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

Te Pou o Te Whakaaro Nui
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RESEARCH
TRANSLATING RESEARCH

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CONTENTS

EXECUTIVE SUMMARY

PROJECT BACKGROUND

Te Tāhuhu – Improving Mental Health 2005-2015 and *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015* identified the need to develop national research agendas for mental health and addiction in a number of specific populations groups. Te Pou was commissioned by the Ministry of Health to develop the mental health and addiction research agenda for New Zealand's refugee and migrant populations. Separate agendas have been developed to identify priorities for New Zealand's Asian, Maori and Pacific populations.

This refugee and migrant agenda is intended to be a resource for researchers, funders of research, students and others interested in mental health and addiction in refugee and migrant communities.

METHOD

This refugee and migrant research agenda brought together representatives from the Ministry of Health, district health boards and primary health organisations, government agencies, government and non-government service providers, Asian, refugee and migrant community representatives, service users, and New Zealand researchers. The different priorities suggested by each group were considered, synthesised and compared with existing literature then revised to form a final set of research questions. The answers to these research questions can influence services and government policies to be more responsive to mental health and addiction in New Zealand's refugee and migrant communities.

RESEARCH TOPICS IDENTIFIED

During the consultation and literature review, research needs relating to three areas were identified: the context of mental illness, interventions to support mental well-being and information on workforce development. Research questions were organised within seven topics under these broad research needs:

Understanding the context

1. Prevalence of mental illness and addiction within refugee and migrant communities in New Zealand.
Research is needed to provide useful and culturally appropriate information about the mental health and addiction needs of refugee and migrant communities.

2. Risk and protective factors for mental well-being among refugee and migrant communities.
Questions remain about the extent to which different risk factors relate to mental illness and to addiction in particular. There are also questions about which risk factors should be targeted by service providers and policy in health, social services and other government sectors.

Developing interventions

3. Developing mental health promotion to improve mental well-being among refugee and migrant communities.
Little is known about the impact of mainstream and culturally targeted mental health promotion initiatives or community development projects on mental health and well-being in refugee and migrant communities.

4. Improving service access for refugee and migrant communities in New Zealand.
Research is needed to evaluate what types of service access initiatives are most effective for refugee and migrant communities.

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

6. Enhancing the responsiveness of New Zealand's mental health and addiction services for refugee and migrant communities.
Increased knowledge about effective mental health services and treatment approaches is needed to influence service development and service funding decisions in New Zealand.

Informing workforce development

7. Developing New Zealand's workforce to provide culturally appropriate mental health and addiction care for refugee and migrant communities.
Further research is needed on the effectiveness of cultural competencies, training methods and other workforce initiatives for improving mental health and addiction care for refugee and migrant communities.

RECOMMENDATIONS

The following recommendations aim to support knowledge development to improve the mental health and addiction needs of refugee and migrant communities in New Zealand.

1. Establish research collaborations between service providers, researchers and members of refugee and migrant communities to enhance the quality and applicability of the research.
2. Establish an ongoing group to lead the monitoring of the agenda, further prioritisation, and dissemination of research findings.
3. Identify multiple funding sources that can commit to funding the implementation of the agenda.
4. Researchers use technically and culturally appropriate research methods and advocate for the inclusion of mental health measures in New Zealand settlement research.
5. Disseminate research findings widely to service providers, planners and funders, policy makers, and communities with specific reference to the implications of these findings for their work.

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

INTRODUCTION

PROJECT BACKGROUND

Under the New Zealand *Public Health and Disability Act 2000*, district health boards (DHBs) have a responsibility to "improve, promote and protect the health of the population within their district" (section 22). Addressing the health needs of people from a refugee and migrant background is an important component of meeting this responsibility.

Recent Ministry of Health (MOH) plans have emphasised the need for mental health and addiction services to be responsive to Asian communities. *Te Tāhuhu – Improving Mental Health 2005-2015* challenged the mental health and addiction sector to respond to the "unique needs of special population groups" such as "refugee and migrant communities"(Minister of Health, 2005, p.11). In *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015* increasing understanding of refugee and migrant mental health and addiction needs was identified as a specific action to support responsiveness to refugee and migrant people (Minister of Health, 2006, p.31). This agenda overlaps with the Asian mental health and addiction research agenda developed by Te Pou and the Pacific research agenda developed by Le Va.[1]

In this context, Te Pou was commissioned by the MOH to develop a refugee and migrant mental health and addiction research agenda that will identify target topics and priorities for research in the next three to five years. Agenda development involved collaboration with key stakeholders, including the MOH, DHBs and primary health organisations (PHOs), government and non-governmental agencies and service providers, refugee and migrant community representatives and service users, and New Zealand researchers. The agenda aims to contribute to mental health and well-being and reduced health inequalities for refugee and migrant populations. It is envisioned that many agencies will support implementation of the research agenda.

NEED FOR THE AGENDA

A variety of information is required to address the mental health and addiction service needs of refugee and migrant communities. At present little is known about the prevalence of mental illness and addiction disorders within New Zealand's refugee and migrant communities and what services and mental health promotion approaches are most appropriate for these communities (Abbott, 1997; Gray & Elliot, 2001). Information on the context of mental well-being, effective interventions and workforce development is also vital to influence service and policy developments[2]. Responsive policy and services will in turn support the mental health and addiction needs of refugee and migrants who resettle in New Zealand.

WHO CAN USE THE AGENDA?

1 A Maori research agenda has also been developed by Te Rau Matatini.

2 In *Building on Strengths* the Ministry of Health identified research and evaluation as a priority action to support the development of healthy public policy which supports mental well-being (Ministry of Health, 2002).

This agenda can be used by researchers, funding agencies, students, service providers and research institutions looking to fund and/or undertake research that addresses the mental health and addiction needs of refugee and migrant communities in New Zealand. The questions address the impact of a range of different agencies, interventions and sectors on mental health. Thus, a range of agencies are expected to be interested in supporting and undertaking questions outlined in this agenda. The research questions and populations of interest have been framed broadly so that researchers may design studies which contribute to particular aspects of a question.

OVERLAPS WITH THE ASIAN RESEARCH AGENDA

This refugee and migrant mental health and addiction research agenda was developed in parallel with the mental health and addiction research agenda for Asian communities[3]. More precisely, the initial round of question development and community consultations was conducted in a single process. Further literature review and prioritisation of questions were conducted individually for each population.

Overlap in population definitions and the needs of Asian, refugee and migrant populations complicate the scope of the Asian and the refugee and migrant research agendas[4]. This refugee and migrant agenda addresses mental health and addiction issues which relate to the pre-migration, migration and resettlement experiences of refugee and migrant people in New Zealand. Literature, issues and questions that are specific to the Asian ethnicities and culture are covered in the Asian agenda. People interested in research with Asian immigrant or Asian refugee communities may draw from information and questions from both research agendas.

OTHER SPECIFIC POPULATIONS RESEARCH AGENDAS

Mental health and addiction research agendas for Maori and Pacific population groups were also outlined as specific actions within *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015*. Te Rau Matatini is responsible for the development of the Maori research agenda, and Le Va - Pasifika within Te Pou is responsible for the development of the Pacific research agenda. There is some overlap between Pacific and migrant communities in New Zealand; in 2006 15.5 % of overseas born people living in New Zealand were from Pacific Island nations (Statistics New Zealand, 2008). Both the Pacific and this refugee and migrant research agenda may be useful when planning mental health and addiction research with Pacific migrants to New Zealand.

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

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

CONTEXT: REFUGEE AND MIGRANT COMMUNITIES AND MENTAL HEALTH AND ADDICTION

REFUGEE

Population

The term 'refugee' is used to describe a particular category of migrants who are forced to migrate from their home country. Most countries, including New Zealand through the Immigration Act 1987, recognise a refugee according to the 1951 Refugee Convention definition.

> Under the UNHCR definition, a refugee is a person that:
>
> *"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 or her nationality, and is unable, or owing to such fear is unwilling to avail himself/herself of the protection of that country"* (United Nations High Commissioner for Refugees [UNHCR], 1951, p.16).

People from a refugee background enter New Zealand under three categories, the UNHCR quota system, family reunification migration status and as asylum seekers. The UNHCR quota system accepts approximately 750 refugees annually. Six hundred of these places are allocated to protection cases, 75 to women at risk and 75 to people with medical or disability issues (Ministry of Health, 2001c). These quota refugees arrive in six intakes each year.

An additional 300 people enter New Zealand as family reunification refugees under the immigration category of Refugee Family Support. The people in this group are relatives[5] of resident refugees who do not have immediate family in New Zealand or who are the sole carer of dependent relatives (Immigration New Zealand, 2008). The third group of people from a refugee background enter Zealand and remain whilst they are awaiting the outcome of refugee status applications. A handful of asylum seekers enter Zealand annually. If these asylum seekers are granted refugee status they become known as convention refugees.

During the 1990s, most refugee people entering New Zealand originated from Cambodia and South-East Asia. In recent years most refugees have come from Iraq, Somalia, Ethiopia, Afghanistan, and Burma/Myanmar (Refugee Resettlement New Zealand, 2005a). Family reunification and asylum seekers typically reflect the country of origin of the quota refugee intake. Each intake has a unique range of pre-migration, migration, and post-migration experiences, as well as different levels of education, language ability, cultural values and cultural patterns of responding to stress (Department of Labour, 2004; Ministry of Health, 2001c; Sowey, 2005). Health, social and immigration services must respond to the unique needs of each refugee intake.

5 Grandparents, aunts, uncles, nephews, children and parents (and that person's partner or dependent children) may be sponsored under the Refugee Family Support category (Immigration New Zealand, 2008).

New Zealand response to services for refugee mental well-being

Within New Zealand both mainstream and refugee specific services contribute to mental well-being in refugee communities. Eligibility for these services differs according to the category of refugee entry. Quota refugees are eligible for full health screening and mental health support, whereas family reunification and asylum seekers are eligible for public health services but may not be eligible for all specialist refugee mental health services. See Table A1 in Appendix A for further details on health service eligibility.

Refugee specific mental health services have been offered by Refugees as Survivors (RAS) in Auckland and Wellington since the mid to late 1990's. The Refugees as Survivors service in Mangere, Auckland, provides quota refugees and detained asylum seekers with free access to physical and mental health support when they arrive in New Zealand. The Mangere Refugees as Survivors centre has a mobile mental health team and is involved in health promotion and health education within Auckland's refugee communities. The Wellington centre offers counselling, assessment, advocacy, community capacity building and referral services for individuals and families who have experienced torture and trauma. Canterbury DHB has a specialist mental health service dedicated to working with refugee and migrant clients, and Christchurch Resettlement Services provide general counselling and health promotion services to refugees (Briggs, 2001; 2004). The RAS centres and the Canterbury mental health service do some cultural consultancy work to train mainstream practitioners to work more effectively with refugee clients. In the central region of New Zealand, home health visits are organised for newly settled refugee clients (Fraser, 2007). There are few other mental health support services specifically tailored to refugees who settle outside the Auckland, Wellington and Christchurch regions.

Across New Zealand the psychological needs of many refugees are dealt with by mainstream primary and acute mental health services (Fraser, 2007; Jackson, 2006). Acute DHB mental health services may also respond to severe cases of mental illness for quota refugees, refugees staying at the Mangere centre, asylum seekers, and family reunification refugees in later stages of resettlement (Fraser, 2007). Some refugees may also access alternative healthcare providers, including traditional herbal and spiritual healers (Fraser, 2007; Jackson, 2006).

Mental well-being in refugee communities is also supported by Refugee Services which help quota refugees to arrange practical support including banking, housing and access to English as a second language (ESOL) tuition, social services, education, health and employment. These services operate in Auckland, Wellington, Hutt Valley, Porirua, Christchurch, Hamilton, Palmerston North and Nelson (Refugee Resettlement New Zealand, 2005b). Refugee services are contracted to provide assistance to refugees during their first six months in New Zealand. Christchurch also has a resettlement service which works closely with Canterbury DHB's specialist mental health service to deliver a 'system of care' across both services.

Mainstream social, economic and other government agencies are also involved in supporting the settlement of refugee and migrant people[6]. A national settlement strategy and an Auckland sub-strategy have been developed to coordinate government support for refugee

6 See the migrant section for further information.

and migrant resettlement. The *Wellington Regional Action plan for Refugee Health and Well-being* outlines how different agencies in the region respond to refugee resettlement.

Similarities and differences between refugee and migrant populations

Both migrant and refugee people may experience barriers to successful settlement in New Zealand. Challenges by both groups include limited knowledge of the healthcare system, language difficulties, limited access to appropriate employment, and challenges maintaining family and social networks (Auckland Sustainable Cities Programme, 2006).

Language is a greater barrier for refugee resettlement than migrant resettlement because there are no language competency requirements for this group. In contrast migrants must have some English language skills to enter New Zealand. Refugees also face additional difficulties as a result of a forced departure from their home country, limited control over their future, family separation and greater likelihood of stigma. These additional stressors have implications for the level and types of support needed to support mental well-being in refugee relative to migrant communities. Appendix B displays a table from *Refugee Health Care: A Handbook for Health Professionals* (Minister of Health, 2001) which provides further detail about key population differences.

MIGRANT

Population

Migrants[7] are people born overseas who come to settle in New Zealand. New Zealand has received over 50,000 new immigrants annually (Office of the Auditor General, 2007).

In 2006, one in five (22.9 %) of New Zealand's current population were born overseas[8] (Statistics New Zealand, 2007). This compares with one in eight people in the United States and one in fifteen people in Europe (Statistics New Zealand, 2007). Many migrants choose to settle in Auckland; in this region 37 % of the population were born overseas (Statistics New Zealand, 2007).

New Zealand's migrant population identify with a diverse range of ethnic groups. This document uses 'ethnic migrants' to refer to people born overseas who meet the New Zealand government definition of ethnic: "those who identify with a culture and/or heritage that is different from the larger society" (Office of Ethnic Affairs & Statistics New Zealand, 2007, p.14).[9]

Diversity within the migrant population is also reflected in a range of languages, cultures, social norms and settlement needs. Ethnic migrants with language and cultural traditions which differ from larger New Zealand society are likely to face additional challenges accessing and adapting to life in New Zealand (Cioffi, 2003). For example, limited English language ability can be a barrier to employment, accessing services, daily needs and societal participation (Auckland Sustainable Cities Programme, 2006).

Overseas born[10] 'ethnic' New Zealanders include people from Asia (28.6 % of overseas born New Zealanders) and the Pacific (15.5 %). A further 7.7 % of immigrants came from Europe and 9.5 % from countries outside Europe, North America and Australasia (such as South Africa and the Middle East) (Statistics New Zealand, 2008). Thirty-nine per cent of overseas born New Zealanders come from countries that are linguistically and culturally similar to New Zealand such as Australia, the UK or North America (Statistics New Zealand, 2008). Further details on the regional origins of overseas born New Zealanders are provided in Table C1 in Appendix C.

New Zealand response to services for immigrant mental well-being

The health and mental health concerns of migrants are principally dealt with by mainstream population health services. Once a migrant becomes a New Zealand resident they are entitled

7 In this research agenda the term 'immigrant' and 'migrant' are used synonymously. Research questions and background information use the term migrant to achieve consistency with Ministry of Health documents (e.g. Te Kōkiri). Research and international documents commonly refer to 'immigrants' and this term is therefore applied when discussing existing literature.
8 Overseas born includes people who arrive in New Zealand under refugee as well as immigrant categories. Statistics on overseas born have most significance for immigrant populations that make up the vast majority of overseas born people arriving in New Zealand each year (50,000 relative to 750).
9 In this document 'other migrants' refers to migrants who share the culture and heritage of larger New Zealand society.
10 These two population groups are covered with other specific populations mental health and addiction research agendas.

to mainstream health services at the same cost as New Zealand citizens.[11] Specialist mental health services relevant to migrant groups include a refugee and migrant mental health service in Christchurch as well as Asian and Pacific services in Auckland, and Pacific services in Wellington.

Settlement services have been developed to assist migrants to adapt to life in New Zealand. Settlement Support New Zealand provides referrals to useful support agencies such as housing, employment, education and career services. The Office of Ethnic Affairs plays a role in promoting and supporting cultural and linguistic diversity in New Zealand and lobbying for the needs of ethnic communities with the government. It also offers a language line telephone interpreting service to assist people who do not speak English to access government services.

In Wellington the ChangeMakers Refugee Forum works with people from a refugee background to encourage personal and community development and full participation in New Zealand society (ChangeMakers Refugee Forum, 2008). Wellington also has a multicultural centre that hosts five agencies that respond to refugee and migrant mental health and settlement needs. These agencies are Refugees as Survivors centre for refugees and migrants who have experienced torture or trauma, English language home tutors, interpreting services, Refugee Services and Multicultural Learning and Support Services (MCLASS). MCLASS provides English language classes, orientation for resettlement, job search support and mother tongue language courses.

A national settlement strategy and Auckland and Wellington sub-strategies have developed to support ongoing development in services and support for the settlement of new migrants.

HEALTH INFORMATION COLLECTION SYSTEMS

There is little data about the current and future health needs of refugee and migrant communities in New Zealand (Mortensen, 2007). The Level 2 classification of ethnicity collected in most health services is too broad to be useful for health planning for refugee and migrant populations.[12] Furthermore, refugee status, migrant status, time in New Zealand and country of origin are not collected in patient records.[13] This lack of information limits the ability of mental health services to monitor their progress at improving mental health and well-being for their refugee and migrant populations.

11 Ministry of Health funding does not typically apply to short-staying migrants, such as foreign full-fee paying international students and seasonal workers, who may reside in New Zealand but do not intend to settle here.

12 Proposals have been made to change to a more detailed level of ethnicity collection (the Level 4 Statistics New Zealand ethnicity system) by 2011.

13 Details on migrant status, time in New Zealand and country of origin are often contained in psychiatric assessments.

MENTAL HEALTH AND ADDICTION DEFINITIONS

Definitions relating to mental wellbeing and mental health services are presented in Box 1.

Box 1. Mental health and addiction definitions

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

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

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

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

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

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DEVELOPING THE AGENDA

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

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

PHASE I

An initial scan of New Zealand and international Asian, refugee and migrant research reviews was undertaken (Abbott, 1997; Fazel, Wheeler., & Danesh, 2007; Gray & Elliot, 2001; Ho et al., 2002; Keyes, 2000; Lustig, Kia-Keating, Knight, Geltman, Ellis, Kinzie, Terence, & Saxe, 2003; Watters, 2001). A further search of academic journals and websites of New Zealand research institutions was conducted to identify topics addressed by recent research that had not been included in the above literature reviews.

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

PHASE II

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

Fifty-six people with an interest in Asian, refugee or migrant mental health and addiction were identified via personal contacts, email networks and the internet. A further 20 people were identified through snowballing. These people were invited to attend the consultation meetings via email and follow up phone calls Email feedback was also requested from PHOs and DHB funders and planners around New Zealand.

Stakeholders considered which questions were the main priorities for refugees and which for migrant communities. At the same time, they considered which questions were most

important for Asian communities. Group discussions provided broader feedback on the research topics, and community and sector issues, and further questions of importance. The results of the first consultation round supported the development, elimination and refinement of questions in Phase III.

PHASE III (REFUGEE AND MIGRANT SPECIFIC)

A focused literature search, specific to refugee and migrant populations, was used to identify literature relating to questions and issues raised by stakeholders during Phase I and Phase II consultations. This involved a search of peer reviewed and non-peer reviewed articles published since the year 2000 using the Google Scholar search engine.

The search used terms relating to questions identified through consultation (e.g. prevalence, stigma, mental health promotion, workforce, risk factors, primary health, GPs, screening, intervention, treatment, services, psychiatric, service access) combined with terms relating to mental health (e.g. mental health, addiction, psychiatric, mental well-being, mental illness, psychological, depression) and terms relating to refugee and migrant populations (refugee, asylum seeker, migrant, immigrant, immigration, ethnic and cross-cultural). Cross-cultural and other ethnic research was only reviewed for questions when relevant refugee and migrant specific research could not be located. The reference lists of the latest articles and reviews were also scanned to identify important contributions which included some articles pre-dating 2000. The standard Google search engine was then used to identify non-peer reviewed literature by government departments, health and immigration agencies in New Zealand and overseas. Similar search terms were applied to this search. It was noted that very little research had been conducted specific to refugee and immigrant populations in many areas of stakeholder interest. Over 150 abstracts and full text articles were reviewed.

The scope of the literature search had a number of limitations. The search aimed to provide an overview of whether stakeholders' questions of interest had been covered by existing research and thus did not seek to identify every piece of research on each topic. Furthermore, only English language documents were reviewed, and the review focused on documents published in peer review journals and government or health agency websites. Researchers should review the conclusions about the existing research when embarking on a particular research question.

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

A small group presentation and feedback session was held with refugee community facilitators at the Mangere Refugee Resettlement Centre. Discussions focused on research that would support the development of services that were more responsive to their needs. People working in refugee and migrant services were also approached to provide feedback on particular topics.

The reference group continued to provide information about health sector developments, barriers to service responsiveness and existing and upcoming research studies throughout

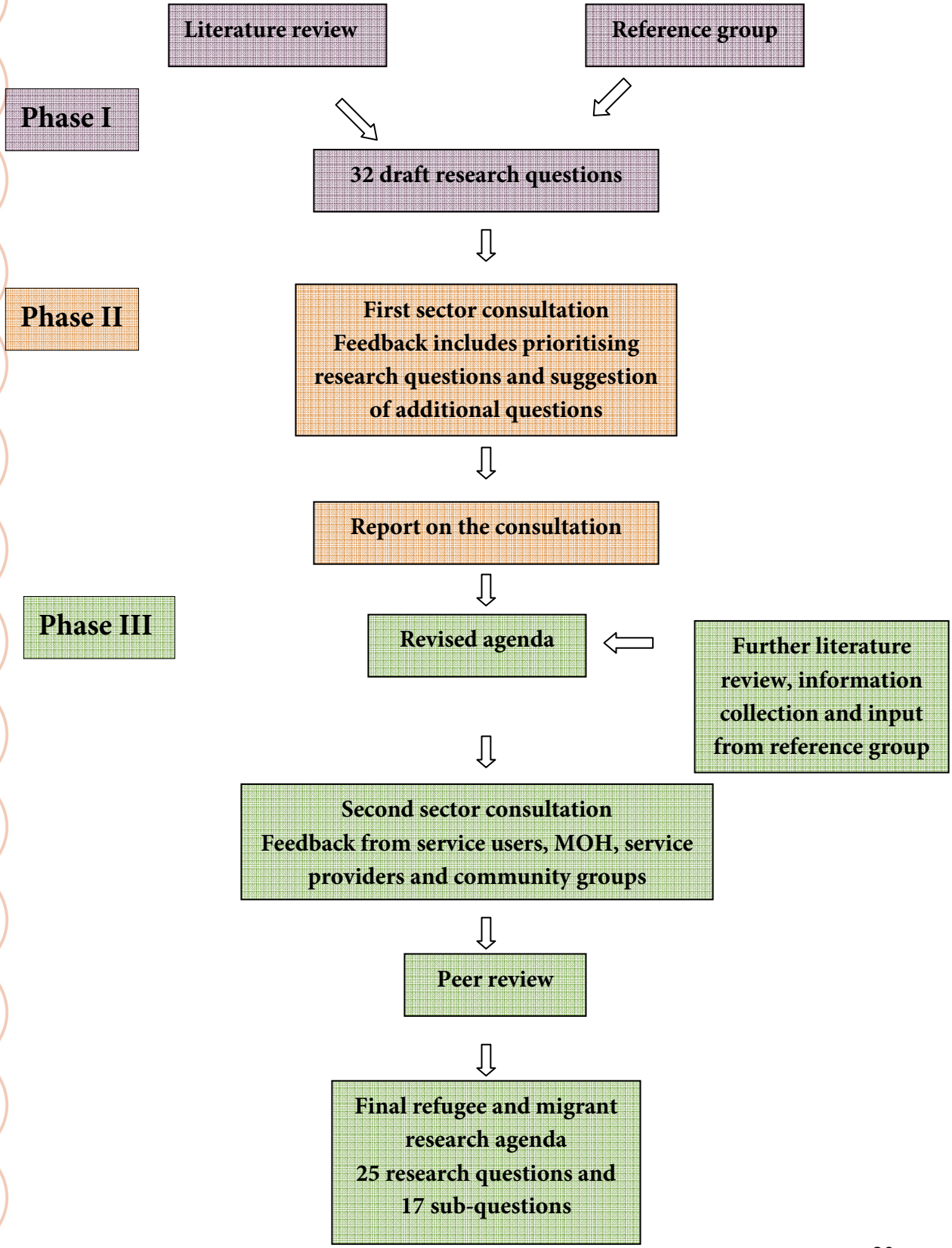
Phase III of research agenda development. Other groups and organisations consulted in Phases I, II and III of the agenda are listed in the Appendix D.

Information collected in the consultation, service user feedback, project reference group meetings, targeted phone interviews and the literature review was used to revise the research questions further. Questions were excluded if they could not influence policy, mental health promotion or service delivery for refugee and migrant communities, or if they had been well addressed by previous research.[14] The literature review and consultation processes also identified three refugee and migrant sub-groups that we particularly need to understand more about.

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

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

FIGURE 1. AGENDA DEVELOPMENT PROCESS



REFUGEE AND MIGRANT RESEARCH AGENDA

AGENDA OVERVIEW

This refugee and migrant mental health and addiction research agenda discusses existing research findings, and recommends questions that address service provider, planning and funding, and policy responses to the mental health and addiction needs of refugee and migrant communities.

Refugee and migrant mental health and addiction research needs have been organised under seven topics relating to three broad themes.

Understanding the context

1. Prevalence of mental illness and addiction within refugee and migrant communities.
2. Risk and protective factors for mental well-being among refugee and migrant communities.

Developing interventions

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

Informing workforce development

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

Each topic summarises a sample of the relevant international and available New Zealand research. In cases where there is no literature available for refugee or migrant populations, research looking at cultural differences is also presented. Tables have been included as appendices to help explain the different issues for refugee, ethnic migrant and non-ethnic migrant populations. At the end of each section the research needs identified by stakeholders are presented, followed by a summary of the knowledge gaps and a list of priority research questions.

PRIORITY REFUGEE AND MIGRANT COMMUNITIES FOR RESEARCH

There is little mental health or addiction research relating to New Zealand's refugee or migrant communities. The settlement experiences, pre-migration experiences and mental health and addiction needs of New Zealand's refugee and migrant communities may differ from communities studied in international research. Consequently, New Zealand specific research is important.

Research into sub-groups of refugee and migrant populations is also needed for service and policy development. Some sub-groups can experience unique patterns of mental health problems, for example higher rates of depression and anxiety disorders have been noted in particular refugee and migrant communities. The type of interventions which are most effective may also differ between refugee and migrant sub-groups. Sub-groups based on cross-cutting variables such as religion, language ability, family structures and cultural values may have greater relevance than grouping refugee and migrant people by world region (Office of Ethnic Affairs & Statistics New Zealand, 2007).

Research on the following three sub-groups is particularly important for influencing service and policy development for refugee and migrant communities.

Research into African and Middle-Eastern people from a refugee background
Many recent refugees to New Zealand have come from Africa and the Middle East, but little research has been conducted with refugees from these countries. International research has focused on refugees from South-East Asia and Eastern Europe[15], with less research available on refugees from Africa, the Middle East and South and Central America (Lustig et al., 2003). There a need for further research on African refugees, and other refugee groups who have not been covered in existing research (Lustig et al., 2003).

Ethnic migrant communities
Service and policy development for migrant communities is likely to benefit most from information on ethnic migrant communities. Ethnic migrants are likely to have higher rates of mental illness than migrants who share New Zealand cultures and traditions because of the impact of cultural and linguistic diversity on the settlement experiences of this group (Cantor-Graae & Selten, 2005; Cartor, Bernal, Hardoy, Maria, 2005). Cultural and language diversity may also provide barriers to service access and limit the effectiveness of interventions designed for mainstream populations (Bhui, & Sashidaran, 2003).

Second generation refugee and migrant communities
Recent studies suggest that mental health and adjustment issues are more common in second generation migrants than in their migrant parents (Cantor-Graae & Selten, 2005; Kinsie, 2006). Furthermore second generation migrants can have lower rates of service access than their parents (Abe-Kim, Takeuchi, Hong, Zane, Sue, Spencer, Appel, Nicado & Alegria, 2007). Existing research has focused on foreign born migrants and less research is available on the needs of second generation migrant families. There also appears to be little information about the mental health needs for second generations of people from a refugee background.

15 This may reflect greater numbers of refugees from these countries in previous years.

UNDERSTANDING THE CONTEXT

1. Prevalence of mental illness and addictions within refugee and migrant communities in New Zealand[16]

Prevalence refers to the proportion of people within a population who experience a condition within a specified period of time[17] (Goldner, Hsu, Waraich & Somers, 2002).

Research has consistently documented high rates of mental illness in refugee communities (Abbott, 1997; Kinsie, 2006). Estimates suggest that up to 60 % of people from a refugee background suffer from post-traumatic stress disorder (PTSD) or depression (Kinsie, 2006). Other mental illnesses common in refugee populations include anxiety, psychosis, and dissociation (Fazel, Wheeler & Danesh, 2005; Keyes, 2000). In refugee communities, as in other populations, there is often a high comorbidity between different types of mental illness, including addiction disorders (Lustig et al., 2003). Although there is a general trend for higher risk of mental illness in refugee communities, research has produced widely varying prevalence figures (Schmidt & Poole, in press). Schmidt & Poole (in press) reviewed estimates ranging from 20 to 68 % for depression, and 26 to 52 % for PTSD. Higher than average rates of mental illness have been noted across age groups of people from a refugee background relative to host population in resettlement countries (Schmidt & Poole, in press).

Reports on the rates of mental illness in migrant communities are also inconsistent. In addition to differences in prevalence figures, some comparisons between migrant communities and host communities have reported higher rates of mental illness for migrants, and others report rates which are lower than the national average (Bhugra, 2003; Cantor-Graee & Selten, 2005; Kinsie, 2006; Swinnen & Selten, 2007). For example, a meta-analysis by Cantor-Graae & Selten (2005) noted that on average schizophrenia was 2.7 times more commonly experienced by migrants, compared with the host population of the country (Cantor-Graae & Selten, 2005). In contrast, Grant, Stinson, Hasin, Dawson, Chou and Anderson (2004) noted lower rates of mental illness in Mexican migrants relative to the American born people of Mexican ethnicity, or the non-Hispanic White US population. Recording migrant status is unlikely to provide substantial information to estimate risk for mental illness.

Less is known about the rates of alcohol and drug use within refugee or migrant communities. There are indications that some refugee and migrant groups have lower than average levels of alcohol and drug abuse than the host population of Australia and the United States. For example, one large US study reported that Mexican immigrants have lower rates of alcohol abuse than US born white and US born Mexican population groups (Grant et al., 2005). Low rates of alcohol use disorder have also been noted in long-settled South-East Asian refugees living in the United States (US) and Australia (Marshall, Schell, Elliott, Berthold, & Chun, 2005; Steel, Silove, Chey, Bauman, Phan & Phan, 2005). This literature review was unable to locate any research on rates of addiction in non-Asian refugee communities.

16 Prevalence rates are consistently higher for refugee relative to migrant communities and therefore prevalence rates are discussed in separate sections to limit confusion.

17 Typical timeframes used for prevalence estimates are (the number of cases who experienced a condition) within the previous year or within their lifetime to date

The diversity in language, culture, pre-settlement and settlement experiences within refugee and migrant populations and research samples may help to explain variation in prevalence estimates. Research has consistently recorded higher rates of schizophrenia when there is a large difference in the social and cultural practices of sending and host nations (Cantor-Graae & Selten, 2005; Cartor, Bernal, Hardoy, Maria, 2005). This increase has been attributed to greater challenges adjusting to life in a dissimilar country. However for Asian migrants, rates of mental illness are typically lower than for Western populations, despite their cultural and linguistic diversity[18] (Ho et al., 2002). Higher rates of mental illness have been noted in elderly migrants relative to younger migrants, and elderly refugees relative to younger refugees (Porter & Haslam, 2005; Pumariega, Rothe & Pumariega, 2005). Female refugee samples also often have higher average rates of mental illness than men from a refugee background (Porter & Haslam, 2005).

Country of origin appears to have an impact on substance abuse rates, possibly due to differences in previous drinking practices (Cantor et al., 2005). For example Peurto Rican migrants to the United States have a greater risk of a substance use disorder than other Hispanic immigrants have (Kinsie, 2006). It has also been predicted that religious affiliations will have an impact on rates of addiction disorders within refugee and migrant communities (Cantor et al., 2005).

Time following settlement is also associated with changes in the prevalence of mental illness in refugee and migrant communities. Second generation migrant communities appear to have higher rates of mental illness than their parents who were born overseas (Kinsie, 2006). For schizophrenia, risk is estimated to be 4.5 times higher for second generation migrant communities compared with the host population, but only 2.7 times higher for foreign born migrant population groups (Cantor-Graae & Selten, 2005). A number of pieces of research on migrants from a range of ethnicities have noted higher rates of mental illness in subsequent generations of migrants (Pumariega, Rothe & Pumariega, 2005).

Time after resettlement may also impact on the level of prevalence in refugee communities. A number of pieces of research have noted that some refugees will develop mental illness following, rather than prior to resettlement (Davidson et al., 2008; Kinsie, 2006). One study found that rates of depression in Vietnamese refugees to America continued to increase over the first 10-12 years after resettlement and then declined (Davidson et al., 2008). Bhugra (2003) suggests that refugees are particularly vulnerable immediately following migration, as well as 5-7 years later when their expectations for resettlement have not been met. Nonetheless some of the highest estimates of mental illness (62 % experiencing PTSD and 51 % experiencing depression) have been made on refugee communities that have lived in the US for an average of two decades (Marshall et al., 2005).

Within longitudinal studies there is large variation in long-term risk, possibly due to the support provided by different resettlement environments. For example Steel et al (2005) recorded that refugees resettled in Australia for a decade had much lower rates of mental illness (9.9 %) than was noted in Marshall et al (2005) or noted in the host Australian

18 Detailed information about research mental health and addiction in Asian communities is provided in the Asian research agenda

population. Such comparisons should be made with caution due to the likelihood of vastly differing characteristics and pre-migration experiences (e.g. level of trauma exposure) of different refugee groups. It is difficult to assess the impact of resettlement experiences because few studies other than Davidson et al (2008) have tracked changes within a single group over time. This literature review was unable to find research comparing prevalence rates between foreign-born refugees and subsequent generations of refugee communities.

Variation in prevalence estimates may also result from methodological factors, including the inconsistent and perhaps inappropriate choice of measurement tools, procedures and sampling techniques (Davidson, Murray & Schweitzer, 2008). Refugee prevalence estimates can also be biased by the cultural assumptions of Western researchers and a tendency of refugee people to under-report symptoms of mental illness. Refugee participants may be unwilling to disclose psychological symptoms due to cultural stigma and fear of jeopardising their refugee status (Guerin, Guerin, & Diirye, September 2004; Guerin & Guerin, 2007). Western researchers have been known to incorrectly interpret refugee behaviours or comments, particularly when they do not speak the refugee's first language (Fazel, Wheeler & Danesh, 2005; Guerin, Guerin, & Diirye, September 2004; Guerin & Guerin, 2007).

There is ongoing debate about the best tools and procedures to measure the prevalence of mental illness in ethnic communities, particularly those from a refugee background. People have questioned whether Western measurement systems are sensitive to culturally specific symptoms of psychological distress (Bhui, Mohamud, Warfa, Craig, & Stansfield, 2003; Davidson et al., 2008).[19] Critics of the PTSD concept accuse it of interpreting responses to stressors as pathological and argue that PTSD overlaps heavily with other psychiatric concepts (Davidson et al., 2008; Summerfield, 1999). Attempts have been made to validate measures of mental illness with specific refugee populations (see Grant, Stinson, Hasin, & Dawson, 2004; Hollifield, Warner, Lian, Krakow, Jenkins, Kesler, Stevenson, & Westermeyer, 2002). However, concerns remain that tools with a basis in Western diagnostic systems may ignore refugee "traditions, meaning systems and active priorities" (Summerfield, 1999, p.1449). On the other hand, the tendency to use multiple different types of assessment and screening methodology in refugee research has resulted in variable and often non-comparable estimates of prevalence (Davidson et al., 2008).

The high variation in overseas prevalence figures and the unique demographic characteristics (pre-migration, migration and resettlement experiences) of New Zealand's refugee intakes complicate generalisations from overseas estimates. Furthermore overseas prevalence figures may underestimate the rate of mental illness in New Zealand's refugee communities because New Zealand is one of few countries that will accept refugees known to be experiencing mental illness. Overseas migrant prevalence may not generalise to New Zealand's migrant communities due to the unique settlement experiences in New Zealand and ethnic differences from migrant groups often studied in international research.

Very little research has specifically looked at the prevalence of mental illness or addiction in New Zealand's refugee or migrant communities. One 1994 study recorded similar rates of

19 See Bhui, Mohamud, Warfa, Craig, & Stansfield (2003), Hollifield, Hewage, Gunawardena, Kodituwakku, Bopagoda, & Weerarathnege (2008), Hollifield, Warner, Lian, Krakow, Jenkins, Kesler, Stevenson, & Westermeyer (2002) and Jeon, Yoshioka, &. Mollica (2008) for discussions about developing culturally appropriate measures and concepts.

depression (12 %) for Cambodian refugees to Dunedin and the general Dunedin adult population, but noted that Cambodian refugees experienced higher rates (12 %) of PTSD (Cheung, 1994, as cited in Ho et al., 2002). With this exception, no other prevalence estimates for a New Zealand refugee community could be located in this literature review.

Anecdotal reports from refugee support workers and a Department of Labour survey suggest New Zealand's refugee communities have high levels of mental health needs (Fraser, 2007; New Zealand Immigration Service, 2002). In the Department of Labour survey, one third of refugees (n=209) reported experiencing emotional problems as a result of previous or current stressful events (New Zealand Immigration Service, 2002).

Some New Zealand research exists on selected immigrant communities and appears to confirm the patterns of variation noted in international research. For example, Pernice and Brook (1996) noted lower rates of mental illness (4 %) in British migrants who share a similar language and culture to many New Zealanders, relative to Pacific migrants (18 %). Lower than average symptoms of mental illness have been noted in Asian adults and youth relative to New Zealand Pakeha (Ministry of Health, 2006; Ward, 2008).[20] With the exception of the Pernice and Brook (1996) study, no other information on non-Asian, or non-Pacific migrants to New Zealand was located in this literature review.

This literature review was also unable to locate any estimates of the rates of alcohol and drug issues in non-Asian and non-Pacific migrant communities, or refugee communities in New Zealand.[21] Furthermore, New Zealand research does not appear to have explored generational differences in mental well-being for non-Asian and non-Pacific migrants, or refugee communities to New Zealand (Gray & Elliot, 2001).

The Ministry of Health has indicated that gaining knowledge about population needs is a key task for health providers in New Zealand (Ministry of Health, 2004). However, many service providers consulted during Phase II noted that they have little knowledge about the prevalence of mental illness within refugee and migrant communities. Knowledge about prevalence rates can be used to plan services and lobby for additional mental health, health and social services for these population groups (Kumar, Tse, Fernando, & Wong, 2006). Information about variation in prevalence by country of origin/ethnicity and time in New Zealand will help to identify high risk refugee and migrant groups to inform service planning.

Summary

International research suggests that refugee communities are likely to have high rates of mental illness, particularly depression and post-traumatic stress disorder. Within migrant populations, non-Asian ethnic[22] migrant groups may have elevated risk of mental illness. A "healthy migrant" effect where new migrants have better mental health than longer-settled and second generation migrants has also been identified in international research.

20 Further information on Pacific and Asian mental health and addiction rates is given in separate research agendas.
21 As part of the 2007-2010 problem gambling strategy, the Ministry of Health is planning to scope the impact of problem gambling in refugee and asylum seeker communities.

There is no reliable data on the prevalence of mental illness or addiction in New Zealand's refugee or migrant communities. Generalising prevalence estimates from international studies and between different refugee intakes to New Zealand may not be appropriate due to the unique experiences of different refugee groups. There is debate about how to document the mental well-being of refugee and ethnic migrant communities in ways which are culturally appropriate and sufficiently rigorous to allow changes over time and population comparisons to be monitored.

Research questions

1.1. What are the prevalence rates of common mental illnesses and addiction in New Zealand's refugee and/or migrant communities? Consider mild, moderate and severe levels where possible.

1.2. What differences exist in refugee and/or migrant prevalence rates according to ethnic group, country of origin and time spent in New Zealand? What may account for changes in prevalence rates over time?

1.3. What are appropriate ways to measure prevalence in refugee and ethnic migrant communities?

UNDERSTANDING THE CONTEXT

2. Risk and protective factors for mental well-being among refugee and migrant communities in New Zealand

A risk factor correlates with an increased likelihood of mental illness (Ho et al., 2002; Cheung, Nguyen, & Yeung, 2004).

A protective[23] factor is associated with positive mental well-being and/or a reduced likelihood of mental illness.

Members of both refugee and migrant communities have been exposed to pre-migration, migration and post migration[24] risk and protective factors, but refugees are likely to experience more risk factors and fewer protective factors than migrant communities. Appendix E presents a table which presents a broad comparison of the proportion of refugee, ethnic migrant and non-ethnic migrants who are likely to experience particular risk and protective factors. The differential exposure to these risk and protective factors is believed to be partially responsible for differences in the prevalence of mental illness between and within refugee and migrant communities.

Various pre-migration and migration experiences are associated with mental illness and addiction experienced following resettlement (Abbott, 1997; Bhugra & Ayonrinde, 2004; Ho et al., 2002; Pumariega, Rothe & Pumariega, 2005). Research has shown that high exposure to torture and/or trauma[25] is related to greater psychological disturbance (Davidson et al., 2008; Kinsie, 2006). However, little is known about the long-term emotional impact of torture independent of the impact of other traumatic life events (Basoglu, 2001; Tor & Yarvin, 2001). Stressors associated with migration can also increase the risk of mental illness (Bhugra & Ayonrinde, 2004; Ho et al., 2002; Gray & Elliot, 2001). For example, relocation to a new country can involve stressful experiences such as multiple refugee claim appeals, family separation, overcrowding and a loss of control (Lustig et al., 2003).

Experiences and social and economic circumstances following arrival in the resettlement country also impact on refugee and migrant well-being. For example, higher mental well-being in refugee and migrant groups is associated with good English language skills (Abbott, 1997; Briggs & Macleod, 2006; Briggs et al, 2007; Gray & Elliot, 2001; Pernice & Brook, 1996), good physical health (Pumariega, Rothe & Pumariega, 2005), stable permanent accommodation (Porter & Haslam, 2005) and high income and employment (Takeuchi, Chung, Lin, Shen, Kurasaki, Chun & Sue, 1998). Discrimination, hostility, marginalisation and a lack of acceptance from the host population exacerbate the risk of mental illness (Abbott, 1997; Gray & Elliot, 2001). Many of these experiences are related to social and economic factors (often referred to as social and economic determinants of health), which can

23 Goodman & Patel (2007) distinguish protective factors as relating to an absence of mental illness, and use the term 'promoting factors' to refer to factors which elevate the level of mental well-being.
24 Many of post-migration risk and protective factors are often referred to as social and economic determinants of health.
25 Trauma can result from experiences such as traumatic loss of friends and family, threats to life and breaches of other human rights (Davidson, Murray & Schweitzer, 2008; Gray & Elliot, 2001; Ho et al., 2002; Kinsie, 2006; Marshall et al., 2005).

be addressed to some extent through public policy and social and economic support (Ministry of Health, 2002).

A decline in living situation and social status following migration also appears to have an impact on refugee mental well-being. Higher rates of mental illness are found when refugees were highly educated, or had higher incomes prior to migration (Porter & Haslam, 2005). Higher rates of mental illness have also been noted in refugees from rural communities (Porter & Haslam, 2005). This increased risk may result from a mismatch in lifestyle or a mismatch between the skills acquired for rural life and skills needed for successful resettlement in the host country.

Turmoil in the home country of a person from a refugee background can continue to have a negative impact on mental well-being following resettlement. A meta-analysis revealed that refugees who come from countries where conflict has not been resolved typically have poorer mental health (Porter & Haslam, 2005). Refugees in New Zealand also report that ongoing conflict and bad news have a negative impact on their mental well-being (Briggs & Macleod, 2006; Peterson, Barnes, & Duncan 2008).

Social support is widely believed to be the most important protective factor against mental illness. A refugee or migrants' social support, particularly perceived social support from their own community, is associated with higher mental well-being in refugee communities (Abbott, 1997; Briggs & Macleod, 2006; Briggs et al, 2007; Schweitzer, Meville, Steel & Lacherez, 2006). Rudmin (2003) discusses a large body of literature comparing the benefits of contact with their own culture relative to the host culture. Benefits appear to be greatest when people have contact with people from both their home culture and their new host culture (Jackson, 2006; Rudmin, 2003; Schmidt & Poole, in press). However, research has noted that this type of integration is not associated with better mental well-being in every instance (Rudmin, 2003).

For refugee children in particular, family can be a key mediator in the risk of mental illness (Davidson et al., 2008; Lustig et al., 2003). Refugee and migrant family structures are often disrupted by isolation from extended families and changing gender roles (Bhui, Warfa, Edonya, McKenzie & Bhugra, 2007). This disruption can have negative implications for mental health because family are an important point of social support (Briggs & Macleod, 2006; Briggs et al 2007; Ho et al., 2002). Anecdotal reports suggest that family conflict and problem behaviours in youth can arise if differences between parental and child acculturation levels lead to value and expectation clashes (Gonzales, Deardoff, Formoso, Barr & Barrera, 2006).

Despite these predictions there is mixed evidence about whether immigrant families experience greater value discrepancies than non-immigrant families (Sam & Virta, 3003) and whether discrepancies have an impact on mental well-being (Gonzales et al., 2003; Phinney & Ong, 2002). There does not appear to be any research investigating the extent to which intergenerational conflict is related to experiences of mental illness in refugee or immigrant families in New Zealand.

Family reunification is predicted to have a positive impact on refugee and migrant mental well-being (Briggs & Macleod, 2006; Briggs et al, 2007; Ho et al., 2002). Initiatives to improve

social support and reunite family members have been developed in New Zealand and overseas, but their impact on mental well-being is still to be evaluated.

Recovery models argue that mental health care should link people with community services and resources (O'Hagan, 2001). For refugee and migrant groups, community resources such as cultural, spiritual and religious practices may act as supports for maintaining mental well-being. Consultation attendees were interested in research evidence about the impact of community practices and resources as well as methods to integrate these practices in mental health promotion and formal mental health interventions for refugee and migrant communities. This literature review was unable to locate any information measuring the impact of such interventions.

International research suggests that pre- and post-migration factors may also impact on the risk of addiction disorders within refugee and migrant communities. Risk factors for mental illness also appear to elevate the risk of drug and alcohol abuse (Sowey, 2005; Takeuchi et al., 1998). Furthermore, risk factors for substance abuse in mainstream youth, such as being male, having low family stability or academic problems, are also associated with substance abuse in refugee and migrant youth (Sowey, 2005; Takeuchi et al., 1998). Experience of mental illness, such as PTSD, is a major risk factor for the development of alcohol and drug disorders (Sowey, 2005). Existing research suggests that mental illness is more likely to be the cause rather than the result of alcohol and drug addiction (Sowey, 2005).

At least two pieces of New Zealand research have directly measured the association between pre- and post-settlement experiences and mental well-being in refugee or migrant communities (Cheung, 1999 as cited in Ho et al., 2002; Pernice & Brook, 1996). These studies focused on Pacific migrants, British migrants and Cambodian refugees living in Dunedin during the early 1990s (Ho et al., 2002). Negative pre-migration stressors and poor coping styles were related to the number of mental illness symptoms experienced by Cambodian refugees (Cheung, 1999 as cited in Ho et al., 2002). Pernice & Brook (1996) recorded associations between post-migration stressors and symptoms of mental illness in both refugee and migrant communities. Risk factors for mental illness included not having close friends, spending most of their time with their own ethnic group and being unemployed (Pernice and Brook, 1996). Briggs & MacLeod (2006) concluded that family reunification may be a protective factor against mental illness because concerns for family remaining in a danger area appeared to have negative implications on refugee clients' mental well-being. There does not appear to be any research looking at risk and protective factors for addictions within New Zealand's refugee or migrant communities. Furthermore, Gray & Elliot (2001) and Schmidt & Poole (in press), both argue that more work should be done to investigate the impact of post-settlement experiences on mental health of refugees.

The impact of post-migration experiences and service access on mental health can be investigated by including measures of mental well-being in longitudinal settlement research. Longitudinal information on mental well-being can also be used to identify the level of need for long-term service access. Longitudinal research on refugee and migrant settlement experiences in New Zealand has not explored the associations between settlement experiences and mental health (Gray & Elliot, 2001). Many consultation attendees were interested to know whether family reunification refugees who did not go through the Mangere centre experienced poorer mental health and resettlement outcomes as a result.

Knowledge about protective factors can influence practitioner and health promotion decisions about potential targets for treatment and mental health promotion interventions (Hermann Saxena & Moodie, 2005; Ho et al., 2002). Treatment outcomes may be improved when practitioners are aware of risk and protective factors when screening, diagnosing and treating refugee and migrant clients (Briggs & Macleod, 2006; Briggs et al. 2007; R. Margetic-Sosa, personal communication, October 7, 2008). Many of the people consulted on this agenda were interested in the potential for cultural and community resources to support mental health. Research should focus on the practical implications of risk and protective factors for improving the mental well-being of refugee and migrant communities living in New Zealand.

Summary

There is a need to further investigate what factors alleviate or reduce risk for addiction disorders, and how community social resources can contribute to positive mental well-being. There is also little information about the relationship between different New Zealand post-migration experiences and mental well-being in refugee and migrant communities.[26] Research questions about the effectiveness of strategies which target protective factors or reduce exposure to risk factors are also discussed in the following section on mental health promotion.

Research questions

2.1. What are the most important risk and protective factors to target in order to reduce addiction in refugee and migrant communities?

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

2.3. What is the extent and what are the positive and negative impacts of intergenerational cultural differences in refugee and ethnic migrant populations in New Zealand?

2.3a. What supports would most effectively assist families to address any negative impacts of intergenerational culture differences?

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

2.5. Compare the positive and negative post-migration experiences encountered by family reunification refugees according to the services they access upon arrival in New Zealand.

2.5a. Consider the impact of these experiences on mental health and well-being and whether all refugees should arrive through the Mangere centre.

26 The Department of Labour has conducted longitudinal research into immigrants and is planning a cohort study into outcomes for quota refugees who have lived in New Zealand for 10 years (V. Krishnan, personal communication, September 19, 2008).

INTERVENTIONS

3. Developing mental health promotion to improve mental well-being among refugee and migrant communities

Mental health promotion builds the innate ability to achieve and maintain good mental health and reduces barriers to good health for individuals and communities (Pollet, 2007).[27]

Traditional mental health promotion programmes include mental health education, community development and anti-stigma social marketing initiatives. These programmes typically target factors known or believed to contribute to mental well-being (Pollet, 2007). [28]

Mental health promotion strategies have been implemented and evaluated in many Western countries. The World Health Organization (WHO) identified that a range of programmes can be cost-effective at improving mental health (WHO, 2007). These programmes included early childhood interventions, support for children, social support for elderly, mental health promotion activities in schools, interventions at work, community development and housing policies (WHO, 2007). However, little is known about the effectiveness of these approaches for refugee or migrant communities (The WHO World Mental Health Survey Consortium, 2004).

There are reports that mainstream mental health promotion interventions and resources may need to be adapted in order to be effective for ethnic groups (Jackson, Yeo, & Lee, unpublished paper; Milat, Carroll, & Taylor, 2005). For example, ethnic groups in New Zealand and the United States report dislike for resources not in their native language, that are direct translations of mainstream resources, and that use 'tag lines' originally designed for Western cultures (Jackson, Yeo, & Lee, unpublished paper; Palinkas, Pickwell, Brandstein, Clark, Hill, Moser, & Osman, 2003). Mental health promotion initiatives that increase access to social and physical activities which are religiously or culturally inappropriate will not be effective for certain refugee and migrant groups. To develop effective culturally specific programmes we need to know what components of health promotion campaigns remain effective across cultures and settings (Saxena, Hermann, Moodie & Saraceno, 2005).

Few evaluations of refugee targeted mental health initiatives have been conducted (Milat et al., 2005). One study investigated a mental health promotion education campaign which used pamphlets and radio screenings to educate Afghani asylum seekers in Australia about treatment, causes and safe medication use for depression (Multicultural Mental Health Australia, 2005). Little information on the impact of mental health was produced from the evaluation, which relied on focus groups and interviews with mental health professionals to investigate effectiveness. Other existing evaluations have similar methodological limitations, such as relying on consumer satisfaction reports rather than measures of service access, knowledge, behaviour or symptoms of mental illness (Milat et al., 2005). Furthermore, most evaluations of mental health promotion in refugee and migrant groups have not included baseline or control measures (Milat et al., 2005). Without baseline or control measures, or

27 Research into strategies to reduce barriers to healthcare access are discussed in the following section.
28. Such factors include social support, discrimination, access to income and employment and knowledge about mental health and service access. More information about these and other risk and protective factors is outlined in topic two.

objective indices of change, there is little certainty about whether a programme has any effect on the mental health of their target population.

Research on mental health promotion in immigrant populations is also very limited. One randomised control trial of a group health education and physical activity programme noted improvement in mental well-being for elderly Turkish immigrants settled in the Netherlands (Reijneveld, Westhoff, & Hopman-Rock, 2003). With this exception, there is little evidence on interventions which have a positive impact on mental well-being in migrant populations.

Types of interventions (e.g. education or social support) that are effective for improving mental well-being in refugee and migrant communities may also be effective for reducing rates of addiction disorders. Addiction and mental health disorders are often co-occurring and there are similarities in the risk and protective factors for mental health and addiction. Little research has assessed the effectiveness of these approaches for reducing addiction disorders. The majority of mainstream research on addiction prevention campaign has focused on anti-substance abuse campaigns for youth. However, there is insufficient research to assess if these programmes will be effective for youth from refugee and migrant backgrounds.

A major social marketing campaign in New Zealand, called Like Minds, Like Mine, aims to improve knowledge and remove stigma and discrimination towards mental illness. Migrants who are culturally and linguistically similar to mainstream New Zealand may benefit from this campaign, but it is less likely to be effective for refugee and ethnic migrants of different language and cultural identification. Pamphlets have been developed in a limited number of refugee and migrant languages to educate refugee and migrant people in New Zealand about mental health. The effectiveness of the Like Mine, Like Minds campaign, mental health education pamphlets and other mental health promotion activities for New Zealand's refugee and migrant communities have not been investigated.

In New Zealand, mental health, social and government services contribute to building refugee and migrant community resilience and reducing barriers to good health (Pollett, 2007). The Mangere Refugees as Survivors centre works with a group of refugee facilitators to build refugee communities' own strengths and social networks, improve mental health awareness and increase support for people with mental illness. Some New Zealand government departments also contribute to mental well-being in refugee and migrant communities indirectly through housing, ESOL, economic and information support.

Many interventions target factors known or believed to be associated with improvements in mental health. However, changes produced by these interventions may have limited ability to create measurable change if other risk and protective factors in a person's life remain constant. For example, although discrimination is associated with poorer mental well-being, it is not known whether anti-discrimination campaigns change how the host community regards refugee and migrant communities to the extent that it has a measurable impact on their mental well-being (Rychetnik & Todd, 2004).

During the consultation for this document, attendees ranked mental health promotion as a key research need for both refugee and migrant communities. Service user and community group stakeholders emphasised that community groups, social and peer support and reducing

stigma were particularly important for the mental well-being of refugee and immigrant communities. Many consultation attendees were interested in the potential benefits of anti-discrimination campaigns. There was also substantial interest in identifying useful mental health promotion strategies for smaller immigrant and refugee communities who did not have a lot of access to social support. Refugee community facilitators reported that first language information sources were a key need for refugee communities.

Summary

There is little evidence about what type of mental health promotion campaigns[29] will be effective for refugee and migrant communities. There appears to be no information on the impact of existing New Zealand mental health promotion strategies on mental health related knowledge, behaviour or mental well-being outcomes for refugee and migrant populations. Furthermore, there is little information about the best ways to develop mental health promotion interventions which target addiction.

Research questions

3.1. Test and compare the effectiveness of new and existing New Zealand programmes, services and information sources for promoting mental well-being in refugee communities.
3.1a. Consider the cost-benefit of each method.

3.2. Evaluate and compare the effectiveness of new and existing methods and services for promoting mental well-being in migrant communities.
3.2a. Consider the cost-benefit of each method.

3.3. Evaluate the efficacy[30] and effectiveness[31] of methods to challenge negative attitudes, including collaborative interventions to reduce discrimination towards refugee and migrant populations.

29 See Doughty 2005; Pollet, 2007; Saxena, Hermann, Moodie & Saraceno, 2005 and WHO (2005) for reviews of mental health promotion effectiveness in mainstream populations.
30 Efficacy is the extent to which an intervention (technology, treatment, procedure, service, or program) does more good than harm when delivered under optimal conditions [Flay, 1986; Last, 1988] (Society for Prevention Research, 2004, p.1).
31 Effectiveness trials test whether interventions are effective under "real-world" conditions or in "natural" settings. Effectiveness trials may also establish for whom, and under what conditions of delivery, the intervention is effective (Society for Prevention Research, 2004, p.7).

INTERVENTIONS

4. Enhancing service access for refugee and migrant communities in New Zealand

Service access refers to a potential service user's ability to obtain the right service when they need it within the appropriate time (Minister of Health, 2006). Effective service access includes effective first contact access and access to appropriate follow up care.

There are anecdotal reports that New Zealand's refugee communities may underutilise health and mental health services relative to the level of need in these communities (Fraser, 2007). Service providers and overseas research report that adult and adolescent refugees typically reach more serious levels of mental illness before they seek mental health care compared with the host population (Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006). Underutilisation of services by refugees who experience mental illness have been noted in some studies (e.g. Chow, Jaffee & Choi, 1999), but other studies have reported similar utilisation of services between refugee and host nation born people who experience mental illness (Steel et al., 2005).

Research suggests that immigrant populations are less likely to access general health and mental services than the host population of their new country (Have & Bijl, 1999; Pumariega, Rothe & Pumariega, 2005). Patterns of service use appear to differ across immigrant population groups and service types. Whilst many studies note lower rates of access to general mental health services, higher rates of crisis mental health service use and social service use have been reported (e.g. Have & Bijl, 1999; Ziguras, Klimidis, Lewis, & Stuart, 2003). Furthermore, some ethnic migrant groups reportedly have higher hospitalisation rates for schizophrenia than the host population (Abbott, 1997; Cartor et al., 2005).

Little is known about the number of refugees in New Zealand who experience mental illness but do not access services. A Department of Immigration study noted that 83 % of refugees had seen a GP since arriving in New Zealand, however 10 % reported that they had been unable to see a doctor when they needed to for reasons such as communication difficulties, financial costs, transportation and a lack of available appointments (New Zealand Immigration Service, 2002). New Zealand refugee communities have higher hospitalisation rates than the population average (Department of Labour, 2004). High presentation to services could be a result of relatively high levels of mental illness in refugee populations. Few, if any estimates have been calculated on the level of unmet need in New Zealand's refugee or migrant communities.

Most of the New Zealand information on refugee and migrant service access comes from anecdotal reports by service providers rather than service use statistics. Service use statistics provide little information because refugee and migrant status is not collected in service use records. Furthermore, information on ethnicity is grouped into broad ethnic categories which cannot be use as a proxy for immigrant or refugee status.[32] Even if refugee and migrant service

32 For further detail about current data collection practices see the earlier section on health information collection systems.

access figures were available it would be difficult to estimate the level of service underutilisation without data on prevalence or level of need in these communities.

Service access barriers

Healthcare service use can be influenced by client help-seeking behaviours and characteristics of health and other services. Both sources can influence initial access to services and links to ongoing and appropriate care (Fraser, 2007). A summary of potential barriers to service access for refugee, ethnic migrant and non-ethnic migrants is presented in Appendix E.

A lack of awareness about health services is a major barrier to help-seeking for potential migrant and refugee service users (Department of Labour, 2004). Refugee and migrant communities both experience difficulty understanding how the health system works, what the different roles of health workers are and knowing where to go to access health services (Sheikh-Mohammed, MacIntyre, Wood, Leask & Isaacs, 2006). Different beliefs about the nature, causes and potential treatments for mental illness are also believed to reduce motivation to access services (Fraser, 2007; Briggs & Macleod, 2006; Briggs et al, 2007; Briggs, 2004, 2001). Fraser (2007) argues that education about the causes and the effects of mental illness is a prerequisite before interventions and services can be effective for many refugee clients.

Cultural beliefs about mental illness can also limit help-seeking behaviours and service access in refugee and migrant communities (Fraser, 2007; Briggs 2004, 2001). Fear of being stigmatised by the community is another barrier to help-seeking, as is the low priority given to psychological concerns by many refugees (Schmidt & Poole, in press). Most refugees experiencing emotional distress consider economic and social supports, such as family reunification, as most beneficial for alleviating their distress (Summerfield, 1999).

Patterns of low use of health services and preference for alternative medicines also influence help-seeking behaviours, perceptions and expectations in New Zealand (Ngai, Latimer & Cheung, 2001). Many refugees come from countries where religious leaders and herbal medicines have been used to treat mental illness (see Jackson, 2006). Religious readings and casting-stone ceremonies are known to continue to some extent (Fraser, 2007). Doctor participation in torture procedures in a number of refugee countries means that many refugees also distrust medical professionals (Jackson, 2006).

Financial barriers and transport difficulties also impact on service access by potential refugee and migrant service users (Department of Labour, 2004; Lessard & Ku, 2003). A study of Somali refugees in Hamilton, noted that medical costs and transportation posed difficulties to accessing GP services, but considered that these were less major than the language barriers faced (Guerin, Abdi, & Guerin, ,2003). Limited finances and transport is commonly reported as a barrier for refugee but is less likely to be a problem for migrant communities.

The limited availability of refugee and migrant services are also believed to limit healthcare utilisation (Department of Labour, 2004). There are few healthcare providers who offer culturally targeted service for refugee or migrant groups. Resettlement services which refer refugees to helping services are targeted to the initial resettlement phase despite evidence that many mental health and adjustment issues are ongoing (Kinsie, 2006; Schmidt & Poole in press). Access to ongoing and follow up care is limited by the difficulties doctors experience diagnosing concerns, and the cases where doctors have not followed up referrals to mental health services (Fraser, 2007).

Strategies to improve refugee and migrant service access have recently been developed in New Zealand. Strategies include provider initiated contact for quota refugees, cultural competency training for health staff, greater numbers of settlement referral services and language appropriate information pamphlets about mental health and healthcare systems. In addition a new mobile mental health team for refugees has been set up in Auckland, collaborative

meetings are held between settlement services and health providers in Hamilton, and the Wellington Refugees as Survivors Trust mental health service has been situated within a multicultural settlement support centre. The overseas literature predicts that these strategies are likely to be effective methods for improving rates of access (Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003). It has been predicted that support from community and spiritual leaders is also likely to improve the effectiveness of service access strategies (Fraser, 2007). There is no research from New Zealand to measure the effectiveness of these strategies and assess which should be extended to other regions of New Zealand.

Stakeholders consulted in Phase II believed that poor information collection systems, ineffective referral systems and the inability to track family reunification refugees who did not go through the Mangere centre were major barriers to providing effective services for refugee communities. Provider initiated follow up of clients was recommended by refugee community representatives and service providers as a means to reduce the level of unmet mental health needs in refugee communities. This literature review was unable to locate any existing research on the efficacy of follow up contact for refugee and migrant clients.

Summary

The number of refugee and migrants who do not access health services when needed is unknown in New Zealand. Strategies to encourage service access have been developed, however research has not evaluated the effectiveness of these approaches. The bulk of the existing research has focused on barriers to service access rather than investigating factors that encourage help-seeking behaviours and promote effective health service utilisation. Information about barriers and enablers to help-seeking, and evaluations of existing strategies and/or piloting new strategies is important for service development and funding decisions.

Research questions

4.1. Determine the number of refugee and migrants in New Zealand that experience mild, moderate and severe levels of mental illness and/or addiction but are not currently accessing services? (Consider for different regions and different ethnicities.)

4.2. Identify the help-seeking behaviour patterns and critical decision points in the process of accessing primary and mental health services for refugee and/or migrant people who experience symptoms of psychological distress or addiction.

4.2a. Apply knowledge about critical decision points to develop ways to encourage access to services for refugee and migrant communities.

4.3. Evaluate the effectiveness of existing methods that encourage refugee and migrant access to primary care and mental health services.

4.3a. Consider the cost-benefit of each method. Is there a need for these services in more New Zealand regions?

4.3b. Pilot the effectiveness of refugee case worker follow ups for missed appointments and/or a 1-2 year follow up initiative for refugee's who access mental health services.

INTERVENTIONS

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

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

Primary healthcare is likely to be an important source of psychological support for refugee and immigrant populations in New Zealand. Research has noted that South-East Asian refugees are more likely to access primary health professionals relative to mental health professionals in response to psychological concerns than the mainstream population of the US and Australia (Berthold, Wong, Schell, Marshall, Elliot, Takeuchi & Hambarsoomians, 2007; Steel et al., 2005). Furthermore Steel et al (2005) noted that 81 % of mental health attendances by Vietnamese refugees resettled in Australia were to a GP, compared with 51 % of mental health attendances by people born in Australia (Steel et al., 2005).

New Zealand research suggests that similar to the general population of New Zealand, refugee and migrant communities commonly use primary care as a first point of call for psychological concerns (Fraser, 2007). Somali refugees living in Hamilton reported high use of primary care services for issues such as stress and anxiety (Guerin, Abdi, & Guerin, 2003). There are no statistics on how many migrants and refugees in New Zealand seek help from a GP for psychological concerns. There is also no data on the proportion of migrants and refugees who experience psychological distress but do not seek help.

Practitioners in New Zealand have noted difficulty screening, diagnosing and treating mental illness in refugee and migrant clients (Ngai et al., 2001). However, research has not observed whether the quality of care provided to refugee and migrant clients differs from that provided to other New Zealanders. In the United States the quality of healthcare for ethnic minority clients, including refugee and migrant people, is reported to be lower than that provided to non-ethnic American clients (Mayberry, Mili, Vaid, Samadi, Ofili, McNeal, Griffith, LaBrie, 1999).

Effective screening and treatment of mental illness in primary care settings is important for initiating appropriate referrals and responding to concerns which are below the threshold dealt with in specialist mental health services. At present there is little knowledge about the best screening methods and tools, or appropriate treatment options for primary care settings. The *New Zealand Guidelines on Identification of Common Disorders and Management of Depression in Primary Care* includes a recommendation that cultural competency is important, but does not make specific recommendations for screening and treatment options for ethnic groups.[33]

33 Topics seven and eight of this agenda include further information on the difficulties associated with diagnosing and treating mental illness in refugee and migrant populations.

Primary care practitioners in New Zealand and Australia have also noted difficulties encouraging refugee clients to adhere to treatment recommendations (Fraser, 2007; Multicultural Mentalhealth Australia, 2005). Difficulty in adhering to prescribed treatment is often attributed to language difficulties, differences about mental illness knowledge and different understandings of mental illness (Briggs & Macleod, 2006; Briggs et al, 2007: Fraser, 2007).[34] In Australia fact sheets have been used to encourage refugee communities to adhere to safe medication use (Multicultural Mental Health Australia, 2005). However, it is not known whether this programme had a positive impact on treatment compliance (Multicultural Mental Health Australia, 2005). There appears to be little research evaluating approaches to improve clients' adherence to recommended treatment.

Summary

It is not known to what extent the mental health needs of refugee and migrant communities have been met by primary healthcare services in New Zealand. There is a need to investigate what methods are most effective for diagnosing and screening for mental illness, addiction and co-existing disorders in refugee and migrant clients with New Zealand's primary care services.

Research questions

5.1. How well do primary health services address the mental health, addiction and co-existing concerns of refugee populations?

5.2. How appropriate are the methods currently used by primary care services to screen for mental illness, addiction and trauma in refugee and ethnic migrant populations? Consider the effectiveness for different sub-groups of these populations.

5.2a. Develop or identify alternative methods and test whether these are more effective.[35]

5.3. How effectively do primary health services refer refugee and migrant patients presenting with symptoms of mental illness and/or addiction to secondary providers and refugee specific services?

5.3a. Consider the outcomes for refugee and migrant clients who experience moderate or severe mental illness but are not referred from primary to secondary mental health services.

34 Health promotion and workforce strategies to address these issues are discussed within those topics.

35 This question overlaps with question 6.1 and 6.1a on trauma assessment in mental health services.

INTERVENTIONS

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

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

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

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

A number of people assert that Western models of mental health care are less effective for refugee and ethnic migrant service users (Ho et al., 2002; Schmidt & Poole, in press). However, little evidence is available to assess the relative efficacy of different treatment methods or service delivery models for mental well-being in refugee or migrant clients (Ho et al., 2001; Office of the Auditor General, 2001).

For non-ethnic populations, systematic reviews have investigated which treatments (e.g. cognitive behaviour therapy, brief intervention counselling) are most effective for alleviating depression, PTSD and other mental health issues (e.g. Bisson Ehlers, Matthews, Pilling, Richards, & Turner, 2007). However, there are no reviews, and only a few studies, that have specifically looked at the efficacy of treatments for people from a refugee or migrant background (Mollica, & Yoshioka, 2001c). Services based on holistic approaches, multidisciplinary teams and cross-sector collaboration are predicted to be most appropriate for treating mental illness in refugee communities (Guerin & Guerin, 2007: Lustig et al., 2003; Keyes, 2000; Watters, 2001). However further work is needed to evaluate the effectiveness of holistic approaches to treatment (Lustig et al., 2003).

The psychological impacts of trauma and torture are a key mental health issue for refugees. However, there is little research available to inform service providers about how best to treat these symptoms in refugee communities (Basoglu, 2001). Difficulties treating refugees who have experienced torture or trauma include communication difficulties, distrust of medical professionals, co-occurring physical impact of torture, and the risk of re-traumatising service users by asking them to recount their exposure experiences (Jackson, 2006). Campbell (2007) reviewed different methods of assessment, diagnosis and treatment for survivors of torture, noting that there are few well designed studies of treatment effectiveness for torture survivors.

A review of clinical trials of PTSD treatment approaches (not exclusively on refugee populations) noted that trauma focused cognitive behavioural therapy (CBT), eye movement desensitisation and reprocessing therapy, and stress management were effective at treating

PTSD in adults (Bisson et al., 2007). A practitioner review also concluded that these approaches may be effective with children (Ehnholt & Yule, 2006), and a systematic review found evidence that group and individual CBT was effective for treating symptoms of PTSD in high income countries (Wethington, Hahn, Fugua-Whitley, Sipe, Crosby, Johnson, Liberman, Eve Mos´cicki, Price & Tuma, Kalra & Chattopadhyay, Task Force on Community Preventive Services, 2008). None of the three reviews specifically looked at samples of refugee communities, and each provided only tentative indications that these therapies will be effective for refugee or migrant populations (Bisson et al., 2007).

Some work has been done to develop refugee specific treatment options, guidelines, checklists and service recommendations for working with refugee and migrants internationally and in New Zealand (see Davidson et al., 2008; Lustig et al., 2003). The *National Mental Health Sector Standard* (New Zealand Standards, 2001) includes recommendations for working with refugee, migrant and ethnic clients in its outline of responsibilities for the health and disability sector workforce in New Zealand. Specific refugee recommendations are also included in New Zealand's *Assessment and Management of People at Risk of Suicide* guideline (New Zealand Guidelines Group, 2003). At present, New Zealand's other mental health treatment guidelines do not include specific recommendations for refugee or migrant communities. Due to limitations in the research base, the recommendations in international and New Zealand guidelines are often based on clinician advice, rather than objective evidence of effectiveness (Davidson et al., 2008; Lustig et al., 2003; New Zealand Guidelines Group, 2003).

A number of service users, service providers and researchers argue that specialist services should be developed for refugee and migrant clients (e.g. Schmidt & Poole, in press; Watters, 2001). There is limited empirical data to support or contest whether specialist services will have a major impact on refugee and migrant mental well-being. Few refugee or migrant mental health services have been set up internationally, and even fewer have been evaluated for their impact on treatment outcomes or mental health (Forbes, 2001). Australia and US research has noted better rates of service access for clients who visit same ethnicity clinicians (Ziguras, Klimidis, Lewis, & Stuart, 2003). Ziguras et al., (2003) noted that ethnic clinician matching was associated with reduced contact with crisis intervention teams. They concluded that this was due to better patient management when ethnically matched clinicians were seen (Ziguras et al., 2003). Despite this information on service access, this literature review was unable to locate any evidence that specialist services or ethnic matching have greater benefits on mental health outcomes.

Cultural competency models have been developed as another method to provide culturally competent service delivery. Staff from cultural consultation services support mainstream staff to review case notes, and may attend their appointments with refugee or migrant clients in some instances (Kirmayer et al., 2003). Community and cultural knowledge brokers may also inform diagnoses and treatment planning (Whitler, Kirmayer & Jarvis, 2004). Cultural competency models may be more resource efficient than ethnic specialist services are, particularly when a population includes a multitude of small ethnic groups (Whitler et al., 2004). At present there is limited evidence on the relative effectiveness of specialist services, cultural competency models or mainstream services for refugee and migrant communities (Bhui, & Sashidaran, 2003).

In New Zealand, refugee specific services are available in the Refugees as Survivors centres in Wellington and Auckland and the Christchurch refugee and migrant mental health service. The Auckland Refugees as Survivors (RAS) centre includes a multi-disciplinary team of nurses, social workers, psychologists, body therapists and interpreters (Fraser, 2007). A mobile team works with refugees living in multiple Auckland communities. The Auckland Refugees as Survivors centre is also involved in health promotion, health education and primary prevention work. A recent evaluation of the regional Refugee Mobile Team has collected monitoring information on the use and effectiveness of their service.

The Wellington Refugees as Survivors Trust (RAS) deals primarily with survivors of trauma and torture. Wellington RAS employs a multidisciplinary team including a psychiatrist, clinical psychologists, psychotherapists, counsellors and social workers (J. Thomas, personal communication September 16, 2008). The service contracts an interpreter for most clients and uses a range of treatment approaches including CBT, Gestalt, narrative and problem solving. Wellington RAS also trains mainstream health and mental health staff to work more effectively with refugee clients and is involved in capacity building within refugee communities (Wellington Refugees as Survivors Trust, 2008).

The Canterbury DHB has a dedicated specialist refugee and migrant mental health service in Christchurch. Referrals are accepted from the Mangere resettlement centre, local GPs and other local professional and community agencies. The model of care includes a full comprehensive mental health assessment, diagnosis, medication reviews and ongoing treatment using a range of therapeutic models. Appropriately trained interpreters are used throughout the treatment process. The service also offers consultation and teaching/training to a range of other health professionals, including GPs, and formal lectures to teaching institutions (Briggs, 2001). This service appears to be the only migrant-focused mental health service in New Zealand.

The small number of migrants who are not from Asia or the Pacific means that culturally specialist services for these ethnic communities are unlikely to be a major funding priority. There do not appear to be any refugee or migrant specific addiction services currently available in New Zealand.[36] Without estimates of the prevalence of addiction, it is difficult to estimate the needs for addiction services for these populations.

Similar to overseas, evaluations of refugee services in New Zealand have focused on monitoring service delivery targets and service access (K. Jackson, personal communication, 21 August, 2008). Services can use outcome measures to assess changes in mental health, but Kirmayer et al (2003) argue that these may need to be translated into the patient's language and standardised according to the patient's level of education if they are to provide valid information. In New Zealand, specific Maori and Pacific outcomes measures have been developed due to concerns about the validity of mainstream measures for these populations, Specific outcomes measures have not been developed for refugee and migrant populations and there is limited evidence about the validity, reliability, sensitivity to change, or of existing measures for refugee and migrant communities.

36 The provision of culturally specialist addiction services is not outlined as a research question in this agenda, but it is a key issue for a DHB needs assessment to investigate.

A key Ministry of Health objective is to develop services which are responsive to specific populations, including refugee and migrant communities (Minister of Health, 2006). Consultation attendees suggested a number of ways to improve the responsiveness of mental health services to these populations. Suggestions included increasing the availability of culture specific mental health services and resources, improving accessibility and sharing of service user information, improving coordination and collaboration between mainstream and refugee specific services and between New Zealand regions. A number of authors highlight that refugees should be involved in identifying priorities for service development and potential innovations to address their needs (Keyes, 2000; Lustig et al., 2003; Watters, 1999). Increased knowledge about effective service models and treatment approaches is required to inform the development and modification of existing services for refugee and migrant populations in New Zealand.

Consultation attendees were particularly interested in service delivery models that could be provided in the community, and ways to adapt mainstream services when funding for specific refugee and migrant services was not available. Lustig et al. (2003) emphasised it is also important to identify models which are effective across different refugee communities. Multi-purpose models are important because the cultural and service needs of each intake differ and services must be flexible towards to cater for these differences.

Summary

Little research has been conducted internationally on what type of mental health services will be most effective for improving treatments outcomes for refugee or migrant service users. Increased knowledge about effective mental health services and treatment approaches, particularly those which can be offered in mainstream services is needed to inform service development and service funding decisions in New Zealand.

Research questions

6.1. Review the existing research literature to identify what methods of screening and intervention are most likely to be effective for reducing the negative impacts of trauma exposure in refugee and migrant populations.

6.1a. What trauma screening and trauma intervention practices are currently used by New Zealand mental health services? What improvements could be made to these practices?

6.2. How effective are mainstream and refugee/migrant specific mental health and addiction services for improving mental well-being in refugee and migrant communities? Consider their impact on mental illness, addiction and co-existing mental health and addiction disorder.

6.2a. Assess specifically the effectiveness of mental health services for refugee and migrant survivors of trauma, refugee women and their children.

6.2b. Is there a need for Refugee as Survivors services outside Auckland and Wellington?

6.2c. What are the long-term outcomes of access to specialist mental health and addition services?

6.2d. Examine the existing research literature to identify any effective community based alternatives to inpatient services for refugee and migrant populations.

6.3. Investigate the level and methods of collaboration between mental health services and other health, social and immigration services in relation to refugee and migrant clients. Identify successful models of cross-sector collaboration for refugee populations, particularly for smaller New Zealand towns.

6.4. What types of psychological therapies and practical support have the greatest positive impact on mental health in refugee populations?

6.4a. Investigate whether holistic family based therapies are acceptable and effective for refugee and migrant people from different religious and ethnic backgrounds.

6.5. What are the most culturally appropriate tools to measure mental health, addiction and social outcomes for refugee and ethnic migrant groups?

6.5a. Examine whether the tools[37] currently used in New Zealand are effective and appropriate for assessing outcomes for refugee and migrant communities.

37 Possible things to consider when measuring effectiveness of these tools include: the cultural appropriateness and psychometric properties such as validity and reliability, the sensitivity to change following interventions, the utility of the tools to support the delivery of care to individual refugee clients, and the utility of the tools to support funding, planning, monitoring and policy development for services for refugee service users.

WORKFORCE DEVELOPMENT

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

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

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

Staff working in health and mental health services must respond to refugee and migrant mental health, addiction and co-existing disorder[38] needs, but some practitioners do not possess the skills and knowledge to do so. Most health practitioners in New Zealand and overseas do not appear to have the skills to appropriately assess the cultural presentation of symptoms in refugee and ethnic migrant clients (Briggs, 2001, 2004; Fraser, 2007; Jackson, 2006).

A range of knowledge is needed to support effective mental health care for refugee and migrant communities. Important knowledge includes an awareness of: cultural beliefs about mental illness, symptom expression and communication norms, cultural and situation experiences of refugee and migrant clients, and post-migration risk factors for refugee and migrant clients (Bhui et al., 2007; Briggs, 2001, 2004; Gray & Elliot, 2001; Jackson, 2006; Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003; Serafica, 2005; Watters, 2001). Different refugee communities have different beliefs about mental illness. These beliefs include attributing mental illness to past wrongdoings, supernatural powers, spirit possession, and physical imbalances (Jackson, 2006). Further information about cultural conceptualisations of mental illness in refugee countries is available in Jackson (2006).

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

38 Responding to refugee and migrant clients who have co-existing mental health and addiction disorders is likely to pose additional challenges to staff. Few are trained in both co-existing disorder screening and treatment and cultural competencies for working with refugee and ethnic migrant clients (J. Crosland, personal communication October 6, 2008).

Workforce training is used in many countries[39] to develop these knowledge and skill areas, but there is little evidence for the effectiveness of these training programmes. Some cultural competency training programmes have reported improvements in knowledge, attitudes and skills of health staff and patient satisfaction (Beach, Price, Gary, Robinson, Gozu, Palacio, Smarth, Jenckes, Feuerstein, Bass, Powe, Cooper, 2005; Bhui et al, 2007). However, most migrant research has looked at Mexican, Asian and Pacific Island Americans (Beach et al. 2002) and little, if any, research has looked at refugee communities (Jackson, 2006). There is insufficient research to evaluate whether cultural competency training or having culturally competent staff benefits the mental health outcomes of their clients (Brach & Fraser, 2000 DeSouza & Garrett, 2005; Taylor & Lurie, 2004).

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

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

Another option to improve workforce cultural competencies is to recruit staff who match the ethnicity of their client base. Often matching clinician and patient ethnicity is impractical, particularly when there is a high degree of ethnic diversity in a particular region (Brach & Fraser, 2001; De Souza & Garrett, 2005; Fortier & Bishop, 2003; Taylor & Lurie, 2004).[40] Cultural experts can also be recruited as consultation staff to input cultural knowledge into diagnosis, treatment and patient support (Whitler et al., 2004). However, a number of refugee and migrant people who experience mental illness fear their confidentiality will be breached if they are seen by someone from their own community (Bhui et al., 2007).

One-off workshops have typically been used in New Zealand to improve competencies for staff who work with refugee and migrant clients. Waitemata DHB and Refugees as Survivors New Zealand are conducting a pilot programme to train heath practitioners across New Zealand in skills for working with refugee and migrant clients. The evaluation of the training will measure its impact on the knowledge, skills and confidence of the workforce (S. Lim, personal communication, 9 July 2007). However, measurements of client satisfaction and

39 See http://www.mcgill.ca/tcpsych/publications/report/appendices/review/ for a review of different models of cross-cultural care and cross-cultural training used in different countries internationally.

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

impacts on the clinical outcomes for refugee and migrant clients are not included in the evaluation (S. Lim, personal communication, 12 August 2007). A couple of Auckland DHB services have also recruited refugee community health workers to encourage health service access by refugee families. These community health workers engage in community health promotion and collaborate with health and other support agencies.

Professional interpreting services have been identified as a key need for refugees and ethnic migrant clients in primary or mental healthcare within New Zealand (Briggs, 2001, 2004; Fraser, 2007; Ngai, et al., 2001). Nonetheless, there is little international research which has investigated the impact of using an interpreter on the quality of care or outcome of treatment (Bowen, 2000; van Ryn, Burgess, Malat & Griffin, 2006). Training healthcare professionals about how to work with interpreters and training interpreters about mental health concepts are important for creating effective interpreter-client-practitioner communication (Kirmayer et al., 2003).

Traditionally there has been limited use of interpreters in New Zealand primary care settings (North, Lovell, Trilin, 2006). A pilot programme for interpreting services in primary care within Auckland will be conducted during 2008-2010. There are plans to evaluate the effectiveness of the interpreters for improving healthcare access, treatment provision and crisis service use (S. Lim, personal communication, 10 July 2008). In Hamilton, a service has been piloted where refugees can get interpreting assistance over the phone (Fraser, 2007). International research suggests that phone interpretations can be effective for simple medical cases but are unlikely to be adequate for complicated cases or for clients with very limited English language skills (Fraser, 2007).

During the consultation, many people noted that a lack of cultural competency was a key barrier in responding to refugee and migrant mental health concerns, particularly in the area of primary care. Improving the cultural competencies of mainstream health practitioners is a key need, and a number of workforce training programmes have recently been developed to target this. Research can support further initiatives and service development by providing information about what types of workforce training are most likely to lead to improvements in treatment and treatment outcomes.

Summary

Existing research indicates that resources, training and organisational support are needed to effectively develop workforce cultural competencies (Nayar & Tse, 2006). However, there is little evidence about what types of cultural competency behaviours should be trained (Anderson, Scrimshay, Fullilove, Fielding, Normand, and Task Force on Community Preventive Services, 2003; Beach Price, Gary, Robinson, Gozu, Palacio, Smarth, Jenckes, Feuerstein, Bass, Power, & Cooper, 2005). There is also limited evidence about the relative benefit of different types of training programmes or the long-term impact of workforce training on staff behaviour and the health outcomes of clients.

Research questions

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

7.2. Examine and compare the effectiveness of different methods of training and ongoing support and mentoring to improve the cultural competency of the mental health workforce, particularly in relation to improved recovery outcomes for clients.
7.2a Examine the lasting effects of cultural competency training for healthcare providers. How frequently should training be repeated?

7.3. What impact do refugee community health workers have on the quality of primary and mental health service delivery?

DISCUSSION

RESEARCH AGENDA CONTEXT AND VALUE

The goal of this research agenda is to contribute to the mental well-being of refugee and migrant communities. It aims to do this by guiding research that will support the development of responsive mental health and addiction services and mental health policy. At present, little is known about refugee and migrant mental health and addiction needs and the most effective ways to respond to these needs (Ho et al., 2002). This agenda aims to support the development of an evidence base around what works and what does not work for refugee and migrant mental health promotion, service access and service delivery.

The research agenda was identified as a key milestone in *Te Kōkiri's* leading challenge of responsiveness. This challenge focuses attention on the need "to build responsive services for people who are severely affected by mental illness and/or addiction, with immediate emphasis on improving service responsiveness of services for… refugee and migrant communities" (p.27). The research agenda is one of a series of population specific mental health and addiction research agendas developed over the last year. Emphasising the agenda priorities, in combination with ongoing DHB needs assessments and evaluations are crucial to alleviating knowledge gaps that impede service responsiveness.

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

While refugee and migrant communities are grouped together in this agenda, it is important to acknowledge the unique needs of each population group, as well as the unique needs of individuals within these population groups. In particular, refugee populations have higher mental health needs with greater challenges associated with meeting these needs. For this reason, more research questions are devoted to refugee populations. When culture or language but not settlement is likely to contribute to an issue, some migrant questions refer specifically to ethnic migrant communities.

AGENDA DEVELOPMENT AND KEY RESULTS

The development of this refugee and migrant research agenda was grounded in a review of the literature and community consultations. An initial set of research questions was developed with the project reference group after a preliminary process of literature review. Information from community consultations and a further literature review was used to revise and add to the initial set of questions.

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

literature review, question analysis, stakeholder consultation and service user review were conducted independently for refugee and migrant populations.

Community consultation occurred in three rounds, using multiple methods, to maximise the opportunities for communities, practitioners and researchers to participate in the agenda setting process. A project reference group provided an overview and analysis of the key issues at the beginning of the project and continued to feed in information throughout the project. Secondly, a wider group of individuals (government representatives, service providers, researchers, community groups and service users) were approached to provide feedback on the questions. Lastly, refugee community facilitators and a wider stakeholder audience were invited to provide feedback on the near final set of research questions and draft agenda. Feedback was collected via email, phone interviews, written prioritisation tasks as well as small and large group discussion and brainstorming sessions.

During the consultation meetings it was a challenging task for people without a research or academic background to rank the importance of research questions. Stakeholder comments and suggested questions were therefore combined with the question rankings to provide a fuller picture of stakeholder perspectives. A focus group of refugee community facilitators along with phone interviews with refugee community leaders and migrant service providers were used to supplement information provided during the main consultation processes. Future research planning processes should allow substantial time for consultation and draw on creative and culturally appropriate ways to engage refugee and migrant communities at the grassroots level.

Two literature review were conducted to investigate whether questions suggested by stakeholders had been addressed by existing research. Literature searches were used to assess whether questions had been effectively answered in the existing research base. Further analysis of the literature should be undertaken when embarking on research questions because the literature is constantly evolving and some research may have been missed in this review.

The finalised set of questions in this agenda reflects knowledge gaps that limit the ability to provide responsive services to refugee and migrant communities.

Key knowledge gaps include:

- how to improve promote mental health by developing resilience in refugee and migrant communities
- longitudinal research into the impact of settlement experiences and service access on refugee and migrant mental health
- effective mental health treatment approaches for refugee clients
- how to train mainstream staff to respond more appropriately to the mental health concerns of refugee client.

Service evaluation questions in this agenda extend current evaluation work in New Zealand and internationally by focusing on the impact of initiatives on mental health outcomes, not just on service access or staff perceptions of care.

SOME METHODOLOGICAL CONSIDERATIONS

A number of methodological issues need to be considered when developing and implementing research that addresses refugee and migrant communities' mental health and addiction needs. In particular it is crucial that research with refugee and migrant populations considers the diversity among refugee and migrant communities. Information which does not consider this diversity is likely to have little utility for informing service responsiveness to these populations.

Research methodology should reflect respect for the cultural knowledge and values of these communities, as well as recognising the culture bound nature of one's own practices (Kearns & Dyck, 2004, cited in DeSouza, 2007). For example, Western researchers may incorrectly code or translate comments as a result of divergences of cultural norms, beliefs, and languages (Hunt & Bhopal, 2004). Western mental health measures are based on biomedical models, which do not fully acknowledge refugee and ethnic worldviews on the causes and cures for mental illness. Furthermore, Western measurement tools typically focus on symptoms of mental illness expressed within Western cultures and may not be sensitive to unique symptoms expressed by ethnic refugee and migrant communities (Takeuchi et al., 1998). There is also a need to develop culturally appropriate and standardised measures to evaluate services (Zane, 2001). When measuring the level of change associated with an intervention it is important to consider 'clinical significance' and 'cultural significance', not just whether the level of change meets criteria for 'statistical significance'.

Multiple and diverse methods of data collection may also be useful for conducting research with refugees. Possible methods include questionnaires, focus groups, oral histories, in-depth clinical interviews, ethnographic studies and field work, and event calendars to assist accurate recall and creative works (e.g. autobiographies, poems and plays) (Mollica, & Yoshioka, 2001b).

Cultural norms, communication norms and resettlement perspectives must be considered if research is to be ethical, valid and responsive to refugee and migrant communities (DeSouza, 2007). Peterson et al. (2008) describe a number of approaches they used to ensure refugee focus group members were fully aware of their rights and the nature of the research to be undertaken. In this piece of research, cultural communication norms were considered in the choice of data recording procedures and the management of focus group discussions. Furthermore, a refugee mental health practitioner was contracted to conduct the focus group (see Peterson et al, 2008, pp.50-52). Guerin et al (September 2004) suggest that researchers should spend substantial time with refugee communities before undertaking research with them. Securing the involvement of refugee leaders, mental health and other support people who work with refugees on a daily basis is likely to be useful strategy for conducting effective and ethical research with refugee groups.

Careful planning and community collaborations are needed to recruit refugee and migrant people who are willing to participate in research (Porter & Haslam, 2005). Refugee and migrant communities are often unwilling to assist with mental health research due to competing settlement demands on their time, cultural stigma and fear of jeopardising their refugee or migrant status (Guerin, Guerin, & Diirye, September 2004). Retaining refugee and

migrants in long-term studies can also be difficult, because many immigrant and refugee people move between New Zealand locations or to locations outside New Zealand. It is important to involve refugees in decision making about what they want researched and how they want the question investigated (DeSouza, 2004).

AGENDA IMPLEMENTATION

The development of this refugee and migrant mental health and addiction research agenda presents a significant step forward towards a more strategic approach to research selection. A central group would be useful to promote, facilitate, and review the progress of the agenda over the next 3-5 years.

For the agenda to have the desired impact, it will be critical to develop a plan for efficient implementation of research priorities. A large number of questions were selected to allow flexibility for researcher creativity, multiple funding sources and different levels of research expertise. The priorities identified have implications for health strategies, primary and secondary NGO and DHB mental health services, and training institutions. In particular, the topics of risk and protective factors and mental health promotion have implications for immigration support and community development. It is envisioned that a number of agencies will commit to funding the research questions outlined in this agenda. These targets will be determined through a further round of selection as described in Appendix G. An implementation strategy outlining these major research targets will be made available on the Te Pou website.[41]

Work is needed to develop New Zealand's capacity for conducting refugee and migrant mental health research. There are few researchers with knowledge and experience in mental health and refugee and migrant research considerations. Research establishments, such as the Centre for Asian Health Research & Evaluation, The University of Auckland; the Migration Research Group, University of Waikato; the Centre for Applied Cross-cultural Research, Victoria University of Wellington; the Integration of Immigrants programme run by Massey University and Auckland University of Technology's Centre for Asian and Migrant Health Research, can play a pivotal role in developing this capacity. Collaborations across national and international research establishments and New Zealand settlement related government agencies (e.g. Department of Labour, Ministry for Social Development, and the Office of Ethnic Affairs) are also important for maximising the benefit of research expertise and research funding for refugee and migrant communities.

Continued involvement from stakeholder groups (service users, service providers, clinicians, researchers, service funders and policy maker) will be important in undertaking research and implementing research findings in practice. "Clinical activities need culturally sensitive evaluation research; useful research needs active and involved clinicians and patients" (Tashima, 2001, p.96). Collaboration and exchanging of ideas is important for developing research that will effectively meet service knowledge needs. Collaboration between service providers and researchers in mental health and related fields is particularly important (Lustig et al., 2003).

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

Refugee and migrant service users and wider communities also need to be supported to engage in, understand and utilise research (DeSouza, 2007; Rose, Thornicroft, & Slade, 2006). Supporting and building on existing links between refugee and migrant communities and researchers is critical to the development of research which is relevant to, useful for and based on the experiences of refugee and migrant people who experience mental illness and/or addiction.

To translate research findings into improved service delivery and health outcomes, it is crucial that information is disseminated widely. Service provider and decision-makers across health, mental health, social and immigration sectors as well as refugee and migrant communities could benefit from the information resulting from this research. Research dissemination must use methods and include information tailored to each group's decision-making needs, interests and levels of existing knowledge (Kerner, 2006; Office of Ethnic Affairs & Statistics New Zealand, 2007). Modes of communication often used to support research translation include guidelines, practice recommendations and skills based training (Kerner, 2006).

This research agenda was developed to address knowledge gaps about the mental health and addiction needs of refugee and migrant communities and the responsiveness of New Zealand mental health and addiction services to these needs. The strategic and consultative nature of this research agenda acknowledges the importance of developing research directed at addressing the needs of refugee and migrant people living in New Zealand. Processes of literature review and community consultations were central to the development of the research priorities outlined in this document. Funding of priorities, dissemination of research findings, and service provider and community engagement are crucial to the translation of research into improved mental well-being for refugee and migrant communities in New Zealand.

RECOMMENDATIONS

1. Establish research collaborations between service providers, researchers and members of refugee and migrant communities to enhance the quality and applicability of research.
2. Establish an ongoing group to lead the monitoring of the agenda, further prioritisation, and dissemination of research findings.
3. Identify multiple funding sources that can commit to funding the implementation of the agenda.
4. Researchers use technically and culturally appropriate research methods and advocate for the inclusion of mental health measures in New Zealand settlement research.
5. Disseminate research findings widely to service providers, planners and funders, policy makers and communities, with specific reference to the implications of these findings for their work.

CONCLUSION

This refugee and migrant research agenda identifies research questions that address gaps in knowledge about the mental health and addiction needs of New Zealand's refugee and migrant communities, and effective ways to respond to these needs. Literature review and community consultation were central to the development of the research priorities outlined in this agenda. The strategic and consultative nature of this research agenda acknowledges the importance of developing research that directly addresses the needs of communities living in New Zealand. Funding of priorities, dissemination of research findings, and collaboration between researchers, service providers and communities are crucial to the translation of research into improved mental well-being of refugee and migrant communities in New Zealand.

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APPENDIX A – REFUGEE ENTITLEMENT TO HEALTH SERVICES IN NEW ZEALAND

The following table describes eligibility of different refugee categories for mainstream and specialist health and mental health services in New Zealand. This table comes from the report on Goal 4 of the Auckland Regional Settlement Strategy (Auckland Sustainable Cities Programme, 2006, pp. 23-24), and has been updated by the Ministry of Health, November 2008.

Table A1. Refugee entitlement to health services in New Zealand

Health service	Refugee group		
	Quota refugee	**Family reunion**	**Asylum seeker**
Access to health screening/ healthcare on arrival	Receive free comprehensive health screening/healthcare, including dental care, on arrival by Auckland Regional Public Health Service (ARPHS), with follow up treatment and management as required.	Screened prior to arrival as per the New Zealand IS health screening requirements. Eligible for comprehensive health screening by ARPHS on arrival.	If detained on arrival at the Mangere Refugee Reception Centre (MRRC), free comprehensive health screening/healthcare, including dental care, with follow up treatment and management as required. If not detained, free comprehensive health screening at the ARPHS Asylum clinic at Greenlane Hospital.
Publicly funded health services	Eligible for all publicly funded provided health services (MoH 2003).	Eligible for all publicly funded health services (MoH 2003).	Eligible for all publicly funded health services once application for refugee status is accepted by Immigration New Zealand. Eligibility is lost if refugee status is declined and any appeal to the refugee status appeal authority is lost.
PHO services	Able to register with a PHO for general practitioner services.	Able to register with PHO for general practitioner services if resident.	Able to register with a PHO for general practitioner services while eligible for publicly funded health services.
Mental health services	Refugees as Survivors provide assessment and treatment for mental health and community support.	Not eligible for Refugees as Survivors mental health and community support services.	May be eligible for Refugees as Survivors mental health and community support services, and the Christchurch mental health services.

Table from Auckland Sustainable Cities Programme. (2006). Auckland Regional Settlement Strategy, Goal 4: Physical and Mental Health. Retrieved June 20, 2008 from http://www.immigration.govt.nz/settlement/regionalstrategies/auckland.htm. Updated by the Ministry of Health in November 2008.

APPENDIX B – DIFFERENCES BETWEEN MIGRANTS AND REFUGEES

The table below outlines some of the key differences between migrant and refugee populations. This table is directly extracted from *Refugee Health Care: A Handbook for Health Professionals* (Minister of Health, 2001). Please note that some migrants have similar pre-migration, migration and resettlement experiences to those listed for refugee communities (Minister of Health, 2001).

Table B1. Differences between migrants and refugees

Migrants	Refugees
Migrants choose to leave their homeland and settle in a country of their choice. They arrange the most suitable method of travel and pack the possessions they wish to take. They can sell or dispose of possessions they don't wish to take.	Refugees do not choose to leave their homeland. They flee in response to a crisis. They have little choice in where they go and by what means they will travel. They have no time to pack or to distribute possessions. Everything is left behind.
Migrants have time to emotionally prepare for their departure and to farewell friends and family appropriately.	Refugees, due to their hurried, often secret departure, are unprepared emotionally for leaving, and have no time to farewell loved ones.
Migrants take with them their travel documents, passports, and other documentation including educational qualifications.	Refugees often flee without any documentation whatsoever.
Migrants usually emigrate with their families.	Refugees must often leave family members behind.
Migrants depart for their new country knowing that they can return to their homeland for visits, or return permanently if they cannot settle.	Refugees, although they dream of returning home, know that this is unlikely to happen.[i]
Migrants are usually well prepared and well motivated to settle in a new country. Many will have found out about schools, employment and local conditions before they left their homeland.	Refugees arrive in their new country ill prepared and often traumatised. They have little in the way of possessions and financial resources. They are often debilitated by a pervading sense of loss, grief; worry and guilt about the family left behind.
Migrants, due to their better levels of health, education and economic independence are less likely to encounter negative attitudes in their resettlement country.	Refugees may experience stigma and prejudice in their resettlement country in relation to cultural differences, disease prevalence, low education levels and perceived burdening of the welfare system.

Table excerpt from *Refugee Health Care: A Handbook for Health Professionals* (Minister of Health, 2001).

APPENDIX C – COUNTRIES OF BIRTH OF FOREIGN BORN NEW ZEALANDERS

The countries of birth of foreign born New Zealanders are displayed in Table C1below. These figures will include people who have entered New Zealand under immigrant or refugee status. The figures come from Statistics New Zealand 2006 census.

Table C1. Country of birth of foreign born New Zealanders

Birthplace	Number of people	% of overseas born
'Traditional' countries		
Australia	62742	7.1%
United Kingdom and Ireland	251688	28.6%
United States of America	17748	2.0%
Canada	8994	1.0%
Pacific Islands		
Samoa	50649	5.8%
Fiji	37749	4.3%
Tonga	20523	2.3%
Cook Islands	14694	1.7%
Other Pacific Islands	12237	1.4%
Asia		
South-East Asia	58266	6.6%
North-East Asia (China, Korea, Taiwan, Japan, Hong Kong)	135168	15.4%
India	43341	4.9%
Southern and Central Asia (Sri Lanka, Pakistan, Afghanistan, Bangladesh, excl India)	57699	1.5%
Other non-English dominant countries		
North-West Europe	44106	5.0%
Southern and Eastern Europe	23964	2.7%
North Africa and the Middle East	16533	1.9%
Americas (excl Canada/US)	7635	0.9%
South Africa	41676	4.7%
Sub-Saharan Africa (excl South Africa)	17439	2.0%
Total Overseas born	**879543**	99.8%
Total New Zealand Population	4027947	

Data from Statistics New Zealand (2008b).

APPENDIX D – ORGANISATIONS AND COMMUNITY GROUPS CONSULTED ON THIS AGENDA

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

Consumer and consumer advocates

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

Community groups

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

Mental health specific services

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

Primary care

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

DHB/ NGO health services (unspecified area)

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

Social and settlement support services

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

Researchers

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

Government agencies

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

APPENDIX E – RISK AND PROTECTIVE FACTORS FOR MENTAL HEALTH IN REFUGEE AND MIGRANT COMMUNITIES

Table E1 and E2 list risk and protective factors associated with mental health for refugee, ethnic migrant and other migrant populations. On average, non-ethnic migrants are likely to experience fewer pre-migration and migration risk factors and a greater number of protective factors. Please note that these tables provide a general picture of the relative experiences of these and exceptions to these generalisations exist.

Table E1. Pre-migration and migration risk factors: likelihood of experience by refugees, ethnic migrants and other migrants

Pre-migration risk factor	Refugee[42]	Ethnic migrant	Other migrant[43]	Associated references
Pre-migration				
Torture	**	-	-	Abbott, 1997; Basoglu, 2001; Ho et al., 2002.; Kinsie, 2006; Marshall et al., 2005; Pumariega et al., 2005
Trauma	**	-	-	Abbott, 1997; Davidson, Murray & Schweitzer, 2008; Gray & Elliot, 2001; Ho et al., 2002; Kinsie, 2006; Pumariega et al., 2005
Other stressful pre-migration life events	**	-	-	Abbott, 1997; Gray & Elliot, 2001; Ho et al., 2002., Kinsie, 2006; Pumariega et al., 2005
Migration stressors	**	*	*	Gray & Elliot, 2001; Ho et al., 2002

** commonly experienced

* only experienced to a small extent or by a small proportion of this group

\- typically not experienced by members of this group

42 Includes quota refugees, asylum seekers and family reunification refugees.

43 'Other migrants' refers to migrants who share the culture and heritage of larger New Zealand society.

Table E2. Post-migration protective factors: likelihood of experience by refugees, ethnic migrants and non-ethnic migrants

Post-migration protective factor	Refugee	Ethnic migrant	Other migrant	Associated references
Welcome and absence of discrimination from the host society	*	*	**	Abbott, 1997; Gray & Elliot, 2001
Integration (close ties with home and host culture)	-	*	**	Abbott, 1997; Gray & Elliot, 2001; Ho et al., 2002
Good English language skills	-	*	**	Abbott, 1997; Gray & Elliot, 2001
Moderate-high income	-	*	*	Ho et al., 2002; Takeuchi, Chung, Lin, Shen, Kuraski, Chun & Sue, 1998
Social support	*	*	*	Ho et al., 2002; Schweitzer, Melville, Steel & Lacherez, 2006
Employment	-	*	**	Ho et al., 2002; Takeuchi et al., 1998
Stable accommodation	-	*	*	Porter & Haslam, 2005
Cessation of turmoil in home country	-	**	**	Porter & Haslam, 2005
Social and economic status maintained or improved	-	*	*	Porter & Haslam, 2005
Good physical health	-	*	*	Pumariega et al., 2005

** commonly experienced

* only experienced to a small extent or by a small proportion of this group

\- typically not experienced by members of this group

APPENDIX F – POTENTIAL BARRIERS TO SERVICE ACCESS

Table F1 provides a general picture of the relative level of service access barriers faced by refugee, ethnic migrant and other migrants. Overall refugee communities are likely to experience a greater range and intensity of barriers but some ethnic and other migrants will experience a similar level and range of these barriers.

Table F1. Potential barriers to service access for refugee, ethnic migrant and other migrant communities in New Zealand

	Refugee[44]	Ethnic migrant	Other migrant[45]	References
Client characteristics				
Lack of knowledge about the health system	**	**	**	Auckland Sustainable Cities Programme, 2006; Department of Labour, 2004
Beliefs about mental illness that do not support help-seeking from Western services	**	**	*	Fraser, 2007
Fear of community stigma	**	**	*	Auckland Sustainable Cities Programme, 2006; Briggs 2001; Fraser, 2007; Schmidt & Poole, in press
Limited English language	**	**	-	Department of Labour, 2004; Ngai, Latimer & Cheung, 2001
Limited financial resources	*	-	-	Auckland Sustainable Cities Programme, 2006; Department of Labour, 2004; Guerin, Abdi & Guerin, 2003
Limited transport options	*	-	-	Guerin, Abdi & Guerin, 2003; Ngai, Latimer & Cheung, 2001
Competing priorities	*	-	-	Fraser, 2007; Schmidt & Poole, in press
Health system characteristics				
Inaccurate diagnoses	*	*	-	Fraser, 2007
Insufficient interpreting services	*	*	-	Auckland Sustainable Cities Programme, 2006
Appropriate referrals not provided	*	*	*	Fraser, 2007
Lack of refugee or migrant specific services	*	*	-	Department of Labour, 2004
Limited cross-sector collaboration and referrals	**	**	*	Fraser, 2007

** Likely to be a barrier to effective service access for this group

* May sometimes be a barrier

\- does not commonly limit service access

44 Includes quota refugees, asylum seekers and family reunification refugees

45 'Other migrants' refers to migrants who share the culture and heritage of larger New Zealand society.

APPENDIX G – IMPLEMENTATION OF CRITICAL RESEARCH QUESTIONS

FURTHER PRIORITISATION

This refugee and migrant mental health and addiction research agenda was developed through parallel processes of literature review and consultation. Twenty-five questions and seventeen associated sub-questions were identified as important and not well covered in existing research by researchers, policy makers, service planners and funders, frontline staff and service users and community representatives.

To encourage implementation, a small set of priorities will be identified to promote to key funding agencies. Research questions of importance are those which are feasible and most likely to translate into improved outcomes for refugee and/or migrant mental health and well-being. A range of stakeholder representatives will select research questions based on the following criteria relating to topic importance and feasibility.

Mental health importance/applicability

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

Research feasibility

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

PROMOTING PRIORITY RESEARCH QUESTIONS

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

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

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

FIGURE 1G. FURTHER PRIORITISATION AND PROMOTION PROCESS