

**“Train the trainers project”  
Asian mental health workforce development**

**PHASE ONE  
REPORT  
13 December 2006**

**COLLATION OF PROGRAMME RESOURCES**

**Primary outcomes of this phase:**

- Locate resources relating to programmes using a train the trainers’ concept.
- Identify additional information pertaining to Asian mental health that may be incorporated into the materials trainers use when teaching the programme to future participants.

**Background**

The New Zealand census data has established that the Asian population is one of the fastest growing ethnic groups in New Zealand. Policy and research documents over the past ten years have also highlighted the need for the health service workforce to be able to respond to the mental health service needs of New Zealand Asian population (Tse *et al.*, 2005). A review of New Zealand literature on cultural competence suggests that there is no national strategy or policy to address the mental health issues of the full range of ethnic groups living in New Zealand (Ministry of Health, 2004), and that cultural workforce development is at its early stage in New Zealand. In order to gain the knowledge, attitudes and skills needed to effectively work with Asian people affected by mental illness; mental health workers must receive appropriate education and training.

“Health care providers can deal with their clients more competently if they are knowledgeable of their clients’ cultural beliefs, their interpretation of mental illness and mental well-being, their help seeking patterns and choice of traditional alternative health practices” (Ho, Au, Bedford & Cooper, 2002, p. 51). Health services that provide culturally competent care can prevent inappropriate advice, misdiagnosis, inappropriate treatments and inadequate interventions therefore minimising the national health costs (Bedell *et al.*, 2004; Bhui & Bhugra, 1997; Bhui *et al.*, 2003; Kirmayer, 2002).

## **1. RESOURCES RELATING TO THE PROGRAMME**

### **1.1 Literature on Cultural Competence:**

#### **A) Work undertaken by the Asian Mental Health Workforce Development Feasibility Project**

The Asian Mental Health Workforce Development Feasibility Project (Tse *et al.*, 2005) examined national and international literature on cultural competence in mental health. The review of international literature provided a wider context within which the cultural capability and cultural competence in mental health care for Asians could be discussed. The literature search included strategic documents on workforce developments and cultural competence and cultural capability in Asian mental health. It also identified theoretical work done in cultural capability and cultural competence models that focus on workforce cultural responsiveness and culturally safe practice.

A review of the literature (ibid: 41) shows that cultural competence and capability comprise thought and action at several levels:

1. The organisational, health care context and policy environment is critical to the success of culturally responsive mental health services.
2. Attitudes, knowledge and skills of staff are key to developing an effective workforce. This includes personal development dealing with conflicts and informed discourse around ethnicity, culture, and dealing with the “other”. Staff here refers not only to practitioners, but to team leaders, service advisors, managers, commissioners and policy makers.
3. There are specific issues to do with specific populations of interest. Much work in New Zealand focuses on Maori people, and shows great respect and nurturance for identity. Does this lead to better clinical outcomes, or are there still disparities?
4. There is much to learn across specialities of health care, but also from social care practices and from “traditional” or “indigenous” approaches to recovery and resilience. Specific conditions may challenge either the diagnosis, intervention delivery, engagement, or all of them. Therefore syndrome based diagnostic practice or needs assessment in mental health care requires regulation and safeguards the needs articulation by professional bodies and governance committees of service providers.
5. Much of the above is geared towards ensuring accurate assessment, and appropriate interpretation of distress experiences. Interventions must then be appropriately offered, and considered within a “choice” agenda for service users to adapt. Providing accurate information and explaining choice dilemmas with respect before intervention is important but time consuming, and perhaps one key finding is that such work requires time, and not just good intentions. Thus psycho-education for a patient for whom medication is taboo, takes time. If time is not available, hasty decision making may lead to a breach in the therapeutic alliance, or worse still, activate compulsory procedures.

6. Strengthening cultural capability to care delivery must be systematised; service users and practitioners will need to change ways of working with each other; existing professional curricula will need to change, as well as continuing professional development portfolios within professional bodies.

7. Service models for especially hard to reach or socially excluded populations (for example, people with refugee background, older Asian people) are necessary, but must be carefully interfaced with mainstream services.

8. Finally, there is a need for active evaluation of service models, and methods of providing interventions. Evidence based evaluations are few. This process of developing an evidence base is crucial. This need not only be formalised research, but consumer inspections of facilities, and organisational performance frameworks. These are linked with commissioning frameworks and practice standards at all levels. Regular feedback from consumers about the services they use and do not use must be the most powerful evaluation process.

### *Recommendations of the Feasibility Study*

Based on the literature review, the above-mentioned feasibility study proposed an educational programme and recommended that:

- The above models and their proposed educational programme are offered for consultation, but that a portfolio of models may be more appropriate. Asking consumers to participate in this crucial stage of policy and service development in Aotearoa New Zealand is important, perhaps even asking consumer organisations to be commissioned to oversee the work through a partnership approach spanning across diverse communities.
- Adopting any model whilst perpetuating institutional or conventional practices is not the objective. All the models clearly show a great deal of developmental work on individuals and organisations. The work must thus require each organisation and professional body to demonstrate their active engagement with these issues, whilst providing the workforce with accredited training processes that are ongoing.
- For the Asian population, and future migrant groups, a systems approach to cultural capability should address narrow and broader issues. For example, understanding the specific spiritual life of Maori may engender a different approach to engagement when compared with a Chinese person. The knowledge and skills of practitioners have to include this fine detail. The educational programme we recommend is aimed at initiating personnel development challenges and knowledge base. Skills development will be in practice, and will have to be regulated through existing professional regulations, and governance processes.
- Key stakeholders are identified, and funding explicitly agreed to progress this programme that could maximise health care benefits to all New Zealand citizens.

## **B) The Beginning Phase of Asian Mental Health Training in Aotearoa New Zealand**

The Beginning Phase of Asian Mental Health Training in Aotearoa New Zealand (Tse *et al.*, 2006) developed and implemented the educational programme proposed in the Feasibility Study (Tse *et al.*, 2005) in the form of pilot workshops in Auckland, Wellington, Christchurch and Dunedin. This study identified a demand for more training across the nation. This is supported by national and international literature and by Ministry of Health policy and strategy recommendations.

Specific *recommendations* from this report include:

- Continue development and delivery of training programmes for Mental Health clinicians working in primary mental health sectors, non-government organisations and primary health organisations.
- Research and evaluation: Develop evidence-based processes to underpin the service delivery of the Asian Mental Health Workforce Development programmes.
- Promote partnerships with tertiary training providers and other identified stakeholders to support delivery of training and create clear qualifications pathways into the sector.

### **Resources from the past work that will benefit the present project:**

1. Knowledge gained from delivering a two-day block course to mental health practitioners e.g. the learning needs identified by practitioners
2. A network already built between the Asian health centre and key people from DHBs in the four major cities.
3. An educational resource to be used for further development in this project
4. Participant pre-workshop questionnaire
5. Participant pre and post-workshop evaluation forms
6. Discussion guidelines for use with training DVD
7. Workshop Handouts including the following:

#### *Booklet 1: Culture and Mental Health: Principles of Cross Cultural Practice: The Asian Perspective*

- Overview of what is meant by the term ‘Asian’
- A framework to understand culture and health practices
- Practical implications of framework
- Culturally endorsed adaptive strategies
- Issues/themes associated with mental health
- Impact of migration on mental health
- Common cultural themes associated with mental health
- Intergenerational conflict

- The principles/skills of assessment and management
- Specific skills: Interviewing
- Specific skills: Working with young people
- Specific skills: Working with interpreters
- Skills in cross cultural ethics
- Chinese migrant issues
- Case vignettes
- Natural medications: indications, doses and adverse effects
- Hamilton Depression Scale in Cantonese
- Mini Mental Scale in Cantonese
- Becks Depression Inventory in Cantonese

*Booklet 2: Culture and Mental Health: Principles of Cross Cultural Practice: The Asian Perspective – Putting it Together Day Two*

- Culture schemas: Functions of culture in relationship to mental health
- Practical implications: Cultural endorsed adaptive strategies
- Skills in assessment and management
- Improving on clinician qualities
- Utilisation of knowledge/clinical sense to rationalise management
- Applying clinician qualities, knowledge/skills in formulating management
- Special issues: Use of interpreters
- Special issues: Mental status exam
- Chinese examples
- Special issues: Ethics
- Special issues: Planning and finding resources
- Special issues: Culture bound syndrome
- Special issues: Eating disorders
- Special issues: Japanese population
- Special issues: International students
- Special issues: Sexual issues
- Special issues: Spirituality
- Special issues: Gambling
- Special issues: Migrant issues
- Interaction with community support workers
- Need for support

*Additional Handouts:*

- Symptom Checklist in Cantonese
- Cognitive Programming
- Culture, ethnicity and mental illness
- Guide to case studies
- Formulation guide to case studies

*Book of Readings and Resources:*

- Nine printed articles
- Four pages of additional references to reading material
- Resource List – both Auckland based and nationwide available resources
  - Information/Education/Advice

- Counselling/Psychotherapies
- Health Services
- Rehabilitation
- Social Support Services
- Client Support Groups
- Peer Support, Professional and Staff Development
- Health Interpreter Service

This project follows on from the beginning phase and develops an improved education programme to “train the trainers” who will then train the mental health workforce.

The practical experiences, the teaching and learning material used in delivering the training on Asian mental health will enhance new developments of the train the trainer programme and the New Zealand mental health workforce’s cultural capability to work with Asian service users and their families.

## **1.2 Cultural Training: The Inclusive Cultural Empathy (ICE) perspective and The Interpersonal Cultural Grid**

Apart from the literature that has already informed the development of the initial educational programme, the following perspective on cultural empathy may be a useful tool in informing the further development of the educational programme to be utilised to train the trainers.

Pedersen (2006) proposes the concept of an Inclusive Cultural Empathy (ICE) which is applied to a culture-centred perspective of counselling. It sees Asian cultural empathy as “divergent” and inclusive, and moving from the individual person toward inclusion of the broadly defined cultural context in which that individual lives. In contrast, conventional empathy typically develops out of similarities between two people. ICE describes a dynamic perspective that balances both similarities and differences at the same time integrating skills developed to nurturing a deep comprehensive understanding of the counselling relationship in its cultural context. Inclusive Cultural Empathy has two defining features: (1) culture is defined broadly to include “culture teachers” from the client’s ethnographic (ethnicity and nationality) demographic (age, gender, life-style, residence) status (social, educational, economic) and affiliation (formal or informal) backgrounds and (2) the empathic counselling relationship values the full range of differences and similarities or positive and negative features as contributing to the quality of that relationship in a dynamic balance. ICE goes beyond the exclusive interaction of a counsellor with a client to include the comprehensive network of inter-relationships with culture teachers in the client’s cultural context.

ICE does not require the compromising exclusion of categories to find common ground but rather enriches the counselling relationship through inclusion of both the counsellor and the client’s diverse perspectives as they contribute to the growing and ever-changing relationship. The ultimate outcome of such multicultural awareness, as Segal, Dasan, Berry and Poortinga (1990) suggest, is a contextual understanding. Multiculturalism has now become recognized as a powerful force, not just for

understanding “specific” groups but for understanding ourselves and those with whom we work (Sue, Ivey & Pedersen, 1996).

An understanding of ICE moves from gaining increased

- **Awareness** (of culturally learned assumptions, context, and experiences) as a primary prevention strategy to gaining increased
- **Knowledge** (information and essential facts about the cultural context) as a comprehension protection strategy to gaining increased
- **Skill** (making decisions and taking action based on accurate awareness and a meaningful understanding of the cultural context) as an accurate and interactive promotion strategy

Inclusive Cultural Empathy recognizes that the same behaviours may have different meanings and different behaviours may have the same meaning. By establishing the shared positive expectations between and among people the accurate interpretation of behaviours becomes possible. The Interpersonal Cultural Grid is used to understand how cultural differences influence the interaction of two or more individuals.

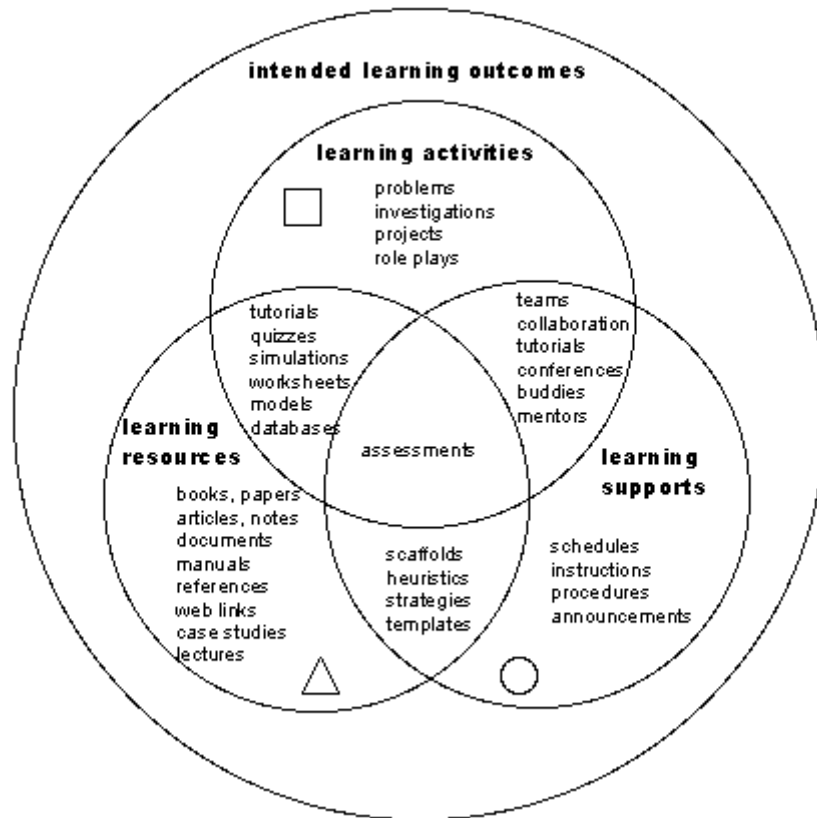
This perspective is relevant to this project and applicable to the whole mental health workforce, and will inform the development of the programme as well as the cultural philosophy and understanding of the trainees.

### **1.3 Learning Design including Multi-media Learning:**

This project will focus on learning designs implemented with the use of Information and Communication Technologies (ICT). The learning design will comprise the following key elements (Oliver, 1999):

- Tasks that learners are required to do.
- Resources that support learners to conduct the task.
- Support mechanisms that exist from a teacher implementing it.

The basis for this construct is informed by the work of Oliver (1999, 2001) and Oliver and Herrington (2001) that identifies the critical elements required in a learning design, particularly when ICT mediated. The critical elements comprise the content or resources learners interact with, the tasks or activities learners are required to perform, and the support mechanisms provided to assist learners to engage with the tasks and resources. This is illustrated in Figure 1.



**Figure 1:** Components of a learning design

- **Learning Activities:** This will include:

- 1) *Training on Asian mental health issues:* this will cover material similar to that used in the previous round of training, with specific emphasis on: understanding Asian philosophies and their impact on Asian mental health, covering various ethnic groups within Asian populations, working with young people, older people, and people with addictive problems.
- 2) *Training the trainers:* this will cover developing reflective skills, self-awareness and multicultural awareness and basic tips on how to be effective teachers, and understand practitioners' and patients' needs.

- **Learning Resources:** This will include:

- 1) *CD:* this will cover aspects such as self-reflection, self-awareness and multicultural awareness, and Asian philosophies.
- 2) *Book of Readings:* this will include relevant articles, papers, documents, case studies, web links pertaining to the issues listed above (if possible, the readings will be in PDF format as part of the CD resources)

- **Learning Supports:** This will include:

- 1) Specific instructions and procedures for training
- 2) Ongoing telephone and email support to trainers during the course of the one year programme.

The following publication on adult and online learning and teaching could further inform our work: The publication entitled: “Adult Learning Styles. Implications for Traditional and Online Learning” by Judith M. Smith (2006), explains differences in adult learning styles and their implications for traditional and online learning. It will assist us with identifying the best ways in which to present our programme to trainees at the workshop and on line.

## **2. ADDITIONAL INFORMATION PERTAINING TO ASIAN MENTAL HEALTH THAT MAY BE INCORPORATED INTO THE MATERIALS**

### **2.1 Effective Trainer**

To be an effective trainer, the following two components need to be paid particular attention:

- Self-reflection, awareness of own cultural heritage and origin, and multicultural awareness
- Asian philosophies and their impact on Asian mental health

#### ***Training for Self-reflection, Self-awareness and Multicultural awareness:***

In order to be able to train others in cultural competence, one needs first to know oneself. Self-reflection will enable understanding of one's own culture to facilitate understanding of another's culture. To achieve this, a cultural role-playing exercise may be useful. This is based on the four synthetic cultures (Pedersen, 2006) of Alpha, Beta, Gamma and Delta. Such an exercise will enable participants to:

- Identify one's own culture
- Increase one's multicultural self awareness
- Develop a framework for understanding other cultures including similarities and differences between cultures

#### ***Understanding Asian philosophies and their impact on Asian mental health:***

It is well documented that Asian people have their specific worldviews and beliefs toward mental health problems. The following points are intended to highlight some pertinent issues which are relevant to this "Train the Trainers" project.

- Utilisation of mental health services: Asian people, in particular immigrants, often do not present early to mental health services when they need to. Rather, they seek professional help when their condition is extremely severe and other resources have been exhausted. For some Asian people, lack of knowledge of services available, distrust, perceived racism and language difficulties pose the primary barriers. Stigmatisation and the 'taboo' of psychiatric illness compound the problem further resulting in the reluctance of Asian patients and/or family members seeking early intervention or treatment.
- Holistic and naturalistic orientation: Traditional Asian concepts for example, Chinese concept of mental health advocate a holistic and naturalistic approach. This involves the notions of harmony, an integration of mind and body, individual and universe, which may not be taken account of in studies about the larger population or Western medical practice.
- Use of traditional and alternative treatment: Traditional treatments, for example, herbal medicine, acupuncture and therapeutic massage have been popular among, and long used, by Asian people in general, for healing sickness - physical and mental. This training programme will cover brief discussion on the effects of traditional treatments as an important factor for recovery.
- Collective orientation: Within traditional Asian concepts of mental health, the sense of self-worth, social functioning and satisfaction are defined by others. Generally speaking, Asian culture places high importance on family (including

extended family - local or overseas in some cases), hierarchical order, and social norms such as deference to seniority.

- The role of the family/whanau: In Asian traditions, the family is the fundamental unit of society and source of strength for the individual in times of adversity such as suffering mental illness. In many cases, a family member's mental illness can upset the balance or harmony of family relationships.
- Confucianism and Taoism (affecting South East Asian & East Asian): Asian people under the influence of traditional culture may interpret 'advocacy' and 'empowerment' as a challenge to deep-rooted Confucianism with its emphasis on self-sacrifice, suppressive harmony, benevolence and forgiveness. Similarly, in the Taoistic concept of mental health, the virtue of tolerance and endurance to ensure the fulfilment of the "Law of Nature" may be preferred to exercising 'self-determination'.
- The principle of Karma (affecting Hindus and Buddhists): Asian ethnic groups are influenced by the concept of Karma which maintains that cause and effect is determined by our own actions, i.e. positive actions bring positive effects and vice versa. This mindset facilitates the acceptance of negative phenomena such as illness as part of life, and encourages endurance of pain. Hence, many view suffering and illness as an unavoidable part of life, which inhibits them from seeking medical help for illness, especially mental illness.

Furthermore the following publications on Asian philosophies will assist in understanding these philosophies and their impact on Asian mental health. They will also inform the programme, and relevant sections will be included in the book of readings:

- Morgan, D. (2001). *The best guide to eastern philosophy and religion*. Los Angeles, Ca : Renaissance Books.

This book provides a thorough discussion of the most widely practiced belief systems of the East. It directs the materialistic, linear way of Western thinking toward a comprehension of the cyclical, metaphysical essence of Eastern philosophy.

- Ram-Prasad, C. (2005). *Eastern philosophy*. London : Weidenfeld & Nicolson.

The book discusses the philosophies and thought systems of the East, including Indian, Chinese and Japanese, encompassing the key themes of all major systems of thought. It gives a sense of the diversity and depth of these philosophical cultures, and will facilitate understanding of the Asian mindset.

- Leaman, O. (2002). *Eastern philosophy: key readings* [electronic resource]. London : Routledge.
- Billington, R. (2003). *Understanding Eastern philosophy* [electronic resource]. London ; New York : Routledge.
- Nakamura, H. (1964). *Ways of thinking of Eastern peoples: India, China, Tibet, Japan*. Rev. English translation, edited by Philip P. Wiener. Honolulu, East-West Center Press.

These books discuss the philosophies of India, China and other eastern countries. Relevant readings from these publications will inform discussions and be included in the book of readings.

## 2.2 International studies on Asian mental health

- Silverman, M. (1979). *Vietnamese in Denver: Cultural conflicts in health care. Proceedings of the First Annual Conference on Indochinese Refugees*. George Mason University: Fairfax, VA. (pp. 23-6).
- Tung, T. (1980). The Indochinese refugees as patients. *Journal of Refugee Resettlement, 1*, 53-60
- Thao, X. (1984). Southeast Asian refugees of Rhode Island: the Hmong perception of illness. *Rhode Island Medical Journal, 67*, 323-30
- Carlin, J., & Sokoloff, B. (1985). Mental health treatment issues for Southeast Asian refugee children. In T. Owen (Ed.). *Department of Health and Human Services Publication No. (ADM) 85-1399*. US Department of Health and Human Services (pp. 91-112).
- Brainard, J. (1989). Changing health beliefs and behaviours of resettled Laotian refugees. *Social Science & Medicine, 29*, 845-52
- Chang, D. F., & Kleinman, A. (2003). Growing pains: Mental health care in a developing China. *Yale-China Health Studies Journal, 1*(1), 85-98
- Yip, K.S. (2003). Traditional Chinese concepts of mental health: The implications for multi-cultural professional counselling practice. In W.O. Phoon & I. Macindoe (Eds.). *Untangling the thread: Perspective on mental health in Chinese communities* (pp.127-143). Sydney: Transcultural Mental Health Centre
- Kuo, G.M., Hawley, S.T., Weiss, L.T., Balkrishnan, R., & Volk, R.J. (2004). Factors associated with herbal use among urban multiethnic primary care patients: A cross-sectional survey. *BMC Complementary and Alternative Medicine, 4*, 18-27
- Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Racism and health: The relationship between experience of racial discrimination and health in New Zealand. *Social Science and Medicine, 63*(6), 428-441
- Porter, M., & Haslam, N. (2006). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons. *Journal of American Medical Association, 294*(5), 602-612
- Huang, S-L., & Spurgeon, A. (2006). The mental health of Chinese immigrants in Birmingham, UK. *Ethnicity and Health, 11*(4), 365-387

## 2.3 New Zealand studies

Findings of a recent New Zealand study will be utilized to inform the programme content, particularly aspects concerning the impact of Asian worldview on mental and physical wellbeing:

Tse, S., Sobrun-Maharaj, A., & Hoque, E. (2006). *Research and Evaluation of Barriers to Asian People accessing Injury Related Services and Entitlements*. Centre for Asian Health Research and Evaluation, Auckland UniServices Limited, University of Auckland. Prepared for Accident Compensation Corporation, 102pp.

Nayar, S., & Tse, S. (2006). Cultural competence and models in mental health: Working with Asian Service Users. *International Journal of Psychosocial Rehabilitation*, 10 (2), 79-87.

Nayar, S. (2005). Understanding Western and Hindu women's identities: a basis for culturally safe practice. *New Zealand Journal of Occupational Therapy*, 52(1), 38-44.

Other relevant publications and material will be included as the project progresses.

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