

# **Physical and Mental Health**

**Goal four: Auckland Regional Settlement Strategy**

## Introduction

It is a commonly-accepted wisdom that maintaining a good level of health and well-being significantly contributes to an individual's quality of life and their ability to make meaningful social and economic contributions to the wider community. Although pre-migration health screening for migrants and at-border health screening for refugees are designed to establish the health status of all immigrants on arrival, these systems fail to recognise the profound physical and mental health implications arising from the settlement process itself.

When stress arises from the challenges of settling (e.g. under-employment and unemployment, language and cultural barriers) individuals may be more susceptible to physical and mental illness. Pre-migration and 'refugee experiences' (e.g. post-traumatic stress issues and anguish arising from forced resettlement) can increase this susceptibility, especially amongst refugee communities.

New Zealand is a signatory to the International Covenant on Economic, Social and Cultural Rights, which recognises *the right of everyone to the highest attainable standard of physical and mental health*<sup>1</sup>. Signatories have an obligation to ensure the availability, accessibility, acceptability and quality of health services<sup>2</sup> for all citizens, regardless of other status.

While access and the ability to use appropriate healthcare services are critical for all migrants and refugees, those from countries with similar cultural and language backgrounds to New Zealand usually only require minimum levels of support to achieve this. General information about entitlements and access<sup>3</sup> is often enough to enable them to make good use of health services.

This chapter focuses on communities from diverse cultural and language backgrounds, who require higher levels of support because they have difficulties accessing and utilising appropriate health care and mental health services. It considers the barriers and challenges identified by migrants and refugees and other stakeholders including health professionals. It recommends opportunities for the health sector to offer enhanced healthcare services for migrants and refugees from diverse cultural and language backgrounds that:

- are accessible and responsive to the needs of migrants and refugees;
- do not create health inequalities;

---

<sup>1</sup> Article 12, International Covenant on Economic, Social and Cultural Rights in force since 1979.

<sup>2</sup> Economic and Social Council General Comment 14, 2000.

<sup>3</sup> For example, via the [www.everybody.co.nz](http://www.everybody.co.nz) web site.

- incorporate population health promotion strategies that encompass refugees and migrants;
- address the mental health needs of migrants and refugees.

## **Barriers and challenges: what migrants, refugees and other stakeholders said**

### ***Determinants that impact on the health of migrants and refugees***

Stakeholders involved in the development of the *Auckland Regional Settlement Strategy* recognise that settlement is multi-faceted and that many health determinants have causes external to the health sector. For example, the following issues, discussed in other chapters and summarised below, are believed to impact upon the physical and mental health outcomes of migrants and refugees from diverse cultural and language backgrounds:

- language difficulties, especially for women, older migrants and refugees;
- challenges in accessing employment appropriate to their qualifications and skills;
- challenges in maintaining family and social support networks;
- acculturation attitudes - the extent to which migrants and refugees have integrated into the local culture<sup>4</sup>;
- where migrants and refugees perceive they are occupying a marginal position in society, this can create a condition of disempowerment and alienation<sup>5</sup>. This, in turn, can affect the ability of migrants and refugees to achieve their settlement goals.

### ***Common barriers and challenges for migrants and refugees***

During the development of the *Auckland Regional Settlement Strategy*, migrants and refugees identified common challenges and barriers for migrants and refugees accessing health services, including:

- having little knowledge of New Zealand's healthcare system, services and entitlements, especially those from diverse cultural and language groups;

---

<sup>4</sup> Mental health issues for Asians in New Zealand: a literature review. Mental Health Commission 2002.

<sup>5</sup> For example, being portrayed in media and popular discourses as the unwelcome 'other' competing for scarce resources such as income support, housing and jobs, Danso, 2001:3.

- insufficient interpreting services to support those facing language and/or literacy barriers, which discourages use of the primary healthcare system;
- some healthcare providers having little exposure to cultural differences, or not being aware of the impact of their services and practice on the health of migrants and refugees. In addition, some migrant and refugee communities have expectations and patterns of seeking healthcare that differ from common norms in New Zealand.
- in some migrant and refugee communities, the stigma associated with mental health which prevents individuals and family members from accessing appropriate assessment and treatment services;
- financial barriers, such as the cost of consultation fees, medicine and travel (particularly in the Auckland region which is renowned for its poor public transport systems) which can provide a significant barrier for migrants and refugees on low incomes. This is especially so for refugees who arrive with minimal assets, and have more complex health needs requiring them to have access to a wider range of health providers/services.

### ***Additional challenges for refugees***

While all of these issues apply to both migrants and refugees, they are amplified for those with higher and more complex health needs with pre-migration experiences associated with trauma and distress<sup>6</sup>. In particular, forced migration is a major life change with a profound impact on health.

Although quota refugees are entitled to health screening on arrival at the Mangere Refugee Resettlement Centre (MRRC), this does not take into account the health impacts arising after arrival and/or from the resettlement process. As well as any issues of poor mental health, patterns of poor physical health, such as obesity and diabetes, which are evident in other low income New Zealanders, are also emerging in refugee groups<sup>7</sup>.

Once refugee status is confirmed, refugees are New Zealand citizens and entitled to access generic public healthcare service.<sup>8</sup> There are, however, particular challenges in accessing health services, particularly primary care. This is especially true for those refugees whose previous lifestyles differed greatly from an urban New Zealand experience and who came

---

<sup>6</sup> Kalipeni and Oppong, 1998, Clinton-Davis and Fassil, 1992.

<sup>7</sup> Solomon 1999.

<sup>8</sup> See Appendix 3 for more information on entitlement to healthcare by refugee status.

from places with a fundamental lack of infrastructure and lived in largely rural and subsistence type environments. The most common challenges for refugees are language difficulties, cultural differences and cost, and there are additional challenges relating to mental health.

### *Language difficulties*

Many refugees are pre-literate in their own language and have little or no English language proficiency or literacy<sup>9</sup>. The emphasis on talk as the currency of healthcare interactions has highlighted the importance of translation and interpretation in practice settings given the rarity of practitioners speaking minority, ethnic community languages<sup>10</sup>. The absence of appropriate and skilled interpreters and of bi-lingual health workers, therefore, significantly impedes access to services, and creates communication barriers between the health practitioner and refugee service users. For example, a United Kingdom study<sup>11</sup> found that other barriers could only be addressed once language problems were resolved.

### *Cultural differences*

Refugees may have different understandings of illnesses and healthcare systems. Their previous experiences of norms and practices serve to shape their help-seeking behaviour in New Zealand. For example, disproportionate numbers of refugee families go to emergency departments at a late stage of illness, rather than seeking primary healthcare earlier on. This reflects the fact that, in many countries of origin, hospitals rather than primary healthcare services are the first port of call. It may also be a consequence of difficulties faced in accessing appropriate primary care.

### *Cost*

As for other low-income population groups, the cost of consultations and medicine can be a barrier even when these are subsidised. Another issue concerning cost is the idea of *value for money*. Some refugees believe that unless they come out of a doctor's appointment with a prescription, their visit has not been good value for money<sup>12</sup>. Refugees with multiple and complex health problems may require a wider range of health providers and services. Often, specialist appointments are located in a variety of locations across Auckland and associated transport costs can be prohibitive if patients lack private transport or do not have ready access to public transport.

---

<sup>9</sup> Ministry of Education (2003a, p.13) *Adult ESOL Strategy*.

<sup>10</sup> J.Lawrence & R Kearns, *Health and Social Care in the Community* 13(5), 451-461.

<sup>11</sup> Burnett A & Peel M, 2001 *What Brings Asylum Seekers to the United Kingdom?* British Medical Journal 322, 485-488.

<sup>12</sup> J.Lawrence & R Kearns, *Health and Social Care in the Community* 13(5), 451-461.

## *Mental health*

In addition to any mental health consequences of pre-migration experiences, it may take refugees three to five years to regain a sense of confidence and control over their new lives<sup>13</sup>. Experience indicates that mental health problems arising from differences in expectations and experience, the effects of discrimination, problems in adapting, and failure to achieve settlement goals may appear two or three years after the 'honeymoon period' is over. For some, serious mental health problems may be delayed through the deferred effects of pre-migration trauma while the immediate issues of resettlement are dealt with.

Problems that particularly hinder access to appropriate mental health services are:

- stigma associated with mental illness, arising from cultural beliefs;
- different interpretations of the nature of mental illness and well-being and different patterns of seeking help;
- mental health services that are not responsive to the special needs of refugees.

### ***Barriers and challenges identified by primary health practitioners delivering health services to refugees***

A recent study<sup>14</sup> of a general practice clinic in Auckland that provides affordable and accessible primary healthcare services to locally based, low-income communities, where there are a high number of refugees, identified five key challenges clinic staff faced in delivering healthcare services to refugees. Similar challenges are likely to be faced when dealing with migrants with vastly differing pre-migration experiences and environments, as discussed in the Summary Report. The challenges for primary healthcare practitioners include:

#### *Medical challenges*

Refugee health needs tend to be complex, longstanding and may not have been encountered before by the local general practitioner.

#### *Cultural challenges*

Many healthcare workers may have limited knowledge, skill and awareness about working with refugees from different cultures, and of refugee-specific health issues arising from pre-migration and re-settlement experiences.

#### *Communication challenges*

---

<sup>13</sup> San Duy Nguyen 1989: *Towards a successful resettlement of refugees*.

<sup>14</sup> J.Lawrence & R Kearns, *Health and Social Care in the Community* 13(5), 451-461.

Communication with migrant and refugee patients is a major barrier for general practitioners. For example, when families interpret and/or the interpreter has limited English, it can be difficult for general practitioners to determine the exact nature of the complaint.

### *Operational costs*

These include challenges from:

- the funding model, which does not adequately provide for the extended consultation time required to address complex need and language difficulties, nor the high utilisation rates common for refugee patients;
- the cost of interpreters that must be met by either the patient or the practice;
- clinic staff experiencing considerable stress associated with providing healthcare in the absence of appropriate interpreting services. The cost of this can sometimes be seen in terms of reduced efficiency and productivity and increased sick leave.
- the cost of providing professional supervision (where it exists) to health professionals dealing with torture and trauma patients, which must be met by the practice.

### *High need for mental health services*

There is a shortage of refugee-specific providers of mental health services. Refugee mental health needs are complex and varied and may present at later stages of settlement, often once more immediate concerns such as housing have been met. For example, there are insufficient services for children who have had traumatic refugee experiences and require mental health treatment. The discontinuation of funding for the On TRACC<sup>15</sup> pilot will exacerbate this capacity issue, and there is concern that the proposed replacement services will not have the specialist mental health competencies needed for this target group.

---

<sup>15</sup> The On TRACC pilot service was developed in 2003 and is operated by ADHB's Kari Centre, ESOL Refugee and Migrant Team in the Ministry of Education, Auckland City Special Education in the Ministry of Education and the Royal Oak and Grey Lynn offices in the Department Of Child Youth and Family Services.

# Context for Government support - structure and resourcing of the health sector

## *Structure of the Health Sector*

The organisation of health and disability services in New Zealand has undergone a number of changes in the last decade<sup>16</sup> resulting in 21 District Health Boards with the overall responsibility for assessing the health and disability needs of their population, and managing resources and service delivery to best meet these needs.

### *District Health Boards*

District Health Boards (DHBs) provide the range of services determined by the Ministry of Health, either directly or through contracts for service via their funding arms. Services provided directly by DHBs include those delivered by public hospitals, secondary mental health and addiction services, dental and community health services. DHBs also fund other health providers, including primary health organisations (PHOs) and non-government organisations (NGOs) to achieve the Government's health goals<sup>17</sup>.

There are three DHBs in the Auckland region – Auckland (covering Auckland City), Waitemata (covering North Shore and Waitakere Cities and Rodney District) and Counties-Manukau (covering Manukau and Papakura Cities and Franklin District).

### *Primary Health Organisations (PHOs)*

With the release of the Government's *Primary Health Care Strategy* in 2001 and the first tranche of significant additional funding for primary health care, providers (e.g. local general practitioners, Maori and Pacific providers) were encouraged to combine to form Primary Health Organisations<sup>18</sup>. The *Primary Health Care Strategy* signalled a new approach to primary health care with a greater focus on tackling the causes of ill health, greater community involvement and better coordination of care across service areas.

There are currently 19 PHOs within the Auckland region, ranging in size from around 5,000 enrolled patients to over 300,000. DHBs work with multiple PHOs within their district to plan for a range of locally appropriate services.

---

<sup>16</sup> The current system was implemented through the New Zealand Public Health and Disability Act 2000.

<sup>17</sup> These goals are set out in the New Zealand Health Strategy, the New Zealand Disability Strategy and the Primary Healthcare Strategy.

<sup>18</sup> PHOs were to be funded on the basis of their combined patient enrolments, adjusted for age, ethnicity and NZ DEP status.

### *Public Health: Health Protection and Health Promotion Services*

The *NZ Health Strategy* (NZHS) requires the health sector ‘to work cooperatively towards common goals’<sup>19</sup> and reconfigures the sector to adopt a ‘population health’ approach to improving the health status of New Zealanders. This focus on ‘population health’ involves complementary roles for personal and public health providers to achieving shared goals.

DHBs and the Ministry of Health’s Public Health Directorate have a joint responsibility to improve, promote and protect the health of people and communities in the geographical areas they serve, by working together and with other sectors that influence public health outcomes, such as local authorities. The Public Health Directorate, in consultation with the DHBs in the region, directly funds a range of public health service providers.

In Auckland, approximately half of public health funding goes to the Auckland Regional Public Health Service (ARPHS) governed by the Auckland DHB, but also providing core health protection and health promotion services for Waitemata and Counties Manukau DHBs. The other half of public health funding for the Auckland region and some of the national public health funding allocation is allocated to non-government organisations (NGOs) which undertake a range of health promotion programmes, e.g. the National Heart Foundation, Family Planning Association and the Mental Health Foundation.

### ***National Health Policy and Funding***

The New Zealand Public Health and Disability Act 2000 provides the policy framework for the delivery of personal health, public health, and disability support services, with the following objectives:

- improving, promoting and protecting health;
- promoting the inclusion and participation in society and the independence of disabled people;
- ensuring the best care and support of those in need of services;
- reducing health disparities.

The *New Zealand Health Strategy 2000* sets out the Government’s priorities for action, focusing particularly on inequalities in health. While the strategy does not identify migrant or refugee population groups as having specific needs or priorities, the *Primary Health Care Strategy*, released the following year, makes specific reference to the need for additional services and funding for refugee populations. The strategy also

---

<sup>19</sup> *New Zealand Health Strategy*, Ministry of Health 2000, p.3.

acknowledges that 'The costs of reaching such populations are often not sufficiently taken into account in funding formulae'<sup>20</sup>.

Recent changes have seen the recognition of migrant and refugee populations within health sector policy frameworks. This is an important first step in the creation of effective approaches to service development and provision for these populations. From 2006/07, the Operations Policy Framework for DHBs recognises ethnic populations and requires DHBs to consult with them on strategy or service development and build capacity for participation of ethnic peoples in planning processes and service delivery to ethnic peoples. DHBs are also to work with PHOs with significant ethnic populations to ensure that consultation and capacity-building occurs at the PHO level.

Responding to the Government's Ethnic Perspectives in Policy, the Ministry of Health is developing a strategic framework for Ethnic Action and Responsiveness to Health (EARTH) as a tool to lead the development of comprehensive policy, funding, service and workforce requirements for ethnic peoples across the health sector.

In addition, there is a case for developing a refugee-specific health strategy to address their higher and more complex health needs based on:

- pre-migration and 'refugee' experiences that are traumatic and significantly different from the experience of others, and deprive refugees of significant mental and physical resources;
- the mental health problems experienced by this population that can present at later stages of settlement and require specialist treatment;
- the vulnerability of refugees who are generally a lower socio-economic population, more likely to experience financial barriers and be high users of the health system.

### *District Health Boards*

The reduction of health inequalities for high-needs populations, however defined, is a Government priority for which DHBs have a statutory responsibility. All three Auckland DHBs now recognise, through their draft strategic health plans, that refugees are a significant population requiring healthcare services. DHBs are funded by the Ministry of Health to meet the needs of their population through a population-based funding formula (PBFF) which acknowledges not only the size of their total population, but also a variety of factors that influence health needs. These include age, sex, socioeconomic deprivation and ethnicity. Ethnicity is categorised as

---

<sup>20</sup> Primary Health Care Strategy, Ministry of Health 2001 p.14.

*Maori, Pacific and Other.* Ethnic populations are included (with *European*) in *Other* and do not generate increased funding for a DHB as *Maori* and *Pacific* do.

The high health needs of the refugee population, however, are acknowledged in the PBFF through the Overseas Visitors' Adjuster. Six DHBs – including the three Auckland DHBs – attract this additional funding. This additional funding reflects costs associated with refugee-specific health services such as health screening and mental health services provided at the Mangere Refugee Resettlement Centre (MRRC), and for some coordination between MRRC and primary care<sup>21</sup>.

DHBs are expected to absorb the costs of acute health services for new migrants and refugees in their ordinary operations. The Ministry has advised the Auckland DHBs that the issue of ad hoc access to acute services will be clearly identified when the population-based funding formula is next reviewed.<sup>22</sup>

#### *Primary Healthcare Organisations*

Services to Improve Access (SIA) is the funding mechanism to improve accessibility of primary care services for high-needs populations. PHOs determine which groups in their communities face access barriers, although use of SIA funds must have the support of their local DHB. SIA funding is determined by the number of Maori and Pacific people and people living in high deprivation areas (quintile 5) enrolled in a PHO. Enrolment of ethnic populations does not generate SIA funding, unless they live in a high deprivation area. Without such specification in the funding framework, primary care's ability to respond to the specific health needs of the migrant and refugee populations is limited.

In November 2005, specific funding for refugee primary healthcare services was announced for those DHBs with sizable refugee populations. The funding - \$1.248 million annually - is designed to provide ongoing support for those primary care providers that provide 'wrap around' services to their refugee enrollees. The funding is based on current patterns of refugee settlement around the country, and current and developing service provision. The adequacy of the funding and its distribution among DHBs is being reviewed over the next 12 months, and any consequent adjustments that are necessary as a result of changing numbers or patterns of resettlement will be made from July 2007.

---

<sup>21</sup> Ministry of Health 2004, Population Based Funding Formula 2003.

<sup>22</sup> Ministry of Health to Auckland Regional Public Health Service, 23 November 2005.

## *Mental Health Services*

Improvement in mental health services has been a government priority since 1994<sup>23</sup> and there has been an emphasis on the need for more and better services, including the development of community-based services. The policy framework for mental health services was further developed by the Mental Health Commission's *Blueprint for Mental Health Services in New Zealand (1998.)*<sup>24</sup>

Since then, there have been significant changes in mental health services, health system structures, and other social and demographic changes affecting the way services need to be developed and delivered. In 2005, the Ministry of Health published its second New Zealand Mental Health and Addiction Plan, *Te Tahuhu: Improving Mental Health 2005-2015*. This strategic plan focuses on the outcomes Government expects from mental health services and, for the first time, specifically identifies the need to improve responsiveness of services for refugee and migrant communities<sup>25</sup>.

DHBs have a responsibility to deliver on this plan by identifying specific gaps in service delivery against national benchmarks, and prioritising service development to address these gaps. New funding must be directed at specified local and regional priorities within the context of national policy direction.

Within Auckland, each DHB plans and manages its own mental health service and strategic plan. However, the Northern Regional Mental Health and Addictions Strategic Direction 2005-2010 steers service development regionally. The strategy's goals for robust mental health and addictions services to meet the mental health needs of the region are to:

- ensure equal opportunity to access quality services delivered in a culturally appropriate manner for refugee and recent Asian migrant clients and their families;
- ensure access to professionally trained and qualified interpreting services to meet the needs of migrants and refugees with experience of mental illness and their families.

---

<sup>23</sup> signalled by the publication of its policy document *Looking Forward* (Ministry of Health 1994) and accompanying plan, *Moving Forward* (Ministry of Health 1997).

<sup>24</sup> which details the benchmark quantities of service required to meet the needs of the estimated 3% of the population with serious mental health disorders, and prioritises the 0.6% of the population who also have high support needs.

<sup>25</sup> The Action Plan being developed to accompany the strategy includes the development of an Asian profile but will be restricted to whatever ethnic categories can be collected. Refer to the section on planning for information on limitations on current data collection regarding ethnicity.

The strategy identifies refugees and recent Asian migrants<sup>26</sup> as a significant population, but points out that there is, as yet, no agreed vision or direction to address their specific mental health needs. Work is being undertaken by an Asian advisory group to develop a detailed strategy, and a specific project is underway to increase and improve interpreter services for Asian mental health clients accessing DHB mental health services.

## **Government health services**

There is compelling evidence that many avoidable health inequalities are linked to other social determinants, including employment, education and housing related issues<sup>27</sup>. While the Ministry of Health is responsible for national health policy and funding, and can be expected to provide leadership in addressing health issues, inter-sectoral collaboration and planning is essential to address many of these other social determinants that impact on the health of migrants and refugees. This requires coordination between agencies responsible for settlement related services.

Planning to inform service development is particularly important in the Auckland region, where the greatest percentage of refugees and migrants from diverse cultural and language backgrounds are located. Two-thirds of people of Asian ethnicity live in the Auckland region, constituting 12 percent of the population<sup>28</sup>. This has highlighted the need for responsive health services to this significant and growing population. Appendix 6 contains more detail on the demographic and socio-economic profile of Auckland's Asian population.

### ***Data to inform planning***

Currently there is no consistency in the collection and use of data by central government agencies involved in settlement-related activities which identifies migrant and refugee populations.

The health sector, for example, currently uses Statistics New Zealand Level 2 ethnicity classification<sup>29</sup>. This can identify broad ethnic groups of Asian, African and Middle Eastern peoples, but is too aggregated to support health service provision, needs assessment or planning for migrant and refugee populations. The recent New Zealand Classification and Outcomes Study (CAOS), aimed at providing information that could

---

<sup>26</sup> See Appendix 6.

<sup>27</sup> National Health Committee 1998, Social, Cultural and Economic Determinants of Health.

<sup>28</sup> See Appendix 6.

<sup>29</sup> See Appendix 5 for further details on Statistics New Zealand classification levels.

potentially inform the planning and delivery of mental health services, only has a small number of identifiable migrant and refugee consumers<sup>30</sup>.

### ***Services targeted at addressing migrant and refugee health needs***

Interpreting services are funded for publicly-provided health services (e.g. hospitals), but not for primary care (unless SIA funds are available) and other NGO providers, such as Plunket. This means that a range of health professionals rely on family members or volunteers to interpret.

The Waitemata DHB Asian Health Support Service has attempted to improve access for migrants from diverse cultural and language backgrounds through its interpreting service (Waitemata Asian Translation and Interpreting Service – WATIS).

Employment of people from refugee and migrant backgrounds in public health, primary and secondary health provision and mental health services enhances workforce capability and responsiveness to these communities. The following are examples of services in Auckland that have employed people from these backgrounds.

### ***Services targeted at addressing Asian health needs***

Some good approaches have been developed by individual DHBs to address the needs of migrants, mostly focusing on the needs of Asian migrants. For example, the Waitemata DHB has established an Asian Health Support Service (AHSS) providing advice to management and DHB services on how to improve their responsiveness to the healthcare needs of the Asian population residing in its district. Refer Appendix 1. The AHSS website is [www.asianhealthservices.co.nz](http://www.asianhealthservices.co.nz).

The Auckland Regional Public Health Service (ARPHS) is contracted by the Ministry of Health to provide public health services for Asian migrants as well as medical screening for refugees on arrival in New Zealand. ARPHS has health promotion staff able to support Asian migrant and refugee communities through their initial and post-settlement phases, and provide information about their specific health needs and issues. This includes advancing the incorporation of a refugee and Asian migrant population focus in policy and service development with central government agencies, local government authorities and district health boards. It also has a website, [www.asianhealth.govt.nz](http://www.asianhealth.govt.nz).

The Ministry also contracts with The Asian Network (TANI), a community-based organisation to represent the views of Asians in Auckland to the Ministry, DHBs and service providers. Other public health services are

---

<sup>30</sup> The Mental Health Epidemiology Survey expected to report later this year will provide some data, but it will be restricted to Indian and Chinese ethnicities..

provided by the Mental Health Foundation and the Family Planning Association.

In the field of mental health, the Mental Health Commission's literature review on mental health issues for Asians in New Zealand identifies the need to promote mental health services in Asian communities and promote cultural responsiveness in mental health services. There are two projects<sup>31</sup> aimed at improving the cultural and communication capability of the workforce for Asian mental health. This includes developing skilled interpreters in this field. These are referred to in Appendix 2.

To improve the understanding of issues affecting the health of Asian communities, Auckland University's School of Population Health has established a centre for Asian Health research and evaluation. Auckland University of Technology has established a centre for Asian and migrant health research.

#### *Services targeted at addressing refugee-specific health needs*

Refugee entitlement to health services, including health screening and publicly-funded health services in New Zealand are described in Appendix 3.

For example, on arrival in New Zealand at the Mangere Refugee Resettlement Centre (MRRC), UN Quota refugees are required to undertake immigration medical screening and are entitled to access generic public healthcare provision. Family unification refugees are screened before arrival, and are also entitled to the medical services available at MRRC. Convention refugees (asylum-seekers) who are detained at MRRC are also offered medical screening, although it is not required until their immigration status is determined<sup>32</sup>.

Refugees As Survivors (RAS) is a non-governmental charitable trust contracted to provide mental health assessment and initial treatment services at MRRC and to network with DHB services to meet more complex and longer term needs. Resources have also been placed with DHB mental health services in the region to provide ongoing clinical support for refugees who require specialist clinical services.

When refugees move from the MRRC into the community, ARPHS arranges referral to a general practice. A small number of general practices have specialised in meeting the needs of refugees, where there has been a critical mass providing strong motivation for doing so.

---

<sup>31</sup> the National Asian Workforce Development and Training Programme and the Workforce Development for Asian Mental Health Interpreters Project

<sup>32</sup> Appendix 3 provides further information about refugee entitlement to health services in New Zealand.

The Auckland Regional Public Health Service has developed specific health resources and programmes aimed at health promotion and prevention for refugee communities. Appendix 4 refers.

In addition to the work undertaken by ARPHS health promoters, Auckland District Health Board (ADHB) has also established some community-based initiatives including:

- three refugee community health workers within its Community Child Health and Disability services;
- an adult trans-cultural mental health team within Auckland DHB's community health services;
- a trans-cultural care centre (On TRACC) described earlier that began in October 2003 as a two-year demonstration pilot, but will not continue to be funded.

## **The way forward: *Auckland Regional Settlement Strategy***

### ***Goal to enhance physical and mental health outcomes***

The *Auckland Settlement Strategy's* goal for enhancing physical and mental health outcomes for migrants and refugees is:

*Healthcare services are accessible and responsive to the physical and mental health needs of migrants and refugees, and do not create health inequalities.*

### **Opportunities to enhance physical and mental health outcomes**

It is recommended that the Ministry of Health and District Health Boards ensure that their work programmes for improving physical and mental health outcomes for migrants and refugees from diverse cultural and language backgrounds are aligned to the longer-term work programmes for the *New Zealand Settlement Strategy* and the *Auckland Regional Settlement Strategy*. It is recommended that the following opportunities are considered for this purpose.

#### *Policy, funding and planning*

- Given the costs of providing healthcare services to refugees and the affordability issues for refugees with complex health needs, consideration should be given to reviewing current healthcare funding to ensure it adequately addresses these issues. This would include:
  - reviewing population based funding formulae;
  - reviewing and refining mechanisms for targeting funding to primary health services working with refugee populations;
  - developing accessible and cost-effective interpreter services for primary care providers with patients from diverse cultural and language backgrounds
- Improve healthcare planning and service delivery, so that it is accessible, appropriate and available to migrants and refugees, by ensuring DHBs and other health service providers have robust information about these populations<sup>33</sup>. This requires more accurate

---

<sup>33</sup> Statistics New Zealand Level 2 ethnicity classification is too aggregated to assist identify health service provision needs, assessment or planning for migrant and refugees from a range of ethnic populations.

information on their health needs, where they are living and their countries of origin<sup>34</sup>.

- Use the existing whole-of-government *New Zealand Settlement Strategy's* Senior Officials Group, to improve forward planning, information sharing and collaboration, including the collection and sharing of ethnicity data in a consistent manner. This will improve policy and service development in healthcare and other settlement related areas for migrant and refugee communities.

### *Service Delivery*

Initiatives are needed to address the most common barriers of language, cultural differences and costs faced by migrants and refugees. These include:

#### Communication

- Ensure an adequately funded *interpreting service* is available to primary care providers. This includes having trained interpreters present at initial visits for refugees to obtain a comprehensive medical history and phone-interpreting services available at follow-up visits.
- Develop a centralised healthcare, phone-interpreting service and consider existing options such as the AHSS interpreting service (Waitemata Asian Translation and Interpreting Service – WATIS) and Language Line<sup>35</sup>.

#### Workforce development

- Develop a workforce development strategy that enhances the cultural competencies of healthcare workers providing primary and secondary healthcare services to migrant and refugee communities, and encourages the employment of healthcare workers from these communities. This could include:
  - training programmes for existing mainstream healthcare workers;
  - professional supervision as part of occupational safety and health practices (as with counselling and social work roles) for those working with refugee communities, particularly in primary care;

---

<sup>34</sup> For example, information on intakes of quota refugees including numbers being accepted, countries of origin, people accepted for family reunification, and where these people are being settled.

<sup>35</sup> Language Line is a free telephone interpreting service which supports six government agencies delivering services to people from non-English speaking backgrounds. Language Line supports 35 languages.

- the health sector, in conjunction with health professional bodies and communities, encouraging employment of migrant and refugee health workers by providing community-based healthcare information, training programmes and scholarships.

### Mental healthcare

- Extend current work targeted at Asian populations to address the needs of wider migrant and refugee populations. This includes work underway on developing professionally trained and qualified interpreting services and providing equal opportunity of access to quality services delivered in a culturally appropriate manner.
- Develop specialist mental health services to meet the needs of refugees, including those presenting mental health problems at later stages of settlement, and for specific age groups such as adolescents<sup>36</sup>
- Develop a mental health promotion strategy for migrants from refugee-producing countries with similar high and complex settlement support and mental health needs to quota refugees.
- Promote research on mental health needs of migrants and refugees in the areas identified in the Mental Health Commission's literature review<sup>37</sup>, and other needs identified in DHB needs assessments

### Collaborative approach across the region

- Ensure healthcare providers across the Auckland region are building upon existing models of good practice and, where appropriate, working together on a more 'regional' (as opposed to local) level to develop more consistent and efficient services.

## **Appendix 1**

### ***An example of a DHB response - Waitemata DHB's Asian Health Support Service***

---

<sup>36</sup> Previously serviced by On TRACC.

<sup>37</sup> See Appendix 7 for more information on limitations of research on migrant mental health identified by the Mental Health Commission.

The Waitemata DHB's Asian Health Support Service (AHSS), supports Asian people and other migrants and refugees to effectively make use of the health.

The model of culturally-responsive services developed by them has been a progressive one. Although originally aimed at Asian people, since 2003 it has been broadened to include other migrant and refugee communities from diverse cultural and language backgrounds.

The model, which is available online at [www.asianhealthservices.co.nz](http://www.asianhealthservices.co.nz), focuses on:

- supporting a range of primary, secondary and tertiary healthcare services for migrants and refugees;
- helping migrants and refugees make use of health services, by providing information and advice, advocacy, patient education, culturally-specific services and interpreter services;
- providing a framework for measuring the success of the service.

A key component of keeping track of the range of services and various 'parts' involved in supporting service delivery is a comprehensive database, which provides a patient/client management, business management and service development tool, an information and advice management tool and a volunteer management tool.

The AHSS provides a range of services as follows:

- translation and interpreting available 24 hours a day, seven days per week to all language speakers to access all mainstream DHB services. Face-to-face interpreting services will be provided for the initial GP visit to help obtain a comprehensive medical history and assessment. Phone-interpreting services are available for subsequent visits.
- information, advice and education on the New Zealand health system is provided to migrant and refugee communities through a variety of different mediums;
- volunteer support programmes providing support at the primary and secondary care levels and in the community, including meet and greet support at hospitals, patient/client support to overcome cultural and basic communication barriers and community support to assist with home visits, and to resource migrant health information workshops and call centre support;
- patient education programmes on specific health issues targeted at migrants;

- provision of assessment, home help services and support;
- workshops for DHB health professionals (primary and secondary health services) to support workers in delivering effective community healthcare;
- ensuring a migrant and refugee voice on secondary and primary healthcare.

## Appendix 2

### *Workforce development for Asian Mental Health*

There are three areas of workforce development that are important in the mental health field:

- supporting service providers to develop their cultural capability;
- recruiting mental health workers from migrant and refugee backgrounds;
- having trained and skilled support staff, including interpreters and other bi-cultural support staff to assist both health providers and new settlers.

Two projects, the National Asian Workforce Development and Training programme<sup>38</sup> and the Workforce Development for Asian Mental Health Interpreters project specifically focus on:

- improving the cultural capability of the workforce;
- developing skilled interpreters in the mental health field.

The National Asian Workforce Development and Training programme will:

- provide a review of the literature on cultural capability in mental healthcare;
- identify the knowledge and skills required to improve the workforce's cultural response to the well-being of Asian populations;
- provide learning materials for widespread implementation.

The project was due for completion by May 2005 for national and regional implementation. However, in order to invest in the finished product, DHBs and regional funders would need to see the programme 'adding value', and this in turn is likely to require greater involvement and wider consultation.

The Workforce Development for Asian Mental Health Interpreters project<sup>39</sup> aims to improve the mental health assessment process and the delivery of culturally responsive interventions to mental health clients from diverse Asian cultural and language backgrounds. It intends to develop, a training programme for, and guidelines on, working effectively with Asian mental health interpreters.

---

<sup>38</sup> Tse, Bhui, Thapliyal, Choy & Bray, 2005.

<sup>39</sup> Commissioned through the Draft Northern Regional Mental Health and Addictions Strategic Plan 2005-2010.

## Appendix 3

### *Refugee entitlement to health services in New Zealand*

The following diagram indicates that all refugees are entitled to health screening <sup>40</sup> and access generic public healthcare provision. Quota refugees are the only refugee group eligible to access refugee-specific mental health services offered at the Mangere Refugee Reception Centre.

	<b>Quota refugee</b>	<b>Family reunion</b>	<b>Asylum seeker</b>
<b>Access to health screening/healthcare on arrival</b>	Receive free comprehensive health screening/healthcare, including dental care, on arrival by Auckland Regional Public Health Service (ARPHS), with follow up treatment and management as required.	Screened prior to arrival as per the NZIS health screening requirements. Eligible for comprehensive health screening by ARPHS on arrival.	If detained on arrival at the Mangere Refugee Reception Centre (MRRC), free comprehensive health screening/healthcare, including dental care, with follow up treatment and management as required.  If not detained, free comprehensive health screening at the ARPHS Asylum clinic at Greenlane Hospital.
<b>Publicly funded health services</b>	Eligible for all publicly provided health services (MoH 2003).	Eligible for all publicly provided health services (MoH 2003).	Eligible for all publicly provided health services (MoH 2003).
<b>PHO services</b>	Able to register with a PHO for general practitioner services.	Able to register with PHO for general practitioner services if resident.	Able to register with a PHO for general practitioner services.
<b>Mental health services</b>	Refugees-as-Survivors provide assessment and treatment for mental health and community support	Not eligible for Refugees-as-Survivors mental health and community support services.	Not eligible for Refugees-as-Survivors mental health and community support services.

<sup>40</sup> *Refugee Health Care: a Handbook for Health Professionals*, 2001.

	services available within the MRRC. Any body requiring ongoing treatment are referred onto mainstream organisations.		
--	--	--	--

## Appendix 4

### *Health promotion and prevention for refugees*

Auckland Regional Public Health Service is, as part of its public health promotion responsibilities, developing specific resources and health programmes aimed at health promotion and prevention for refugee communities.

#### *Key health information for refugees*

The Refugee Health website, [www.refugeehealth.govt.nz](http://www.refugeehealth.govt.nz), provides literate refugees with information about the New Zealand health system. The information is available in English and a range of refugee languages. In addition, other key health information has been translated into refugee languages such as Farsi, Arabic, Somali and Amharic. Refugee health programmes include:

- a women's nutrition programme aimed at offering healthy eating programmes that provide language and culturally appropriate nutritional messages and practices in accordance with the key population health messages<sup>41</sup>. The programmes address the health and well-being of refugee communities in the following ways:
  - early intervention and prevention for nutrition-related conditions such as iron deficiency, iron deficiency anaemia, poor oral health, rickets, obesity, Type 2 diabetes, cardiovascular disease and psycho-social problems;
  - improved child health e.g. reduction of iron deficient anaemia and prevention of rickets;
  - the development of language and culture appropriate nutrition health promotion materials;
  - better access to mainstream nutrition and health promotion services for refugee and migrant communities from Muslim backgrounds;
  - increasing primary care providers' awareness of the nutritional, cultural and religious requirements of Muslim communities in Auckland.

---

<sup>41</sup> Ministry of Health, Healthy Eating, Healthy Action, 2003.

- the Muslim Women's Swimming programme whereby a pool is hired for the exclusive use of Muslim women one evening per week. This is run in conjunction with Pro-Care;
- a refugee parenting programme;
- a Refugee Youth Physical Activity Programme aimed at increasing physical activity and fitness among refugee youth, including smoking reduction;
- a refugee smoking cessation programme for the refugee community.

## Appendix 5

### *Statistics New Zealand Classification Levels*

No. of level*	Level-one	Level-two	Level-three	Level-four
Type of group at each level	Broad ethnic groups predominant in New Zealand ⇒ More specific individual ethnic groups			
Brief description	This is made up of the 5 main ethnic groups predominant in New Zealand: European Māori Pacific Island Asian Other Ethnic Groups	This includes 25 categories further broken down according to geographic location or origin, cultural differences and size.	This includes 41 categories, classified according to criteria just described.	This includes 231 ethnic groups disaggregated according to geographic location or origin, cultural differences.
Examples	European	Other European	British and Irish	Scottish (Scots)
	Other Ethnic Groups	Middle Eastern	Middle Eastern	Israeli/Jewish/Hebrew
	Asian	Southeast Asian	Vietnamese	Vietnamese

\* There is an additional super-aggregated level, level-zero, above level-one. It is the same as level-one, except that there is no separate category for the 'Asian' category, which falls under 'Other Ethnic Groups'.

#### 4.1 Number and types of categories

From the tables above, it is obvious that the Australian and New Zealand standards have different classification procedures. Some of these have been implicitly suggested in previous discussions, but this section will address them directly.

In contrast to Australia, New Zealand's classification has only five first-level ethnic groups. These are derived not from a geographic base, but from the main ethnic groups present in New Zealand, some of which are important for policy purposes. They are 'European', 'New Zealand Māori', 'Pacific Island', 'Asian' and 'Other Ethnic Groups'. Therefore, at level-one (and level-two), comparison between the NZSCE and ASCCEG is virtually impossible, though comparison between the ASCCEG's base level and the NZSCE's third and fourth levels may be possible. At levels two and three, these are broken down into progressively more specific ethnic groups, culminating in the level-four ethnic groups.

Source: Review of the Measure of Ethnicity. Comparison of the Measurement of Ethnicity between New Zealand and Australia- Main Paper, Statistics NZ, July 2001.

## Appendix 6

### *Asian Mental Health in Auckland*

The 2001 census found that the number of people of Asian ethnicity had more than doubled between 1991 and 2001, and there are now more people of Asian than Pacific ethnicity in New Zealand. Two-thirds of people of Asian ethnicity live in the Auckland region, constituting approximately 12 percent of the population.

The term 'Asian' includes an extremely diverse population from Pakistan and Afghanistan to Japan (Statistics New Zealand 2001). It encompasses people from over thirty ethnic groups, predominantly Chinese, Indian, and Korean, but also every other country in the same region, with widely diverse languages, cultures and migration experiences, as well as third and fourth generation New Zealanders.

*Table: Number and percentage of Asian population by DHB 2000*

<b>DHB</b>	<b>Number of Asian</b>	<b>%Asian</b>
Auckland	63,2443	27.9
Counties Manukau	42,498	18.8
Waitemata	40,362	17.8

The demographic and socio-economic profile of Auckland's Asian population is also extremely diverse.

It includes every category of immigrant, including those with professional skills and investment capital, foreign fee-paying students, as well as refugees, with diverse social and economic resources and health needs. The particular characteristics of the refugee population are discussed below.

Overall the Asian population has above average education, but below average income. This reflects the youthfulness of the immigrant population, including the large number of students. However, many better-educated Asian migrants may also be still seeking work or under-employed, with associated loss of social status, frustration and financial stress. Language skills and the challenge of coping with cultural adaptation affect almost all migrants.

The general health status of the Asian population is good, with predominant causes of mortality and morbidity similar to the general population. But the Asian Public Health Report identified concerns regarding mental health, cardiovascular disease and diabetes, sexual health, tuberculosis and traffic injuries. Migrants may experience mental health problems two or three years after the 'honeymoon period' is over (i.e. getting residency and getting settled). These may be due to the

differences between expectations and experience, the effects of discrimination, problems in adapting and so on.

Source: *Asian Public Health Project Report*, February 2003.

## Appendix 7

### ***Mental Health Commission's identification of research limitations on mental health of migrants from diverse cultural and language backgrounds***

The Mental Health Commission's literature review points out the limitations of current research on the mental health of migrants from diverse cultural and language backgrounds including:

- within New Zealand most research has focused on recent immigrants and has involved Chinese, and to a lesser extent Koreans and Indians, while the research on refugees has focused on Cambodians;
- prevalence studies. Because of the relatively small and rapidly changing population it is difficult to obtain representative samples.
- overseas studies (and the limited New Zealand research available) indicate particular mental health problems associated with particular migration experiences. For example, high rates of depression among older Chinese migrants; post-traumatic stress disorder among Cambodian refugees; loneliness among students.
- High-risk groups requiring further research include women, students, older people and refugees.

In spite of these limitations, the review recommends the following strategies as a useful starting point for working with other organisations that impact on the mental health of Asian communities and for developing mental health services to better meet their mental health needs to:

- promote mental health in Asian Communities;
- improve cultural responsiveness in Mental Health Services.