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FINAL REPORT

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Prepared for Te Pou

Asian Mental Health *Training and Development for Real Skills*

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On behalf of:
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For:
Te Pou
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Health Research, Information and
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Asian Mental Health

Training and Development for Real Skills

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Finally, we wish to thank Ms. Roby Shearer, Associate Professor Sandy Simpson and Mr. Martin Molly for their kind words, and notes of encouragement in Forewords.

Samson Tse

Conflict of Interest Statement

All members of the project team involved in the present project and production of the Final Report are employed by universities or organisations with whom they are affiliated.

The project team declares no conflict of interests to this research project.

Disclaimer

This report summarises key findings associated with developing a 'Real Skills' training curriculum for Asian mental health. Members of the project team have taken all care to accurately capture and interpret the views of training institutions while maintaining their privacy and confidentiality.

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Foreword by Ms Robyn Shearer

Asian peoples make up the biggest and fastest-growing ethnic community in New Zealand. Statistics New Zealand (2006) estimates that 9.5% of New Zealand's current population is Asian. This proportion is expected to grow to almost 15% of the national population by 2020.

Cultural capability of the workforce, especially the mental health workforce, is essential to ensure that Asians have equity in access to appropriate and high quality services. This includes individual practitioner-client transactions and relations, as well as the systems and organisational cultures within which care is provided. However, there have been few practical projects aimed at developing the workforce to meet the health and social services needs of the New Zealand Asian population. The Office of Ethnic Affairs and other research data show that health and social services are under-utilised by Asians, and that one of the barriers to utilisation is that services are not responsive to cultural differences or needs. Clearly, it is time for health practitioners in New Zealand to become culturally responsive in working with Asian clients.

This current project: Asian Mental Health: Training and Development for Real Skills, aligns itself well to the workforce development initiative led by the Ministry of Health in conjunction with Te Pou, The National Centre of Mental Health Research, Information and Workforce Development. It is an opportunity for tertiary educational institutions across New Zealand to get involved and ensure that undergraduate health students seeking a career in mental health complete their qualifications with some understanding of Asian mental health needs and issues.

With the rapid growth in the Asian population residing within New Zealand, the creation of a curriculum aimed at 'training and developing real skills in Asian mental health' amongst undergraduate health professions has arrived at a critical time in the changing face of New Zealand communities and health care.

We hope this resource provides an opportunity for further developing a workforce that provides the care and treatment required to effectively work with Asian service users and their families – in the right way, at the right time.

Robyn Shearer

**Group Manager (Acting)
Mental Health Group, Population Health Directorate
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Foreword by Associate Professor Sandy Simpson

The key to all clinical interaction is the development of a shared understanding between the person in need of care and support, and often their family too, and those of us as clinicians who have the ability to help them. Shared understanding facilitates the evaluation of the problems the person has, and allows for the matching of the range of potential interventions that may benefit the person to their particular needs and preferences. Development of a shared understanding has many barriers: the personal skills of the clinician, the particular type of problem the person is presenting with and the cultural assumptions that both bring to the interaction. These issues commence long before the clinical interaction occurs, of course. Help seeking behaviour is culturally determined and service design and provision is often the manifestation of cultural values also.

If we are to provide services that meet the needs of those we serve, we must understand these dynamics at an individual practitioner level through to the service purchase and design level.

This project is a significant contribution to this process for practitioners working with people of Asian ethnicity, especially relevant to those who are recent immigrants and less likely to understand the structure of New Zealand health services. As the authors point out, recent immigrants are an increasingly important proportion of the people we serve and their particular needs are very important to understand. We have all had experiences when we do not understand the social and cultural landmarks that allow us to feel safe and secure. At a time when one is unwell, especially mentally unwell, service responses must be able to acknowledge those landmarks, or the pillars of values, culture and meaning, that support our mental wellbeing.

This project, and the CD it has produced is a very valuable tool to help develop practitioners with the skills to work in a culturally responsive and safe mental health system. In commencing on self reflection, it encourages us to understand our own culture before we engage with others, the type of reflective practice necessary for all cross cultural practice. The information on Asian philosophy, help seeking behaviour and cultural concepts of health and sickness is succinct and accessible, presented in a manner that is easily understood and should have successful learning outcomes. Clearly the feedback from the tertiary providers indicates this is so.

This work is to be celebrated and I want to acknowledge the fine work of all who have contributed to it. May it enhance understanding and help equip us all as health practitioners who can be responsive to our communities.

Sandy Simpson

**Hon Clinical Associate Professor, University of Auckland
Clinical Director and Director of Area Mental Health Services, Auckland Regional
Forensic Psychiatry Service
Acting Regional Director Mental Health, Northern DHB Support Agency**

Foreword by Mr Martin Molly

The Te Pou Workforce Programme's ultimate goal is to ensure better mental health outcomes for service users. It is working to achieve this by building both the capacity and the capability of human resources within the mental health sector.

The way people who work in the mental health and addiction sector think, speak and act can have an enormous impact (positively or negatively) on the speed and fullness of recovery for someone who is experiencing mental illness

In recent years, there has been considerable investment in training and development in the sector, yet there are still stories from service users about disrespectful and harmful mental health services.

With the changing demographic of New Zealand we must be ready to assist the current and future workforce to be able to work alongside service users most effectively. We believe that this programme goes towards enabling our future workforce to do this.

Te Pou has a charitable purpose and remains committed to developing the sector and being a conduit for knowledge, learning and, above all, inspiration. With this in mind programmes that we fund are made available free for all to use.

I would like to personally acknowledge and thank everyone who has been involved in the development of the Asian Mental Health Training and Development Real Skills training tool, your hard work, commitment and above all else passion in this work shows in the quality and usefulness of this exciting and innovative training tool.

Martin Molloy

**Te Pou, The National Centre of Mental Health Research, Information and Workforce Development
Project Development, Asian projects portfolio**

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Executive Summary

Context

In 2006, following the successful implementation of 'A Beginning Phase of Mental Health Training in Aotearoa, New Zealand' it became apparent that there was both a need and a demand from practitioners for more resources and knowledge pertaining to the mental health needs of Asian peoples in New Zealand. A key recommendation from the final report was for the ongoing development and delivery of an education programme covering both theoretical, in-depth analysis of relevant cultural issues, and its practices, with a view to effect changes on attitude, affect and behaviours

Aims

The specific aim of this project is to create an educational programme loaded on an interactive CD focusing on Asian mental health for use within tertiary educational institutions across New Zealand as part of undergraduate health programmes.

Methods

Drawing on models of teaching and learning, and methods to improve cultural capability, in addition to information identified in literature and in consultation with Asian mental health service users and tertiary institutions, a curriculum on Asian mental health was compiled and formatted on an interactive CD. This CD was then delivered to over ten tertiary education institutions across New Zealand for implementation in their undergraduate health programmes.

Outcomes

Initial response by tertiary education providers indicated a high level of enthusiasm and welcome for this type of educational resource. There was unanimous acknowledgement within the education sector of the growing demand for students to be culturally aware and responsive to differing cultures within New Zealand when practicing as a member of the workforce.

The CD consists of three modules: Self-reflection, Asian Philosophy and Clinical Issues. The CD seeks to increase learners': 1) self-awareness when engaging in cross-cultural communication, 2) knowledge about major Asian health-related philosophy and values, 3) understanding of key considerations when working with Asian mental health clients, 4) ability to begin developing culturally appropriate skills in working with Asian clients and 5) awareness of key literature on relevant topics. Following further meetings and delivery of the CD to identified tertiary education institutions, responses overwhelmingly indicate that this would be an invaluable resource for inclusion in the curricula of undergraduate health programmes.

Key Recommendations

This project is a positive step in assisting tertiary education providers to educate undergraduate health students on the mental health needs and issues of people from

diverse cultural backgrounds in Aotearoa, New Zealand. However, there is a demand for more training across the nation. Thus, this project has to be seen as a beginning towards implementing a training curriculum at a nation wide level.

In conclusion, the outcomes suggest that the Asian Mental Health: Training and Development for Real Skills Project should:

1. Continue to promote partnerships with tertiary training providers and other identified stakeholders to support delivery of training and create clear qualifications pathways into the sector.
2. Continue to develop and make accessible this resource to all students interested in a career in mental health.
3. Research and evaluation: Develop evidence-based processes to underpin the delivery of the Asian Mental Health: Training and Development for Real Skills Programme.

Chapter 1: Introduction

Asian peoples make up the fastest growing ethnic community in New Zealand. The Asian population doubled in the decade between 1991 and 2001, and currently makes up 9.2% of the New Zealand population (Statistics New Zealand, 2006). This figure is projected to grow to approximately 15% by 2021.

The Asian population comprises a diverse range of Asian communities and cultures with their unique worldviews that impact on their ways of being. This includes their responses to mental health issues. There are several initiatives being undertaken taken by the Ministry of Health to identify the health needs and issues of the Asian population and many services and resources are now available to this group. However, a key issue facing mental health services is a shortage of appropriately trained specialist workforce. According to the “Strategic Principles for Workforce Development in New Zealand” (Health Workforce Advisory Committee, 2006), New Zealand currently relies on overseas practitioners to “ensure the availability of appropriate health services for specific ethnic communities” (p. 8). The report further acknowledges a need for New Zealand to ensure a sustainable supply of practitioners skilled in addressing cultural factors within the workplace. Access to a highly skilled, culturally competent and effective mental health workforce can, however, only be achieved with the collective participation by a variety of stakeholders such as the funders and planners, the District Health Boards (DHBs) and education and training organisations.

To address this need and provide more appropriate services, mental health practitioners must become more knowledgeable about the profound and intrinsic impact of cultural factors on the prevention, presentation and treatment of mental health issues; and every aspect of training and psychotherapy (Falender & Shafranske, 2006), and more skilled in interacting with Asian peoples. In response to this need, the Centre for Asian Health Research and Evaluation (CAHRE) within the University of Auckland, in conjunction with Pou, The National Centre of Mental Health Research, Information and Workforce Development, has developed this project, the aim of which, is to equip tertiary education teachers to deliver preparatory information regarding Asian immigrant mental health issues within their nominated institutions.

1.1 Objectives of Current Report

1. Outline the progress of the Education Programme, including: development of the project team, overview of curriculum components and compilation of materials used in the programme;
2. Provide a review of the scoping exercise;
3. Evaluate effectiveness and report on results of the Education Programme; and
4. Identify specific mechanisms/pathways to align the Education Programme with Continuing Education/Competence Plan of key professional groups.

1.2 Aims and Objectives of Present Project

The general aim of this project is to equip teachers within tertiary education institutions to feel confident in using and delivering preparatory information on Asian mental health issues to undergraduate students within their respective programmes.

1.2.1 Objectives:

1. Collate resources/literature on information pertaining to mental health issues for Asian peoples for consideration of inclusion in the programme.
2. Develop an Asian mental health education programme for teachers that can be taught to students studying in health programmes; with the objective that these teachers are available as a resource within their institutions to deliver the programme to undergraduate students. The education programme will build on past work developing a workshop module outlining the topics to be taught and methods for teaching, as well as provide resources such as a CD to supplement research findings.
3. Implement the education programme nationwide with teachers from tertiary institutions who volunteer to participate in the programme.
4. Provide telephone and email support to teachers during implementation.

1.2.2 Four phases:

The objectives were achieved through the following four phases:

1. Phase One: Collate programme resources
2. Phase Two: Scoping exercise - To find out how many tertiary providers there are across New Zealand and the undergraduate health programmes each institution offers; and to identify and evaluate what is on offer regarding Asian mental health issues within the current curriculum.
3. Phase 3: Develop an education training programme that teachers can deliver as part of current curricula. This programme will include advice on best delivery methods such as a two-hour lecture or a three-hour interactive workshop.
4. Phase 4: Meet with teachers to deliver training programme and offer support.

1.2.3 Outcomes:

Utilising appropriate teaching-learning technology including online, electronic and printed options, and the experience accumulated from previous Asian mental health workforce training, the project:

1. Has developed an Asian mental health education programme for teachers in tertiary education institutions to increase their capability to deliver preparatory

information regarding Asian mental health issues to students studying in health programmes.

2. Will provide support to the teachers while they implement the material on Asian mental health issues, on offer as part of the programme.
3. Will generate a group of tertiary education teachers who will facilitate the education/training of students within their respective programmes in Asian mental health issues. This will ensure sustainability for the future in terms of enhancing workforce capacity to work with Asian clients.

1.3 Project Team

AP Samson Tse, director and key contributor to previous Asian Mental Health Workforce Development training was the principal investigator on this project. His role was to oversee the project, ensuring that the project met the proposal objectives and reached completion on time. In addition, Samson provided the link between the project team and Te Pou. As the project leader, Dr. Amritha Sobrun-Maharaj brought a depth of experience in terms of education and service delivery. Amritha's roles included collating resources required for developing an Asian mental health programme as well as designing the overall programme.

Ms. Shoba Nayar was involved as a research fellow, assisting with the development of the education programme and primarily facilitating the scoping exercise. Ms. Cherry Hsu was the fourth member of the research team. She brought to this project an expertise in delivering teaching modules using educational technology; in particular, formatting the interactive CD as part of the education programme.

To support the project team, an Advisory Group was established to ensure the development of an education programme that met the needs of students and represented the experiences of Asian service users.

1.3.1 Advisory Group:

The advisory group was created to aide the project team in three key areas. First, to provide the perspective of Asian peoples who have experienced first hand what it is like to receive intervention from New Zealand mental health services. Second, inform the project team in terms of other activities currently being undertaken in the mental health sector; and third, assist the team in the creation of an interactive CD housing the education programme.

Members of the advisory group included:

Ms. Jo – Jo is Chinese and is currently a user of mental health services.

Mr. Mathijs Lucassen – Mathijs has experience in developing a learning resource using multimedia.

Associate Professor Manying Ip – an experienced teacher and researcher at University of Auckland in Asian Studies, with valuable knowledge and expertise in the area of

Asian philosophies. Dr. Ip was not able to attend the Advisory Group Meeting but she shared her teaching resources when Samson Tse went to meet her twice individually.

Dr. Shizuka Torii – currently working in private practice as a psychotherapist and at the University of Auckland in the students' disability sector, Shizuka contributed as a clinician to Module 3.

1.4 Background to the Curriculum

Central to the impetus and development of this current project was previous work in the Asian mental health sector led by the CAHRE. This includes the 'Asian Mental Health Workforce Development Feasibility Project' (Tse, Bhui, Thapliyal, Choy, & Bray, 2005) and the 'Beginning Phase of Asian Mental Health Training in Aotearoa, New Zealand' (Tse, Nayar, Thapliyal, & Bhui, 2006).

1.4.1 Asian Mental Health Workforce Development Project:

In 2006, a report on the 'Beginning Phase of Asian Mental Health Training in Aotearoa, New Zealand' (Tse, et al., 2006) was prepared. The report was a summary of a project that implemented an education programme in four main cities across the country to enhance the knowledge and capabilities of mental health clinicians working with Asian service users.

In presenting the education programme, positive feedback was received from participants, including, an acknowledgement that this type of training was much needed. The report recognised that the project was only a starting point, a "beginning phase", to implement such training nation wide. The report stated that "further development is required in terms of ensuring this training is available to all mental health clinicians working with Asian people(s) and in supporting participants upon completion of the training" (Tse et al., 2006, p. 49). Furthermore, the report offered specific recommendations regarding the future development of such training packages within the Asian mental health workforce, claiming, "it is envisaged that in the coming years, this training will be critical for not only individual mental health clinicians, but also mental health services as a whole" (Tse et al., 2006, p. 49).

This current project initially sought to develop further the education programme established in the above report. However, meetings with representatives of those involved in the mental health sector indicated an overlap in sector approaches to Asian mental health training, requiring a shift in focus for this current project.

1.4.2 Current Sector Activities:

In the initial phases of this project, team members met with representatives from Auckland and Waitemata DHBs, to outline the purpose of the project. This resulted in concerns raised by DBH representatives regarding a perceived overlap between a proposed national programme and their existing initiatives in the region. It was recognised that the programmes currently being implemented by the DBHs and the programme proposed in this project were not mutually exclusive. Discussions between

the organisations involved (spanning November 2006 to March 2007) were used to clarify the purpose of this current project and ways in which the organisations could work together to provide their respective training and best meet the needs of the sector, while avoiding an overlap in potential participants and material presented.

In March 2007, a further meeting involving members of the current project team and Northern District Health Board Support Agency (NDSA) Project Team took place. From this meeting, a clear gap in the sector was identified in the knowledge base of graduates entering the mental health workforce regarding Asian mental health needs. It was proposed that a possible way forward to proceed with this current project was to focus on training of mental health professionals (e.g. nurses, occupational therapists, community support workers, social workers, clinical psychologists) at the graduate and post-graduate level in tertiary education institutions. In essence, the training modules seek to:

1. Raise learners' self-awareness when engaging in cross-cultural communication
2. Increase learners' level of understanding about major Asian health-related philosophy and values by referring to relevant material and research studies
3. Highlight the key considerations when working with Asian mental health clients
4. Help learners develop culturally appropriate skills in working with Asian clients (at entry level)
5. Introduce learners to key literature on relevant topics

Following this meeting, members of the project team met with the funder, Te Pou, to discuss this possible change in direction. Ms. Robyn Shearer from the Ministry of Health was able to confirm that the current funding available for the project could be applied for the development of a training curriculum for mental health professionals at graduate level in the tertiary sector. Given these discussions, Te Pou was ready to proceed with the revised proposal.

Chapter 2: Curriculum

2.1 Planning the Curriculum

Compiling an education package of this nature involved much time, meetings with individuals; and consultation of literature to ensure that the most appropriate, and up to date information was included in the programme.

2.1.1 Team Meetings:

Team meetings were convened consistently throughout the duration of the project. At the start of the project, meetings were primarily centred on clarifying the purposes and place of the current project within the sector. As these issues were resolved, team meetings shifted focus to developing the education programme, including seeking input from the tertiary sector. Finally as the project drew to a close, team meetings were centred on ensuring completion of the curriculum on CD format and providing feedback on interactions with tertiary institutions. For a detailed description of these meetings, please refer to Appendix A.

2.1.2 Advisory Group:

Consultation occurred with an Advisory Group throughout this project to direct the development and implementation of the curriculum. Meetings were either face to face or over the telephone and addressed issues such as what material should be included/excluded from the curriculum, where to access best resources, identifying gaps in the development of the curriculum, and best methods for presenting the curriculum using interactive media.

2.1.3 Clinician Consultation:

Once an initial draft of the curriculum had been established by the project team, clinicians were consulted regarding content of the programme and potential involvement by way of contribution to the education programme. A summary of these meetings can be found in Appendix A and further details will be discussed later in this chapter, under 2.5 Module 3: Clinical Issues.

2.1.4 Tertiary Education Sector Consultation:

In addition to the Advisory Group and consultation with clinicians, the tertiary education sector was also consulted in the early stages to seek input into the need for such a curriculum, and the content of the curriculum. An overview of this consultation process will be discussed in further detail in Chapter 3.

2.1.5 Service User and Family Consultation:

Apart from the consultations listed above, two service users and one family member were also consulted on the need for and appropriateness of the curriculum. Specific activities include:

- One service user served as a member on the Advisory Group
- Two service users and family member were involved in recording their voices/ perspectives on “working with Asian clients”
- Through individual meetings/ visits, Samson Tse had the opportunity to give an overview of the training modules on CD and gather feedback from users and family member

2.2 Development

The curriculum aimed to provide psychological and sociological theory, and empirical information on the following three modules:

- a) Self-reflection
- b) Asian Philosophy
- c) Mental Health Clinical Issues

Each module includes:

1. Context and relevant considerations (e.g. values, principles, target populations)
2. Session aims and objectives
3. Session content
4. Teaching and learning activities and corresponding objectives
5. Teaching resources/material
6. Key references

The CD training programme is a mixture of both *interactive and didactic learning* that allows for both *teaching of skills and knowledge*, and *participant reflection*. In addition, training sessions involve the use of *case studies* (e.g. first person account, personal experiences as a service user or caregiver), promoting reflective practice and clinical reasoning.

2.2.1 Methods:

This project focuses on providing theoretical material that supports the learning of cultural competence in undergraduate mental health students, focussing on Asian immigrant mental health issues. This includes psychological and social theory relevant to these issues.

The following approach for multicultural competencies for practice provided by Hansen, Pepitone-Arreola-Rockwell, and Greene (2000) is considered useful for infusing multiculturalism in general into this training curriculum, and is incorporated into the three modules:

1. Awareness of how one's own cultural heritage, gender, class, ethnic identity, sexual orientation, disability, and age cohort help shape personal values, assumptions, and biases related to identified groups (*Module 1*).
2. Knowledge of the following factors:
 - historical and cultural embeddedness and change of psychological theory, inquiry methods (*Module 1*), and professional practices (*Module 3*).
 - history, manifestation, and psychological sequelae of oppression, prejudice, and discrimination (*Module 1*).
 - socio-political influences (e.g., poverty, stereotyping, stigmatisation, and marginalisation) impinging on identified groups (*Module 1*).
 - culture-specific diagnosis (*Module 3*); normative values about illness, worldview, family structures, and gender roles; impacts on personality formation; developmental outcomes; and manifestation of illness (*Module 2*).
 - culture-specific assessment techniques (*Module 3*).
3. Ability to do the following: (*Module 3*)
 - evaluate emic (conceptions common to a particular ethnic or minority group) and etic (conceptions universal to people across culture) hypotheses.
 - self-assess multicultural competence.
 - modify assessment tools and qualify conclusions.
 - design and implement nonbiased effective treatment plans and interventions for multiple groups.

2.3 Module 1: Self-reflection

2.3.1 Context and Relevant Considerations:

A recognised barrier to implementing culturally competent service is the lack of focus on self-knowledge and exploration, both cognitive and emotional in mental health training (Carter, 2001). Consequently, trainers and practitioners have an academic view of culture, distant from their own personal being. Self-awareness involves developing a basic understanding of life, society and the concept of culture, and knowing oneself as a cultural being, i.e. worldviews, attitudes, values, assumptions, beliefs, behaviours, prejudices and preconceived ideas. This can be attained through self-reflection, which will enable understanding of one's own culture to facilitate understanding of another's culture, and respect and empathy for others. Self-knowledge and awareness of one's own cultural self are critical preconditions to cultural awareness (Falender & Shafranske, 2006). Understanding of one's own and others' cultures will be done within the New Zealand context.

Although self-awareness is a component of cultural competence, incorporation of an integrated awareness, understanding, and competence with one's own cultural or multidiverse background has been slow to appear in training environments (Falender & Shafranske, 2006). An important consideration to be taken into account during this module is that self-reflection can be an uncomfortable and threatening experience. The

process of self-discovery and acknowledging one's own cultural biases and prejudices may induce resistance, defensiveness and inhibition (Abreu, 2001).

Cultural relevance:

Cultural values, beliefs, and practices, as well as relevant historical events, have to be considered in developing a curriculum, to avoid ethnocentrism and encourage cultural awareness. Ethnocentrism is best described as the assumption that all cultures function similar to one's own, which often means mainstream, dominant culture (Cavaiola & Colford, 2006). Cultural awareness refers to acknowledging and appreciating the different values, beliefs, behaviours, and rituals of a particular culture (Cavaiola & Colford, 2006). Developing a culturally aware curriculum is important to better equip mental health professionals to work with culturally diverse clientele, and to ensure that clients are understood by mental health professionals, and feel confident that they will have their needs met. Therefore, cultural factors, such as family, community, religious/spiritual beliefs, and practices, and relevant historical events impacting on the lives of ethnic minorities have been carefully considered when developing the curriculum.

2.3.2 Session Aims and Objectives:

The *aim* of an exercise in self-reflection is:

- To get participants to know and understand themselves and increase self-awareness

The *objectives* of self-reflection are to enable participants to:

- Identify their own ethnic origins, culture, values, attitudes, prejudices, preconceived ideas and assumptions, and their origins and influences
- Increase their multicultural awareness, understanding and appreciation
- Understand the concept of cultural competency
- Develop a framework for: understanding and appreciation of other cultures including similarities and differences between cultures, respect and empathy
- Identify cultural influences on the way people think and act
- Understand the role of stereotypes in cross-cultural work
- Recognise and overcome barriers to cross-cultural communication
- Recognise and develop an understanding of personal limitations and the importance of seeking supervision and mentoring when branching out to a new area of practice

2.3.3 Session Content:

The module provides psychological and sociological theory and practical information on:

- Developing self-awareness: Understanding yourself as a cultural and environmental being, identifying your own attitudes, values, prejudices, preconceived ideas, your worldview and their worldview
- Understanding the New Zealand context
- Understanding the concept of culture
- Understanding the concept of cultural competency

Self-awareness:

Self-reflection is an important process for developing personal self-awareness, and personal self-awareness is an essential element of cultural competence. Self-awareness of one's own culture, biases, and beliefs is a necessary step in developing cultural competence (Bigby, 2003). To understand how they relate to others, clinicians must first understand themselves. This requires personal self-reflection and self-critiques of the various personal, historical and social influences that impact on our conduct.

Clinicians draw on both personal and professional sources during psychological treatment. The values derived from these sources often become intertwined to the point of being impossible to differentiate amongst them. Clinicians must understand the influences, "from conscious beliefs and culturally embedded values to unresolved conflicts at the margin of awareness" that influence their practice (Falender & Shafranske, 2006, p. 81). The theories and techniques that guide the therapeutic process are therefore infused with personal beliefs and beliefs about human nature. Hence, clinicians must be aware of the beliefs, values, and dispositions that influence their conduct.

It is also important to recognise the importance of power in multicultural settings that contribute to understandings of and beliefs about peoples, and impact on the clinician/patient relationship. The implication of not recognising power is to leave existing "traditional" ways and frameworks intact without critique and evaluation (Liu & Pope-Davis, in Pope-Davis et al., 2003). Similarly, the relevance of historical events in this power structure needs to be recognised as history shapes beliefs and attitudes. To this end, the impact of colonialism on the understanding of self and inter-ethnic understandings and relations needs exploration.

The New Zealand Context:

Acculturation Orientations: Acculturation is often considered by European host populations, including New Zealanders, to be a process that immigrants, especially ethnic minority immigrants, must achieve when living in a western society. Usually, they expect ethnic minority immigrants to assimilate into their society, i.e. they must give up their cultural identities and adopt that of the host society. However, the condition considered most appropriate by ethnic minorities globally and in New Zealand is integration (Berry, 1997), i.e. retaining ones own cultural identity and getting to know and pursuing relations with the host society - a bidirectional process. Ethnic minorities in New Zealand also perceive acculturation to be a two-way street in which both hosts and immigrants must get to know each other's cultural identities if there is to be optimal understanding and acceptance.

The acculturation orientation of the clinician is therefore crucial in understanding other cultures and reconciling cultural differences, as well as in understanding oneself. Hence, clinicians need to analyse, and perhaps reconsider, their orientations to acculturation. This will enable them to integrate their personal morality with professional ethical standards so that they may acquire an ethical identity and professional acculturation (Handelsman, Gottlieb, & Knapp, 2002, in Falender and Shafranske, 2006).

Acculturation in New Zealand:

New Zealand has long been regarded as a bi-cultural society with the two main ethnic groups being the Pakeha (European) and Maori. However, Maori appear to be more

integrated into the Pakeha culture than otherwise and this expectation is transferred to all other ethnic minorities. Accordingly, immigrants are expected to accommodate New Zealand ways (Jackson, 2006), but anecdotal evidence, especially from the media, suggests that the host population is not willing to accommodate the cultural differences of immigrants. New Zealand has clearly become a multi-cultural society and Jackson (2006) suggests that New Zealanders need to develop flexibility in interaction and understanding of others.

The Concept of Culture:

Culture is generally defined as a shared system of values, beliefs, and learned patterns of behaviour. However, it is more complex. Culture is not a thing, but a process that people adapt to over time and in which they interpret and make meanings of their daily experiences and structure their internal and external environments. Culture is not a static concept, but dynamic, changing with time (Phoon & Macindoe, 2003).

Cultural knowledge includes not only knowledge of a patient's cultural beliefs, but also an awareness of historical perspective, i.e. the way history shapes beliefs and attitudes; cultural context, i.e. the cultural norms that shape health behaviours (e.g. the role of the family in decision making), and epidemiological and biological expressions of disease and response to treatment. Clinicians should become skilled in exploring how or whether these beliefs are important or relevant to a specific individual (Bigby, 2003).

Cultural Competence:

Cultural competence is the ability to engage in actions or create conditions that maximise the optimal development of client and client systems and has been defined as: A "therapist's awareness of assumptions about human behaviour, values, biases, preconceived notions, personal limitations; understanding the worldview of the culturally different client without negative judgments; and developing and practicing appropriate, relevant and sensitive intervention strategies and skills in working with culturally different clients" (Sue, Arredondo, & McDavis, 1992, in Falender and Shafranske, 2006, p. 481).

Multicultural counselling competence extends the above definition, adding the notion of social justice. Being more operationalised to a training setting, multicultural competence includes knowledge of clients' culture and status, actual experiences with these clients, and the ability to devise innovative strategies vis-à-vis the unique client's needs. "A multiculturally competent programme instils in students these competencies, infuses minority issues into all programme courses..., and has adequate representation of minority students and faculty members" (Ponterotto & Casas, 1987, in Falender and Shafranske, 2006, p. 433).

Cultural competency is the acceptance and respect for difference, a continuous self-assessment regarding culture, an attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations (Cross et al., 1989, in Saldana, 2001). It is the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programmes that match the individual's culture and increase the quality and appropriateness of health care and outcomes (Davis, 1997, in Saldana, 2001).

2.3.4 Teaching and Learning Activities:

The following activities have been selected to assist with achieving the objectives of the course:

Activities	Objectives
1. Answer The Cultural Self-assessment Questionnaire (Cutler, 2005)	To introduce the concept of cultural sensitivity and to reflect on their current level of cultural sensitivity
2. Answer the Knowing Your Body Language Questionnaire (Cutler, 2005)	To raise awareness of non-verbal communication behaviours

2.3.5 Teaching Resources:

- *Web link* Cultural competency - <http://www.hogg.utexas.edu/PDF/Saldana.pdf>
- *References* – A list of pertinent readings are referenced at the end of the module along with a brief synopsis of each reading.

2.4 Module 2: Asian Philosophy

2.4.1 Context and Relevant Considerations:

Recent New Zealand demographics (Statistics New Zealand, 2006) indicate that attention to Asian cultural issues in mental health is a necessity, not an option. To date mental health treatment has had a Eurocentric bias. It is now imperative that the mental health workforce becomes culturally competent in Asian culture, its impact on mental health and its implications for treatment. Falender and Shafranske (2006) suggest, it is time “to integrate the strengths of culture and diversity into pedagogy and conceptual frameworks” (p. 117). The appreciation of and education of cultural diversity will address underlying racism, prejudice and negative cultural attitudes and lead to the culturally competent practitioner considering the strengths of the individual, culture and community; and how these factors can be integrated into a plan for treatment and development.

It is suggested that culture does not feature in curricula because teachers do not know enough about cultural competency (Bernard, 1994) or diversity, that few curricula take an integrated cultural approach, and most relegate culture to a single course or just a few courses (Yutrzenka, 1995).

2.4.2 Session Aims:

- To understand the diverse ethnic subgroups within the Asian population and their cultures, worldviews, values, attitudes and religious practices
- To understand the implications of worldviews and culture for mental health
- To attain personal cultural competency in order to be able to impart this to mental health students

2.4.3 Session Content:

This module covers the “Asian” worldview, being the way people see life and the world, cultures, values and cultural and religious practices as well as commonalities of values/ beliefs across the Asian world, e.g. Collectivism, Spiritual beliefs, Family, Importance of education, Implications for mental health.

Asians

Knowledge about Asians usually constitutes information about Chinese and Indians. However, the Asian ethnic group consists of many subgroups that come from a vast Asian subcontinent with their own cultures, worldviews, values, attitudes, etc. The definition of Asian used in New Zealand is that developed by Statistics New Zealand (1996), which includes people with origins in the Asian continent from Afghanistan in the west, to Japan in the east; and from China in the north, to Indonesia in the south. It excludes people originating from the Middle East, Central Asia (except Afghanistan) and Asian Russia. Hence, the broad group “Asian” clearly consists of a diverse group of people, indeed, it covers more than half of the world’s population. Asian New Zealanders differ widely not only in language and culture, but also in socioeconomic status, English-language ability and settlement history in New Zealand. Because all these factors can impact health, there are limitations in using ‘Asian’ as a catchall ethnic descriptor. In particular, smaller ethnic minorities may be lost by averaging within the grouping, and their specific health needs rendered invisible as a result (Ministry of Health, 2006).

Despite their obvious differences, many Asian communities share common values, with a strong emphasis on family, education and community ties (Inoguchi & Newman, 1997, in Ministry of Health, 2006). These commonalities are seen in the Asian worldview.

Asian Worldview

The Asian worldview has been described as fatalistic, deterministic and collectivistic, and values reflect an emphasis on group orientation and interdependence. This worldview also emphasises cooperation and harmony, respect, duty, obligation, and self-discipline (Bigby, 2003).

Collectivism

Collectivism is a term used to describe any moral, political, or social outlook that stresses human interdependence and the importance of a collective, rather than the importance of separate individuals. Collectivists focus on community and society, and give priority to group goals over individual goals. The philosophical underpinnings of collectivism are often related to holism or organicism – the view that the whole is greater than the sum of its parts. Specifically, a society as a whole can be seen as having more meaning or value than the separate individuals that make up that society. This group orientation stems from and results in close personal ties with family, including the extended family.

Cultural Values

Culture affects one’s values, attitudes and emotional responses, and impacts on perceptions about matters of mental health. Price (1995) state “one’s culture in large

part determines how mental illness is defined, manifested, and effectively treated” (p. 17).

Interpersonal Relationships: Smooth interpersonal relationships and harmony are important to Asians. Many Asian families continue to function in a complex process of a natural support system of reciprocity within interdependent/dependent relationships based on extended family membership, group harmony and loyalty, respect for elders and authority, and kinship that goes beyond strong biological connections (McBride 1996). Filipinos consider this a core value called *kapwa*, defined as “shared identity, interacting on an equal basis with a fellow human being” (McBride, 1996). *Kapwa* is expressed as sensitivity and regard for others, respect and concern, helping out, understanding and making up for others’ limitations, rapport and acceptance, and comradeship (ibid.). Indian culture emphasises established hierarchical relationships, hence Indians are always conscious of social order and their status relative to other people, be they family, friends or strangers.

Family and Filial Responsibility: In Asian societies (South, East and Southeast), multigenerational households are accepted arrangements where respect and love for parents and older family members are taught and expected of the children. Caring for aging relatives is integrated over time into these relationships, and interdependence is deeply embedded in the culture. Many contemporary families function within an extended family structure with strong emphasis on interpersonal dynamics, group harmony and loyalty, respect for elders and authority, and maintenance of a natural support system by a complex process of building interdependent/dependent relationships and family roles (McBride 1996). This extends to Asians living abroad often sending money to their families in their home countries (Tse, Sobrun-Maharaj, & Hoque, 2006).

Spiritual Life and Religiosity: Spiritual life and religiosity are important to most Asians and this is reflected in the predominance of prayer, church and temple affiliation, spiritual fellowship, and spiritual counselling. Studies have shown that having the capacity to practice one’s faith can be a measure of wellness (Valencia-Go, 1989, in McBride, 1996). Using prayer and spiritual counselling can be a part of a treatment plan with assistance from a traditional healer or a clergy. Some elders and their families consider physical or emotional pain as a challenge to one’s spirituality (McBride, 1996).

Spiritual Philosophies/Beliefs

The spiritual philosophies and beliefs espoused by Asians influence their theories of illness, their health beliefs and behaviours, including the way they cope with illness and their rehabilitation processes. Some of these philosophies and beliefs include:

Karma: the concept of "action" or "deed" denotes the entire cycle of cause and effect described in Hindu, Jain, Sikh and Buddhist philosophies. Karma is most easily described as intentional, good or bad action (Burnard et al., 2006). Such action can in turn affect future aspects of a person’s life or future lives. Avoidance of bad karma is an essential part of life. The larger concept behind karma is the idea that all actions have consequences, or ‘do bad and receive bad; do good and receive good’. Karma, then, is also linked to unpleasant, disturbing or dangerous events in a person’s life (Burnard et al., 2006).

Merit making: is a Buddhist concept (Harvey, 1990, in Burnard et al., 2006). Merit making consists largely of doing good and is often expressed by a person visiting the temple, offering alms to monks or the poor and, generally, helping other people. Merit making has at least two functions. First, it is a demonstration of a person's commitment to the principles of living a 'good' life: it is a good thing to 'do good' for its own sake. Second, it is sometimes felt to be a method of leavening the effects of bad karma (accrued from this or a previous life).

Kwan: In Thailand, *Kwan* is an animist concept that lives alongside Buddhist teachings. It is not, however, a Buddhist concept. *Kwan* is perhaps best described as a 'life spirit' or a 'life force'. In extreme illness or debility (or in cases of shock) it is sometimes thought that *Kwan* leaves the body (or '*Kwan* goes away'). When a child falls over and hurts herself, the mother can sometimes be heard to be quietly 'calling *Kwan* back' (Burnard et al., 2006).

Yin and Yang: The dual concepts of yin and yang – or the single concept Yin-Yang – originate in ancient Chinese philosophy and metaphysics, which describe two primal opposing but complementary principles or cosmic forces said to be found in all non-static objects and processes in the universe. The concept is the cornerstone for Taoism and traditional Chinese medicine. *Yin* is the dark element: it is passive, dark, feminine, downward-seeking, and corresponds to the night. *Yang* is active, light, masculine, upward-seeking and corresponds to the day. Yin is often symbolized by water or earth, while yang is symbolized by fire or wind. Yin (the receptive, feminine, dark, passive force) and yang (the creative, masculine, bright, active force) are descriptions of complementary opposites rather than absolutes. All forces in nature can be seen as having yin and yang states, and the two are in movement rather than held in absolute stasis.

Health Beliefs

Indigenous Health Beliefs

Principle of Balance - This is a key indigenous health concept that includes a complex set of fundamental principles. A range of "hot" and "cold" beliefs concerning humoral balances in the body and food and dietary balances include the following:

- Rapid shifts from "hot" to "cold" lead to illness
- "Warm" environment is essential to maintain optimal health
- Cold drinks or cooling foods should be avoided in the morning
- An overheated body (as in childbirth or fever) is vulnerable; and heated body or muscles can get "shocked" when cooled suddenly
- A layer of fat ("being stout") is preferred to maintain "warmth" and protect vital energy
- Heat and cooling relate to quality and balance of air (hanging, "winds") in the body
- Sudden changes in weather patterns, cool breezes or exposure in evening hours to low temperature, presence of hot sun immediately after a lengthy rain, vapours rising from the soil all may upset the body balance by simply blowing on the body surface (McBride, 1996)

Theories of Illness and Principles of Recovery

Physical and mental health and illness are viewed holistically as an equilibrium model. Explanatory models may include mystical, personalistic, or naturalistic causes (McBride, 1996).

Mystical causes are often associated with experiences or behaviours such as retribution from ancestors for unfulfilled obligations, or as bad karma that has accumulated because of misdeeds done in past lives, a belief espoused by Hindus and Buddhists.

Personalistic causes may be attributed to social punishment or retribution by supernatural beings such as an evil spirit. A stronger spirit such as a healer or priest may counteract this force.

Naturalistic causes include a range of factors from nature events (thunder, lightning, drafts, etc.), excessive stress, incompatible food and drugs, infection, or familial susceptibility.

The basic logic of health and illness consists of prevention (avoiding inappropriate behaviour that leads to imbalance) and curing (restoring balance); it is a system oriented to moderation. Parallel to this holistic belief system is the understanding of modern medicine with its own basic logic and principles that treat certain types of diseases. These two systems co-exist, and Asians use a dual system of health care (McBride, 1996).

Health Promotion/Treatment Concepts

Beliefs are oriented towards protection of the body.

Flushing: The body is thought to be a vessel or container, which can collect impurities and must be cleansed of debris by stimulating physiological events such as sweating, vomiting, expelling gas, or bowel motions.

Heating: Related to balance described above.

Protecting: A gate keeping system to guard the body.

Indigenous Community Resources

Cultural healers help to “protect” the body and treat supernaturally with herbal/medicinal treatments, incantations, and offerings. The tribal priest or indigenous practitioner uses three types of treatment: prayers and rituals, herbal plants, and massage/manipulation of bones and body tissues.

Health Behaviours

Response to illness: For all Asians health does not appear to be the first priority. Asians may often follow a pathway to seeking professional health care that begins with self-monitoring of symptoms to ascertain possible cause, severity, threat to one’s functional capacity, and economic and/or emotional inconvenience to the family. The concern is often discussed with a trusted family member, friend, or spiritual counsellor/healer. Some Asians try to cope with pain as going to the doctor may be seen as a sign of weakness. Broken bones and loss of blood and children’s injuries constitute serious injuries for which professional help is sought (Tse, et al., 2006).

Help-seeking behaviours:

The usual course of action for most Asians (except Koreans and some younger people) for the treatment of illnesses, injuries and pain appears to be:

1. Self-diagnose and medicate with home remedies and medication brought from their home countries.
2. Visit a traditional practitioner such as an acupuncturist, masseur or an ayurvedic doctor.
3. Seek professional help (preferably a private practitioner from their own ethnic groups rather than the public health system) for more serious illnesses or injuries.

Families support each other in making decisions on the course of action to be taken. Asians do not always have a permanent family doctor, but if they do, s/he is the gatekeeper and makes decisions about the course of action to follow. Economics and knowledge (i.e. information about New Zealand systems), rather than people, appear to be the main determinants of where help will be sought (Tse, et al., 2006).

Health promotion and disease prevention: An equilibrium model stresses the importance of balance and moderation as key concepts to maintain health and prevent disequilibrium (i.e., diseases). Emphasis on cleanliness, orderliness, appropriate social conduct in various situations, and avoidance of social, emotional, or psychological distress helps to keep one's body strong.

Implications for mental health

The factors listed above have implications for mental health: how it is perceived, health beliefs, help-seeking behaviours, and stigma against people with mental illness, who holds control, who influences changes. Most Asian cultures appear to view mental illness negatively. In India, for example, mental health is known to be bound by traditional religious and cultural beliefs and mental illness is viewed as a stigma for the family involved. Similarly, the Japanese seem to look down upon the mentally ill. Mental illness is also regarded as a shameful thing in the Vietnamese culture. Because of this shame, mental illness is often feared or denied, and those who are ill are hidden away by their families until the family can no longer care for them. In Vietnam, those with a mental illness may be taken to hospitals and abandoned.

Ethical considerations

It is widely agreed that culture-specific knowledge is essential to multicultural therapy (Ridley & Kleiner, 2003, in Pope-Davis et al., 2003). Consequently, it would be an ethical infraction to treat clients without having basic understanding in issues of their culture and their implications for mental health. Furthermore, clinician bias, which is reflected in some individual clinicians' beliefs and actions including their hostility, naïveté, and general intolerance, as well as their tendency to label clients as unresponsive to treatment, which leads to over diagnosis and misdiagnosis, impact on services (Rosenberg & Rosenberg, 2006). It is therefore ethically imperative for clinicians to be culturally responsive when working with culturally and ethnically different clients.

2.4.4 Teaching and Learning Activities:

Activities	Objectives
1. Asian Philosophy Quiz	To ensure active reading and processing of material by asking general questions and testing retention of information on Asian philosophies.

2.4.5 Teaching Resources:

The CD has *Web links* to relevant sites on Asian philosophy. The websites listed in CD include generic overviews of Asian philosophy from a New Zealand and a United States perspective, as well as websites focussing on specifically on the following Asian regions: China, Japan, Korea, India, Sri Lanka, South East Asia, Vietnam, Philippines, Malaysia, Indonesia, and Thailand. For a list of websites, refer to Appendix B.

2.5 Module 3: Clinical Issues

2.5.1 Context and Relevant Considerations:

This module concentrates on specific issues or skills (introductory level) required when working with Asian people affected by mental health problems. The introductory section entitled “Considerations for Working with Asian Clients with Mental Illness” provides an overview of key factors to be considered in a therapeutic encounter between mental health practitioners and Asian clients as Prepared by Dr Koong-Hean Foo. Dr Foo obtained his PhD from Massey University, New Zealand, and is currently lecturing at James Cook University, Singapore. The following excerpt is adapted from his doctoral thesis (Foo, 2007).

Different Asian cultures manifest mental distress differently, and in their appraisals and management of these manifestations (Foo, 2007). For example, a study by Ball, Mustafa and Moselle (1994) found that young Muslim adults coped with their problems through praying and control of emotions. Most Muslim patients would have visited their traditional healer before consulting a psychiatrist for their mental illness (Razali & Najib, 2000). With Indians, the exhibition of possession syndrome is a socially acceptable coping behaviour. In Chinese and Vietnamese cultures, ghosts or spirits play a role in human dealings, and a person who experienced feelings of fear, anxiety or depression might assume that his or her home was haunted. The guidance from elders to children when they faced feelings of frustration or anxiety is simply “don't think about it”; as thinking would lead to negative experiences of affect (Sue & Sue, 1999).

By large, help-seeking behaviours of Asians are determined by their cultural causal beliefs of mental illness (Sheikh & Furnham, 2000). Furthermore, Asians tend to solve psychological problems preferably on their own, relying on family members, close relatives and friends, or traditional healing practices rather than with mental health practitioners (Ngai, Latimer, & Cheung, 2000). Thus, given their cultural dispositions, Asian clients might be perceived by the Western therapist as dependent, unable to make decisions on their own, lacking in maturity and possibly repressed (Sue & Sue, 1999).

Consequently, a lack of understanding of Asians may lead to myths, images and stereotypes.

The clinical aspect of cultural competence for mental health workers is a highly specialised field. As such, it would be best delivered by practitioners in the field who have first hand experience of working with mental health patients and understand the specifics of the work. For this reason, practitioners present material on various clinical issues.

2.5.2 Session Aims:

- To provide theoretical and empirical information that will facilitate understanding of specific clinical issues pertaining to Asian peoples that impact on mental health treatment.

2.5.3 Session Content:

The content for this session was formulated over two meetings. In the first meeting, the project team met with clinicians to introduce them to the project, review Modules 1 and 2 and request their contribution to this project. The second meeting resulted in the formulation of topics pertaining to Asian mental health, which the clinicians then chose to address using power point presentations with spoken voice-over. The presentations cover a variety of topics including:

- International Students *Dr. Shizuka Torii*
- Working with Young Asian People and Family *Dr. Chohye Park*
- Mental Health Assessment and Diagnosis of Asian Adults: Challenges *Dr. Ashok Malur*
- Treatment Issues in Asian Mental Health *Dr. Ashok Malur*
- Complementary and Alternative Medicine *Dr. Rajendra Pavagada*
- A Memorial Quilt for Asian Grief and Loss *Ms. Candy Vong*
- Working with Chinese Couples and Family *Mr. Patrick Au*
- Assessment and diagnosis in cross-cultural setting: The Chinese example *Dr. Sai Wong*

2.5.4 Teaching Resources:

The CD has *Web link* and *References* to relevant readings regarding clinical issues.

Chapter 3: Engaging the Tertiary Education Sector

3.1 Scoping Phase

The purpose of this scoping evaluation was to gain an understanding of the current graduate curriculum and the extent to which Asian mental health was being addressed.

The scoping evaluation consisted of two parts. The first was an informal discussion with colleagues based in the tertiary education sector regarding the need for an Asian mental health component within current curricula. The second part entailed a formal scoping evaluation with identified tertiary education providers.

3.1.1 Part One. Informal Discussions:

Throughout the second and third weeks of March, members of the project team met with colleagues in the tertiary education sector to discuss the proposed project and assess the value of implementing such a project within the current curriculum. Discussions with colleagues based in two tertiary institutions within the Auckland district raised the following points:

1. There was recognition of the growing Asian population within New Zealand society and the need for further training to be able to best support this group. However, there was some concern regarding how 'easy' it would be to fit an Asian mental health module into the current curriculum. Some felt it would be difficult as there was already pressure to address other areas in detail, such as Maori and Pacifica health, and time constraints meant that it might not be possible to add another dimension. It was felt that perhaps an online resource of some kind (such as a workbook and related online activities) that students could access if it was an area of interest would be of benefit. In addition, guest lecturers already knowledgeable about Asian mental health who were willing to come in for a 1-2 hour lecture with students would also be welcome.
2. Some questioned whether at this stage an Asian mental health module was too specialised to go into the curriculum. It was suggested that not every student who undertakes a health qualification within the tertiary sector would necessarily go on to work in mental health, and work with Asians who are experiencing mental health difficulties. Given this limitation, it was felt that an Asian mental health module may be considered as an 'optional' rather than a mandatory part of the training.
3. Another issue raised was the implementation of such a module. Many of the lecturers felt that they and their colleagues were already stretched in terms of time and did not feel that they would be willing to either send someone or go along for training in order to implement such a module.

Overall, it seemed that the tertiary sector was acknowledging the need for awareness of Asian mental health needs; however, restraints such as time and current curriculum demands meant that there was uncertainty as to how best to go about implementing such a programme. Nevertheless, it was felt that these informal discussions represented a beginning phase of the consultation process, and that a wider perspective from tertiary education institutions around the country was needed in order to clarify: 1) what exactly

the gaps in the current curriculum being delivered were, 2) was there a need for Asian mental health theory in the current curriculum, and if so, 3) how best could this theory be delivered within the current curriculum and tertiary training environment.

3.1.2 Part Two. Email Survey: Scoping Exercise

At the end of March, the project team met to discuss the revised brief and move ahead with the scoping phase. At this meeting, it was decided to draft:

- 1) three or four open questions to send to the tertiary institutions for feedback regarding the curriculum currently on offer and the place of Asian mental health within this curriculum (Refer Appendix C).
- 2) an introduction letter outlining who the project team are and what the project involves (Refer Appendix D).

For the purposes of this project, the project team decided to target tertiary education institutions that had government support and funding. This limited the sector to 25 institutions providing undergraduate health programmes throughout the country. For a list of tertiary institutions contacted, refer to Appendix E. Following this decision, a spreadsheet consisting of the names of the tertiary institutions and the contact details for the Heads of Department (HODs) of health related undergraduate programmes was compiled to track the feedback of the scoping evaluations. On the 30th March, both the letter and the questionnaire were sent via email to the HODs of undergraduate health programmes at tertiary education providers across the country. In addition, the HODs were asked to identify a contact person who the project team could contact to follow up with and discuss any further issues.

Following initial contact, seven responses were received within the first week, and no further responses seemed forthcoming. After another week, a reminder email was sent out to participants, which elicited one more response. Over the next five weeks, two further email reminders were sent to participants, encouraging them to respond to the scoping evaluation. At times the repeated request via email for completion of the scoping evaluation felt intrusive; however, the project team felt that continual attempts at engaging participants was necessary to ensure maximum feedback that would contribute to a curriculum being developed that met the needs of the tertiary institutions.

As the end of May and the deadline for completing the scoping evaluation approached, follow up phone calls were made in a final attempt to engage individuals at each of the tertiary education institutions who were identified as not having responded to the emailed scoping evaluation. In summary 25 phone calls were made. Of these phone calls, only one individual was spoken to directly, with the outcome that she would attend to the matter directly. A further 21 messages were left with other individuals and three phone calls resulted in being unable to make contact or leave a message with the individual identified.

3.1.3 Part Three. Response to Scoping Exercise:

Following the initial contact via email, a total of 50 emails were sent to individuals heading undergraduate health programmes within 25 tertiary education institutions. Out of these 50 emails:

- 15 responded with completed evaluations (representing 10 tertiary education institutions)
- 1 responded stating they were unable to participate in the evaluation
- 9 were unable to be contacted (emails bounced back or were blocked)

After the follow up phone calls had been made, one further response was received resulting in a total of 16 responses.

Following the phone calls, a further round of contact both by phone and by email was made by different members of the team. From this, five further responses were received resulting in a total of 21 responses. This represents a 51% return rate.

3.2 Findings

As evaluations were returned via email, a table was created in which replies were compiled, which allowed the project team to clearly see the variations and similarities in responses. A detailed summary of responses from returned emails to the scoping evaluation questions have been included in Appendices F, G and H.

3.2.1 Question One:

In response to this question, a resounding majority stated that their respective curricula did not specifically cover Asian mental health. Two respondents indicated that reference to cultural diversity and working in a multicultural society were covered in the curriculum and that within this reference was made to Asian as a ‘cultural group’ different from Pakeha, Maori and Pacifica. One institution acknowledged that specific immigrant and refugee issues were covered within the mental health component.

3.2.2 Question Two:

Again, there was an *overwhelming majority* response to this question, with respondents indicating a need for specific training information/materials regarding Asian mental health. The most common reason given for this response was the acknowledgement of the growing Asian communities within New Zealand society. Of the three respondents who felt that there was not a need to address Asian mental health, two felt that there was a higher demand for Maori and Pacifica models of mental health and the third felt that generally a more holistic and cultural approach to practice was needed.

3.3.3 Question Three:

This question proved to produce the most diverse answers. There are a number of ways to deliver information and in response to this question, a variety of delivery options was proposed. These ranged from online resources, to workbooks, to lectures and workshops. When it came to providing lectures or workshops, the general feeling was that these would best be delivered by guest lecturers, e.g. someone knowledgeable in the field of Asian mental health or Asian groups. There seemed to be a common agreement that an outside ‘expert’ would be better able to deliver the information rather

than the information coming from a lecturer already delivering the curriculum within the tertiary institution.

3.4 Summary

Overall, the scoping exercise undertaken for this particular project faced a number of difficulties for example, training institution's readiness to address Asian mental health issues, and lack of detail in some responses. Issues raised in undertaking this exercise were:

1. Time – lengthy discussions at the beginning of this project regarding the purpose and goals for the project, and the target audience, meant that the scoping exercise was delayed. With the initial intention of targeting DHBs, the scoping exercise should have been completed during the months of January and February 2007. This was then delayed to the start of March with the expectation that this phase of the project would be completed by the end of April. In reality, the scoping exercise took at least, a month longer than anticipated to complete, with time given until the end of May to collate participant responses.
2. Responses received – Despite repeated attempts to engage the tertiary sector in canvassing their opinions regarding the development of this project, the responses to the scoping evaluation have not been very forthcoming. A longer timeframe for the exercise may have allowed for a great response rate; however, given the consistent reminders, this is somewhat doubtful. In addition, some of the responses to the questions were rather limited and without a contact name or number as requested, it was difficult to follow up on some of these responses to discuss issues further.
3. Development of the project curriculum – while progress continued to be made on the project curriculum, it was not as smooth or as quick as anticipated, due to delays while the project team waited for responses from tertiary institutions to the scoping evaluation.

3.5 Follow Up Contact: Establishing Partnerships

Utilising the feedback received from the tertiary sector in the initial scoping exercise, consultation with clinicians and service users, development of the curriculum continued. In September, discussions amongst the project team indicated the need to make contact once again with the tertiary education institutions. The purpose of this contact was to update them on the project and introduce the education package as 'free' resource for use within their curriculum. For a copy of this contact letter refer to Appendix I.

In exchange for providing tertiary institutions with the educational resource, the project team requested that each institution identify a contact person within the department who would be responsible for handling the CD and overseeing the implementation of the resource as part of the curriculum. The project team was keen to establish a direct partnership with the tertiary institution and have a liaison person with whom the project

team could engage with, in regard to providing support while utilising the education resource and seeking feedback on the success of such a resource within the curriculum.

3.5.1 Responses to Request:

Within a week of the email being sent out, nine institutions responded indicating a desire to be involved in the project. A further response arrived in the week following, and this proved to be the last response received by the project team (refer to Appendix J for list of responding institutions). From within these ten institutions, 18 departments nominated a contact person with whom the project team could liaise.

3.6 Follow Up Contact: Showcasing Prototype

By the beginning of November, the project team had the fourth prototype of the education programme loaded on to CD in a form deemed suitable to take to the tertiary education institutions. With the assistance of Mr. Vishal Rishi (CAHRE administrator) times were arranged for a member of the project team to either meet face to face or discuss over the phone with the nominated persons at each tertiary education institution, and present the CD.

The purpose of this meeting was to establish the relationship between the project team and tertiary institutions and showcase the prototype before the final version was sent out to be incorporated into curricula. Conversations included an overview of the project team, background to the current work and presentation of the CD curriculum. Feedback was sought from teachers regarding gaps identified on the CD, enhancements to CD for ease of use and how the CD may be utilised within curricula.

Following presentation of the prototype, a few suggestions were made regarding the formatting of the CD, such as utilising more case studies and involving family perspectives; however, for the most part, teachers were impressed by the comprehensiveness of the programme. Other specific comments include:

- The analysis on cross-cultural communication can apply to various population groups, not only Asian people
- The consultation process, the design and trial of the project serves as a “useful model” for other workforce development initiatives
- Respondents in the consultation process are appreciative to the amount of work involved in producing this resources
- The involvement of Asian clinicians from multiple country of origins is seen as a strength
- Inputs from service users are helpful
- The present set of resources will be distributed to institutions at no cost
- Some respondents thought the interactive aspect of the CD will be helpful to engaging students in their learning
- The web links to various articles and resources on mental health topics (covering multiple Asian countries) are going to be very useful
- The material in fact will be useful for student health centre staff, colleagues responsible for pastoral care for international students
- Some colleagues like the flexibility of the learning modules, for example some can be used in class, some can be accessed by students outside classrooms and

students can be directed to different levels of readings depending on the type of training students are undergoing (e.g. certificate vs. diploma level)

Discussion indicated that the teachers were readily able to identify slots in their current curricula where the information provided in this education programme could be successfully implemented.

The representatives from the tertiary institutions attending the meeting were keen to distribute the education programme to other faculties within their institution. The project team indicated that this would be appropriate, and requested that a person from each faculty be nominated as someone who would be willing to liaise with and provide feedback to the project team. Overall, the presentation of the prototype received a positive response, and teachers confirmed that the education programme was necessary in the current education climate and would be a valuable resource for their curricula.

Chapter 4: Next Steps

4.1 Implementation

At the end of November, the representatives from each tertiary educational institution with whom the project team met were each sent a final copy of the CD. Along with the CD, a two-page summary was provided indicating how different aspects of the educational programme might be used for example in a two-hour lecture or a workshop style presentation (refer to Appendix K). However, there are no set guidelines as to how the educational programme is to be used. It is at the discretion of the individual teachers to determine how best to incorporate the material within their current curricula.

It is intended however, that those tertiary educational institutions who have agreed to participate in this project and utilise the education programme, will do so during their courses starting in 2008.

The CD has been developed so that teachers can either utilise the material during classroom sessions and/or the education programme can be loaded on the institutions' intranet for students to access as part of self-directed learning. Information on the CD can be printed off and used within the class setting, such as the activity sheets, which may be beneficial to complete as part of a group exercise.

4.2 Follow Up

At this stage it is intended that follow up will take place on two occasions during 2008, at the end of Semester One and the end of Semester Two. Follow up will be in the form of phone conversations with the nominated representatives and will cover:

- How the education programme has been incorporated into current curricula
- What has worked well
- What was missing from the education programme
- Where are the rooms for improvement
- What has been the feedback from students

4.3 Evaluation

There are two parts to the evaluation of this programme. One is evaluation provided by students and the other is evaluation provided by tertiary institutions involved with implementing the education programme.

4.3.1 Student Evaluation:

On the front page of the CD, an evaluation section has been created. Teachers will be asked to encourage students to go online and complete this written evaluation once they have covered the material. Upon completion of the evaluation, the form will be automatically emailed back to CAHRE so that evaluations can be compiled and reviewed over time.

4.3.2 Tertiary Institution Evaluation:

Teachers are encouraged to stay in touch with the project team at CAHRE to discuss how the educational programme has been implemented, what has worked well, what could be improved upon etc.

It is vital to ensure feedback from both the students and the tertiary education providers are received in order to assess the benefits of such a resource and determine the need for such a resource to be implemented throughout tertiary education institutions nationwide.

Chapter 5: Recommendations and Conclusion

This project is a new initiative in the landscape of Asian mental health in Aotearoa, New Zealand. The project team believes that there is potential for this project to grow and become a recognised component of tertiary education for undergraduate students studying to become health professionals. This chapter presents a summary of the strengths and limitations of the present project and possibilities for future directions involving this type of education programme.

5.1 Strengths and Limitations of the Present Project

5.1.1 Strengths

- A fully developed education package presented on an interactive CD has been compiled and can be utilised in future tertiary curricula.
- Presenting material on CD or intranet means that the contents can be revised and updated easily if required.
- Initial feedback from tertiary institutions participating in the project indicates a strong need for this type of resource in the current educational climate.
- Initial feedback from tertiary institutions following showcasing of the prototype indicates that the education programme will be utilised in their curriculum planning for 2008.
- Members of the project team have strong backgrounds in mental health, Asian cultural issues and education, and their collective experience contributed to the knowledge and topics chosen for the education package.
- Consultations with key stakeholders informed the creation of the education programme around identified needs of undergraduate health students in the tertiary education sector.
- The final report and outcomes are timely with regard to other concurrent projects in the field.
- The work is of relevance to developing a generic process for all cultural groups.

5.1.2 Limitations

- Difficulty initially in engaging the tertiary education sector has meant a reduced number who have opted to participate in the initial implementation of this project.
- Limited time to create an Advisory Group before the education programme was implemented meant that an Asian service user's family member could not be found to participate. Having a family member as part of the advisory group would have been beneficial in providing the project team with information regarding best practises for involving family members while creating the education programme.

5.2 Future Development

5.2.1 Short and medium term: Next 6-8 months, 2008

- Send the training module on CD and notes of suggestions of how the material can be used in their teaching
- Continue to work with the departments whom the project team met over the last three weeks to support them using the material
- Collect feedback and comments from teachers and students who have used the training modules
- Modify and keep improving the work in response to feedback gathered
- Attempt to evaluate the impact of training on students' effectiveness in working with Asian clients perhaps during the course of their placement
- Liaise with prospective funders (e.g. Ministry of Education, Te Pou, Tertiary Education Commission) to introduce the training modules on Asian mental health to most of the mental health training institutions
- Explore the need and ways of introducing the training modules to relevant professional groups for example New Zealand Psychological Association, and service providers e.g. primary health care groups

5.2.2 Long term

- Introduce the learning modules to relevant educational and service providers nationwide
- Continue to examine and evaluate: 1) quality of delivery of the training modules, 2) impacts of the training on quality of care for mental health service users- clients and their family members

5.3 Final Conclusion

The Asian population is one of the fastest growing ethnic groups in Aotearoa New Zealand, which creates a demand for health service providers to address the needs of people from diverse cultural backgrounds. Yet a key issue facing mental health services in New Zealand is a shortage of appropriately trained specialist workforce. There is a need for New Zealand to ensure a sustainable supply of practitioners skilled in addressing cultural factors within the workplace. To address this need and provide appropriate services, mental health practitioners must be provided with knowledge about the influence of cultural factors on the prevention, presentation and treatment of mental health issues so that they are more skilled in interacting with Asian peoples.

Access to a highly skilled, culturally competent and effective mental health workforce can only be achieved with the participation of education and training organisations, amongst others. Tertiary education teachers of undergraduate mental health students need to be supported to deliver preparatory information regarding Asian immigrant mental health issues within their nominated institutions. The project is a starting point for ensuring that tertiary education teachers do have the resources to enhance the knowledge and preparedness of undergraduate mental health students who are likely to work with Asian service users.

In presenting the education programme at tertiary education establishments across New Zealand, positive feedback has been received from nominated representatives, including, an acknowledgement that this programme is much needed in today's education climate and that the resource will be an invaluable contribution to the development of their curricula. It is recognised; however, that this project has only been a starting point to implementing this form of training nation wide. Further development is required in terms of ensuring the education programme is implemented in curricula throughout tertiary education providers nationally.

Finally, specific recommendations have been offered concerning the future development of such education programmes regarding Asian mental health within the tertiary education sector. It is envisaged that in the coming years, this education will be critical for not only individual mental health students, but also mental health services as a whole.

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Appendices

Appendix A: Team Meetings

Appendix B: Links to Websites on Asian Philosophy

Appendix C: Scoping Project Part Two: Email Evaluation

Appendix D: Letter of Introduction

Appendix E: List of Tertiary Education Providers Invited to Take Part in Scoping Exercise

Appendix F: Scoping Evaluation: Response to Question One

Appendix G: Scoping Evaluation: Response to Question Two

Appendix H: Scoping Evaluation: Response to Question Three

Appendix I: Follow Up Contact with Tertiary Institutions

Appendix J: Names of Tertiary Institutions Participating in Trial of Using the CD in their Mental Health Teaching

Appendix K: Supplementary Notes to CD

Appendix A: Team Meetings

2006

16 November

Attendees: Samson Tse, Shoba Nayar, Cherry Hsu, Amritha Sobrun-Maharaj

Discussion: Getting to know each other as team members, briefing on the project, developing ideas and setting the boundary for the work – scope of study, roles of team members, and milestones of the project.

20 November

Attendees: Shoba Nayar, Amritha Sobrun-Maharaj

Discussion: Reviewed previous work on Asian mental health completed by CAHRE, outlined duties.

2007

23 January

Attendees: Samson Tse, Amritha Sobrun-Maharaj, Martin Molloy, Sue Lim, Ratana Walker, Bram Kukler, Karla Bergquist, Anil Thapliyal, Patrick Au

Discussion: Meeting between the 'Train the Trainers' project team and Auckland region DHB representatives to discuss the links between Asian projects in Auckland.

1 February

Present: Samson Tse, Shoba Nayar, Amritha Sobrun-Maharaj

Discussion: Recruitment of trainers, timeline, development of curriculum, focus on immigrants as opposed to refugees.

8 February

Attendees: Samson Tse, Amritha Sobrun-Maharaj, Shoba Nayar

Discussion: Development of curriculum, engaging the Regional Workforce Coordinators to assist with promoting curriculum in DHBs.

12 March

Attendees: Bram Kukler, Robyn Shearer, Karl Metzler, Martin Molloy, Samson Tse, Amritha Sobrun-Maharaj, Shireen Nanayakkara-McDonald, Shoba Nayar, Anil Thapliyal, Ratana Walker, Patrick Au, Sue Lim

Discussion: Focus of Asian mental health projects within the sector and how best to work together.

27 March

Present: Amritha Sobrun-Maharaj, Samson Tse, Cherry Hsu, Shoba Nayar

Discussion: Revised focus of project, new milestones and activities to be achieved, scoping exercise, drafting outline of curriculum.

24 April

Attendees: Candy Vong, Sai Wong, Shizuka Torii, Chohye Park, Ashok Malur, Patrick Au, Cherry Hsu, Amritha Sobrun-Maharaj, Samson Tse, Shoba Nayar

Discussion: Meeting with clinicians to introduce project and invite them to participate in Module 3.

24 May

Attendees: Amritha Sobrun-Maharaj, Samson Tse, Martin Molloy, Cherry Hsu, Shoba Nayar

Discussion: Review of meeting with clinicians, update on scoping exercise, progress of curriculum development, implementation of CD, need to develop Advisory Group, launch of curriculum.

11 June

Attendees: Amritha Sobrun-Maharaj, Samson Tse, Cherry Hsu, Shoba Nayar

Discussion: Feedback on conclusion of scoping exercise, times for clinicians to prepare presentations, presentation of curriculum material on CD, introduction to Module 3, potential people to join Advisory Group.

25 June

Attendees: Candy Vong, Dr. Shizuka Torii, Dr. Chohye Park, Dr. Ashok Malur, Patrick Au, Shoba Nayar, Cherry Hsu, Ass. Prof. Samson Tse, Dr. Amritha Sobrun-Maharaj, Martin Molloy, Lucille Coward

Discussion: Update on scoping exercise, review of Modules 1 and 2, introduction to curriculum on CD, introduction to Module 3.

3 July

Attendees: Cherry Hsu, Shoba Nayar

Discussion: Formatting written curriculum on to CD.

17 July

Attendees: Samson Tse, Cherry Hsu, Amritha Sobrun-Maharaj

Discussion: Review of curriculum progress and presentation, plans for launch of CD.

17 September

Attendees: Samson Tse, Shoba Nayar

Discussion: How to proceed with liaising with tertiary education providers.

26 September

Attendees: Jolie Wai Luen Cheng Wong, Martin Molloy, Jane Vanderpyl, Mathijs Lucassen, Amritha Sobrun-Maharaj, Samson Tse, Cherry Hsu, Shoba Nayar

Discussion: Review of curriculum prototype, linking with tertiary sector, logo design.

8 November

Attendees: Samson Tse, Amritha Sobrun-Maharaj, Shoba Nayar

Discussion: Meeting with tertiary education providers, presentation of curriculum, launch of CD, writing of final report.

Appendix B: Links to Websites on Asian Philosophy

Generic New Zealand:

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

<http://home.xtra.co.nz/hosts/asianhealth/documents/Publications/MHC%20-%20Asian%20Mental%20Health%20Literature%20Review.pdf>

Synopsis: This literature review, prepared for the Mental Health Commission of NZ by Ho et al. (2003), has some useful references. The report highlights the importance of improving the cultural responsiveness of mental health services to the needs of Asian people, identifies risk factors and seeks a more collaborative approach between agencies if these risks are to be minimised. The report also confirms that eliminating discrimination and removing barriers to participation are fundamental to positive well-being.

Asian Health Chart Book 2006

[http://www.moh.govt.nz/moh.nsf/pagesmh/4925/\\$File/asian-health-chart-book-2006.doc](http://www.moh.govt.nz/moh.nsf/pagesmh/4925/$File/asian-health-chart-book-2006.doc)

Synopsis: This report is a joint collaboration between Public Health Intelligence (Ministry of Health), Auckland Regional Public Health Service, the Centre for Asian Health Research and Evaluation (University of Auckland), and the Asian Network Incorporated. The *Asian Health Chart Book 2006* is the first comprehensive review of Asian health. It focuses attention on specific health issues of particular importance to Asian peoples. Information is presented on more than 80 indicators covering four domains: health status, health risk profile, social determinants of health, and patterns of health service utilisation.

Generic United States:

Cultural factors influencing the mental health of Asian Americans (Chinese, Japanese, Korean and Vietnamese)

<http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1071736&blobtype=pdf>

Synopsis: The article by Kramer et al. (2002) discusses key cultural factors that influence mental health of Asians in America, such as language, age, gender, level of acculturation, occupational issues, family structure and intergenerational issues, religious beliefs and spirituality, and traditional beliefs about mental health; as well as eliciting patients' views about their illness.

Asian-American mental health

<http://www.apa.org/monitor/feb06/health.html>

Synopsis: This paper by Laurie Meyers (2006) presents the first national study of Asian-American mental health, which finds that the second generation is more likely than their immigrant parents to have emotional disorders. It covers topics such as prejudice and mental health, family matters, cultural stress and getting help.

Improving the mental health of Asian Americans

<http://www.bmj.com/cgi/reprint/bmjusa.02110007v1.pdf>

Synopsis: Presents the importance of training in cultural competence. Research shows that training primary care providers and educating patients can improve the outcomes of depressed patients. They have developed a model for providing primary mental health care to Asian Americans in New York. The model, known as the Bridge Program,

involves training primary care providers in the early detection and management of common mental disorders, educating the Asian community about mental health issues, and giving providers the communication tools to offer culturally responsive care.

Chinese

Social characteristics and customs

<http://www.immigrantinfo.org/kin/china.htm>

Synopsis: The article by Ken Colson (2002) provides a discussion of the social characteristics and customs, amongst others, of Chinese people including health care practices and emotional support.

<http://www.immigrantinfo.org/kin/taiwan.htm>

Synopsis: Ken Colson (2002) also provides a discussion of the social characteristics and customs of Taiwanese people including health care practices and emotional support.

Mental Health and Chinese Clients

<http://www.gmd.net.nz/index.lasso?view=26>

Synopsis: This article by Dr. Sai Wong (2000-2007) discusses culture, culture specific stresses, coping strategies, symptom presentations, and psychological approaches to the treatment of Chinese peoples. It provides a list of further reading.

Emotions and Mental Health in Chinese People

<http://www.springerlink.com/content/j8x33p3022842630/fulltext.pdf>

Synopsis: Leung (1998) discusses the concept of emotion as understood by Chinese people and how it influences their behaviour, and examines the relationship between emotion and mental health practices in Chinese societies.

Folk belief, illness behaviour and mental health in Taiwan

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=9607258&dopt=Abstract

Synopsis: In this paper by Zhi (1998), an overview of the literature relevant to the issues of illness behaviour and help-seeking behaviour in relation to mental health and illness, focusing on the Taiwan area is presented. Arguments for the prioritization and appreciation of the folk perspective of mental illness and health are addressed.

Japanese

The influence of culture on mental health and psychopathology in Japan

<http://artsci.wustl.edu/~copeland/rosen.html>

Synopsis: Erica Rossen discusses the profound effect that the collectivist nature of Japanese culture has on issues dealing with mental health in Japan, including how psychopathological behaviour is defined and manifested within people of Japan, the reaction of society to the mentally ill, as well as the actual treatments and therapies available to the mentally ill population within Japan. The Japanese place a high value on uniformity, hierarchy, reciprocity, and harmony, and seem to look down upon the mentally ill. The Japanese treat mental illness to alleviate suffering and not to better understand one's self (Draguns, 1990).

The Healthy Human: American and Japanese conceptualizations of mental health

http://eric.ed.gov/ERICDocs/data/ericdocs2/content_storage_01/0000000b/80/10/94/3a.pdf

Synopsis: Futoshi Kobayashi (1999) discusses Japanese ideology and its definition of mental health, the definition's unique problems, and the impact that some traditions within Japanese culture have on an individual's mental health.

Korean

Social characteristics and customs

<http://www.immigrantinfo.org/kin/southkorea.htm>

Synopsis: Rani Chandran (2002) provides a discussion of the social characteristics and customs, amongst others, of Korean people including health care practices and emotional support.

Mental Health Beliefs and Help Seeking Behaviors of Korean American Parents of Adult Children with Schizophrenia

http://findarticles.com/p/articles/mi_qa3919/is_200507/ai_n14825642

Synopsis: Donnelly (2005) explored the mental health beliefs and help-seeking attitudes of ten Korean American parents of children with schizophrenia. Three themes explored are: 1. Help seeking: Moving from traditional to Western, 2. Dancing with the rhythms of mental illness, and 3. Family shame and stigma. The study strongly indicated the need for culturally appropriate community-based treatment programs with family education. It raised awareness that cultural conceptions of mental health determined their help-seeking.

Mental Health Attitudes Among Caucasian-American and Korean Counseling Students

<http://www.springerlink.com/content/h326200mm27577qw/fulltext.pdf>

Synopsis: This study by Gellis et al. (2003) provides evidence for the existence of cultural differences in mental health attitudes among Koreans and Caucasian American counselling students. It suggests that the role that culture plays in attitude formation should be recognised. It is important for mental health counsellors to have the knowledge and experiences necessary to be culturally sensitive to diverse groups.

An Introduction to Korean Culture for Rehabilitation Service Providers

<http://cirrie.buffalo.edu/monographs/korea.pdf>

Synopsis: Weol Soon Kim-Rupnow (2001) provides an introduction to Korean culture for rehabilitation service providers so that they may understand Korean culture and the perceptions of disability and rehabilitation that prevail within that culture.

Indian

Social characteristics and customs

<http://www.immigrantinfo.org/kin/india.htm>

Synopsis: Ken Colson (2002) provides a discussion of the social characteristics and customs, amongst others, of Indian people including health care practices and emotional support.

Mental Health and Indian Clients

<http://www.gmd.net.nz/index.lasso?view=27>

Synopsis: Puthenpadath (2000-2007) discusses Indian culture, culture specific stresses, symptom presentations, coping strategies and psychological approaches to treatment.

Indian Women and their Views on Mental Health

<http://proquest.umi.com/pqdweb?did=1130591631&Fmt=6&clientId=13395&RQT=309&VName=PQD>

Synopsis: This thesis by Jagajanani Suthahar (2005) provides valuable insight into the Indian culture and its impact on mental health, especially as it relates to Indian women. Topics such as the role of women in family and society, marriage patterns, religious practices, health beliefs and practices are discussed.

Sri Lankan

A case study: how a disaster mental health volunteer provided spiritually, culturally, and historically sensitive trauma training to teacher-counselors and other mental health professionals in Sri Lanka, 4 weeks after the Tsunami

<http://brief-treatment.oxfordjournals.org/cgi/reprint/mhl012v1.pdf>

Synopsis: Jordan (2006) discusses a case study describing how a trauma training curriculum was developed and taught after the tsunami hit Sri Lanka. Embedded within the article is valuable and informative information about the Sri Lankan people and their culture.

Post traumatic stress disorder (PTSD) and anxiety effects of the tsunami and terrorist attacks in Sri Lanka

<http://72.14.253.104/search?q=cache:wAaqy3lfT0QJ:aladinrc.wrlc.org/bitstream/1961/3569/1/Anoma%2BHapangama.ppt+indonesian+culture+belief+mental+health&hl=en&ct=clnk&cd=62&gl=nz>

Synopsis: This article by Hapangama and Abbe (2006) discusses the effects of stressful events on Sri Lankans in terms of their cultural views and religious philosophies, and cross-cultural considerations for clinical psychologists to enhance therapy. It also has links to other useful sites.

Southeast Asian

Southeast Asian Women: Immigrants and refugees- Physical and mental health, domestic/sexual violence

<http://globetrotter.berkeley.edu/GlobalGender/sea.am.health2.html>

Synopsis: This is a reference list compiled by Julie Shackford-Bradley (December, 1996), which provides useful reference relating to mental health amongst Southeast Asian women.

Vietnamese

Social characteristics and customs

<http://www.immigrantinfo.org/kin/vietnam.htm>

Synopsis: Ken Colson (2002) provides a discussion of the social characteristics and customs, amongst others, of Vietnamese people including health care practices and emotional support.

Cultural and social attitudes towards mental illness in Ho Chi Minh City, Vietnam

<http://surj.stanford.edu/2003/pdfs/PsychiatryVietnam.pdf>

Synopsis: This paper by Anne Nguyen (2003) describes research on cultural and social attitudes towards mental illness in Ho Chi Minh City in the south of Vietnam, and illustrates the social and cultural factors that contribute to modern day views of mental illness, and the impact of such views on the lives of psychiatrists and families of the mentally ill.

Vietnamese cultural profile

http://ethnomed.org/cultures/vietnamese/vietnamese_cp.html

Synopsis: Pamela LaBorde, MD (1996) provides a detailed, informative and useful description of Vietnamese culture and belief systems and traditional medical practice, amongst other things.

Filipinos

The Mental Health of Filipino-born Women 5 and 14 Years after they have given birth in Australia: A longitudinal study

<http://www.atypon-link.com/EMP/doi/pdf/10.5555/hesr.2004.13.2.145?cookieSet=1>

Synopsis: Mental health impairment of Filipino women migrating to Australia to marry Australian men is discussed by Alati et al. (2003). The paper investigates the relationship between place of birth, social network size and symptoms of poor mental health, and concludes that these women experience greater distress and poorer social networks than their Australian counterparts in the early years after birth.

Health and health care of Filipino American elders

<http://www.stanford.edu/group/ethnoger/filipino.html>

Synopsis: This article by Helen McBride (1996) outlines a module for health care of Filipino American elders, and focuses on geriatric care. It also provides useful information about Filipinos in the US and the Filipino culture, values, communication, health beliefs and behaviours.

Hazel's story

<http://www.mpoweryouth.org/411ReadStoryHazel.htm>

Synopsis: This short article provides a young Filipino woman's (Hazel Moran, 2004) account on the perception of mental illness in her family and its relation to culture.

Malaysian

Mental Health Concepts and Program Development in Malaysia

<http://taylorandfrancis.metapress.com/content/w2x981v057u66u26/fulltext.pdf>

Synopsis: This article by Amber Haque (2005), explores the concepts of mental health within the different Malaysian ethnic/religious groups, and discusses indigenous psychology and cultural beliefs in Malaysia.

Indonesian

Mental Disorders in Indonesia (interesting read)

<http://faculty.fortlewis.edu/.../student%20presentations/Mental%20Disorders%20in%20Indonesia.ppt>

Synopsis: This power point presentation by Monica Hausler (2005) discusses the impact of culture on the mental health of Malaysians. Culture bound syndromes and the effects of the tsunami are discussed.

Mental health services and traditional healing in Indonesia

<http://www.springerlink.com/content/kn34r1r224001255/fulltext.pdf>

Synopsis: This paper by Salan and Maretzki discusses traditional healing in Indonesia and its implications for policies regarding relations between health and mental health services and traditional healers.

Thai

Views of mental illness and mental health care in Thailand: a report of an ethnographic study (need to check if this can be accessed outside Auckland University)

<http://www.blackwell-synergy.com/doi/pdf/10.1111/j.1365-2850.2006.01028.x>

Synopsis: This informative paper by Burnard et al. (2006), reports on causes of mental illness; status of the mentally ill; Karma, Merit making, Kwan; Treatment and care, amongst other things, in the Thai community. It illuminates aspects of Thai culture as they relate to mental health and mental health nursing.

Appendix C: Scoping Project Part Two: Email Evaluation

This evaluation is to help us gain a better understanding of the need for increased knowledge and awareness of Asian mental health issues within your current curriculum. We would appreciate it if you could please consider and answer the following questions and return as soon as possible to: Shoba Nayar - s.nayar@auckland.ac.nz.

Kind regards,
Asian Mental Health Project Team, Centre for Asian Health Research and Evaluation

QUESTION ONE: Does your undergraduate curriculum cover the topic of Asian mental health? If so, what aspects does it cover?

Please delete and type answer here

QUESTION TWO: Do you consider there to be a need for specific training information/materials regarding Asian mental health? Please explain.

QUESTION THREE: What do you think are the best ways to deliver information regarding Asian mental health to students e.g. lecture, workshop, online resources, workbook etc.

Appendix D: Letter of Introduction



THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND
HEALTH SCIENCES

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Moririn Road, Glenn Innes
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Email: a.sobrun-maharaj@auckland.ac.nz

30th March 2007

Re: CURRICULUM DEVELOPMENT: ASIAN MENTAL HEALTH

Dear Colleague

Asian peoples make up the fastest growing ethnic community in New Zealand and increasingly Asian peoples are accessing the mental health system. To provide appropriate services, mental health practitioners must become more knowledgeable about the influence of cultural factors on the prevention, presentation and treatment of mental health issues, and more skilled in interacting with Asian peoples.

In response to this need, the Centre for Asian Health Research and Evaluation (CAHRE) within the University of Auckland has in conjunction with Mental Health Programmes Limited trading as Te Pou, developed a project, which aims to train and equip tertiary education teachers to deliver preparatory information regarding Asian mental health issues within their nominated institutions.

We would like to invite you to be part of this project. At this stage, we would ask you to nominate a contact person in your department who will answer a few questions (attached) to provide us with a better understanding of what you are currently providing and what you feel would best work in a training programme such as the one we are proposing. This will be followed up by a telephone call to discuss relevant issues in more detail. Following analysis of your responses, our team will compile the training programme and keep you informed about the development.

We look forward to having your involvement and support with this project. If you have any further questions, please do not hesitate to contact us.

Kind regards,

Shoba Nayar
Research Fellow

Dr. Amritha Sobrun-Maharaj
Project Coordinator

Appendix E: List of Tertiary Education Providers Invited to Take Part in Scoping Exercise

Aoraki Polytechnic
AUT University (MH Support Work, Occupational Therapy, Psychology, Nursing)
Bay of Plenty Polytechnic (Counselling)
Christchurch Polytechnic (MH Support Work, Social Work)
Eastern Institute of Technology
Manukau Institute of Technology (Nursing)
Massey University
Nelson Marlborough Institute of Technology
Northland Polytechnic (Social Work)
Open Polytechnic
Otago Polytechnic (Nursing, Occupational Therapy)
Southern Institute of Technology
Tairāwhiti Polytechnic
Universal College of Learning
Unitec (Nursing)
University of Auckland (Nursing, Psychology, Medicine)
University of Canterbury
University of Otago (Psychology)
University of Waikato
Victoria University
Waiariki Institute of Technology (Nursing)
Waikato Institute of Technology
Wellington Institute of Technology
Western Institute of Technology
Whitireia Community Polytechnic (MH Support Work, Nursing, Social Work)

Appendix F: Scoping Evaluation: Response to Question One

QUESTION ONE: Does your undergraduate curriculum cover the topic of Asian mental health? If so, what aspects does it cover?

Response	Comment
1	We cover a limited range of mental health topics in an Introduction to Psychology paper at Level 4. From 2008 we will offer Level 5 papers in Psychology and Sociology. These will make some reference to cultural diversity including Asian, but it is very limited. Also from 2008 we will be delivering the National Certificate in Mental Health (Level 4). I would like to see information on Asian mental health included in the delivery of this programme.
2	We cover working in a multi cultural society and use Asian as a cultural group different from Pakeha, Maori and Pacifika. We have guest lecturers who specialise in Asian Health. They have focused on the immigrant experience, what it is like to live between two cultures, and how this affects mental health.
3	The topic of Asian Mental Health is covered in a 3 hour workshop/lecture which is centred around gender and ethnicity related to mental health concepts. There is no specific session on Asian Mental Health.
4	No, but students do attend a Treaty of Waitangi and intercultural skills workshop where they consider working with people from different cultures other than their own.
5	Not as a specific topic, as far as I know. However, I do not know the details of each UG paper's specific curriculum.
6	We do not have any specific curriculum content on Asian mental health at this time.
7	No not specifically, but is included within cultural discussions.
8	Not Specifically.
9	No it does not have any specific material about Asian mental health.
10	No our curriculum does not cover the topic of Asian mental health specifically. It does provide a critical analysis of cultural perspectives of mental health in the third year of the programme. Asian perspectives would be covered along with Maori, Pacific Island and a range of other cultural groups.
11	No, not specifically, student expected to work with the beliefs and values of the person / family they are nursing as per cultural safety guidelines.
12	In Theory & Practice 3 we discuss Asian culture in relation to gambling.
13	Immigrant and refugees and the issues that they face is covered in the mental health component of the nursing degree. This is in the 2 nd semester of the 2 nd year
14	No. It gets a brief treatment in two UG courses – one stage 2 course, Theories of Personality and Development, and a stage 3 course, Introduction to Clinical Psychology
15	An introduction to cross-cultural communication issues, when working with Asian patients. This is related to general medical training, rather than mental health specifically.
16	The course I teach has a bit of a focus on cultural safety, but nothing specific on Asian health. I'm uncertain about prioritising specific information about Asian health perspectives in the course that I teach - which is a postgrad certificate course on rehabilitation principles and practice - because I'm not sure how I could fit it into the programme. I think I would need to remove some other component of the programme to do the topic justice. I wonder if an Asian health course component

	would be better placed in a more specific mental health course, where it is more of an issue (??) - rather than a generic, introduction rehabilitation course such as mine.
17	Since I am not involved in teaching mental health paper, I have no comments on this question. There is mental health paper in the programme, I hope that you can get the details from the course co-ordinator if possible.
18	We do not have any specific curriculum content on Asian mental health at this time. What is delivered is integrated into the course and comes predominantly in the cultural sensitivity teaching and is dependent on individual tutor awareness and orientation to the topic being taught in mental health.
19	We briefly look at this in mental health support work when looking at working with families and whanau
20	No
21	No

Appendix G: Scoping Evaluation: Response to Question Two

QUESTION TWO: Do you consider there to be a need for specific training information/materials regarding Asian mental health? Please explain.

Response	Comment
1	Yes, with the increasing numbers of Asian persons in our communities it is essential to have more understanding of mental health from an Asian perspective.
2	Yes. As it is helpful for graduates to know about Maori and Pacifica models of health I think it is useful to know about Asian models of health. To reach this population I suspect that health practitioners need to know more about the balancing of the Yin Yan energies, the relationship between health and keeping family who have died (often translated poorly as ghosts) honoured or appeased, the dependency on what is translated as luck. I am sure there is more.
3	There is a need for information and training. We are faced in nursing education with limits to the content we can cover - especially mental health which, as I am sure you are aware, is a very wide field. It comes down to a limited time period to cover a vast expanse of knowledge. More materials and resources would be valuable.
4	This would be useful to our students, especially given your information about the increase in numbers of Asian peoples. However the XXX (name of the educational programme) is restricted in what can be covered in the curriculum, the focus is on XXX knowledge and skills as well as ensuring students meet the required clinical supervision hours.
5	Anecdotally, I would imagine that there is a need, particularly in light of the ever increasing number of Asian immigrants, and the many related stresses that come with migration.
6	We definitely feel there is need for Asian mental health to be covered. The areas of cultural expression of illnesses. Customs and practices related to mental health and how main stream services can improve their delivery of services. Differences in use of substances and gambling and support for refugees and migrants are some of the topics that spring to mind.
7	Yes. I am talking most specifically about the mental health Support Work national certificate and Diploma. We are hearing more from students on placement that they are working with people of Asian descent and want some guidance re this.
8	Yes, we are aware of the changing demographics and the limited response as yet to the needs of specific groups.
9	No. Our highest demand would be for Maori mental health. Next highest population group would be Pacific Island focused mental health information. Less than 1% of clients presenting at services identify as other ethnic groups. However, we have two students (who identify as Korean) who are completing our certificate course in Mental Health to help with the impact on the mental health of their whanau. Some indication of training requirement.
10	The culturally specific check list kind of approach is not helpful to undergraduates learning. Students are educated to approach mental health nursing from a humanistic model that seeks to care for individuals with specific or particular needs rather than from a cultural check list which can reinforce cultural stereotyping. Courses in Cultural Safety help to educate nurses to be aware of difference and to respond in ways that are culturally safe. Nurses carry out holistic nursing assessments and deliver holistic nursing care based on particular needs

	rather than generalised assumptions about race, ethnicity and culture. No I do not think there needs to be specific curriculum content for Asian mental health. Immigrant and refugees and the issues that they face is covered in the mental health component of the nursing degree. This is in the 2 nd semester of the 2 nd year
11	Given the demographics are changing for the total NZ population, with Asian peoples the 4 th dominant cultural group now in NZ, then yes, access to resources re Asian mental health issues would be helpful. I am always mindful that a checklist approach re cultural issues is not helpful and I am presuming this is not what is planned.
12	Yes, Asian community is one of the fastest growing populations in New Zealand.
13	Yes would be valuable as increasing number of Asian students, international students Information should include: A broad definition of mental health issues, types of interventions that are appropriate, Interpersonal/communication skills most useful in dealing with/managing a crisis and how to actually manage and support Knowledge regarding discrimination/stigma related to mental health issues in Asian cultures
14	Yes, but for this Department, at graduate level in the context of professional; training programmes. These programmes include clinical psychology, health psychology, applied behaviour analysis. I cannot comment on needs in other department courses.
15	Yes. It is a topic most of us non-asians are ignorant about.
16	Yes. I had the recent experience involving stroke rehabilitation for an Asian NZer. He was Buddhist, and blamed his stroke on 'not having worked hard enough' or 'not having done enough good work' in his life. I picked this bit of information up during interviews for a qualitative study - rather than through clinical interaction. I wondered what impact this belief had on his recovery (which was poor). I suspect the rehabilitation team did not know this bit of information about this man and I wonder what they would have done (if anything) if they did know. (I did pass this information on to the team, but did not see any consequences from having done so.) How would you screen for this type of clinical information in the first place? Of note: Asian NZers don't seem to be a large demographic in the stroke population - particular in the smaller NZ hospitals.
17	Yes. Beliefs and values that Asian people hold in terms of general health and mental health care are apparently different from that/those of the mainstream culture/s in New Zealand. Besides, there exists heterogeneity in the health belief systems among the Asian cultures and subcultures. It would be very essential to provide specific information/materials when a particular Asian ethnic group is addressed. It would avoid people coming to a presumption that all Asian people are same in this aspect.
18	We definitely feel there is need for Asian mental health to be covered. The areas of cultural expression of illnesses. Customs and practices related to mental health and how main stream services can improve their delivery of services. Differences in use of substances and gambling and support for refugees and migrants are some of the topics that spring to mind.
19	Yes I do, support workers need an awareness of how culture may impact on their recovery
20	Yes. To have an understanding of how Asian peoples view mental health as a concept, issues around mental health diagnosis and treatment, access to appropriate mental health services and support etc. Are there mental health issues specific to new migrants from Asian countries as opposed to people New Zealand born of Asian descent.

21	Not at present. Our curriculum has a particular focus on Maori and Pacific models of practice. This might be an area to move towards if service demands increase.
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Appendix H: Scoping Evaluation: Response to Question Three

QUESTION THREE: What do think are the best ways to deliver information regarding Asian mental health to students e.g. lecture, workshop, online resources, workbook etc.

Response	Comment
1	Our programmes are currently classroom based delivery. For the future it would be very helpful if there was a website that had resources and information on Asian mental health that student could access whether they were classroom based, part time at work students, or studying on line.
2	Principles of adult education demonstrate that action learning methods stimulating enquiry work best. I work with smaller classes – 20 to 30 people -, use vignettes small group discussion report to the whole group. I am prepared for people who do not have a good command of English and repeat things clearly with minimal (I hope) ambiguity. This has allowed Asian student to move beyond their expectations of education being learning what they are told. They move into really learning, making links to previous knowledge and life experience. This makes for excellence health professionals
3	A combination of workshop and on-line resources would be helpful for this topic area.
4	I believe that an on-line resource would be the best option. Students could be directed to this resource. It could include a range of information and even have mini tests to help students understand Asian cultures. We could easily direct students to such a resource and link it to the Universities on-line learning platform
5	I do not have enough background information to conjecture. I would guess that any of the methods noted above would be effective, depending on the class and subject.
6	Such content needs to be integrated across the whole curriculum and as such needs to be delivered by all modes of teaching. Specifically in mental health an interactive approach with ability to consolidate in clinical practice would appear to be best practice but given the lack of Asian service providers in the Role it is difficult to provide currently.
7	A workbook and guest lectures. We have found that stories of personal experiences form individuals have really enhanced students learning.
8	This depends on the programme/course and the level of students. A range of methods of delivery to meet the varying needs of students, the different types of delivery methods in the courses they have chosen and the depth of knowledge they need. ie Level 4 Cert in Community Studies needs an awareness based face to face style versus a Level 7 Bachelor in Social Work student completing a Mental Health course needs awareness plus a deeper level of content, context and networks.
9	At level 4 training a combination of approaches is required: lecture, resources and workbook to internalise the information provided by the first two options.
10	Effective teaching supported by clinical practice is the best way to deliver a quality nursing education. If you only want to deliver information then I guess that's a different question. Information giving is different from education – so this is a difficult question to respond to in a short time.
11	Online resources, regional populations vary.
12	All of above, especially given by an Asian representative.
13	Lectures/ workshop provided by Asian groups, Online resources
14	This depends on the context. Which course? Which students? In professional programmes in Psychology, we use workshops. In UG programmes, lectures with

	associated resources.
15	Lectures can be expedient, and online resources are able to be more widely utilised. Lectures tend to give a subject a certain face-validity, and this increases the chance that people think about the subject a bit more seriously.
16	Lectures, workshop, online resources
17	I think that all of the ways mentioned are useful. The critical point is to provide opportunities for other people to know about what mental health means to the Asian people. Workshop can be more helpful for students of other cultures to ask questions and clarify any misunderstandings. Health care professionals or consumers from certain Asian cultural groups can be invited or involved in the workshop presentation and discussion. It will convey a clear message and enhance the communication.
18	We definitely feel there is need for Asian mental health to be covered. The areas of cultural expression of illnesses. Customs and practices related to mental health and how main stream services can improve their delivery of services. Differences in use of substances and gambling and support for refugees and migrants are some of the topics that spring to mind.
19	lecture followed up with workshop that is interacted with the students.
20	Lecture and workshop to enable discussion and untangling of issues. On line resources to support in class discussion.
21	A range of methods might be appropriate, depending on the student group, their level of formal qualifications, their access to study resources and their knowledge of computer related technology.

Appendix I: Follow Up Contact with Tertiary Institutions

Dear Sir/Madam,

Firstly we would like to thank you for taking the time to respond to our request earlier this year for feedback regarding the place of 'Asian Mental Health' training within your current curriculum.

The responses suggest that there is a need for Asian mental health training. This is supported by:

- Our New Zealand population statistics show that Asian peoples make up the biggest and fastest-growing ethnic community, comprising 9.5% of our current population.
- This proportion is expected to grow to almost 15% of the national population by 2020.

Consequently, cultural capability of the future mental health workforce is essential to ensure that Asians have equity in access to appropriate and high quality services.

Our project team has been working hard on developing such material which you can incorporate into your teaching. At this stage the material will be presented in a CD format, which we envision can be used as part of your mental health teaching module. The key features of the Asian mental health curriculum include:

- Powerpoint slides with the presenters' voice that you can use in one or two 50-minute lectures
- Another 2-3 hours interactive, self directed learning material which students can access it thru your institution list server in their own time

We will be offering this valuable teaching resource FREE for your use. In return, we would appreciate it if you could nominate someone who would be responsible for using this material and incorporating it in to the curriculum. We would like to remain in contact with this person to discuss the implementation of the material and ascertain further down the line, the usefulness of such a resource. If we could please have the Name, Phone Number, and Email address for this person, it would be very much appreciated.

We look forward to hearing from you.

Kind regards,
Amritha Sobrun-Maharaj (Project Coordinator)
Shoba Nayar (Research Fellow)

Appendix J: Names of Tertiary Institutions Participating in Trial of Using the CD in their Mental Health Teaching

Aoraki Polytechnic (Mental Health Support Work)
AUT University (Mental Health Support Work, Occupational Therapy, Nursing)
Christchurch Polytechnic (Mental Health Support Work, Social Work)
Northland Polytechnic (Social Work, Nursing)
Southern Institute of Technology (Nursing, Mental Health Support Work)
Unitec (Counselling, Social Work)
University of Otago (Psychology, Clinical Psychology)
Otago Polytechnic (Occupational Therapy)
Waiariki Institute of Technology (Nursing)
Waikato Institute of Technology (Mental Health Support Work, Social Work)
Whitireia Community Polytechnic (Mental Health Support Work, Social Work)

Appendix K: Supplementary Notes to CD

Use of CD

Before you use this CD, you need to ensure your computer has the necessary software. This can be checked by referring to the help section at the bottom of the home page.

This CD may be utilised in various ways to best suit your purpose. It is designed as an interactive module; hence, we would encourage you to modify it to meet your needs. Suggestions for use range from using it as a two hour lecture to lectures, workshops and tutorials over two days.

Example: 2 hour lecture

Recommendations for a 2-hour lecture include the following:

- Click and play the “scenario” section on the CD to set the scene for the study; there may be places/ slides where you wish to pause and invite the class for a discussion.
- Module 1: Introduce the concept of self-reflection and its purpose in such a study; encourage learners to do it on-line and in own time. Please note one of the activities in Module 1 entitled “Knowing your body language” is particularly suitable for small group discussion.
- Module 2: Introduce the concept of Asian philosophy and some guidelines on how to use Module 2; encourage learners to do it on-line and in own time. Please note in the resources section, there are materials specific to various ethnic groups (e.g. Japanese, Vietnamese) within the Asian populations.
- Module 3: Introduce Module 3– Clinical Issues, and its purpose; encourage learners to do it on-line and in own time; there are eight powerpoint lectures on various important topics pertinent to Asian mental health.
- Select and play relevant Powerpoint lectures within Module 3 over the 2-hour lecture slots in class. Our suggestions are:
 - “Mental health assessment and diagnosis of Asian adults: Challenges” by Ashok Malur (consultant psychiatrist) (approximately 30 mins)
 - “Working with young Asian people and family” by Chohye Park (consultant psychiatrist) (approximately 18 mins)
 - “Working with international students” by Shizuka Torii (psychotherapist) (approximately 25 mins)
 - “Assessment and diagnosis in cross-cultural setting: The Chinese example” by Sai Wong (consultant psychiatrist) (approximately 1 hr 10 mins; you can stop after slide 22, “rapport in nutshell” and encourage learners to go through the case study in the remaining slides in their own time)

Other options:

- Students may engage in self-study of modules followed by tutorials and class discussions
- Self-study may be followed by answering questionnaires/quizzes in class, which will generate further discussion. The questionnaire on “Knowing your body language” would be best used for class discussion rather than individual work.
- Questionnaires may be printed and used in class
- Lectures or powerpoint notes may also be printed and used as handouts