65+		M	F
	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%
Chinese	10	9	14	19	35	42	77	85	24	27
Indian	5	7	6	7	10	23	29	56	8	14
Korean	15	12	22	30	27	34	--	--	22	28
Cambodian	20	26	30	44	43	66	--	--	33	47
Vietnamese	15	21	32	39	55	60	--	--	31	38
Total Asian recent immigrants	9	9	14	15	24	33	62	71	17	21
Total NZ recent immigrants	7	7	9	9	13	21	41	46	10	14

-- Percentages not given when numbers are very small.

For the Chinese, Indian and Korean groups, a majority of their recent immigrants who had been resident in New Zealand for less than 10 years in 2001 came under the Skilled or Business category. Unlike these groups, Cambodian and Vietnamese recent immigrants came primarily under the Family or Humanitarian category (see Section 2.1). Many of them spoke no English prior to arrival to New Zealand. Table 9b shows that the proportions with no English or Maori amongst recent Cambodian and Vietnamese immigrants were considerably higher than those in their total populations. In the 15-24 year age group, 15-26% could not speak English or Maori. The percentages rose to 30-39% in the 25-39 year age group, then to 43-66% in the 40-64 year age group.

Among all recent immigrants in the total population as a whole, 10% of men and 14% of women aged 15 years and over could speak other languages but not English or Maori (Table 9b). In the older working age group and people aged 65 years and over, the percentages were even higher, especially among women.

Recent immigrants with no English language ability face major difficulties in starting a new life in New Zealand (Ho *et al.*, 2000). Not only do they lack the skills to access the local information system, they also do not have the ability to negotiate with health care providers and other social services. The mental health-related implications of a lack of English language ability among recent Asian immigrants, refugees and fee-paying students will be further explored in Section 4 of this report.

Education and Qualifications

There is considerable variation within the Asian population with regard to the educational qualifications they completed. As Table 10 shows, compared with the adult New Zealand population as a whole, the Chinese, Indian and Korean groups were less likely to report that they had no academic or vocational qualifications at the 2001 census. However, nearly half of the Cambodian group, and about one in three Vietnamese aged 15 years and over, had no formal qualifications. In all of the ethnic groups, women are more likely than men to have no formal educational qualifications. People over 40 years of age are also more likely than those in the younger age groups to have no qualifications.

Table 10 Percentages of the Asian population aged 15 years and over with no qualifications, by selected ethnic groups, age groups and gender, 2001

Ethnic Group	Age Group (Years)								Total, 15+	
	15-24		25-39		40-64		65+		M	F
	M	F	M	F	M	F	M	F	%	%
Chinese	9	7	8	8	16	18	31	46	13	14
Indian	10	10	7	7	13	22	33	48	11	15
Korean	11	9	2	3	3	4	--	--	6	6
Cambodian	25	28	38	47	56	67	--	--	40	50
Vietnamese	17	18	24	34	40	44	--	--	27	33
Total Asian	10	9	9	8	14	18	29	43	12	13
Total NZ	22	18	19	16	26	27	33	34	24	23

-- Percentages not given when numbers are very small.

At the higher end of educational scale, Chinese and Indians aged 15 years and over were twice as likely as all New Zealanders to have a university qualification in 2001 (Table 11a). In the case of Koreans, between 13% and 16% had university qualifications. Comparatively smaller proportions of Cambodians and Vietnamese (between 2% and 8%) reported that they had a university degree and/or higher qualifications in 2001.

In all of the ethnic groups, Asian men are more likely to have a university qualification than Asian women. Across age groups, people in the younger working age group (those aged 25-39) are the most likely to have a university qualification, then those in the older working age group (40-64 years).

Table 11a Incidence of university qualifications in the Asian population aged 15 years and over, by selected ethnic groups, age groups and gender, 2001

Ethnic Group	Age Group (Years)								Total, 15+	
	15-24		25-39		40-64		65+			
	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%
Chinese	7	10	39	35	24	14	11	4	21	18
Indian	8	11	30	30	26	18	--	--	23	21
Korean	2	4	23	21	24	16	--	--	16	13
Cambodian	--	--	--	--	--	--	--	--	4	2
Vietnamese	--	--	--	--	--	--	--	--	8	8
Total Asian	6	9	36	30	26	18	12	5	22	19
Total NZ	5	7	15	16	12	9	6	2	11	10

-- Percentages not given when numbers are very small.

Compared with the Cambodian and Vietnamese groups, Chinese, Indians and Koreans have higher proportions of people with a university qualification, and smaller proportions with no qualifications. The selective immigration to New Zealand of skilled people with university qualifications amongst the Chinese, Indian and Korean groups accounted for some of these differences. In addition, many Chinese come to New Zealand to undertake university studies (see Table 3) and stay behind afterwards. As Table 11b shows, compared with their total populations, larger proportions of Chinese, Indian and Korean recent immigrants have a university qualification, particularly in the 25-39, and the 40-64 year age groups. Amongst Cambodian and Vietnamese recent immigrants, only very small proportions (between 0% and 5%) had a university qualification.

Table 11b Incidence of university qualifications among Asian recent immigrants aged 15 years and over, by selected ethnic groups, age groups and gender, 2001

Ethnic Group	Age Group (Years)								Total, 15+	
	15-24		25-39		40-64		65+			
	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%
Chinese	6	9	45	37	27	15	14	6	23	19
Indian	9	11	37	38	37	25	--	--	30	26
Korean	2	3	24	21	25	16	--	--	16	13
Cambodian	--	--	--	--	--	--	--	--	2	0
Vietnamese	--	--	--	--	--	--	--	--	5	5
Total Asian recent immigrants	5	10	39	33	32	21	13	6	24	21
Total NZ recent immigrants	5	8	33	32	34	25	14	6	25	22

-- Percentages not given when numbers are very small.

Unemployment

Although Asians were twice as likely as all New Zealanders to have a university qualification, their unemployment rates (13% for men and 14% for women) were nearly double those of the total population (7% and 8% respectively) in 2001 (Table 12a). Even amongst the better qualified Chinese, Indian and Korean groups, unemployment levels were between 10% and 17%. In the Cambodian and Vietnamese groups, unemployment rates were even higher (between 15% and 19%). In all of the five ethnic groups under study, women were more likely to be unemployed than men, except the Chinese group, where unemployment levels among males and females were the same (14%).

Across age groups, unemployment rates among both the Asian and total populations were highest in the 15-24 year age group. Within the Asian population, one in three Koreans and one in five Indians in the labour force were unemployed (Table 12a). In the Chinese, Cambodian and Vietnamese groups, one in four were unemployed. Among the total population, 16% of males and 18% of females in the 15-24 year age group were unemployed.

Table 12a Unemployment rates in the Asian population aged 15 years and over, by selected ethnic groups, age groups and gender, 2001

Ethnic Group	Age Group (Years)								Total, 15+	
	15-24		25-39		40-64		65+		M	F
	M	F	M	F	M	F	M	F	%	%
Chinese	27	25	11	11	10	10	--	--	14	14
Indian	18	20	8	10	9	10	--	--	10	12
Korean	31	36	14	13	11	12	--	--	15	17
Cambodian	26	22	10	12	12	20	--	--	15	18
Vietnamese	26	25	12	18	11	12	--	--	16	19
Total Asian	23	23	10	11	10	9	11	11	13	14
Total NZ	16	18	6	8	4	4	2	2	7	8

-- Percentages not given when numbers are very small.

Among the total population, unemployment falls as age increases. As mentioned above, unemployment in the total population was highest in the 15-24 year age group (16% for males and 18% for females). From this highest point unemployment dropped sharply to 6% for men and 8% for women in the 25-39 year age group, and continued to fall to 4% (for both men and women) in the 40-64 year age group, then to 2% in the 65+ age group (Table 12a).

In the Asian population, however, unemployment dropped from 23% in the 15-24 year age group to 10% in the 25-39 year age group, and remained about this level into the 40-64 and the 65+ year age groups. Similar patterns are found among both the Asian recent immigrant population and total recent immigrant population, although the unemployment rates are much higher among Asian recent immigrants (Table 12b).

Within the Asian recent immigrant population, unemployment levels amongst the Chinese, Cambodian and Vietnamese groups were between 20% and 24% (Table 12b). In the Indian and Korean groups, they were between 13% and 18%. Previous studies using 1996 census data reported unemployment rates of between 19% and 20% for Chinese recent immigrants, and between 15% and 17% for Indian recent immigrants (Thomson, 1999). Clearly, the issue of difficulty in gaining employment has been a major obstacle faced by Asian recent immigrants since the 1990s. The mental health related implications of unemployment will be dealt with in greater detail in Section 4.

Table 12b Unemployment rates among Asian recent immigrants aged 15 years and over, by selected ethnic groups, age groups and gender, 2001

Ethnic Group	Age Group (Years)								Total, 15+	
	15-24		25-39		40-64		65+		M	F
	M	F	M	F	M	F	M	F	%	%
Chinese	35	33	16	17	19	20	--	--	22	21
Indian	19	24	9	13	15	17	--	--	13	17
Korean	32	37	13	14	12	12	--	--	15	18
Cambodian	--	--	--	--	--	--	--	--	20	22
Vietnamese	--	--	--	--	--	--	--	--	22	24
Total Asian recent immigrants	28	28	12	14	12	17	--	--	17	18
Total NZ recent immigrants	24	24	9	11	11	12	--	--	12	14

-- Percentages not given when numbers are very small.

Income

At the 2001 Census, 57% of Asian men and 66% of Asian women reported having incomes of less than \$30,000 per annum. This compared with 43% of males and 64% of females in the total population (Table 13a). The age structure of the Asian populations is a factor influencing their overall income levels. As incomes tend to increase with age and experience, Asian populations with younger age structures are likely to have, on average, lower income levels than New Zealand's total population as a whole. Besides, income also varies with work status (full-time or part-time), employment status (e.g., wage or salary earners, self-employed, unpaid family workers) and occupation (e.g., professionals, service and sales workers). However, it is not the place to examine these factors in detail in this brief statistical analysis.

Table 13a Income distribution in the Asian population, by selected ethnic groups and gender, 2001

Ethnic Group	Income (\$)											
	Under 15,000		15,001 – 30,000		30,001 – 50,000		50,001 – 70,000		70,001+		Not Specified	
	M	F	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%	%	%
Chinese	29	37	25	28	22	21	9	6	8	3	7	5
Indian	23	34	29	31	25	21	9	5	8	2	6	7
Korean	35	49	32	25	14	9	3	2	3	1	13	14
Cambodian	35	48	37	32	14	9	3	1	1	0	10	10
Vietnamese	27	40	32	30	18	13	4	2	3	1	16	14
Total Asian	29	36	28	30	22	19	8	5	7	2	6	8
Total NZ	16	32	27	32	30	24	12	6	11	3	4	3

Table 13a shows that there are considerable variations in incomes within the Asian population. At the 2001 Census, Cambodians were the most likely to have incomes of less than \$30,000 (72% of men and 80% of women), then Koreans (67%, 74%) and Vietnamese (59%, 70%). At the upper end of the income scale, 17% of Chinese men and 17% of Indian men had incomes of over \$50,000 (Table 13a). In all other groups and among women, the proportions earning more than \$50,000 per annum were very small. For example, only 4% of Cambodian men and 1% of Cambodian women earned over \$50,000 per annum in 2001. As in the total population, Asian women earned less, on average, than Asian men. Part of the reason for this is that women are more likely than men to work part-time.

A majority of Asian recent immigrants earned less than \$30,000 per annum, much higher percentages than those in their total populations (Table 13b). Across ethnic groups, the proportions of recent immigrants earning over \$50,000 were also lower than those in their total populations. However, it is important to note that the non-response rates among the Asian ethnic groups to the income question in the census were very high, particularly amongst the Cambodian and Vietnamese recent immigrants (between 14% and 22%). In a community survey of 375 Chinese new immigrants in Auckland conducted in 1996, the non-response rate to the income question was even higher – over 200 respondents failed to fill in their current income levels, although they were very forthcoming in listing their income levels prior to migration (Friesen & Ip, 1997). The researchers explained that this usually indicated that the non-respondents had no current source of wage or salary income, but were living on savings, interest, or other sources.

Table 13b Income distribution among Asian recent immigrants, by selected ethnic groups and gender, 2001

Ethnic Group	Income (\$)											
	Under 15,000		15,001 – 30,000		30,001 – 50,000		50,001 – 70,000		70,001+		Not Specified	
	M	F	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%	%	%
Chinese	37	45	27	28	18	16	6	3	3	1	9	7
Indian	27	39	30	30	23	20	8	4	5	1	7	6
Korean	37	51	34	26	14	9	3	1	3	1	9	12
Cambodian	48	53	31	29	3	2	1	0	1	1	16	15
Vietnamese	30	43	37	36	10	6	1	0	0	1	22	14
Total Asian recent immigrants	32	42	29	30	19	16	6	3	4	1	10	8
Total NZ recent immigrants	24	37	25	27	23	21	11	6	11	3	6	6

Income Support

For many New Zealanders, income support is a major source of income. Income support refers to community wages, student allowance and other government benefits but not ACC or NZ Superannuation. As Table 14 shows, at the 2001 Census, 19% of Asian men and 21% of Asian women aged 15 years and over had received some form of income support in the previous year. This compared with 16% and 21% in the total population.

Table 14 Percentages of the Asian total population and Asian recent immigrants aged 15 years and over, with one or more sources of income support, by selected ethnic groups and gender, 2001

Ethnic Group	Total Population		Recent Immigrants	
	M	F	M	F
	%	%	%	%
Chinese	19	21	22	17
Indian	17	21	19	23
Korean	20	20	20	20
Cambodian	29	42	36	45
Vietnamese	29	35	35	39
Total Asian	19	21	21	22
Total NZ	16	21	18	21

Within the Asian population, the proportions of Cambodians (29% of men and 42% of women) and Vietnamese (29%, 35%) who received income support payments were considerably higher than the Asian average. In the Chinese, Indian and Korean groups, the proportions with one or more sources of income support were about the same as the Asian average.

Table 14 also shows the proportions of Asian recent immigrants who had received one or more income support payments in the year before the 2001 Census. About two in five Cambodian and Vietnamese recent immigrants had some form of income support. In the Chinese, Indian, and Korean group, about one in five recent immigrants received income support payments.

However, many Asian immigrants are reluctant to get income support from the government, especially among those skilled migrants who used to have well-paid jobs before migration (Friesen & Ip, 1997; Lidgard *et al.*, 1998). Some are unaware of such services because they do not have the skills to access information. Besides, since 1998, newly arrived immigrants are restricted from applying for income support until they have been resident in New Zealand for two years. These are some of the factors influencing the levels of income support received by the Asian recent immigrants.

In both the Asian and total populations, the two most common forms of income support are “Community Wage – Job Seeker” and “Student Allowance”. “Community Wage – Job Seeker” is a kind of income support for people who are looking for work. “Student Allowance” is for students in full-time study to help with their living costs. At the 2001 Census, between 6% and 7% of Chinese, Indians and Koreans received Community Wage. Amongst Cambodians and Vietnamese, the proportions were 12-13% (Table 15a). In addition, one in five Koreans, and between 4% and 7% of Chinese, Indian, Cambodian and Vietnamese received Student Allowance.

Table 15a Sources of income support among Asians aged 15 years and over, by selected ethnic groups and gender, 2001

Ethnic Group	Community Wage – Job Seeker		Sickness Benefit		Domestic Purposes Benefit		Invalids Benefit		Student Allowance		Other government benefits	
	M	F	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%	%	%
Chinese	7	6	1	1	1	2	1	1	7	7	5	6
Indian	7	6	3	3	1	4	1	1	4	4	4	6
Korean	7	6	1	1	1	1	0	0	13	11	3	4
Cambodian	12	13	4	5	1	7	2	2	6	5	8	14
Vietnamese	12	13	5	5	2	6	1	2	6	5	6	9
Total Asian	7	6	2	2	1	3	1	1	7	6	5	6
Total NZ	7	6	2	2	1	6	2	2	3	3	3	5

Other forms of income support include: Sickness Benefit (for people who are unable to work due to sickness, injury, disability or pregnancy); Domestic Purposes Benefit (a family benefit which may be paid to a parent caring for children without the support of a partner, or to a person caring for

someone at home who needs constant care); Invalids Benefit (for people permanently and severely restricted in their capacity for work because of a sickness, injury or disability); and Widow Benefit (for women whose husband or partner has died). In both the Asian and the total populations, the proportions receiving these forms of income support were low.

Table 15b gives the sources of income support received by Asian recent immigrants at the 2001 Census. 14-15% of Cambodian and Vietnamese recent immigrants received Job Seeker Benefit, and 8-13% of Chinese and Korean recent immigrants received Student Allowance in 2001. These percentages were higher than those in their total populations (Table 15a).

Table 15b Sources of income support among Asian recent immigrants aged 15 years and over, by selected ethnic groups and gender, 2001

Ethnic Group	Community Wage – Job Seeker		Sickness Benefit		Domestic Purposes Benefit		Invalids Benefit		Student Allowance		Other government benefits	
	M	F	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%	%	%
Chinese	7	7	1	1	1	2	0	0	9	8	6	7
Indian	7	7	2	3	1	3	0	1	4	4	6	7
Korean	7	6	--	--	--	1	--	--	13	12	3	4
Cambodian	15	15	4	4	1	6	2	1	6	3	13	19
Vietnamese	15	14	7	7	2	6	1	1	5	3	7	10
Total Asian recent immigrants	8	7	1	1	1	2	0	0	8	7	6	7
Total NZ recent immigrants	7	6	1	2	1	3	0	1	6	5	5	7

-- Percentages not given because numbers are very small.

As mentioned in Section 2.7, unemployment rates among Asian recent immigrants in 2001 were quite high (Table 12b). It is, therefore, not surprising to find that slightly higher proportions of Asian recent immigrants than those in their total populations had received Job Seeker Benefits in 2001. At the same time, many Asian recent immigrants also use other strategies, such as re-training, to cope with unemployment in the new country (Henderson, Trlin & Watts, 2001; Lidgard *et al.*, 1998). Across ethnic groups, Chinese and Korean recent immigrants had the highest proportions receiving Student Allowance in 2001 (Table 15b).

Discussion of Main Findings

This brief examination of the 2001 census data of Asian people in New Zealand highlights considerable variations in religion, culture, language, education, and socio-economic experiences within the Asian population in New Zealand. As Vasil & Yoon (1996) pointed out, “it is difficult to view ... the great variety of peoples of the different countries of Asia as Asians. There is no

substantial and easily definable Asianness that is represented by them. Together they all do not constitute a collectivity. Asia is too large and diverse to be able to develop much beyond an essentially geographical entity” (p.5).

Secondly, immigrants comprise an increasing proportion of the ethnic groups within the Asian population in recent years. Although Asian recent immigrants as a whole are highly qualified and skilled, there are considerable barriers to their employment in the labour market. A lack of English language proficiency is a fundamental barrier to their effective participation in the labour market and adaptation in a new society.

Thirdly, many Asian ethnic groups in New Zealand have youthful age structures. In 2001, nearly half of all Asian New Zealanders were under 24 years of age. Coping with cultural differences is a major challenge faced by many Asian young migrants upon immigration to a new country (Eyou, Adair & Dixon, 2000; Ho, 1995a). The issue of unemployment is an additional obstacle they encounter.

Fourthly, despite the youthful structure of the Asian population, the proportions of people aged 65 years and over amongst many Asian ethnic groups are increasing rapidly. Older Asian immigrants face the most difficulties in participating in the activities of their new society. Their inability to communicate effectively in English and their dependence on their family members to provide transport for them are the main obstacles.

Finally, the experiences of Asian migrant women in New Zealand are very diverse. There are those women in ‘astronaut’ family structures whose husbands have returned to their country of origin to work. There are women who were in professional jobs prior to migration who have experienced considerable downward occupational mobility upon immigration to New Zealand. There are also women from traditional religious backgrounds and with limited English language ability who have to cope with considerable social and cultural isolation in their new country. The experiences of Asian migrant women have implications for their own mental health, as well as for the mental health of their families.

The remaining part of this report will focus on a review of mental health-related research published since 1990 on Asian recent immigrants, refugees and fee-paying students in New Zealand. The research findings will be discussed under five main topic areas: adaptation problems and difficulties; prevalence studies; risk and protective factors; barriers to mental health service utilisation; and traditional healing practices. Before turning to the research findings, an overview of the New Zealand literature reviewed is given in the next section.

3. NEW ZEALAND LITERATURE OVERVIEW

3.1 Overview of Research on Asian Recent Immigrants

Most of the research on Asian recent immigrants published since 1990 has been conducted in Auckland, the city where two-thirds of Asian immigrants reside. Studies undertaken by Auckland-based research teams include Abbott *et al.*'s (1999, 2000, 2002) research into the adaptation and mental health of Chinese immigrants; Friesen & Ip's (1997) community survey of Chinese new immigrants; and Yoon's (1995, 1997) ethnography of Taiwanese, Japanese, Filipino, Vietnamese, Indonesian and Hong Kong immigrants living in Auckland. Also included are the research reports commissioned by local authorities investigating the communication profiles and settlement service needs of Asian communities in Auckland (Acumen, 2001; Jones & Ainsworth, 2001; Kudos Organisational Dynamics, 2000). There have also been special purpose surveys into the employment experiences of Chinese (Pakuranga Chinese Baptist Church Employment Action Group, 1998) and Sri Lankan migrants (Basnayake, 1999); as well as surveys into the health needs of Auckland's Asian population (Ngai, Latimer & Cheung, 2001; Walker *et al.*, 1998).

Three FRST-funded research programmes based outside Auckland have also contributed to the substantive literature on Asian recent immigrants. They are:

the Massey-based *New Settlers Programme*, which involves an extensive longitudinal study of 90 new settler families from the People's Republic of China, India and South Africa (Henderson, Trlin & Watts, 2001; Pernice *et al.*, 2000), and a series of supplementary surveys investigating a range of settlement issues confronting new migrants (Trlin *et al.*, 2001; Watts & Trlin, 2000; Watts, White & Trlin, 2001; White, Watts & Trlin, 2001);

the Waikato-based *Demographic Directions Programme*, which has a migration objective dealing with the impacts of migration on New Zealand society. Studies carried out under this objective from 1993 to the present included a school survey of Chinese and Korean immigrant students in Auckland on their adaptation to training and participation in the workforce (Ho & Chen, 1997a; Ho *et al.*, 1996, 1997d); substantive analyses of the socio-economic characteristics of selected groups of East Asian migrant families using census data (Ho & Farmer, 1994; Ho, Bedford & Goodwin, 1999a; Ho *et al.*, 1998); a special purpose survey of 42 recent immigrants from Korea, Taiwan and Hong Kong on their migration and employment experiences (Ho & Lidgard, 1997b; Lidgard, 1996; Lidgard & Yoon, 1999; Lidgard *et al.*, 1998); as well as a longitudinal survey to explore the dynamic changes in family structures and settlement experiences of a group of Hong Kong Chinese families that have settled in New Zealand during the early 1990s (Ho, 1995a, 2002; Ho, Bedford & Goodwin, 1997c; Ho, Ip & Bedford, 2001);

the Wellington-based research programme on *Inter-Generational Relations and Positive Ageing*, which examines inter-generational relationships and communication among 100 Chinese and 100 Pakeha families in Wellington (Liu *et al.*, 2000; Ng *et al.*, 1997, 1998).

In cooperation with the New Zealand Asia 2000 Foundation, the Institute of Policy Studies in Wellington also published a series of books to promote public understanding of Asian migrants and immigration to New Zealand (Bennett, 1998; McKinnon, 1996; Vasil & Yoon, 1996).

Overall, a considerable amount of the research on Asian recent immigrants has involved Chinese immigrants, and to a lesser extent, Koreans (Starks & Youn, 1998; Lidgard & Yoon, 1999; Lidgard *et al.*, 1998; Yoon, 2000) and Indians (Grant, 1996; Pernice *et al.*, 2000). In addition to these, there have been “case studies” of other Asian immigrant groups, as in Yoon’s (1995, 1997) ethnography of Japanese, Filipino, Vietnamese and Indonesian immigrants in Auckland, and in Buckland’s (1997) *New New Zealanders: Celebrating Our Cultural Diversity*. A number of masters and PhD theses were also completed by migrant students researching into their own communities (M. Chu, 1997; Eyou, Adair & Dixon, 2000; Ho, 1995b; Lee, 1995; Leung, 2002; J. Wong, 2001).

3.2 Overview of Research on Indo-Chinese Refugees

The majority of the research into mental health issues for Indo-Chinese refugees in New Zealand was conducted during the 1980s and early 1990s. Some of the earlier studies are contained in Abbott’s (1989) edited volume, *Refugee Resettlement and Wellbeing* (see for example, Farmer & Hafez, 1989; Henderson, 1989; Liev, 1989; and Pernice, 1989). More recent studies include P. Cheung’s (1993, 1994, 1995; Cheung & Spears, 1995a, 1995b) research into the mental health problems and use of health services among Cambodian refugees who had settled in Dunedin; Pernice & Brook’s (1994, 1996a, 1996b) investigation into factors affecting the mental health of Indo-Chinese refugees, Pacific Island immigrants and British immigrants in New Zealand; Blakely’s (1996) survey of the health needs of Cambodian and Vietnamese refugees in Porirua; and Smith’s (1996) investigation into the use of English language in the Lao community of Wellington.

A number of masters and doctoral research projects have also provided substantive information about the adaptational experiences of refugees in New Zealand. For example, North’s (1995) doctoral research used an ethnographic method to determine illness experiences of resettled Cambodian refugees in Palmerston North; Crosland’s (1991) masters thesis investigated the changing roles, attitudes and experiences of Cambodian refugee women in Wellington; Hafez’s (1988) research was on the employment and settlement experiences of 114 Cambodian, Lao and Vietnamese refugees who came to New Zealand between 1983 and 1985; and Tan (1995) investigated pre-migrational and post-migrational problems and their effects on the mental health of Cambodian and Vietnamese refugees.

Overall, a considerable amount of research has been focused on Cambodian refugees. The smaller communities of Vietnamese and Lao have tended to be overlooked, and have often been studied as part of a general investigation of Indo-Chinese or Southeast Asian refugees. Few studies exist on the mental health needs of smaller refugee groups such as the Sri Lankan.

3.3 Overview of Research on Asian Students

With the phenomenal growth in the number of Asian students in New Zealand, there has been a corresponding increase in the demand for research to provide information to improve our understanding of the needs and adjustments of these students. Most of the studies focusing on tertiary students have been conducted by either students or staff from the universities, as in Lee’s (1995) investigation into the cultural identity issues confronting Malaysian, Taiwanese and Hong Kong Chinese students within the context of the university milieu; Beaver & Tuck’s (1998) research into the adjustment issues facing Asian and Polynesian tertiary students; Mills’ (1997)

study of the interactional experiences of Indonesian, Thai, Malaysian and Singaporean students in tertiary classrooms; and Welsh's (2001) survey of the homestay experiences of tertiary Non-English speaking background (NESB) students.

In addition, research completed by Bennett (1998), Campbell & Cheah (2000), Fam & Thomas (2000a, 2000b), Holmes (2000a), Searle & Ward (1990) and Ward & Searle (1991) has also provided useful insights into the needs and cross-cultural experiences of Asian tertiary students, and the implications of these experiences for improving the effectiveness of the international marketing of New Zealand educational institutions. McGrath's (1997) study provides a different perspective by looking at adjustment issues related to re-entry among graduates of New Zealand universities returning home to Singapore, Malaysia and Indonesia.

Only limited research has been carried out regarding the needs and adjustments of Asian secondary school students. Some of the available studies have focused on language problems, teaching and learning styles, and other adjustment problems Asian secondary school students encountered in their new environment, and the implications of these findings for schools to provide programmes and support to better meet the needs of their Asian students (Aston, 1996; Chu, 1997; Kennedy & Dewar, 1997; Neilson & Liddle, 1997; Oliver & Ramsay, 1992; Syme, 1995). A few studies examined issues of intercultural contact between Asian students and New Zealand students, and the relationship between Asian students and their homestay families as well as members of the host communities (Butcher *et al.*, 2002; Christchurch City Council, 1999; McFedries, 2002; Ward, 2001). More recently, concerns have been raised regarding the high rates of abortion among Asian women, as well as other issues such as driving and gambling problems (Gregory, 2002; Keen, 2002; Philip, 2001; Shephard, 2002). However, there has been little substantive research addressing these concerns.

There seems little doubt that the trend for Asian students to come to New Zealand will continue, whether it be as fee-paying students or as immigrants (Ministry of Education, 2001a; 2001b). Our knowledge of Asian students' mental health problems, and their needs for mental health services is very limited. It is therefore imperative that future research continues to provide information to assist government agencies, educational institutions, and providers of social, health and recreational services in formulating policies and programmes to minimise the problems encountered by Asian students and immigrants and increase opportunities for newcomers and members of the dominant society to come together and learn about one another.

4. ADAPTATION PROBLEMS AND DIFFICULTIES

A considerable amount of contemporary research on Asian immigrants, refugees and student sojourners in New Zealand has concentrated on adaptation problems and difficulties. This section examines the major problems and difficulties they encounter, and the mental health-related implications of these problems.

It is important to note that although new immigrants, refugees and sojourners experience some common adaptation problems such as language difficulties and social isolation, the three groups differ in the degree of voluntariness, movement, and permanence of contact with another culture (Berry *et al.*, 1987). Whereas immigrants and refugees are both first-generation arrivals to a new country by way of migration, immigrants as voluntary migrants are likely to experience less difficulty than refugees who have not had a choice with regard to leaving their home country. Sojourners, on the other hand, are temporary immigrants who tend to have little permanent support in their new place of residence. They may experience more mental health problems than those permanent residents who are more settled and established (Berry *et al.*, 1987).

Language Difficulties

The inability to communicate effectively with the host population has been identified as an important factor influencing the psychological well-being of new immigrants, refugees and student sojourners. A lack of English proficiency affects all aspects of a newcomer's life and exacerbates virtually every problem he/she faces (Ho *et al.*, 2000). Learning a new language is, however, difficult for most newcomers. Analysis of the 2001 census data in Section 2.5 showed that one in five Asians aged 15 years and over who had been resident in New Zealand for less than 10 years could not speak English or Maori (Table 9b). Across ethnic groups, the percentages with English language difficulties were highest among the Cambodian and Vietnamese groups. Besides, large proportions of older migrants and women were found to have no English language ability (Table 9b).

Henderson's (1989) study of the language needs of, and provision for, Indo-Chinese refugees found that refugees, who are usually under severe financial pressure on arrival in their country of resettlement, tended to give priority to employment at the expense of learning English. However, a lack of English proficiency may mean that many of them end up doing unskilled jobs that give them little opportunities for improving their English (Smith, 1996).

Within the Asian immigrant population, women and older migrants who are unable to communicate effectively in English often have to rely on their children or grandchildren for interpretation and translation (Beiser *et al.*, 1995). When these children leave home, they will be left without language support. In Australia, Mak & Chan (1995) found that many aged Chinese immigrants suffered from intense isolation as a result of their inability to speak adequate English and their dependence on their family members to provide transport for them. The language needs of Asian immigrant women and older migrants in New Zealand are not well studied.

In the case of Asian students, language is a problem for students from countries where the main medium of instruction is a non-English language (Christchurch City Council, 1999). For these students, a lack of proficiency in English creates problems at both academic and social levels:

Lack of English language skills made it difficult for the Asian students to cope with certain academic subjects. This in turn, created many a frustrating moment for teachers and students alike. English language proficiency was also a leading factor contributing to the lack of interaction between the Asian students and New Zealand students. It was also a major factor in difficulties experienced by the Asian students in adjustment to their new environment. (Oliver & Ramsay, 1992, p.40)

There have been a few studies exploring the best provisions for new learners of English in secondary schools (Kennedy & Dewar, 1997; Syme, 1995). At the wider community level, NESB students also need a supportive learning environment which provides them with a variety of opportunities to experience and practice language with others – in much the same way as they learnt their first language as a young child. Additionally, first language maintenance is identified as playing a key role in facilitating NESB students' acquisition of English and cultural identity development (Kennedy & Dewar, 1997; Starks & Youn, 1998).

4.2 Employment Problems

Even if the language barrier is overcome, refugees and new immigrants may suffer loss of status when the qualifications they have gained in their country of origin are not accepted in the new country. In the 1990s, the Department of Internal Affairs (1996) undertook a survey investigating qualifications, training and employment issues facing skilled migrants who had settled in New Zealand since the 1980s. The survey findings had led to some key immigration policy changes introduced in 1998, including the alignment of the qualifications recognised for immigration purposes with those recognised by the National Qualifications Framework in New Zealand (Bedford & Ho, 1998).

Despite these changes, employers' prejudice remains a major barrier to employment faced by many highly skilled and well-qualified professional migrants (Basnayake, 1999; Ho & Cheung, 1999c). Despite their high educational attainments and substantive work experiences, many foreign-trained Asian migrants find it extremely difficult to enter the workforce because New Zealand employers are reluctant to hire people whose first language is not English, or who have overseas qualifications and a different cultural background to the locally born job applicants. A survey conducted by the Pakuranga Chinese Baptist Church Employment Action Group (1998) found that English language difficulties and a lack of local work experiences are additional employment barriers. At the 2001 census, unemployment levels amongst Chinese, Cambodian and Vietnamese recent immigrants were between 20% and 24% (Table 12b, Section 2.7).

As a consequence of barriers to successful participation in the labour force, many Asian migrants may be required to receive further training in order to be able to work in their original field (Henderson, Trlin & Watts, 2001; Lidgard *et al.*, 1998). However, retraining is expensive, and is not a feasible option for those immigrants and refugees with little monetary wealth. Consequently, many Asian migrants and refugees are found to be under-employed, that is, working at a job whose status is less than prior education or achievement (Boyer, 1996; Farmer & Hafeez, 1989; Friesen & Ip, 1997; Ho *et al.*, 1997d).

Contemporary overseas studies have demonstrated that problems of unemployment and under-employment have negative impacts on both psychological well-being and adaptation. Aycan & Berry (1996) considered that unemployment is associated not only with financial strain, but also with loss of self esteem and restriction of social contact:

Work has functions other than providing income. It provides purpose to life, it defines status and identity, and enables individuals to establish relationships with others in the society. It is especially the latter function that becomes critical for immigrants, because adaptation is facilitated by social interactions. The more one interacts with the groups in the larger society, the faster one acquires skills to manage everyday life. Therefore, for those who are out of work, the result is not only a decline in psychological well-being, but also a delay in adaptation. (p.248)

Unemployment also increases the risk of depression. In Canada, Beiser, Johnson & Turner's (1993) study of unemployment among Indo-Chinese refugees found that many refugees felt it their duty to provide not only for themselves and the family present in the country of resettlement, but also for all those other family members and relatives left behind. Thus unemployment creates distress "not only because of personal economic deprivation but also because of a failed sense of duty" (p.738).

In New Zealand, a few studies have investigated the relationship between unemployment and psychological well-being among Asian immigrants and refugees. For example, Pernice & Brook's (1996a, 1996b) study of British and Pacific Island immigrants and Indo-Chinese refugees found that unemployment was related to depression and anxiety levels. Abbott *et al.*'s (1999) study of Chinese recent immigrants aged 18 years and over found that unemployment is a predictor of poor adjustment. The study also found that unemployment is a predictor of minor mental disorder for migrants resident in New Zealand for less than two years.

A more recent study by Pernice *et al.* (2000) examined mental health levels among three groups of skilled immigrants to New Zealand from the People's Republic of China, India and South Africa. They found that mental health levels for the three immigrant groups were low. Even though unemployment is usually a cause of mental distress, the study found no significant differences between employed and unemployed migrants. The researchers explained that the low levels of mental health among those who were employed could be due to under-employment, occupational stress or a combination of these factors.

According to a report completed for the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988b), under-employment may create a mental health risk. In Australia, Mak (1991) explored the psychological costs of under-employment among formerly successful immigrants from Hong Kong. The study found that under-employment is associated with real or perceived status loss, which is likely to result in personal frustration and family stress. Besides, linguistic and cultural differences in the workplace may be additional sources of stress and social anxiety (Mak, 1998). However, the mental health implications of under-employment among new immigrants in New Zealand have been under-researched.

Disruption of Family and Social Support Networks

Many Indo-Chinese refugees experienced family separation and its adverse effects at various stages of flight and during resettlement (Beiser *et al.*, 1995). A study by Hafeez (1988) of 114 Cambodian, Lao and Vietnamese refugees in New Zealand found that two-thirds of them reported family separation as a cause of mental distress. Refugees who were separated from their families demonstrated various signs of sadness, depression, and physical ailments such as headaches and body pains (Tan, 1995). Some have sought to reduce their negative feelings towards separation by making regular contact and providing financial support to the remaining relatives in the home country as a form of compensation (Tan, 1995). However, most have often experienced an overwhelming sadness for the loss of family members and relatives through death or missing, and the destruction of traditional family lifestyles. After resettlement, many Indo-Chinese refugees may be socially and culturally isolated if the local ethnic community is not well established (Tan, 1995).

Within the immigrant population, a number of Asian families also have to cope with the psychological consequences of family separation. In the early 1990s, a mobility pattern termed 'astronaut' migration attracted considerable attention from both researchers and policy makers (Pe-Pua *et al.*, 1996; Skeldon, 1994). In this type of migration, one or more members of an immigrant family return to their country of origin to work, while the rest of the family remains in the country of destination. The returnees are popularly known as 'astronauts', while the children left with one or no parent in the country of destination are known as 'parachute kids'. New Zealand research on the psychological impact of an 'astronaut' family arrangement on family members is progressing (Aye & Guerin, 2001; Beal & Sos, 1999; Boyer, 1996; Ho, 2002; Ho, Ip & Bedford, 2001; Ho *et al.*, 1997c; Lidgard, 1996). The findings are consistent with overseas studies, suggesting that 'split' family arrangements cause strain in family relationships, and may result in marital discord, parent-child conflict and behavioural problems (Lam, 1994; Mak & Chan, 1995; Pe-Pua *et al.*, 1996).

Loneliness has been cited as a common problem experienced by student sojourners (Aston, 1996; Baker *et al.*, 1991; Pe-Pua, 1994). For many of them, it may be the first time that they have left their own families. As temporary immigrants, however, student sojourners tend to have less social support in their new place of residence than those permanent residents who are more settled and established. Research has suggested that although student sojourners expect and desire contact with members of the host society, the amount of interaction with the host community is low (Ward, 2001; Ward, Bochner & Furnham, 2002).

Some Asian students in New Zealand have found their homestay experiences the source of significant distress (Aston, 1996; McFedries, 2002; Welsh, 2001). Aston (1996) found that almost half of the 406 homestay students surveyed had changed their homestay accommodation on one or more occasions since arriving in New Zealand, with "problems with homestay parents" (23%) and "location of house in relation to school" (18%) being cited as the main reasons for changing homestay accommodation.

For many student sojourners, homestay is not only an accommodation option, it also offers an opportunity to learn more English and to get to know a different culture (Welsh, 2001). In reality, however, Welsh's (2001) study reported that many homestay students were dissatisfied with the limited amount of time that their homestay families spent with them. This situation seemed to be contrary to the expectation that they will be cared for and supported by the homestay family:

For many of them, it may be the first time that they have left their homes and their own families. They need to be welcomed into the homestay as a 'new' member of the family and not simply as someone who is using the facility to provide food and shelter. (Welsh, 2001, p.112)

4.3 Acculturation Attitudes

Acculturation refers to changes in behaviour, attitudes, values and identity that occur when individuals from one cultural group are in continuous contact with people from another cultural group (Berry *et al.*, 1987). Research on acculturation attitudes among immigrants has suggested that as immigrants become more acculturated to their host society and adopt the host society's behaviours and attitudes, they may increasingly identify with the new culture. However, their ethnic identity and attachment to their home culture can also remain strong (Berry, 1997). This acculturation attitude is called integration. Other acculturation attitudes include: assimilation, separation, and marginalisation.

The empirical studies available to date suggest that the integrationist strategy is the most adaptive strategy for immigrants, marginalisation is the least adaptive; and assimilation and separation strategies are intermediate (Berry, 1997; Berry & Sam, 1996). In integration, the individual retains his or her heritage identity while taking on host society's culture and values. This strategy involves a willingness for mutual accommodation, supportive relationships with members of the dominant society as well as one's heritage culture, as well as being flexible in personality; all these factors are associated with successful adaptation and mental health (Berry, 1997). On the other hand, marginalisation involves rejection by the dominant society, combined with own-culture loss. This means the presence of hostility and much reduced social support (Berry, 1997). Assimilation involves rejection of own culture, whereas separation involves rejection of the dominant culture. Both of these strategies imply the loss of a social support system.

Consistent with contemporary international literature, research conducted among Asians in New Zealand has demonstrated that integration is a predictor of more positive mental health among immigrants (Eyou *et al.*, 2000; Ho, 1995b). Asian immigrants who are integrated have higher self-esteem than their peers who are separated or marginalised. On the other hand, marginalisation is associated with the poorest mental health. Asian new immigrants who are poorly equipped to deal with the conflicting demands of their dual cultural environment are prone to marginalisation.

4.4 Traumatic Experiences Prior to Migration

Many Indo-Chinese refugees have suffered severe trauma and torture prior to resettlement. These pre-migration problems continue to have adverse effects on the mental health of refugees during resettlement, and the effects can be very long-lasting (Kinzie *et al.*, 1990; Silove *et al.*, 1991). Mental disorders such as post-traumatic stress disorder (PTSD), depression, and psychosomatic problems are common among those who have experienced torture and trauma (Cunningham & Cunningham, 1997; Nguyen, 1982). Similar findings have been reported in P. Cheung's (1993, 1994) study of 223 Cambodian refugees in Dunedin.

The literature review in this section highlights major pre-migration and post-migration problems encountered by Asian immigrants, refugees and student sojourners who are in transition from one culture to another. While the presence of these problems may increase mental health risk, they do not inevitably result in maladaptation and mental illness. In Section 6, some factors that protect and promote well-being and mental health among migrants and refugees are discussed.

5. PREVALENCE STUDIES

Prevalence studies attempt to “specify the new and ongoing cases of disorders in a particular population over a specified period of time” (Sue, 1994, p.262). Studies of the prevalence of mental disorders are usually accomplished by surveying a population or a representative sample of the population, using a valid measure of psychological disturbance. For example, in the Epidemiologic Catchment Area (ECA) study of the 1980s, the Diagnostic Interview Schedule was used to ascertain the mental health status of nearly 20,000 Americans in different cities across the United States. The diagnosis of a mental disorder such as schizophrenia or depression is made using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic criteria established by the American Psychiatric Association. The ECA study found that over a 6-month period, nearly 20% of Americans had experienced or were currently experiencing a mental disorder. The most frequent disorders involved were anxiety and depression (Sue, 1994).

Other than the community survey method, hospital admission study is another common methodology employed in prevalence studies. Either approach, when used to assess the mental health of migrant populations, raises the central concern of cross-cultural equivalence of concepts, measures and sampling frames (Canadian Task Force, 1988a).

5.1 Hospital Studies

In the United States, early studies to assess the mental health of Asians were based on hospitalisation rates. The findings have revealed that Asians are less likely than the general population to use services, and those who do use services exhibit a greater level of disturbance (Leong, 1986; Sue & Morishima, 1982). The phenomenon of low utilisation coupled with severe disturbance among users seems to suggest that moderately disturbed Asians in the United States, who may be in need of services, are not seeking treatment (Sue *et al.*, 1998).

These early studies demonstrate that a major methodological difficulty in using inpatient hospital records to derive the rates of mental disorders is that “they confound prevalence with issues such as patterns of help seeking and service use, which are known to be quite different in native-born and immigrant communities” (Minas, 1990, p. 256). The issue of under-utilisation of mental health services among Asians will be elaborated in Section 7.

In New Zealand, hospital admission statistics are incomplete as far as variables such as place of birth and length of residence are concerned. Therefore, it is not possible to determine the prevalence of mental disorders for Asian immigrants from hospital records (Abbott, 1997).

5.2 Community Surveys

In considering relative prevalence of mental disorders in immigrant and native-born populations, the community survey method has a number of advantages over the hospital admission study (Minas, 1990). The community survey method avoids potential problems associated with differential use of hospital-based services, and problems of the reliability of different diagnostic practices in different hospitals by the use of a standardised psychiatric screening instrument. In addition, in a community survey, “it is possible to collect information unavailable in hospital

admission data that may allow testing of hypotheses concerning the possible contributors of differential psychosocial adjustment in different groups” (Minas, 1990, p.259).

These advantages notwithstanding, very few adequately controlled community-based studies of the prevalence of mental illness in immigrant communities have been carried out. The Chinese American Psychiatric Epidemiological Study (CAPES) was a comprehensive epidemiological survey involving the largest number of respondents ever found in a mental health survey of any Asian groups in the United States (US Department of Health and Human Services, 2001). The study, conducted in 1993 and 1994, examined rates of depression among more than 1,700 Chinese Americans in Los Angeles County. The results showed that Chinese in the United States had moderate levels of depressive disorders. About 7 percent of the respondents reported experiencing depression in their lifetimes, and a little over 3 percent had been depressed during the past year. These rates were lower than those found in the general population.

Among Southeast Asian refugees, many are at risk for post-traumatic stress disorder (PTSD) associated with the trauma they experienced prior to resettlement (US Department of Health and Human Services, 2001). A large community survey of Southeast Asian refugees in the United States (Chung & Kagawa-Singer, 1993, cited in US Department of Health and Human Services, 2001) found that pre-migration trauma events and refugee camp experiences were significant predictors of psychological distress even five years or more after migration. Significant subgroup differences were also found. Cambodians reported the highest levels of distress, followed by Laotians and Vietnamese.

High rates of PTSD were also found in studies of Southeast Asian refugees receiving mental health care. Kinzie *et al.*'s (1990) study reported that 70% of their clinical sample of Southeast Asian refugee patients met *Diagnostic and Statistical Manual for Mental Disorders* (DSM-III-R; American Psychiatric Association, 1987) criteria for PTSD. Certain groups had even higher prevalence rates. For example, 95% of the Mien group from the highlands of Laos and 92% of Cambodians suffered from PTSD. In addition, Kinzie *et al.* (1990) also found that 82% of their overall clinical sample suffered from depression, the most common non-PTSD diagnosis, whereas approximately 16% had schizophrenia.

In New Zealand, a few community surveys have been completed to assess the prevalence of mental disorders and certain mental health problems among selected Asian ethnic groups. In three of the studies, the General Health Questionnaire (GHQ) was used (Abbott *et al.*, 1999; P. Cheung & Spears, 1992, 1995). GHQ has been widely used as a self-administered screening instrument to identify non-psychotic mental disorders in community settings. It has been validated among Chinese (D.W. Chan, 1985; D.W. Chan & T.S.C. Chan, 1983; Cheng & Williams, 1986) and Cambodian populations (P. Cheung & Spears, 1994).

In 1992, P. Cheung & Spears completed a survey of 127 Chinese women living in Dunedin, using the 28-item version of General Health Questionnaire (GHQ-28). They found that the overall rate of minor mental disorders of Dunedin Chinese women (21%) did not differ from their European counterparts. No significant difference in mental health levels between the local and foreign born Chinese women was found. Among migrants, those who were born in China, came to New Zealand following the lead of family or for family reunion (as against those whose reason for migration was employment), had resided in New Zealand for ten years or more and spoke English infrequently, tended to have higher levels of psychological disturbance.

P. Cheung & Spears (1995a, 1995b) also examined the prevalence of minor mental disorders among 223 Cambodian adults living in Dunedin. They found a prevalence rate of 16%, similar to that of the general adult population of Dunedin. In addition, 12% of the sample were diagnosed as suffering from PTSD. The relationship between acculturation and minor psychiatric morbidity was also examined. Most respondents preferred an integrated mode of acculturation where they could retain their parent culture while also seeking to participate in the host society activities. Those who were older, widowed, less educated, had been in New Zealand for shorter periods, and of lower socioeconomic status, were less acculturated. Overall, higher rates of minor psychiatric morbidity were found among respondents who were less acculturated.

Pernice & Brook (1994) investigated and compared mental health levels among community samples of Indo-Chinese refugees, Pacific Island immigrants and British immigrants, using translated versions of the Hopkins Symptom Checklist. Larger proportions of Indo-Chinese refugees (25%) and Pacific Island immigrants (18%) experienced emotional distress in comparison to British immigrants (4%). Similar levels of anxiety were experienced by refugees and immigrants, but the incidence of clinical depression was noticeably higher for Indo-Chinese refugees (29% versus 18%). The strongest predictors of symptomatology were having experienced discrimination in New Zealand, not having close friends, being unemployed and spending most of one's time with one's own ethnic group (Pernice & Brook, 1996a, 1996b).

More recently, Abbott *et al.* (1999) completed a survey examining the prevalence of minor mental disorders amongst 271 recent Chinese migrants aged 15 years or older living in Auckland, using the 12-item version of the Chinese Health Questionnaire (CHQ-12). The CHQ is a screening instrument adapted from GHQ for use with Chinese (Chong & Wilkinson, 1989). The study found that the psychiatric morbidity rate among Chinese recent migrants was 19%. This rate did not differ from that of the general population.

Abbott *et al.*'s (1999) study also examined the relationships between psychiatric morbidity and risk factors, and found that unemployment, low English proficiency, lack of university education, younger age (26-35 years), shorter residency, and regrets about coming to New Zealand are major predictors of poor adjustment. Predictors of minor mental disorders included regretting coming, female gender and younger age. For migrants resident in New Zealand for less than two years, unemployment and under-employment were additional risk factors. Mothers with absent husbands and young people with absent parents also had elevated rates of mental disorder.

In addition, Abbott *et al.* (2002) completed a community survey assessing the prevalence of depressive symptoms² among 162 Chinese migrants aged 55 years and over. Using a Chinese version of the Geriatric Depression Scale and other measures, the study found a prevalence rate of depressive symptoms of 26% amongst the respondents. This rate appears to be very high relative to that of older people in the general population. However, it is not clear if the participants in this study also had high rates of depression prior to migration. Since very little research has focused on

² In studies of depressive symptoms, individuals are asked to indicate whether or not they have specific depressive symptoms and how many days in the past week they experienced these symptoms (US Department of Health and Human Services, 2001, p.114). Individuals who have depressive symptoms may not suffer from a mental disorder, as the diagnosis of a depressive disorder relies both on the presence of symptoms and on additional strict guidelines about the intensity and duration of symptoms, such as *the Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic criteria.

depression in Chinese migrant or ethnic minority populations, more extensive epidemiological study is required.

Abbott *et al.*'s (2002) survey also identified risk factors for depression, and found that lower emotional support, doctor visits, difficulties in accessing health services and low New Zealand cultural orientation increase the risk of being depressed. Less acculturated Chinese older migrants also had a significantly higher rate of depression.

The above review of prevalence studies among Asian ethnic groups in New Zealand shows that the estimates for mental disorders for these populations are different in different studies. A major reason for this is that the studies were based on different kinds of samples. In all of the studies, convenience samples were used. Because the population of the Asian ethnic groups is relatively small (6.4% of the New Zealand total population, see Section 2), and the demographic characteristics of these groups are changing, researchers have had difficulty finding adequate and representative samples with which to conduct studies. Besides, lack of funding for research on Asian ethnic groups have also hindered a more precise determination of prevalence rates among this population.

5.3 Sociocultural Factors that Relate to Mental Health

Aside from interest in the rates and distribution of mental disorders among Asian ethnic groups, researchers have also focused attention on identifying the specific ways that social and cultural factors influence the manifestation of mental disorders among Asians. For example, it has been established that somatisation, the physical expression of psychological distress, is more common among Asians than people in Western societies (F.M. Cheung and Lau, 1982; Hsu & Folstein, 1997; Nguyen, 1982). Culture is an important factor shaping the expression of distress among Asians:

The influence of the teachings and philosophies of a Confucian, collectivist tradition discourages open displays of emotions, in order to maintain social and family harmony or to avoid exposure of personal illness. Mental illness is highly stigmatizing in many Asian cultures. In these societies, mental illness reflects poorly on one's family lineage and can influence others' beliefs about how suitable someone is for marriage if he or she comes from a family with a history of mental illness. Thus, either consciously or unconsciously, Asians are thought to deny the experience and expression of emotions. These factors make it more acceptable for psychological distress to be expressed through the body rather than the mind (US Department of Health and Human Services, 2001, p.111).

In New Zealand, very little is known about how sociocultural factors influence the experiences of, and explanations for, mental health and illness among Asian ethnic groups. This is a critical research issue as growing population diversity in New Zealand raises concerns for increased sensitivity to and respect for differences in beliefs and cultural practices. In terms of mental health service utilisation, recent surveys conducted by Walker *et al.* (1998) and Ngai, Latimer & Cheung (2001) have revealed major sociocultural barriers to health care access by Asians. These issues will be discussed in greater detail in Section 7.

6. RISK AND PROTECTIVE FACTORS

In the study of migration and mental health, one of the most frequently asked question is: “Is migration associated with an increased risk of mental illness?”

In the late 1980s, a Task Force was established in Canada to identify factors influencing the mental health of immigrants and refugees. Over a two-year period, the Task Force reviewed over 1,000 publications as well as unpublished reports, from which the following conclusion was drawn:

While moving from one country and culture to another inevitably entails stress, it does not necessarily threaten mental health. The mental health of immigrants and refugees becomes a concern when additional risk factors combine with the stress of migration (Canadian Task Force, 1988b, p.i).

6.1 Risk Factors

The factors associated with increased risk of mental disorder among immigrants and refugees, which have been identified by the Canadian Task Force (1988a, p.i), include:

- drop in personal socio-economic status following migration;
- inability to speak the language of the host country;
- separation from family;
- lack of friendly reception by surrounding host population;
- isolation from persons of similar cultural background;
- traumatic experience or prolonged stress prior to migration; and
- adolescent or senior age at time of migration.

Although New Zealand literature on the mental health of Asian immigrants, refugees and student sojourners is limited, sufficient evidence does exist to show that these risk factors also affect the mental health of Asians in New Zealand (see Sections 4 & 5). Future research is required to identify which combinations of factors increase the risk of mental disorder for particular Asian ethnic groups, and how such knowledge may be used to develop strategies that can promote mental health.

6.2 Protective Factors

Aside from risk factors, there are factors that protect against the development of mental illness that may also be harnessed in the development of preventive mental health programmes (Minas, 1990). According to the Canadian Task Force (1988b), social support is a major protective factor.

Moving to a new country entails the disruption of former support systems and the initiation of new relationships. During the process of settlement, most newcomers derive support from diverse sources, such as relatives and friends, ethno-cultural community groups, social and health service agencies, neighbours, school teachers, shopkeepers, bus drivers, landlords and many others.

The psychological support provided by family is an important source of promoting well-being and preventing emotional disorder (Beiser *et al.*, 1995). The University of British Columbia (UBC) Refugee Resettlement study of 1,300 Southeast Asian newcomers documented higher rates of depression and anxiety among single, separated, divorced, or widowed persons than among those who were living with their spouses. Those people who reunited with spouses or went on to marry during the two years of study experienced improved mental health (Canadian Task Force, 1988b).

Friendships are also important. Such friendships most naturally occur between persons of the same ethno-cultural group, but the relationships with friends from other ethnic backgrounds can also greatly reduce the loneliness and social alienation often experienced by newcomers (Bochner, McLeod & Lin, 1977; Horenczyk & Tatar, 1998). Friendships are particularly important during adolescence; they provide a source of social support and play a role in assisting the adolescents' development of self and identity, and psychological well-being (Compas, 1987; Hartup, 1993; Wentzel, 1999). According to Kuo (1976), immigrants who settle in areas in which good support systems are available have fewer mental health problems than those who have limited access to suitable support resources.

Additionally, local ethnic communities help newcomers to maintain their ethnic identity and replace the lost familial and social networks so important to mental balance:

While ethnic communities provide practical assistance to newcomers, research evidence suggests that they help to protect mental health mainly by affirming cultural and personal identity. Religious institutions, for instance, reinforce personal faith which can act as a buffer to stress. Speaking one's mother tongue relieves the strain and exhaustion of constantly translating. Simple recreational and cultural activities enable immigrants to "let go" and "be themselves" (Canadian Task Force, 1988b, p.18).

Research with Asian immigrants, refugees and student sojourners in New Zealand has generally shown that social support can help newcomers cope better with the stress of migration and reduce the risk of emotional disorders (Abbott *et al.*, 1999, 2002; Pernice & Brooks, 1996a, 1996b; Searle & Ward, 1990; Ward & Searle, 1991). Most of these studies, however, have been focused on migrants and refugees from large and well-established ethnic communities (e.g., Chinese, Cambodian). The difficulties in obtaining social support faced by migrants from smaller ethnic groups have tended to be overlooked.

Other than social support derived from family, friends and like-ethnic community, the receptivity of the host society is another source of support (Berry, 1997). Fernando (1993) has designated racism as the most serious problem and risk factor facing immigrants and their mental health. According to the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988b):

Among the many factors determining whether migration will be a negative or positive experience, the orientation the host society displays towards newcomers is among the most important. Attitudes of government and the general population establish the emotional context in which immigrants see themselves and act. Perceived hostility may only breed further hostility, both in the immigrant and host communities, with a consequent rise in mental health problems for all (p.13).

7. BARRIERS TO MENTAL HEALTH SERVICE UTILISATION

Contemporary overseas studies of mental health care delivery have consistently demonstrated under-utilisation and treatment delays among Asians (Canadian Task Force, 1988a; Lin & Cheung, 1999; McDonald & Steel, 1997; Stephenson, 1995; Sue, 1994). A number of factors affecting utilisation and effectiveness of mental health services have been identified, including accessibility, appropriateness and availability of services, and existence of alternative services. The first three factors are discussed in this section.

7.1 Accessibility of Mental Health Services

Lack of English proficiency is a key barrier preventing Asian people from using mental health services. Many Asians are not aware that such services exist because they simply do not have the language skills to access the information. In addition, problems such as inability to explain their emotions and personal problems in English, and not understanding medical conditions, assessment and treatment, also create significant stress and confusion for people for whom English is a second language. The following quote from a Vietnamese migrant is illustrative:

I think the biggest problem for me was that I could not understand the doctors and the nurses. Whatever they told me I tried to understand and do. If I don't understand then I just don't do. I tried to tell them about my problems, but my English is not very good so I don't think that they understood me. Sometimes I got very frustrated because I could not make myself understood, but I just got used to it. I am so used to not understanding everything now that I don't even get frustrated any more (Stephenson, 1995, p. 1635).

Inadequate translation and interpreter services also lead to under-utilisation and/or delayed use. Although many Asians tend to rely on relatives or friends to do the interpreting for them, utilising family members as interpreters is often a problem (Beiser *et al.*, 1995). It makes privacy within the family impossible. Besides, when children are used as interpreters, it “reverses the hierarchical structure in traditional households, and can be quite difficult for all persons involved” (Stephenson, 1995, p.1638).

Alongside language barriers, cultural conceptions of mental health and mental disorder also play a major role in determining the extent to which Asian people access mental health services. As mentioned in Section 5.3 above, mental illness is highly stigmatising in many Asian cultures. In these societies, some forms of mental illness such as schizophrenia or organic brain disorder are conceived of as supernatural punishments for wrong-doings, and as such entail enormous shame and stigma (Canadian Task force, 1988a; Nguyen, 1982). Consequently, afflicted individuals avoid making their conditions known, and may be concealed by their families for extended periods of time (Lin *et al.*, 1978, 1982; Ngai and Chu, 2001).

Research on help seeking pathways for emotional problems among Asians reveal that Asian people are less likely than other ethnic groups to request outside help for their difficulties (Lin *et al.*, 1982). They tend to consult with family members and use traditional health care methods extensively, and accept psychiatric referral only as the last resort. This leads to under-utilisation, and more prolonged delay in mental health contact than for other ethnic groups.

7.2 Appropriateness of Mental Health Services

Cultural differences in Asian and Western styles of assessment and treatment create difficulties for both the health professionals and the Asian clients. Inefficient or incorrect assessment or treatment can impact greatly on the quality of service, and “may cause prolonged stay in the service or hospital thus increasing the running costs of the health service” (Ngai, Latimer & Cheung, 2001, p.56). With regard to mental health, professionals may find it difficult to understand the patients’ socio-cultural background, and “what is ‘normal’ and ‘abnormal’ behaviour and beliefs in their ethnic communities” (Ngai, Latimer & Cheung, 2001, p.59). An example of how cultural barriers may lead to incorrect assessment is given in the Canadian Task Force (1988b) report:

Depression is one of the most common of all emotional disorders and one of the most debilitating. Depending on cultural background, a person suffering from depression may try to ignore it, accept his or her suffering as fate, talk to a religious leader, seek treatment from a folk healer, discuss the problem with family, or consult a family physician. ... In Asian cultures, it is unacceptable to complain to a doctor about feeling despondent, lonely, or suicidal. Chinese, Vietnamese, Laotian and Cambodian patients will concentrate instead on the physical symptoms of depression such as sleeplessness, weight loss, appetite disturbance and pain, all of which are considered more legitimate reasons to seek medical help. The result may be a misdiagnosis or a missed opportunity to refer someone for mental health care (pp. 37-38).

On the part of the Asian clients themselves, perceived unfriendliness and the relative youth of general practitioners, and discomfort with styles of providing information, such as “the directness with which prognosis for serious illness is provided”, can create difficulties for Asians (Jiriwong & Manderson, 2001). Cultural differences also affect Asian clients’ responses to treatment:

Assessment is a two-way process: while therapists diagnose their patients, the clients are deciding whether their potential therapist is likely to help them. Premature termination of treatment is a major problem. Many ethnic patients do not continue treatment after their first mental care contact and as many as half drop out before five contacts. The most common reason for dropping out of treatment is because of negative feelings toward therapists. Clients often suspect that their therapist is racist. Unfortunately, clients rarely discuss these feelings with the therapists or with anyone else (Canadian Task Force, 1988b, p.40).

The development of culturally appropriate mental health services for Asians has recently begun in North America. The research findings have suggested that cultural responsiveness in the health care system can be increased by establishing ethnic-specific mental health services, increasing the number of bilingual and bicultural staff, encouraging communication and funding innovative programmes (Lau & Zane, 2000). Ma (1999), in particular, found that Chinese immigrants prefer to consult Chinese therapists of their own ethnic background because of the mutual sympathy, common language, and flexible appointment schedules. In a study to examine if treatment outcomes would be better with ethnically matched versus unmatched therapists, Sue (1994) found Asian clients who are matched with Asian therapists are less likely to leave treatment prematurely than Asian clients who are not match ethnically with their therapists. The study also found that ethnic match also increased length of treatment, even after other sociodemographic and clinical variables

were controlled. Not surprisingly, an ethnic and linguistic match between the client and health care provider is more important for clients who are relatively less acculturated (e.g. immigrants) than for those clients who are more immersed in the mainstream society.

7.3 Availability of Services

In New Zealand, community surveys conducted among Asian immigrants in Auckland (Abbott *et al.*, 2000, 2002; Ngai, Latimer & Cheung, 2001; Walker *et al.*, 1998) and Cambodian refugees in Wellington (Blakely, 1996) and Dunedin (P. Cheung and Spears, 1995) have shown that large proportions of the survey participants reported having difficulties accessing health services due to language and cultural barriers. The shortages of health care providers who possess appropriate language skills and understanding of the cultural experiences of clients, and lack of provision of resources such as interpreters, limit their ability to use the mental health care system.

With regard to support services that could help health care providers better cater for the needs of Asian clients, a survey among health care providers in 2001 found that the availability of interpreters at health services is regarded as most useful for improving services to Asian clients, followed by pamphlets printed in Asian languages, an Asian helpline service, Asian health support workers, more Asian health professionals, and healthcare services with cultural sensitivity (Ngai, Latimer & Cheung, 2001, p.62).

The health professionals also regard information and training on Asian cultures, and support from Asian health professionals and Asian health support workers as very useful in facilitating their provision of culturally appropriate health services to the Asian communities they serve. Cultural awareness for mental health professionals should also include a knowledge of healing resources within ethnic communities. This topic will be discussed in the next section.

8. USE OF TRADITIONAL HEALING PRACTICES

Limited studies are available on the use of traditional health practices by Asian migrants. The scant literature focuses primarily on Chinese, Cambodians and Vietnamese. Little is known about the use patterns of alternative health practices in other ethnic communities such as Korean, Sri Lankan and Thai.

8.1 Patterns of Use

A review of the available studies suggest that some Asians seek traditional methods of health care simply because they do not know what other services are available to them (Ma, 1999; Stephenson, 1995; L.K. Wong *et al.*, 1998). This is especially true for new immigrants. As pointed out in the previous section, communication and language difficulties, unfamiliarity with the mainstream health care system, and lack of understanding of Western concepts and terminology of illness and diseases, are key barriers preventing new immigrants from using mainstream mental health services. Besides, some new immigrants delay using mainstream health services because of the fear that their citizenship status will be jeopardized if they are found to have mental problems.

Simultaneous use of both Western and traditional health practices is very common among Chinese immigrants. Migrants from Hong Kong, China or Taiwan tend to see little conflict in using this strategy as they grow up in an environment where Western and Chinese medicines are considered complementary to one another (L.K. Wong *et al.*, 1998). Generally, Chinese believe that Western medicine is more effective in the acute stage of many diseases, such as heart diseases, tuberculosis, hepatitis B, cancer, and severe stomach problems, whereas traditional Chinese medicine is better for chronic conditions or for health promotion (C.W. Chan & Chang, 1976; Ma, 1999). However, although Western medicine works much faster than traditional medicine on acute diseases, it creates more adverse side effects than traditional medicine. Therefore, Chinese herbs are needed to offset these side effects.

Vietnamese, Cambodian and some other Asian communities tend to use an eclectic approach, that is, combining folk-healing practices from traditional cultural heritage with a range of available Western and Asian health methods (North, 1995; Stephenson, 1995). Unlike the Chinese, many Vietnamese and Cambodians are unfamiliar with the Western health care system prior to migration. At the same time, their communities are often too small to be able to maintain their traditional customs and ritual practices. As a result, they tend to rely on a range of Asian health methods available in the new country to supplement their own healing techniques.

North (1995) studied the transformation of the Cambodian system of healing in New Zealand, and argued that as a result of the refugee experience of deprivation, trauma, bereavement and exile, as well as the demands of adjusting to the new country, the emergent Cambodian-New Zealand system of healing is unlike both the Cambodian system of Pre-Pol Pot Cambodia and the biomedical system of New Zealand:

A result of exile is that familiar Cambodian systems of healing are no longer relevant, and at the same time, conditions of exile and transition cast doubt on former theories of illness, leading to a search both for understanding and for healing. Employing Cambodian self-care techniques together with Western and Asian medicines, resettled Cambodians

are actively creating a transitional system of healing appropriate to their transitional status (p. i).

Chinese herbal medicine is the largest group of Traditional Chinese Medicine (TCM) used by Chinese, Cambodians, Vietnamese and other Asian migrants. In a study of TCM in Auckland, it was found that other than Asians, many Maori and Pacific Island peoples also use Chinese traditional therapies because of the similarities between TCM healing philosophies and methods and traditional Maori and Pacific Island healing practices (MacGregor-Reid, 2001). There are also people who use TCM because they resist the biomedical norms of health care in New Zealand.

8.2 Implications for Health Care Providers

In Asian societies, a popular use of Chinese herbs is for the treatment of mental illness. However, because patients often do not volunteer the information that they are using alternative treatment, mental health professionals are generally unaware of the extent to which herbal treatments are used in different ethnic communities, and the extent to which these practices might interact with the Western mental health care system (Walter & Rey, 1999). In recent years, there is increased demand for mental health practitioners to improve communication with, and the quality of health care for, Asian clients. As a result, training resources are developed to promote cultural awareness and sensitivity to Asian health beliefs and practices, such as Ngai's (2000) *Cultural Perspectives in Asian Patient Care*, and Young's (2001) *Goh Kyol. Rubbing the Wind. The Cambodian Health Practice of Coining*.

9. CONCLUSION AND RECOMMENDATIONS

Until recently, the mental health of Asians in New Zealand has received very little public and professional attention. A popular belief has been that Asians are extremely well adjusted, as reflected in their low rates of crime and divorce as well as high educational and occupational attainment. This brief literature review challenges the stereotypes of extraordinary well-being and mental health amongst Asians.

Two themes dominate recent mental health-related research on Asians in New Zealand. One focuses on their adaptational problems, mental health status, and factors contributing to or hindering their successful adaptation and mental health. The second theme concerns the utilisation of mental health services by Asians, especially the barriers preventing their access to services. The research review has found that language problems, failure to find employment, separation from family and community, negative public attitudes and traumatic experiences prior to migration are key factors associated with increased risk of mental disorders among Asian immigrants, refugees and student sojourners. Most of these factors are amenable to change. Thus attending to risk factors can help improve the adaptation and mental health of Asian communities.

The research review has also been found that stigma is a major obstacle preventing Asians from using mainstream mental health services. Among Asian recent immigrants, a lack of English proficiency, inadequate knowledge and awareness of existing services, and cultural differences in the assessment and treatment of mental illness, are additional barriers to their use of the mental health care system. These issues draw attention to the need for more responsiveness to the needs of Asian service users and their families in the mental health system.

Based on the findings from the research review, the following recommendations are developed to promote mental health in Asian communities and improve cultural responsiveness in mental health services. In addition, four groups that experience a high risk of developing mental health difficulties are identified for further research.

9.1 Recommendations for Promoting Mental Health in Asian Communities

9.1.1 Increase public support for cultural diversity

Among the many factors determining whether migration will be a negative or positive experience, host societies' receptivity towards newcomers and their tolerance for cultural diversity are among the most important. Public education is useful to improve receptivity by increasing awareness of the benefits of cultural diversity, the contributions of people from different ethnic and cultural backgrounds to New Zealand society, and the difficulties faced by Asian immigrants, refugees and student sojourners. Public support for cultural diversity can be promoted in school and university curricula, in work settings as well as in the media. A culturally diverse workforce, for instance, will increase the opportunity of employment among new immigrants and refugees, which in turn can facilitate their economic and social participation in New Zealand society.

9.1.2 Provide extensive information before and after migration

Access to information and support networks is a vital part of the settlement process. Providing information to increase the newcomers' knowledge of the resources and opportunities in the host society before and after migration will help them have a more realistic outlook and expectation, which in turn will improve their participation in New Zealand society. Topics addressed should include employment, housing, schooling, language training, psychological adaptation and social and cultural relations.

9.1.3 Improve access to English language education

Inability to speak the language of the host country is a major factor affecting the mental health of new immigrants, refugees and student sojourners. Besides the isolation and loneliness it imposes, a lack of proficiency in the English language is also a barrier to utilisation of mainstream services in various areas. Mastering a local language and understanding native ways of life through language courses translate into empowerment for the newcomers. They will be more confident and find life as more comprehensible, manageable and meaningful. It will also enhance their opportunities in employment and higher education, thereby facilitating their full and equal participation in the new society.

9.1.4 Encourage and support the development of community support programmes

Social isolation is a taxing problem for newcomers. The provision of practical assistance in housing, transportation and employment at the time of arrival will have long lasting effects on their mental well-being. Community support programmes should also be developed to help those with less potential to participate in the host society (such as women, youth and older people) to have contacts with people from the same culture, thereby forming a supportive subculture for better social interaction and mutual support. In addition, ethnic communities are important sources of social support for newcomers. They help members maintain pride and cultural identity, which can also facilitate their integration with the dominant society.

In view of the lack of local research regarding the particular needs of Asian ethnic groups, ethnic organizations and community services agencies that have daily contacts with Asian migrants should be encouraged to assist in research to provide relevant information to policy makers and service providers to improve understanding of the needs and problems of particular migrant/ethnic groups.

9.2 Recommendations for Improving Cultural Responsiveness in Mental Health Services

9.2.1 Promote the development of educational materials and professional interpreter services

Stigma is a major obstacle preventing Asians from using mainstream mental health services. Public education is one way to promote the appropriate use of mental health services by Asians. Because language is a major barrier confronting Asian people, translations of culturally appropriate materials are necessary to increase understanding of mental disorders and mental health problems, to help counter traditionally held feelings of shame and guilt about mental illness in the family, and to promote earlier help seeking. Ethnic press, radio and television outlets, as well as the church and other valued agencies in ethnic communities, should be used to disseminate information.

There is also a need to make funding available to improve professional interpreter services. It is necessary to train interpreters for each ethnic group. To ensure quality of service, interpreters should be bound by ethnical standards and have an adequate awareness and understanding of the cultural backgrounds and mental health situation in their communities.

9.2.2 Increase service providers' awareness of Asian cultural issues

It is essential that the formal mental health care system becomes more responsive to the needs of the Asian communities. Health care providers can deal with their clients more competently if they are knowledgeable of their clients' cultural beliefs, their interpretation of mental illness and mental well being, their help seeking patterns and choice of traditional alternative health practices.

9.3 High-Risk Groups for Further Research

9.3.1 Women

Studies of Asian immigrant and refugee women in New Zealand are very limited. However, in the international literature, many immigrant and refugee women are found to be in high-risk situations (Canadian Task Force, 1988b; Jirojwong & Manderson, 2001; Lin, Tazuma & Masuda, 1979). While learning the skills of housekeeping and child-rearing in a new cultural system is already a demanding task, many immigrant and refugee women are also forced to seek jobs in order to help support the family financially. For many, lack of English language proficiency creates problems when seeking employment. This often results in women accepting unskilled jobs at the lowest level of the labour market which, in turn, limits the development of their English skills. There is also a need to assess the mental health needs of women from smaller ethnic communities. Many are likely to suffer intense social isolation because migration has cut up their traditional sources of support and the lack of English language ability has deepened their dependence on children and relatives. In addition, lack of a local ethnic community delays opportunities for them to develop support networks.

9.3.2 Students

Research to establish the extent of mental health needs among immigrant and fee-paying students from Asian countries is much needed. The various stressors faced by Asian students, such as language barriers, acculturative stress and the lack of social support networks, place them at risk for emotional and behavioural problems. There is a need for further research, in particular, into the social and cultural integration issues Asian students face outside the classroom. This kind of research will provide information that can assist with the development of programmes to encourage better understanding, participation and cooperation of both newcomers and members of the dominant society.

9.3.3 Older people

There has been very little local research conducted on older migrants and refugees, their mental health needs and utilisation of mental health services. There is however evidence in the

international literature that depression is a major psychological problem that affects older people (Canadian Task Force, 1988b; Jayasuriya, Sang & Fielding, 1994). Elderly Asians are particularly vulnerable because of their poor English language skills, small emotional support networks and limited involvement outside the home. Many have often experienced loneliness, isolation, anxiety, and a feeling of being marginalised by the host society. Some also feel distressed by their adult children's and grandchildren's high levels of acculturation to host society culture and apparent lack of respect. With the growth of the aged population in Asian ethnic groups, there is a need to pay special attention to the problems and mental health needs of older people within the Asian population. Many elderly Asians encounter great difficulties gaining access to mental health services. Research which can provide information to remove barriers to access and make services more effective should receive priority attention.

9.3.4 Refugees

Studies have consistently shown that refugees are at particular risk for depression and post-traumatic stress disorder, because of pre-migration traumas and the post-migration stressors of adapting and living in a new culture. Refugee youth is a special needs group within this high-risk group. In the international literature, it has been suggested that refugee youth experience elevated mental health risk because of language difficulties, identity conflict, racism, and rejection by the labour market (Canadian Task Force, 1988b). Recently, a report from the refugee NGO Groups (2000) also draws special attention to the vulnerability of this group, and their special needs for services.

Refugees from smaller ethnic groups are also vulnerable (Beiser, Turner & Ganesan, 1989). To date, New Zealand research on Asian refugees has been focused on the Cambodians, and to a lesser extent, Vietnamese and Laotians. Those from smaller communities of Sri Lanka, Myanmar and Indonesia are not represented in the literature. However, it is important to recognise the differing cultural perceptions of the distinct ethnic groups which make up the refugee populations. Refugees from smaller ethnic groups often experience added difficulties in the resettlement process, as they do not have as much access to their own community support networks and are therefore subject to higher degrees of isolation.

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