Asian Youth Mental Health Needs and Opportunities

A summary of research in Aotearoa New Zealand

(August 2025, Version 1.0)

Thriving at Crossroads

'People pleaser servant' by Jason Tran

Asian Family Services
Together enriching lives

Waipapa Taumata Rau
University of Auckland

This report is an attempt to collate and summarise recent evidence from Aotearoa New Zealand on Asian mental health and wellbeing identified through a literature review. The authors recommend engaging with the original articles, reports, theses for more detailed description of study findings and recommendations. This is not meant to be an exhaustive review. We will look to release updated versions in future.

Based on evidence about the prevalence and causes of mental health issues among Asian youth, we summarise the factors that support their mental and emotional wellbeing, as well as the barriers that prevent them from thriving in Aotearoa New Zealand. The report highlights knowledge gaps and outlines key actions that the government, government agencies, healthcare providers, and community organisations can take to improve youth mental health in Aotearoa New Zealand. The findings may also be relevant to other marginalised groups.

The report is released as part of the Asian Youth Mental Health Summit 2025, co-hosted by University of Auckland and Asian Family Services, held on 13th August at New Zealand Parliament.

Suggested citation: *Peiris-John R, Sung KH, Sharma V, Lee A, Kang K, Liang R, Simon-Kumar R, Ameratunga S, Ramalho R (2025).* Asian Youth Mental Health Needs and Opportunities: A literature review and summary of research in Aotearoa New Zealand. The University of Auckland.

Contact: Dr Roshini Peiris-John - r.peiris-john@auckland.ac.nz

The Thriving at Crossroads Project

Thriving at Crossroads is a research initiative from Waipapa Taumata Rau (The University of Auckland) aimed to understand the lived experience of ethnic minority youth and the impact of these experiences on their wellbeing.

Our lives are impacted by multiple and shifting identities. For young people on the cusp of adulthood, understanding who they are and where they fit in is essential to their health and influences their future. Here in Aotearoa New Zealand, multiple faultlines shape how identity is experienced, including: ethnicity, culture and gender. Despite this richness of experience, ethnic minorities, defined here as Asian, Middle Eastern, Latin American or African, have remained under-studied and often left uncounted. Within ethnic minorities, those identifying with an additional minority identity, such as gender diverse, disabled, or from financially constrained backgrounds, are even more likely to be rendered invisible.

Thriving at Crossroads aims to change this. We aim to be innovative, flexible and provocative while also grounding our work in the latest research.

Our research questions:

- How do we understand the needs of young people whose identities cross more than one faultline?
- How do we see them more clearly and engage them with services developed to fit their unique needs?

Research team

Associate Professor Roshini Peiris-John (PI)
Dr Rodrigo Ramalho (Co-PI)
Dr Vartika Sharma
Associate Professor Arier Lee
Kristy Kang
Dr Renee Liang
Professor Rachel Simon-Kumar
Professor Shanthi Ameratunga

T@C youth with research team

Acknowledgements

Thank you to the ethnic minority youth who took part in the study, the youth advisory group, research students and youth researchers who continue to contribute to T@C. We enormously appreciate your time, openness and energy.

We acknowledge Health Research Council of New Zealand for providing funding through a Project Grant (#21/425).

Thank you to Dr Kelly Feng and Asian Family Services for partnering with us to enable translation of research to policy and practice by co-hosting the Asian Youth Mental Health Summit 2025.

Asian Family Services
Together enriching lives

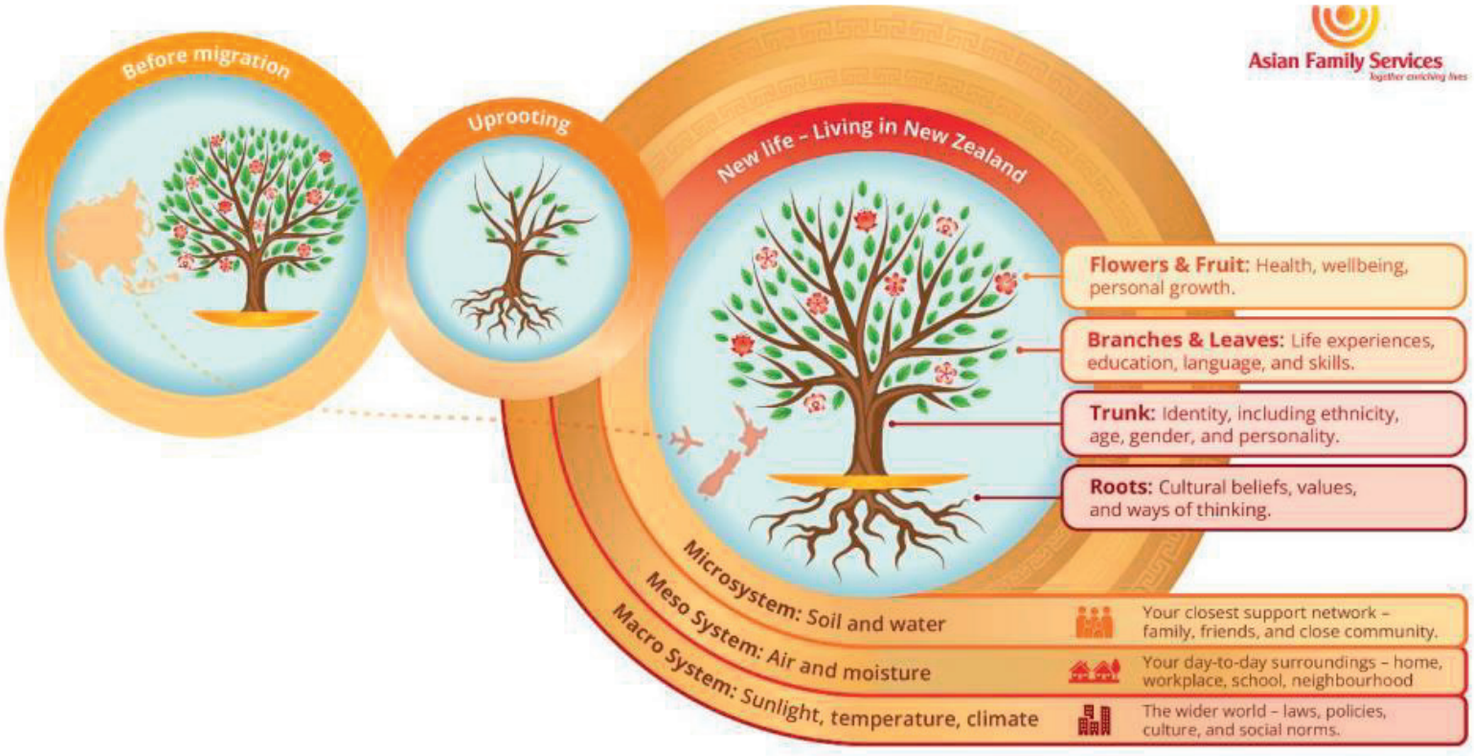
Our History & Our Why – Asian Family Services (AFS) has been providing support to our Asian communities in New Zealand since 1998, initially with a team of three practitioners providing telephone services for Asian people affected by gambling harm. In the nearly 30 years since our inception, with a team of almost 50 people, what drives us has remained the same: Asian New Zealanders deserve to live flourishing lives, and we believe mental wellbeing is a fundamental component. By providing mental health services that are culturally tailored, linguistically matched, evidence and lived experience informed, we have earned the trust of our communities to improve outcomes.

Driving System Change – We are also a voice for our communities in shaping the systems that impact their mental health and wellbeing. Through policy submissions, consultations, and advocacy, we work to embed Asian perspectives in national frameworks. Our input into the Mental Health Act reform, He Ara Awhina, Suicide Prevention Action Plan, Oranga Hinengaro System and Service Framework and many more, has consistently called for Asian people to be recognised as a priority group. We have also contributed to the Department of Internal Affairs' online gambling consultation, advocating for stronger protections. We take pride in that our voice is informed by the lived experience of our community members, facilitated through our lived experience advisory groups and Ethnic Advisory Group.

Serving our Communities – These strategic efforts enable the heart of our work: direct engagement with our communities through trusted, culturally responsive services. Our Asian Helpline is offered in 7 different languages. Our clinical and counselling support includes in-language therapy for gambling harm, mental health, and alcohol and other drug (AOD) challenges. We deliver child, youth, and parenting programmes like Kia Ora Ake and Incredible Years Parenting, tailored to Asian whānau. Our public health work has a big focus on minimising and preventing gambling harm. Its campaigns and community outreach also increases mental health literacy and destigmatises mental health conversations. Research initiatives, including national AOD surveys and our Integrated Tree Model, inform service design and deepen understanding of Asian wellbeing. We also strengthen early intervention and culturally safe pathways across the country, for example, develop suicide prevention training through e-learning for our community leaders and health professionals.

Our Impact – Each year, AFS responds to over 10,000 requests for support, reflecting the trust placed in us by our communities. More than 2,100 individuals experiencing gambling harm receive direct clinical and intervention services, benefiting from culturally safe, in-language care that is responsive to their needs. Our Kia Ora Ake programme delivered over 1,000 school-based sessions with 5-13 year olds in its first year. AFS' Public Health team engages with over 10,000 community members annually. These numbers go beyond just activity and output; it represents a long-term, transformative journey for AFS in supporting our communities to normalise conversations about mental health, encourage help-seeking behaviour across generations and age groups, and empowering Asian New Zealanders to access support that honours their identity, language, and lived experience.

Asian Family Services - The Integrated Tree Model ©



When a tree is moved, its roots may be damaged, and the tree can lose its leaves and produce no fruit. It takes time for the tree to form new feeding roots and to adapt to its new location before new leaves and fruit can grow. Asian people go through a similar process to accomplish their dreams of a better life in New Zealand (Asian Family Services 2017). AFS developed the Integrated Tree Model to help Asian clients discover and resolve problems, enabling them to grow "stronger roots" and work towards health and well-being.

Each part of the tree represents different aspects of an individual's life:

- The roots represent the beliefs, culture and values
- The trunk represents the individual's identity
- The branches and leaves represent the education, language and skills
- The flowers and fruit represent health and well-being

At Asian Family Services (AFS), the Integrated Tree Model not only supports individual healing and growth but also serves as a framework for staff to understand the broader ecological environment influencing a person's wellbeing. Grounded in Bronfenbrenner's Ecological Systems Theory (1989)[1], the model encourages practitioners to consider multiple layers of influence in a client's life:

- Soil and Water - Microsystem – The individual's immediate physical and social surroundings, such as their home, family, and close relationships.
- Air and moisture - Mesosystem – The person's broader social networks and interactions, including school, workplace, community groups, and cultural or religious organisations.
- Sunlight, temperature, climate - Macrosystem – The wider societal structures, including government policies, cultural norms, systemic barriers, and laws that impact the individual and their community.

Asian Family Services incorporates the Integrated Tree Model in service delivery to allow a range of services to be culturally responsive for Asian communities.

Suggested citation: *Asian Family Services - The Integrated Tree Model ©.* https://www.asianfamilyservices.nz/resources/resource-items/20231018-the-integrated-tree-model.

[1]Bronfenbrenner, U. (1989). *Ecological systems theory*

Asian Family Services
Together enriching lives

Contents

Key summaries

Research evidence

What helps Asian and ethnic minority young people in Aotearoa New Zealand to thrive mentally and emotionally?

Findings from The Thriving at Crossroads project

Life in Aotearoa New Zealand is recognised as a canvas to thrive	Young people, ○ Have a profound sense of appreciation for growing up in NZ ○ Value the natural environment and opportunity to enjoy the outdoors ○ Value the opportunities for education, culture and sports
Having appropriate and timely support in finding oneself and acceptance	○ Requires introspection and reflection, and can be isolating, traumatic, without support impacts their mental health. ○ Needing to navigate several layers – e.g. own histories/ trauma; coming to terms with their multiple identities and accepting that they are different and that they no longer needed to work at fitting in with what society wants of them.
Finding one's safe community	○ Validation and safety through sameness ○ The communities most often included people with similar identities (e.g. people of colour queer community). ○ Safe communities help with their healing – e.g. friends, religious group, social media communities, support networks, clubs in university. ○ Not necessarily new communities but also rekindled communities.
Access to connections and conversations that are open, honest, vulnerable and supportive	○ Opening space for conversations was seen as needed within families, and importantly within educational settings, health and social support systems

Continued on next page.

What helps Asian and ethnic minority young people in Aotearoa New Zealand to thrive mentally and emotionally? (continued)

Having safe inclusive spaces to share journeys

- Opens opportunities for reflection, validation, empowerment
- When within trusted 'mainstream' spaces: seen as an opportunity to share rich heritage, challenge stereotype, and build connections, but at times challenging (having to carry the burden of responsibility often being the only one in the room)
- need for increasing social awareness of lived experience, and greater appreciation of histories

Setting own boundaries

- Young people having to navigating tensions between the need to 'fit in' (or assimilate) and moving away from trying to fit in and choosing spaces which feel safe for them

Finding strength in the collective, supporting people like themselves

- Sharing experiences and in the idea of helping their peers to thrive

Seeing representation especially amongst positions of power

Having accessible and an aware mental health system

Citation: *Kang K, Liang R, Sharma V, Ramalho R, Simon-Kumar R, Ameratunga S, Lee A, Peiris-John R. Thriving at Crossroads research project.*

Factors preventing Asian youth from thriving

Research shows that the following factors are preventing Asian youth in Aotearoa New Zealand from thriving mentally and emotionally. Some of these reasons are common to all young people and some are particularly relevant to Asian and other ethnic minority youth.

High-level (macro-system) and Mid-level (meso-system) factors
(e.g. laws, policies, economic system, social conditions, media, schools, workplace, neighbourhoods)

- Bullying and feeling unsafe (mostly in schools, but also in public and social settings)
- Experiences of racism - structural, individual and internalised (in schools, neighbourhoods, healthcare, media)
- Intersecting challenges related to racism, sexism, cis-heteronormativity, ability, and cultural expectations, and not fitting into Kiwi and own ethnic cultures (compounding effect of navigating intersecting identities across both New Zealand and ethnic cultures)
- Migrant generation impacts (e.g. language barriers, cultural dissonance, negotiation of conflicting values)
- Caught in between two worlds (as a Kiwi and Asian/ethnic minority)
- Low sense of belonging - peers, school, wider New Zealand (‘*you are welcome, but different*’)
- Experience of being stereotyped in schools, community, healthcare (e.g. model minority, refugee status, negative assumptions associated with ethnic group and intersecting identities)
- High (unreasonable) expectations and pressure from teachers, at the workplace, in the community
- Trauma - childhood, intergenerational
- Negative pre-migration experience
- Post-migration stressors: housing, poverty (including intergenerational), language barriers hindering integration and education, and worries about family left behind/ facing trauma
- Attending low-decile schools, living in low-decile neighbourhoods
- Lack of connectedness, peer-support, caring teachers, no adult close enough to talk to about mental health, loss of established social networks from their home countries
- Social isolation and loneliness
- Gambling harm and addictions (e.g. gaming)

Proximal (micro-system) factors
(e.g. family, friends, extended family, ethnic community)

- High (unreasonable) expectations and pressure to succeed from parents, family (e.g. academic, career expectations, the need to honour parents’ sacrifices)
- Acculturation conflict with parents, family (arising from differences in rate of acculturation)
- Role conflict (e.g. interpreter and cultural brokers for parents/family)
- Discrimination from within Asian cultures (e.g. classism, religious discrimination, sexism, cis-heteronormativity)
- Youth and families unaware of available supports
- Intergenerational conflict
- Mental health stigma
- Pressure to be resilient and avoid emotional expression (including influence of gender roles)
- Don’t have the language to express, differing views on how to manage mental distress
- Lack of pride in their own cultures
- Mental health of parents
- Family violence/ trauma, feeling unsafe at home
- Low family support/ acceptance of minority sexuality (generally conservative/ traditional culture)

Barriers faced by Asian youth in seeking help or healthcare for their mental health

Research shows that Asian youth encounter multiple barriers or difficulties when trying to seek help or support for their mental health. Some of these reasons are common to all young people and some are particularly relevant to Asian and other ethnic minority youth.

High-level (macro-system) and Mid-level (meso-system) barriers

(e.g. laws, policies, economic system, social conditions, media, schools, workplace, neighbourhoods)

- Healthcare system is complex to navigate, difficult processing information about help when in need
- Can't get a timely appointment and gaps in services
- Lack of choice to meet preference - options not flexible throughout the mental health journey
- System is not inclusive
  - Western-based service models
  - Health professional training largely Eurocentric
  - Needs not well understood, mismatch of expectations
- Buying into the assumption that Asians are not mental health 'literate' and thereby, silencing knowledge systems of health and wellbeing across Asian cultures, and healing practices that are very commonly used within Asian communities as antidotes to alleviate suffering.
- Lack of culturally appropriate services, culturally safe modes of care, difficulty finding culturally suitable professionals deter help-seeking
- Poor experience once healthcare is accessed including mistrust, stereotyping, lack of private and confidential care, discrimination
- Unaffordable, lack of transport
- Funding models not culturally sensitive
- Limited diversity and representation in the health workforce
- Intersecting identities and diversity of experiences are often overlooked
- Societal expectations (e.g. of being resilient, a model minority) acts as a barrier to accessing support
- Interpreter service is expensive, unhelpful when family are used as interpreters (confidentiality concerns in small communities)
- Barriers meeting linguistic needs (beyond interpreter service)
- Misdiagnosis due to somatic presentations
- Youth not aware of their healthcare rights in relation to who to go to when harm is experienced within the health system

Proximal (micro-system) barriers

(e.g. family, friends, extended family, ethnic community)

- Most youth don't seek help from professionals and prefer help and support from people they know and trust (e.g. friends, teachers)
- Coping mechanisms: Self-reliance first, peer support next, Family and professional help last
- Limited concept of counselling
- Internal and social stigma, and shame in asking for help
  - Differing cultural view of mental health, lack of conversation around mental health (e.g. only discussed if 'severe case' as mental illness seen as 'crazy' and associated with shame)
- Low mental health literacy (youth and parents), differing views on mental health
- Too embarrassed, don't want to make a fuss, hope the problem will go away
- Fear of misunderstanding or burdening parents, family
- Pressure to conform to cultural values (e.g. conformity to norms, emotional self-control, collectivism and family reputation)

Recommendations for improving youth mental health in Aotearoa New Zealand

The recommendations applicable to all youth are extracted from: *Peiris-John R, Ball J, Clark T, Fleming T, and the Adolescent Health Research Group (2024). Youth Mental Health Needs and Opportunities: Leveraging 25 Years of Research from the Youth2000 survey series. The University of Auckland and Victoria University of Wellington.*

Key Findings	Recommendations
Youth health needs *change* Adolescent health needs and strengths change markedly over time and context	**Continue monitoring** Sustained research using comparable measures and methods allows measuring trends and learning from successes
Youth mental health needs are high and increasing Our analyses and local and international research highlight that youth distress is high and increasing	**Address youth mental health as an urgent priority** Facilitate cross sector, whole of government approaches and harness the power of communities for change
Youth health needs are *unequal* Many youth health needs are over 100% higher in communities exposed to poverty, exclusion and discrimination	**Ensure policies and actions work for those in under-served groups** Including those in AE, NEET, those excluded from school; those involved in Oranga Tamariki, those with disabilities, Rainbow; Indigenous and minoritised groups and those from low-income communities
Young people have powerful insights Adolescents have important ideas about their needs and what works for them	**Involve young people in designing and evaluating solutions** Involve young people in identifying priorities, and opportunities for change to support mental health and wellbeing in communities, schools and services

Continued on next page.

Recommendations for improving youth mental health in Aotearoa New Zealand (Continued)

Key Findings	Recommendations
Most youth don't seek help from professionals Young people prefer help and support from people they know and trust	**Better equip communities to respond** Ensure whānau, schools, peers, and primary healthcare are supported to respond and know when to seek help if needed
Causes and risks for mental ill health are complex and interact	**Ensure efforts are tailored, sustained, multi-level, cross-sector and have cross-party cooperation**
Health services alone cannot stem the tide of distress Accessible health and mental health services are not sufficient to reduce population rates of distress. Health gains have been made in areas with sustained, multilevel, targeted approaches	**A population approach including prevention and equity is key** Prevention is key to reducing distress alongside improving access to helping services. Prevention includes fairer, safer and inclusive communities, as well as addressing youth priorities such as adequate food, income and fairness, loneliness, navigating digital contexts and the climate crisis. International and local evidence, and youth voice highlight key opportunities (see pages 60-62)
Access to health care is poor 17% of all secondary school students report problems getting care when they needed. This is higher among Māori, Pacific, Asian, Rainbow, Disabled young people, low-income communities, and those living in small towns	**Ensure all young people can access healthcare in schools, communities, online & in emergencies** Youth need options and choices that meet their preferences. One-size fits all does not work for youth mental health Services must take a developmental, cultural and localised approach to meet the needs of youth, especially for underserved groups

Continued on next page.

Recommendations for collecting good data through youth surveys

Key Findings	Recommendations
Organisational needs differ from youth needs When developing surveys, unfortunately the needs of researchers or organizations can sometimes take precedence over the needs of young people.	**Put youth wellbeing at the centre** It is important to prioritise youth needs when designing surveys. Consider, how will this data be used? Does it have potential to improve youth health?
Deficit-framing is harmful Young people can internalise negative narratives. Deficit discourses reinforce racist, able-ist and homophobic stereotypes that stigmatise youth.	**Strengths-based research** Monitoring of youth wellbeing should focus on strengths and assets as well as challenges. Reporting of inequities should focus on privileged groups as well as marginalised groups and should put findings in context by explaining the underlying structural causes of disadvantage and inequities.
Trust is paramount Young people may be unwilling to participate and may not give honest answers unless they trust that their answers will be kept confidential, used ethically and not misused.	**Build trust, assure confidentiality** Using language familiar to young people and considering the research process from their perspective is important. Systems to protect confidentiality and ethical use of data are vital; these should be explained to research participants to provide reassurance.
Consistency versus modernisation Ideally survey methods, questions and response options should remain the same in repeated surveys to enable valid comparison over time. However, the world changes, and sometimes updates or improvements are needed.	**Prioritise comparability** The less survey methods and questions are changed year to year the better. Only make changes when absolutely necessary.
Question order matters Question order can affect comprehension, response and response rates.	**Put easy questions first** Avoid placing sensitive questions at the very beginning of the survey. Avoid placing important questions at the very end as response rate typically declines for the final question, especially if the survey is long.

Recommendations for improving Asian youth mental health

Based on the research evidence on Asian youth mental health in Aotearoa New Zealand, we summarise overarching actions that government, government agencies, healthcare providers and community organisations could take to better support Asian (and other ethnic minority) youth mental health and wellbeing (see pages 14-18).

These are presented under five key themes:

1. Co-creation with youth: From tokenism to power-sharing
2. Policy & system-level actions
3. Provision of culturally safe, accessible mental health services
4. Data collection, data reporting and research
5. Inclusion and belonging

The recommendations form the basis for discussion and prioritisation of solutions at the Asian Youth Mental Health Summit 2025. The aim of the summit is to develop practical recommendations for inclusive solutions across policy, education, healthcare, and community systems to improve youth mental health in Aotearoa New Zealand.

1. Co-creation with youth: From tokenism to power-sharing

➢ Develop best practice guidelines for Asian youth engagement both for research and service planning
➢ Involve Asian youth in co-designing mental health services, campaigns, and research, on an ongoing basis
➢ Understand power dynamics and actively create safe co-leadership spaces for Asian youth with lived experience
➢ Enable strength-based framing of messaging
➢ Involve Asian youth in co-designing inclusive spaces for developing connections and having safe conversations, building a sense of belonging
➢ Meaningfully engage with Asian youth in designing culturally responsive resources and training

2. Policy and system-level actions

- Set inclusive monitoring targets (e.g. service uptake at each touch point, retention within health system, mental health outreach)
- Ensure mental health equity through explicit inclusion of disaggregated ethnic-specific monitoring data reporting.
- Explicitly include Asian and other ethnic youth within mental health policies, strategies and planning (recognise heterogeneity in Asian communities)
- Embed Asian youth voice into policymaking and planning structures
- Fund community-rooted, youth-led /youth-centred Asian mental health programs and services
  - e.g. suicide prevention interventions delivered in secondary and tertiary education institutions
- Ensure implementation of mental health promotion and support programs for ethnic youth in collaboration with schools, cultural service providers, youth providers and in health.
- Improve cross-sector, inter-agency collaboration to help Asian youth connect to available support services.
- Ensure educational interventions and diversity training for key care providers, including teachers, health-service providers, and the police around cultural safety, intersectional awareness and the effects of perceived Whiteness and racial bias
- Gap in research on safe digital worlds for Asian youth
  - Gain better understanding of the benefit and harms of social media for Asian youth
  - Regulate and hold Big Tech accountable for harm
  - Address disinformation, misinformation

3. Provision of culturally safe, accessible mental health services

➢ Recognise and address complexities of life experienced by Asian youth in service planing & provision
➢ Train mental and primary care health professionals in cultural humility and culturally safe and respectful service provision, including • Improve providers' sensitivity for identifying and appreciating the potential impact of social oppression and mistreatment • Improve clinicians' capacity for engaging with family members • Provision of language support to ensure barriers to access are reduced • Provision of professional supervision and support for interpreters to manage distress from providing service (e.g. traumatic content) • Improve skills to work sensitively with youth from collectivist cultures • Respect youth preferences regarding the ethnicity of their clinician
➢ Develop and use of culturally validated diagnostic tools
➢ Develop resources and services for delivering culturally informed psychosocial care for Asians
➢ Enable the use of culturally validated treatment approaches for Asian communities
➢ Address affordability and provide culturally sensitive funding models
➢ Enable holistic and relationship-orientated therapies, such as family therapy, ecological therapy, systemic therapy or attachment therapy
➢ Many young people do not like to engage in conventional (i.e. face-to face) therapy. Consider alternative forms of therapeutic services, such as computerised/ gaming therapy, telephone/ internet counselling, digital tools to improve access to mental health support
➢ Ensure meeting needs of Asian youth who value trusting, respectful, and non-judgmental professional interactions and practical support
➢ Refer clients to social services that can meet practical needs. e.g. recognise refugee youth may seek help for practical challenges and needs (beyond historical trauma or mental health symptoms) requiring practical support
➢ Implement Positive Youth Development-oriented mental health services, including peer-support interventions, mentorship programmes, psychoeducation groups, tutoring, or community outreach programmes
➢ Provision of accessible and integrated physical and mental health services especially in highly deprived areas.
➢ Increase representation in health workforce to reflect the diversity of ethnicities and other marginalised identities in New Zealand
➢ Provide a wrap-around primary care service
➢ Create opportunity for knowledge sharing (on culturally responsive care) between ethnic providers (with community knowledge) and mainstream youth mental providers (including PHOs)
➢ Inclusion of cultural wisdom, alternate health philosophies in service planning (including needs assessment)
➢ Improve access to culturally responsive health services for ethnic youth and their families, making available a diversity of services that are tailored to different needs.

4. Data collection, data reporting and research

- Ensure mental health equity through inclusive data collection. Such as,
  - Asking relevant questions (e.g. in youth surveys): exploring migration generation, connection to culture, languages spoken, experiences of stereotyping and racism, internal and social stigma, intersecting identities and diversity of experiences
  - Using culturally validated tools for determining prevalence estimates
- Address data gaps in Asian mental health through disaggregation by ethnicity (avoiding homogenising), addressing invisibility, and bias
  - Systems to protect confidentiality and ethical use of data are vital
- Monitoring of youth wellbeing should focus on strengths and assets as well as challenges. Findings must be placed in context by explaining the underlying structural causes of disadvantage and inequities
- Validating lived experience as evidence in research and program design
- Examine protective factors (including resiliencies) in greater detail to inform interventions across schools, tertiary education, community, and health sectors
- Investigate the relevance, feasibility and efficacy of using non-Eurocentric alternate health systems (e.g. traditional Chinese medicine, yoga, meditation practiced by Eastern cultures)
- Gain a better understanding on how transnational healthcare (including online) impacts the way Asian youth engage (or do not) with mental health services in New Zealand
- Develop and test interventions for improving mental health and wellbeing of Asian youth using participatory and co-design methods
- Develop and apply frameworks and models such as intersectional developmental frameworks to explore mental health differences between different age groups
- Recognise the need for Asian data sovereignty
- Examine identity negotiation in context of: ethnicity, evolution from adolescence to emerging adulthood, environmental influences (e.g. social media, racism and discrimination in public spaces), biculturalism and multiculturalism
- Address family and cultural contexts in research: Examine role of family and community, acculturation, intergenerational conflicts, and cultural identity formation

5. Inclusion and belonging

➢ Increase awareness and include cultural safety training amongst key stakeholders in schools, healthcare, and other relevant government and non-governmental agencies to address ethnic discrimination
➢ Visibilise and address the root cause of social issues embedded in intersecting forms of marginalisation for Asians in Aotearoa New Zealand
➢ Improve cultural intelligence within society
➢ Create safe and inclusive spaces (physical and social) in schools and communities (e.g. where youth can meet peers with shared experiences, fostering belonging and mutual understanding)
➢ Strengthen school policies on diversity and inclusion, anti-bullying, racism and discrimination
➢ Raise the mana of Asian young people in schools and communities, and promote belonging through cultural integration
➢ Address pressures related to the need for assimilation, perfectionism and being the 'model minority'
➢ Address invisibility of experiences related to ethnicity-based exclusion, bullying, othering, discrimination in institutions
➢ Address stereotyping/ made to feel different (othering), bias and discrimination in institutions and within Asian families
➢ Normalising mental health conversations in Asian communities • Develop resources in multiple languages about effective communication, mental health and where and how to seek help • Support youth-led cultural and mental health dialogues (e.g., Asian Diaspora Dialogues, Reimagining Mental Health)
➢ Intervention options should consider targeting relationships with parents including acculturation conflict, expectations around autonomy etc.
➢ Raise community awareness around mental health and how to recognise mental distress.
➢ Address economic inequality at a national level
➢ Initiatives that enable young people's sense of pride in their own cultural diversity and retaining connection with ethnic culture to strengthen identity/foster a strong sense of self
➢ Invest in diversity programs that can support young people to explore and utilise their own cultural resources for resilience
➢ Ensure social supports are included in orientation packs for refugee families

Rapid and unequal decline in adolescent mental health and well-being 2012–2019: Findings from New Zealand cross-sectional surveys

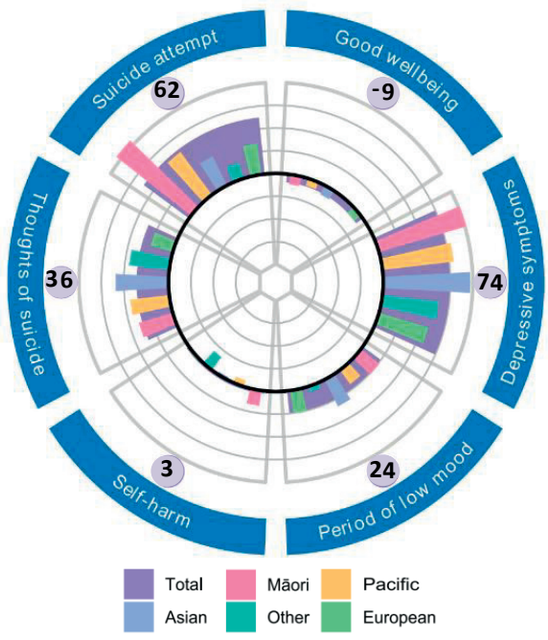
This study investigated prevalence and trends in key mental health and wellbeing indicators among adolescents using data from representative Youth2000 surveys conducted in 2001, 2007, 2012 and 2019 (total n = 34,548), with 2–4% of the New Zealand secondary school population. It is a key Youth19 output providing an overview of mental health trends.

Results

In 2019, overall findings:

- 69.1% of students had good well-being (95%CI 67.6-70.6) measured using World Health Organization 5-item wellbeing index (WHO-5)
- 22.8% had clinically significant depression symptoms (95%CI 21.4-24.1) measured using Reynolds Adolescent Depression Scale (RADS) –Short Form
- 41.8% had possible anxiety symptoms (95%CI 40.5-43.2] measured using the Generalized Anxiety Disorder 2 (GAD-2), adapted. Note this is not a clinical measure but a very short screening tool which indicates frequent feelings of nervousness or anxiety and difficulties stopping worrying.
- **Declines in mental health were unevenly distributed and were generally greater among Asian students** and groups with higher need in 2012 (females, Māori and Pacific students and those from higher deprivation neighbourhoods), resulting in increasing inequity.

Prevalence change on mental health indicators 2012-2019



Conclusion

Adolescent mental health needs are high in New Zealand and have increased sharply from 2012 among all demographic groups, especially females, Māori, Pacific and Asian students and those from high-deprivation neighbourhoods. Ethnic and socioeconomic disparities have widened.

Note for graphic interpretation: Black centre line represents no % change between 2012 and 2019. Purple bar and numeral represent total population % change between 2012 and 2019. Narrow bars represent change for specific groups.

Citation: *Sutcliffe K, Ball J, Clark TC, Archer D, Peiris-John R, Crengle S, Fleming T. Rapid and unequal decline in adolescent mental health and well-being 2012–2019: Findings from New Zealand cross-sectional surveys. Australian & New Zealand Journal of psychiatry. 2023 Feb;57(2):264-82.*

For plain language report see also: *Fleming T, Tiatia-Seath J, Peiris-John R, Sutcliffe K, Archer D, Bavin L, Crengle S, Clark T (2020). Youth19 Rangatahi Smart Survey, Initial Findings: Hauora Hinengaro/ Emotional and Mental Health. The Youth19 Research Group, The University of Auckland and Victoria University of Wellington, New Zealand.*

Health and wellbeing of East Asian, South Asian, Chinese and Indian students in Aotearoa New Zealand: Youth19 Report

This report explores health and wellbeing of secondary school students in New Zealand who have an Asian identity. We disaggregate Asian youth data to provide data specific to East Asian, South Asian, Chinese and Indian students. Many reported significant emotional and mental distress as shown in the graphic. Mental health, particularly among female students, is of significant concern for this population.

Findings

- In 2019, 30% of Asian girls (up from 16% in 2012) and 19% of Asian boys (up from 9% in 2012) reported significant depressive symptoms.
- One in four Asian students reported being treated unfairly by a teacher or healthcare professional because of their ethnicity.
- 10% of Asian students reported being bullied in school because of their ethnicity or religion.
- About half felt unsafe in their neighbourhood.
- One in five reported not being able to get healthcare when they needed it in the last year

See recommendations on next page.

Health and wellbeing of East Asian, South Asian, Chinese and Indian students (continued)

Recommendations for schools and communities

- **Create safe and inclusive spaces (physical and social)**, empowering young people to have a voice in what the safe and inclusive spaces may look like and facilitating dialogue among youth about unspoken challenges (e.g. family harm, mental health, lower school clinic engagement).
- Strengthen school policies on diversity and inclusion, anti-bullying, racism and discrimination.
- Address racism and biases
    - For adults in schools and communities - Increase awareness of unintended or implicit biases (i.e., the unconscious association, belief, or attitude toward any social group); Increase awareness and responses to the challenges faced by young people who face discrimination due to multiple sources of difference, e.g. ethnicity, (dis)ability, non-binary gender, etc.
    - Better support for students who feel the societal pressure of needing to succeed
- Strengthening professional development of educators, support staff in schools and members of the Board of Trustees to promote cultural competence when dealing with young people (similar to the eCALD training for health professionals.
- Find ways to bridge the gap between schools, parents and communities (e.g. develop resources in multiple languages about effective parent-youth communication, mental health stigma)
- Celebrate diverse cultures and raise the mana of Asian young people in schools and communities through cultural or religious events, sharing of food, dance, etc.
- Enhance community networks for youth so that they are supported by peers and friends.
- Young people who have concerns or adverse experiences should be empowered and enabled to express these and get support as required.

Recommendations for healthcare providers, Ministry of Health, Government

- Consider a brief screen of presenting youth regarding experience of bullying, mental health, family violence, sexual health, substance use and gambling and other concerns with referral for appropriate support as required.
- Address the invisibility of Asian health in national health strategies and in planning
- Recognise the diversity of the Asian population and avoid the homogenisation of data.
- Foster health workforce development reflecting the diversity of ethnicities in New Zealand,
- Improve cultural competency and cultural sensitivity to ensure that services (including health, mental health and addiction workforces, and school-based health service providers) being provided are culturally and linguistically responsive to the needs of all young people.
    - Cultural competency training could focus on, for example, migration journeys, cultural practices and values around sexual health, family dynamics, mental health, understanding the reluctance to seek support (e.g., fear of being judged or the entire community being stigmatised or that information provided will not be kept confidential), use of interpreters (suggest parents should not use children as interpreters), sensitivity around certain topics like sex education and mental health, and addressing own biases.
- Take an interagency approach and strengthen collaboration to address gaps in support services
- Meaningfully engage with Asian youth when developing interventions and policies.

Citation: *Peiris-John R, Kang K, Bavin L, Dizon L, Singh N, Clark T, Fleming T, Ameratunga S. (2021). East Asian, South Asian, Chinese and Indian Students in Aotearoa: A Youth19 Report. Auckland: The University of Auckland.*

Understanding deaths by suicide in the Asian population of Aotearoa New Zealand

"...those bereaved and those with lived experience, frontline workers, analysts and academics have conducted sound research over the past few decades in Aotearoa New Zealand around Asian health issues and suicide."

"It is unethical that more has not been done with this collective wisdom and rich source of local knowledge that policy and practice change makers can access easily."

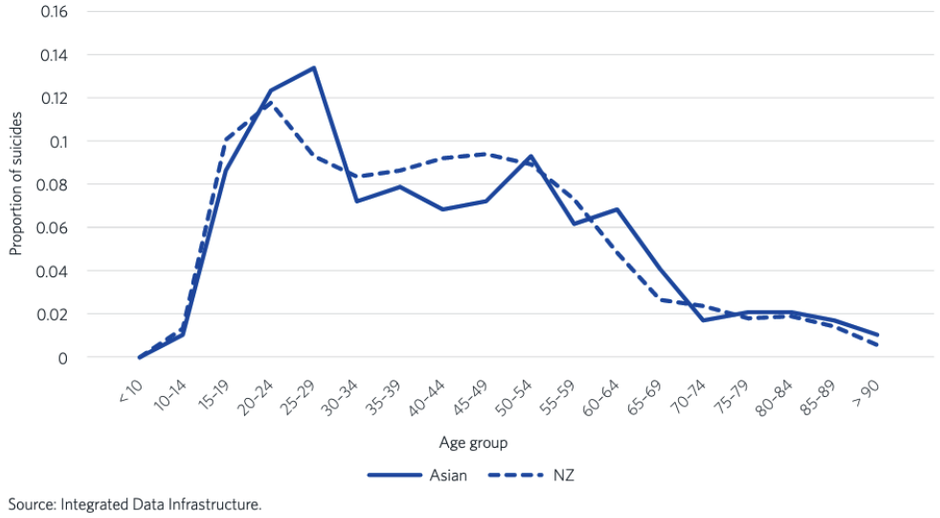
- Suicide Mortality Review Committee (2019)

This Health Quality & Safety Commission Report by the Suicide Mortality Review Committee focuses on the impact of suicide on the Asian population of Aotearoa New Zealand. In reviewing death by suicide affecting Asian people, this report aims to reinforce previous work and highlight areas requiring action in policy development. Suicide rates for Asian populations are lower than Māori and Europeans but have been slowly rising (5.93 per 100,000 in 2007/08 to 8.69 in 2017/18; 7.63 in 2018/19). The population rate of Asian suicide has been resistant to a decrease and, with the projected growth in the Asian population, the rate may rise.

Findings (youth relevant stats extracted from Ministry of Health and StatisticsNZ)

- The Asian population in Aotearoa New Zealand is relatively young: the median age is 30.6 years and a high proportion (31%) is aged between 15 and 29 years.
- The, suicide rates for the Asian ethnic group have been low compared with other main ethnic groups, but higher than for Pacific Peoples.
- Chinese and Other Asian youth have had lower suicide rates than the total population, but Indian youth and Other Asian females have had similar rates to the total population.
- Chinese and Other Asian youth had significantly lower intentional injury hospitalisations than the total population; however, Indian female youth had a higher rate than the total population.
- For Asian youth (and those younger than 65 years), suicide rates were less than 7.0 per 100,000; rates were highest among those living in the most deprived areas, as with other ethnic groups.

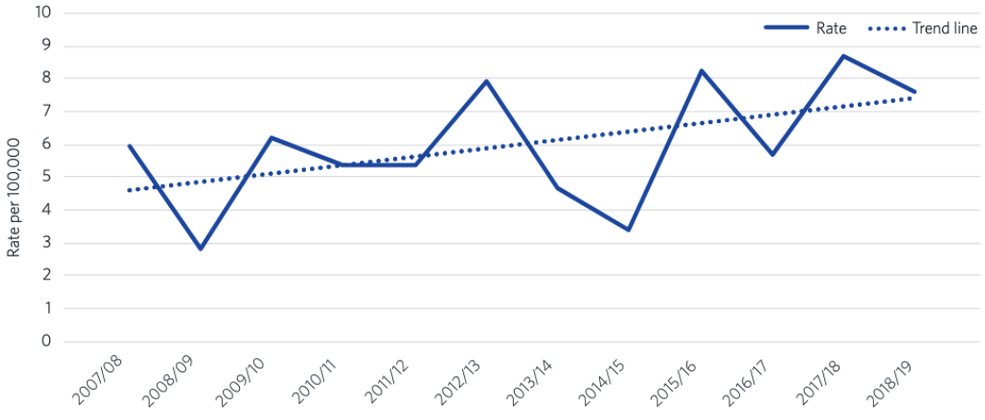
Figure 5: Proportion of confirmed suicides in each age group, by ethnicity (Asian vs non-Asian), 2006–17



Source: Integrated Data Infrastructure.

Understanding deaths by suicide in the Asian population of Aotearoa New Zealand (continued)

Figure 4: Rate of provisional suicides in the Asian population in Aotearoa New Zealand, 2007/08–2018/19



Source: Data from SuMRC database; best available data from Ministry of Health, may include provisional cases for 2017/18.

- Racism is a key factor contributing to suicide with impacts on mental health, accessing support and receiving high-quality services
- Shame and stigma on asking for help is an ongoing issue
- There is a growing need for culturally appropriate services with increasingly culturally and linguistically diverse groups challenging New Zealand's mental health system

Recommendations

- Provide a wrap-around service to support young international students when they first arrive in Aotearoa New Zealand, with a particular focus on coping and problem-solving skills
- Provide a low-intensity cognitive behavioural programme for international students of Asian descent, which has proven effective in reducing depression and anxiety, and in improving adjustment to tertiary study in Aotearoa New Zealand (see study by Lee and Williams, page 57 in this report).
- Ensure international students have good health insurance coverage that includes primary care (GP) services so they can access health care for physical and mental health care needs.

- Categorise 'Asian' mental health and social indicators into more specific ethnic groups at least Chinese, Indian and Korean – to identify emerging risk groups and appropriate interventions.
- Asian communities share a common collective approach to family and social structures, but each community also has unique factors that contribute to deaths by suicide, none of which will be captured in an analysis of factors contributing to suicide events based on a mainstream, invariably Eurocentric perspective.
- Raise community awareness around mental health – Asian communities are still unaware of general health and mental health system and of how to recognise mental distress.
- Address the growing need for culturally appropriate services

Citation: *Suicide Mortality Review Committee (2019). Understanding deaths by suicide in the Asian population of Aotearoa New Zealand - Te whakamārama i ngā mate whakamomori i te taupori Āhia i Aotearoa. Wellington, New Zealand: Health Quality & Safety Commission New Zealand.*

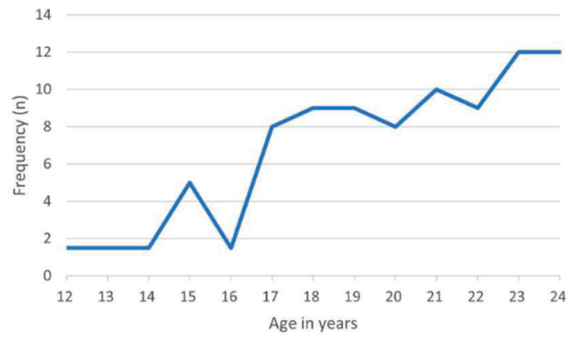
Suicide among Asian young people aged under 25 years in Aotearoa New Zealand

The aim of this study was to describe the characteristics and prevalence of suicide among Asian young people aged 10-24 years between 2002 and 2017. A retrospective review was conducted using the Mortality Review Database at the University of Otago, which contains national data on child and adolescent suicide deaths in New Zealand. The study population included all young people aged 10-24 years who died by suicide in New Zealand during the period from 2002 to 2017.

Key Findings

- Of 1,894 total suicide deaths of young people aged under 25 years, 88 (4.6%) were of Asian ethnicity, with a rate of 4.8 per 100,000.
- No suicide deaths for Asian young people under 12 years. The highest number of deaths for Asian young people occurred at ages 23 and 24 (Figure 1).
- Asian ethnic sub-groups: Indian (n=26); Chinese (n=12); Korean (n=12); Filipino (n=9).
- Young Asian males had twice the suicide rate cf. Asian females: 6.3 vs. 3.2 per 100,000.
- 80.7% (n=71) of Asian youth who died by suicide were born outside New Zealand. Of those born overseas, 83.1% (n=59) were born in an Asian country.

Figure 1: Suicide mortality (frequency) in Asian young people by years of age, New Zealand 2002–2017 (n=88).



All numbers less than 3 have been adjusted to 1.5.

- The most common methods of suicide among Asian young people were:
  - Hanging, strangulation and suffocation (71.6%, n=63)
  - Intentional self-poisoning (12.5%, n=11)
  - Jumping from a high place (6.8%, n=6)
- 63.6% (n=56) of Asian suicide deaths occurred in the Auckland region. Highest rates of Asian suicides were in Mid-Central DHB (12.1 per 100,000) and Waikato DHB (8.1 per 100,000).
- Suicide rates among Asian young people followed a bimodal distribution, with higher rates in both deprivation deciles 1 and in 8 (n=13) and 9 (n=17).

Recommendations

- Secondary and tertiary institutions should consider including delivery of suicide prevention interventions (including pastoral care), given the significant number of suicides in those over 17 years.
- More universal interventions supporting young people to develop healthy problem-solving skills should also be explored.
- Recognise that the Asian community is heterogeneous with regard to country of origin, culture and language, so strategies need to be tailored accordingly.
- The higher prevalence of jumping from a height among Asian young people is consistent with methods common in many Asian countries. Urban planners should consider suicide prevention, especially as high-density housing increases in urban centres.
- Continued development and support of culturally responsive health services is important in areas with high and growing Asian populations, such as Auckland.
- Integrated physical and mental health services should be made accessible in highly deprived areas.
- Further work to de-stigmatise mental illness within the Asian population could be of benefit.

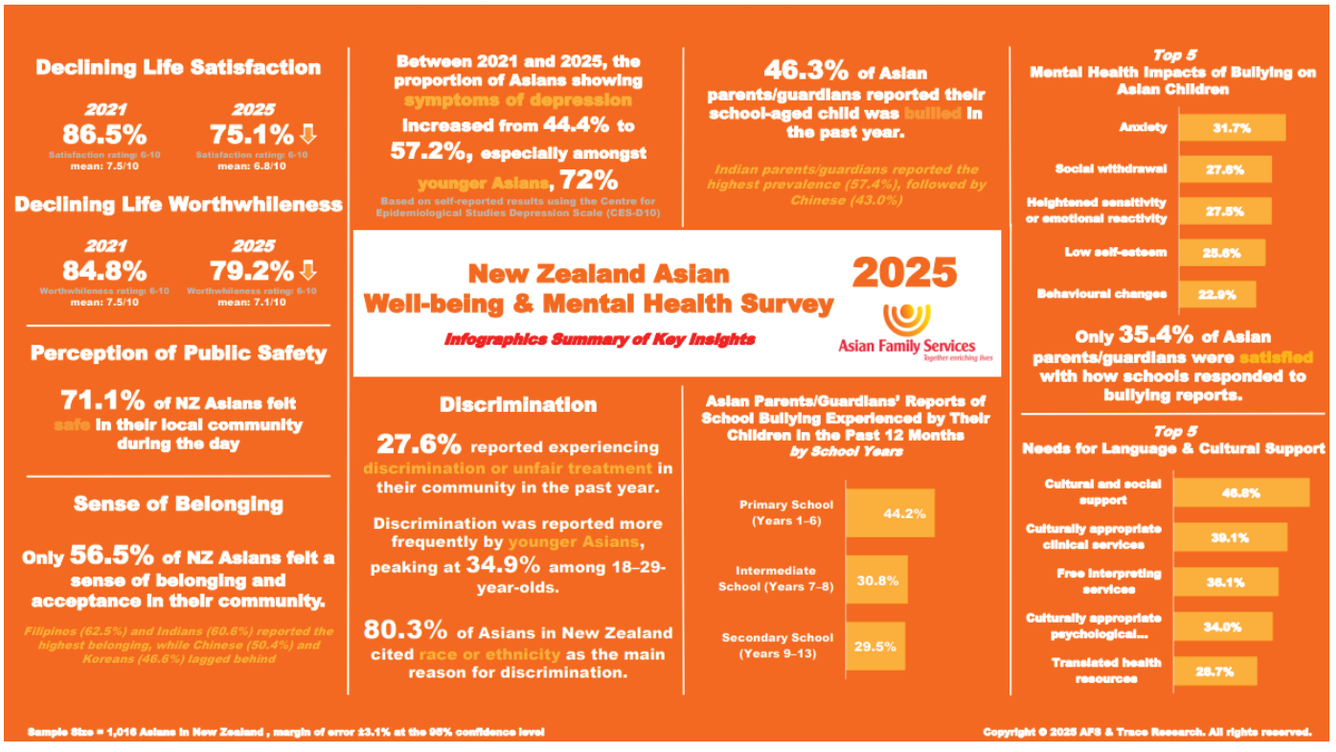
Citation: *Goh J, Fortune S, McDonald G. Suicide among Asian young people aged under 25 years in Aotearoa New Zealand: different methods warrant different preventive initiatives. The New Zealand Medical Journal (Online). 2021 Sep 17;134(1542):84–91.*

New Zealand Asian wellbeing and mental health - 2025

This report presents findings from the 2025 New Zealand Asian Wellbeing & Mental Health Survey, revealing critical concerns, notably declining mental wellbeing, significant experiences of discrimination, and high rates of school bullying among Asian communities.

Key Findings

- 46.3% of Asian parents/ guardians reported their school-aged child experienced bullying in past year
- Bullying had a significant impact on children's mental health, causing anxiety (31.7%), social withdrawal (27.6%) and emotional sensitivity (27.5%)
- Discrimination was reported more frequently by younger Asians, peaking at 34.9%
- Between 2021 and 2025, 72% of younger Asians displayed symptoms of depression



Recommendations

- Targeted mental health promotion, social engagement initiatives, and culturally tailored support are urgently needed
- Culturally responsive, place-based interventions that build trust, visibility, and community connection, ensuring safety and belonging
- The consistent ethnic disparities and rising depression rates call for targeted, culturally appropriate mental health services and youth-focused preventive strategies. Evidence strengthens the case for policy reform, resource allocation, and community engagement tailored to the unique needs of diverse Asian communities in Aotearoa New Zealand
- The persistence of race-related discrimination since COVID-19 underscores a deeply entrenched issue. Racial bias remains systemic and extends beyond crisis periods. Strategies are needed, particularly for visible migrants, youth, and residents in major urban centres
- Policymakers and Asian Family Services should implement ethnically responsive anti-bullying strategies, expanding culturally and linguistically accessible resources for parents. Schools should also embed bicultural liaison roles and enhance teacher training in cultural responsiveness and trauma-informed interventions

Citation: *Zhu A, Asian Family Services & Trace Research. (2025). 2025 New Zealand Asian Well-being & Mental Health Report. Asian Family Services. https://asianfamilyservices.nz/media/ndmpguos/2025-afs-nz-asian-well-being-and-mental-health-survey-report-trace-research.pdf*

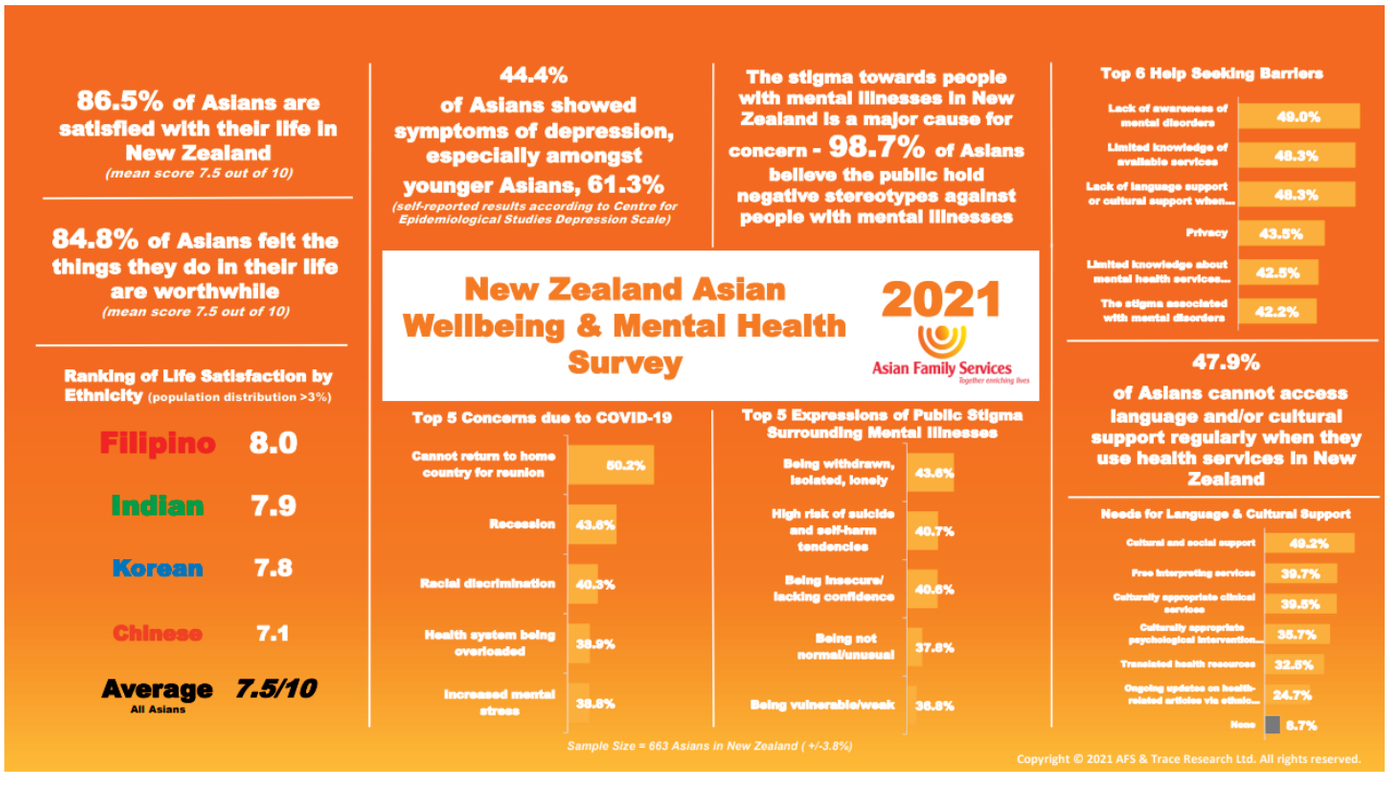
Asian Family Services
Together enriching lives

New Zealand Asian wellbeing and mental health report - 2021

This report presents findings on mental wellbeing of Asians, mental health help-seeking behaviours and related cultural and social issues, especially in the latter stages of COVID-19 to investigate how the pandemic impacted their mental wellbeing.

Key Findings

- 86.5% of Asians reported being satisfied with their lives in New Zealand
  - Filipinos reported the highest
  - Chinese reported the lowest (although over 80% reported satisfaction)
- Feeling lonely, feeling everything was an effort and having restless sleep were the top 3 reported symptoms of depression experienced by Asians who answered feeling depressed “all of the time”
- 44.4% of Asians are at risk of depression
  - Koreans are the most likely group to be at risk, followed by Indians and Filipinos
  - Those younger than 30 years have the highest risk of depression (61.3%) while those who are over 65 years have the lowest (23.4%)
- 98.7% of Asians believe that the public hold negative stereotypes against people with mental illness
  - Indians have the highest expressions of public stigma surrounding mental illness
  - Those over 65 years reported the most public stigma
- 47.9% of Asians experience difficulties accessing cultural/ language support regularly when using health services in New Zealand



Citation: *Zhu A, Asian Family Services, Trace Research (2021). New Zealand Asian Wellbeing & Mental Health Report 2021. Asian Family Services. https://asianfamilyservices.nz/media/rsmi2s4a/asian-family-services-new-zealand-asian-wellbeing-mental-health-report-2021-trace-research.pdf*

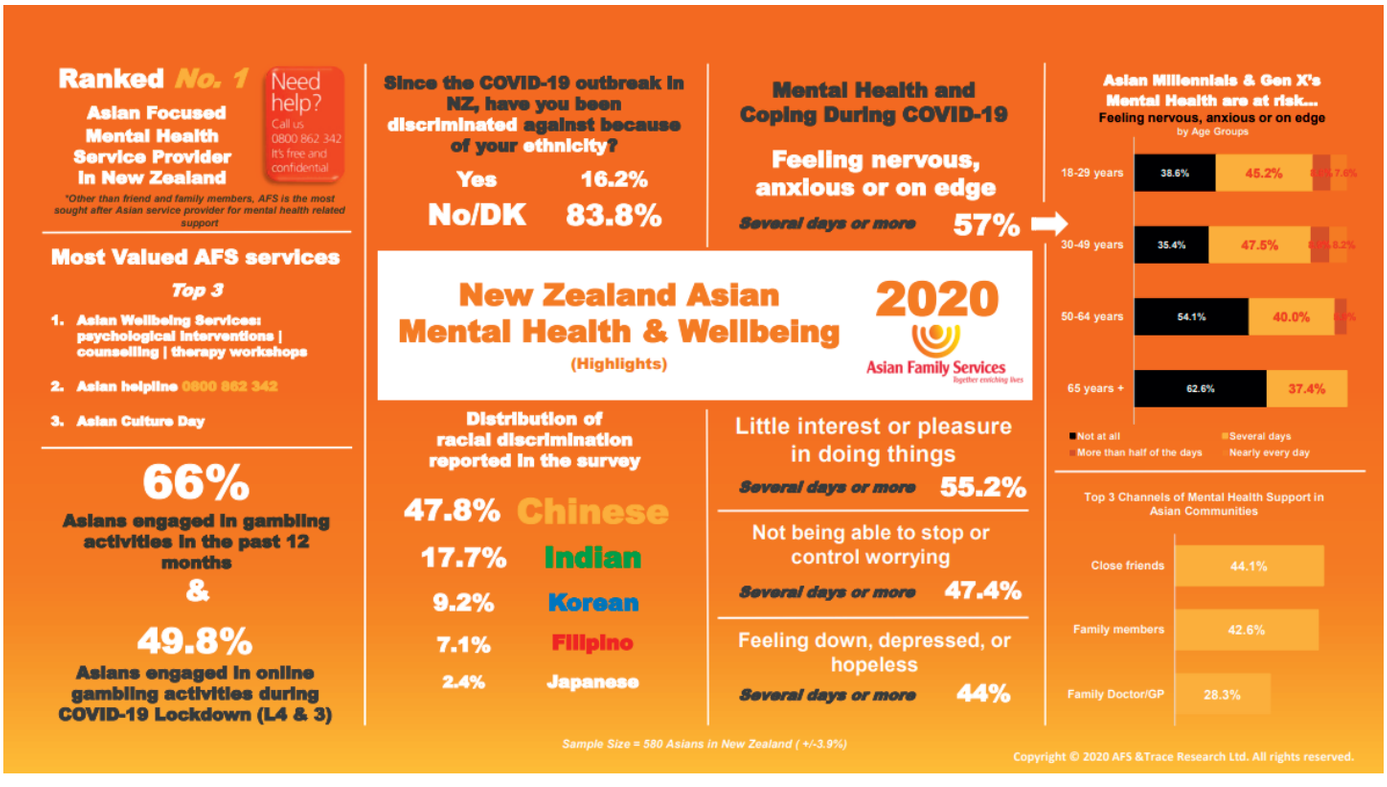
Asian Family Services
Together enriching lives

Asian mental health and wellbeing report - 2020

This report highlights the extent to which Asians in New Zealand were experiencing racism, anxiety and other mental health issues due to the COVID-19 pandemic.

Key Findings

- Asians primarily seek help from close friends (44.1%), family members (42.6%) and their family doctor/GP (28.3%). 14% do not seek any support at all
- 30% of Koreans and 22.3% of Chinese reported racial discrimination. 24.2% of Asian students reported racial discrimination
- 66% of Asians compared to the nation's average of 38.7% engaged in gambling activities in between 2019-2020
- Gamblers (61.2%) and victims of racial discrimination (72.4%) were more prone to experience serious mental health issues



Key Implications/Recommendations

➢ Asians are less likely to seek help from doctors and other health professionals/organisations thus, more campaigns that educate around professional mental health services are needed.

Citation: *Zhu A, Asian Family Services, Trace Research (2020). New Zealand Asian Mental Health & Wellbeing Report 2020. Asian Family Services. https://asianfamilyservices.nz/media/bbjkz4qa/asian_family_services_-_new_zealand_asian_mental_health__wellbeing_report_2020_-_trace_research_-_lite_version.pdf*

Asian Family Services
Together enriching lives

Effects of ethnic classification on substantive findings in adolescent mental health outcomes

This study focused on secondary school students in New Zealand aged 12 to 18 years, with a sample size of 8,275 participants. Its purpose was to examine how different methods of ethnic classification affect findings for three mental health outcomes: overall psychosocial difficulties measured by the Strengths and Difficulties Questionnaire (SDQ), deliberate self-harm, and suicide attempts. Ethnicity was categorised as European, Māori, Pacific, Asian, MELAA (Middle Eastern, Latin American, and African), and Other.

Key findings

Sole Asian youth (n = 738) showed higher rates of:

- suicide attempt than sole European youth (regression estimate 2.7%, 95% CI: 1.7% to 4.1%)

Asian/European youth showed significantly higher rates of:

- suicide attempts than sole European youth (regression estimate 5.5%, 95% CI: 3.1–9.5, $p < 0.01$)
- self-harm than sole European youth (regression estimate 23.3%, 95% CI: 18.1% to 29.5%)

Different classification methods led to changes in reported outcomes within the same ethnic group (effect sizes up to d=0.12) and in differences between ethnic groups (effect sizes up to d=0.25). This variation underscores the need for critical, transparent choices in how ethnicity data are collected and analysed.

The study supports existing evidence that Māori, Pacific, and multiethnic youth/adolescents who identify with more than one ethnic group tend to have higher mental health needs than sole European youth.

Implications

- Mental health outcomes for Asian youth can vary significantly depending on how ethnicity is classified in research.
- Researchers should be explicit and careful about how they classify ethnicity, as their decisions impact the conclusions drawn; which in turn influence findings, policy, and interventions.
- Sole versus Combination ethnic categories can reveal important differences but require cautious interpretation due to fluidity in ethnic identity and small sample sizes for some groups.
- The general principle of minimising harm and maximising benefit should be applied conducting studies which include Indigenous Peoples and ethnic groups traditionally marginalised in research (e.g., Pacific and Asian).
- Nuanced ethnic analyses, including for Asian subgroups, may be useful but require careful handling to avoid misinterpretation.

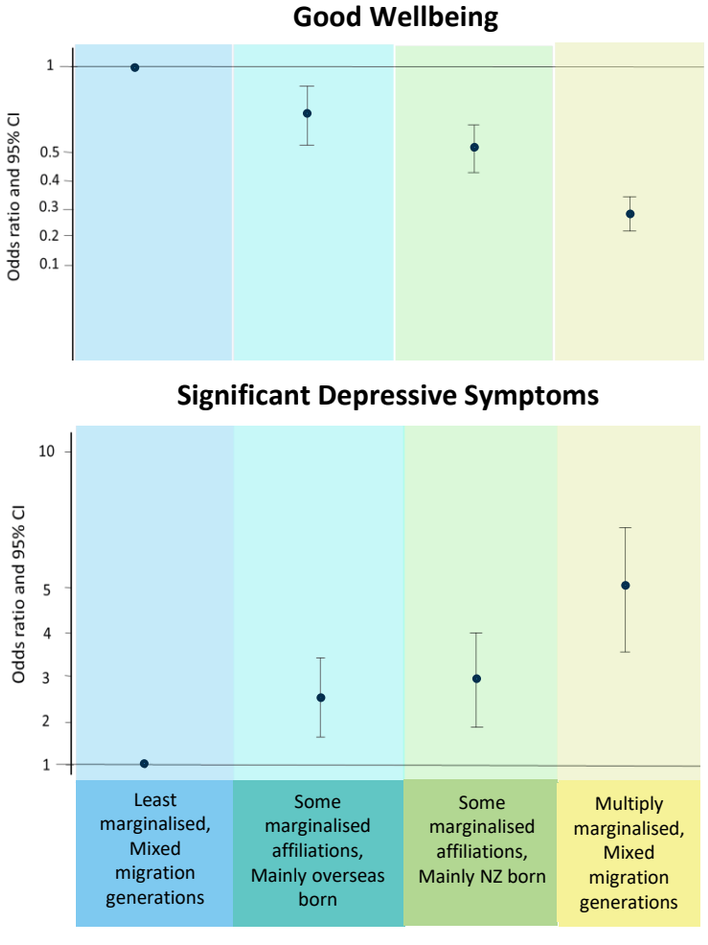
Citation: *Yao ES, Bullen P, Meissel K, Tiatia J, Fleming T, Clark TC. Effects of Ethnic Classification on Substantive Findings in Adolescent Mental Health Outcomes. Journal of Youth and Adolescence. 2022 Aug;51(8):1581–96.*

An intersectional analysis of social identities, wellbeing and mental health among minoritised ethnic youth

This study used an intersectional framework to investigate the mental health of ethnic minority youth (i.e. youth of Asian, Middle Eastern, Latin American and African origins) with varying degrees of marginalised social affiliations (e.g. Sexual and gender minority, living with disability or chronic conditions, single/teen parents, religious minority). This Youth19 analysis included 2,111 ethnic youth.

Key findings

Ethnic minority youth (EMY) with multiply marginalised identities had lower odds of good emotional wellbeing, and higher odds of significant depressive symptoms and self-harm attempts compared to EMY with least marginalised identities.



Note

- Least marginalised: more likely to include EMY identifying as cis-hetero, with no disability or chronic conditions, less spiritual, less deprived, perceived as ethnic minority.

Key differences from least marginalised group

- Some marginalised, Group 1: mainly overseas born, some deprivation, spiritual (Christian)
- Some marginalised, Group 2: mainly NZ born, female, some deprivation, spiritual (mixed religions), living with chronic conditions or disability, mixed perceived ethnicity
- Multiply marginalised: female, sexual or gender minority, chronic conditions/ disability

Implications and recommendations

- Social identities inherently linked to marginalised positions in Aotearoa have cumulative harmful impacts on the mental health of EMY.
- There is a need to resist the convenience to homogenise experiences of diverse communities.
- An intersectional approach helps highlight issues below the surface of affiliations such as ethnicity, gender, disability, and migration status.

Citation: *Lee A, Peiris-John R, Simon-Kumar R, Liang R, Ramalho R, Kang K, Sharma V, Fleming T, Clark T, Ameratunga S. What does it take to thrive at crossroads? An intersectional analysis of social identities, wellbeing and mental health among minoritised ethnic youth in Aotearoa – A Thriving@Crossroads Study.* **For more:** *https://www.thriving.auckland.ac.nz/.*

Intersecting lives: An exploration of mental health and wellbeing among ethnic youth in Aotearoa New Zealand

A scoping review was conducted to map research on mental health and wellbeing among Asian and MELAA youth in New Zealand, focusing on intersecting identities like sexual and gender minority status, immigrant background, and socioeconomic status influence mental health outcomes. Searches across several databases identified 26 relevant studies, published from 2000 to 2023, covering qualitative, quantitative, and mixed-method designs.

A quantitative analysis of Youth19 New Zealand secondary schools survey data was undertaken to examine variations in self-reported mental health and wellbeing outcomes among select intersectional groups of ethnic youth. The analysis also assessed the influence of risk and protective factors, specifically family support, experiences of ethnic discrimination by a teacher, and feelings of self-worth in relation to cultural identity and ethnicity (viz. cultural self-esteem) for each intersectional group.

Findings – Scoping Review

- **Sexual and gender minority ethnic youth** contend with the compounding impacts of homophobia and racism and face a high risk of rejection by families and communities compared to their cis-heterosexual ethnic peers.
- **Resilience factors** for sexual and gender minority youth include cultural connectedness, family support, and identity affirmation.
- **Structural and interpersonal racism** negatively impacts ethnic youth's sense of belonging and acceptance, serving as a significant barrier to integration in wider New Zealand society. Experiences of racial and ethnic discrimination were consistently associated with feelings of distress, sadness, alienation, and shame.
- **Internalised racism** is linked to poor psychological wellbeing in ethnic youth, including negative impacts on self-esteem and self-image.
- **Acculturation challenges** - especially for first and 1.5-generation youth - include language barriers, cultural dissonance, and negotiation of conflicting values.
- **Intergenerational conflict** stemming from cultural and generational gaps is associated with poor wellbeing outcomes.
- **Mental health stigma** in ethnic communities, cultural pressures to succeed, and the model minority stereotype hinder mental health and help-seeking behaviour of ethnic youth.
- **Positive identity integration** (reconciling ethnic and NZ cultural identities) is associated with better wellbeing outcomes for ethnic youth.
- **Healthcare access barriers** include language and cultural differences, lack of awareness of available services, low mental health literacy, and concerns about cultural safety.
- **Clinician competence and cultural safety** were cited as critical barriers to ethnic youth help-seeking.
- **Youth from economically deprived backgrounds**, especially migrants from low- and middle-income countries, experience worse mental health outcomes. However, no clear quantifiable relationship was found between economic status and mental health, indicating a need for further research.

Findings – Quantitative analysis

- Ethnic girls, ethnic sexual and gender minority youth, and ethnic youth from poorer socio-economic backgrounds were at greater risk of significant depressive symptoms, overall poor wellbeing, and attempted suicide or self-harm.
- Second or later generation ethnic youth were more likely to report attempted suicide or self-harm compared to 1.5 generation ethnic youth.
- Ethnic youth who were male, cis-heterosexual, or belonged to higher socio-economic backgrounds had better mental health outcomes

Intersecting lives: An exploration of mental health and wellbeing among ethnic youth (continued)

Policy Recommendations

- Mandatory cultural safety training in schools, educational institutions to address ethnic discrimination.
- Addressing socio-economic inequality at a national level is critical for mitigating the adverse impacts of deprivation on ethnic youth mental health.
- Greater investments in media, community, and educational initiatives promoting equality of gender and sexual minorities are advanced, ensuring representation of ethnic and racial diversity.
- Policy should be targeted at increasing capacity and improving free access to culturally responsive health services for ethnic youth and their families, making available a diversity of services that are tailored to different needs.
- Health providers should ensure implementation of mental health promotion and support programs for ethnic youth in collaboration with schools, cultural service providers, and youth providers.
- Need for greater training opportunities for service providers and practitioners to incorporate cultural safety and intersectional awareness in clinical and community practice.

Research Recommendations

- Increase funding for mental health research focused on ethnic youth.
- Need for greater intersectional data and research involving ethnic youth. Future research efforts should involve the collection of comprehensive data (both qualitative and quantitative) capturing the intersectional factors in ethnic youth populations across both adolescent and young adult age groups with greater specificity.
- Allow for disaggregation at the ethnic level in order to examine potential differences in the challenges and opportunities faced by different communities of ethnic youth (e.g., East Asian, South Asian, South-east Asian, African).
- Develop and apply intersectional developmental frameworks to explore mental health differences between different groups (e.g., ethnic girls and ethnic boys) to gain greater insight into how gender and/or racial socialisation affect adolescent development for ethnic youth in New Zealand.
- A greater focus on the role of resilience and protective factors among ethnic youth from diverse identities is necessary to promote positive mental health outcomes.
- Examine the role of family and community, acculturation, intergenerational conflicts, and cultural identity formation are likely to provide greater understanding of their influences on mental health among intersectional groups of ethnic youth. Addressing family and cultural contexts in research can provide insights for designing interventions and prevention programs that better cater to the mental health needs of ethnic youth.
- Engage families and wider communities in these interventions can enable researchers and practitioners to improve the cultural relevance of mental health support for ethnic youth.
- intersectional approaches can enhance researchers' capacity to accurately identify and analyse health inequalities within intersectional groups.

Citation: *Simon-Kumar N. Intersecting lives: An exploration of mental health and wellbeing among ethnic youth in Aotearoa New Zealand (Masters thesis, University of Auckland). 2023.*

Asian rainbow youth in New Zealand: Protective factors

This study focuses on Asian youth identifying as sexual and/or gender minorities aged 13 to 17 years in Aotearoa New Zealand. Data were drawn from the Youth19 Survey, which included 7,374 students from 45 secondary schools across the upper North Island. The research compares Asian Rainbow youth to two groups: Asian non-Rainbow youth and Pākehā (NZ European) Rainbow youth. The purpose of the study is to explore the impacts of double minority status (ethnic and sexual/gender minority) and protective factors associated with the emotional wellbeing and mental health of Asian Rainbow youth.

Findings

- **Emotional wellbeing** (WHO-5 good wellbeing in past 2 weeks) was **lower amongst Asian Rainbow youth** compared to Asian non-Rainbow youth (Adjusted odds ratio=0.30, 95% CI: 0.22–0.42)
- **Depressive symptoms** (past 12 months) was **higher amongst Asian Rainbow youth** compared to Asian non-Rainbow youth (Adjusted odds ratio=3.73, 95% CI: 2.79–4.97)
- **Anxiety** (past 2 weeks) was **higher amongst Asian Rainbow youth** compared to Asian non-Rainbow youth (Adjusted odds ratio=2.09 (95% CI: 1.59–2.71)
- **Thoughts of attempting suicide** (past 12 months) was **higher amongst Asian Rainbow youth** compared to Asian non-Rainbow youth (Adjusted odds ratio=3.91, 95% CI: 2.87–5.32)
- **Attempted suicide** (past 12 months) was **higher amongst Asian Rainbow youth** compared to Asian non-Rainbow youth (Adjusted odds ratio=2.29, 95% CI: 1.22–4.29)
- **Asian Rainbow youth** were **less likely to report anxiety** than Pākehā Rainbow youth (Adjusted odds ratio=0.65, 95% CI: 0.45–0.94)

Protective Factors

- **Family Acceptance** was associated with:
  - Higher odds of good emotional wellbeing: aOR = 2.01 (95% CI: 1.16–3.47)
  - Lower odds of depressive symptoms: aOR = 0.35 (95% CI: 0.20–0.62)
  - Lower odds of anxiety: aOR = 0.60 (95% CI: 0.42–0.86)
  - Lower odds of suicidal thoughts: aOR = 0.41 (95% CI: 0.19–0.90)
  - Family acceptance is linked to better emotional wellbeing and mental health outcomes
- **Feeling Safe at Home** was associated with:
  - Higher odds of good emotional wellbeing: aOR = 2.86 (95% CI: 1.08–7.58)
  - Lower odds of depressive symptoms: aOR = 0.17 (95% CI: 0.08–0.39)
  - Lower odds of anxiety: aOR = 0.25 (95% CI: 0.08–0.79)
- **Feeling Safe at School** was associated with:
  - Higher odds of good emotional wellbeing: aOR = 3.25 (95% CI: 1.19–8.89)
  - Lower odds of depressive symptoms: aOR = 0.30 (95% CI: 0.13–0.68)
  - Lower odds of anxiety: aOR = 0.29 (95% CI: 0.09–0.95)
  - Lower odds of suicidal thoughts: aOR = 0.33 (95% CI: 0.13–0.82)
- **Teachers/Tutors Care** was associated with:
  - Higher odds of good emotional wellbeing: aOR = 5.12 (95% CI: 1.17–22.41)
  - Lower odds of depressive symptoms: aOR = 0.12 (95% CI: 0.03–0.49)
  - Feeling safe at school and having caring teachers are protective factors

See implications on next page

Asian rainbow youth in New Zealand: Protective factors (continued)

Recommendations

Support Family Acceptance:

- Interventions should support not only Asian Rainbow youth but parents as well, recognising the importance of broader family structure and in collectivist Asian cultures.
- Sexual and gender diversity is often not openly discussed in many Asian communities, and coming out may be seen as taboo. More research is needed on pathways to family acceptance and support in Asian communities.

Enhance School Safety and Support:

- Schools should foster positive relationships between Rainbow students, peers, and teachers.
- Establishing and supporting Gay-Straight Alliances (GSAs) can help Rainbow students feel more connected, validated, and hopeful.

Address Gaps in Peer Support:

- While friendships are important, the study found that having a friend who cares was unexpectedly linked to higher depressive symptoms among Asian Rainbow youth. Programmes that can upskill all peers to help all young people, especially Asian Rainbow youth, may be particularly important to provide earlier mental health interventions for this group

Tailor Approaches to Cultural Diversity:

- While the study adopted a pan-Asian approach, it acknowledges significant cultural diversity within Asian communities. Future research and interventions should explore differences between groups such as South Asian, East Asian, and Middle Eastern communities, as shared cultural values exist but experiences may differ.

Address Specific Needs of Gender Minority Youth:

- The study combined sexual and gender minority youth for statistical reasons but noted that transgender Asian youth may face distinct and potentially greater challenges.
- Further research, especially with larger samples and qualitative methods, is needed to understand and address the unique needs of transgender Asian young people.

Further Research:

- Future qualitative studies are needed to examine protective factors in greater detail to inform interventions across education, community, and health sectors.

Citation: *Koh H, Farrant B, Fenaughty J, Ameratunga S, Peiris-John R, Bavin L. Asian Rainbow Youth in New Zealand: Protective Factors. Journal of Adolescent Health. 2024;75(3):426–34.*

Mental health status of double minority adolescents: Findings from national cross-sectional health surveys

The study focused on secondary school students in Aotearoa New Zealand, primarily aged 13 to 18 years, using combined data from the Youth07 and Youth12 national cross-sectional surveys. The overall sample comprised 17,607 students, including 1,306 who identified as sexual and/or gender minority (SGM) youth. The purpose of the research was to examine mental health and wellbeing among adolescents who belong to both sexual/gender minority groups and ethnic minority groups, referred to as "double minority".

Findings

General Wellbeing (compared to cis-heterosexual young people from the same ethnic group):

- Chinese and East Asian SGM male youth had similar odds (0.61, 95% CI: 0.31–1.19)
- Chinese and East Asian SGM female youth had similar odds (1.12, 95% CI: 0.57–2.18)
- Indian and other Asian SGM male youth had similar odds (0.51, 95% CI: 0.22–1.18)
- **Indian and other Asian SGM female youth had lower odds** (0.38 (95% CI: 0.21–0.67)

Depressive Symptoms (compared to cis-heterosexual young people from the same ethnic group):

- **Chinese and East Asian SGM male youth had higher odds** (2.09, 95% CI: 1.10–3.97)
- **Chinese and East Asian SGM female youth had higher odds** (1.61, 95% CI: 0.99–2.62)
- **Indian and other Asian males SGM male youth had higher odds** (3.18, 95% CI: 1.36–7.44**)**
- Indian and other Asian males SGM female youth had similar odds (2.74, 95% CI: 0.89–8.50)

Suicide Attempts (compared to cis-heterosexual young people from the same ethnic group):

- Chinese and East Asian SGM male youth had similar odds (3.47, 95% CI: 0.93–12.92)
- Chinese and East Asian SGM female youth had similar odds (1.66, 95% CI: 0.50–5.49)
- **Indian and other Asian SGM male youth had higher odds** (7.46, 95% CI: 1.81–30.77)
- Indian and other Asian SGM female youth had similar odds (1.75, 95% CI: 0.60–5.16)

Implications

- Being ethnic or SGM is associated with increased risk of compromised mental health.
- Double minority students have increased risk over SGM students of their own ethnicity.
- Further research is needed to investigate the operation of the intersected identities (i.e. ethnicity, sexuality, gender diversity, and social class) in young people.
- In particular, in-depth qualitative research could be very useful to understand how potentially complex identities can be construed by young people, so that we can better support and further bolster them.

Citation: *Chiang SY, Fleming T, Lucassen M, Fenaughty J, Clark T, Denny S. Mental Health Status of Double Minority Adolescents: Findings from National Cross-Sectional Health Surveys. Journal of Immigrant and Minority Health. 2017;19(3):499–510.*

Migrant Chinese sexual and gender minority young people's views on mental health challenges and supports

This study focused on migrant Chinese sexual and gender minority young people living in Auckland aged 19–29 years. Semi-structured interviews were conducted with 11 participants to explore the mental health challenges and supports they experienced. Three reported social isolation, sadness and emotional discomfort, two had serious depression and anxiety disorders that needed treatment, one reported attempted suicide due to unbearable emotional distress.

Findings

- Participants faced intersecting challenges related to racism, sexism, cis-heteronormativity, and cultural expectations, and not fitting into Kiwi and Chinese cultures
- Protective factors included strong cultural and familial ties, good work ethic, peer support, role models, personal coping strategies and professional help.
- **Barriers to accessing mental health services:** stigma, fear of losing face leading to denial of distress and a lack of culturally and linguistically competent services.

Recommendations

- Retaining connection with ethnic culture may strengthen identity/foster a strong sense of self
- Mental health services should improve cultural and linguistic competence to support Chinese sexual/gender minority youth.
- Mental health organisations, educators and other service providers who work with ethnically diverse youth may have an important opportunity to invest in diversity programmes that can support young people to explore and utilise their own cultural resources for resilience.
- For Chinese sexual/gender minority youth, mental health managers and policy makers could consider ways to train more culturally diverse and sexual/gender minority professionals in the field.
- Mental health professionals and those working in the education sector may need to engage in community outreach, psycho-education or television/social media programmes to help demystify the mental health stigma in migrant communities.
- Free online self-help tools may be helpful and mitigate the potential barriers of shame and fears about confidentiality.
- Future research can work towards developing programmes and interventions that will strengthen the connections of both cultural and sexual/gender minority identities.
- Further investigations are needed to reduce the barriers for sexual/gender minority youth to access mental health services.

Citation: *Chiang SY, Fenaughty J, Lucassen MFG, Fleming T. Navigating double marginalisation: migrant Chinese sexual and gender minority young people's views on mental health challenges and supports. Culture, Health & Sexuality. 2019;21(7):807–21.*

Challenges and opportunities to support Chinese sexual/gender minority young people in New Zealand

This study focused on migrant Chinese sexual and gender minority young people living in Auckland aged 19–29 years. Semi-structured interviews were conducted with 8 therapists to gather their views on working effectively with these youth.

Key findings from therapist interviews

Four categories of mental health challenge emerged:

- needs around love and acceptance
- needs related to migration and Chinese culture
- needs related to managing cis-/heteronormativity and coming out
- intersectional needs relating to 'double rejection'

The findings from this study suggest a "double-minority-specific" therapeutic process is required to support young people through three phases: from exploration of a SG minority orientation, via cautious and well-managed coming out practice, to supporting a sense of accepted, but often discreet and segmented identities.

Recommendations

Mental Health Services:

- More training and education in diversity should be implemented to improve providers' sensitivity for identifying and appreciating the potential impact of social oppression and mistreatment.
- Training programmes to improve clinicians' capacity for engaging with families
- Holistic and relationship-orientated therapies, such as family therapy, ecological therapy, systemic therapy or attachment therapy, may be particularly useful in prioritising the interpersonal context or relational nature of psychological distress as the focus of treatment.
- More diversity in staff and services: Hiring (and training) more culturally and SG diverse providers is recommended, as they can be role models for Chinese SG minority youth
- Reduce cultural barriers and mental health stigma in implementing Positive Youth Development oriented mental health services, including peer-support interventions, mentorship programmes, psychoeducation groups, tutoring, or community outreach programmes in ethnic and/or SG minority communities.
- Most of the young people said they do not like to engage in conventional (i.e., face-to face) therapy. Alternative forms of therapeutic services may need to be considered, such as computerised therapy, gaming therapy, telephone counselling, and/or internet counselling.
- Consider holistic and relationship-orientated therapeutic approach that prioritises bi-cultural competency and strategies in identity management.

Future Research:

- **Causality:** longitudinal research is recommended to determine the causal link between social oppression and youth mental health, and explore the severity of social oppression for New Zealand youth nationwide.
- **Generality:** explore the unique needs of non-Chinese double minority youth in New Zealand such as cultural differences and psychological experiences (e.g. filial piety in Confucianism is specific to Chinese cultures vs. emphasis on family and collectivity shared by many minority groups).
- **Resiliency:** further explore how resilience factors support youth mental health, and how to incorporate them into current practice in mental health services. (.e.g cultural and family connections)
- **Validation:** key therapeutic approaches and practices for Chinese SG minority youth emerged from this research. Further research to validate these key elements, which include cultural connections, relationship-building, and bi-cultural perspectives are needed. In particular, the "holistic and relational therapeutic approach that focuses on identity management" requires validation.

Citation: *Chiang SY. Double minority youth mental health. (Doctoral thesis, University of Auckland). 2019.*

Negotiating ethnic identity for 1.5- and second-generation Southeast Asian (SEA) migrant adolescents

This thesis, based on a mixed-methods study, combined secondary analysis of Youth19 survey data (185 SEA migrants, 326 European migrants, 1655 European non-migrants) with semi-structured interviews involving SEA adolescents (n=8) and stakeholders (n=10) working with Asian or youth. The study culminated in the development of a grounded theory – *Inviting SEA adolescents to be fully known*– this theory describes the ongoing and everyday experiences of 1.5 and 2nd generation SEA adolescents negotiating ethnic identity.

Findings - Quantitative Component (Youth19 data)

- SEA migrant youth were more likely to experience significant depressive symptoms, feeling sad or depressed, feeling anxious, uncontrollable worrying, suicidal ideation, and more likely to report forgone healthcare (inability to access healthcare when needed) compared to their European migrant and non-migrant peers

Findings - Qualitative Component

- **'You're welcome, but also different'** – despite feeling connected to both cultures, SEA adolescents reported feeling unable to fully belong in the spaces they were in, like their homes, schools, SEA community environments, and other public spaces.
  - **Feeling othered** - an isolating experience, negative assumptions from people within and/or outside of SEA community, unsure of NZ etiquette, physical differences
  - **Carrying the burden of different cultures** – academic/ career expectations, the need to honour parents' sacrifices, growing in independence, navigating the laid-back NZ culture
  - Feeling they needed to **choose one culture** rather than being a part of both cultures at once.
- **'Being fully known'** – describes SEA adolescents' experiences of belonging as an SEA adolescent living in NZ and giving them the freedom to decide what this belonging looked like for them.
  - **Making peace with differences**
  - **Being okay with the in-between**
  - **Cultures integrated together**

Implications

The theory of 'inviting SEA adolescents to be fully known' describes the need for SEA adolescents to receive ongoing support from various individuals, services, and organisations as they negotiate their ethnic identity:

- **Validating complex experiences** - importance of listening and validating lived experiences.
- **Cultivating connections with others** - Importance of SEA adolescents having positive connections with peers, parents, and other adults.
- **Providing safe spaces** - SEA adolescents' need for interpersonal and physical spaces where they can feel a sense of belonging and be themselves.

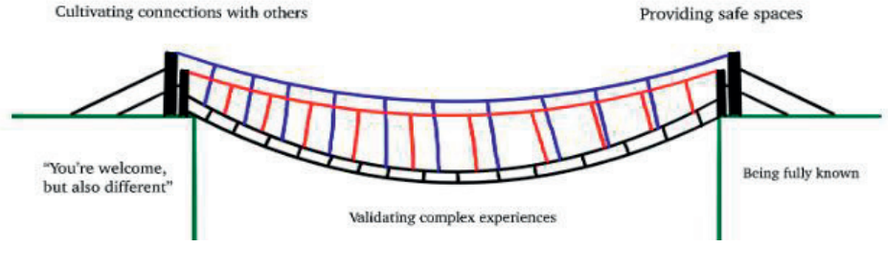


Figure 10.1: Diagram of the theory of inviting 1.5-and second-generation SEA adolescents to be fully known

See recommendations on next page

Negotiating ethnic identity for 1.5- and second-generation Southeast Asian (SEA) migrant adolescents (continued)

Recommendations

Schools and the wider education system

- Promote belonging through cultural integration
- Create safe spaces within schools
- Implement culturally safe training for staff
- Ensure representation of Asian and ethnic minority perspectives

Health Services

- **Cultural Safety Training** for all health service providers, including School-Based Health Services. Existing programmes (eCALD, Culture Matters) are useful starting points but must be adapted or co-designed with SEA adolescents to reflect their lived experiences and specific needs.
- **Co-Design of Services**
  - Develop mental health services in partnership with SEA adolescents to ensure they are relevant, safe, and responsive to cultural and generational complexities.
  - Co-design should prioritise validating complex identity experiences and creating safe, welcoming environments for care.
- **Digital Health Interventions**
  - Explore digital tools to improve access to mental health support
  - Co-design with SEA adolescents to ensure cultural relevance and engagement.
- **Addressing High Levels of Unmet Need in Policy**
  - Explicitly include Asian and ethnic minority adolescents in health strategies to ensure their health and wellbeing are protected and promoted.

Community organisations and services

- **Use Research Insights to Inform Practice**
  - Apply the constructed theory from this study to better understand SEA adolescents' experiences of identity negotiation and associated challenges.
  - Use understanding to design services that address cultural belonging and mental health needs.
- **Co-Design Programmes with SEA Adolescents**
  - Involve SEA adolescents directly in the design, development, and implementation of programmes to ensure relevance and responsiveness.
  - Incorporate SEA adolescents' voices and their lived experiences into community initiatives.
- **Provide Representation and Role Models** using creative means to normalise experiences and reduce feelings of isolation (e.g. theatre productions, short films and podcasts)
- **Facilitate Familiarity and Safe Connection**
  - Create safe spaces and events where SEA adolescents can meet peers with shared experiences, fostering belonging and mutual understanding.
- **Expand Opportunities for Peer and Community Dialogue**
  - Support youth-led cultural and mental health dialogues (e.g., **Asian Diaspora Dialogues**, **Reimagining Mental Health**) and adapt them to focus on SEA adolescent needs.
  - Prioritise opportunities that allow SEA youth to learn from older SEA adults and build intergenerational community support.

Future Research

- Broaden research to other ethnic minority groups
- Use participatory and co-design methods
- Explore environmental influences on identity negotiation
- Consider bicultural and multicultural contexts
- Examine developmental changes over time
- Evaluate effectiveness of interventions and safe spaces

Citation: *Dizon LA. An invitation to be fully known: A mixed methods grounded theory on supporting 1.5-and second- generation Southeast Asian adolescents as they negotiate their ethnic identity. (Doctoral thesis, University of Auckland). 2023.*

1.5/2nd generation Chinese New Zealander's perspectives and attitudes towards mental health

This thesis investigates the perspectives and attitudes 1.5 and 2nd generation Chinese New Zealanders have towards mental health. Study One used the data from the New Zealand Attitudes and Values Study, and Study Two involved a semi-structured interview where participants' (n=10) thoughts and experiences were discussed to gain insight into their perspectives and attitudes.

Findings – Study 1

- Higher age was associated with lower psychological distress.
- perceived discrimination was positively associated with greater psychological distress
- The association between ethnic identity and psychological distress is moderated by country of birth.
- For New Zealand born participants, higher ethnic identity centrality was associated with lower psychological distress (slope = -.99, se = .24, t = -4.17, p< .001).

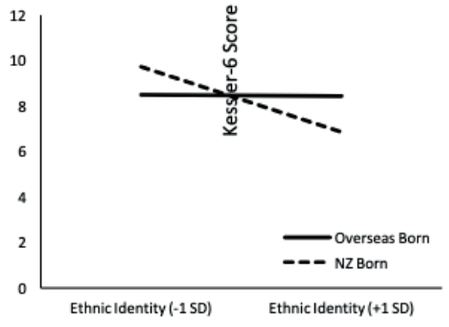


Figure 1. The moderating effect of country of birth (NZ vs Overseas) on the association between ethnic identity and self-reports of anxious and depressive symptoms as indicated by Kessler-6 scores

Findings – Study 2 (Interviews)

1. Perspectives on Mental Health

- Mental health is rarely discussed in Chinese culture, viewed as valid only in severe cases and associated with shame and embarrassment.
- Resilience ("staying strong") is emphasised, leading to suppression rather than seeking help.
- In NZ, mental health is more openly acknowledged (although this shift is relatively recent).
- Participants personally viewed mental health as vital to overall wellbeing and were open-minded towards those experiencing difficulties.
- They recognised stigma persists, stronger in Chinese communities (where mental illness is equated with being "crazy") but also historically present in NZ.
- Male participants noted an added stigma around masculinity and emotional expression.

2. Influences on Mental Health Perspectives

- **Parental Influence -** Parents' limited mental health knowledge and silence on emotional topics initially shaped participants' early views; education and peers later shifted these attitudes.
- **Education** - NZ schooling, especially university, was pivotal in fostering awareness and positive attitudes toward mental health.
- **Friends and Peer Groups** - Peer discussions helped normalise mental health topics and reinforced openness.
- **Religion** - For some, church involvement encouraged open discussion of emotions and positive coping.

3. Unique Mental Health Challenges of 1.5 and 2nd Generation Youth

- **Ethnic Identity:** Mixed "Kiwi-Chinese" identities caused stress and confusion, especially during adolescence. Acceptance of dual identity reduced stress over time.
- **Belongingness:** Difficulty feeling at home in either NZ or their country of origin; sense of limbo impacted wellbeing. Belonging to social groups (not just ethnic) could buffer stress.
- **Discrimination:** Most experienced racism, ranging from overt comments to subtle microaggressions, which negatively affected mood and self-esteem.
- **Family and Culture:** High parental expectations, pressure to succeed, and lack of family understanding of mental health contributed to stress.
- **Gender Roles:** Males felt pressure to appear strong and avoid emotional expression, further suppressing help-seeking.

See findings (continued) and recommendations on next page

1.5/2nd generation Chinese New Zealander's perspectives and attitudes towards mental health (continued)

Findings (continued)

4. Coping Mechanisms

- **Self-Reliance First:** Most initially manage stress themselves (e.g., exercise, planning, taking time out).
- **Peer Support Next:** Turning to friends is common when personal strategies fail.
- **Family and Professional Help Last:** Few discuss mental health with family (fear of misunderstanding or burdening parents). Professional help is considered only in extreme situations, despite willingness to recommend it to friends.

5. Views on Mental Health in NZ

- **Positive Shifts:** Participants acknowledged growing awareness and funding for mental health in NZ compared to China.
- **Remaining Gaps:** Services could better address the needs of ethnic minorities, including cultural barriers and stigma.

6. Barriers to Accessing Support

- **Cultural Barriers:** Concern that clinicians may not understand cultural or family dynamics; preference for professionals with similar cultural/ generational backgrounds (e.g. 1.5/2nd gen Chinese NZers).
- **Language Barriers:** Issues arise when family members with limited English are involved in therapy.
- **Practical Barriers:** Cost, time, difficulty finding culturally suitable professionals deter help-seeking.

Recommendations

Strategies to Overcome Barriers

- Increase Asian representation in mental health services and media to normalise help-seeking.
- Acknowledge cultural differences in therapy and provide culturally safe care.
- Educate Chinese and broader Asian communities about mental health to reduce stigma.
- Use ethnic community platforms (e.g., WeChat) to promote awareness and share resources.

Future Research Recommendations

- **Explore ethnic identity and psychological distress -** Investigate why ethnic identity influences psychological distress differently across studies and identify the underlying mechanisms.
- **Examine generational differences -** Compare perspectives of older 1.5 and second-generation Chinese New Zealanders to younger participants
- **Understand barriers to service use -** Conduct in-depth research on reasons for underutilisation of mental health services to inform strategies that improve access and engagement.
- **Use larger and more diverse samples -** Replicate findings with bigger sample sizes to confirm validity and improve generalisability.

Citation: *Qiu L. Self-Identified 1.5/2nd Generation Chinese New Zealander's perspectives and attitudes towards mental health. (Masters thesis, University of Auckland). 2020.*

Refugee youth resettlement report: Lived experiences of refugee youth in their first 12 months in New Zealand

This report by Red Cross Refugee Services describes the resettlement experiences of refugee youth (aged 12-24 years) in their first 12 months after arrival in New Zealand from the perspective of refugee youth (n=22), parents (n=9), Red Cross Refugee Services staff (n=23) and stakeholders in 18 government and non-government organisations (n=22). Information was gathered through focus groups or interviews with 76 participants. Refugee Youth participants were from Burmese, Somali, Afar, Congolese, Sudanese, and Colombian backgrounds. Red Cross Staff (n=23) across Auckland, Hamilton, Wellington, Palmerston North, Nelson in roles such as cross-cultural workers, social workers, programme coordinators, etc.

The primary aim was to inform improvements in Red Cross resettlement programme. The findings are shared with stakeholders through this report to build awareness and knowledge within the settlement sector that may be useful for stakeholders and community in adapting current processes and programmes to better support refugee youth and families.

Findings

- Youth experienced 'depression' or 'worries' about resettlement problems and past experience/ trauma before arriving in New Zealand.
- Boredom and lack of friends was often identified by some youth as something that led to feelings of 'depression'. Staff and community members noted that young people living on their own required a lot more support to avoid feeling lonely.
- Barriers to using counselling services:
    - Youth unaware of concept of counselling
    - Cost of counselling services
    - Transport
    - Lack of culturally appropriate services
    - Language barrier
    - Confidentiality concerns
- Concern for friends and family left behind: Many older youth felt responsible for people or extended family overseas who needed help. This contributed significantly to their worries.
- Concerns for others and difficulties navigating emotions often led youth to **avoid disclosing distress** to family or professionals.

- **Most refugee youth had experienced bullying in their first 12 months living in New Zealand.**
    - Bullying was most commonly experienced in schools, followed by public and social settings.
    - Youth identified the reason for the bullying as their ethnicity or religion or just being 'a refugee'.
    - Bullying made refugee youth feel stressed and unsafe.
    - Having a home contributed to youth feeling safe living in NZ

- Youth and their parents were often unaware of options available for addressing problems that arose during settlement or as a result of the refugee journey.

- Youth felt 'stigma' of being identified as a refugee: Most participants did not like the term 'refugee' being applied to them, stating they were no longer refugees. They felt the term carried negative stereotypes.

See findings (continued) and recommendations on next page

Refugee youth resettlement report: Lived experiences of refugee youth in their first 12 months (continued)

Findings (continued)

- Cultural identity tensions: Youth felt "caught" between traditional culture and NZ culture; parents feared cultural loss.
- Social isolation: Difficulties making friends outside their ethnic community reinforced feelings of loneliness.
- Organisations/service providers expressed difficulty connecting with refugee youth due to:
    - Language barriers
    - Organisations not being aware of how to provide services for youth from different cultural backgrounds.
    - Youth unaware of activities offered by settlement organisations.
- Sport was identified as an important factor in successful social participation providing both social and physical benefits (good English language skills were not always needed).

Recommendations

- Peer-support, role models and mentoring:
    - Create buddy programmes or orientation information for refugee youth and parents about what support is available.
    - Leverage success stories from settled youth and families to inspire and motivate newcomers.
- Ongoing community education is necessary to overcome barriers to youth and families using services
- Implementing specific youth assessment tools would likely help client services staff and youth.
- Advocate for organisations to have specific refugee or youth-focused roles to provide more opportunities for refugee youth.
- Training of organisations to be more inclusive of refugee youth and to help organisations find ways to eliminate barriers (such as language, or cultural understanding) to youth using their services.
- Cross-sector and/or stakeholder collaboration to help youth connect to services available.
- The two sports-based youth leadership programmes run as part of the review proved to be a great success in building participants' confidence, skill levels and social connections.
- Service providers to ensure they have access to cultural information and training on understanding the refugee journey and resettlement experiences.
- Provision of language support to ensure barriers to participation is reduced.
- Schools play a central role in education, integration and social participation.
- Orientation for youth should be increased across all priority areas of employment, education, health and wellbeing and social participation.

Citation: *O'Connor R. The refugee youth resettlement report: "Then came reality": lived experiences of refugee youth in their first 12 months in New Zealand. New Zealand Red Cross Refugee Services; 2014.*

Refugee youth:
Adaptation and mental health service provision

This study examined on youth from refugee backgrounds explored stressors during pre-migration, transit and post-migration; their coping strategies; and their experiences of mental health services. Focus group discussions were completed with 20 mental health service users and 17 non-service users. An additional 16 individual interviews were completed with service users to gain insight into mental health needs of refugee adolescents, their coping, and, critically, their experience of mental health services in NZ. Participants included refugee youth and mental health service providers.

Findings - Refugee youth perspectives

Pre-migration trauma

- Many youth had experienced war, violence, hardship, and corruption before arriving in NZ.

Post-migration stressors

- Language barriers that hinder integration and education.
- Poverty, financial hardship, overcrowded housing, and lack of privacy.
- Limited opportunities for meaningful activities (e.g. rural families placed in urban settings).
- Discrimination and bullying, both inter-group and intra-group, leading to psychological distress.
- Missing family members or relationships left behind, causing grief and emotional pain.

Acculturation & Family Conflict

- Youth often acculturate to NZ society **faster than their parents,** creating:
  - Role conflicts, with youth expected to act as interpreters and cultural brokers for parents.
  - Frustration due to different cultural expectations between generations.
  - Tension when youth adopt new behaviours or values perceived as unacceptable by parents.
- Parents may hold **high expectations** for children's academic success and behaviour, sometimes imposing significant pressure.
- Parental mental health issues further strain family dynamics and youth wellbeing.

Social Isolation & Peer Challenges

- Difficulties forming friendships cause: Sadness, frustration, and isolation, increased vulnerability to psychological distress.
- Loss of established social networks from their home countries contributes to loneliness.
- Service providers noted that **reduced social support increases risk** of youth forming connections with peers engaging in antisocial behaviour, drugs, or alcohol.

Coping Strategies

- Youth employ varied coping methods: Religious faith and spiritual practices; physical activities, distraction, cognitive reframing (positive thinking), keeping problems private, due to stigma and fear of being seen as "crazy."
- Many youth avoid discussing emotional problems to conform to cultural values like: Conformity to norms, emotional self-control, collectivism and family reputation.
- Concerns over **confidentiality** and stigma limit youth's willingness to access mental health services.

Mental Health Service Engagement

- Youth value: Trusting, respectful, and non-judgemental professionals; practical support for current issues (e.g. help with paperwork, connecting with peers), rather than delving into past trauma.
- Youth more likely to seek support from: GPs, School guidance counsellors.
- Positive experiences were reported once youth engaged with services, though **fear of stigma and confidentiality remain major barriers.**

See findings (continued) and recommendations on next page

Refugee youth:
Adaptation and mental health service provision (continued)

Findings - service provider perspectives

Complex Needs of Refugee Youth

- Refugee youth often present with ongoing effects of pre-migration trauma, stress from adjusting to life in NZ, family pressures and intergenerational conflict.
- Youth were sometimes burdened with caregiving responsibilities, emotionally and practically.

Barriers to Engagement

- **Language barriers**: Lack of qualified interpreters; misinterpretation of mental health concepts due to different cultural frameworks.
- **Cultural barriers**: Refugee youth and families often have different understandings of mental illness; stigma prevents open discussion about mental health issues.
- **Confidentiality concerns**: Youth feared that information shared with professionals of the same ethnicity might spread in small communities; time constraints in service settings make it harder to build the trust needed for effective engagement.

Strategies for Effective Service Delivery

- Importance of taking time to build trust and rapport, engaging youth in conversations relevant to their interests (e.g. sports, makeup), being flexible and tailoring interventions to each individual.
- **Collaboration essential:**
    - Providers recommended working closely with schools, community organisations, and churches to reach youth.
    - Community-based outreach programmes suggested as effective ways to engage refugee youth where they already feel comfortable.
- Providers highlighted the need to:
    - Help youth manage practical challenges, not just mental health symptoms.
    - Link youth with social services for housing, financial aid, or social support.

Interpreter Use

- Professional interpreters preferred over family or friends.
- Confidentiality concerns if interpreters are from the same community.
- Risk of interpreters experiencing trauma themselves from translating distressing content.
- Recommendation for increased training for interpreters to manage distress; providing supervision and debriefing for interpreters after sessions.

Training Needs

Service providers emphasised the need for further cultural competence training (e.g. CALD training), greater awareness of diverse cultural beliefs about mental health, skills to work sensitively with youth from collectivist cultures.

Conclusion

Refugee youth, including those from Asian and MELAA backgrounds, face complex challenges across all stages of migration but show remarkable resilience. Effective support requires culturally responsive, flexible services that integrate social, practical, and psychological care, delivered by well-trained professionals in trusted, community-based settings. **The authors provide an extensive breakdown of recommendations.**

Citation: *Choummanivong C. Refugee youths: adaptation and mental health service provision (Doctoral thesis, University of Auckland). 2013.*

Flexible resources and experiences of racism among a multiethnic adolescent population in Aotearoa

This study focused on New Zealand's secondary school students aged 13 to 17 years, using data from the Youth2000 survey series. It included diverse ethnic groups such as Pākehā, Māori, Pasifika, Asian, and Middle Eastern, Latin American, and African (MELAA) youth. The purpose of the research was to examine how flexible resources, encompassing both structural factors and embodiment, influence experiences of racism and related health outcomes among ethnic minority youth.

Key findings

- Māori, Pasifika and ethnic minority youth are consistently more adversely affected by socioeconomic and mental health inequities than Pākehā groups.
- Experiences of racism and mental health inequities have increased over the 20 years of Youth2000 surveys.
- We found that racism is a fundamental cause of mental health inequity. However, there are variations in the experience of racism among minorities, mitigated by flexible resources such as:
  - Country of origin: Ethnic minority migrants from high-income countries like east Asia fare socioeconomically better than migrants from south Asia or the Pacific.
  - Embodiment of Whiteness that affects everyday interpersonal interactions; those perceived as White had better social experiences than those perceived as non-White.
  - Disadvantage among racialised migrants persisted intergenerationally; it can take several generations before disadvantages begin to abate, particularly for Pasifika populations.

	Deprivation		Unmet healthcare	Mental health outcomes	
	Household	Neighbourhood		symptoms of depression	attempted suicide
Pākehā	10·5 (8·6-12·8)	12·5 (8·4-18·2)	29·3 (26·9-31·8)	22·4 (19·5-25·6)	3·5 (2·8-4·4)
Non-racialised migrants	11·8 (8·6-16·1)	10·2 (6·3-16·2)	28·2 (24·5-32·1)	23·5 (18·8-29·0)	3·5 (1·4-8·1)
Racialised* migrants	20·5 (16·3-25·6)	35·8 (24·7-48·7)	31·8 (28·5-35·2)	25·3 (21·7-29·2)	7·4 (5·4-10·0)
Racialised* non-migrants	21·5 (17·6-26·1)	39·4 (27·4-52·8)	34·8 (31·2-38·6)	27·6 (24·6-30·8)	7·0 (5·1-9·4)
Māori	26·1 (21·7-31·1)	48·5 (37·5-59·5)	38·3 (34·7-42·0)	31·4 (27·2-35·9)	12·7 (9·5-16·8)

Best observed — Worst observed

*Those identifying as Asian, Middle Eastern, African or Pasifika

Recommendations

- Racism and discrimination negatively impact adolescent mental health.
- Anti-racism interventions should recognise the differences in experiences of racism among targeted minorities and privileged groups based on their multiple social identities.
- For migrant youth, these interventions should be targeted for each migrant generation.
- Educational interventions and diversity training around the effects of perceived Whiteness and racial bias are needed for key care providers, including teachers, health-service providers, and the police.
- Initiatives that enable young people's sense of pride in their own cultural diversity and respect for that of others are also crucial to health and wellbeing outcomes.

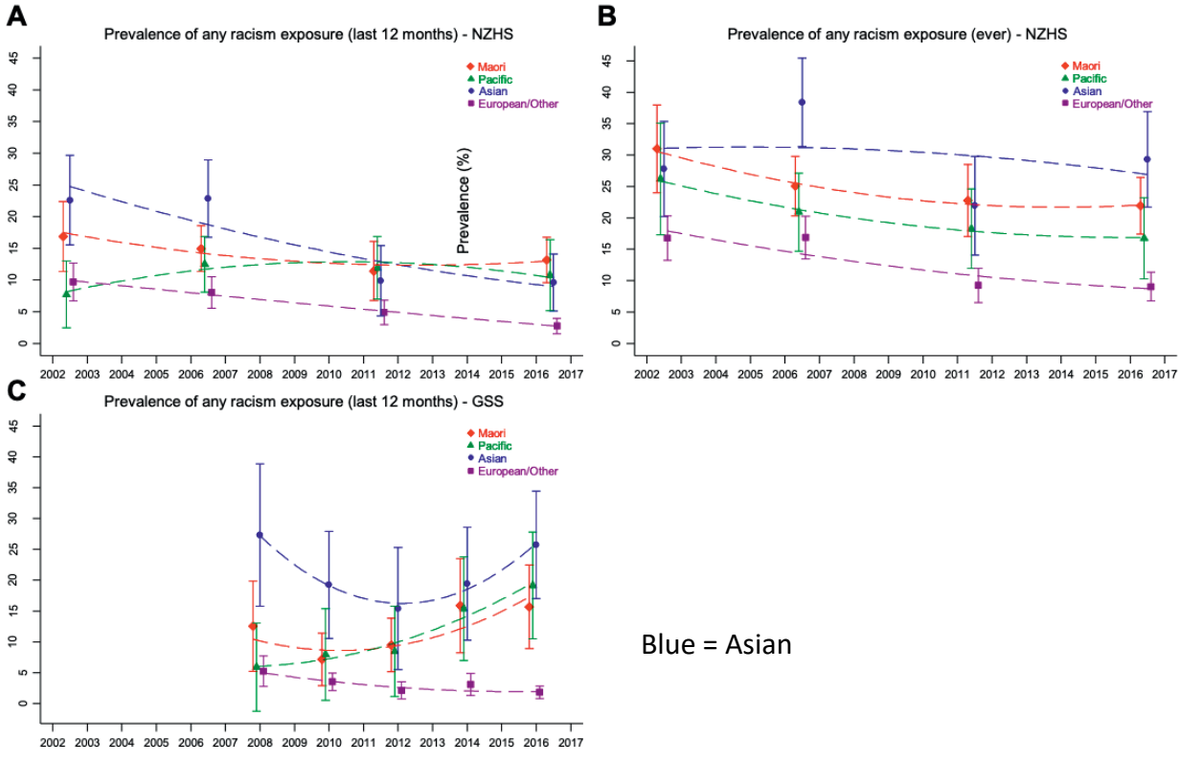
Citation: *Simon-Kumar R, Lewycka S, Clark TC, Fleming T, Peiris-John R. Flexible resources and experiences of racism among a multi-ethnic adolescent population in Aotearoa, New Zealand: an intersectional analysis of health and socioeconomic inequities using survey data. The Lancet. 2022;400(10358):1130-43.*

Racism and health among Aotearoa New Zealand young people aged 15–24 years

This study focused on young people aged 15 to 24 years living in Aotearoa New Zealand, drawing on data from the New Zealand Health Survey (NZHS) and the General Social Survey (GSS) collected between 2002/03 and 2016/17. Its purpose was to examine the prevalence of racism experienced by young people and explore how such experiences relate to mental health, physical health, well-being, identity, and access to healthcare. Ethnicity was categorised into Māori, Pacific, Asian, and European/Other groups.

Findings

Prevalence of racism over time – New Zealand Health Survey, General Social Survey findings



Blue = Asian

- In NZHS 2016/17:
  - 12-month racism prevalence for Asian youth: 10% (cf. 4% in European/Other youth)
  - Ever experienced racism for Asian youth: 27% (cf. 10% in European/Other youth)
- In GSS surveys:
  - 12-month racism prevalence for Asian youth was 27% (cf. 3% in European/Other youth).

- Asian youth living in areas of greater socioeconomic deprivation reported higher experiences of racism.

See findings (continued) and recommendations on next page

Racism and health among Aotearoa New Zealand young people aged 15–24 Years (continued)

Findings (continued)

Health Impacts of Racism

- Racism was associated with negative outcomes in Asian youth including:
  - Lower SF-12 mental health scores.
  - Lower SF-12 physical health scores.
  - Higher psychological distress measured by Kessler Psychological Distress Scale (K10).
  - Lower self-rated general health.
  - Higher odds of being unable to access usual medical care.
  - Lower life satisfaction scores.
  - Greater odds of reporting low sense of belonging in New Zealand.
  - Greater odds of reporting difficulty expressing their identity in New Zealand.

- From meta-analysis pooling across surveys Asian youth had:
  - Over five times higher odds of reporting racism in the past 12 months compared to European/Other youth (Odds Ratio=5.03; 95% CI: 3.17–7.99).
  - Over two times higher odds of reporting ever exposure to racism (Odds Ratio=2.82; 95% CI: 2.08–3.81).

Implications and recommendations

- Non-European young people disproportionately bear the burden of racism in New Zealand with potentially substantial impact on their health and wellbeing.
- Antiracism solutions can contribute to improved health and wellbeing.
- *"Antiracism research and interventions should ensure that rangatahi Māori and other young people are respected and valued by society, that they are able to fully express their identities, and that they and their whānau feel safe in all of the spaces they inhabit."*

Citation: *Harris R, Li C, Stanley J, King PT, Priest N, Curtis E, Ameratunga S, Sorensen D, Tibble F., Tewhaiti-Smith J, Thatcher P, Araroa R, Pihema S, Lee-Kirk S, King SJR, Urlich T, Livingstone N-Z, Brady SK, Matehe C, Paine SJ. Racism and Health Among Aotearoa New Zealand Young People Aged 15–24 years: Analysis of Multiple National Surveys. Journal of Adolescent Health. 2024;75(3):416–25.*

Confronting stereotypes: the dual narratives of ethnic minority youth in Aotearoa New Zealand

This study aimed to explore the complexity of lived realities of ethnic minority youth in Aotearoa New Zealand, offering a deeper understanding of the experiences of racism and discrimination. This knowledge is particularly vital for young people with additional minority identities such as gender minority, disability, etc., having to confront multiple stereotypes including from within the context of their own ethnic communities. Seventeen participants were interviewed.

Findings

- Interviews indicated significant diversity and fluidity in their lived experience.
- Participants felt 'othered' by the wider New Zealand society for their ethnic identity, and thus adapted themselves to be perceived as less different from the majority ethnic group (New Zealand European).
- The pressure to fit in made them see and understand their cultures with a very deficit lens and in a way that discouraged them from adopting their cultural heritage which in turn created a sense of disconnect with their own cultures.
- In contrast, participants felt more marginalized within their ethnic communities and less so by the wider society when navigating their additional minoritised identities.
- Participants experience distress as they navigate their multiple marginialised identities.
- Overall, experiences of marginalization appeared to have a stronger effect on girls, and religious minorities.
- The significant influence of parental migration experiences and the distinct worldviews and value systems that shape parents' understanding of their young person's lived experience, can unintentionally reinforce risks, increase feelings of isolation, and exacerbate poor mental health outcomes among young people.

> *"Someone in a high school production pointed out that I have hooded eyelids which is common in Asian cultures and I remember being so insecure about it, it was something I have never noticed before myself"*
>
> – Japanese-Pākeha women

> *"My mother would always cook me culture-based food for lunch but then they would go "oh it smells"*
>
> – Indian, Hindu

> *"It was just my mum and my brother who had a problem with me being a teen parent. I never felt outcasted otherwise. Even my brother's friends would tell him, "What's wrong with you?" because they also had their sisters that had kids as well (without being married)"*
>
> – Indian, single teen mum with mental health condition

Recommendations

- Cultural and gender-responsive solutions need to be developed in partnership with youth, ethnic communities, and wider society to promote wellbeing and prevent further marginalization.
- Increase awareness of the impacts of discrimination
- Develop training curricula that will enable educators, healthcare providers, and policymakers to better understand and respond to the lived experiences of ethnic minority youth, thereby making programmes and services more effective and relevant, including within mainstream health services and issue-based services (e.g. disability, gender and sexually diverse)
- Improve cultural intelligence within society

Citation: *Sharma V, Ramalho R, Simon-Kumar R, Ameratunga S, Kang K, Liang R, Lee A, Peiris-John R. Confronting stereotypes: the dual narratives of ethnic minority youth in Aotearoa New Zealand. International Journal of Adolescence and Youth. 2025 31;30(1):2456600.*

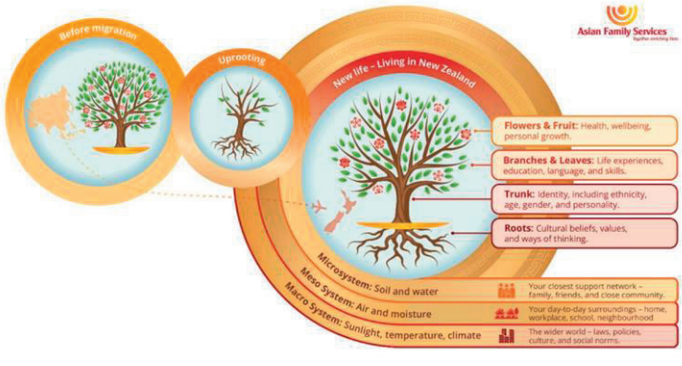
Research on factors influencing Asian migrants' gambling behaviours and comorbid mental health

This research empirically tested risk factors relating Asian migrants' experiences with gambling and mental health, as identified in the Integrated Tree Model, supporting its use as a holistic approach to addressing gambling harm. Through a mixed-methods approach, the study identified key drivers of gambling harm, explores ethnic and acculturative nuances, and provides actionable recommendations for policymakers, clinicians, and communities.

Key Findings

Risk factors around gambling behaviours of the Asian communities are tested and mapped around the Tree Model:

- Roots– Cognitive factors: Erroneous beliefs stemming from cultural background (e.g. fate, luck, ability to predict outcomes).
- Trunk – Demographic and personality influences: Being male, being South Asian, impulsiveness, sensation seeking, and risk taking.
- Branches, leaves– Experiences and acculturative stressors: the findings present how development status in settlement impact risk of gambling harm. The first 2-5 years of migration, lower education and income were structural risk factor. Life course experiences of acculturative stressors and accumulation of adverse life events (e.g. divorce, unemployment, worsened finance) were consistently linked to heightened risk.
- Flowers, fruits – Comorbid mental distress and substance use were linked with gambling risk.
- Soil and water – microsystem: family and close friends – was found across study types.
- Air, moisture and ventilation – mesosystem: accessibility of gambling opportunities and media and marketing messaging – was found across study types to impact risk of gambling harm.
- Sunlight, temperature, climate – macrosystem: Regulatory differences in New Zealand compared with most Asian countries make it easier to gamble and to lose control of gambling behaviour.



Statistical findings further proved that personality and cognition related factors have more explanatory power than demographic factors in predicting gambling harm of Asian migrants. Cultural cognitive distortion and experience in acculturation add to the unique yet important dimensions in explaining gambling risks of the Asian population in NZ.

Recommendations

- Deconstruct cultural myths around luck and fate while respecting cultural values.
- Literacy campaigns on gambling probability knowledge and de-myth superstitions
- Screen for cognitive distortions, impulsiveness and combine CBT with cultural awareness and provide targeted training like mindfulness and vocational support.
- Use family-inclusive and peer-led recovery approaches suited to collectivist cultures.
- Support migrants during high-risk first 2–5 years with multilingual resources, community campaigns, and family financial transparency tools and build a safety net for smoother acculturation.
- Address gambling venue density near Asian migrant hubs (e.g., Auckland).
- Enforce host responsibility policies with cultural and linguistic awareness.

Citation Note: *This information is drawn from the final research report currently awaiting formal sign-off and publication by the Ministry of Health. It represents key preliminary findings intended to support further learning, reflection, and knowledge-sharing*

Asian Family Services
Together enriching lives

New Zealand Asian responsible online gambling report - 2022

This report presents findings from the 2025 New Zealand Asian Wellbeing and Mental Health Survey, revealing critical concerns, notably declining mental wellbeing, significant experiences of discrimination, and high rates of school bullying among Asian communities.

Key Findings

- 84.6% of Asians have engaged in online gambling and gaming activities between 2021 and 2022
  - 73.8% have purchased lottery tickets and 50.8% have played online video games
  - 98.3% of online video gamers have also engaged in other types of online gambling activities
- The top 3 drivers for engaging in online gambling were longing for monetary gain, for excitement and due to curiosity
- 56.5% of Asians were not aware of where to seek help if they or someone else identified with online gambling issues
- Across age groups, younger gamblers perceived slightly more harm from online gambling

Citation: *Zhu A, Asian Family Services, Trace Research (2022). New Zealand Asian Responsible Online Gambling Report 2022. Asian Family Services. https://asianfamilyservices.nz/media/ajjbzdbz/asian-family-services-new-zealand-asian-responsible-online-gambling-report-2022-trace-research-public-version.pdf*

Asian Family Services
Together enriching lives

Identification of gambling, mental health and other addictive issues among Asian peoples enrolled in GP clinics

A survey was conducted in 2021 to identify the extent of gambling problems, other addictions and emotional distress among a sample of Asian peoples enrolled in GP clinics in Auckland. The rates of problem gamblers, moderate-risk gamblers and low-risk gamblers as measured by The Problem Gambling Severity Index (PGSI) obtained from the survey were compared with other national studies to ascertain whether GP clinics can provide a setting for early identification of gambling risk and co-existing issues among Asian peoples.

Key Findings

Through screening 305 Asian peoples aged 15 years and above enrolled in GP clinics for gambling, other addictions, and mental health problems, the study found that:

- One in five Asian respondents were identified as having problems with gambling across a spectrum of severity (8.3% low-risk, 6% moderate-risk and 5.6% problem gambling as measured by PGSI).
- The rate of Asian peoples with, or at risk of, problematic gambling (19.9%) was 10% to 15% higher than the results from the National Gambling Study (NGS) and the Health and Lifestyle Survey (HLS). In NGS2012, NGS2014 and HLS2016, the rates of problem gambling among Asians ranged from 0% to 0.7%, moderate-risk gambling from 1.4% to 2.8%, and low-risk gambling from 3.2% to 5.8%.

Levels of gambling risk among Asians in GP clinics: Comparisons with the Health & Lifestyle Survey (HLS) and the NZ National Gambling Study (NGS)

	Non-gamblers %	Low-risk gamblers %	Moderate-risk gamblers %	Problem gamblers %	Sample size (Asian)
Our survey 2021	80.1	8.3	6.0	5.6	301
HLS 2016	94.0	3.2	2.8	0.0	325
NGS 2012	91.4	5.8	2.2	0.7	798
NGS 2014	93.4	5.2	1.4	0.1	322

- There were co-existing issues among moderate-risk and problem gamblers in our survey.
  - 52.9% of moderate-risk gamblers reported high or very high levels of emotional distress.
  - 35.3% of problem gamblers and 27.8% of moderate-risk gamblers reported that they had six or more drinks on one occasion in the past 12 months.
  - 23.5% of problem gamblers were smokers.
  - 2.6% of survey respondents reported that their family members gambled a moderate amount.
- **These results support the notion that GP clinics can provide an important setting for early identification of gambling risk and co-existing issues among Asian peoples.**

Recommendations

- Harmful gambling, other addictions and mental health issues are often under-reported by Asian peoples due to fear of stigma and embarrassment. The familiar and trustful setting of GP clinics can help to reduce Asian peoples' fear of stigma and provide an important setting for early identification of gambling risk, hazardous drinking, smoking, drug use and other mental health concerns among Asian peoples.
- General practices also have the potential to facilitate early help-seeking for at-risk people who may not have otherwise sought help. Delivering culturally and linguistically responsive early interventions through general practices can improve Asian peoples' access to services by offering them greater choices to address their holistic concerns.

Citation: *Ho E, Feng K, Prasad S (2022). Reaching Out: Early Identification and Intervention of Gambling Problems among Asian People in Primary Care. Auckland: Asian Family Services.*

Asian Family Services
Together enriching lives

Evaluation of a support group programme for Chinese and South Asian migrants and international students with experience of gambling harm

A support group programme was developed and tested with two groups - one Chinese and one South Asian. The programme focussed on helping participants with a history of harmful gambling to increase awareness of the addictiveness of gambling activities, increase knowledge about the triggers for gambling relapses, improve stress management and self-care behaviour, and increase help-seeking intentions. Evaluation of the support group programme was conducted.

Key Findings

Evaluation was undertaken by analysing pre-post changes in participants' levels of gambling severity, help-seeking intentions, attitudes towards harmful gambling, knowledge of the triggers for gambling relapses, stress management and self-care behaviour. The evaluation results found:

- a reduction in participants' levels of gambling severity – participants' gambling risk levels, measured by The Problem Gambling Severity Index (PGSI), had decreased from a median score of 8.4 before the group to 4.8 after group intervention.
- the intended outcomes of increasing participants' help-seeking intentions, increasing awareness of the addictiveness of gambling activities, increasing knowledge about the triggers for gambling relapses and improving stress management and self-care behaviours had all been achieved.

Recommendations

- Migrant and international students of Asian backgrounds are at high risk of gambling relapses. The evaluation findings show that a strengths-based, recovery-oriented support group programme can help to minimize the risk of relapses through peer support, and by recognizing the relapse triggers and improving self-care and stress management skills.
- Peer support empowers people to work through their difficult experiences to solve their own problems. Participants learn that they are not alone on their recovery journey. Sharing their feelings with others having similar experiences helps to decrease their shame of talking about gambling, reduce their feelings of isolation, and inspire them to make progress in their lives.

Citation: *Ho E, Feng K, Prasad S, Kew CF, Law R (2022). Helping Self, Helping Others: A support group project for Chinese and South Asian people with experience of harmful gambling. Auckland: Asian Family Services.*

Asian Family Services
Together enriching lives

Voices of lived experience: Asian people's journeys from gambling to recovery

This study explored the lived experience of recovery of 28 Asian people who once had a gambling problem. Two in-depth interviews were conducted with each participant to gain a deep understanding of their journeys from gambling to recovery.

Key Findings

How they got into gambling: Coming from Asian countries where gambling is generally prohibited or strictly regulated, most participants started gambling in NZ. Novelty seeking, casino promotions & winning experiences were the reasons given for starting to gamble.

From recreational to problem gambling: The transition was a complex process – some used gambling to escape from stress or boredom, some turned to gambling as a solution to financial problems, leading to a cycle of chasing losses.

Harmful impacts of problem gambling: Multifaceted impacts from mounting debts, chronic stress, increased anxiety & depression to job losses, fractured friendships, strained family relationships and in severe cases, relationship breakdowns.

Diverse paths to recovery: Recovery journeys were highly personal and could take many forms – e.g. different levels of abstinence or controlled gambling; different recovery strategies from self-help to treatment-assisted recovery and/or peer supported recovery; linear or non-linear with cycles of progress and relapses.

Key factors of gambling recovery

- Acknowledge problem gambling – breaking the cycle of denial
- A sense of agency – taking ownership of the recovery journey
- Effective goal setting – staying focus on the recovery process
- Implement financial control measures – rebuilding finances & addressing gambling-related debts
- Engage in relapse prevention strategies – managing gambling urges
- Address co-existing problems – e.g. substance abuse, anxiety & depression
- Build a support system – e.g. trusted friends, family members, peer support groups, faith-based supportive communities
- Access counselling & support services – addressing underlying issues that may be contributing to gambling

Recommendations

The recovery of individuals & families impacted by gambling harm is not only possible but attainable.

- Promote early help-seeking
- Enhance access to early intervention services and self-help resources
- Improve accessibility and cultural responsiveness of gambling harm treatment services & support
- Build support for long-term maintenance of recovery
- Advocate for more effective gambling regulations and host responsibilities

Citation: *Ho E, Feng K (2025). Voices of lived experience: Asian people's journeys from gambling to recovery. Auckland: Asian Family Services.*

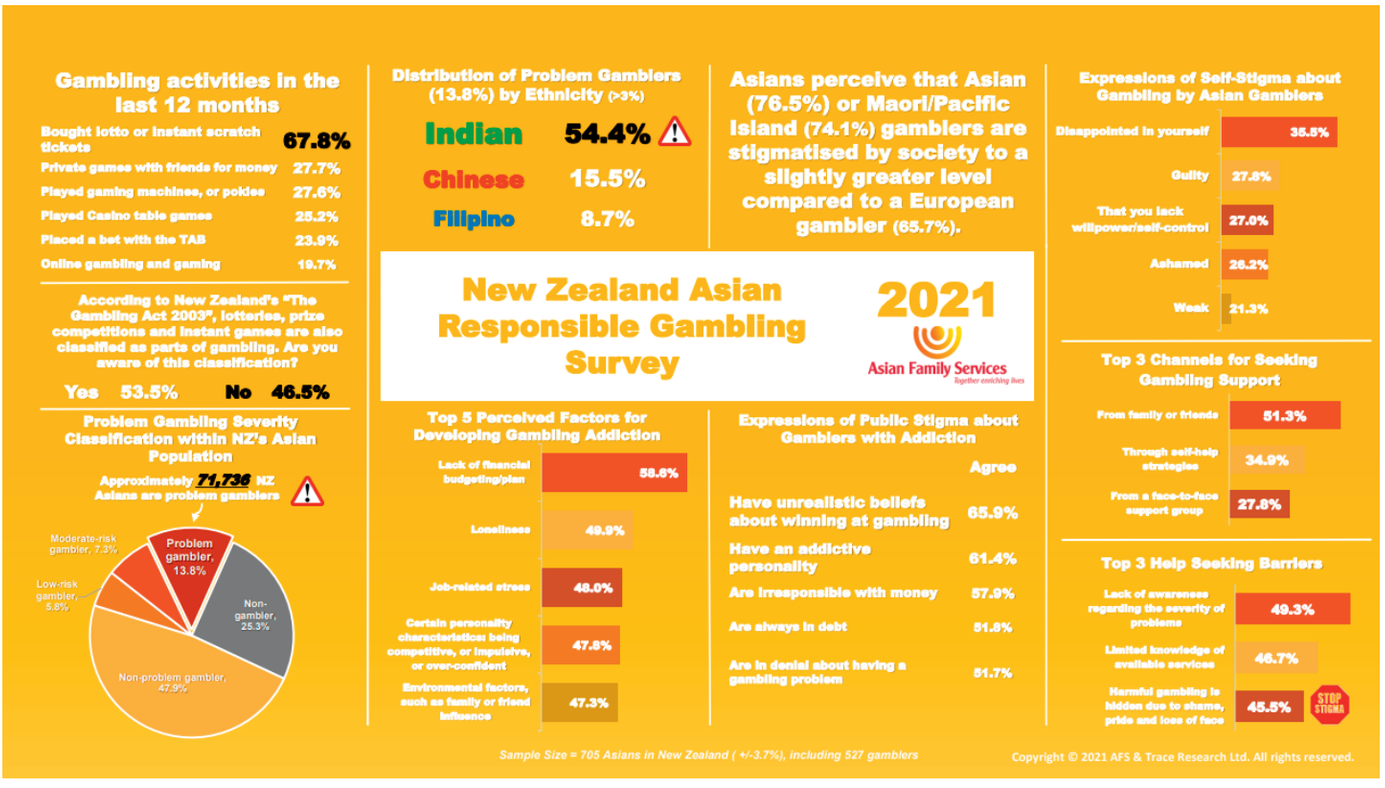
Asian Family Services
Together enriching lives

New Zealand Asian responsible gambling report - 2021

This report presents findings from the 2025 New Zealand Asian Wellbeing and Mental Health Survey, revealing critical concerns, notably declining mental wellbeing, significant experiences of discrimination, and high rates of school bullying among Asian communities.

Key Findings

- 74.7% of Asians engaged in some form of gambling activity in the year 2020-2021. The most common activity is buying lottery tickets.
- Among the gambling population, Asian problem gamblers make up 13.8%, 54.4% are Indian
- Lack of financial planning, loneliness and job-related stress are the top 3 factors that Asian perceive as risk factors for developing an addiction to gambling
- Asians believe that society carries stronger levels of stigmatisation towards excessive gambling (78.7%) than recreational gambling (52.3%)
- 78.9% of gamblers experience some form of self-stigmatisation: feeling disappointed in self (35.5%), guilt (27.8%) and feeling lack of self-control (27%) were the top 3
- When seeking support for gambling, Asians manly turn to family and friends (51.3%), self-help strategies (34.9%), and in-person support groups (27.8%)
- Stigma is the main barrier to seeking gambling support



Citation: *Zhu A, Asian Family Services, Trace Research (2021). New Zealand Asian Responsible Gambling Report 2021. Asian Family Services. https://asianfamilyservices.nz/media/bzvdtzv5/asian-family-services-new-zealand-asian-responsible-gambling-report-2021-trace-research.pdf*

Asian Family Services
Together enriching lives

Asians in Aotearoa:
Visibilising and dismantling our oppression in Psychology

This review critically discusses the oppression of Asian psychologies in Aotearoa New Zealand, driven by the dominance of Eurocentric perspectives privileged within the discipline. the article offers recommendations on how psychologists and institutional psychological bodies can incorporate more Asian psychologies within psychological research, education, and practice in Aotearoa New Zealand.

Findings

Several stereotypical 'assumptions' about Asian communities lead to limited research and a lack of tangible strategies responsive to the needs of Asians.

- The racialisation of Asians under stereotypical myths undercuts the very reality of being Asian in Aotearoa and the psychosocial experiences.
- The argument that there is no need to focus on Asians due to low utilisation of mental health services does not reflect the growing consensus among Asian health practitioners and researchers that the need for targeted psychosocial support in Asian communities is increasing more rapidly than previously recognised.
- The assumption that because stigma exists, conversations around psychological needs are taboo. While we cannot ignore the impact of stigma in Asian families, painting psychological topics as taboo or stigmatised inadvertently reinforces it, perpetuating the problem and exacerbating the 'silence'.
- The assumption that Asians are homogenous and the continuation of homogenizing prevents accounting for the heterogeneity that reflects Asian psychologies, Asian identities, psychological strengths, and needs.
- The assumption that Asians are not mental health 'literate' - Buying into this assumption silences both (1) Indigenous knowledge systems of health and well-being across Asian cultures and (2) Indigenous healing practices that are very commonly used within Asian communities as antidotes to alleviate suffering.

Recommendations

a) Visibilise and address the root cause of social issues embedded in intersecting forms of marginalisation for Asians in Aotearoa New Zealand
b) Develop resources and services for delivering culturally informed psychosocial care for Asians

- Curriculum transformation: Integrate Asian psychologies into every stage of the psychological curricula in academic institutions.
- Collate existing Asian research in a formal sourcebook
- Prioritise and encourage future research alongside and for Asians.
- Psychology researchers and practitioners (established, early-career, and students)should connect through an Asian psychology network.
- Resource the Asian psychology workforce with efforts to develop Asian capacity in psychology
- Promote leadership for Asian psychologists and researchers.
- Modify existing psychology training by updating professional psychologist training programmes, and other mental health-related professions to include Asian cultural knowledge and practices.
- Increase the number of Asian psychologists.
- Improve resourcing and access to Asian led psychological services.
- Offer professional development for existing psychologists.

Citation: *Tasker K, D'Silva C. Asians in Aotearoa: Visibilising and dismantling our oppression in Psychology. New Zealand Journal of Psychology 2025:54(1);94-109.*

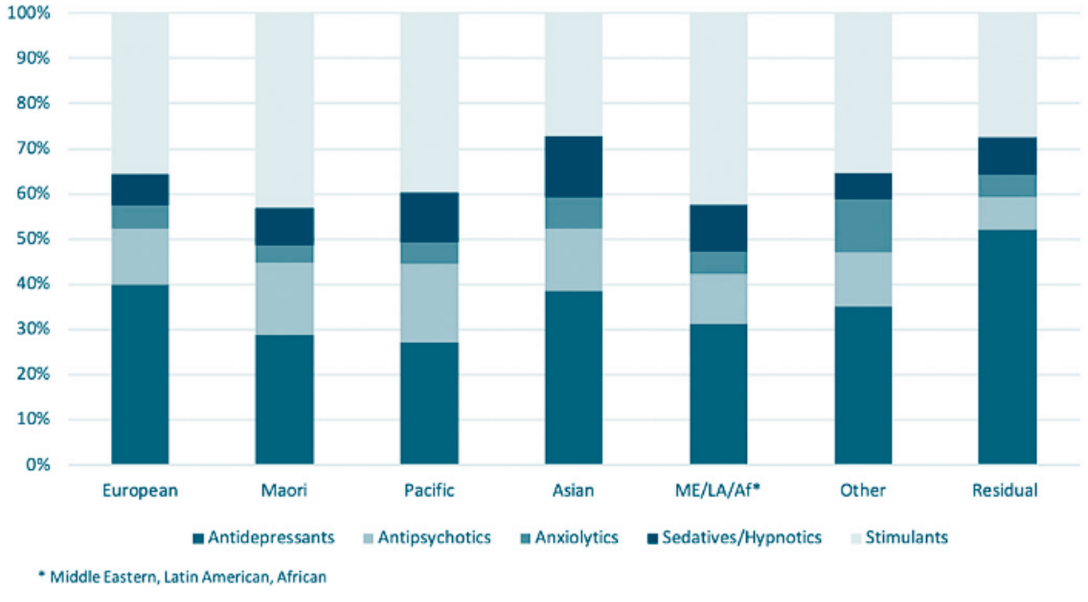
Psychotropic medication prescription rates and trends for New Zealand children and adolescents 2008–2016

This study focused on New Zealand children and adolescents aged 0–17 years, examining prescription rates and trends for psychotropic medications between 2008 and 2016. National prescription data were obtained from PHARMAC and included medications such as antidepressants, antipsychotics, anxiolytics, sedatives/hypnotics, and stimulants used for ADHD. The analysis also explored differences across major ethnic groups, including European, Māori, Pacific, Asian, and Middle Eastern/Latin American/African (MELAA) populations.

Key findings

- In 2016, antidepressants were the medication class most likely to be prescribed to Asian youth.
- In contrast, for MELAA youth, stimulants were the medication class most likely to be prescribed.
- Specifically:
  "Stimulants were the medication most likely to be prescribed to Māori, Pacific, and Middle Eastern/Latin American/African groups, with antidepressants most likely for European and Asian groups."
- Māori were prescribed medications at rates lower than the general population, but this finding does not specifically mention Asian or MELAA youth being prescribed at lower rates overall.

Percentage breakdown of total population for each medication class in 2016, by ethnicity



Interpretation:

- The results suggest that different ethnic groups have different prescribing patterns that might reflect differences in mental health needs, help-seeking behaviours, or prescribing practices.

Citation: *Barczyk ZA, Rucklidge JJ, Eggleston M, Mulder RT. Psychotropic Medication Prescription Rates and Trends for New Zealand Children and Adolescents 2008–2016. Journal of Child and Adolescent Psychopharmacology. 2020 Mar;30(2):87–96.*

The effectiveness and cultural compatibility of a guided self-help cognitive-behaviour programme for Asian students

This study evaluated the effectiveness and cultural compatibility of a low-intensity, guided self-help cognitive-behavioural therapy (CBT) programme, *Living Life to the Full (LLTTF)*, for Asian international students in New Zealand. Eleven East and Southeast Asian tertiary students participated in an 8-week intervention, delivered individually rather than in groups to reduce stigma and increase cultural acceptability. The study used a repeated-measures design with quantitative assessments of depression, anxiety, quality of life, and tertiary adjustment, alongside qualitative interviews exploring cultural fit.

The participants were aged 20-29 years (mean=23.8, SD=3.2) and had lived in New Zealand for a mean of 7.9 years (SD=8.6). Most were male (63.6%) and of Chinese descent (63.6%).

Findings

Quantitative Outcomes

- Significant reductions in depression and anxiety:
  - PHQ-9 (depression) scores decreased from mean=10.55 to mean=3.36 ($p=0.001$).
  - GAD-7 (anxiety) scores decreased from mean=10.45 to mean=3.18 ($p<0.0005$).
  - Large effect sizes ($\eta^2=0.69$ for depression; $\eta^2=0.79$ for anxiety).
- Quality of life improved significantly across physical, psychological, relational, and environmental domains. (WHOQOL-BREF subscales).
- Improved tertiary adjustment: Significant gains in academic, social, emotional, and institutional attachment scores (Student Adaptation to College Questionnaire (SACQ)
- Clinical significance: 64% showed clinically meaningful reductions in depression, 73% in anxiety; by programme end, no participants remained in the clinical range (not all participants were in the clinical range for depression or anxiety at the beginning of the programme).

Qualitative Insights (Cultural Compatibility)

- Programme was culturally compatible; principles of CBT did not conflict with cultural values
- Stigma and shame around mental health were key barriers; help-seeking was perceived as weakness.
- Family dynamics: Parental expectations for academic success and limited emotional communication influenced distress; students struggled to discuss mental health with family.
- Coping styles: Prior strategies included avoidance, isolation, or overwork; LLTTF introduced new skills such as reflection, planning, and behavioural activation.
- Facilitator factors: Having an ethnically matched facilitator who could explain concepts in Mandarin increased trust and engagement.

Recommendations

- **Low-intensity CBT can be effective and acceptable** for Asian international students, especially when adapted for cultural sensitivities (e.g., delivered individually, in an educational and didactic manner).
- **Guided format preferred over unguided self-help**: Facilitator support improved adherence and outcomes, suggesting stepped-care models should include human support elements. Ethnicity match with the facilitator may have been a factor to the high retention rate.
- **Cultural adaptations needed**: Incorporate understanding of collectivist values, stigma around mental illness, and family dynamics (e.g., filial piety, academic pressure).
- **Policy relevance**: Counselling services in tertiary institutions should anticipate issues specific to Asian international students, including acculturation stress, discrimination, and academic pressure.
- **Further research**: Determine the format that Asian international students would prefer low-intensity CBT and how effective the differing delivery styles would be.
  (specifically LLTTF is delivered individually and as a group)

Citation: *Lee KCK, Williams MWM. The effectiveness and cultural compatibility of a guided self-help cognitive-behaviour programme for Asian students in New Zealand. 2017;46(2).*

Ethnic youth and sexual identity: the role of clinical and social support for 'double minorities'

The purpose of this study was to examine how ethnicity and culture influence mental health challenges and access to support for "double minorities," referring to individuals who are both ethnic minority and sexual minority. The article is based on a narrative review of existing literature and observations.

Findings

Risk factors for Asian sexual minority youth:

- Asian cultures are generally conservative, with stigma associated with both mental illness and sexual minority status.
- Being gay in many Asian countries remains largely hidden and taboo.
- Younger Asian people living outside traditional environments (e.g. in New Zealand) may be more willing to express sexual identities due to reduced stigma.
- Many Asian youth only "come out" during university or working age, after leaving family homes.

Family support context:

- Asian elders typically live close to younger generations; unconventional ideas and behaviours are often hidden from "traditional" elders.
- Familial support is likely to be low for Asian sexual minorities, contributing to increased risk of mental illness and suicide.

Healthcare barriers:

- Clinicians should recognise that sexual-minority patients, especially from ethnic minorities, may perceive a lack of support and face higher mental health risks.
- There is limited information on how Asian sexual minorities perceive and access clinical and social support services in New Zealand.

Recommendations

- Marked mental health disparities faced by sexual-minority youth need to be addressed.
- Greater understanding is needed on how Asians in western societies perceive sexual minorities, how clinicians manage 'double-minority' patients, and how such patients perceive and access support from families, friends and clinicians."
- Knowledge gaps exists on circumstances and age at which Asians living in New Zealand and Australia begin to openly identify as belonging to a sexual minority.
- Empathic clinical support has the potential to relieve psychological distress amongst sexual-minority youth, particularly in the absence of adequate peer or family support.

Citation: *Wong N, Menkes DB. Ethnic youth and sexual identity: the role of clinical and social support for "double minorities." Australasian Psychiatry. 2018;26(2):181–3.*

The relationship between perceptions of parenting and depressive symptoms for Korean immigrant adolescents

This thesis investigates Korean immigrant adolescents living in New Zealand: 67 high school students with a mean age of 15.37 years (SD = 1.57) and 89 university students with a mean age of 20.63 years (SD = 1.70). The research aims to examine the relationship between adolescents' perceptions of parenting (specifically supportive and discordant relationship qualities, and acculturative conflict) and depressive symptoms. Acculturative family conflict is tension between parents and children that arise due to differences in rates of acculturation.

Depressive symptoms were assessed using the CES-D scale, where scores of 16 or higher indicate elevated symptoms and scores of 24 or above represent more severe symptoms. Parent relationship qualities were measured using the Network of Relationships Inventory – Relationship Quality Version (NRI-RQV).

Findings

Prevalence of Depressive Symptoms

- 69% of high school students showed signs of depression.
- 41% University students showed signs of depression.

Amongst high school students, depressive symptoms were linked to**:**

- Perceived relational conflict with and criticism from mothers
- Acculturative conflict with fathers and mothers.
- Feeling less companionship with fathers.

Amongst university students, depressive symptoms were linked to:

- Feeling less satisfied in relationships with mothers.
- More frequent acculturative conflict with fathers.
- Feeling less approval, closeness, and relationship satisfaction from fathers.

High school students' perception of the seriousness of acculturative conflict with their fathers was a significant predictor of depressive symptoms ($\beta = .473$, $p = .001$).

Recommendations

- The prevalence and factors associated with depressive symptoms in the Korean immigrant high school and university student population needs further exploration.
- Intervention options should consider targeting relationships with parents, taking into account both the age of the adolescent and the gender of the parent.
- Future research could expand this study to include parental perspectives and also examine whether the findings are similar for other Asian ethnicities living in New Zealand.
- Investigate mental health outcomes for first-generation New Zealand-born Korean youth compared to Korean-born adolescents.
- Explore additional relationship factors that may influence depressive symptoms, such as differences in adolescent and parental acculturation levels or expectations around autonomy.
- Future research should consider longitudinal designs to assess adolescent-parent relationships and depressive symptoms across time from early to late adolescence.

Citation: *Maskell L. The Relationship Between Perceptions of Parenting and Depressive Symptoms for Korean Immigrant Adolescents (Masters thesis, University of Auckland). 2016.*

Youth19 youth voice brief: The biggest challenges for young people in Aotearoa and opportunities to support

Youth19 included open text questions inviting students to express their views on key issues. This brief summarises their responses to questions about the biggest problems for young people today and their views on what should be changed to support young people in New Zealand better. These questions were clearly marked as optional, and over 2700 students responded. The following graphics represent the biggest problems and what needs to change respectively. Other youth voice briefs explore other questions and the views of specific groups of young people.

Citation: *Fleming T, Ball J , Kang K, Sutcliffe K, Lambert M, Peiris-John R, Clark T (2020). Youth19: Youth Voice Brief. The Youth19 Research Group, Wellington. Via www.youth19.ac.nz*

Youth19 youth voice brief:
What would help young people who feel down?

This brief summarises students' responses to an open text question: "What is one thing that would make things better for young people who have a hard time or feel bad?" This question was clearly marked as optional, and almost 2500 students responded (32% of the sample).

Young people highlighted five key themes or areas for helping those who have a hard time or feel bad:

a) Connection and talking are the foundations

Students highlighted the importance of connection, whanaungatanga, and talking. Comments around this theme were by far the most common across all demographic groups. There were many nuances and specific suggestions.

b) Positive environments and systems

Many students expressed that young people's wellbeing could be supported by ensuring the systems and environments around them are healthy, safe, and inclusive. This includes immediate settings (such as homes, schools, communities, and mental health services) as well as broader systems (e.g., at national/policy and even international levels).

c) Trust in young people's knowledge and skills

Many students suggested strategies and tools that young people could use to support themselves through difficult times. In contrast to comments about connection and spending time with others (Theme 1), some students emphasised the need for space, time alone, and a break from it all. Others talked about hobbies, entertainment (such as gaming, TV, music, movies, YouTube), and fun and laughter. Some explicitly described the importance of distraction and taking your mind off problems. There was an emphasis on recognising that youth have their own coping skills and should be supported to develop and use these skills.

d) Support healthy technology use and safety online

Students' comments about new technologies and time online spanned all aspects of life. There was a sense that new technologies have shaped the worlds young people inhabit and the way they inhabit them, even for those who may not spend a lot of time online. Young people expressed that games, social media and online time can be both helpful and harmful. They had suggestions for limiting online time or using it in helpful ways.

e) The way we think and talk about mental health matters

A small yet significant number of students expressed that changing the way we think and talk about mental health and wellbeing may be an important part of supporting young people who are experiencing difficulties. This includes young people themselves, the adults around them (e.g., parents, teachers), and broader social messaging. Some students expressed a need for education and destigmatisation around mental health issues and help-seeking. They wanted practical information about mental health conditions and how to get help, as well as reassurance that it's OK to ask for help. Some suggested that there is a particular need for reducing stigma around help-seeking for boys and young men.

Youth19 youth voice brief:
What would help young people who feel down? (continued)

Young people and their families want options, a range of strategies to support them when having a hard time. There is no 'one size fits all', and students may want or need different things at different times. When young people seek help, they need friends and adults who are supportive and take their concerns seriously, and services that are appropriate.

Recommendations for policy and practice

- ensuring that family/teachers/friends know how to support young people who are facing challenges
- ensuring that mental health and support services are accessible, and culturally and developmentally responsive (e.g., available in schools and communities without long waits)
- ensuring that all young people have opportunities for genuine connections in their communities (e.g., through arts, sports, cultural groups, community groups etc.). As well as help when things go wrong, young people want big picture changes so all have opportunities now and futures to look forward to. These include:
  - Addressing violence, racism and discrimination (e.g., anti-bullying policies in schools, family violence prevention strategies, anti-racism and anti-hate speech policies, safe digital environments).
  - addressing the climate crisis
  - addressing the housing crisis, food insecurity and lack of opportunities.

"Get them someone they can get close to and trust, not just some person that goes hey what's bothering you - oh that's beyond my reach and give up on them"

Māori, non-binary, age 15, decile 1–3

"It is really hard to be put into the mental health system and takes a long time to get help from a psychologist or psychiatrist... So I would want that process to be faster so that young people like me don't have to wait and get worse before they get help."

Pākehā female, age 16, decile 1–3

"Go back to your home where you are from. Feel the wind of your home talk to your tūpuna. Go and see your koros and nanas it gives you a purpose in this world rangatahi mā"

Māori male, age 17, decile 1–3

"Honestly, technology actually helps a lot of young people feel better. Even though older people think it makes things worse...it helps a lot of us forget our problems for a while."

Māori female, age 14, decile 1–3

"Educate the adults caregivers or parents so they know what to do in case their children are in those situations."

Asian female, age 16, decile 8–10

Citation: *Sutcliffe K, Ball J, Clark TC, Fleming T (2023). What would help young people who feel down? Voices of young people. A Youth19 Brief. The Youth19 Research Group, The University of Auckland and Victoria University of Wellington, New Zealand.*

A place to rest
A home to belong
A community to build
A place to be from
A people to love
A weight to put down
A place to rest
A home to belong

by Hope Milo (T@C)

Thriving at Crossroads