Making Education Easy

Issue 13 – 2015

In this issue:

- *Mental health services and culturally competent care*
- *Promoting CALD cultural competence in NZ mental health/addiction services*
- *WDHB Asian Health Awareness Week: Mental health presentations*

Abbreviations used in this issue

CADS = Community Alcohol and Drugs Services
CALD = Culturally and Linguistically Diverse
NEAC = New Zealand National Ethics Advisory Committee
WDHB = Waitemata District Health Board

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Welcome to the thirteenth issue of Asian Health Research Review.

This issue is focused on mental health in Culturally and Linguistically Diverse (CALD) populations. The first five articles reviewed originated from a conference which focused on an interdisciplinary conversation about the tensions at the intersection of evidence-based practice and cultural competence. Gone (2015) contends that much evidence-based practice is based on narrowly prescriptive clinical practices and approaches. The author reminds us of the need for cultural humility and for ongoing, interdisciplinary dialogue between psychologists, psychiatrists, anthropologists, sociologists and social work researchers to constantly test and recast basic professional assumptions about the delivery of evidence-based mental health services to culturally diverse populations. This debate is highly informative for New Zealand at a time where as Professor Paul Spoonley, Pro Vice-Chancellor, College of Humanities and Social Sciences at Massey University says the Auckland region is "super diverse". This is a sociological term which reflects the diversity of our migrant and ethnic communities and, as well, the significant size of the non-majority population in Auckland where 25% of the population are Asian, Middle Eastern, Latin American and African. We are now one of the most migrant-dependent cities in the world with 56% of residents either migrants or the children of migrants. In total, 213 ethnic groups were identified in the 2013 Census and our ethnic diversity is increasing. The biggest increases since the 2006 Census have come from Asian groups and of these the top three are the Chinese, Indian, and Filipino ethnic groups.

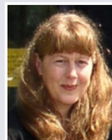
This issue of Asian Health Review will answer the questions:

- Why do psychiatry and mental health services lead medicine and health care in promoting culturally competent care nationally and internationally?
- What can we learn from international debates on cultural competence and evidence-based practice?
- What is happening locally to promote CALD cultural competence in New Zealand mental health and addiction services?

We hope you enjoy this issue and look forward to receiving any feedback you may have.

Kind regards,
Dr Annette Mortensen
annettemortensen@researchreview.co.nz

Independent commentary by Dr Annette Mortensen



Dr Annette Mortensen has worked to improve the health of newcomers to New Zealand from ethnically diverse backgrounds for the last 15 years. From 2000 to 2007 she worked as the Refugee Health Coordinator for the Auckland Regional Public Health Service. In 2007, Annette was awarded with the Supreme Harmony Award for her contribution to Muslim relations in New Zealand by the Federation of Islamic Associations of New Zealand (FIANZ). In 2008, Annette received a doctorate from Massey University, New Zealand. The subject of her thesis was *'Refugees as 'Others': Social and Cultural Citizenship Rights for Refugees in New Zealand Health Services'*. Since 2007 Annette has worked as the Asian, Refugee and Migrant Health Programme Manager for the Northern Regional Alliance on behalf of the Auckland region District Health Boards.

The Asian Health Review has been commissioned by the Northern Regional Alliance (NRA), which manages the Asian, migrant and refugee health action plan on behalf of the Waitemata, Auckland and Counties Manukau District Health Boards.

Why do psychiatry and mental health services lead medicine and health care in promoting culturally competent care nationally and internationally?

The Waitemata District Health Board (WDHB), Asian health week seminar held from the 17-21st August has highlighted the lead that mental health has taken in providing culturally competent health care in the Auckland region (a report on the seminar is posted on the eCALD website www.ecald.com). I asked myself why this was, and found a compelling explanation in answer to the first question in the article by Good and Hannah 2015 who state that: *"The answer is that historically, psychiatry has held a fascination for cultural differences in how mental illness is expressed, experienced, understood, and treated. Thus, psychiatry is the ideal medical specialty to study where culture counts, what culture means, and how disparities and inequalities in treatment by race and ethnicity are linked to issues of culture as they are debated and discussed. It is the field of medicine where the meaning of culture is most seriously and frequently considered and assessed; where culture is used as a clinical frame and a valuable concept for teaching [mental health practitioners] how to create trusting relationships with patients, where universalism and cultural specificity are common in discourses on patient care, therapeutics, and diagnostics; and where cultural systems of meaning and experience are relevant for clinicians as much as for their patients".*

What can we learn from international debates on cultural competence and evidence-based practice?

"Shattering culture": perspectives on cultural competence and evidence-based practice in mental health services

Authors: Good MJ and Hannah SD

Summary/Comment: Good and Hannah ask the question; Have the efforts since the 1960s to improve the cultural competence of care for ethnic minority groups in American mental health services succeeded? The authors cite continuing inequalities and disparities in mental health care and treatment for ethnic minority groups compared to other groups as evidence that the model needs to reflect 21st Century "hyper-diverse" cultural realities. They call for more nuanced approaches to cultural competency training, in response to the increasingly complex cultural and demographic diversity in contemporary American society. The article reflects the tensions between on the one-hand universalising psychiatry which leads to unequal treatment of minority cultural groups, and on the other the pitfalls of over-essentialising client's cultures. Good and Hannah don't, in my view, effectively "shatter culture", rather they highlight the importance of taking a more individualised approach to culturally competent care which takes account not only of the client's culture, but also their migration history, refugee experience, class and educational background, experiences post migration, and stage of acculturation and intergenerational impacts on families.

Reference: Transcult Psychiatry 2015;52(2):198-221
Abstract

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What is happening locally to promote CALD cultural competence in New Zealand mental health and addiction services?

This month eCALD cultural competency training has been launched nationally. eCALD courses are for anyone working in the New Zealand public, primary, secondary and NGO health sectors. To find out more about CALD learning tools and resources or eligibility criteria, please visit www.ecald.com.

In response to the dangers highlighted by Good and Hannah (see above) of "over-essentialising", we advise participants as follows:

- Remember: while it is important to understand how beliefs can influence approaches to mental health, your client is an individual and needs to be treated as such. Making assumptions about your client's behaviours or beliefs can lead to stereotyping and inappropriate practitioner-client interactions
- Further, we place emphasis on cultural competence as a life-long learning journey. It requires the learner to commit to their (and others) ongoing education including: undertaking research to become better informed; developing approaches based on cultural considerations; seeking ongoing mentoring; and seeking or providing supervision of cultural practice in order to advance along the cultural competence continuum
- It's important that practitioners complete an assessment of where they fall along the cultural competence continuum (Cross et al., 1989; see www.ecald.com). Such an assessment can be useful for further development of cross-cultural knowledge and skills. Cultural proficiency, the aim of eCALD cultural competence training, is characterised by practitioners interdependence with co-workers; personal change and transformation; alliance with groups other than one's own; adding to their knowledge-base by conducting research; developing new therapeutic approaches based on cultural considerations; follow-through by taking social responsibility to fight discrimination and advocating for social inclusion for all ethnic groups.

An examination of the evidence in culturally adapted evidence-based or emperically supported interventions

Author: Helms JE

Summary: Meta-analyses of culturally adapted treatments examined the incorporation of measures of racial and ethnic cultural dynamics as explicit factors in interventions. Standard measures were not adapted to address cultural influences nor were symptoms defined from participants' cultural or racial experiences. Although criteria for judging good research design exist, they may or may not be feasible for research with non-dominant racial and ethnic groups and there are no paradigms for developing or interpreting measures to incorporate ethnicity and racialised experience. Principles based on cross-cultural assessment research suggest how measures of culturally adapted interventions for non-dominant ethnic and racialised groups could be developed.

Comment: This article is concerned with how good is the cultural evidence for evidence-based mental health practice. I checked out the New Zealand National Ethics Advisory Committee (NEAC) 2012 *Ethical Guidelines for Intervention studies* and for *Observational research, audits and related activities*, which offer researchers the following directions on research with culturally and linguistically diverse groups.

"As they conduct observational studies, investigators should understand, respect and make due allowance for diversity among participants and their communities." See also the Code of Rights, Right 1(3): *"Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori."*

Studies which constitute more than minimal risk and therefore require an ethics committee review include *"People with English as a second language and/or a different cultural background to the investigators (for studies whose details are primarily, or only, stated in English)"* (NEAC, 2012). Helpfully, Helms suggests that researchers undertaking studies of CALD responsive mental health interventions use treatment and measurement equivalence assumptions including: inquiring about the participant's linguistic background and administering measures in the participants preferred language; developing or interpreting measures according to what is culturally normative in the participants' culture; and using standard procedures of back translation to assure the researcher that the items have the same meaning to study participants.

Reference: Transcult Psychiatry 2015;52(2):174-97
Abstract

Practice to research: Integrating evidence-based practices with culture and context

Authors: Weisner TS and Hay MC

Summary: Culturally competent services and evidence-based practices improve the patient, family and community experience of health problems, and increase the effectiveness of practitioners. Partnership research models integrate culturally competent services and evidence-based practice, involving both clinicians and practitioners in research and integrating qualitative and quantitative mixed methods. Examples of integrated culturally competent services and evidence-based practice include: ongoing collection of patient, clinician and staff information (evidence farming); continuous improvement and study of activities and accommodations; and use of evidence of tacit, implicit and explicit cultural scripts and norms. Collaborative partnerships produce research with both culture and context, establishing stronger research models, methods and analysis units.

Comment: Weisner and Hay (2015) highlight the need for "practice to research" models, rather than "research to practice" models of evidence-based practice. Their point is that few interventions, no matter how well researched, will be implemented in the daily routines and activities of practitioners and service planners unless they are relevant to their local mental health care setting. They therefore recommend an "evidence farming" concept which focuses on local populations and their clinical situations and sociocultural contexts. Collaborative partnerships in New Zealand between researchers, clinicians and subsets of participants can be effective in producing evidence-based practice that is culturally contextual with better outcomes for CALD clients and their families. Some good examples of localised, culturally appropriate evidence-based practice studies are included in the report on the WDHB Asian Health Awareness Week – Mental Health presentations August 18th 2015.

Reference: Transcult Psychiatry 2015;52(2):222-43
Abstract

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to read previous issues of Asian Health Review

Disclaimer: This publication is not intended as a replacement for regular medical education but to assist in the process. The reviews are a summarised interpretation of the published study and reflect the opinion of the writer rather than those of the research group or scientific journal. It is suggested readers review the full trial data before forming a final conclusion on its merits.

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Practitioner characteristics and organizational contexts as essential elements in the evidence-based practice versus cultural competence debate

Author: Jackson VH

Summary: Different pathways providing relief for mental health challenges reflect differing tacit assumptions about the human condition and lead to disagreements over the intervention strategies best suited to individuals or populations. Although evidence-based practice and culturally competent services have been viewed as opposites, neither captures all elements embodying the full treatment experience. Although rarely included in the discourse, a framework is presented that includes the practitioner's personal identity and the organisational context as elements that serve as active agents in the therapeutic relationship.

Comment: In the context of the evidence-based practice versus cultural competence debate, Jackson (2015) highlights the importance to the effectiveness of the therapeutic relationship of practitioners who are on a journey of cultural competence. However, practitioners cannot act in isolation and organisational cultural competence is also critical. Organisational contexts best reflect cultural competence by: valuing the importance of culture and language; acknowledging the role of racism and discrimination; and recognising the need for continuous cross-cultural education and learning for the benefit of the workforce and the clients.

Mental health practitioners, planners, service managers and clinical leaders can begin their journey to cultural competence by accessing the New Zealand eCALD website www.ecald.com where they will find useful cultural competence self-assessment tools (See http://www.ecald.com/Resources/Cultural-Competence-Assessment-Tools).

For organisations wanting to become CALD culturally competent, a useful framework is the WDHB (2014) *Best Practice Principles: CALD Cultural Competency Standards and Framework* http://www.ecald.com/Resources/Resources-Publications/ID/830/Waitemata-DHB-Best-Practice-Principles-CALD-Cultural-Competency-Standards-and-Framework-2014

Reference: Transcult Psychiatry 2015:52(2):150-73
Abstract

Reconciling evidence-based practice and cultural competence in mental health services: Introduction to a special issue

Author: Gone JP

Summary: Evidence-based practice and cultural competence represent influential mandates in mental health. Evidence-based practice advocates seek standardisation of clinical practice in mental health services by using only treatment with scientifically demonstrated therapeutic outcomes. Cultural competence advocates seek diversification of clinical practice with treatment for a multicultural clientele having a wide variety of psychological orientations and life experiences. The collision of these mandates poses a fundamental challenge to the accommodation of substantive cultural divergences in psychosocial experience in the context of narrowly prescriptive clinical practices and approaches. Interdisciplinary conversations between and among anthropologists, psychologists, psychiatrists, and social work researchers are required.

Comment: Gone 2015 rightly states that the challenge is to accommodate nontrivial cultural divergences in psychosocial experience, without either requiring a complete abandonment of clinical expertise (a trivialisation of professional knowledge), or embracing merely superficial alterations in professional conventions toward otherwise familiar therapeutic objectives (a trivialisation of cultural difference). Mental health practitioners can access peer reviewed, evaluated mental health CALD cultural competency training (online or face-to-face) on the eCALD website http://www.ecald.com/Courses/CALD-Courses-Overview/Courses-for-Working-with-Patients and additionally supplementary resources on working in mental health settings with Muslim peoples; working with Asian mental health clients; and working with Middle Eastern and African mental health clients. The eCALD cultural competency training has been developed for the New Zealand mental health workforce as a collaboration between clinical leaders; service providers and Asian, refugee and migrant stakeholder organisations.

Reference: Transcult Psychiatry 2015;52(2):139-49
Abstract

Time spent reading this publication has been approved for CME for Royal New Zealand College of General Practitioners (RNZCGP) General Practice Educational Programme Stage 2 (GPEP2) and the Maintenance of Professional Standards (MOPS) purposes, provided that a Learning Reflection Form is completed. Please **CLICK HERE** to download your CPD MOPS Learning Reflection Form. One form per review read would be required.

Time spent reading this publication has been approved for CNE by The College of Nurses Aotearoa (NZ) for RNs and NPs. For more information on how to claim CNE hours please **CLICK HERE.**

REPORT ON THE WDHB ASIAN HEALTH AWARENESS WEEK – MENTAL HEALTH PRESENTATIONS AUGUST 18TH 2015

The WDHB Asian Health Awareness Week showcased a range of models of best-practice in mental health and addiction services; research studies and service developments including:

- **Sue Lim and Kelly Feng's** presentation on consumer views of the WDHB Asian Mental Health Cultural Support Coordination Service (AMHCSC). Information about the WDHB AMHCSC model can be found on this website (http://www.healthpoint.co.nz/public/other/waitemata-dhb-asian-health-support-services/asian-mental-health-cultural-support-coordination/). Asian mental health consumer's voices are rarely heard in mainstream consumer feedback surveys. The Consumer Satisfaction Survey which the service undertook from April 2013-14 was the first of its kind in NZ and offers a robust methodology for the inclusion of Asian views in service evaluation surveys. Importantly, there was a good response rate to the survey at 64% and participation from across the spectrum of Asian groups settled in the WDHB region. Translation into Chinese and Korean and interpretation for the range of other languages was the key to participation. The survey found the service helpful and that client's recovery was well supported; the service was readily accessible and culturally appropriate. Clients reported that information provided in the language of the client was highly valued.
- **Dr Gary Cheung's** research on depression and suicidal behaviours in older people has identified three predictive factors, which should alert the clinician to the risks of suicide: depression; poor self-rated health and lack of support. Importantly, clinicians can utilise a number of factors to foster resilience in the older Asian person. These are the older person's coping skills; their religious and spiritual beliefs; and support from family, friends and community.
- **Assoc Prof. Elsie Ho and Patrick Au** have completed a research study on suicide trends among Asian New Zealanders compared to the general population in New Zealand, the factors which influence suicide and how well services are doing in terms of assessment, prevention and postvention of suicide within Asian communities. The number of suicide deaths among Kiwi Asians has been on the rise in recent years. While overall suicide rates for Asians are lower than that of the general population, the rates for Asians aged 65 years and above are higher than those of the general population in the same age bracket. Furthermore, Asian New Zealanders also have a lower male-to-female suicide gender ratio. The project reviewed both international and national literature on suicide in relation to Asian people, to identify recent trends as well as risk and protective factors for these communities. Particularly, the influence of migration and its accompanied cultural transitions, such as the disruption of traditional family structures and changing roles of its members, was explored. Addressing suicide within NZ's Asian communities is important as it may be the final outcome of a variety of acculturation stresses that have been overlooked. Furthermore, it is becoming a concerning issue as the NZ Asian population grows and becomes more ethnically diverse.
- **Dr Aram Kim** presented on ethnicity & response to psychotropic medication. Biological and ethnicity based sensitivity is an important factor affecting the cross-cultural application of psychotropic medication. It was previously thought that medication responses were universal. However, research has shown that there are ethnic variations in responses to medications and that clinician awareness of this helps to build therapeutic alliance in medication treatment. Up to 50-70% of Asians are intermediate metabolisers. The clinical implications are that Asian groups may require lower than normal doses of medication and may be more sensitive to side effects. There are also a number of other factors involved in prescribing including drug interactions with other medications and traditional medicines as well as diet.
  Other environmental and dietary and psycho-socio-cultural factors affect both the kinetics and dynamics of medication. In summary, Dr Kim's advice is "Start low, go slow"
- **Dr Roshini Peiris-John** presented on the mental health of New Zealand secondary school students. The study was derived from analysis of: the University of Auckland Youth 2007 study; The Health and Wellbeing of Secondary School Students in New Zealand Suicide Behaviours and Mental Health in 2001 and 2007, and Stability and Change in the Mental Health of New Zealand Secondary School Students 2007–2012: Results from the National Adolescent Health Surveys. The analysis group was 12% Asian. One finding was that depressive symptoms were more common in Asian students (13.5%) than NZ European students (9.3%). Compared to non-immigrant peers 1st and 2nd generation immigrants had lower risks of smoking cigarettes; 1st generation immigrants has lower risks of consuming alcohol and marijuana weekly; 2nd generation immigrants has similar risks of consuming alcohol and marijuana weekly (Di Cosmo et al., 2011). A high proportion of Asian youth enjoy good health with positive family and school connections. However, disproportionately higher proportions, compared to NZ European reported depressive symptoms; being victims of bullying; ethnic discrimination and difficulties accessing health care. The Asian Youth Project conducted by Agnes Wong, Roshini Peiris-John, Amritha Sobrun-Maharaj and Shanthi Ameratunga in 2013 found that Asian students were predominantly concerned about racism and discrimination. Students who experienced ethnic discrimination were less likely to report good self-rated general health and were more likely to have adverse outcomes including: depression, cigarette smoking and self-rated school achievement (Crengle et al., 2012). Mental health and wellbeing of Asian youth is influenced by: migration experiences; social and economic determinants; racism and discrimination; sources of resilience, especially connections to families, communities, schools and employment opportunities; and poor access for emotional health needs particular attention.

Waitemata District Health Board
Best Care for Everyone

The Opening Celebration Event for Waitemata DHB's Asian Health Week was held on 17th August 2015

Asian Health Services are celebrating a decade of achievements in providing innovative culturally appropriate and quality services to Asian clients and families.

Three Key Initiatives Were Launched

- Our **Asian Health Week Seminar** on **"The Health of Asian Populations in New Zealand"** which showcases the latest research and information on the health status of Asian populations in New Zealand.
- The **national roll-out** of Asian Health Services' **eCALD™ courses and resources** and the new **eCALD™ website** www.eCALD.com. eCALD™ courses and resources are funded by the Ministry of Health via the Northern Regional Alliance (NRA) Ltd.
- The **"Asian Health in Aotearoa 2012-2013: trends since 2006-2007"** study conducted by Professor Robert Scragg. This report was commissioned by the Northern Regional Alliance Ltd and is the third report completed by Professor Scragg on Asian health trends using the NZ Health Survey data beginning in 2002.

For more information contact Ivan.Yeo@waitematadhb.govt.nz

- **Dr Hagyun Kim** presented on the occupational experiences of Korean immigrants settling in NZ. Despite Koreans being the fourth largest group of Asian immigrants in New Zealand, their experiences of settling in New Zealand have been largely unheard. Language barriers and limited social networks, compounded by prejudice and discrimination towards Korean migrants have limited participation in chosen occupations with impacts on physical and mental health, alongside family's financial security.

- **Jungim Cho,** presented on – "A Case of Contagion: Can Psychological Maladjustment of First Generation Korean Migrants be transmitted to Successive Generations?" In Jungim's experience, an aspect often missed in counselling Korean clients is the impact of war trauma on the older generation and how this affects the relationship between older and younger generations. Korean peoples lived through war from 1909 to 1953 resulting in multiple losses and psychological trauma to Korean people. Many suffered enduring personality and attitudinal changes characterised by hostility and mistrust, which in some cases is passed on to the second generation. These issues are exacerbated by the stress of migration. Understanding the impact of trauma can lead to more empathic relationships between younger and older generations.

- **Khalid Shah**, local service coordinator for WDHB Adult Mental Health services has developed the Muslim Mental Health Awareness Project. The project, the first of its kind in New Zealand, has explored the needs of Muslim communities and developed training both for practitioners working with Muslim clients; as well as for Imams in recognising and responding to mental health issues in the Muslim community. The purpose of the project was to increase Imams' and community leaders' understanding of available mental health services and their knowledge of how to access these services to improve early access for Muslim consumers to mainstream metal health services, to develop a clear pathway for community mental health teams to access Muslim cultural support/guidance, and to agree on an access pathway for mental health service users to link with support/education activities that operate through Mosques and other Muslim social services. The project ran 'mental health workshops' at a Mosque in West Auckland to raise awareness and help de-stigmatise mental health. The project was successful in raising Imams' awareness of mental health issues, services, and access pathways, supporting them to act as guides/resources within Muslim communities and establishing relationships between the local Imams/other Muslim community leaders, and community mental health services. Practical Tips for Working with Muslim Mental Health Clients can be accessed at: http://www.ecald.com/Portals/49/Docs/Toolkits/Toolkit%20Muslim%20MH%20Clients.pdf

- **The Asian Smokefree Communities Service (http://www.comprehensivecare.co.nz/services-and-programmes/addictions/smokefree-communities/)** is a highly successful service started by WDHB Asian Health Service in 2006. The service now provided by Waitemata PHO has Korean, Chinese and Hindi speaking coordinators. The team use nicotine replacement therapy alongside Cognitive Behavioral Therapy, motivational interviewing and counselling. The Asian Smokefree Communities Service offers a range of programmes and support for people who want to stop smoking in English, Chinese (Mandarin and Cantonese), Korean, Hindi and Gujarati and additionally provides interpreters for speakers of other languages.

- **Rebecca Zhang –** Community Alcohol and Drugs Services (CADS) – Asian Counselling Service. The regional WDHB CADS Asian Counselling Service is the only Asian focused, community based, alcohol and drug service in New Zealand. The CADS-Asian counselling service team as well as offering support for those with alcohol and/or drug problems also offer help with gambling problems. The services offered are in Chinese (Cantonese and Mandarin), Korean and English languages. The services include information and education, individual and family counselling services, both face-to-face, online, and referrals to other health professionals where required.

Exciting News!!

Culturally And Linguistically Diverse

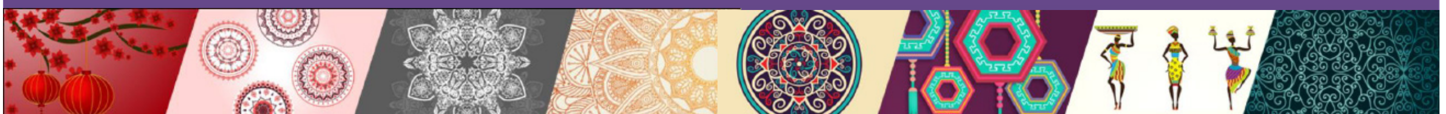
CALD Cultural Competency Courses are going national on 28th August 2015

eCALD™ provides a range of online and face-to-face training courses for the New Zealand health workforce to develop CALD cultural competencies.

We are pleased to announce that all District Health Boards' workforces will be eligible to access free CALD cultural competency online and Auckland-based face-to-face courses from 28th August 2015.

eCALD™ courses and resources are developed and managed by Waitemata DHB's Asian Health Services and funded by the Ministry of Health via the Northern Regional Alliance Ltd.

(CALD refers to culturally and linguistically diverse groups who are migrants and refugees from Asian, Middle Eastern, Latin American and African (MELAA) backgrounds).



For further information about courses and resources, eligibility, cost and registration details please visit

www.eCALD.com

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