This fact sheet outlines evidence for people advocating for, developing, adapting, contracting, funding or planning mental health or addiction services for Asian, refugee and migrant communities with experience of mental illness and/or addiction.

This fact sheet summarises research relating to the effectiveness of:

- interpreting services
- cultural competency training
- cultural experts
- adapting therapeutic interventions
- culturally appropriate information
- inter-service collaboration
- community collaboration.

Many of these initiatives are listed as key service delivery components within the new mental health and addiction service specifications for Asian, refugee and migrant populations. This fact sheet outlines some of the evidence supporting the use of these initiatives in services for these population groups.

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

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1. National service framework: Asian, migrant or refugee service specifications. These specifications outline what should be included in services that are contracted to respond to Asian, migrant or refugee populations. Planners and funders use these documents when developing contracts for service delivery. The content aligns with research where this exists, and expert opinion where no research is available.
Overview of Service Responsiveness Impact

Initiatives that have been developed or adapted to improve cultural responsiveness of services are popular with ethnic minority communities. There is also growing evidence that culturally targeted service delivery can increase access to services and improve mental wellbeing. A recent review of research into the outcomes of attending culturally responsive interventions noted these to be moderately effective at improving service access, completion of treatment and service user satisfaction relative to mainstream services ($d = .40$). The review also identified that on average, mental wellbeing improved following access to culturally-responsive interventions ($d = 0.3$). Culturally adapted services were found to be most beneficial for people whose cultural practices differ markedly from the host society. The size of the improvements noted in the review are similar to those used to justify the use of depression medication ($d = 0.50$) and anti-psychotic medication for schizophrenia ($d = 0.29$). The review found that cultural adaptations were generally equally effective across ethnic groups. Better outcomes for older persons relative to younger age groups and for interventions specifically tailored for a single ethnic group, compared with those designed for multiple ethnic groups.

**Interpreting Services**

Why do we need Interpreters?

Professional interpreting services are identified as a key need for primary and secondary mental healthcare in New Zealand. For example, New Zealand General Practitioners (GPs) were interviewed about their interactions with people for whom English was a second language. GPs reported experiencing communication difficulties that compromised service user safety, such as difficulties making accurate diagnoses, limited understanding of GP advice by the service user and flow-on impacts on treatment adherence.

Communication errors and consequences for quality of care are likely to continue unless there is good access to properly trained interpreters. International research suggests that untrained interpreters are more likely not to pass on information about medication side-effects, under-emphasise or over-emphasise symptoms of mental illness, and make communication errors that have clinical implications. In mainstream health, research has also linked untrained and ad-hoc interpreters (such as family members) with poor service outcomes such as reduced quality of care and higher medical costs.

The effectiveness of communication depends on the quality and skill set of the interpreting services provided. As noted above, untrained interpreters typically make more errors, can reduce the quality of care and increase medical costs. To be effective, interpreters need training about mental health and addiction concepts. Likewise healthcare professionals need training about how to work with interpreters. Training about how and when to use interpreters is typically included in recent cultural competency programmes.

There is research evidence that trained interpreters can lead to improvements in service access and service delivery.

Evidence of Improved Outcomes

A recent review presents research evidence that well trained interpreters can positively impact on service access, medical costs, service user satisfaction and understanding of diagnosis and treatment options.
PROVIDING CULTURALLY APPROPRIATE INFORMATION

Asian, refugee and migrant communities are often not familiar with the types of mental health and addiction support in New Zealand and the pathways, appointment and referral processes to access services. Many consultations with members of Asian communities have noted this as a key area for service development. Appropriate information about how and when to access services needs to be readily available for all three communities. Previous resource development work suggests that information resources should not only be presented in the language of the potential client, but the content, presentation and type of resource should also fit with cultural norms and preferences.13

- See fact sheet 4 for a list of mental health and addiction information resources and a guide for adapting your own resources for other cultures.

“Responsive services… give access to full information” 11,p27

IMPROVING WORKFORCE CULTURAL COMPETENCY

Limited workforce cultural competency is a key barrier in responding to Asian, refugee, migrant mental health and addiction concerns, particularly in the area of primary care provision. Barriers are noted in research, needs assessments and opinion papers from New Zealand and overseas.2,8,12,15

Workforce development typically involves either:

- recruitment of people with expert knowledge or membership of target population groups
- training staff in knowledge, skills and behaviours that support effective liaison with target communities.

Cultural competence is defined in many ways by different professional groups. The New Zealand Guidelines group defines cultural competence as when “a practitioner has the attitude, skills and knowledge to work effectively and respectfully with people of other cultural backgrounds.”16,p27

Organisations can also demonstrate cultural competence. Organisation cultural competence occurs when organisational values, communication and training promote working effectively and respectfully with people of other cultural backgrounds.2

CULTURAL COMPETENCE TRAINING FOR STAFF

A range of workforce training programmes have recently been developed to improve cultural competence, both in New Zealand and overseas. In 2009 Te Pou funded Waitemata District Health Board and Refugees As Survivors New Zealand to pilot and evaluate their face-to-face CALD (Culturally and Linguistically Diverse) training programme with over 110 practitioners from a range of disciplines. Almost all participants reported feeling more confident about working with refugee and migrant clients (93 per cent) and that they would strongly recommend the programme to others (97 per cent).17

Evidence of improved service user outcomes is difficult to gather, and there is little information to demonstrate that cultural competency training improves service user outcomes. Limited evaluation of workforce development programmes has been undertaken, evaluations that do exist demonstrate improvements in self-reported knowledge, skills and confidence.2,17,18

- Links to New Zealand workforce development programmes and international resources are provided in fact sheet 4.

Cultural support workers and cultural clinicians can improve service access and the quality of service delivery.

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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 respectfuiy 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.\[13\], p.26

Same-ethnicity clinicians provide therapeutic interventions in some services, particularly in services in the United States that work with large Latino and African American populations.\[2,18,20\] Better rates of service access, and reduced crisis intervention have been noted in Australia and the US when same ethnicity clinicians have been used.\[21\]

In New Zealand same-ethnicity clinicians are sometimes available within Maori, Pacific, Asian and refugee mental health services. However the diversity of small ethnic groups and absence of trained staff mean that same-ethnicity services may not be feasible in some New Zealand locations or for some ethnic groups. Furthermore smaller communities have expressed concerns that seeing a clinician from their ethnic community may threaten confidentiality.

Employing lay or semi-trained people from ethnic minority and religious communities may be a more feasible method of enhancing cultural responsiveness than hiring culturally-matched clinicians. Cultural support workers and community link worker roles have been developed to provide cultural advice to clinicians and provide clients with practical and advocacy support in New Zealand and internationally.

Cultural support and community link workers have the advantage of being less expensive to train, support and employ than mainstream health professionals.

Evidence is emerging of the value of cultural support workers. Feedback from a 2-year evaluation of the Refugees as Survivors New Zealand mobile team demonstrated that service users and other service providers considered cultural support workers key to meeting refugee community needs.\[19\]

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Beliefs about mental health causes and helping practices differ between cultures. Consequently recommendations for therapeutic practice that are based on Western biomedical models do not always address client attitudes to mental illness, beliefs about the causes of mental illness, somatisation symptoms, and cultural expectations about how symptoms should be addressed. Collectivist concepts and joint family responsibility are key features of many Asian, refugee and migrant cultures, and special consideration may need to be placed on how to effectively involve these families in diagnosis and intervention.

To provide culturally competent services the beliefs and practices of the target communities should be considered. Clinicians and researchers should focus on identifying the useful factors from these frameworks and merging them with aspects of Western scientific evidence.

- Some of the beliefs and practices of refugees from a range of countries are described in the book *Fate, Spirits and Curses* referred to in fact sheet 4.

“Responsive services respectfully listen to service users and tangata whaiora”

Much of the scientific evidence on therapeutic effectiveness focuses on Western populations. Few pieces of research have looked specifically at the evidence for ethnic minority, Asian, refugee and migrant populations. Some studies have noted clinical improvements in post-traumatic stress disorder (PTSD) symptoms following narrative exposure therapy, trauma counselling and cognitive behaviour therapy (CBT) for refugee communities. Some research has evaluated the use of adapted therapeutic techniques with refugee populations. For example one study found that a culturally adapted form of CBT was effective at reducing physical cultural symptoms as well as psychological symptoms of PTSD, depression, anxiety in Vietnamese refugees. Cultural adaptation of this intervention included, inclusion of mindfulness relaxation techniques, using cultural imagery to illustrate concepts such as a lotus flower as a metaphor and gathering cultural support and translation assistance from Vietnamese social workers. Further details on how the intervention was adapted are available in the research article. This study did not compare the effectiveness of culturally-adapted CBT approach with a non-adapted CBT approach.

- Please refer to fact sheet 4 for guidelines and checklists about how diagnosis, communication and therapeutic practices for a range of conditions can be adapted for Asian, refugee and migrant communities.
**IMPROVING SERVICE ACCESS: LINKING WITH SERVICES AND THE COMMUNITY**

**COLLABORATION WITH OTHER SERVICES**

Cross-sector collaboration is predicted to be another important factor for addressing mental health and addiction, particularly in refugee and migrant communities.7, 36, 37

Positive mental health in Asian, refugee and migrant communities is associated with:

- access to adequate employment39, 40
- stable and permanent housing38
- good English language skills23, 40, 41,42
- good physical health23
- perceived social support44, 45

These practical, social and physical health outcomes are key interests for Asian, refugee and migrant populations, and are often prioritised over mental health support.41, 45

Evidence that refugee communities appreciate support in these practical areas is documented in an evaluation of a New Zealand refugee mobile team service.19 Addressing these health promoting factors may contribute to improved mental health by:

- reducing risk for mental illness
- increasing community interest and subsequent trust and use of mental health services.

Collaboration with agencies such as Settlement Support New Zealand, migrant resource centres, Office of Ethnic Affairs, Refugee Services and English Language Partners New Zealand is one avenue for supporting these needs. Collaboration with these services can also provide insight into community needs, at-risk individuals and approaches for successful engagement with these communities. Some New Zealand mental health services have co-situated themselves with other refugee, migrant or ethnic relevant services to facilitate this collaboration.

**COLLABORATION WITH THE COMMUNITY**

A number of researchers and cultural service experts highlight that Asian, refugee and migrant communities should be involved in identifying priorities and methods for service development.35, 46, 47

Changes have been made to increase population representation on governance boards and in service priority setting nationally and internationally. Nonetheless, Adam Awad, Board Chair of New Zealanders ChangeMakers Refugee Forum, challenges us to move decision making and solution development for refugee people into the hands of these communities.46

ChangeMakers Refugee forum has developed a resource to assist government and non-government agencies to work with refugee groups www.crf.org.nz
Mental health services for Asian, refugee and migrant populations can be improved by incorporating many of the opportunities for cultural responsiveness noted above. Whilst there is strong evidence for adapting services, and using interpreters, evidence about specific methods of adapting interventions to be culturally responsiveness comes mainly from service evaluations, expert opinion and community feedback. The indirect nature of many service initiatives on mental health outcomes poses a challenge to developing more rigorous service user outcomes evidence for some aspects of culturally responsive service delivery.

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<tr>
<th>Recommendation</th>
<th>Example</th>
<th>Evidence level</th>
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<tbody>
<tr>
<td>1. Adapt existing services to consider cultural and linguistic needs.</td>
<td>Adapting an existing service or developing a new service that includes cultural responsiveness initiatives such as those listed in this document.</td>
<td>Meta-analyses and systematic evaluations of existing research demonstrate greater improvements in mental health symptoms, service access and service user satisfaction across cultural groups. Evidence indicates that broad types of adaptations may be useful (see below) but is not sufficient to determine which initiatives are ‘critical’ to improve service user outcomes.</td>
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<td>2. Use trained interpreters.</td>
<td>Involving face-to-face interpreters that have undergone specific training about translating in a mental health context.</td>
<td>Controlled research trials and case study evaluations show reduced communication errors, increased service access, medical prescribing and service user satisfaction.</td>
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<td>3. Cultural competency training.</td>
<td>Face-to-face training on knowledge, skills and/or behaviours for working with population groups, including training about working with interpreters.</td>
<td>Controlled research trials and case study evaluations show improvements in self-reported knowledge, skills and confidence.</td>
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<td>4. Adapting information resources.</td>
<td>Working with community representatives to adapt resources so that the information, language and mode of presentation is interesting and acceptable for communities.</td>
<td>Service evaluations demonstrate increased interest and positive community focus group feedback and increased treatment adherence. New Zealand and international experts also support the need for adapted information.</td>
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<td>5. Adapting therapeutic interventions.</td>
<td>Cognitive behaviour therapy approach adapted to be more appropriate for Asian communities.</td>
<td>Some service evaluations and controlled research studies suggest clinical improvements from adaptations. However no studies have compared if whether culturally adapted practices are better than non-adapted interventions.</td>
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<td>6. Utilise community representative clinicians.</td>
<td>Recruiting clinicians who match the ethnicity of service user groups.</td>
<td>Service evaluations show better rates of service access and reduced crisis interventions.</td>
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<td>7. Inter-service collaboration.</td>
<td>Mental health services working together with social support services to deliver mental health promotion education.</td>
<td>Communities, practitioners and researchers from New Zealand and overseas recommend inter-service collaboration.</td>
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<td>8. Community collaboration.</td>
<td>Inviting a group of community members to meet and give feedback to the service about critical community issues and experiences with services.</td>
<td>Communities, practitioners and researchers from New Zealand and overseas recommend community collaboration in service delivery and decision making.</td>
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<td>9. Utilise community consultants.</td>
<td>Employing community members as paraprofessionals to enhance consideration of culture in service delivery.</td>
<td>Community members and clinicians in New Zealand report positive feedback about these roles. The roles are increasingly used internationally, for example UK Delivering Race Equality project.</td>
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REFERENCES


