FACT SHEET 1:
WHY DELIVER RESPONSIVE SERVICES?

SERVICE RESPONSIVENESS FOR ASIAN, REFUGEE AND MIGRANT POPULATIONS

This fact sheet outlines why we should all be taking action to improve service responsiveness for Asian, refugee and migrant communities with experience of mental illness and/or addiction. It finishes with specific recommendations for how different stakeholders can work to improve mental health and addiction service responsiveness for these groups.

Delivering effective mental health and addiction services for ethnic minority groups is a key service development area both in New Zealand and internationally.[1] A range of factors have driven the increased focus on the need for responsive services:

- the range and size of ethnic minority groups in New Zealand is increasing
- evidence is increasing of unequal access to health and mental health services
- communities are advocating for services that consider their unique cultural perspectives
- innovative adaptations are being developed to improve cultural responsiveness
- cultural responsiveness is increasingly being recognised in health service law and policy.

THIS SERIES OF FACT SHEETS IS AIMED AT PEOPLE ADVOCATING FOR, DEVELOPING, ADAPTING, CONTRACTING, FUNDING OR PLANNING MENTAL HEALTH OR ADDICTION SERVICES.

There are four fact sheets in the series.

1: Why deliver responsive services?
2: Planning and funding
3: The evidence base
4: Useful resources and links

1 - See fact sheet 2 for statistics from other urban centres.

++See fact sheet 2 for more information.

Te Pou o Te Whakaaro Nui
RESEARCH
TRANSLATING RESEARCH

POPULATION SIZE

The Asian population is our third largest ethnic group (9% of the population in 2006) behind European and Maori.[1] The proportion of Asian people in New Zealand is predicted to increase to 16 per cent by 2026. In Auckland, Asian is the second largest ethnic group, making up 23% of Auckland city, 20% of Manukau, 15% of Waitakere, 18% of North Shore city populations.[1]

Between 3 and 13 per cent of many other New Zealand urban populations also identify as Asian. For example, Asian communities make up 13 per cent of the population of Wellington, 11 per cent in Hamilton, 8 per cent in Christchurch and 7 per cent in Palmerston North. [1*] The largest ethnic groups within the Asian population are Chinese, Indian and Korean.

One in five New Zealanders were born overseas, representing a significant part of our population. Similar to the Asian population, migrants tend to reside in New Zealand urban centres. A number of migrants (approx 65%) come from countries with languages, cultural practices, beliefs and values that are distinct from New Zealand's European or Maori traditions.[**] This includes people from Asia (28.6 % of overseas born New Zealanders), the Pacific (15.5 %) Europe (7.5%) and from countries outside Europe, North America and Australasia (such as South Africa and the Middle East) (9.5 %).[1] The children of people born overseas (second generation migrant and refugee communities) are also recognised as having unique needs from the mainstream New Zealand population. Furthermore, mental illness appears to be more common in second and third generation migrants than overseas born migrants[6]. The 2004 New Zealand Mental Health Survey found that New Zealand-born Pacific people (second and third generation migrants) were twice as likely to have experienced mental illness in the previous 12months compared with overseas born Pacific people (31.4 vs. 15.0%).[2]

Refugee communities make up a smaller but important part of our population. Each year, around 1000 people from a refugee background enter New Zealand. During the 1990s, most refugee people entering New Zealand originated from Cambodia and South-East Asia. In recent years most refugees have come from Iraq, Somalia, Ethiopia, Afghanistan, and Burma/Myanmar.[3] Following a six week orientation to New Zealand, refugees are placed in one of the eight resettlement cities - Auckland, Hamilton, Palmerston North, Wellington, Hutt Valley, Porirua, Nelson or Christchurch.[3]

NEED FOR HEALTHCARE SERVICES

Asian, refugee and migrant population groups have a range of languages, cultures, religions, social norms and settlement needs. These groups also have traditional beliefs and practices for responding to mental health concerns.

Settlement challenges are experienced by members of all three groups, and these challenges elevate the risk of mental illness. Settlement risk factors include limited knowledge of the healthcare system, language difficulties, limited access to appropriate employment, and challenges maintaining family and social networks.[4] Refugee communities also have added stressors associated with forced migration, including increased rates of trauma and family separation (see reference 6).

The rate of mental illness in Asian, refugee and migrant population groups in New Zealand is unknown. International research suggests that rates of mental illness vary within Asian and migrant populations. Variation in rates of mental illness in part reflects different levels of exposure to the risk factors noted above. [5,6] International research suggests that refugee communities have particularly high levels of mental illness.[5]

The high rates of mental illness in refugee communities and experience of pre-migration, migration, settlement stressors increase the importance of providing specialist care to refugee communities.

LOW ACCESS TO SERVICES

Despite apparent need, Asian and migrant communities are less likely to access health and mental health services than the general population.[7,8] For all three groups rates of service access do not match the predicted levels of mental illness.[8, 9] High levels of acuity on entry to services, combined with relatively low rates of access suggests that these population groups often delay seeking help from services until they have acute distressing mental illness symptoms.[9]

A number of barriers contribute to low rates of service access.[4, 15, 16] Some of the key service access barriers are noted below;

HEALTH SYSTEM CHARACTERISTICS

- Inaccurate diagnoses.
- Insufficient interpreting services.
- Appropriate referrals not provided.
- Lack of refugee or migrant specific services.
- Limited cross-sector collaboration and referrals.

CULTURAL PERSPECTIVES

- Beliefs about mental illness that do not support seeking help from Western services.
- Fear of mental illness stigma and discrimination from their own communities.

PRACTICAL AND INFORMATION RESOURCES

- Limited knowledge about the health system.
- English is often a second language.
- Limited financial resources.
- Limited transport options.
- Competing priorities.

Many of these barriers are likely to be more common and inhibiting for refugee communities relative to Asian and migrant communities.[5, 6]

RESPONSIVE PRIMARY CARE SERVICES

The first step nature of primary care services means they can play crucial functions in healthcare access, providing mental health education, problem identification and referral. Primary care services also carry less stigma in these communities than do secondary mental health services. Resources, time and training are important for primary care to perform these crucial functions. Primary care practitioners experience similar cultural responsiveness challenges to mental health services but also have the added challenge of less intensive training and experience in mental health and addiction recovery.

OUTCOMES OF SERVICE RESPONSIVENESS INITIATIVES

Initiatives that have been developed or adapted to improve cultural responsiveness have been popular with ethnic minority clients.[10] There is also emerging evidence that culturally targeted service delivery can increase access to services and reduce experience of distressing symptoms.[10]

SERVICE RESPONSIVENESS RECOGNISED IN LAW AND POLICY

New Zealand's National Health and Disability Sector Standards[11] and the New Zealand Public Health and Disability Act 2000[12] (section 22) both recognise cultural responsiveness as a crucial aspect of service delivery. Recent Ministry of Health plans have also emphasised the need for mental health and addiction services to be more responsive to Asian, refugee and migrant communities.[13 14]

> **The New Zealand Health and Disability Sector Standards (2008)** *state that consumers must "receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs". S1.6.1, p.11.*[12]

> **The New Zealand Public Health and Disability Act 2000** *clearly states that district health boards have a responsibility to "improve, promote and protect the health of the population within their district". Section 22.*[13]

Te Tāhuhu[13] and *Te Kōkiri*[14] also identify the importance of building responsive mental health services for Asian, refugee and migrant, as well as Maori, Pacific, disability and family/whanau populations.

Financial and policy support from central authorities is argued to be crucial for sustaining ethnic responsive services.[9] In the United Kingdom ethnic specific projects have often had uncertain funding. Resources have been lost when projects have moved into mainstream services.[9] Similar under funding of services has been noted in the United States.[8]

NATIONAL SERVICE FRAMEWORK: ASIAN, MIGRANT OR REFUGEE SERVICE SPECIFICATIONS (MINISTRY OF HEALTH, 2010)

These specifications outline what should be included in services contracted to respond to Asian, migrant or refugee populations. The documents will be used by district health board planners and funders when developing contracts for service delivery. The content of the service specifications aligns with existing research and expert opinion where no research is available.

- Tier one of the service specifications applies to all mental health and addiction services.
- Tier two outlines what should be included in all services for Asian, refugee and migrant populations.
- A range of tier three documents can then be selected from according to population size and resourcing.

RESPONSIVE SERVICES – WHAT DOES THIS MEAN?

"Responsive services focus on recovery, **reflect relevant cultural models of health, and take into account the clinical and cultural needs of people affected by mental illness and addiction**… Responsive services respectfully listen to service users and tangata whaiora, give access to full information, use collaborative processes at all levels, encourage feedback, and do 'whatever it takes' to support easy and timely access to services." p.27. [14]

INFORMATION BARRIERS TO SERVICE RESPONSIVENESS

Most services in New Zealand and overseas do not routinely analyse or report whether symptoms of mental illness in Asian, refugee or migrant service users improve following mental health service access. Thus information about service access is often the only indicator of service effectiveness. Furthermore we do not know how many Asian, refugee or migrant people experience mental illness and/or addiction in New Zealand, and thus cannot explicitly calculate the level of unmet need by comparing service access with rates of mental illness.

IMPLICATIONS FOR POLICY MAKERS

Health policies in New Zealand and overseas are increasingly recognising the need to improve service outcomes and responsiveness to minority population groups. Policies for Asian and refugee communities are underdeveloped in relation to those for Maori and Pacific communities. This is despite the large Asian population size and the high needs of refugee communities.

Major gaps in research, health service information, target setting and monitoring for these populations are a barrier to service responsiveness. Policy makers could consider whether additional funding or policy support is needed to help in the development of responsive services, including assistance for the primary care sector. In particular policy makers can consider incentives to encourage national access to resources, workforce development and service development initiatives. Strong links between mental health and language, housing, employment and other settlement factors give good reason to increase resourcing for cross-sector services, workforce roles, funding and policy.

IMPLICATIONS FOR FUNDERS

International evidence and anecdotal reports from New Zealand suggest that services are not adequately meeting the needs of Asian, refugee and migrant population groups. Whilst services exist in some New Zealand centres, there are areas of significant population size that do not have specific mental health services or programmes for these groups. Where services do exist, these are often not sufficiently funded to respond to the population size and need of their area.

- Fact sheet 2 outlines population demographics and existing services for these communities. It also describes the types of initiatives that can be undertaken to be more responsive, including examples of New Zealand services.

There is evidence that adapting services to be more culturally responsive can improve service user mental health, service access, treatment completion and satisfaction. Primary care service delivery may offer opportunities for addressing issues around service access. It is important to build evaluation processes into service funding so services can be modified or reconfigured in an informed manner to get the best outcomes for service users, within available resources. Representatives of Asian, refugee and migrant communities hold vital information about how services can best be adapted and delivered, and formal mechanisms should be established for gathering this input.

- Fact sheet 3 outlines existing research evidence for initiatives to improve service responsiveness.

IMPLICATIONS FOR CLINICAL AND SERVICE LEADERS AND MANAGERS

There is evidence that service adaptations can improve mental health, service access and service user satisfaction for ethnic minority groups. Limited population numbers and funding in New Zealand mean that staff commitment, as well as inter-sector and inter-agency collaboration, is important to driving workforce and service development programmes. It is important to gather and utilise feedback from communities about what is working, and monitor service access and patient improvement.

- Fact sheet 3 lists a number of ways in which services can be more responsive.
- Fact sheet 4 lists tools for workforce development and adapting diagnosis and treatment processes.

IMPLICATIONS FOR RESEARCHERS

Gaps in information about rates of mental illness and service access present a key challenge to justifying and delivering mental health services for Asian, refugee and migrant groups. Evidence is emerging that cultural responsiveness initiatives can result in better outcomes for ethnic minorities. To inform policy and service planning, further research is needed to identify how best to deliver services that work for minority ethnic groups. This includes investigating what types of initiatives are most effective, and comparing mental health improvements resulting from culturally adapted services relative to mainstream services.

- An Asian and a refugee and migrant mental health and addiction research agenda outline research gaps derived from sector, community feedback and a review of the existing literature. The agendas can be downloaded from www.tepou.co.nz.

CONCLUSIONS

There is evidence that Western models of mental health provision do not reflect the diverse range of cultural beliefs that exist in New Zealand. Evidence shows that cultural responsiveness initiatives can be a valuable method of improving service delivery to Asian, refugee and migrant communities. A number of promising models of service delivery have been developed both here and overseas. Commitment from funders, policy makers, leaders, managers and researchers is needed to develop and implement similar initiatives in New Zealand.

FOR MORE INFORMATION

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