Sailing in a new direction: Multicultural mental health in New Zealand

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Abstract

Migrants and refugees make up an increasingly significant number of Aotearoa/New Zealand's population with one in five New Zealanders being born in another country compared with one in eight people in the United States and one in fifteen in Europe. Increasingly efforts are being made to ensure that settlement services are provided and that mental health service delivery is cognisant of their needs. This paper describes some of the efforts being undertaken in Aotearoa/New Zealand and the implications of such efforts; in particular the mental health of Asians, a growing group, is explored. The author suggests that there is a need to learn from Pacific people's ventures, to broaden the bicultural dialogue and finally to expand the new focus from Asians, refugees and migrants to also include the needs of long term settled communities and international students.

Keywords

multicultural, bicultural, multicultural mental health, mental health policy, Māori, Pacific peoples, Asian people

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Simply by sailing in a new direction
You could enlarge the world.
(Curnow, 1997, p.226)

A sailing metaphor seems apt as the focus of this paper is on the people who have crossed the ocean to reach Aotearoa/New Zealand. Around 1300 AD the ancestors of Māori used the stars and the winds to sail southward from Hawaiiki in their waka (canoes) to Aotearoa/New Zealand. Thousands of years earlier, the world's first seafarers had set off from South-East Asia, sailing into the Pacific on rafts. Tasman's arrival in 1642, followed by Cook in 1769 marked the arrival of Europeans. Organised settlement followed the signing of the Treaty of Waitangi in 1840. Pacific migration increased from a trickle after World War II as manufacturing and service industries grew. Asians too had been coming to New Zealand since the 1800s but their numbers were small until after 1987.

Young Chinese men from Guangdong province travelled to the goldfields of Otago in the 1860s (Ip, 2005) and Indian connections with New Zealand began in the late 1800s with Lascars (Indian seamen) and Sepoys (Indian soldiers) arriving after deserting their British East India Company ships (Swarbrick, 2005). The earliest refugees arrived between 1870–1890 and included Danes, Russian Jews and French Huguenots. Subsequently, refugees from Nazism (1933–39), Poland (1944), Hungary (1956–58), 'handicapped' refugees (1959), Chinese (1962–71), Russian Christians from China (1965), Asians from Uganda (1972–73), Chileans, Soviet Jews, Eastern Europeans, people from the Middle East, South-East Asia (Indo-Chinese), Somalia, Zimbabwe, Afghanistan, Bosnia, Ethiopia, Eritrea, Iran and the Sudan have resettled in New Zealand. More recently, Asian foreign fee-paying students have impacted on the

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education system, becoming important to the national economy and more visible in society (International Division & Data Management and Analysis, 2005).

It's time to enlarge our world

Migrants to New Zealand are caught between two charged agendas: the colonial ideal of a homogeneous society, replicating Britain, and the desire of Māori for recognition as people of the land, or Tangata whenua, with specific rights. New Zealand's founding document, The Treaty of Waitangi and the social policy principle of biculturalism have become an explicit template for relationships between indigenous Māori and subsequent migrants. The racialising and othering of migrant groups, along with past migration policy designed to keep the country white (Beaglehole, 2005), have implicitly shaped the treatment of migrants.

Changing migration patterns

The 2001 Census found that Europeans/Pākehā (Māori name for white New Zealanders) made up 79.6% of the population, followed by New Zealand Māori with 14.5%, people from the Pacific Islands 5.6%, and Asians 6.6% (adds to more than 100% because ethnicity is self-defined; people could select more than one ethnicity). Of the Asians, the largest groups are Chinese who make up 2.2% and Indians who make up 1.2% of the total New Zealand population (Statistics New Zealand, 2002b). Asians are the fastest growing ethnic group, increasing by around 140% over the last ten years and predicted to increase by 122% by 2021. In comparison, Pākehā will increase by 1%, Māori 28% and Pacific People 58%. This new diversity is in stark contrast to the previous assimilationist post-1945 migration policy which positioned the ideal migrant as 'invisible'. Linguistic and religious diversity were also a hallmark of the 2001 Census which noted a 20% increase in the number of multilingual people and an increase in the percentage of people whose religion was non-Christian, including Hindu 56%, Buddhist 48% and Islam 74%.

Policy changes: From monocultural to bicultural to multicultural

Canada and Australia embraced multiculturalism during the 1960s, transforming the notion of settlement into a two way process; change was required by both migrants and the host society. New Zealand policy made this strategic move only as recently as 1986. The 1980s were a pivotal period in discussions of New Zealand identity, featuring biculturalism and its incorporation into social policy in New Zealand (Bartley & Spoonley, 2004). Discussions of multiculturalism began with the arrival of Pacific peoples in the 1970s and required Pākehā to cede the monopoly on power and decision making and the allocation of resources (Bartley & Spoonley, 2004). An attempt to address the bicultural/multicultural relationship came about with proposals that biculturalism should take precedence and subsequent arrivals to Aotearoa needed to negotiate a primary relationship with Māori (Bartley & Spoonley, 2004). Multi-culturalism would then be the outcome of a network of completed bicultural negotiations; however, no process was ever suggested for this to occur (Bartley & Spoonley, 2004). The bicultural/multicultural debate remains un-resolved and problematic (DeSouza, 2004a; Mohanram, 1998; Thakur, 1995; Walker, 1995; Wittman, 1998). However, rather that biculturalism being a barrier to multiculturalism, I believe that it has paved the way for the majority culture to consider cultural issues at large. The *Immigration Act 1987* eased access into New Zealand from non-traditional source countries and replaced entry criteria based on nationality and culture with criteria initially based on skills. The policy changes led to unprecedented cultural diversity. In particular, Asians became a sizable majority of migrants, increasing from 18.7% of permanent and long term arrivals in 1987 to 48% in 1993 (Bartley & Spoonley, 2004).

A growing Asian population

'Asian' is a term that has differing definitions depending on the geographical context in which it is used. In New Zealand 'Asian' tends to refer to people from South East Asia and there are debates about whether an umbrella term such as 'Asian' is useful or merely an expedient construct that potentially provides benefits but disguises disparities within groups (Rasanathan, Craig & Perkins, 2004; Workshop Organising Team, 2005). In the 2001 Census, 44% of Asians identified with the Chinese ethnic group, 26% with the Indian ethnic group, 8% Korean, 5% Filipino, 4% Japanese, 3% Sri Lankan, 2%

Cambodian, 2% Thai, and 8% with other Asian ethnic groups (note that people could give more than one response; therefore, these percentages do not add to 100) (Statistics New Zealand, 2002a). Asians in New Zealand are a relatively young population and are generally in good health. Most live in the Auckland region and over half are aged between 25 and 65 years, around 20% are aged 15 to 24 years and 20% are aged below 14 years (Asian Public Health Project Team, 2003). This age-distribution is similar to Māori and Pacific people, but Asians are younger (on average) than Europeans. The rapid growth of the Asian population has exposed a lack of policy and structures to evaluate and address their needs (Workshop Organising Team, 2005).

Access issues and underutilisation of mental health services

A survey examining health status in a large representative sample of Asian people (Scragg & Maitra, 2005) found that Asians underutilise health services:

- Asian people were less likely than other New Zealanders, Māori and Pacific people to have visited a health practitioner (or service) when they were first unwell.
- Asian people were less likely than Europeans to visit a health practitioner about a chronic disease (doctor, specialist, nurse or complementary healer).
- Asian women were less likely than other New Zealand women to have had a mammogram or cervical screening test in the last three years.
- Asians were less likely than all New Zealanders to use any type of telephone helpline in the last 12 months.
- Asians also only wanted to see their general practitioner for a short term illness or a routine check up rather than visiting for an injury, poisoning, or for mental or emotional health reasons.

Another study found that barriers to accessing services for Chinese people included lack of language proficiency of respondents, lack of knowledge about civil rights and problems accessing general practitioners (DeSouza & Garrett, 2005).

This underutilisation is further reflected in mental health statistics. Of the 87,576 mental health clients seen by District Health Boards in 2002, only 1.9% were Asian despite making up over 6.5% of the population (New Zealand Health Information Service, 2005). This could in part be due to the bias of New Zealand's migration policy which selects young and healthy migrants but it is clear that Asians underutilise mental health services and this does not necessarily mean that they are keeping well (Ho, Au, Bedford & Cooper, 2002). A study among recent Chinese migrants using the General Health Questionnaire found that 19% reported psychiatric morbidity (Abbott, Wong, Williams et al., 1999). A study of older Chinese migrants aged over 55 found that 26% showed depressive symptoms (Abbott, Wong, Giles et al., 2003). Lower emotional supports, greater number of visits to a doctor, difficulties in accessing health services and low understanding and engagement with New Zealand society increased the risk of developing depression. Interestingly, while participants with depressive symptoms consulted general practitioners more than their counterparts without such symptoms, they reported greater difficulty in accessing health services. Research with Asian migrants, refugees and student sojourners in New Zealand shows that social supports can assist newcomers to cope with the stresses of migration and reduce the risk of emotional disorder (Abbott et al., 1999). Conversely, research shows that language and cultural barriers can limit access to health services (Abbott et al., 1999; DeSouza & Garrett, 2005; Ngai, Latimer & Cheung, 2001).

Need for workforce development

The cultural competence of mental health staff for working with Asian consumers has not been researched. However, a recent project investigating the intercultural experiences of social workers in New Zealand found that contact with migrants, refugees or asylum seekers was infrequent, especially outside of Auckland (Nash & Trlin, 2004), but that the majority of social workers felt competent or better than competent in terms of working interculturally. Respondents recommended that further training in cross-cultural social work, staff training and better support services be available, in tandem with improvements in community services and the education of the host community to see new settlers as valuable

additions to society. In another study, psychiatrists were surveyed by Johnstone and Read (2000), who found that out of 247 psychiatrists surveyed, only 40% believed that their training had prepared them to work effectively with Māori. Some of the suggested recommendations for improving how they worked with Māori included needing to understand Māori perspectives of well-being, and increasing the number of Māori professionals and Māori run services. Of psychiatrists who responded to the survey, 70% believed that there was a need to consult with Māori when working with Māori. A training package is being developed by University of Auckland, funded by the Health Research Council, to develop cultural competence in mental health staff working with Asians. Further development in this area is signalled in the next mental health action plan discussed later in this paper.

Omission in health research

Asian ethnic groups have been largely neglected by New Zealand health policies and research, despite their population growth (Duncan, Schofield, Duncan et al., 2004). Duncan et al. cite the example of the 2002 National Children's Nutrition Survey, where both over-sampling and separate analysis of Māori and Pacific Island children occurred while Asian children were subsumed with New Zealand Europeans. Large-scale studies are needed to determine health risk across all major ethnic groups in New Zealand, which will in turn enable development of ethnic-specific data. Even more critical is the need for data concerning ethnic variation in other areas of health so that effective interventions can be developed and implemented (Duncan et al., 2004). This omission and exclusion is by no means a rare occurrence in national surveys and prevents the development of an understanding of the public health needs of Asian communities in New Zealand, necessary for the development of appropriate preventative health strategies.

Settlement issues

A report commissioned by the New Zealand Immigration service found that migrants had four areas of need: everyday needs, learning English, employment, and supportive connections (Ho, Cheung, Bedford & Leung,

2000). Factors such as unemployment or underemployment, having experienced discrimination in New Zealand, not having close friends, being unemployed and spending most of one's time with one's own ethnic group were predictors for poor adjustment among migrant groups (Pernice, Trlin, Henderson & North, 2000). In the last few years, a range of settlement programmes have been funded nationally with the development of an *Immigration Settlement Strategy* (New Zealand Immigration Service, 2003) for migrants, refugees and their families. The strategy's six goals provide a broad base for enhancing wellbeing and include appropriate employment; confidence with using English or accessing appropriate language support; accessing appropriate information and responsive services; supportive social networks and sustainable community identity; expressing ethnic identity and acceptance and inclusion of the wider host community; and participation in activities.

Visible but invisible groups

The arrival of primarily Asian fee-paying students has had an impact on the education system, a greater importance to the national economy in terms of providing increased funding to educational institutions, and higher visibility in society in that most of the international students have come from China (International Division & Data Management and Analysis, 2005). Asian enrolment numbers rose by 318% over a five year period (1999-2003) to nearly 119,000, with an estimated economic value NZ$2.2 billion New Zealand dollars and providing 40,101 jobs (Infometrics, 2006). These numbers declined in the 2003-2004 period, leading to concern about the rapid development of the sector and raising the need for better quality assurance systems, which are now implemented through the *Code of Practice for the Pastoral Care of Foreign Fee-Paying Students* (Section 238H of the Education Act 1989). Levies paid by institutions with international students are used to support activities and projects relating to the export education industry such as promotion, communications, capability development, quality assurance, research and the administration of the Code (Ministry of Education, 2003). However, other than being able to use counselling services

within their institutions, most international students are not entitled to access publicly funded (mental) health services while in New Zealand and are liable for the full costs of treatment unless they are sectioned under the *Mental Health Act*, and then only for the duration of that process. Once they are no longer under the Act, they are charged. Remaining voluntarily on an acute unit can incur a charge of approximately NZ$900 a day. International students are required to have appropriate and current medical and travel insurance while studying in New Zealand as a condition of enrolment (including mental health as long as it is not a pre-existing condition); however, insurance cover is capped at NZ$2,000 so if students need access to in-patient services they must cover their own costs.

The needs of long term settled communities have been brought into focus with the launch of the *Asian Health Chart Book* (Ministry of Health, 2006a) which demonstrates the need to focus not only on new migrants but also on longer-term settled migrant Asian communities. Major differences in health and health service use between recent migrants and longstanding migrants show that recent or first generation migrants have better health status than longstanding migrants or the New Zealand born, demonstrating the acculturative effects of the dominant culture.

Mental health services: Sailing in a new direction

Mental health services are responding to new migrant populations to varying degrees. Following on from a report on the mental health of Asians in New Zealand (Ho et al., 2002) has been an increased responsiveness to the needs of those communities (Yee, 2003). Research activity, information provision, collaboration and Asian-focused operational activities and policy are some of the strategies that are being used by government agencies (Yee, 2003). Other developments that will assist in meeting this gap include the New Zealand Mental Health Classification and Outcomes study (Gaines, Bower, Buckingham et al., 2003), which includes a small number of Asians, and a planned mental health epidemiological survey which will also assist but is currently limited to the two largest Asian communities, Indian and

Chinese. This section briefly reviews national, regional and local developments and initiatives.

Developing visibility and responsiveness in mental health services

Asian researchers (Lim & Walker, 2006; Tse, Bhui, Thapliyal et al., 2005) have outlined the legislative and policy frameworks that support culturally sensitive mental health service provision. These include *The Health and Disability Commissioner Act 1995* and the *Health and Disability Code of Rights 1996* which require that services acknowledge the needs of people from a range of cultures and provide for these needs while also protecting culturally diverse people from coercion, discrimination and exploitation. A culturally sensitive approach and acknowledgement of the person's cultural and ethnic identity, language, and religious or ethical beliefs is also advocated in the *Mental Health (Compulsory Assessment and Treatment) Act 1992* and the 1999 amendments. In addition, one of the objectives of the *New Zealand Public Health and Disability Act 2000* is that health outcomes be improved for Māori and other population groups through the reduction of health disparities. The *Human Rights Act 1993* requires that mental health and addiction services do not unlawfully discriminate on the grounds of culture and ethnicity. Lastly, the *Health Professional Competency Assurance Act 2003* requires practitioners to demonstrate cultural competence.

National mental health strategy and recovery

Te Tāhuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan (Ministry of Health, 2005b) builds on the current Mental Health Strategy contained in

- *Looking Forward: Strategic Directions for the Mental Health Services* (Ministry of Health, 1994);
- *Moving Forward: The National Mental Health Plan for More and Better Services* (Ministry of Health, 1997); and
- The Mental Health Commission's *Blueprint for Mental Health Services in New Zealand: How Things Need to Be* (Mental Health Commission, 1998).

Te Tāhuhu acknowledges that 'there is no national strategy or policy to address the mental

health issues of the full range of ethnic groups living in New Zealand. Building stronger relationships with people from diverse cultures and ethnic groups will be essential as we work towards developing strategies to address their particular needs' (Ministry of Health, 2005b, p.37). *Te Tāhuhu* focuses on developing a comprehensive integrated mental health and addiction system that provides hope for developing a multicultural mental health agenda, compared to the other documents that make specific cultural mention of Māori and Pacific peoples but minimal reference to other groups. *Te Tāhuhu* emphasises early access to effective primary health care (a key entry point to mental health services for Asians), and an improved range and quality of specialist community based mental health and addiction services built on collaborative relationships (Ministry of Health, 2005b). It covers the spectrum of interventions from promotion/prevention to primary care to specialist services, and in particular the draft action plan (Ministry of Health, 2006b)

- acknowledges the presence not only of Asian peoples but also migrants and refugees, and the need for mental health services to be able to respond to the unique needs of all New Zealanders;
- acknowledges the need for responsiveness to Asian peoples and other ethnic communities and refugee and migrant communities;
- aims to build a quality mental health and addiction workforce that supports recovery, is person centered, and is culturally capable to deliver services for Asian peoples (that will require new skills and areas of specialised knowledge);
- aims to strengthen the cultural capability of workers in mainstream services to work effectively with Asian, refugee and migrant populations through training programmes;
- aims to increase the understanding of the mental health and addiction needs of Asian, ethnic, refugee and migrant communities through developing a profile of their mental health, and developing a mental health and addiction research agenda;
- aims to implement national and local training for the mental health services workforce to work more effectively with them and use

research evidence in service planning and delivery; and
- aims to develop culturally responsive problem gambling intervention services for Asian peoples.

In addition, The Mental Health Commission's *Recovery Competencies for Mental Health Workers* (O'Hagan, 2001) requires that a competent mental health worker acknowledges the different cultures of Aotearoa/New Zealand and knows how to provide a service in partnership with them. It suggests that every mental health and addiction service worker should demonstrate

- knowledge of diversity within Asian cultures;
- knowledge of Asian culture, for example importance of family, religious traditions, duty, respect for authority, honour, shame and harmony;
- the ability to articulate Asian views on health;
- knowledge of traditional Asian treatments; and
- the ability to involve Asian families, communities and service users in services.

In response to a report on Asian Public Health (Asian Public Health Project Team, 2003) the Mental Health Foundation have also created information sheets written in Chinese as a step towards meeting the mental health needs of Asians. They focus in particular on the mental health needs of Chinese adults and older Korean people. The emphasis on Chinese recognises that they comprise the largest of all Asian ethnic groups and the high number of Chinese international students in New Zealand, particularly in Auckland.

The potential of broader health policy

Developments in population based health policy offer promise in addressing barriers to accessing services by Asian communities. The *New Zealand Health Strategy* (NZHS) guides the development and provision of new services in the health and disability sector to improve the health of New Zealanders (Ministry of Health, 2000). Administered through District Health Boards (DHBs), the strategy aims to reduce inequalities in health status for Māori, Pacific peoples and people from lower socio-economic groups. It claims to focus on quality of service in order to ensure health outcomes are improved

and health disparities reduced. There is scant reference to migrant health in the NZHS, other than a recommendation 'to assess the health needs of refugees, asylum seekers and Asian immigrants' (Ministry of Health, 2000, p.47) without any attempt to explain how this might be achieved.

A key strand of the NZHS involves improving responsiveness in the field of primary care. Primary Health Organisations (PHOs) have been established as 'community-led' organisations that guide the development of local services and their role defined in the *Primary Health Care Strategy* (Ministry of Health, 2001). The governance model is intended to involve local people in the planning and delivery of local primary health care services. This promotes the role of health workers as being to reduce health inequalities and address the causes of poor health status. Whilst accessibility, affordability and co-ordination are key, there is no mention of Asian and migrant populations in the strategy, which aligns with the NZHS focus on Māori, Pacific populations and lower socio-economic groups. The needs of Asian communities in New Zealand will need to be proactively considered given their projected population growth and evidence of different health needs to the wider population. Findings from the *Asian Health Chart Book* (Ministry of Health, 2006a) show that Asian people had positive health outcomes on a range of health indicators compared to the total New Zealand population. Of concern, however, was the lower usage of health services by the Asian population. The report provides a useful baseline on Asian health and it is hoped that it helps in identifying the health needs of Asian peoples in New Zealand and that it will be a tool for Asian communities themselves to advocate for appropriate health services.

Regional developments

The Northern Region Mental Health and Addictions Strategic Direction 2005-2010 (Northern DHB Support Agency & Network North Coalition, 2004) has two foci for its vision. The first is a specific focus on 'equal opportunity to access quality services delivered in a culturally appropriate manner for refugee and recent Asian migrant clients and families' and the second is 'access to professionally trained and qualified interpreting services to

meet the needs of migrant and refugees with experience of mental illness and their families' (p.22). Recently a project was developed for training Asian interpreters and mental health practitioners who provide secondary mental health services for the diverse Asian immigrant population in the Auckland region, focussing on cultural competency and appropriate skills to work together effectively (Lim & Walker, 2006).

Local developments

At a local level, the twenty-one District Health Boards (DHBs) are responsible for deciding on the mix, level and quality of health and disability services to be provided for populations within government-set parameters. Some specialised mental health services, for example the 'Refugees as Survivors' (RAS) centres have been established, while others have developed 'transcultural' teams with clinicians who have an interest in the area or Asian mental health workers. Asian peer support workers are employed by consumer run organisations such as Mind and Body consultants to support Asian users of Auckland District Health Board Mental Health Services. There are also two Chinese consumers' self-help groups: Bo Ai She and Yu Ai She. Community Alcohol and Drug services have two Chinese counsellors and non-governmental organisations (NGO) have begun responding to the needs of Asians by employing Chinese staff in community and family support roles such as Action for Mental Health Services, Supporting Families and Affinity. In the Auckland DHB there are two Asian community support workers with a focus on psychiatric rehabilitation. A great many of the developments have been in response to advocacy from ethnic community members and a desire to increase responsiveness to presenting clients.

Learning from the experience of Pacific peoples

There is much that newer migrant groups and mainstream services can learn from the experience of Pacific peoples, who are a diverse group representing over 20 different cultures. The largest group are Samoan making up 50% of Pacific peoples, followed by Cook Islanders (23%), Tongans (16%), Niueans (9%) Fijians (4%) and Tokelauans (2%) (self-identified; more than one response possible) (Mental Health

Commission, 2001). A youthful population concentrated in the Auckland region with smaller numbers scattered throughout the country (Ministry of Health, 2005a), Pacific peoples make up 6% of the New Zealand population, which will rise to 12% by the year 2051. Pacific migration to New Zealand after the second world war increased as a result of growing industrialisation and demands for a manufacturing and service industry workforce (Spoonley, 2001). Large numbers of Pacific people migrated to urban areas of New Zealand, accelerating in the 1960s and early 1970s (Spoonley, 2001). The mid-1970s economic downturn led to many Pacific people losing their jobs. Unemployment, low income, poor housing, the breakdown of extended family networks, cultural fragmentation, and rising alcohol and drug problems have had a significant impact on the mental health of Pacific peoples, with rates of mental illness being generally higher among Pacific males and Pacific older people than the rest of the population (Ministry of Health, 2005a). However, Pacific peoples are a little less likely to use mental health services than any other group in New Zealand (Ministry of Health, 2005a).

Innovative health models such as the 'Fonofale' created by Fuimaono Karl Pulotu-Endemann (Crawley, Pulotu-Endemann, Stanley-Findlay & New Zealand Ministry of Health, 1995) have promoted holism and continuity. Similar to Durie's (1994) Te Whare Tapa Wha, the Fonofale model uses the metaphor of a Pacific Island house and incorporates the values and beliefs of various Pacific Island groups. In addition, two key mechanisms have been advanced to improve social and economic outcomes for Pacific peoples. These are to improve 'the responsiveness and accountability of public sector agencies to Pacific health needs and priorities, and to build the capacity of Pacific peoples, through provider, workforce and professional development, to deliver health and disability services and to develop their own solutions to health issues' (Mental Health Commission, 2001, p.15). The key agencies in this task are The Ministry of Pacific Island Affairs, the Ministry of Health, District Health Boards and the Mental Health Commission. Other strategies are that services for Pacific peoples should: include Pacific views of mental

health and wellbeing (which also includes all other aspects of health); take into account the relatively young Pacific population; acknowledge that there are isolated communities throughout New Zealand; consider the socioeconomic status of Pacific peoples; consider the diverse needs of New Zealand-born versus Island-born people and people of mixed ethnicity; and include the issue of alcohol and other drug use. In parallel, mainstream providers need to incorporate practices that properly address the above issues which will require building networks with Pacific organisations and groups able to advise on culturally acceptable methods of treatment (Mental Health Commission, 2001).

Conclusion: Exploring uncharted waters

Parts of the journey ahead are charted clearly. There are legislative and policy imperatives in place for mental health services to ensure that they are responsive in both policy and practice for 'migrants, refugees and Asians'. How this is operationalised varies around the country but developments are promising, particularly in Auckland where the population of Asians is 12%. However, there are murky waters ahead that must be navigated. Further discussion is needed about the terms 'migrants, refugees and Asians' which are referred to in *Te Tāhuhu* and are an attempt at inclusion. The diversity contained within labels will have to be disentangled, so that the needs of the diverse people within labels such as 'migrants, refugees and Asians' are identified. Consideration must also be given to the needs of long term settled ethnic communities and international students, both of whom are neglected. Diving even deeper, the intersection of ethnicity, religion and socioeconomic status needs exploration. Consideration also needs to be given to how we work with the 'buzz words' such as cultural safety, cultural capability, cultural awareness and cultural competence and how they sit together (DeSouza, 2004b, 2006; Wood, Bradley & DeSouza, 2004).

Finally, a more strategic response to New Zealand's changing demographics is required as until now the majority of developments have been ad hoc, reactive and operational, based on lobbying from ethnic community groups and non-governmental organisations such that

responses are geared to our current situation rather than our future. It is necessary to address the place of the Treaty of Waitangi in the context of how multiculturalism is to be accommodated. Some see biculturalism as an obstacle to the acknowledgement of a more diverse society; however, I suggest that multiculturalism through biculturalism remains a possible solution that has been under-explored and under-operationalised. Future developments in Asian, migrant and refugee health need to heed the unique status of Māori and learn from the experiences of Pacific peoples, who have charted these waters already and know the currents and prevailing winds.

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