WDHB MENTAL HEALTH & ADDICTIONS SERVICE DEVELOPMENT PLAN

(2010-2015)

ASIAN CHAPTER

Version 4
April 2009

WDHB Asian Mental Health and Addictions Chapter

Preamble

Waitemata District Health Board (WDHB) is currently developing a District Strategic Plan for its services for the next ten years (2010-2020). This Asian Chapter is intended to support and assist its first five year planning and decision-making on mental health and addictions service development with evidence-based propositions.

The content of this Chapter is an outcome of a series of consultations with service users, communities and service providers, prioritisation workshops with stakeholders, and a literature review of recommended best practice from local and international research studies.

As a crown health agency, WDHB is obliged under statutory requirements and government policies such as the Human Rights Act 1993, The Health and Disability Commissioner Code of Health and disability Services Consumers' Rights 1996, and Ministry of Health's direction to ensure that every person has equal access to health care and quality treatment irrespective of race, colour, or national origin. As a responsible health care planner and provider, WDHB is committed to provide quality, accessible, seamless, efficient and effective health services for all its populations and to reduce health inequalities. The provision of culturally competent services is one of the important means to achieve this end.

There are over 481,000 people living in Waitemata district. Asian[1] is the second largest ethnic group (13.8% of WDHB population as of 2006) in the district and the fastest growing population (62.8%) in the country. However, it embodies a heterogeneous group of huge linguistic, cultural, education, religious diversity and different migratory experiences.

The term 'Asian' is not only an umbrella term covering a broad range of people from different backgrounds but also includes recent migrants, well established migrants and third and fourth generation Asians born in New Zealand. Asian population is a subset of the ethnic population, comprises of migrants, refugees, foreign fee-paying students on fixed term visas and local born Asians.

Refugee[2], though a small group by comparison, are coming to the country under the UN quota of 750 a year. The majority of them choose to remain in the Auckland metropolitan area after entering the country.

Auckland is the biggest city in New Zealand with more than 1.3 million residents. One in five of those usually living in the region are born overseas (Statistics New Zealand, 2006). To ensure these populations of diverse cultural, linguistic, education and religious backgrounds have equitable access to the services and their special needs are met, WDHB has undertaken a detailed and lengthy process of consultations and literature research to understand their health needs and barriers to services.

This Chapter reports the major access and communication barriers faced by most Asians (including refugees), and proposes actions for addressing these barriers. The key actions are further prioritised in terms of their perceived urgency so that they can be implemented timely according to resources available.

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[1] **Asian** refers to immigrants from Asia including people coming from West Asia including countries like Afghanistan, Nepal, to South Asia, covering the Indian sub-continent, East Asia covering China, North and South Korea, Taiwan, Hong Kong, Japan and South East Asia, consisting of countries like Singapore, Malaysia, Philippines, Vietnam, Thailand, Myanmar, Laos, and Kampuchea, (Statistics NZ 1995, 1999, 2003)

[2] During 2007-08, the largest groups of **refugees** were from Myanmar (33%), followed by Sudan (4%) and Rwanda (3.3%). About 44% of the total refugee population in 2007-08 were under the age of 18 years of age (Department of Labour, Immigration New Zealand (INZ) (2009)

To solve the barrier issues highlighted in a coordinated, effective and resource efficient manner, this Chapter suggests an implementation of an integrated service model for mental health and addiction services in Waitemata.

The proposed integrated service model is one that ensures clear, effective communication between mainstream clinicians[3] and Asian service users. This proposed model will enhance adequate cultural competence[4] throughout the diagnostic and treatment process by means of workforce training, and inputs of cultural clinical advisers and interpreters through a central cultural support coordination function. This integrated model aims to meet the health needs of the Asian population from linguistic, cultural and religious diverse backgrounds. It is seamless, is cost effective, allows optimal use of resources, increases accessibility, and facilitates social integration[5] between immigrants and the host community. The details of the model will be explained in the following section.

[3] **Mainstream clinicians** refer to all mental health practitioners who provide non-ethno specific service to the general population, whose ethnicity may be NZ European, Maori, Pacific, Chinese, Indian, Korean, Iraqi, Afghani, Burmese, Japanese, Cambodian, American, British, African, Filipino, etc, and who may be from ethnic communities themselves.

[4] **Cultural competence**, according to the Medical Council of New Zealand, requires clinicians to be aware of cultural diversity, have the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. A culturally competent doctor will acknowledge that New Zealand has a culturally diverse population; that a doctor's culture and belief systems influence his or her interactions with patients and accepts this may impact on the doctor-patient relationship; and that a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding.

[5] **Integration** is defined by Penninx (2005, p.1) as the process of becoming an accepted part of society. There are two parties involved in integration processes: the immigrants, with their particular characteristics, efforts and adaptation and the receiving society with its reactions to newcomers. The interaction between the two determines the direction and the ultimate outcome of the integration process. They are, however, unequal partners. The receiving society, its institutions, structures and the ways it reacts to newcomers is much more decisive for the outcome of the process.

Summary of key points on Asian perspectives of mental health and addiction service responsiveness

The migration influx of Asian people into New Zealand began in the late 1980's, peaked in 1995 and continued to lead the net migration figures with an average of over 15,000 people per year over 1996 to 2002, making Asian people the fastest growing population in New Zealand. Asians make up 14% (68,151. P.14 of Zhou 2009) of the overall population in Waitemata DHB, the second largest population group after Europeans (Statistics New Zealand, 2006). The increasing number of Asian migrants and issues of ethnic differences, cultural diversity, spiritual and religious faith, and varying English proficiency has presented both a challenge and opportunity for more responsive and innovative health care for the district health board and its workforce.

Characteristics of the Asian Population in WDHB

There is a very detailed description of the demographic characteristics, socio-economic status, protective and risk factors, health outcomes and service utilisation about the Asian and refugee populations in WDHB Health Needs Assessment for Asian People. For full details, see Zhou (2009).

Service Barriers

Current experience and research conducted in New Zealand show that Asian migrants and refugees are encountering difficulties in accessing New Zealand mental health and addictions services. In addition to the many wider systemic barriers, it has been found that the language and cultural issues are two most widely experienced barriers to service, adversely affecting equitable access to appropriate and quality care (Walker, Wu, Sooth-O-Soth, & Parr, 1998; Ngai, Latimar, & Cheung, 2001 Ho, Au, Bedford, & Cooper, 2003; Ministry of Health, 2003).

There has been ample research into language barriers impacting on initial access and communication between providers and clients affecting diagnosis and treatment. The first set of barrier affects clients in relation to presenting for assessment and care, while the second set of barriers has an impact on the quality of care obtained. When language is an issue, non-English speaking clients generally prefer interacting with a health professional who can speak their first language, (Bowen, 2001; Holt, Crezee, & Rasalingam, 2001). In mental health sector where diagnosis relies significantly on affective understanding and verbal communication, it has been suggested that the preferred approach for health providers is to match a qualified professional to the client's first language where possible, to ensure adequate diagnosis and appropriate treatment (Craig, 1999). Other suggestions include employing more Asian mental health professionals, which although would improve access to services is not considered a feasible option given the great diversity of culture, language and dialect of our Asian communities.

The second best approach suggested by research is to use skilled professional interpreters to address the communication barrier (Bulwada, 2004). However the use of interpreters who have not been specifically trained to work in mental health can be problematic and can hinder the communication process. This increases the risk of misinterpretation, non-diagnosis or misdiagnosis of the client's illness, and may lead to treatment errors and/or non-compliance. It may have a negative impact on treatment compliance or result in termination of prescribed treatment, and/or reluctance to seek further or early medical intervention, leading to more serious or prolonged illness and unnecessary cost (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Hattar-Pollara & Meleis, 1995; Craig, 1999; Lin & Cheung, 1999; Kleinman, 2004; Tse, 2004).

In addition to language issues, culture can have a considerable impact on the clients' presentation of symptoms or problems, the way clients experience depression, clients' help seeking patterns, as well as client-practitioner communication and relationship, and professional practice (Craig, 1999; Kleinman, 2004).

Efforts need to be made to increase the cultural competence of both workforce and service providers (Tse et al., 2005).

An Innovative Service Model for responding to Asian Needs

Given the significant linguistic and cultural diversities of the Asian population in the Waitemata health district, a segregated or ethno-specific service model is not considered an optimal support model for the Asian communities. To meet the specific needs of these people within the mainstream provision, an innovative service model is required. The stakeholder consultation has led to a proposal of an integrated cultural support service model which has all the health, societal, cost, and political benefits. It meets clients' needs at different entry points, provides seamless service across prevention, early intervention, diagnosis, treatment and recovery, and serves Asian clients of all ages, genders, ethnic backgrounds, individuals as well as families. It supports and empowers clients in their recovery and enhances and maximises mainstream professionals and services.

The main structure of this model consist three levels:

- a core team of bi-lingual Asian mental health cultural support coordinators
- a team of contracted clinical cultural advisers (preferably bi-lingual)
- a team of contracted professional interpreters

Each level has different functions. The core team of cultural support coordinators helps direct and engage clients when they experience access issues and provides case clinicians with inputs on clients' social, cultural and religious needs. The team of clinical cultural advisers helps case clinicians make appropriate clinical assessment in a culturally safe, acceptable and competent manner. The team of professional interpreters helps facilitate the communication process of clinical assessment and treatment by overcoming the language barriers.

For a detailed description of how each level functions, please refer to Appendix 1.

This 3-level service model will enhance and integrate with the mainstream services and clinicians to provide a seamless, culturally appropriate, acceptable, accessible, accommodating, social integrative, and culturally safe and responsive mental health service for clients from Asian backgrounds. This service model provides a valuable and cost effective support for the district mental health services until all mental health services have developed a multi-ethno mainstream workforce that are able to match practitioners' language and culture of the clients when required and a mainstream workforce that is culturally capable to work with clients from diverse linguistic and cultural backgrounds without a cultural support function.

The Asian population is expected to continue to grow in the region and the district in the next ten years. The demand for effective and responsive mental health and addiction services from this population will rise. To meet these increasing and complex demands, significant service enhancements and developments of the mental health services and infrastructure are required. The achievable actions detailed inside this Chapter and the proposed best practice model outlined above are considered to be the strategic direction and pathways to rise to and successfully meet the challenges facing Waitemata DHB now and in the coming decade.

WDHB Asian Mental Health and Addictions Action Plan 2010-2015 (next 5 years)

An implementation plan, '*Improving mental health services responsiveness to Asian communities in Waitemata District* (2006-2010)', was developed and signed off by the WDHB Board in September, 2006. It contains service delivery recommendations pertaining to the regional strategy, *Regional Mental Health and Addictions Strategy for Asian Service Users* (Northern DHB support Agency, 2006) and regional implementation plan, *Improving mental health services responsiveness to Asian communities: Implementation Plan 2006-2010,* (NDSA, 2*006*). These recommendations were consistent with national and regional strategic documents. It serves as a foundation and a reference for the development of this document which proposes a five-year (2010-2015) strategy and action plan for Asian mental health and addiction services within Waitemata DHB (WDHB) locality.

Vision

"Our vision is to ensure our mental health and addictions services are seamless, accessible, culturally responsive, acceptable and appropriate, consumer-orientated and effective for all age groups of Asian communities in every aspects of the health spectrum from promotion, prevention, treatment, provision of care to recovery with no stigma and discrimination."

Mission

Our mission is to enable

- *Our Workforce to have the ability and confidence to work cross-culturally to better service the Asian communities*
- *Our Services to be integrated, effective and culturally responsive, acceptable and appropriate to respond to the diverse nature of the Asian communities*
- *Our Asian communities to have confidence in WDHB mental health and addiction services*

Goal

The overall goal of this "Action Plan" is to ensure a sustained and coordinated implementation of the identified objectives and prioritised actions including development, enhancement, evaluation, and funding in the Waitemata District.

Key Objectives and Actions for the next 5 years (2010-2015)

There was a consensus at the Visioning Workshop (1 Oct 2008) hosted by the Waitemata Stakeholder Network that there is a need to address responsiveness within the following nine key components. Responsive objectives and actions for the next five years are grouped under the following headings to ensure alignment with the overall District Mental Health & Addictions Plan for the next five years (2010-2015).

1. Holistic – wider continuum of care
2. Early intervention
3. Cultural responsive services
4. Family involvement
5. Primary care
6. Collaboration/Integration
7. Information and resources
8. Workforce
9. Consumer-led services

The objectives and actions under each of the above identified component have been extracted from the following sources:

- Improving mental health and addiction services responsiveness to Asian communities in Waitemata District: Implementation Plan 2006 to 2010" (WDHB, 2006)
- Improving mental health services responsiveness to Asian communities: Auckland Regional Asian Mental Health and Addictions Implementation Plan 2006 to 2010" (NDSA, 2006)
- Northern Region Mental Health and Addiction Strategy for Asian Service Users (NDSA, 2006)
- Recommendations from *Draft* Asian Workstream Report, WDHB Infant, Child, Youth Mental Health & Addiction Service Stocktake Project 2008 (including Literature Review: Mental Health Services and Best Practice for Asian Migrant and Refugee Child &Youth) (Li, 2008)
- Recommendations from *Draft* WDHB Health Promotion Strategy for Older people – the Healthy Aging Strategy, 2009
- Alcohol Advisory Council (ALAC) New Zealand Occasional Paper No.22 Alcohol and Drugs in NZ: An Asian Perspective (ALACNZ, 2004).
- An Overview of Help Seeking by Problem Gamblers and their Families including Barriers to and Relevance of Services (Clarke, Abbott, DeSouza, & Bellringer, 2007)
- Researching the Health Needs of Elderly Indian Migrants to NZ (DeSouza, 2006)
- Sailing in a new direction: Multicultural mental health in NZ (DeSouza, 2006)
- Wellness for all: the possibilities of cultural safety and cultural competence in NZ (DeSouza, 2008)
- Recommendations from Health Needs Assessment for Asian People in Waitemata District (Zhou, 2009)
- Discrimination: Section 4 of Human Rights Commission /Race Relations Report 2008
- Access Issues for Chinese People in NZ prepared for ACC (DeSouza & Garrett, 2005)
- Statement on Cultural Competence, Medical Council of NZ, 2006
- Cultural Competence and models in mental health: Working with Asian Service Users (Nayar & Tse, 2006)
- Asian Mental Health and Addiction Research Agenda (Te Pou, 2008)
- Refugee and Migrant Mental Health and Addiction Research Agenda (Te Pou, 2008)
- Auckland Regional Settlement Strategy, 2006
- Feedback from Asian stakeholders at WDHB MHSOP Planning Day 22/9/08
- Feedback from Asian stakeholders at the WDHB DMHS Meetings on 12/11/08, 29/1/09 and 26/2/09 (See Appendix 2 for list of stakeholders who contributed to the chapter development)

Implementation Indicators

A	Able to be provided within existing resources
P	Partial implementation possible within existing resources
R	Some services are available but could be extended or re-configured
N	New funding required prior to delivery

1. Holistic – Wider Continuum of Care

Holistic health is a philosophy of medical care that views physical, mental and spiritual aspects of life as closely interconnected and equally important approaches to treatment. It is frequently associated with alternative medicine, and also increasingly used in mainstream medical practice as part of a broad view of patient care (Wikipedia).

Asian is a heterogeneous service user group. Therefore it is important that a holistic approach and a wider, flexible, culturally sensitive and responsive continuum of care can be employed to accommodate the cultural diversities of the Asian people, where some service users may have more and some less inclination towards achieving a combined harmony of their body, mind, emotions, spiritual, and family, depending on individuals' culture, faith, gender orientation, and migratory experience.

Objective 1.1:

Mental health and addiction services for all ages shall take the form of a care continuum including collaboration/partnership with other agencies; and that the services provided are culturally responsive and competent to:

- Take into account clients' beliefs systems and cultural values about mental illness and behavioural disorders in diagnosis and treatment plan
- Understand the difficulties of adjusting to a new culture
- Be sensitive to communication difficulties
- Emphasise on strengths
- Respond respectfully and effectively to clients from all cultures, races, classes, ethnic backgrounds and religions

(Health Canada, 2008; Walker, 2005; Whittaker, Hardy, Lewis, & Buchan, 2005; Tse et al, 2005; Yeo et al, 2005; Eisenbruch, et al, 2004; Wu, 2001; Matsuoka, 1990; Lee, 1988; Rack, 1982)

Specific Actions (applicable to all age-groups)		Timeframe	Implementation	Lead
a.	Develop policy to ensure mandatory culturally competency training for all mental health and addictions workforce and that there is organisation support for continuing cultural competency training to increase cultural awareness	2010	A	Clinical Director/GM MH Group/Quality Manager
b.	Review current assessment tools to ensure that they are appropriate (for screening and outcome measurement), culturally sensitive and effective to work through issues such as stigma, language, trauma, torture, culture, financial, transport and access to continuum of care/services	2010	A	Clinical Director/GM Mental Health Group
c.	Set up culturally appropriate therapeutic intervention	2011	N	Clinical Director/GM Mental Health Group

2. Prevention and Early Intervention

The importance of prevention, early intervention and provision of information is acknowledged in both national and regional health documents, for example, *Action Plan: Te Tāhuhu – Improving Mental Health 2005–2015 The Second New Zealand Mental Health and Addiction Plan (MoH, 2005)*, and *Northern Region Mental Health & Addictions Services Strategic Direction 2005–2010 (NDSA, 2004).*

Stigma has been cited as a major obstacle preventing Asian people from using mainstream mental health services, and a major reason for their late presentation to service. There are also a number of other barriers which include unfamiliarity with the mental health, social and legal systems[6]. The provision of information (especially translated information) and access to professional interpreters are arguably the most effective response to access barriers and improving early intervention for Asian communities (Ho, Au, Bedford, and Cooper, 2002).

Objective 2.1: ▪ To improve access to and through the continuum of mental health and addiction services for the Asian community by eliminating barriers				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Improve preventative strategies by looking at ways to de-stigmatise mental illness on a societal level (e.g. social marketing)	2011	A	Provider (Asian Service Providers)
b.	Provide culturally appropriate information and education to Asian people through all kinds of communication means including ethnic media	2011	N	Provider (Asian MH Service)
c.	Improve competencies and screening in primary care[7] that are culturally responsive and effective to work through issues such as stigma, language, trauma, culture, financial, transport and access to continuum of care/services	2013	A	Primary care/ Clinical Director/GM Mental Health Group/Asian MH Service
d.	Collaborate between NGO, DHB and Asian communities (including religious groups) to raise awareness on, and promote access/ usage of, mental health and addiction services	2013-2015	A	All
e.	Develop Asian liaison coordination function in primary care	2015	N	Primary care/ Clinical Director/GM Mental Health Group

[6] Implementation plan, "Improving mental health services responsiveness to Asian communities in Waitemata District", (2006-2010) Page 11

[7] Primary care here includes all care providers who can be accessed by clients directly without referrals, such as GPs, pharmacists, teachers, school nurses, and school counsellors.

Objective 2.2: ▪ Improve sector and community understanding of existing services to enable seamless service provision and accessing the right service				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Explore and develop a cross-fertilisation (or multi-agency) approach	2011	A	Funder
b.	Stocktake all relevant services	2012	A	Funder
c.	Review existing available "community based centres" which provide advice/ information (specific answers not referrals) with a view to explore the following areas: ▪ "Citizen Advice Bureau" model – "surface model" ▪ Asian helpline (with extended hours) to provide information and advice	2013	A	Funder
Specific Actions (specific to child and youth age group)		**Timeframe**	**Implementation**	**Lead**
d.	Work with CYFS to develop early intervention strategy to promote and provide education	2011	A	Clinical Director/GM Mental Health Group
Specific Actions (specific to older adult age group)		**Timeframe**	**Implementation**	**Lead**
e.	Increase information reach ("Activity Stream One" *Draft* WDHB Health Promotion Strategy for Older people – the Healthy Aging Strategy, 2009) (S)	Healthy Aging Strategy, 2009	Healthy Aging Strategy, 2009	Healthy Aging Strategy, 2009

3. Culturally Responsive Services

In the *Action Plan: Te Tāhuhu – Improving Mental Health 2005–2015 The Second New Zealand Mental Health and Addiction Plan*, the Ministry of Health (2005) outlines the importance and relevance of 'responsiveness' within mental health services:

"*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. Services working together will also ensure adequate referrals between mainstream services and those services developed to meet the unique needs of specific population groups. Ultimately, this will improve access to services for some population groups that are currently presenting at times of crisis and will also improve the quality of services they receive.*

Responsive services respectfully listen to service users and tangata whaiora, give access to full information, use collaborative processes at all levels, encourage feedback, and do 'whatever it takes' to support easy and timely access to services. Responsive services recognise the impact that mental illness and addiction can have on families and whānau and the important role they can play in treatment and the recovery process (p. 24)."

Objective 3.1:

To develop integrated, effective, culturally responsive services to meet the needs of the diverse nature of the Asian communities. This means that:

- Services and clinical assessment tools are culturally appropriate and sensitive, taken into consideration of the fact that different cultures bring along different perspectives, attitudes, values, and spiritual and cultural beliefs depending on the patient's background
- Asian people are not discriminated against or disadvantaged in any stage of service planning, development and delivery
- Outcomes for Asian clients are regularly evaluated
- Continuum of care from primary to tertiary is culturally appropriate and responsive
- Services are people-centred, strength-based, inclusive and health promoting
- Qualified interpreters are available to ensure effective communication between practitioners, clients and their family
- Improve sector and community understanding of existing services to enable seamless service provision and accessing the right service

Specific Actions (applicable to all age-groups)			Timeframe	Implementation	Lead
a.	Review existing services and service model to close the gaps		2010	A	Provider
	a.1	Support sustainable funding for the existing Asian mental health cultural support service to support clinical teams with building rapport, client engagement, brief clinical cultural assessment intervention, social-cultural assessment, psycho-education life-skill counselling, and cultural support services)	2010	A	Funder, Clinical Director/GM Mental Health Group
	a.2	Review and ensure adequate capacity of Asian community support work-type roles	2010	N	Provider/NGO
	a.3	Provide access to professional interpreter services for the whole continuum of care	2011	N	All
	a.4	Review capacity of clinical cultural advisers within (a.1)	2012	A	Provider/Primary Care

	a.5 Fund the development of Asian-specific peer support groups and a network of peer support groups	2012	N	Funder
	a.6 Scope the "one-stop shop" with one point of entry (integrated service) concept for consideration	2013	A	All
b.	Develop a clear and consistent referral process across the region	2010	A	Regional MH Coordinator/Asian MH Service
c.	Develop culturally appropriate assessment tools (for screening and outcome measurement) that are culturally sensitive and effective to work through issues such as stigma, language, trauma, culture, financial, transport and access to continuum of care/services	2013	P	Primary Care/ Clinical Director/GM Mental Health Group
d.	Build organisational capacity and capability(refer to Workforce Section)			
e.	Use technology e.g. MSN, Skype, internet, e-therapy to improve access to services	2015	F	All Providers
Specific Actions (specific to child and youth age group)		**Timeframe**	**Implementation**	**Lead**
f.	Develop Community-based psychosocial intervention ▪ Such as in the form of a youth club where young people can receive help with the understanding and interpreting of traumatic events, and learn how to reduce suffering from traumatic experience and find new goals for the future. ▪ Or a culturally-sensitive mental health schools-based programme where adolescents talk about adaptation and cultural issues, develop coping skills, and learn to make a successful adaptation to the host countries	2013	P	Provider
g.	Develop outreach services for young people with alcohol and drug issues with services directly "on the street"	2013	N	Primary care and Provider
h.	Set up group therapy where participants can share similar experiences with others and learn how to address adjustment difficulties in their daily life	2013	N	Primary care and Provider
Specific Actions (specific to older adult age group)		**Timeframe**	**Implementation**	**Lead**
i.	Access to cultural appropriate home based support services /respite services	2011	N	Funder/Provider
j.	Access to cultural appropriate meals on wheels	2013	A	Provider
k.	Access to cultural-specific Asian day-programmes or day-centres for older people with mental health issues (eg short term day centre for adult and older adult with the provision of transportation and activity coordination function)	2013	N	Funder/Provider
l.	Access to cultural appropriate rest homes and facilities or mobile team to go into rest homes to	2013	N	Funder/Provider

	service the Asian service users			
m.	Support Asian family to look after their own elderly if they prefer, or to access appropriate services	2013	N	Funder/Provider
n.	Provide age-friendly service provision ("Activity Stream Three" *Draft* WDHB Health Promotion Strategy for Older people – the Healthy Aging Strategy, 2009)	Healthy Aging Strategy, 2009	Healthy Aging Strategy, 2009	Healthy Aging Strategy, 2009

Objective 3.2: Evaluate outcomes for Asian clients using services				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Establish / formalise an Asian Mental Health & Addiction Reference Group to monitor and govern the implementation of an evaluation plan and monitor progress	2010	A	Clinical Director/GM Mental Health Group
b.	Review current client satisfaction evaluation/survey	2011	A	Quality Manager
c.	Also see Evaluation Objective 7.3			

4. Family/Whanau Involvement

Objective 4.1: Involve Asian consumers and family in strategic planning and development of mental health addiction services				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Ensure Asian representation/participation in strategic and service planning processes	2010	A	All providers
b.	Ensure organisational support in place to enhance Asian consumer and family representation	2010	A	Clinical Director/GM Mental Health Group
Objective 4.2: To help consumers and family members to access specific information and services				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Stocktake translated mental health resources in major languages and source from websites for other language translated information	2011	A	Regional Coordinator/Asian MH Service
b.	Explore the development of accessible counselling centres with counsellors who have the same cultural background as the Asian clients	2013	A	Asian MH Service
Specific Actions (specific to child and youth age group)		**Timeframe**	**Implementation**	**Lead**
c.	Provide psycho-education sessions for families in their native languages	2011	N	Child Youth & Family Services
d.	De-stigmatisation of issues within families	2013	N	Child Youth & Family Services
Objective 4.3: Ensure culturally appropriate solutions or models involving Asian consumers and family members				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Explore and develop the concept of "Whole Family" model ("Family Resilience") with Asian family input	2013	A	Regional Coordinator/Asian MH Service
Specific Actions (specific to child and youth age group)		**Timeframe**	**Implementation**	**Lead**
b.	Explore a working model to address 'intergenerational issues' with Asian family	2011	P	Asian MH Service
c.	Facilitate an 'Intergenerational Forum' on how to bridge the gap between migrants parents/whanau and children who are NZ born or have been here for most of their lives	2011	P	Asian MH Service

5. Primary Care

Objective 5.1: Ensure that Primary mental health services are effective, culturally appropriate, relevant and responsive services to meet the needs of the diverse nature of the Asian communities. For service implications, refer to *Culturally Responsive Services* under Objective 3.1.				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Review existing service responsiveness and service model in primary care sector to meet the needs of Asian consumers with a focus on the following aspects	2011	A	Primary Care
	a.1 Support sustainable and increase funding for the existing Asian mental health cultural support service to support clinical teams with building rapport, client engagement, brief clinical cultural assessment intervention, social-cultural assessment, psycho-education life-skill counselling, and cultural support services)	2011	N	Primary Care
	a.2 Review and ensure adequate capacity of Asian community support work-type roles	2011	N	Primary Care
	a.3 Provide access to professional interpreter services for the whole continuum of care	2011	N	Funder
	a.4 Review capacity of clinical cultural advisers within (a.1)	2013	N	Primary Care
b.	Improve competencies and screening in primary care to improve access to services	2013	P	Primary Care
c.	Review and ensure culturally appropriate model (a.1) is developed within the continuum of care/services	2013	A	Clinical Director/GM Mental Health Group
d.	Training is made available for primary care professionals on how to work in a culturally respectful way with Asian consumers (related to workforce development)	2011	A	Learning and Development
Specific Actions (specific to older adult age group)		**Timeframe**	**Implementation**	**Lead**
e.	Provide age-friendly primary health service ("Activity Stream Two" *Draft* WDHB Health Promotion Strategy for Older people – the Healthy Aging Strategy, 2009)	Healthy Aging Strategy, 2009	Healthy Aging Strategy, 2009	Healthy Aging Strategy, 2009

Objective 5.2: Focus on early intervention and promotion				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Provide translated information about mental health and addiction disorders and NZ health system and services to consumers	2011	A	All services
b.	Explore the development of a web-based information centre or hotline for easy access for information and resources on mental health & addictions issues and services	2013	A	Funder
c.	Collaborate with other organisations (to encourage service access, increase cultural responsiveness, increase community supports for people with mental illness or addiction issue, etc.)	2011	A	All providers

Objective 5.3: Have a primary health workforce which is culturally capable and has the confidence to work cross-culturally with Asian people				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Refer to the "Workforce section"			
b.	Define/ develop cultural appropriate model with primary mental health service to work with Asian communities	2013	A	Primary Care (Asian MH Service)

6. Collaboration / Integration

Objective 6.1: All services are working in collaboration to achieve integrated, effective and culturally appropriate services, programmes and initiatives to respond to the diverse nature of the Asian communities including children and young adults				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Conduct a stocktake of services	2011	A	Planners and Funders
b.	Ensure that Asian participation at all service planning process	2011	A	All providers
c.	Develop a unified working model of Asian mental health and addiction services across the three Auckland-metro DHBs	2011	A	Regional
d.	Identify successful models of coordination and integration through case studies and examples of best practice	2013	A	Funder/ Quality Manager
e.	Look at a collaborative mechanism around information collection and sharing	2013	A	Quality Manager
f.	Identify barriers and proactively promote the utilisation of existing services provided by other agencies (e.g. youthline)	2011	A	Quality Manager
g.	Set up mechanism to encourage effective sharing of knowledge, information, ideas and mutual support between CYF and MOE (GSE) and Child and Youth mental health service	2013	A	Clinical Director/GM Mental Health Group
h.	Set up a model that enable collaborative links with schools, primary health care, MoE, MSD, Asian community support network, and community child mental health teams (M)	2013	A	Quality Manager
i.	Celebration of Asian champions through community led events	2015	A	All
Specific Actions (specific to older adult age group)		**Timeframe**	**Implementation**	**Lead**
j.	Provide age-friendly infrastructure ("Activity Stream Four" *Draft* WDHB Health Promotion Strategy for Older people – the Healthy Aging Strategy, 2009)	Healthy Aging Strategy, 2009	Healthy Aging Strategy, 2009	Healthy Aging Strategy, 2009
Objective 6.2: Addiction and gambling treatment services are working in collaboration with other mental health and addiction services to provide an integrated, effective and culturally responsive approach.				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Ensure that CADS is part of the whole service model	2011	A	Provider
b.	Ensure that Problem Gambling is part of the whole service model	2011	A	Provider
c.	Collaborate with all other specialty services	2013	A	Provider

7. Information and Resources *(including Evaluation)*

Information is vital and fundamental to service take-up, improvement and development. The Government has stated clearly that it wanted "an environment that supports the dissemination of knowledge and information", and "a research and evaluation-based approach to recovery practice" as they are important "for maintaining quality practice, and promoting innovation in policy, planning and practice". (Te Kokiri, 2006, p.62).

Objective 7.1: Improve access to information and advice to mental health services, Asian migrant services, and service user, support and community groups				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Develop a resource about services and community that can be accessed by practitioners and support services online	2011	N	Regional
b.	Develop a database of cultural specific services/resources for primary, secondary and NGO service providers to support consumers' recovery process	2011	N	Regional
c.	Conduct a stocktake and gaps analysis of existing database of mental health services, Asian migrant services, support and community groups, other networks and individuals relevant to Asian mental health and create a database of services for practitioners	2011	N	Regional
d.	Conduct a stocktake and gaps analysis on Asian mental health information resources (e.g. what is available in main Asian languages and on international websites for other languages)	2011	N	Regional
e.	Scope the development of a WARMLINE (if hotline for crisis) or multicultural community centre to help the communities to access correct information and navigate through the system	2013	N	Funder
f.	Promote information resources via websites and community networks (printed handouts)	2013	A	All (Asian MH Service)

Objective 7.2: Identify and recognise different needs of different Asian groups (for example, Chinese/Korean vs. South Asian) to address specific high needs culminating in long-term health inequalities				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Conduct or support epidemiology study on Asian mental health prevalence to identify high risk groups in Asian population to reduce health inequalities	2013	A	Funder/Provider
b.	Track and report on Asian service utilisation data (i.e. by different ethnic groups and outcomes of service to identify the important areas that services need for focus on)	2011	A	Provider
c.	Conduct more research on Asian elderly, women and young people issues	2012	N	Funder
d.	Undertake reflective practice on how services could do better and share this information with others	2013-2015	A	Regional
e.	Implement the policy of including ethnic sub-Asian and age-specific (different age categories); gender, length of stay, religion, decile (social determinants of health) when undertaking any Asian health needs assessment/research/evaluation	2015	A	Provider/Funder

Objective 7.3: Collect information and evaluation feedback from clients and stakeholders to inform service assessment, development, funding and clinical practice to support better health outcomes for Asian clients				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Build in client satisfaction survey as part of service delivery with specific criteria for identifying whether the objectives in the service development plan have been achieved	2011	A	Provider
b.	Use survey information and clinical data (e.g. service access and health issues) to inform service development, funding and clinical decision-making	2011	A	Provider
c.	Conduct bi-annual surveys or focus group meetings among service users and providers to inform service planning and clinical quality	2013	A	Provider

8. Workforce

"..the future, emerging workforce will need to ensure that it can deliver the right "mix" of services for people – with perhaps the most significant factor shaping the need for new skills and areas of specialised knowledge being the change in the make-up of our demographics, with an increase in the number of Maori and Pacific and Asian people making up our population".

"Without good people, the sector cannot be effective, and we need to continue to develop a workforce that has the skills and a commitment that enables and encourages service users to take leadership and governance roles".
(Te Tahuhu, 2005, p.12)

Objective 8.1:
Promote recruitment and retention (through training and supervision) of Asian people and service users into mental health and addiction workforce across the continuum of care (primary, secondary and NGO sectors)

	Specific Actions (applicable to all age-groups)	**Timeframe**	**Implementation**	**Lead**
a.	Ensure the workforce ratio reflect the ratio of the Asian population to increase the ability to match practitioners' cultural to clients	2011	A	Funder, Clinical Director/GM Mental Health Group
b.	Provide necessary training/supervision for Asian workforce	2011	A	MH&A Management
c.	Create pathways for Asian consumers into mental health & addictions workforce	2011	A	Clinical Director/GM Mental Health Group
d.	Provide professional development pathways for Asian workforce (eg. Leadership development)	2011	A	MH&A Workforce Coordinator
e.	Provide regular training and supervision for interpreters working in mental health and addictions sector	2015	A	Interpreting Service
f.	Promote mental health and addiction roles as a desired profession to Asian communities	2013	A	MH&A Workforce Coordinator
g.	Promote mental health and addiction roles as an option to tertiary training institutes	2013	A	MH&A Workforce Coordinator

Objective 8.2: Mental health and addiction workforce working in primary, secondary and NGO sectors are culturally capable and have the confidence and competence to work with Asian clients (refer to Objective 1.1)				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Provide cultural diversity and competency training for the entire workforce to maximise outcomes for Asian people	Ongoing	A	MH&A Workforce Coordinator
b.	Develop a consistent cultural competence framework across the region	2011	A	Regional
c.	Ensure that practitioners in primary, secondary and NGO sectors have the necessary cultural assessment skills (that account for cultural issues pertaining to the diverse Asian cultures)	Ongoing	A	MH&A Workforce Coordinator
d.	Set up half yearly regional forums and workshops pertaining to Asian mental health & additions to increase information sharing	Ongoing	A	GM Mental Health Group
e.	Develop culturally appropriate assessment tools (for screening and outcome measurement) that are culturally sensitive and effective to work through issues such as stigma, language, trauma, torture, culture, financial, transport and access to continuum of care/services	2013	A	Clinical Director
f.	Develop policies and protocols for working effectively with different groups of the Asian population	2013	A	Funder

Objective 8.3: Establish competent workforce development policies and strategies				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Develop policy requiring workforce from primary, secondary and NGO sectors to attend cultural diversity training	2011	A	All
b.	Ensure workforce knows when and how to access cultural resources	2011	A	All
c.	Develop core cultural competence criteria applicable to each area of service	2013	A	All
d.	Develop policy for unpaid workforce (in support networks and peer support)	2013	A	All

9. Consumer-led Services

Objective 9.1: Promote the development of peer leadership and peer support concepts				
Specific Actions (applicable to all age-groups)		**Timeframe**	**Implementation**	**Lead**
a.	Develop cultural specific peer support groups	2013	F	Funder
b.	Develop sustainable peer support networks	2013	F	Funder
c.	Promote the development of consumer workforce and leadership	2013	F	Funder

Conclusion

This Action Plan is an output of a series of rigorous consultation exercises undertaken over a period of seven months (Aug 2008 to Feb 2009). Each of the objectives and action points presented in this plan is decided collectively by a group of dedicated and experienced stakeholders from the Waitemata health district and across the Auckland Region, based on feedback and inputs from the communities, service users, clinicians, service providers and researchers.

The ultimate goal of this plan is to improve service access and responsiveness for the Asian and refugee communities so that they can enjoy the same quality services and health outcomes.

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Asian Mental Health & Addictions Chapter – Appendix 1

The Structure of the Proposed Integrated Service Model

The service is a three-level structure consisting of a core team of cultural support coordinators, a contracted team of clinical cultural advisers, and the support of professional trained interpreters, with different roles for different levels. The functions and requirements of each level are detailed below:

1. **The Asian Mental Health Cultural Support Coordinator** is bi-lingual and has a thorough knowledge of their own cultural perspectives and understands the perspectives of an individual and a family from similar cultural backgrounds; good understanding of spirituality issues and how it may influence the client's experience and presentation. (The coordinator must have mental health qualifications or social work or counseling, or diploma in mental health support work and must be culturally competent to work with clients cross-culturally). The role of the cultural support coordinator includes:
   - Provision of engagement and communication support between clients/family members and mainstream key clinicians/workers at clinical meetings, crisis intervention over the phone, client's home, inpatient setting etc
   - Provision of psycho-social and cultural assessment
   - Provision of life skill counselling
   - Provision psycho-education to client /family members
   - Coordination of consultation with clinical cultural advisor, when needed
   - Ensuring efficient and effective communication via HCC, email, phone, fax
   - Promotion mental health information to Asian community
   - Coordinating (sourcing) translated mental health resources for key workers and clients
   - Coordinating bi-lingual professionals therapists (fee for service), when required
   - Provision of social and cultural support services to support client's recovery process
   - Coordination of self help groups to support clients in the recovery process

2. **The Clinical Cultural Adviser** is the cultural expert (a psychiatrist, or psychologist, or mental health professional) who have extensive experience and knowledge working with cross-cultural clients and competent with clinical cultural assessment, preferably b-lingual and from Chinese, Korean and Indian backgrounds to match the major cultural groups of the Asian population in WDHB. The adviser may not be the cultural expert at times, but will be the most experienced person who has the best understanding of how to effectively work cross-culturally with clients with the support of a matching culture and language trained interpreter and /or cultural staff when doing the clinical cultural assessment. The role of the adviser is to provide one off brief intervention and clinical cultural assessment, with a review date if required, to assist the mainstream key clinician with their diagnostic, assessment and treatment process. The brief intervention and assessment could be provided face to face or via conference call, with or without the attendance of the key mainstream clinician.

3. **The Professional Interpreter** is bi-lingual and must be fluent in the identified target ethnic language and English, and has acquired minimum qualifications for interpreting in health settings and completed training on how to interpret in mental health. The interpreter role is to interpret accurately for clinicians and clients, clarifying metaphorical meanings within cultural concept and provide a necessary framework for the message being translated. The role also requires the interpreter to inform either party about relevant cultural practices and expectations, ethics and etiquette when there is either apparent or potential misunderstanding, and to assist in maintaining a good therapeutic relationship through mutual cultural respect and understanding. *(Interpreters are not cultural experts, but would complement the team when working with a client whose language does not match the language of the mainstream clinicians or clinical cultural advisors or cultural support coordinators*

Asian Mental Health & Addictions Chapter – Appendix 2

Participants Invited to the series of workshops Nov 2008 to Feb 2009

The project sponsor would like to acknowledge the contribution from the group of dedicated and experienced stakeholders from the Waitemata district and across the Auckland Region to enable us to put together a comprehensive and detailed Action Plan from the rigorous discussion and consultation exercises.

Name	Position	Role
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Fiona Ironside	Mental Health Programme Manager WDHB	Facilitator
Dr Ratana Walker	Senior Advisor Executive Leadership Team, WDHB	Chair/ Facilitator
Sue Lim	Service Manager Asian Health Support Services, WDHB	Team Leader for this workstream
Jenny Long	Te Pou Researcher	Stakeholder
Dr Sai Wong	Consultant Psychiatrist	Regional Member
Ruth Williams	Ops Manager Connect for Recovery	Stakeholder
Judy He	Chinese Community Leader - North	Stakeholder
Patrick Hinchey	Team Leader, Mental Health Service WDHB	WDHB Reference Group
Cheng Goh	Raeburn House Settlement Support Coordinator	Stakeholder
Rebecca Zhang	Asian Service Coordinator CADS	Regional Member
Kelly Feng	WDHB Asian Mental Health Cultural Support Coordination Service Team Leader	Stakeholder
Alex Craig	Associate Mental Health Nursing Director WDHB	WDHB Reference Group
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Dr Margaret Mitchelle-Lowe	Clinical Director - Child & Youth WDHB	WDHB Reference Group
Lorna Murray	CEO Connect for Recovery	WDHB Reference Group
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Ivan Yeo	MH Foundation	Stakeholder
Olga Pascan	Ministry of Education	Stakeholder
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Name	Position	Role
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NB: The above stakeholders were sent information about the chapter development and the different versions of the chapter for comment, even if they were not able to attend, to have the opportunity to provide views.