

Asian and Refugee Mental Health Newsletter

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Northern DHB Support Agency

In this issue:

- Strategies to enhance service access for Asian Communities at Counties Manukau Health District
- Reflexions of a mental health interpreter

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This newsletter is the property of Northern DHB Support Agency (NDSA), a shared services agency jointly owned by Auckland, Counties Manukau, and Waitemata DHBs. NDSA also provides services to Northland DHB as a client.

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Strategies to enhance service access for Asian Communities At Counties Manukau Health District



Mental wellness leaflets in Chinese

Counties Manukau District Health Board (CMDHB) is committed to provide the best services to its patients. To enhance the responsiveness and accessibility of mental health and addiction services to the needs of Asian people, a number of key strategies have been identified and adopted, which include: availability of mental health information in different Asian languages, workforce training and development in cross-cultural competency, and enhancement of community-based support for Asian people with mental health issues.

A lot of progress has been made since 2008. In terms of information, four community mental health centres' service leaflets, Tiaho Mai (acute inpatient psychiatric ward) information booklets, and wellness and recovery plan have been translated into Chinese, Korean and Vietnamese.

A number of cross-cultural training workshops have been held for staff. Furthermore, an introduction to CMDHB mental health services has been made to various community groups, such as, Chinese Christian churches, Buddhist temple, and local information centres. Closer connections were also made with local Asian GPs to facilitate better integrated services between primary and secondary health providers.

Earlier this year, translation of the psychiatric liaison information leaflets has begun. Leaflets on how to cope with anxiety, sleep difficulties, and depression are now available in Chinese (as in picture), with Korean, Vietnamese, Hindi, Punjabi, Tamil, and Gujarati versions in the pipeline.

For more information, please contact **Kitty Ko**, Asian Service Development Coordinator on 09-5380700 or kos@middlemore.co.nz

Reflexions of a mental health interpreter

Hien Mack



One of the situations in which, as a mental health interpreter, I felt most helpless, was when I was interpreting for a client who regularly beat his wife. He had ignored many warnings from both his treatment team and the police. Sadly, such actions are common in the culture that he came from, which is male dominated and in which the beating of a wife is seen as a means of justifiable discipline applied to improve her behaviour or as a means of “education”. If such violence is carried out by an ordinary man in New Zealand he is likely to be dealt with firmly by the law. But what of this man who was mentally ill? Was his behaviour due to his illness, his culture or just because he was violent by nature? This was something that had to be addressed by the mental health professionals and in which I could only contribute by pointing out the cultural norms that this man had grown up with.

I have seen many families from other cultures traumatized by being told that one of their members has a form of mental illness. They are often confused by medical terms and resort to traditional terms equating to madness, or craziness. In some cultures such illness is seen as spirits or ghosts taking control of the individual, and families will try any number of traditional remedies before consulting a Western doctor. In many cases they combine both Western and traditional treatments such as prayer, herbal medicines and consulting spiritualists or exorcists. Psychiatrists and other health professionals need to be aware of this and be sensitive in working to gain the trust and cooperation of their clients and their families. If not, chances are that lip service only will be paid to Western treatments, and traditional treatments will take place behind the doctor’s back, so undermining the hope for outcomes.

In interpreting for clients with mental illness my observations have convinced me that the whole family or whanau needs to be included in the process and immediate family members in particular should be offered support and guidance as well as the client. One case in which support was needed but not forthcoming serves as a good example of this. A client’s wife, at the end of her tether with stress and exhausted by years of domestic violence approached WINZ to set up her own account, separate from her husband so as to give her a chance to live her own life. The agent handling her application was far from helpful and in fact was disapproving and obstructive. Support from the team dealing with her husband’s case could have done much to inform WINZ of the full story and reduce the wife’s feeling of failure and guilt which was engendered by her meeting with an uninformed WINZ officer which only deepened her own despair.

As interpreters we will sometimes see what is not obvious to treatment teams coming from a culture other than that of the client and their family and sometimes, without stepping beyond the bounds of our profession, we may be able to raise issues at the end of a session that can illuminate points that may have been missed by people not fully attuned to the client and their family’s circumstances, so enabling health professionals to make more informed decisions.

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