

# “There is a huge need, and it’s growing endlessly”: perspectives of mental health service providers to ethnic Chinese in Aotearoa New Zealand

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## ABSTRACT

**AIM:** Little is known about the experiences of ethnic Chinese accessing mental health services in Aotearoa New Zealand, resulting in uncertainty around their service preferences, and facilitators or barriers to their mental health help-seeking. This paper investigated the experiences of providers of specific mental health services for ethnic Chinese in Aotearoa, their opinions regarding their patients’ experience, and their suggestions to improve the system.

**METHOD:** Sixteen health professionals with experience and expertise delivering mental health services for ethnic Chinese were interviewed at 12 organisations across Aotearoa. Interviews were recorded, transcribed and analysed using general inductive methods and thematic analysis.

**RESULTS:** Practitioners’ experiences revolved heavily around cultural brokerage, which is vital for culturally appropriate care, but this is time-consuming and receives little formal support. Practitioners thought the patient experience was inadequate, with a lack of language and culturally appropriate services leading to delays in help-seeking. Practitioners’ suggestions for system improvement included increasing resourcing for research, and for expanding the availability of language and culturally appropriate services.

**CONCLUSION:** Current mental health service provision is inadequate for ethnic Chinese seeking help in Aotearoa, and is causing harm by delaying mental health help-seeking. Decisive Government leadership and deeper collaboration between non-Government organisations (NGOs) will be key to improving mental health service accessibility and outcomes.

Despite being Aotearoa New Zealand’s fourth-largest ethnic group (270,100; almost 6% of the population<sup>1</sup>), little is currently known about the experiences of ethnic Chinese patients accessing mental health services in Aotearoa. Ethnic Chinese in Aotearoa form a diverse, culturally-heterogenous group, with these differences driven by distinct waves in migration from differing parts of Asia over the last 150 years.<sup>2</sup> Around three quarters are overseas-born, and approximately 50% are recent immigrants who have been in Aotearoa less than 10 years.<sup>3</sup>

There is evidence suggesting under-utilisation of mental health services among ethnic Chinese relative to the non-Chinese population in Aotearoa,<sup>4</sup> which aligns with findings from ethnic Chinese migrants internationally.<sup>5,6</sup> In addition, recent reviews into Aotearoa’s mental health system have found that it does not provide enough culturally-specific, holistic options for treatment.<sup>7,8</sup> More recently, challenges have been presented by the COVID-19 pandemic, which has further negatively impacted ethnic Chinese mental health.<sup>9</sup>

In situations where linguistic and cultural barriers exist between patients and health practitioners, cultural brokerage plays an important role in health service provision both within Aotearoa<sup>10</sup> and internationally.<sup>11,12</sup> Cultural brokers are described as being both “liaisons between patients/consumers within their cultural group or community and the providers in their health care agency”, as well as being cultural guides who “not only understand the strengths and needs of the community, but also are cognisant of the structures and functions of the healthcare setting”.<sup>13</sup> Culturally-specific factors, such as traditional Chinese conceptualisations of mental health and the influence of wider family networks, also impact upon the course of mental illness, as well as the timing and willingness of ethnic Chinese to access mental health services.<sup>5,14</sup>

While there is increasing research internationally focused on mental health service access among East Asian immigrant populations (including ethnic Chinese), current knowledge is largely focused on North

America.<sup>15–17</sup> In 2021, a scoping review found health research related to Asian and other ethnic minority communities in Aotearoa was “limited in quantity and research areas covered”, with research focusing on the “use and impact of health and community care” particularly lacking.<sup>18</sup>

In light of this, along with the significant health-care reforms being introduced by the Government, it is timely to seek further understanding of the experiences of ethnic Chinese patients and their whānau. This study seeks to guide and improve the future provision of such services, by exploring the perspectives of health professionals who have particular experience and expertise in delivering mental health services to ethnic Chinese.

## Method

### Recruitment and participants

Recruitment was undertaken using purposive sampling. We contacted organisations who advertised mental health related services specifically for Asian populations in general, and/or for the ethnic Chinese population in particular. Twelve organisations agreed to participate, all based in one island of Aotearoa. Five were non-Government organisations (NGOs), four were services provided by District Health Boards (DHBs), two were alternative medicine practices and one was a general practice.

A total of 16 individuals participated: seven managerial staff, four social workers, three health professionals (one GP, one clinical psychologist, one nurse specialist), and two alternative medicine practitioners (one acupuncturist, and one acupuncturist/herbalist). Particularly for the staff from NGOs, there was substantial overlap between roles, with many managerial staff also involved in frontline social work. Recruitment for interviewing continued until data saturation occurred. Interviews were all between 50–65 minutes in duration.

### Data collection

Fully informed, written consent was obtained from all participants. Twelve semi-structured interviews were carried out by DWKC; eight occurred face-to-face and four were conducted via Zoom. Some interviews were group interviews with more than one participant involved. All interviews were audio-recorded and, upon completion, the audio-file was transcribed by a professional transcription service under a confidentiality agreement. Transcript anonymisation and insertion of pseudonyms was performed by DWKC, and explanatory notes were added where necessary. Member checking occurred, with only one participant requesting substantive

changes to the transcript to remove material which they “preferred not to be recorded”. The audio recordings were then deleted.

### Data analysis

NVivo was used for thematic data analysis. A general inductive approach, which uses “detailed readings of raw data to derive concepts, themes or a model... from the frequent, dominant or significant themes inherent in raw data”,<sup>19</sup> was used as its exploratory and open-ended nature makes it particularly suitable for studies where little information is available prior to the study. A codebook, initially constructed by DWKC, was agreed upon by all authors. Subsequent coding underwent several iterative cycles negotiating shared agreement between all four authors. The combined backgrounds of the authors allowed for various lenses to be brought to the analysis, including Chinese medicine, bioethics, medical anthropology, medical education and Western clinical medicine.

### Ethical approval

Ethics approval was received from the University of Otago Human Ethics Committee (reference number D21/012). Appropriate locality approvals were applied for, and received, for research done with DHB participants. Consultation with Te Komiti Rakahau ki Kāi Tahu/the Ngāi Tahu Research Consultation Committee was also undertaken.

## Results

Interview data were grouped into three domains reflecting the interview structure: practitioners’ experiences, practitioners’ views of the patient experience, and practitioners’ suggestions for system improvement. Within these domains, six themes and 29 sub-themes were identified, as shown in Table 1. All quotes below are published under pseudonyms.

### Practitioners’ experiences

The practitioners’ experiences were particularly defined by the sub-theme of cultural brokerage:

If you come to see the psychiatrist, they will ask you, ‘Oh, how do you translate this into Chinese?’ Zing san beng ji sang [CANTONESE: 精神病醫生]. A ‘mental illness doctor,’ literally. And they feel offended. But if you say you are coming to see a ‘psychological doctor,’ sam lei ji sang [CANTONESE: 心理醫生], it will be better accepted. Because a ‘mental health

doctor' means I have a mental health disorder. But then a 'psychological' problem, people say, 'Ah yes, this can be easily fixed.' (Roman, DHB staff member)

Respect and cultural sensitivity is vital, especially when interacting with patients whose viewpoints can vary significantly from the mainstream. Practitioners often linked these views to external, sociocultural factors, and emphasised the importance of a holistic assessment taking these into account:

We always have to go back to the time before the migration. Some literature actually says, 'Why now? This is a problem you have been dealing with for some time, but how come suddenly your GP wants to refer you to us? Why now? And it was not a problem in the past, why is it now?' (Roman, DHB staff member).

Often, a degree of flexibility around conventional first-line therapies was necessary:

Most of the Westernised counselling models, they think people have the capability to explore it on their own, so they are supporting them to keep exploring, to get a solution on their own. But when those people come to a new country, and new setting, who don't know about information and systems, they're not capable. (Andy, NGO social worker)

Cultural brokerage's adaptability makes it important for building trust and rapport, especially for patients who often have little familiarity with the health system in Aotearoa and may hold differing views regarding mental health and mental illness. Good relationships often encourage and maintain help-seeking behaviours, with skilled cultural brokers trusted more than mainstream health professionals in some instances:

They [patients] only trusted [Anita and Sandy, DHB staff members]. So, when they do postvention, they tried to engage with the family, but they don't engage with the new people... There is a number of cases, they don't trust mainstream key workers, but come back to them. (Faye, DHB manager)

Maintaining this sensitivity to differing cultural

nuances was seen as important, especially considering the diversity of the "ethnic Chinese" group. Although aspects of culture may be shared, participants were keen to emphasise that the term "ethnic Chinese" encompasses vastly differing individuals:

Not every Chinese is a migrant... some Chinese consider themselves Kiwis. Others may consider themselves as integrated into the host culture, while still maintaining some traditional Chinese values and beliefs, and are able to navigate Chinese, Kiwi and other ethnic minority cultures comfortably. (Vivian, DHB manager)

While the cultural broker role is valuable for patient interactions, it is often an informal and ad hoc one, with little in the way of formal support structures or resourcing to assist practitioners performing this role. This can result in a considerable workload:

For a European social worker, their cases average 10 hours... For all my cases average is 40. My max is 70. Why? Because they don't speak the language. I need to be the person going to different organisations, talking to different parties and all come back to me. (Sam, NGO social worker)

In addition, bureaucratic and financial struggles were common concerns, especially for participants in the NGO sector. One directly asked the interviewer for help navigating the system (a request which was politely declined due to conflict of interest concerns):

We want to become so very good. We want to involve more [health] professionals, but we need funding to support their salary. We need to prepare heaps of documentation, we don't know who can help us to do this kind of professional documentation... So, if you do have any resources or you have some students who can help, please let me know. (Teresa, NGO manager)

Cumulatively, these concerns led to a widespread feeling of cynicism, with many believing ethnic Chinese health in particular, or even Asian health in general, was being ignored by the Government:

I think there is a brain and heart difference. Maybe Government and DHB leader-

**Table 1:** Domains, themes, and sub-themes from this study.

Domain	Theme	Sub-themes
<b>Practitioners' experiences</b>		
	<b>Patient interactions</b>	Cultural brokerage <i>A process of mediating different cultural views, in which respect and cultural sensitivity is vital.</i>
		Cultural sensitivity in assessment and treatment <i>Being careful to take sociocultural factors into account when assessing and treating patients.</i>
		Diversity of ethnic Chinese <i>The term "ethnic Chinese" encompasses a wide range of individuals with differing health needs.</i>
	<b>External factors</b>	Organisational challenges <i>Practitioners often face significant administrative workloads and financial constraints.</i>
		Feeling ignored <i>There is a perception that the Government has largely not taken practitioners' long-standing concerns seriously.</i>
		Role of alternative medicine <i>Practitioners of alternative medicine felt they could provide a complementary, potentially more culturally-comfortable service.</i>
<b>Practitioners' views of patient experiences</b>		
	<b>Pre-service</b>	
		Low awareness of mental health <i>The perception of mental health as something to "get over", rather than receive treatment for is still reasonably widespread.</i>
		Stigma & shame <i>Mental illness is still seen as shameful, often conflated with psychosis or insanity.</i>

**Table 1 (continued):** Domains, themes, and sub-themes from this study.

Domain	Theme	Sub-themes
		Effects on wider family <i>The stigma of mental illness can affect family members too, discouraging help-seeking.</i>
		Isolation from support systems <i>Having fewer family or social supports can make help-seeking particularly challenging.</i>
		Lack of language, culturally appropriate services <i>Even individuals who are willing to seek help struggle to find suitable mental health services.</i>
	Within service	Trustworthiness of Government services <i>Government mental health services are seen as more credible, and are appreciated for their affordability.</i>
		Language & cultural barriers <i>Some patients struggle to adjust to language barriers and differing cultural expectations within mainstream mental health services.</i>
		Delayed in help-seeking <i>Anecdotal evidence indicates that patients generally don't seek help until a late-stage "breaking point".</i>
Suggestions for system improvement		
	Frontline changes	Someone like them <i>Seen as the ideal: practitioners with a similar cultural background and fluent in the patient's mother tongue.</i>
	Systemic changes	Resourcing for research <i>More clarity on the needs within the community were seen as vital foundational work for any further action.</i>
		Improving mental health awareness <i>Further psychoeducation to encourage increased awareness of mental health and mental illness among ethnic Chinese.</i>
		Giving patients choice <i>Expanding the availability of language and culturally appropriate services, and allowing patients more freedom to choose what works for them.</i>
		Increased representation <i>Seen as important to ensure ethnic Chinese and Asian viewpoints on mental health are given sufficient attention.</i>

ship, they recognise in their brain, and they judge that, 'Right, Asian populations are quickly growing, so we need to prepare and provide some service'. But their heart is still very cold and frozen, not willing to fund or allocate. (Sandy, DHB manager)

Outside of the conventional medical sphere, alternative medicine practitioners felt they could play an important complementary role in mental health treatment, particularly for patients who find accessing and utilising mainstream services challenging:

People more often open up to their close friends and family members. So if there's something, they rarely say it. 'Why am I going to tell you? You can do nothing. But you can help me with acupuncture and herbs, because I know I'm going to feel better.' It's a different approach, but it's seen as an antidepressant, anti-anxiety medication, Chinese medicine. And talking is always seen as superficial. (Leon, acupuncturist/Chinese herbalist)

### Practitioners' views of patient experiences

Although acknowledging this could vary depending on patient background, practitioners thought ethnic Chinese had low awareness about mental health:

We ran a couple of focus groups. You can feel the differences in generation. They feel that if you are just minor depressed, you should just get over it by yourself... Don't rely on society. They still have that mindset. (Cass, NGO social worker)

This is particularly manifest through stigmatisation of mental health issues. Practitioners pointed out the common use of the term *jing shen bing* [MANDARIN: 精神病], which literally translates to "mental illness" but is commonly used as a lay-term for psychosis or insanity. They noted the two are often conflated:

They think that people have mental health issues, it means that they are crazy, and they will do something to hurt people. (Sally, NGO manager)

The traditionally more collectivist, family-centric nature of Chinese culture also means an individual's stigma can affect their wider family, further discouraging help-seeking behaviours:

Our Chinese, we have a saying: gaa chaau bat ho ngoi joeng [CANTONESE: 家醜不可外揚; 'household shame cannot be made public']. When there's a conflict in the family, they don't want to talk to anyone because of the face, because of the stigma or maybe they don't want to tell people about the bad thing about their family. There's a lot of cases being hidden. (Sam, NGO manager)

Isolation from support systems was cited as another major barrier, as well as being a common factor in exacerbating mental illness:

The isolation, the cultural barriers, not understanding how things work and being dependent so much on their children, whereas in China, they could just get about. They have a social network, whereas here, it's very difficult. (George, GP)

Even for ethnic Chinese willing and able to seek help, the mental health system is currently seen as inadequate. The availability of language and culturally appropriate mental health services for the ethnic Chinese population, or even the Asian population in general, is severely lacking:

Some of the clients we met, their mental illness is serious enough to access mental health services under their DHB's mental health unit. But they still cannot get culturally and linguistically appropriate services. They will help their language by using interpreters, [to] go through the process. When you're doing the assessment, it's still OK, but when you go through a therapeutic intervention, it just doesn't work. (Sally, NGO manager)

Additionally, there is little promotion of the language and culturally appropriate services that do exist, leading to low awareness of them among ethnic Chinese communities. In at least one case, this was by design, due to financial constraints preventing their NGO from effectively meeting expected demand:

We didn't do too much promotion. Because we don't have enough staff on the ground is the first thing, all my staff are part time. When you open the floodgates, we are the one in the front treating all the cases... You can't see the numbers, but there is a



huge need, and it's growing endlessly. (Sam, NGO social worker)

Within mental health services, the patient experience seems to be mixed. One participant said Government services, in particular, were seen as trustworthy and affordable, and that the issue was primarily a lack of awareness and promotion:

They have many Asians in the mainstream services. And they're really happy because they trust: this is a Government service, and this is free... Government has credibility. I guess it's only how well the Western colleagues translate those good things about Government services to the people here. (Priscilla, DHB psychologist)

Others said language barriers and cultural barriers (e.g., differing conceptualisations of mental health and mental illness) presented significant issues for ethnic Chinese who are seeking mental health support:

I think they [patients] need more time to get into it. And they got language problems and the culture problem. That they have to understand it, but it takes time. They're not confident to use it. When people get into trouble, they need the confidence. (Teresa, NGO manager)

Overall, delays in help-seeking seem to be very common, with presentations generally late-stage and more severe, and only occurring after a "breaking point" at which activities of daily living become severely affected:

Under-reported, lack of access. Definitely. But we can see the increase in the suicide rate, lay presentation... [ethnic Chinese access mental health services] too late. So what they are dealing is very significant, serious cases. So mainstream always say, 'Why Asian cases are always dramatic?' (Faye, DHB manager)

### **Suggestions for system improvement**

Having a patient seen by "someone like them"—a health professional from a similar cultural background, and fluent in the patient's mother tongue—was seen as the ideal for individual clinical practice, particularly from a mental health context:

I think the best way is using those people who have similar or same cultural background, and understand the language. Because with counselling, you need to be very focused on—even small language that the clients use, you need to be sensitive and pick up what it means. But those people who do not understand the language, it's not possible. (Andy, NGO social worker)

In light of the diversity of Aotearoa's ethnic Chinese population, though, it was emphasised that having practitioners from a similar cultural background, and sharing the same language, was not a replacement for cultural sensitivity:

There are assumptions that just because a person is from a certain Asian background, they fully understand the cultural values, customs, practices, beliefs, and norms held by clients from a variety of Asian backgrounds... there is still a need to be mindful not to impose their own value or norms on their Chinese clients. (Vivian, DHB manager)

Many suggestions for systemic changes revolved around the theme of increased resourcing. Participants pointed out further research, to better detail the needs within the ethnic Chinese community, was a necessary precursor to any future actions:

If you don't understand the population and the community, then how can you provide the service? How can you design a service that you say is more culturally appropriate? That's why I think that there's more research needed to know where we're at currently and what are the needs and why people not coming forward in the early stage. (Jenny, NGO manager)

Resourcing to improve mental health awareness among ethnic Chinese was advocated:

I'd like to see more psychoeducation on anxiety and depression, domestic violence. Parent-child relationship, as opposed to high-achiever kind of parenting style. They are the seeds for anxiety. Suicide prevention, mood dysregulation. This is the main problem at the moment. Lots of Asians without knowing, they've got huge problems

around mood dysregulation. (Priscilla, DHB psychologist)

In addition, there were suggestions to “give patients choice”. Expanding the availability of language and culturally appropriate services, and allowing patients to choose the service that suits them best, was seen as key to driving greater acceptability, and utilisation, of mental health services:

They could have made their workforce representative of the population, and make a team for culturally and linguistically appropriate services... People still have a choice. Second generation of Asian, they see themselves as Kiwi, they can use mainstream services, that's fine. For someone who have a problem with the language barrier or cultural issues, then they can choose to use that particular service. (Jenny, NGO manager)

NGOs currently provide the majority of these services, and while they benefit from being seen as less stigmatising and more community-focused than larger Government-linked organisations, they are currently restricted by fragmentation and competition for scarce resources:

Funding issues become one of the factors that create competition rather than collaboration. From a community perspective, we hope to see better cooperation to improve the Chinese community's psychological health, but these sometimes run into difficulties for various reasons. (Cass, NGO social worker; translated from Mandarin)

Some felt representation in mental health governance was vital to ensure the ethnic Chinese, or even Asian, viewpoint on mental health was given sufficient attention:

We need enough people up at government level who are representative of the groups they're trying to represent... It's good that we have a few Asian doctors, for example, who are part of the Labour Party. Where we want them to be is at ministerial level. If the Minister of Health was a Chinese person, they'll make a huge difference to the funding Asian people get. I wouldn't doubt that. (George, GP)

Ultimately, most said that the primary issue was one of recognition, and that the provision of language and culturally appropriate services was being constrained primarily by the Ministry of Health and local DHBs not recognising the needs of ethnic Chinese in their strategic planning. These reflected a central, long-standing concern for many interviewees:

My highlight comment, the Government really needs to look into the policy to establish a specific funding for the Asian. Because they do have special funding for the Māori, Pacific, but not for the Asian. That one shoe fits all policy is not really working here. (Sam, NGO manager)

## Discussion

The three primary themes that emerged from our interviews with practitioners were: that mental health service provision in Aotearoa is inadequate for ethnic Chinese seeking help; that these inadequacies are causing harm by delaying mental health help-seeking for ethnic Chinese; and that these inadequacies largely arise from Government neglect and inaction regarding Asian mental health in general, and ethnic Chinese mental health in particular.

Firstly, practitioners felt mental health service provision in Aotearoa was inadequate for ethnic Chinese seeking help, with low utilisation of mental health services. This aligns with results from the last major study of Asian mental health help-seeking patterns in Aotearoa.<sup>4</sup> Whilst that report hypothesised that this was likely due to a lower underlying prevalence of mental illness among the ethnic Chinese population, practitioners we spoke to largely disagreed with this view. Instead, they saw the problem as being a lack of mental health awareness within the ethnic Chinese community; a lack of awareness among practitioners regarding the needs of ethnic Chinese patients; and a lack of policy and funding support for language and culturally appropriate services. These findings almost exactly paralleled concerns raised in a 2013 study of health professionals in Ōtautahi/Christchurch,<sup>20</sup> indicating little progress has been made since then. A more recent (2021) study echoed these concerns: over half of Chinese still reported difficulties in receiving language and culturally appropriate support when accessing health services.<sup>21</sup>

The sparse progress made since 2013 shows much work remains to be done around the resourcing and promotion of language and culturally appropriate mental health services for ethnic Chinese in



Aotearoa. The urgency of this is emphasised as our study found the current system could be causing harm to ethnic Chinese in Aotearoa, mainly by delaying their help-seeking. There were strong concerns that ethnic Chinese were not seeking help for mild-to-moderate mental illness, but either delaying treatment until it had significant adverse effects on daily functioning; or, prior to COVID-19 border restrictions, until they could seek language and culturally appropriate care in their home countries.

The primary concerns raised by practitioners included financial constraints and heavy workloads, which are long-standing and not unusual in Aotearoa New Zealand's health system.<sup>22–24</sup> This study, however, provides a novel perspective on the particular challenges these raise for cross-cultural practitioners working in mental health care in Aotearoa. The time consuming nature of effective cultural brokerage, combined with its lack of formal support in the wider health system, means that language and culturally appropriate mental health services for ethnic Chinese often cannot be delivered in a consistent and sustainable way. A previous study from 2013 raised the prospect of a reinforced “negative cycle” for ethnic Chinese mental health in Aotearoa, where widespread under-utilisation of mental health services leads to low awareness of ethnic Chinese mental health needs and concerns, resulting in neglect from policy-makers, and little funding and policy support as a result.<sup>20</sup> Our findings support these concerns, and show that they have not been adequately addressed in the last eight years.

Most practitioners believed that the ability to break this negative cycle was largely in the Government's hands. In recent years, increasing research within Aotearoa,<sup>4,18,20,21</sup> as well as mainstream media coverage<sup>25–27</sup> largely driven by NGOs, has brought more attention to the issue of Asian mental health. Despite this, no Government action seems to be forthcoming. Recent reviews into the mental health system<sup>7,8</sup> and the major reforms announced for the health system at large<sup>28</sup> have made little mention of initiatives to improve accessibility for ethnic Chinese, Asians or even the migrant population as a whole.

It is clear that a renewed focus must be placed upon ethnic Chinese mental health provision in Aotearoa,

to adequately meet the needs of the rapidly growing ethnic Chinese community. More resourcing for research—in particular, better quality data around mental health prevalence, utilisation and key barriers and facilitators to mental health service access—is an urgent foundational need, vital for informing any future actions around the mental health system. In addition, the provision of language and culturally appropriate mental health services also needs to be a higher priority for the Ministry of Health, to ensure subordinate agencies are adequately empowered to establish, resource and promote these services, whether directly or through NGOs. Further collaboration between NGOs, such as charitable organisations and community associations, needs to be encouraged, to ensure these services can be reliably and sustainably provided. Although these changes would benefit the ethnic Chinese community, there is significant potential for these changes to improve mental health service provision for other ethnic minority groups in Aotearoa as well.

While a previous study has explored the opinions of health professionals regarding mental health service provision for ethnic Chinese in Aotearoa,<sup>20</sup> this study is unique in also exploring practitioners' experiences when providing these services. It is also the first to explore the role of cultural brokerage in mental healthcare for ethnic Chinese in Aotearoa, including the costs and burdens it can impose on practitioners.

A key strength of this study was its ability to cover a broad range of health professional perspectives, from frontline practitioners to managers and the alternative medicine sphere. Combined with the qualitative nature of this study, based on semi-structured interviews, this allowed for a broad-based view encompassing both “frontline” experiences interacting with patients, and “behind the scenes” financial and administrative issues.

The primary limitations of this study were its limited generalisability, due to its small sample size and the fact that all participants were based in one island of Aotearoa. In addition, the experiences and opinions of ethnic Chinese patients were related by health practitioners and managers, not obtained directly: as an extension to this study, we are investigating this further.

**COMPETING INTERESTS**

Nil.

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