

# **Pacific Models of Mental Health Service Delivery in New Zealand (“PMMHSD”) Project**

Clinical Research and Resource Centre  
Waitemata District Health Board Auckland

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“...I believe that our Pacific people understand in our own way what discrimination and stigma is, through their own personal experience, can help see people for who they are, that they aren’t just being mental health [consumers], they are actually consumers who have communities, who have value outside of the label that’s forced on them.”  
(Pacific mental health consumer).

“As Pacific Island people we are still very community minded, we are not from the capitalist world. There is a danger of working too much from our heart, with our calculating financial cost and all that. We need to balance it. But I think they [Pacific mental health service providers] are very much...working from the heart in a way that people who were brought up under the capitalist system are not...and I think those are the things that make us, makes our [Pacific] service uniquely Pacific and makes it work well, because you can connect.”  
(Pacific family member).

“...One most significant and very important [thing] I see, is the culture.[...] It is not only the way we talk but [the] way of bringing people together and talk about our own understanding of the sickness.”  
(Pacific Service Provider Participant).

“For the Native person to be whole, the physical, the mental, the emotional, the spiritual all have to be in the circle. All those things have to be in balance for a person to be healthy. [...] I want to see our Native ways of knowing, learning and teaching recognized. We need to ensure that our Native ways are being taught as well as the ways of the western world.”  
(Patricia Longley Cochran, Executive Director of the Alaska Native Science Commission).

“Defining mental health is almost as tricky as defining spirituality. It is another elusive concept and like spirituality, an utterly subjective experience. For me, it means knowing who I am and accepting that. Mental health is the state of freedom which comes from accepting one’s self and taking responsibility for one’s actions. It is many other things as well of course – acceptance of others as they are, acceptance of life as it is, knowing when and how to change and when and how to let go.”  
(Julie Leibrich, 2001).



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## Glossary of Acronyms and Key Terms

ADHB	Auckland District Health Board
DHB	District Health Board
DSW	Department of Social Welfare
GP	General Practitioner (usually medical)
MoH	Ministry of Health
MHC	Mental Health Commission
NGO	Non Government Organisation
WDHB	Waitemata District Health Board
WHO	World Health Organisation

The following terms/concepts/phrases are for the purposes of this research used in the following manner:

**Consumer** refers to those persons with the mental illness. It does not include families of those persons. This meaning is adopted to keep in line with that used predominantly by the participants of this study.

**'Fono'** is a Samoan term adopted generically in this report to refer to a ‘meeting of peoples’.

**‘Gerontocracy’** refers to a system of government by elders.

**‘Models of service delivery’** refers to the theoretical and philosophical approaches to service delivery adopted by a service.

**‘Youth’** refers to those persons who identified themselves in the focus groups as a ‘youth consumer’. The term ‘youth’ is widely defined in many Pacific contexts, but often refers to those ‘young people’ who are either not yet married, or still at ‘school’ or of adolescent age.

**‘New Zealand-born’ and ‘Island-born’** categories refer to those persons who were born and raised in New Zealand or a Pacific island country for most of their lives. New Zealand-born refers to those persons who were born and/or raised mostly in New Zealand. Island-born refers to those persons who were born and/or raised mostly in a Pacific island country.



# **Executive Summary**

The key findings from the Pacific *fonos* were as follows:

- There were eight different models of care raised by participants: the ‘wellness model’; the ‘illness model’; the ‘*Fonofale* model’; the ‘*Te Vaka* model’; the ‘*Faafaleletui* model’; the ‘Strands or Pandanus Mat Model’; the ‘Strengths-based model’; and the ‘Traditional Healing model’. Participants raised these models in passing. Apart from the traditional healing model, the other models cited are more health belief type models rather than service delivery models. They inform service delivery but are not in themselves models of service delivery.
- Participants suggest the need to examine in further depth the clinical and cultural efficacy of Pacific holistic ‘extra mile’ approaches to mental health care and the resource implications of such approaches.
- The ‘Pacific for Pacific by Pacific’ approach to service delivery is a political strategy that still has value today (as evidenced by participants’ comments). Many of the above models raised by participants in this study developed from this political strategy.
- Pacific models of care privilege the Pacific island-born adult perspective. A number of participants argue for the need to include ‘New Zealand-born’ Pacific youth issues and perspectives within these models.
- To talk about what is uniquely Pacific about Pacific service or care approaches is to highlight the philosophical value system adopted by these approaches. This value system is inherent or embodied in many of the different techniques adopted by Pacific service providers, such as the ‘roundabout’ rapport building approach, understandings of spirituality, the cultural value of group therapy and so on. The uniquely Pacific aspects were seen to be more implicit than explicit. According to *fono* participants the uniqueness of Pacific styles of delivery lies more than just in the use of ethnic-specific Pacific languages, it also lies in a “way of doing and thinking”, in a particular belief or value system.
- Spirituality is a key component in Pacific models of care and exists alongside the physical, mental and social aspects of a person’s wellbeing. The spiritual component was used in both Christian and Pacific ancient cosmological senses by the participants. Both types of spirituality co-exist in Pacific New Zealand-based contexts in ways that suggest that each exists in its own sphere. Issues arise when exploring how the spirituality of old sits with the spirituality of Christianity as practiced by Pacific youth.
- According to some of the Pacific mental health consumers who contributed to this study, continuing Pacific beliefs in traditional cosmologies allows Pacific service providers to be more sensitive towards ‘spiritual warfare’ issues than psychiatrists.
- Building trust and rapport with Pacific consumers, especially for the first time, often requires utilising the ‘roundabout’ Pacific rapport building approach. This ‘roundabout’ rapport building approach is a technique used by Pacific service workers to ascertain whether there might be any potential barriers to working with the Pacific consumer and/or family. It is a technique best learnt through actual practice rather than through the classroom.

- For participants providing an inviting service atmosphere for Pacific consumers and families involves having familiar physical surroundings with friendly and culturally and clinically competent staff.
- Ethnic matching of consumers and/or families with service workers or therapy groups is not necessarily appropriate for all Pacific cases according to service provider narratives. What is more important is that the consumer and/or family is able to build a rapport with the service worker and/or therapy group members. This was especially so for youth consumers.
- Group therapy, when appropriately organised for key variables such as age, gender and language competency, works well for Pacific consumers and their family carers according to the participants of this study.
- According to some participants, ethnic specific Pacific group therapy approaches often adopt an island-born-adult emphasis that can exclude New Zealand-born youth consumers. More inclusive approaches need to be developed so that all types of Pacific consumers can be involved.
- Whilst Pacific families are acknowledged as integral to the recovery of Pacific consumers, it cannot be assumed that all Pacific consumers want to have their family involved in their recovery process. Pacific opinion leaders argue that service workers need to ensure that blanket assumptions or stereotypes are not unfairly adopted.
- Pacific family caregivers often have multiple caring responsibilities within their families and so juggle caring for their mentally unwell family member/s with their caring for other family dependents/members. Many family participants found it difficult because of pride or distance to call on extended family for assistance. Oftentimes it is easier for them to call on the state for help; unfortunately, this is usually done only at times of crisis. Finding ways to provide these Pacific families with access to culturally sensitive state help before a crisis point develops needs to be further explored.
- Having a regular normal job, keeping busy doing meaningful tasks and/or having close family and friends who trust and believe in them was raised by consumer participants as being key factors towards helping consumers to get well.
- Participants raised the need to have destigmatisation strategies for the home. Church and local Pacific community sites also need to be targeted. Strategies for approaching these sites need to be developed and implemented using destigmatised ethnic specific Pacific terms and concepts.
- The stigma attached to older people with mental illness was perceived by some participants to be less than that for youth mental health consumers, regardless of ethnicity. This suggests that Pacific youth consumers face a double dose of discrimination; by the general public and by their own ethnic group. This further supports the urgent need to find ways to better address Pacific youth issues within Pacific matrices of care.
- Determining what is cultural and what is clinical, the elements within and the differences between them are confusing for many of the service workers and managers interviewed. This confusion is heightened by the ‘sometimes interchangeable-sometimes not’ use of language operating across different DHBs and between DHBs and NGOs. Participants argue that to develop meaningful competency frameworks for working with Pacific

consumers and their families or carers there is a need to closely examine the relationship between ‘the cultural’ and ‘the clinical’ within Pacific mental health.

- Pacific consumers argued for the need to have the side-effects of their medication better explained to them and their families.
- The persistence of Pacific gerontocracies in New Zealand Pacific settings and the tensions this raises for Pacific youth consumers need to be factored into the building of Pacific mental health cultural and clinical competencies.
- To build cultural and clinical competency amongst all staff, an appropriate training programme acknowledging the value of practical experience is required. Participants contend that finding qualified people to lead these training programmes is crucial to their success.
- Consumer access to support mechanisms has improved according to some of the consumers and family members in this study. They also note, however, that more can be done to disseminate information on the availability and the pros and cons of these different support mechanisms, especially the different respite care options available.
- Communication pathways between community support services, hospitals, families and consumers need to be kept open at all times. A breakdown in communication often leads to consumer and family dissatisfaction with community and/or hospital services. Participants spoke of how Pacific community support workers in both types of organisations (i.e. NGO and DHB-based organisations) were key to keeping these lines of communication open. The skills involved in doing this need to be documented as part of core competency training for those working with Pacific consumers and their family or carers.
- The differences between a Pacific specific mental health NGO service as opposed to a DHB-based Pacific mental health service is not as marked as it once was a number of years ago.
- According to service provider participants the main benefit perceived by NGO services to being an NGO is the relative autonomy they have to make budgetary type decisions as opposed to their DHB-based colleagues. DHB-based services however perceive that the benefit of being part of a DHB lies mostly in their potentially larger resource pool.
- Differences in the standard of care received and the differences in use of Pacific models by either a NGO or DHB-based Pacific service is minimal, according to participant narratives.
- Whilst Pacific specific NGOs were in the past developed to provide more ‘culturally appropriate’ services (compared to services offered by mainstream organisations), today Pacific specific NGOs are merely another option in the repertoire of Pacific specific services now available to Pacific consumers and family today.
- Encouraging inter-service collaborations and/or group events across DHB and/or NGO sectors was viewed by some participants as a positive and safe way in which to get consumers out into the wider community.

The key findings for the overseas indigenous and ethnic minority mental health literature on models of service delivery were as follows:

- Language, land, family and beliefs in spirituality, traditional healing and the holistic being are core components of Māori models of health belief and underscore Māori models, styles and/or systems of service delivery.
- For the USA correspondents, there is a need to:
  - (1) Engage ‘user’ (or consumer) communities in mental health research;
  - (2) Explore the value of the ‘participatory model’ to engaging communities in mental health programmes and mental health research;
  - (3) Develop more awareness of the need to recognise the importance of having different service models, such as those offered by the faith community, to meeting the needs of diverse ethnic groups; and
  - (4) Work through how to address the real difficulties of actually implementing ethnic specific competency frameworks within a country that has large volumes of different minority ethnic groups.
- According to the literature cited in this report there are clear similarities between Pacific models of health belief and other ethnic minority group models of health belief overseas. The Hispanic group, as a non-Polynesian cultural group, showed striking similarities in health beliefs to that advocated by Pacific peoples in New Zealand.
- The Alaskan Southcentral Foundation model of service delivery is the most comprehensive integrated indigenous values-based health service delivery model found within the literature. It is a model that moves from the indigenous and ethnic minority models of health belief towards a sustained model of service delivery that systematically integrates the Alaskan ‘indigenous value system’ into every stage of service delivery – from establishing a service philosophy to building a service structure to actual implementation of service goals. An exploration of the viability of adopting such a model within New Zealand for Māori, Pacific peoples and other ethnic minorities should be conducted.
- The ‘cultural competency and/or cultural relevance’ literatures and the information received on the Alaskan Southcentral Foundation model provide the most sustained discussion around how one might think beyond Pacific models of health belief towards explicating Pacific models of service delivery.

In comparing the findings of the three sets of data collected in this study the research team concludes that:

- Pacific models of care are informed by Pacific models of health belief. Pacific models of service delivery are also informed by these types of models. Pacific models of service delivery exist in implicit rather than explicit forms. To develop more explicit articulations of Pacific models of service delivery, services need to develop written expositions of how these models might be framed taking into equal account cultural, clinical and service management issues.
- The Pacific styles of service delivery advocated by Pacific *fono* participants to be uniquely Pacific are indeed unique when compared to ‘White’ western styles of delivery. When compared to the service delivery styles of Māori, Hawaiian, Asian-American, British Black and Afro-Caribbean, American Hispanics and Alaskan peoples, however, this uniqueness becomes more debatable.

- According to participants and the literature having appropriate family and community support networks, appropriate living environments for consumers, meaningful work for consumers and competent mental health staff are what helps towards getting consumers well and towards assisting families.
- The fact that the Pacific population is a significantly young population means that the question of how to incorporate Pacific youth consumer issues in Pacific matrices of care needs to be urgently addressed by the Pacific mental health sector.
- Culturally sensitive and methodologically rigorous Pacific research is severely undercosted.
- Further research is required into the gap areas identified in the recommendations section of this study, such as the issues around building a more youth sensitive Pacific matrix of care and more effective models of family assistance or involvement in consumer recovery plans.



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# **1. Introduction**

## **1.1 Background**

### **1.1.1 Demographic Breakdown of Pacific Peoples in New Zealand**

Pacific peoples<sup>1</sup> living in New Zealand total 231,798 (NZ Census, 2001), approximately six percent of the total New Zealand population. The Pacific population is ethnically diverse. It is predominantly made up of four island groups, namely Samoan (fifty percent of total Pacific population), Cook Island (twenty-three percent), Tongan (sixteen percent) and Niuean (nine percent). Smaller Pacific ethnic groups include the Fijians, Tokelauans and Tuvaluans. Except for the Fijians these ethnic groups are primarily Polynesian.

From latest Census figures, the majority of Pacific peoples (fifty eight percent) are born in New Zealand. Of those Pacific people who were born in the Pacific islands most are well-settled in New Zealand, i.e. sixty one percent have lived in New Zealand for ten years or more (Foliaki, 2001: 1).

Almost ninety percent of the Pacific population in New Zealand speaks English. The Samoan and Tongan peoples have the largest proportions of non-English speaking persons. About half of the Pacific population in New Zealand recorded in the 2001 Census reported the ability to speak two languages.

Compared to mainstream New Zealand the Pacific population is a young and predominantly urban-based population. Cook et al (2001) predict that in the next fifty years the Pacific population, with its high fertility rate and high population growth rate, will have doubled. This finds many similarities with the projected growth rates for the Hispanic population, the largest ethnic minority group in the USA (DHHS, 2000: 3).

Foliaki (2001: 1) highlights that it is also a population group that seems to be moving away from forming marriage relationships and/or are marrying later in life – a trend Foliaki (*ibid*) notes is more associated with mainstream New Zealanders. The statistic of 1 in 3 Pacific families being ‘a solo parent family’ contributes some context to this trend.

In terms of the types of family living arrangements found amongst Pacific households, Foliaki (*ibid*) also finds that about one third of the Pacific population continue to live in extended family arrangements.

The largest numbers of Pacific people live in the Auckland region, with Manukau City having at least 1 in 4 of its population being of Pacific ethnicity (NZ Census, 2001).

### **1.1.2 Pacific Mental Health in New Zealand and Pacific Mental Health Services**

Mental disorders are recognised by the New Zealand Government and the WHO as major public health issues. Unlike western understandings of mental disorders, Pacific peoples generally do not consider ‘mental illness’ to be a disorder that necessarily originates only from within a

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<sup>1</sup> ‘Pacific people’ describes the wide variety of people living in New Zealand who have migrated from the Pacific Islands or who identify with the Pacific Islands because of ancestry or heritage. The term encompasses a range of ethnic, national, language and cultural groupings. It also includes smaller concentrations of people from the Melanesian (namely Papua New Guinea, Vanuatu and the Solomon Islands) and Micronesian islands (mainly from Kiribati) (Bathgate et al, 1994).

person (Bathgate and Pulu-Tu-Endemann, 1997: 106). Rather, as various Pacific health practitioners and researchers (Ma’ia’i, 1997; Tamasese et al, 1997; Crawley et al, 1995; Anae, 1998) have suggested over time, Pacific peoples often view mental disorder as ‘spiritual possession’ that is usually caused through the breach of a sacred covenant between peoples or between peoples and their gods. The traditional approach to healing such mental disorders is, therefore, to seek the input of traditional healers believed to have the spiritual powers necessary to restore the spiritual balance upset by the ‘possessed’ person or someone close to them. Such beliefs about mental health and traditional healing are common to many other non-western indigenous peoples (e.g. Native Americans and Hawaiians, see Bird et al, 2002). These beliefs and practices continue to be held and exercised by many Pacific peoples living in New Zealand today.

In the mid 1980s Pacific peoples with mental health disorders were recorded as being more likely to be committed to psychiatric care than Māori or other New Zealanders (Bridgman, 1996). This was read however as arising because Pacific peoples presented at much later stages of mental illness than the others (Malo, 2000). Accessing mental health services was for Pacific peoples done mainly, according to anecdotal evidence, at severe points of crisis. Often mental health services were only accessed because the Pacific consumer was referred to a mental health service through a statutory agent (i.e. the Police or DSW or hospital) (Chaplow, 1993). Until the consumer presented him or herself to a mental health service the extent of the burden of his or her mental illness on his or her family was unknown. Pacific peoples suggest that the main reasons for late or mandatory presentations involved issues of shame or pride (Ieremia, 2003).

Mental health services in New Zealand have traditionally been very monocultural in all aspects of service delivery. It has only been in the last ten years or so since the deinstitutionalisation of mental health services and the greater advocacy by Māori, that mental health services in New Zealand have begun to realise the significance of culture in mental health. This greater awareness and growing sensitivity to the impact of culture in the presentation, assessment and treatment of serious mental disorders has led to the recognition of the need for culturally appropriate services. Funding of culturally appropriate support services and clinical services for Māori (and more recently Pacific peoples) is therefore a relatively recent phenomenon.

With regards to mental health care it is estimated that central Auckland provides care for the greatest number of mentally ill Pacific peoples within the ADHB catchment area. Other New Zealand areas of high Pacific population density are Manukau City, Wellington, Waikato and Canterbury.

Most Pacific mental health services in New Zealand today are provided in the community. This is evidenced by the fact that the Pacific mental health services expenditure for 2001/2002 show that the ‘community/residential services for combined ages’ group took 69% of its budget. This includes Pacific DHB community-based and NGO community mental health services.

Foliaki’s (2001) recent work suggests that because of the low socio-economic status of Pacific peoples in New Zealand society and because of their high risk representations in general population and health statistics, their vulnerability to mental health stressors and/or developing severe mental health disorders is high. There is therefore a need to perform robust research in order to build quality research data to have better understanding of Pacific mental health issues and to find ways of appropriately servicing them.

### **1.1.3 Pacific Models of Mental Health**

With regard to the development of ethnic specific Pacific models of mental health service delivery and/or care, Pacific experts have proposed a variety of metaphoric frameworks for

thinking through how Pacific health is conceptualised and thus how Pacific service approaches should be framed. These frameworks include the:

- Samoan *Fonofale* and *Faafaleletui* models (Pulotu-Endemann<sup>2</sup> and Tamasese et al, 1997);
- Tongan *Kakala* model (by Helu-Thaman, cited in HRC, 2004); and
- Cook Islands *Tivaevae* model (by Maua-Hodges, cited in HRC, 2004).

These models all point to the importance of focusing on the process of interventions and understanding of Pacific concepts such as the use of Pacific languages, spirituality, gender, responsibilities and intergenerational concepts.

Whilst workers in the mental health sector may practice specific treatment models there may be a trend towards integrating different models of practice and developing appropriate tools to measure culturally specific service delivery processes and their effectiveness as a therapeutic approach. The importance of social and cultural issues in understanding a person's mental health disorder and to the identification of effective mental health interventions is today widely recognised (Lopez and Guarnaccia, 2000). The New Zealand government is moving to integrate primary and secondary care approaches, for example services such as DHB-based Pacific service *Isa Lei* working closely with NGO service *Pasifika Healthcare* in West Auckland and *Faleola* with *TaPasefika* in Manukau City. This is one example of finding ways to build more effective mental health interventions by integrating treatment models even within culturally specific services.

Earlier works on Pacific models of health or wellbeing (especially the *Fonofale* model) have been incorporated into the service frameworks of different Pacific and mainstream health services. A number of these models support the message that having access to a service run by Pacific staff and using Pacific principles of health and wellbeing is fundamental to the Pacific mental health consumer's recovery (Malo, 2000). Many of the Pacific mental health services created over the last two decades operate on this belief. With the change in government in 1999, mainstream mental health services also began to find explicit ways to be more responsive to Pacific mental health concerns (NMHWDCC, 1999).

#### **1.1.4 Pacific Mental Health Research**

As with many other indigenous and ethnic minority populations there is a paucity of indepth information, qualitative or quantitative, regarding Pacific mental health status in New Zealand. The need for ethnic specific research is international. In the UK there is a call for more "ethnographic inputs into policy" (Mulgan, 2003: 36). In the USA and Canada similar sentiments underline calls for the development of cultural competency frameworks or approaches (Williams, 1997; Weaver, 1999; Purnell and Paulanka, 1998; CMHS, 2000). These calls for culturally specific ethnographic information are premised on the recognition in social and health governance circles that there exist real disparities in the health outcomes of ethnic minorities compared with their 'white' mainstream counterparts (CMHS, 2000; NIMHE, 2003; Bathgate et al, 1994).

In New Zealand there currently is very little information regarding significant factors associated with access to mental health care by Pacific peoples. There are a small number of community surveys on the prevalence of mental disorders in adults (see Wells, Bushnell et al, 1989). There is also information regarding admission rates data giving prevalence estimates for mental

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<sup>2</sup> Foliaki (2001) provides a detailed explanation of Fuimaono Karl Pulotu-Endemann's *Fonofale* model. Of all the Pacific models listed above this is the most widely used in mental health service provider settings.

disorders and data on patterns of health service use (Oakley-Browne, Joyce et al, 1989; Roman-Clarkson, Walton et al, 1990; Hornblow, Bushnell et al, 1990). This data does not however provide information about the relationship between the mental disorders or disabilities of Pacific peoples and their mental health service use and whether Pacific users of mental health services perceive their needs as being met. The literature available examining Pacific models of mental health service delivery and/or care, specifically or generally, and Pacific peoples perceptions of Pacific mental health services is currently small and largely descriptive. This study aims to provide some in-depth data exploring these Pacific perceptions and the relationship between the theory, practice and consumption of Pacific mental health services in New Zealand today.

## **1.2 Research Aims**

Based on the contracted research terms of reference, this research project has five main aims:

1. To document the findings from focus group and individual interviews with Pacific mental health consumers, their family support persons and Pacific mental health service providers discussing:
  - (a) What models of care are being practiced in the New Zealand Pacific mental health sector today? What are the uniquely Pacific styles within these models?
  - (b) How are Pacific mental health services delivered to Pacific consumers and their families in New Zealand today? What are the uniquely Pacific styles within these delivery approaches?
  - (c) What helps Pacific mental health consumers ‘get well’?
  - (d) How have Pacific families supported their family members with mental health problems to ‘get well’?
2. To outline an annotated bibliography of published research and unpublished reports about models of service delivery for Pacific services.
3. To compare and contrast the qualitative focus group and interview findings with information from the overseas literature and overseas informants on models of service delivery for indigenous or migrant groups.
4. To identify information gaps and research needs that may assist the further development of effective Pacific mental health service delivery.
5. To provide Pacific mental health workers and the community with the opportunity to be involved in the research.

## **1.3 Report Structure**

The body of the report addresses research aims one to four.

In terms of the fifth aim, the research team included three Pacific mental health workers. Each had varying degrees of experience in research work. All three were engaged in collecting, collating and analysing the data for Phases I and IV (see below) and all three were involved in feeding back to the participants the preliminary findings from the data collated from these two phases.

After this introductory section, the body of the report will deal firstly with the overseas indigenous and ethnic minority data (Phase III) before attending to findings from the local Pacific service provider, consumer and family focus group interviews (Phases I and IV). Apart from including some relevant literature findings from the annotated bibliography (Phase II) into the literature review discussion of Phase III, there is no Phase II specific discussion. The annotated bibliography is recorded using Endnote 7.

The report provides a discussion section of the key findings from each of the different phases and then ends with a conclusion section and some recommendations for policy, service development and future research.

## 1.4 Research Methodology

This study was performed in order to provide a snapshot of a particular point in time in Pacific peoples' mental health history. As suggested earlier, this snapshot is focused on providing some answers to the four key questions noted in the first aim.

The snapshot is taken from a variety of points of view:

- The Pacific service provider;
- The Pacific mental health consumer;
- The family member;
- Relevant literatures; and
- From some indigenous and/or ethnic minority health specialists overseas.

Each point of view informs a particular phase of the study as noted below. The findings from the data collected from these phases are to be read alongside each other. Together they inform the conclusions and recommendations.

The four data collection phases of the study were:

- Phase I: Collection of qualitative focus group interviews with Pacific service providers and relevant community and consumer advisors.
- Phase II: Compilation of an annotated bibliography as per the second aim.
- Phase III: Collation of personal correspondences (e.g. personal communications via email) and focused literature review as per the third aim.
- Phase IV: Collection of qualitative focus group interviews with Pacific mental health consumers and family members.

These four phases involved different types of research methodologies.

- Phase I and IV adopted the inductive qualitative grounded theory methodology (Glaser, 1998).
- Phase II simply involved an expanded literature search, review and collation of relevant published and unpublished material into an Endnote database programme.
- Phase III utilised a mixture of research methods. These included: primary structured interviews; a focused literature review; compilation of observational notes; and collated email correspondences.

Thus, the research methods utilised in the study included: unstructured qualitative interviews; structured qualitative interviews; literature reviews; and 'personal correspondence' reviews.

National ethical approval was gained for all four phases of the study. The project utilised the existing national process via lead application to the Auckland Ethics Committee.

Pacific principles such as the Samoan *va fealoaloa'i* (caring for interpersonal relationships) and the Tongan *feveitokai'aki* (respect) (see HRC, 2004) were adopted throughout the process of organising the focus groups and collecting and feeding back on the focus group data. By and large adopting these principles involved ensuring that cultural, ethical and professional concerns surrounding the relationship between the researchers and the participants were carefully

considered. For example, the research team ensured that the project was culturally recognised by carrying out a project blessing ceremony. This was conducted by key members of the Pacific mental health service provider community. In line with Pacific cultural etiquette food and *meaalofa* (cultural gifts) were also provided in reciprocal cultural recognition of the importance of the relationship between researchers and participants and for the spirit of sharing exchanged or to be exchanged during meetings or *fono*.

#### **1.4.1 Qualitative Focus Group and Individual Interviews – Qualitative Grounded Theory Approach (Phases I and IV)**

##### ***Data Collection: Breakdown of Focus Groups and Focus Group Process***

Although focused service provider and consumer and family interviews were noted in the research contract as separate phases, the data collection processes for both phases occurred simultaneously. That is, after weighing up practical and methodological concerns the research team decided that where possible these focus group interviews would be carried out at the same time.

Holding these interviews simultaneously minimised the study's interruption of services as in addition to their role as participants in the study, service workers were requested to organise the attendance of consumers and family members to the focus group *fono*. In order to maintain methodological integrity a clear distinction was made between statements relating to consumers and family members and those relating to service providers in the transcribing process.

Focus groups were organised according to the three key group identities raised in the contract. That is, those of 'service provider', 'family' and 'consumer'. Participants identified two more group identities as equally important. These included a group for 'women' issues and a group for 'youth' issues. The service provider groups were organised mainly according to ethnicity where numbers allowed. That is all those participants who wanted to speak using their 'service provider hat' joined the 'service provider' group. Where there were few service provider members of one ethnicity these members would join with another service provider group if agreeable to all. The consumer and family groups were sometimes combined at the request of the participants (especially the consumers) themselves.

Participants self-selected the group they wished to join. At the beginning of each focus group each participant had to identify him or herself and note the particular 'hat' they were wearing when providing comments. This, when done well, made for much smoother transcribing processes.

All consumer, family and service provider focus group sessions were held simultaneously for the Wellington and Christchurch sites. Christchurch had a total of 3 focus groups: 1 service provider; 1 consumer; and 1 family group. Wellington had a total of 6 focus groups: 1 consumer only group; 1 combined consumer and family group; 1 family only group; 1 youth group; and 2 service provider groups.

In Auckland there were 11 focus groups in total. These were carried out in three stages due to difficulties in organising suitable times and the traveling distances involved compared to Christchurch and Wellington. In Auckland there were 3 service provider groups; 1 women's group; 1 youth group; 2 combined consumer and family groups; 2 consumer only groups; and 2 Pacific Leaders groups.

Two individual interviews were conducted for two different service providers: one in Wellington and one in Hamilton. The Wellington service provider preferred to be interviewed

individually. This interview was therefore conducted by one of the research team members separately from the other focus group interviews that were held simultaneously. The Hamilton service provider interview was conducted separately and individually as it was the only service provider from Hamilton involved in the study.

The focus groups were conducted using a topic guide (see Appendix C). The discussion was unstructured in the sense that aside from the general topic areas that needed to be covered, the specific direction of the discussion under each topic was to be guided by how people responded to each other rather than by set questions. This type of unstructured focus group approach is generally referred to as the ‘qualitative grounded theory’ approach (see Patton, 1990; Glaser, 1998).

### ***Data Collation, Analysis and Write-up***

Each taped focus group discussion was transcribed verbatim. Each of the four Pacific research team members were allocated focus group and individual interview tapes and were responsible for transcribing these. Any Pacific ethnic language was firstly transcribed verbatim in the language of origin and then translated. All original verbatim transcriptions, language translations and meeting and observational notes made were included in the material to be analysed. Once transcriptions were completed and notes collated the full research team met to discuss the themes arising from the transcribed and translated data. The themes that emerged from the first full research team’s discussion of the data was as follows:

1. Assessment;
2. Physical environment (‘bricks and mortar’);
3. Infrastructural design;
4. Communication;
5. Competencies;
6. Documentation;
7. Employment;
8. Ethnic specificity;
9. Family;
10. ‘Going the extra mile’;
11. Programme interventions and consumer use of time;
12. Language;
13. Matua;
14. Medication;
15. Philosophical foundations and cultural values;
16. Mental health promotion;
17. Relationships;
18. Resources;
19. Spirituality;
20. Standards;
21. Training;
22. Treatment; and
23. Youth.

Twenty-three themes arose in total. All transcribed and translated focus group and individual interview data were then thematically organised according to these initial twenty-three themes.

Once the verbatim and translated data was organised according to these twenty-three themes, the material collated per theme was then divided amongst the three Pacific researchers for initial write-up. From this collation process participant perspectives were able to be distilled for how they responded to the four key research question areas noted earlier, both as a whole and as separate groups.

Once the first write-up of the focus group and individual interviews was completed, a draft report was compiled and the research team together with the Reference Group organised feedback forums to feedback key findings to participants from each of the three main sites. The participants who attended the forums were given a presentation on the key findings and copies of the draft report of the findings from these two phases were distributed for ‘in-house’ reading (i.e. the draft reports could only be read during the feedback *fono* time). All three feedback forums affirmed the key findings and were appreciative of the feedback process.

### ***Translations***

Non-English transcripts were transcribed verbatim and then translated using a ‘double checking’ process. The first stage involved transcribers fluent in the Pacific language. Their transcriptions were then passed on to an ‘expert’ in the ethnic language to ‘double check’ for spelling, meaning and nuance. This process was adopted for all Samoan, Tongan, Niuean and Cook Island data. The bulk of the data gathered was primarily in the English language.

Where ‘Pacific’ language quotes are used in this report, the English translation is provided in the main text and the original ethnic language verbatim is given as a footnote. This option gives the report narrative better flow.

### **1.4.2 Annotated Bibliography (Phase II)**

#### ***Endnote 7***

The annotated bibliography is recorded using the Endnote 7 bibliographic formatting programme. The programme allows for the inclusion of keywords thus enabling keyword searches under the fourteen suggested keyword headings provided in the research tender. Three more headings were added to this list of fourteen to account for the related but separate themes of ‘spirituality’, ‘church’ and ‘religion’ that arose within the literature. The headings are listed below:

1. Policy;
2. Prevalence;
3. Access to services;
4. Assessment and treatment;
5. Cultural competencies;
6. Models of service provision;
7. Service evaluation;
8. Health service governance models;
9. Relationship with communities;
10. Religion;
11. Spirituality;
12. Church;
13. Outcomes;

14. Workforce development;
15. Health promotion strategies;
16. Traditional Healing; and
17. Discrimination and Stigma.

By searching under any of the above headings, singularly or in combinations, the Endnote 7 programme will be able to download any relevant publications cited using those keywords.

### **Literature Search: Sites and Search Process**

Search sites included the University of Auckland Voyager library catalogue system; the MED-LINE and expanded academic databases; and personal bibliographies held by research team members and colleagues.

There were four primary key word search groups. These were widely framed as follows:

1. “Pacific people’s mental health”;
2. “Indigenous mental health”;
3. “Ethnic minority mental health”; and
4. “Mental health models”.

Relevant sources found using these general key word search groups have been recorded in the Endnote 7 project file.

#### **1.4.3 Overseas Migrant and Indigenous Models of Service Delivery (Phase III)**

This data collection phase adopted four different data collection methods. It collected data using:

- Structured qualitative key person interviews;
- Researcher notes of observations made during a visit to the Alaskan Southcentral Foundation (an indigenous health service in Alaska);
- Email messages from key indigenous and/or ethnic minority health workers overseas; and
- A focused literature review of published material on overseas migrant and indigenous models of service delivery.

The findings for this phase are provided in Part 2 of this report.

### **1.5 Methodological Constraints**

As with any multi-site, multi-team, multi-layered research exercise the theoretical ideal is not always possible to achieve given time, resource and workforce constraints. In qualitative research the reliability of qualitative data is closely linked to the ability to ensure, among other things, quality taping or note taking and group facilitation or individual interviewing practices.

In terms of facilitation practices it is essential for data integrity to keep participant comments as ‘true’ to their views as possible. Ensuring that the interviewer/facilitator does not lead the discussion in potentially biased ways is by no means easy, even for the most experienced facilitators. A certain amount of facilitation bias often arises, particularly when at the outset the study faces limitations in terms of the time and resources available to adequately train qualitative facilitators or to find them.

The research team argues that this facilitation bias is potentially exacerbated when Pacific facilitators operate within the usual Pacific frames of *talanoa*<sup>3</sup> (Manu'atu, 2000). As these frames often expect the sharing of opinion between facilitators/interviewers and group members or interviewees the potential to *lead* rather than to *facilitate* is high. The research team encourages closer examination of this point and recommends further theoretical development of this as a methodological issue (especially in terms of developing sound culturally appropriate qualitative research).

Notwithstanding these methodological constraints the study amply provides rich insights into the different perceptions of its various focus group and individual interview participants. These participant perceptions when placed alongside relevant literature findings and overseas indigenous and ethnic minority health programmes, policies and consumer perspectives make for some interesting and informative discussion of the research aims of this study.

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<sup>3</sup> *Talanoa* is a Polynesian term translated by Samoans and Tongans to refer to the action of talking or sharing a conversation. Linita Manu'atu (2000) draws on the 'talanoa' method as a method unique to the Polynesian context, one that deliberately invites the sharing of information and knowledge between researcher and research participant.

## **2. Key Findings**

The key findings are organised into two parts. The first part details the qualitative interview findings. The second part details findings from the overseas literature and correspondences.

### **2.1 Findings from Focus Group and Individual Interviews with Pacific Mental Health Consumers, Families and Service Providers**

This part of the report is divided into four sections. The first section deals with the questions: “What models of mental health care are being practiced within the New Zealand Pacific mental health sector”? and “what are the uniquely Pacific styles within these models”? The second section addresses the issues: “How are Pacific mental health services delivered to Pacific consumers and their families in New Zealand today?” and “what are the uniquely Pacific ‘styles’ within these delivery approaches?” The third section looks at: “What helps mental health consumers “get well”?” The fourth and final question involves: “How have Pacific family members supported Pacific mental health consumers to “get well”?”

#### **2.1.1 What models of mental health care are being practiced in the New Zealand Pacific mental health sector? What are the uniquely Pacific ‘styles’ within these models?**

The aim of this first research question area is to collate any discussion raised by participants in this study about (a) models of ‘mental health care’ known to participants and (b) what participants thought were the uniquely Pacific ‘styles’ within these models.

Often when participants referred to a model they did not elaborate on what they understood these models to mean or contain. In part this may have been because within the focus group setting it was assumed that participants understood what the model raised was. It may have been because the emphasis of the focus group discussion at that point did not make it appropriate to elaborate further. Alternatively, perhaps the participant who raised it was not sure him or herself of the details of the model. Whichever way, what was raised by participants is limited. Nevertheless, that which was raised is still useful to note.

#### ***Summary of Findings***

Participants raised eight different “models”. These were referred to as:

1. The Wellness model;
2. The Illness model’;
3. The *Fonofale* model;
4. The *Te Vaka* model;
5. The *Faafaleletui* model;
6. The Strands or Pandanus Mat model’;
7. The Strengths-based model; and
8. The Traditional Healing Treatment model.

These were the only models explicitly raised by participants. Whilst most of these eight models were raised in passing and by only a few participants, one – the *Fonofale* model – was frequently mentioned and by the most number of participants.

One participant noted that there are many models and that having many models provides consumers with service options or service providers with different perspectives on how to assess the many different service needs that arise within Pacific mental health contexts.

What is uniquely ‘Pacific’ about these eight models was expressed by most participants to be the emphasis these models placed on the ‘holistic’ context of care, in particular the importance of the ‘spiritual’ alongside the ‘physical’.

The resource implications of the ‘holistic’ approach are potentially huge and complicated. Participants argue however that to make good on having these models such cost implications should be carefully and openly explored.

### ***Findings by Specific Model Type***

#### ***‘Illness’ versus ‘Wellness’ Models***

Participants variously found that the health models currently known to them fall into two general types. These they described as ‘illness’ models on the one hand and ‘wellness’ models on the other. Pacific models of mental health care, they argued, sat more within the latter category; whilst bio-medical western models sat more within the former category.

According to one opinion leader, Pacific peoples find it difficult to embrace the ‘illness’ model in mental health because of the assumption that mental illnesses (once diagnosed) are incurable. This is in contrast to the belief (especially in Samoan contexts), he suggests, where mental health problems are perceived as curable. Thus, he argues, in promoting mental health treatment via the ‘illness’ model, doctors are effectively keeping many Pacific consumers away. This perception of a difference of opinion in curability of mental health problems is what according to this opinion leader underlines why “they [Pacific people] are not likely to come and see a doctor” because they believe that “the doctor thinks of it [their mental illness] differently from what they think of it” and “that is one of the reasons why they only present, or we [Pacific services only] get to them, when they’re really unwell”.

Other participants concurred with the point that the attitude of the medical profession to these illnesses seemed, in their opinion, to privilege a detached clinical approach to assessment or service delivery, where interpersonal rapport building is kept to a minimum. These participants found that for Pacific cultures, which privilege the role of building inter-personal relationships between doctor and patient, utilising this detached approach can cause offence. The detached professionalism of the medical profession is a principle that was suggested by participants as one that runs contrary to Pacific principles such as the Samoan *va fealoaloa'i*. The seeming mismatch between the interpersonal service approach of Polynesian cultures and the detached service approach of the medical professional underlies the tension between the illness and wellness models.

The wellness model was argued to emphasise notions of holistic care and personal strengths. Whilst the illness model was seen as disease focused in that it emphasised curing the disease rather than the person. Some participants saw the illness model as a “one-sided” model in that it privileged the health knowledge of the clinician or medical professional. In contrast, the wellness model was seen to be more balanced in recognising medical and non-medical knowledges. The wellness model therefore seemed to allow for a holistic emphasis to health care, treatment and service delivery, where the person rather than the disease was prioritised.

### *Faafaleletui Model*

The *Faafaleletui* model was raised by some participants as a model that is sometimes referred to by Pacific people in different Pacific mental health settings. It was interestingly referred to by a couple of participants as a “Wellington” model, meaning it came out of the Samoan-specific Wellington based qualitative mental health research work, produced by the Wellington Family Centre (Tamasese et al, 1997). This work was titled, *O le Taeao Afua: A New Morning – A Qualitative Investigation into Samoan Perspectives on Mental Health and Culturally Appropriate Services* and was published in 1997.

As discussion of this model was made in passing, no elaboration on its uniquely Pacific aspects is provided. The Samoan term *faafaleletui* loosely refers to a method for holding a discussion on a particular matter. Further work is required on this ‘model’ to ascertain its meaning, metaphoric significance and application as a potential mental health service delivery model.

### *Fonofale Model*

Most participants cited the *Fonofale* (Pulotu-Endemann, cited in MoH, 1995 and MoH 1997) model as one of the key models used by service providers to address specifically Pacific health needs. For many the model provides the value system that informs service delivery. When talking about the “holistic approach” participants often used the *Fonofale* model as an example.

Of all the models noted here, this model seemed the best known to participants (both in focus groups and individual interviews). It was perceived as uniquely Pacific in its promotion of a holistic view of health care.

### *Strands or Pandanus Mat Model*

One service provider raised this model<sup>4</sup> when referring to their approach to working with Pacific consumers and their families. This service provider manager discussed the model in terms of her service’s approach to dealing with the different strands within the various types of cases their Pacific service deals with. She tells that there *are* different strands in a case and that not all strands are woven together in the same way when dealing with Pacific families. The model is useful, she asserts, because it highlights the fact that not all Pacific families are the same. Responding to the needs of a Pacific consumer and his/her family therefore requires recognition of the heterogeneity of Pacific problems.

Weaving together the strands of the Pandanus mat was raised as a metaphor for how the different strands of a (mental health) case are woven together. The point being that the strands interlock to form a whole and that the mat’s durability depends on how well the strands are woven together. The suggestion is that like a good Pandanus mat, a good health and wellbeing model requires that all the key strands of a person’s life needs to be well thatched to be able to withstand the test of time and different elements.

### *Strengths-based Model*

This model was raised as another example of a holistic approach to mental health care. It was raised by a participant who was a social work student and was working part-time in a Pacific mental health service. She argued that this was a model that was useful for Pacific mental

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<sup>4</sup> Pacific cultures use finely woven Pandanus mats as special ceremonial gifts. These mats have high cultural exchange value.

health services because it reiterates the holistic emphasis of wellness models. She explained that the strengths-based model emphasised consumers' strengths rather than just their problems. When determining appropriate recovery care plans or service pathways this model would exploit these strengths. By concentrating on the strengths of the consumer, keeping the consumer motivated to "getting well" would arguably be easier.

### ***Te Vaka Model***

The *Te Vaka* model was raised as another model used in Pacific mental health settings alongside the *Fonofale* model. This model utilises the Tokelauan term *vaka* meaning canoe. No discussion was offered on the significance of this model or how it differed from other Pacific health models.

### ***Traditional Healing Treatment Model***

The 'traditional healing treatment model' was implicitly suggested by some to be another model of health care. Discussion centred on participants' understandings of the *fofo* (Samoan term for traditional massage) and of the healers who carried out the traditional *fofo* practices (i.e. to the *taulasea* or *tohunga*). Many made references to the different types of ingredients used by *tohunga* to make traditional remedies (e.g. particular leaves, herbs, oils, liquids, and other such ingredients), as well as massage techniques.

Participants noted that these traditional healers often specialised in different health problems, including mental health conditions. The skills of the traditional healer is still believed to be a gift handed down and/or developed within families, usually from one generation to the next and only to those who have shown both skills and respect for the practice and its philosophical premises.

In modern day contexts, it has become another alternative in the repertoire of treatment options available to Pacific peoples in New Zealand. Some participants noted that in many cases this option would be taken up simultaneously with other more 'western-based' medical options. So, rather than an either/or situation, it exists 'as well as'.

As a model it is by definition 'uniquely Pacific' in its terms of reference and design. It perpetuates because, as participants point out, there continues amongst Pacific peoples a belief in "the spirituality of 'old'" (i.e. in the cosmological beliefs of their Pacific ancestors). A number of participants noted that despite western dismissals of the traditional healing model, there have been some significant accommodations in recent times in countries like New Zealand of traditional healing practices. These participants caution that the struggle for full recognition still continues, particularly when considered in terms of eligibility for public funding, however, they recognise that western health regimes nowadays are more responsive to traditional healing practices than in the past.

### ***Resource Implications***

The resource implications of all of these models noted here is acknowledged by participants to be "huge". To carry out a holistic model properly requires access to a large pool of resources. In an environment where resources are scarce and highly contested for, making a case for proper funding of these models is always going to be difficult. Participants argued, however, this was no reason not to look for ways to find some accommodation from both sides (i.e. the capitalist side and the holistic side).

As suggested by one opinion leader participant, there are many different Pacific models of care available today for Pacific service providers. He doubted that “we can ever find one that can apply all across the board”. He suggests though that, “there is a number of things...that can assist us” and that “if we can have a collection of these [models], some understanding [of these models], then we may use [them in our] practice”. This supports the value of having a range of perspectives. In any case, providing cost-effective services requires (among other things) building better understanding of what each of these models refers to and how they might play out in different mental health service practice settings.

### **2.1.2 How are Pacific mental health services delivered to Pacific consumers and their families in New Zealand today? What are the uniquely Pacific ‘styles’ within these delivery approaches?**

To adequately address the above questions this section draws mostly from the qualitative data organised under the following twelve theme areas. The themes were titled:

1. “Assessments”;
2. “Standards”;
3. “Documentation Requirements”;
4. “Bricks and Mortar”;
5. “Workforce Competencies”;
6. “Philosophical Frameworks”;
7. “Spirituality”;
8. “Going the Extra Mile”;
9. “Building ‘Trust’ Relationships via the ‘Roundabout’ Approach”;
10. “The ‘Pacific for Pacific by Pacific’ Approach”;
11. “Youth Consumers”; and
12. “Pacific NGO vs. DHB-based Services”.

The findings are discussed in summary form first followed by more detailed discussions under each theme.

#### ***Summary of Findings***

Cultural assessments, holistic models of care, an inviting atmosphere using Pacific motifs and hospitality practices, and use of Pacific languages and co-existing ‘spiritualities’ were each raised as uniquely Pacific elements in the service delivery approaches adopted by the Pacific services that participants were either aware of or part of.

Each of these uniquely Pacific elements gave rise to several interesting points for discussion and further review. In terms of Pacific practice standards, Pacific opinion leaders advocate for the need to review Pacific practice standards alongside mainstream practice standards to ensure that the logic between them is consistent and that expectations are not unrealistic or that standards set are culturally and/or professionally unsafe.

In terms of documentation requirements, some Pacific service provider managers and service workers argued that the documentation or reporting requirements expected of them by their funders was merely a “number crunching” exercise that is unable to capture the ‘extra mile’ tasks they carry out as part of their ‘holistic’ Pacific models of care. A review of reporting requirements for Pacific service workers was therefore requested alongside a survey of Pacific service worker competencies in this area.

Pacific mental health workforce competencies are currently divided into two component parts, those considered ‘clinical’ and those considered ‘cultural’. Cultural competence is currently measured largely in terms of ethnic ‘island-born’ Pacific-Christian understandings of ‘culture’. Ethnic language, traditional protocols, values and philosophies are cited as the key indicators of ‘cultural’ competence. Discussion on clinical competence is minimal and in the main assumes a bio-medical understanding of what constitutes ‘clinical’. There is some work to be done on how these two types of competencies come together or not, and what other aspects of both models need to be incorporated.

The institutionalisation of the role of *matua* or elders in Pacific mental health services was considered by participants to be something that is ‘uniquely Pacific’. It is a position considered necessary for ‘cultural supervision’ purposes or for the development of ‘in-house cultural competencies’. Further examination of the full implications of this position for Pacific mental health services is required.

In terms of Pacific philosophical frameworks participants talked about the importance of recognising the sacred or *tapu* bonds and socio-centric relations between peoples themselves, between peoples and nature and between peoples and their God(s) of creation. Within these frameworks sit principles of reciprocity and compassion or ‘*ofa*; notions of respect and deference or *faaaloloalo*; and notions of family interconnectedness or *aiga*. The self is understood within this framework to be a relational self; time and space, rights and responsibilities are similarly understood. For many participants, therefore, it is this philosophical framework and its value system that underpins the holistic models of care used by Pacific services and which gives it its ‘uniquely Pacific’ quality.

The two sides of the spiritual, (i.e. as Christian-based on the one hand and as cosmologically defined on the other), was also raised as something that was uniquely Pacific about Pacific health belief models. Such models apparently inform Pacific service delivery approaches.

To work with Pacific consumers often means also working with their families. Families are understood to be made up of both immediate and extended family members. Families, therefore, continue to be recognised by many of the consumers and service workers of this study to be an important part of the consumer’s healing process. Some participants argued however that service workers needed to be mindful of the fact that not all Pacific families are the same and that whilst family involvement is desirable, it may not necessarily be appropriate in the circumstances. Accordingly, caution is needed when assessing Pacific cases so that blanket assumptions about Pacific families are not unfairly adopted. The privileging of the ‘extended’ family type however is still perceived by many participants to be one of the ‘uniquely Pacific’ aspects of Pacific services.

Moreover, service providers also noted that to work with Pacific families often required undertaking work tasks over and above their stated job descriptions. Undertaking these extra tasks is described by some as “going the extra mile” or working “from the heart”. This was seen by some to be another uniquely Pacific aspect of Pacific service delivery. Some evaluation of this claim is required.

For a number of the Pacific opinion leaders interviewed, the “Pacific for Pacific by Pacific” approach often operates on an island-born adult matrix of care that excludes the culture of New Zealand-born Pacific youth. This was raised by opinion leaders and youth consumers to be a fundamental barrier to youth participation in ethnic specific services and therefore a gap area that needs urgent review. The question of whether there are uniquely Pacific youth services is yet to be explored.

Lastly, in terms of the differences between NGO and DHB-based Pacific services, there seems to be none. The key advantage of a Pacific NGO-based service is argued to be the relative decision making autonomy NGOs hold in terms of budget allocations and staff movement compared to that available to Pacific DHB-based services. For DHB-based Pacific services, the key advantage is argued to be that they have more access to a potentially larger pool of resources. With regards to standards of care there was little discussion comparing the two. The perception from consumers is that there is little difference between the standard of care received from those working in a DHB-based service and those working in a NGO-based service. For consumers the defining point is more the effectiveness of the staff to client relationship than the institutional arrangement. Thus, what makes a Pacific service uniquely Pacific did not seem to pertain much to its institutional arrangement as either a NGO or a DHB-based service.

### ***Findings by Specific Theme Areas***

#### ***Theme One: Assessments***

Many service providers acknowledged the use of cultural assessments within their services. These are used, they explained, alongside clinical assessments to help contextualise the various mental health needs and/or symptoms raised by consumers.

Clinical assessments, according to service provider participants (who are made up by and large of community support and cultural workers), involve the assessment of a consumer's "bio-medical" history and current mental health symptoms. Cultural assessments, on the other hand, involve the assessment of a consumer's socio-economic and cultural context. The two, they argue, should complement each other.

Although there are areas of overlap between clinical and cultural assessments, they are implemented and perceived by participants as two distinct types. According to one opinion leader, the clinical and cultural are often juxtaposed as inherently competing or conflicting. This is exemplified by the perception raised by some participants "that one is better than the other".

Some service provider participants also raised the point that there are many instances in their work where they have been asked by a clinician to assist with the clinical assessment. This is especially so when there is a language issue. In these cases, the perception of an overlap between the clinical and cultural becomes heightened for many of these Pacific mental health workers.

Notwithstanding underpinning philosophical and employment tensions between the cultural and clinical approaches, one opinion leader found that best practice approach today requires the coming together of both. She states:

"the model that needs to work for us [Pacific peoples] has to make sure that it is robust enough to stand up clinically [and] that it is robust enough to stand up culturally" (Pacific opinion leader).

She acknowledges that finding a comfortable nexus between the cultural and the clinical is a "huge ask", but it is necessary, she suggests, for any real pursuit of culturally appropriate mental health practices.

Service provider participants noted that services are largely responsible for designing their own cultural assessment frameworks or tools. Many of these frameworks or tools adopt the key component areas of the *Fonofale* model (see MoH, 1995). Cultural assessments occur at both a

formal and informal level, that is, some services include the implementation of cultural assessments as part of their formal assessment processes. Others do not. In the latter instance, these services will more informally, usually via implementation of the ‘roundabout’ approach, find out relevant socio-economic and cultural status information to allow for an informal cultural assessment.

For most Pacific service provider workers interviewed cultural assessments can involve joint sessions with both consumer and family, unless this is clearly contrary to the best interests of consumer’s recovery.

Finally, in terms of key points raised by focus group participants, many argued that the DSM-IV assessment framework provided by the American Psychiatric Association and adopted by New Zealand psychiatry is culturally inadequate (at least for their purposes). They argued that in their view it is a “*Palagi* [White Western European] medical model that concentrated on mental health issues using an illness-based rather than a wellness model”. They found that the cultural components of the DSM-IV manual are limited in terms of the ways in which they can be applied “on the ground” by Pacific mental health workers.

In other words, the manual does not have a ready made cultural assessment tool for appropriate use with Pacific consumers. Services with Pacific consumers are required to formulate their own. The emergence of cultural assessments therefore provides a uniquely Pacific response to this need. Some Pacific services (especially those services that have been in practice for some time) have had more experience with cultural assessments than others.

### ***Theme Two: Standards***

As with the tension surrounding setting assessment criteria, some participants expressed similar concern regarding the setting of Mental Health Standards by the Ministry of Health. One concern raised by participants centred on how to deal with tensions between the standards set for family and consumer participation, particularly where consumers “flatly refuse” to have family involved in their care.

The participant who raised this concern noted that she had asked “the Ministry” what they were to do in this situation as the accompanying discussion for these standards was silent on the issue. There does exist within Pacific families, she argues, despite the ideal, some consumers who prefer their families “not to be there”. This can create tension, particularly for Pacific service providers who take a narrow or rigid family-based approach to working with consumers. She states:

“Sometimes...a consumer might say, that ‘I flatly refuse my family to be there’, so sometimes you can’t have family participation for various reasons. [But] somehow they [Ministry of Health] think that there is this magical formula that everything will be ticked off nice and neatly, but the reality is, is that it isn’t always like that. And so I think that is just one of the barriers...one of the things that I have an issue about with standards” (Pacific opinion leader).

Here she suggests that knowing how to navigate the contradictions between the ‘ideals’ of these standards and the realities of everyday practice is something that plagues Pacific workers just as much as it does any other worker in this sector.

In her comments this opinion leader finds that there are indeed occasions where the appropriateness of family participation in consumer recovery processes can not be assumed to be applicable in all Pacific cases. What this raises is the contention, among other things, that

perhaps there exists, not only within mainstream<sup>5</sup> but also within Pacific standard settings exercises, the need to rigorously review the appropriateness of the criteria used or assumptions made by both camps when setting and/or applying such standards.

### *Theme Three: Documentation Requirements*

Some Pacific service provider participants also found it difficult to work with the documentation or report requirements of their various funders. They perceived the criteria and format for reporting, imposed on them by their funders, as something that in its current form was unable to capture the more holistic side of their work.

For example, one participant notes below, that his reporting requirements “just [didn’t] capture the difference [he had] made” to a consumer or family. He rationalised that this was because funders were more interested in having information that allows them to conduct a “number crunching” exercise, rather than information that details the “quality” aspects of what he actually does. He states:

“... [The reporting framework] just doesn’t capture the difference you’ve made. How do you capture a whole lot of work that you’ve done with a family, for example, you’ve put in a lot of work, you’ve got the client permanent residency, they now have access to medications and now they can have respite and things like that, because now it gets paid for...how do you capture that in a reporting [style] that is a number crunching [exercise], they’re [funders are] not interested in quality, in terms of feedback” (Pacific service manager).

Similar sentiments were raised by another participant. He states:

“...so if we report on the Palagi specification or the criteria, then we’re only reporting about a third of what we actually do, ...so we still resist this thing of just doing the numbers game ...the other sixty percent of what we do to actually keep that person well can’t be reported because there is no [category for it], it doesn’t fit into the box” (Pacific opinion leader).

The other side of this discussion relates to the competency of workers to actually engage in the art of report writing. One opinion leader noted that, during his day, for many Pacific service workers filling out their work reports was not an easy task. Not only because the forms did not, *prima facie*, have appropriate categories to cover the different types of tasks they became involved in but also because many in the workforce (at that time) were not proficient in the English language, let alone the language of the funder. Filling out report forms was therefore unsurprisingly resisted, he argued. To him the claim that “we are oral peoples” and therefore are not able to undertake reporting requirements, is a “cop-out”. It is particularly difficult for funders to hear such claims, he continues, “when [even] our oral stuff does not make sense”.

This same participant raised an interesting approach adopted by a Pacific mental health service some years ago in an attempt to address this issue. The approach was called “the *tautala* (talking/oral) reporting approach”. The rationale behind this approach was to create for staff a safe space to engage in the art of reporting. It was seen as a first step in building staff competency in this area. It was to complement rather than to replace written work reports. The *tautala* exercise involved staff meeting together at the end of each month to talk informally about what and how they were handling their various cases. This participant noted that it was well received by staff at the time but had mixed results in terms of its ability to generate the

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<sup>5</sup> The term ‘mainstream’ is used here to refer to the dominant ethno-cultural population group within New Zealand or any other country.

documentation work required. It is also no longer practiced today. Nevertheless, he noted that it was a uniquely Pacific style of addressing a perceived problem.

As a final point, despite the various problems noted above, a number of participants raised the argument that in order to be able to adequately address these criticisms, Pacific peoples had to actively engage themselves in sector debates on how best to develop reporting frameworks and styles that would better suit the type of work they did. The consequences of not doing so, one participant suggests, is implicit in an oft-quoted tale amongst mental health workers regarding a mental health service who one year decided to report on how many beds were not occupied during the year, rather than the specified requirement of reporting on how many beds were occupied. This participant tells that the service did this because they wanted to highlight to their funders that the low number of beds occupied were as a result of consumers returning to live with their families or within the community, highlighting not that they did not need further funding but that this was an example of the success of their service's programmes. The problem, the participant finds, in doing this, is that ultimately the funding formula used by the Ministry of Health was one based on numbers of beds occupied rather than on the success of programmes. This, the participant reasons, is one of the difficulties of working in this environment. The lesson that this participant takes from this story is that "we [therefore] need to be very clear about reporting [requirement] because everything is based on the Ministry's criteria". In other words, the longevity of services depends as much on their funding terms of reference as it does on their reputation for providing quality care to consumers.

#### ***Theme Four: "Bricks and Mortar"***

This theme relates to the physical environment within which clinical and cultural mental health services operate. All the participants of this study, from consumer to family member and service worker, commented on the importance of providing an inviting atmosphere that would not alienate or prevent them from accessing these services. Whilst this theme relates mostly to the atmosphere created by the physical surroundings of a service, the "bricks and mortar", it also relates to the culture promoted within that service or place.

Many participants noted that the presence of things like *tapa* cloth, Pacific ornaments and paintings, the presence of Pacific faces, the use of Pacific languages and Pacific humour, the practice of Pacific hospitality and so on, were each key ingredients to providing an inviting atmosphere. These ingredients, they argued, was what was also to them uniquely Pacific about many of the different Pacific services they attended.

#### ***Theme Five: Workforce Competencies***

To work effectively within the Pacific mental health sector involves a range of skills and knowledge. These skills and knowledge were described as competencies by many of those interviewed. Most of the discussion on competencies is divided according to whether they were cultural or clinical. This separation was reflective of the way in which the sector divided itself.

To be a culturally competent worker in the Pacific mental health workplace, participants argued, workers not only needed to have some understanding of Pacific cultural beliefs and values, but they needed to be able to transfer or utilise those values and beliefs within their professional practice, where appropriate.

Competency in one or more Pacific ethnic languages was highly recommended, as was competency in relevant bureaucratic processes and structures. Knowledge of the socio-economic and health status of Pacific peoples in New Zealand was also viewed as a necessary component to building workforce competency. Each of these skills or knowledge sets was

raised in the discussions on competencies. The focus of much of these discussions was on competencies in terms of working with non-English speaking Pacific consumers or families.

Pacific values and beliefs were often referred to by focus group participants as involving Pacific traditional cultural beliefs on the one hand and Pacific notions of Christianity on the other. A specific ideology of family was also privileged within both value systems. That is, within both traditional Pacific beliefs and within Pacific practices of Christianity, the family and the individual were often articulated as inseparable. Family values were understood to be core parts of Pacific cultural and religious beliefs. Within this paradigm culture and religion was therefore often articulated by participants as inextricably linked.

In terms of cultural competency service provider workers argued that this was something that could only be acquired through lived experience. They argued that it was not something that could be learnt. For example, the art of fishing, as explained by one Tongan participant, is best learnt by actual practice.<sup>6</sup> In most cases those who asserted this argument assumed an ethnic-based definition of culture. This was evident in the types of examples they provided to explain why this was so. The most common example related to learning appropriate cultural communication protocols and/or rapport building techniques.

One person raised the example that “you can not talk to an elderly man the same way you talk to a young man”. This person suggests that this is particularly so “in Pacific communities where [the] strong hierarchical status of chiefs and nobles exist”. Here, he argues, “there is a different set of language and behaviours that the mental health [worker] must be at least aware of. Knowing Pacific terms and names are critical. Knowing when to apply these and when not to is even more critical. Also knowing when to use humour and how is important”. Knowing how and when to implement these cultural protocols, strategies and/or skills requires knowledge of the culture that is better learnt, this participant argues, through actual engagement in real-life cultural settings than in a classroom.

Some participants however also recognised that the requirement for lived experience was fraught with difficulties. One difficulty was how to frame objective workforce competency standards in situations where there are different levels of lived experience. For many a compromise of sorts was inevitable. Training programmes were advocated for on the basis that community and/or cultural experts could assist in finding solutions.

This links to participant discussions on the value of *matua* and the role they play within New Zealand’s current mental health sector today. *Matua* is a term used to describe those persons employed as ‘cultural experts or advisors’ within various Pacific mental health services.

Many service provider participants endorsed the need to have *matua* institutionally recognised in the current Pacific mental health sector. The reasons they offered ranged from the value of *matua* as:

- “Cultural leaders” who hold the necessary traditional cultural knowledge that is fast becoming lost to the modern world;
- Because they are “steadying forces for youthful Pacific naiveté or arrogance”; and
- Because they have extensive networks and *mana* (status) within their respective Pacific communities.

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<sup>6</sup> This participant stated: “...Kapau e ai taha oku fangota eikai poto ha taha ia he fangota kae oua kuo tau o o fangota.” This was translated to mean: “...no one will know how to fish if you don’t go fishing”.

Some participants stated that having a *matua* attached to a Pacific service is like having an elder present within a Pacific family. It is believed that their presence brings *mana* (dignity, respect and status) and stability to the service.

For one consumer, having *matua* present in a service was one of the key reasons for her participation in the service. Furthermore, for one of the Pacific mental health workers, having their *matua* present helped to “lift her spirits”. Also, for a Pacific psychology student, having *matua* present at the different Pacific services she worked at allowed her the opportunity to better reflect on the “cultural side of her profession”. In each case the formal presence of *matua* within Pacific mental health services was for them a uniquely Pacific style to the delivery of that service.

On a slightly different tack, one service provider worker argued that the privileging of *matua* and/or *matai* (person of chiefly status) in some sectors of the Pacific mental health workforce is wrong. He contended that in New Zealand it is possible to “leave my *matai* here and do what I am supposed to do” in, what he called, a “professional manner”. What he suggests here is that there are situations in New Zealand where it may not be appropriate to adopt the more traditional system of rank and status when deciding on the appropriateness of certain approaches and positions such as the use of *matua*. The aim in Pacific mental health, he argues, is to “build Pacific unity”, where all, young and old, Samoan, Tongan, Niuean, Cook Island, and so on, work together. Ultimately, he contends, “the role of the *matai* is [therefore] in the home not the workplace”.

This is supported by an opinion leader who raised similar concerns. This opinion leader suggests that the concept of *matua* is important but fraught with potential problems if not kept in check. He raises the point that *matua* get asked questions that often require more than just ethno-cultural knowledge. He argues that without clear guidance the responses by *matua* can sometimes be “very skewed [and] unsafe”. In both cases, unquestioned adoptions of the uniquely Pacific institutions of *matua* and *matai* within the New Zealand workplace are cautioned against.

The assumption that culture is specifically ethnic was challenged by youth consumers (see discussion in the youth theme). According to some participants, working with Pacific youth consumers involved moving beyond ethnicity to include issues considered more relevant to youth cultures. Participants considered competency in a Pacific ethnic language as secondary when working with a predominantly New Zealand-born Pacific youth population, who were more fluent in English than in the Pacific languages of their parents or grandparents.

Cultural competencies when working with Pacific youth therefore centred more on understanding their youth contexts in New Zealand than on anything else. This is a point reinforced by one of the Pacific opinion leaders interviewed for this study, who advocated for the workforce to think carefully about how our practices and understandings of Pacific culture can sometimes exclude those who are key to its very survival in the future.

To conclude this theme the data suggests that there is a perception amongst participants that funders will only recognise those workers that are ‘qualified’. To be qualified is understood to be “having a tertiary recognised certificate, diploma or degree”. Many participants find that when working with Pacific mental health consumers this is not enough. Such qualifications may provide clinical competence, but it would not suffice in providing appropriate cultural competence. A qualified Pacific workforce is thus a workforce that is both culturally and clinically competent. To build Pacific workforce competencies all participants advocated that “the right people” need to be employed, particularly in supervisory or leadership roles. Effective partnerships between community, family, consumers and mental health agencies

would assist in building such a competent workforce. In making these partnerships work, many counselled that “we have to learn from our past”.

### *Theme Six: Philosophical Frameworks*

This theme attempts to synthesise participant discussions on the philosophical underpinnings of many of their cultural and service approaches and understandings. Samoan participants often referred to the *faaSamoa* as a cultural model or framework. This was similar to the way in which Niuean participants referred to their *aga motu* or *faka-Niue*, or to the way in which Tongan participants referred to their *faka-Tonga*.

Across all of these Pacific groups, notions of *tapu* (sacred bonds), ‘*ofa* (love and compassion), *tautua* (reciprocal service), *faaalolo* (respect and deference) and *aiga* (family) were highlighted, amongst others, as central cultural principles or institutions that informed their respective philosophical frameworks. These frameworks would in turn inform their service delivery models.

Moreover, the ‘Pacific’ self was understood as a relational being, and language was critical because it captured and maintained these understandings of ethnic identity, history, genealogy, place and relational concepts of time and space. It is within this philosophical framing of values and beliefs, practices and protocols that Pacific service delivery models needed to conceive.

Pacific understanding of ‘risk’ therefore presumes these relational conceptions of space, time, responsibility and *tapu*. A number of participants engaged in a discussion on the culture-bound assumptions inherent in the government’s focus on ‘risk’, ‘risk-taking’ and ‘risk-takers’. Participants argued that more deliberate explorations of this concept ‘risk’ within the philosophical frameworks of Pacific peoples was necessary before any substantive criticisms of it could be made.

As a final point in terms of this theme, the cultural maintenance tools such as the Samoan *fagogo* (story-telling practices, usually of legends and myths) were also described by some participants as one of the fundamental ways in which ethnic culture and tradition was passed from one generation to the next. Such tools embodied uniquely Pacific philosophical frameworks and reinforced uniquely Pacific interpretations of concepts such as the self, time, mental health and so forth. The demise of these cultural maintenance tools in Pacific migrant settings has led to a generation of Pacific peoples who no longer know of their traditions and knowledge. There were inferences by those that raised this demise to the possibility of reviving such traditional tools, especially for those contemporary workplace settings seeking to develop their traditional cultural competencies. This became another area that was promoted by some participants for further exploration.

### *Theme Seven: Spirituality*

Spirituality is a theme that is part of the philosophical framework noted above. It is raised as a separate theme, however, not only in order to emphasise its importance to the participants of this study but also to highlight its complexity within Pacific settings. Some of this has already been alluded to.

Spirituality is raised throughout service provider, consumer and family discussions in two ways. On the one hand it refers to traditional Pacific beliefs in ancient cosmology where the ‘spiritual’ is manifested in beliefs in the ethereal connections between peoples, their ancestors and their ancient Polynesian gods. It is within this understanding of spirituality that the “spiritual warfare” that occurs in the Samoan mental health condition of *fasia* (to be possessed by spirits)

sits. On the other hand, spirituality also refers to more contemporary Pacific beliefs in Christianity. Interestingly, participants discuss spirituality using both conceptions without any sense of contradiction. On closer analysis, at least in the Samoan setting, one finds, however, that Samoan participants tend to utilise the traditional cosmological understanding of spirituality when referring to the *faaSamoa* and its associated social principles and cultural institutions. Invoking a more Christian-based understanding of spirituality occurs when participants raise more specific discussions on the value of *lotu* (used variously to describe church, prayer-time or prayer) to Pacific culture and/or conceptions of cultural competencies.

For many service providers (both NGO and DHB-based), as well as for consumers and family participants, the continuation of spiritual elements such as *lotu* and *fasia* in contemporary Pacific life in New Zealand, recognises the prevalence of both the Polynesian cosmological and Christian-based conceptions of the spiritual in migrant settings. Thus, when participants raised the way that Pacific services acknowledge the spiritual side of mental health as something that is uniquely Pacific, often they assume both understandings of the spiritual. What is most unique about the invocation of the spiritual here is perhaps not so much the fact that it is raised at all but the fact that it is raised in such a way, that despite the conflicting philosophies inherent within the two concepts of the spiritual adopted by Pacific peoples here, both conceptions continue to co-exist and co-exists in seemingly unproblematic ways. This is what is perhaps most uniquely Pacific about the Pacific service provider's use of the spiritual in their practices of care.

#### *Theme Eight: "Going the Extra Mile"*

"Going the extra mile" was a phrase raised by a service provider. This provider argued that working with Pacific peoples often involved helping them with tasks that fall outside the service provider's contractual terms of reference. She states:

"It's like, okay, this is our parameters and that's it, and they [state bureaucracies] won't go outside of that. Whereas we would go with the family to WINZ if the father is unemployed or if the mother is unemployed; [or the family had to attend something we would] try to find a car that is more appropriate because they have a disabled child in the house; [or try to arrange a grant for them to get a suitable vehicle because] they are eligible to [have] state funding, because the child has a disability. So we'll **go the extra mile** to make sure that [the] family is [okay], as opposed to WINZ, [who] will say, we can't see you now you have to come in and make an appointment on Wednesday at this time [for example]. [But that's really inconvenient], [and] we may need to really alter our schedule so that we can be there to take them down [to WINZ], that kind of thing" (Pacific service manager).

This service manager finds that "going that extra mile" with consumers and/or their families often leads to them "getting their hands slapped" by their funders. The tension for these Pacific service providers is perceived to lie within the philosophical underpinnings of the Pacific model of care they adopt on the one hand, and the bureaucratic rationalities of funders on the other. She asserts:

"...like there is confidence in Pacific services being able to follow on the model, a Pacific model...[but] we often get slapped on the hand because of our [extra mile] initiatives, because it is very difficult to record that intangible support that you [give]. They [funders] say, well, how come your workers are so busy when they've only got four cases, four bullet points on the paper? So, how do you record that they had to wait for an hour for the whole family to get ready; to help the mother to get the kids off to school? Because it doesn't look as time consuming when you just put down "arrived at the house"; "helped mother get ready to go to WINZ"; "visited the school", you know. Those kinds of things. It doesn't show how much time it actually takes" (Pacific service manager).

Implicit within this discussion is the notion that the relationship between service providers and consumers is one negotiated on a premise of time that differs markedly to that promoted by New Zealand state bureaucracies. Participants suggest that in many respects, this desire to “go the extra mile”, (i.e. beyond the call of duty), can be traced back to Pacific social and moral emphases on the principles of *alofa* (love or compassion) and *tautua* (service), and on the codes of conduct or practice that understandings of these principles invoke.

In the words of one family member, “going the extra mile” might also be described as being “community minded” and “working from the heart” despite living in a capitalist world. Her comments offered below suggest that although “going the extra mile” is not always a good thing, it is what attracts her to Pacific services and what, in her opinion, makes a Pacific service uniquely Pacific. She states:

“As Pacific Island people we are still very community minded, we are not from the capitalist world. There is a danger of working too much from our heart, with our calculating financial cost and all that. We need to balance it. But I think they [Pacific mental health service providers] are very much...working from the heart in a way that people who were brought up under the capitalist system are not...and I think those are the things that make us, makes our [Pacific] service uniquely Pacific and makes it work well, because you can connect” (Pacific family member).

For some consumers, Pacific hospitality practices, together with the emphasis that many Pacific services place on creating a positive spirit of communal relations, especially in their group therapy sessions, presents for them a style of care that adds “value outside of the label forced on them”. The use of Pacific humour by these services, the recognition of the consumer’s spiritual beliefs and the valuing of consumers as persons first and foremost through the privileging of building interpersonal relations, were each factors that often came together in the delivery of Pacific mental health programmes by Pacific services in ways that were seen by these consumers to be uniquely Pacific. The value of “going the extra mile” was therefore for these consumers and for those family members who responded on this issue, immeasurable.

#### *Theme Nine: Building ‘Trust’ Relationships via the ‘Roundabout’ Approach*

The ‘roundabout’ approach noted here is perceived by many service providers to be one of the uniquely Pacific styles of their practices of care. It is, as described by one participant, a necessary part of the process of establishing trust and rapport between a service worker (in whatever role and whether Pacific or not) and the consumer and/or family.

This approach involves, upon first meeting, engaging in a general exploratory type discussion about anything of common interest. This discussion can continue for some time before getting to the purpose of the meeting. One participant suggests that “a worker can start the conversation by finding a point of reference like linking family histories or talk[ing] about Jonah Lomu’s try in the weekend”. “Going straight to the issue, is just not appropriate”, another participant asserts. This participant states:

“Pacific people often do not go straight and talk about the issue; we beat around the bush and then carve your way in. Often there is someone in the family that the mental health worker needs to talk to first because of family status, [this] shows respect” (Pacific opinion leader).

The need for this ‘roundabout’ or ‘beat around the bush’ approach occurs as a result of the valuing of relational principles such as the *va fealoaloa’i* in Samoan culture and its philosophical premises. Within such cultural principles it is high offence to enter the space of a person without acknowledging their *mana* (status) and/or their hospitality. In this frame going

straight to the issue, particularly to potentially sensitive, contentious or confrontational issues, can cause high offence and so demean the dignity of the consumer and/or his/her family. Taking a ‘roundabout’ approach to these issues is believed to help calm potential conflict. This is essential in the minds of the advocates of this approach because it allows for accommodation of a compromise or future negotiation if or when conflict does arise.

Effective employment of this approach therefore often requires, as suggested by one Pacific service manager below, having some intuitive skills. Such skills are gained as much by personal perception as by cultural experience or training.

“...when we go and see a family, we don’t, we can’t peel off their mental health part [and place] over here, or their culture [part and place over there], and deal with just the illness, you know. You’ve got to deal with the whole thing. So when you go in to see the family, you’ve got to go through the proper processes and protocols. Because to us establishing and making a connection with that family and establishing that relationship is the first thing you do. Because then you get onto the real [purpose], what you’re there to do, to get on with the assessment. Because sometimes if you come from a different model, you just straight away [say], ‘Are you hearing voices?’ [Or], ‘Is your TV conveying any messages to you?’ And this family says, “Whoa”! So you’ll be ‘talking to the hand’ pretty shortly or they just shut off and they just answer, ‘yes, yes, yes’, [just] to get you out and ask you to come back in on Friday and conveniently not be there. So again, it’s because we [Pacific] look at things differently [from mainstream]. When we go in – and sometimes we do joint assessments with clinics – that’s quite a conflict there too, because here we are trying to do it our way – which in the long run is the only way it’s going to work – I can see that they [the mainstream approach] get really nervous, fidgety about the whole [roundabout approach] thing. [They] perceive it as going off on a tangent, but it’s not, we’re trying to establish a relationship with the family and get all that out of the way, make it safe for everybody and then you get on to the subject, make it clear and make sure that everything is okay, lifting anything that might be a barrier. So it goes back to those models, I think if you are working from a different model, it’s not a Pacific service, you know, you can’t have a ‘ground’ service working from a *Palagi* model” (Pacific service provider manager).

Adopting the ‘roundabout’ approach is therefore perceived as a very critical tool to the provision of culturally appropriate Pacific services. This is a point that Pacific NGO and Pacific DHB-based mental health services strongly agree on. It is however an approach that is more specifically adopted when working with Pacific consumers of the older generation. That is, those who were born and raised in the islands and who subscribe to traditional Pacific beliefs in principles such as the *va fealoaloa i* (reciprocal relations of respect), its language and service protocols.

How this approach fares for the younger, New Zealand-born generation of consumers was not discussed. According to one Pacific opinion leader, because the model used by Pacific mental health service providers today is predominantly one based on the needs of the island-born adult Pacific consumer, its degree of relevance to the young New Zealand-born generation seems, on its face, minimal. This is an area, he asserts, that needs some critical examination by our Pacific communities.

#### ***Theme Ten: The “Pacific for Pacific by Pacific” Approach***

The term ‘Pacific’ has been invoked as a political category which predominantly includes the Samoan, Tongan, Cook Island, Niuean, Fijian, Tokelauan and Tuvaluan ethnic groups. When describing Pacific mental health services as such, or when invoking the slogan ‘Pacific for

Pacific by Pacific”, the common understanding is that this refers to the delivery of mental health services for Pacific peoples by Pacific peoples from these seven different ethnic groups.

This term/label ‘Pacific’ has not been without its problems. There is ample literature exploring the problems with this categorisation. In New Zealand however it has survived as a political category and is adopted by many Pacific and non-Pacific mental health service providers, Pacific consumers and their families (even in this report) when referring to Pacific specific services. According to participants, the use of the term ‘Pacific’ within the phrase “Pacific for Pacific” needs to be understood with these qualifications in mind.

The ‘Pacific for Pacific’ slogan mirrors the Māori slogan, ‘Māori for Māori’. Inherent in these slogans is the argument that the state is institutionally monocultural in its delivery of services and that this monoculturalism contributes to the disproportional representation of Māori and Pacific peoples within high risk health need areas. The political weight of these arguments led to the development of many ethnic specific NGO and DHB-based Māori and Pacific health services across New Zealand. On the ground, ‘Pacific for Pacific’, is manifested in the various approaches adopted by Pacific services, some of which have already been discussed.

All participants recognise that some understanding and accommodation of the Pacific perspective has been achieved or made by key people in relevant state hierarchies. All participants note however that there is still some way to go. Furthermore, they suggest, that some of the barriers to gaining real address of these tensions unfortunately lies not only within mainstream but also within Pacific. Many participants argued for the need for Pacific communities themselves to openly debate these issues if the ‘Pacific for Pacific’ campaign is to achieve its ideals.

Aside from the philosophical tensions raised above, participants noted that there were also very real, practical constraints on being able to fully implement the ‘Pacific for Pacific’ ideal. The main constraint is the fact that there simply are not the numbers of Pacific workers required to carry out an ethnic matching exercise for all Pacific consumers. Furthermore, one service provider noted that this constraint is complicated by the fact that not all Pacific consumers want to work with a Pacific worker. This point is substantiated by the comments of one of the consumers of this study who pointed out that whilst in many Pacific cases, especially with older Pacific consumers, ethnic matching is appropriate, in her case she preferred not to have a community worker of the same ethnicity as she was. This consumer reasoned that she decided to change groups from her ethnic group to another Pacific ethnic group because she related better to the community worker leading the other group. She states:

“I’m [of this Pacific ethnic group] and I have a community worker from another Pacific ethnic group. The reason why I chose [her] is because she could relate to me and I could relate to her. She was like a mother to me and [when] I get sick she knows how to handle me, you know. She understands how I feel, so that’s why I haven’t gone to a [ethnic worker of my ethnicity]. I feel it is not really the group itself but if she can work better than someone else then it makes sense to the worker. I mean, if you don’t feel comfortable with your support worker, you might as well go somewhere else where [you] most feel comfortable. That’s how I feel. That’s why I went to [another] ethnic group. I can feel more comfortable and more ease with them” (Consumer).

The complexity of this issue is further highlighted by the somewhat contradictory statement made by one Pacific NGO service provider manager who begins by noting a belief that it is possible for a non-Pacific person (with the ‘right’ cultural knowledge and competence, of course) to work with Pacific people, then ends by suggesting however that this is only really “until we have our own people trained up”. He states:

“I believe a *palangi* can also work if the person has the cultural knowledge, some understanding competence, in what he or she does and that …until such a time [as when] we have our own people trained up” (Pacific NGO service provider manager).

The positioning of the ‘Pacific for Pacific’ campaign has moved somewhat from the earlier days. The experiences of both Pacific NGO and Pacific DHB-based mental health services of the realities of working between two inherently opposing systems of care, has been personally taxing for many of the service provider workers of this study. Many continue to fly the ethnic-specific flag in the same political ways as their predecessors. There is however a general sense of shift within the narratives of participants towards the development of a more sophisticated argument for ethnic specificity, one that recognises, among other things, the invisibility of the needs of New Zealand-born Pacific youth consumers in the mental health Pacific matrix of care. This shift is suggested within the comments of one service worker noted below.

“My personal perspective is that Pacific services are at a flux. Because they are still growing and still shifting and shaking, [they are] in that period before it develops into something whole” (Pacific service provider).

#### *Theme Eleven: Youth Consumers*

Participants noted that the area of Pacific youth mental health is today a fundamental gap area in Pacific mental health. Some Pacific service providers are beginning to develop specific Pacific youth approaches; others have yet to follow. This was raised by participants as an area that needs urgent attention, particularly given government projections that the future Pacific population will be predominantly made up of New Zealand-born Pacific people.

The exclusion of youth in the delivery of Pacific models of care runs against the holistic framework of such models, according to one opinion leader. He states:

“Often we talk about how our models [are] holistic, so if we’re going to be holistic, do we open up the door slightly? Because our young people, their issues of wellness [that have come to me], their depression is really, really relevant. High up there, in these [youth] issues, of the problems that come to me, [are] the issues of identity, [they] are high up there. We have had three [youth with] suicide ideations last year. It’s very common amongst our young people, but we tend [not to include them]…[Because], I was just thinking that we’re primarily talking about the adult mental health. …So if we talk about that [holistic] model, adults and youth, [consumer] and family, [all] that needs to be included. I think we’re being exclusive” (Pacific opinion leader).

The privileging of Pacific island-born adult mental health issues was also evident to some youth consumers who participated in the study. They highlighted how the Pacific mental health services they had attended separated their therapy groups according to gender only. One youth consumer felt that:

“Sometimes being put with the older people will definitely drown us, you know, because we’ll be doing what the older people want” (Youth consumer).

This youth consumer advocated for the need to perhaps either separate these groups further by age or to involve an even mix of consumers, where the younger consumers can have others “their age” to mix with in group therapy.

### *Theme Twelve: Pacific NGO versus Pacific DHB-based Services*

Discussion on this theme is mainly drawn from an overall analysis of key issues arising from participant discussions around resourcing.

Participants from both the NGO and DHB sectors agree that there are advantages and disadvantages to both a Pacific specific mental health NGO service and an in-house Pacific specific DHB service. Most participants argue that together they provide the necessary range of service options available to meet the diverse needs of Pacific consumers and/or their families today. How consumers are made aware of these options and how services work together to help make these options work for Pacific consumers and families is key, some suggest, to maximising the value of Pacific specific services overall.

In NGO services some asserted that there were less bureaucratic levels to go through before funding of an activity can be approved. This increases the amount of spontaneous managerial decisions possible compared to state services. One NGO manager (who had also worked in the state sector) noted that there were the same requirements for managerial accountability and transparency as with DHB-based services, but that from her experience there is more autonomy for NGO managers to make the types of practical decisions that can arise quite suddenly within the delivery of day-to-day work. She provides the example of a recent situation where she was able to make a decision to close one of her residential services over a Christmas period after the Christmas plans of some consumers suddenly changed and they were no longer going to be staying at the residence over that period. She asserts that if she had been in a DHB-based organisation, it would have been significantly difficult to make that kind of decision.

The discussion on “going the extra mile” noted earlier, where a NGO service would often go beyond its defined work parameters to deliver extra services also speaks to this issue of NGO versus DHB-based autonomy. Amongst the NGO service managers who participated in the study, many claimed that being able to engage in such extra mile services was easier for NGO services than for DHB-based services. Often what was meant by easier was that there was not the same amount of bureaucratic justification processes involved for NGO services for adopting a particular cultural or professional approach or decision as compared with DHB-based services. The advantage here was not so much about the number of processes to be engaged in, but the ways in which these processes were carried out. That is, in many cases these processes involved situations where if a bureaucratic official was ignorant or doubting of the legitimacy of Pacific models of care then high offence to the integrity and dignity, the *mana*, of the Pacific manager, was usually caused. Participants noted that these situations were often soul destroying and so for many entering the NGO sector was easier and safer.

Other participants raised the point that much also depends on the skills and confidence of the Pacific manager. There are increasingly, they argue, within our Pacific services, even our DHB-based Pacific services, the development of a new breed of Pacific service managers who have been able to make, together with key non-Pacific officials in the state hierarchy, significant inroads into addressing some of the more ignorant practices of various decision-makers within the sector.

Whilst there might be greater autonomy amongst NGO services to provide tailor-made services to meet the specific and day-to-day needs of their consumers, NGO services acknowledge that they do not have the infrastructural and/or budgetary support of the bigger state institutions that are available to those Pacific services based within state organisations. This was seen as one of the advantages of working within the state sector.

For another NGO service provider manager, the issue of *appropriate* resourcing of Pacific specific services turns on the need to gain a “fundamental shift in thinking” about how funding should be allocated and how outputs/outcomes should be defined and measured. This is an issue however that is not peculiar to the NGO sector. It was also raised as an issue that similarly plagues DHB-based Pacific specific services, at least those who commented on this from Auckland.

From consumer narratives one gains a perception that consumers received a similar standard of care across the two types of services. That is, those consumers who attended a Pacific NGO-based service spoke just as highly of their service as did those who attended a Pacific DHB-based service. The focus of their discussion was on key service workers who within these services were able to provide them with the type of assistance they needed. Service workers are therefore key to successful consumer service outcomes.

In terms of current government emphasis on evidence-based practice Pacific service providers recognised the need for both types of services to better understand research and information gathering exercises. Pacific services from both sectors have sought expert assistance both from outside and from within the sector. The ability to do one or the other or both again depends on access to funds, on this front, Pacific DHB-based services fare better.

Furthermore, participants also noted that with the government introduction of specific funding schemes to help build Pacific health workforce capacity, Pacific services have become more and more aware of the benefits of research. The schemes discussed by these participants included new training grants for Pacific health workers across the board to both develop levels of skills and gain formal qualifications. Both sectors, the NGOs and their DHB-based colleagues, have taken up this assistance and speak highly of these opportunities. On top of this both sectors are beginning to engage more actively in research, either as funders or co-funders, or as advisors and/or participating research sites. Having to engage in building evidence-based services has meant for many Pacific NGOs and DHB-based services the need to encourage their staff to enrol in more tertiary-based training workshops or courses. The limited budgets of NGOs significantly reduce their ability to do this. In terms of personal development this can make the NGO health sector somewhat less attractive to the Pacific health worker.

Thus, whilst there were pros and cons raised for both types of institutional arrangements, it was clear to all who participated in this study that there still exists a need for both types at this point in time.

### **2.1.3 What helps Pacific mental health consumers “get well”?**

It is the views and perspectives of the consumer that mainly inform the report’s address of this question area. Where relevant however the perspectives of families and service providers were also drawn upon. To address of this key question area the report draws from seven thematic data sets. These themes were titled:

1. Medication;
2. Family Involvement;
3. Lifting the Spirit;
4. To be treated normally;
5. Holding a Job;
6. Building Communication, Rapport and Trust with Pacific Consumers; and
7. Having more interactions between Pacific services.

The findings are discussed in summary form first followed by more detailed discussions under each theme.

### ***Summary of Findings***

The report finds that “what helps Pacific mental health consumers ‘get well’” is (according to its participants) a range of things from medication through to ‘spirit lifting’ activities (such as engaging in Pacific group therapy, exercise, holding a ‘normal job’, looking after grandchildren’, etc). While some noted the benefits of medication, others cautioned against adopting a naive belief that doctors will always get the medication right. One consumer suggested the need for Pacific consumers to visit psychologists rather than psychiatrists if they wished to avoid the over prescription of medication and/or be ‘listened’ to in terms of the ‘spiritual warfare’ that occurred during the exchanges of ‘voices’ they experienced whilst ill or possessed.

Family involvement in consumer recovery is important to many of the consumers of this study in terms of “what makes them well”. One opinion leader suggests however that this is not necessarily the case for all Pacific consumers, especially youth consumers. Thus, service workers needed to examine the circumstances of each case separately to gain perspective on what would make that consumer well.

Pacific family caregivers often have multiple family caregiving responsibilities and some have found it difficult to juggle these. Asking for help is not easy for these family caregivers and usually only occurs in times of crisis. Family members recognised that drawing on extended family help was also not necessarily possible for practical and cultural reasons. Turning to the state therefore often occurs only as a last resort or through mandatory referral.

Communication pathways between services, hospitals, families and consumers need to be kept open at all times. Ensuring that there are culturally and clinically competent workers, who are able to follow up on tasks where necessary, is important to keeping these communication lines open and ultimately to assisting the Pacific consumer to get well.

Many of the Pacific consumers of this study noted that destigmatisation needs to begin at home with many of our Pacific families. How best to promote these messages within the Pacific family or home needs to be further explored, especially in terms of promoting ethnic specific Pacific terms and usages. To begin with, they argue, positive messages such as those promoted by the ‘Like Mind Like Mine’ campaign need to be adopted and promoted in Pacific sites such as the family and church using these ethnic specific Pacific language strategies. Moreover, even within the mental health workforce sector there exist certain stereotypes about consumer capability that can also unfairly discriminate if not monitored carefully, especially in terms of unfairly limiting the career opportunities of some suitably able consumers. Each of these discriminatory practices can contribute to creating barriers to getting consumers well.

Getting the right community support worker is for many Pacific consumers key to their successful recovery. They provide the people interface between stressed families and unwell consumers and unfeeling bureaucracies. For many consumers and families they enabled the holistic wheel of health and wellbeing to turn.

## **Findings by Specific Theme Areas**

### **Theme Thirteen: Medication**

User friendly type information on the side effects of medication needs to be better disseminated amongst family caregivers, according to a number of the consumers interviewed. The side effects of their medication also needed to be better explained to them as the direct consumers. Consumers felt this would help them to better understand why they sometimes feel like zombies or to understand why they feel like they are “going to die” whilst on medication. A snapshot of a brief discussion between two consumers highlights this point.

“CONS2: A little bit of emphasis on why we feel so zombie out when we take the medication; what the side effects are...

CONS1: Zombie, that’s right, it’s the medication...

CONS2: Sometimes [I] don’t understand why we are tired and the way we talk... [I say] inform us of the side effects; why we take drugs; especially when we are tired...

CONS1: It was only when they change me on the medication [I was on] for six years, when I was on haloperidol, it was the ‘hell-of-peridol’, [and] it was hell! I wanted to die all the time because I know inside myself, this is not me! A zombie, drugged, I can’t do a thing” (Consumers).

Another consumer raised that same point, stating that taking the wrong medication is like,

“You have a death wish all the time, because your life is not worth living, because you are drugged to the eyeballs” (Consumer).

It was not until yet another consumer finally got the courage to ask her doctor about her medication and described how she was feeling to him, that he then changed her medication. With the new medication she felt much better. So much so, she describes, that she has “never been back to hospital” and is even now “holding a part-time job”.

Notwithstanding the above criticisms, taking medication was also recognised by one of these consumers as essential to providing the necessary “chemical balance” required for the brain to operate well. She asserts that it is this “chemical balance” that helps to keep people mentally well.

A final point in this theme relates to the issue of what one consumer describes as the difference between “mental illness” and “spiritual warfare”. She argues that mental illness and spiritual warfare are two different things that doctors who do not understand Pacific spirituality find confusing. She defines mental illness as cases of verbal and physical (including sexual) abuse causing psychological damage. Spiritual warfare however is where “a spirit thing enters you and attacks you verbally”. “Pakeha” doctors, she contends, do not differentiate between mental illness and spiritual warfare and so are unable to recognise Pacific cases where a person has been possessed by the spirits of their ancestors. Because of this, these doctors just prescribe medication without hearing what Pacific consumers are telling them about the ‘voices’, she argues. To her, the Pacific service workers understand this spiritual warfare and so she finds that they would sit down to talk with her about these voices in ways that the *Pakeha* doctors do not. In her own words she tells:

“I told the doctors that I hear voices, they enter me and attack me in my mind. [But] they say, ‘Oh well, we will give you more medication’. I didn’t want the medication, I wanted them to sit and talk with me, and say: ‘What voices are you hearing? What are they saying? How can we help you? Can we help you?’ [But] no, what they say is: ‘We will give you

more medication'. But the Pacific Island, they would sit down with us and talk about our voices" (Consumer).

Utilising psychologists more than psychiatrists is suggested by one other consumer to perhaps be one possible solution for working through this confusion. This was suggested because this consumer felt that psychologists would listen more than psychiatrists because to him psychologists did not focus as much on medication, whereas psychiatrists did. This consumer states:

"We need more psychologists than psychiatrists. Psychiatrists they depend too much on the medication [but] it doesn't stop the voices, it only numbs us so we don't act on it. But it is still there. We need people who understand there is such a thing as *fasia* and all that" (Consumer).

If taking medication enabled chemical balance in the brain then taking the wrong medication would upset that balance. For many Pacific cultures there is an expectation that the doctors will get the medication right all the time. When there is no explicit and meaningful explanation that sometimes doctors can be wrong, combined with no recognition of the need to build interpersonal relations to help smooth over any 'wrong' diagnoses, the communication gap between consumer (and family) and psychiatrist widens. Better explanations of any potential side-effects from the medication needs to be developed, according to consumers, so that they and their families can better cope with the side-effects and/or know when, how and with whom to question the appropriateness of the medication.

#### ***Theme Fourteen: Family Involvement in Recovery***

All consumers who participated in the study agreed that family are "an important part of the healing process" (Consumer). These consumers find that family involvement in their recovery process is not only important for spiritual or moral support, but also to assist with more practical concerns such as providing transport or reminding them to take their medication. Having the trust and support of family members, particularly close family members is therefore very important to them.

Involving families in the recovery process is acknowledged by one consumer as fundamental because the history of the consumer can in most cases be found with those family members who have had the primary responsibility of caring for them. One consumer states that to "get down to the bottom of things" information on "the family, the family tree, the extended family, some of our experiences..." is important to understanding what recovery path would be best for consumers generally.

In terms of monitoring the consumer's medication intake one family member argued that this was not necessarily the responsibility of caregivers/family. This family member found that often providing care to mentally unwell family members was a responsibility that occurs simultaneously with the responsibilities of caring for one's own immediate family. This is very difficult when one has small children, she asserts. For this family member her responsibilities as primary caregiver for her mentally unwell brother and sister, as well as her responsibilities as a mother and wife, finds that many times she is understandably often under some considerable stress. Unfortunately, her experience of working with various mental health services, even Pacific ones, has not been positive. She raises this point in terms of the issue of monitoring the medication of her brother. It is in this context that she argues that it is not the duty of the family or caregiver to ensure that consumers take their medicine. Rather, she finds that this should be the task of the mental health worker (including nurses) who, in her mind, is paid "to work" with the consumer. Monitoring medication intake is, she assumes, part of that work. She states:

“I think I’m against with this, yeah, because I’m here as a caregiver for my brother and sister, who are affected, you know...because I am the one that’s looking after them, and the service for me is not very good. Because [my brother] is in the hospital now and I haven’t been told, I haven’t been contacted. They didn’t contact me. [...]The other thing is, that really gets me [mad], because they should have a nurse here to call in to check him with his medication and all that, but with all that, how can I, for me I’m not, I don’t think that [it is] for me as a caregiver, to keep reminding him, you know, the medication and all that. I can’t do that. I’m honestly; I don’t think I can do that. I’ve got my own family too to look after, but these people are there to work, you know, to do their work” (Family member).

The communication pathway between mental health services and this family member seem fraught with problems. This was something that was picked up on by others in her focus group. The need to work on these communication pathways or to find alternative assistance was acknowledged by this family member as “good advice” from her group. Although it did not alleviate her current frustration, she was encouraged by the support of the members of her group and noted that she would stay in touch with them.

The problem experienced by this family member is also reflected in the issue raised by some of the community support workers who participated in this study around the involvement of family in consumer recovery plans. One community support worker raised the issue that often the ideal of involving extended families is in practice, in New Zealand, impractical. What is often the case is that family caregivers have to take most, if not all, the responsibility for the consumer’s care. This support worker noted that because of Pacific pride some family caregivers are less likely to turn to extended family members for assistance and more likely to turn to the state. Another support worker argued that sometimes it is not even a case of pride, but more one of reality. That is, extended family members live busy lives, have other commitments and/or live far away from the consumer.

Coordinating and monitoring extended family help is in itself a huge ask on many already stretched family caregivers, who are often just managing to cope with the daily care of the consumer. Many family caregivers will continue to cope until a point of crisis. It is at this point that the state becomes involved. The state as a matter of policy does not take over the care responsibilities entirely but rather continues to seek family involvement in the consumer’s recovery. This policy is acknowledged by many of the participants of this study to be culturally appropriate in the Pacific context. The different experiences of Pacific consumers, family members and service workers noted in this study find however that the nature and appropriateness of that involvement differs from case to case. As was raised earlier by one of the Pacific opinion leaders interviewed in this study, the involvement of family can also be flatly refused by consumers.

The involvement of family, whether extended or more immediate therefore comes at a cost for many service providers. That is, the time involved in working with families is often not factored into employment contracts. How to factor the involvement of families into the Pacific model of service delivery becomes a point of contention when measured along narrowly defined, individualised, nuclear-family-based, models of care. Involving families in the consumer’s recovery programme requires building effective communication pathways between families, consumers and service providers. It also requires a deliberate review of the current models of care (both health belief focused models and service delivery focused models) alongside current service provider employment conditions, so that the ability of services to bend towards the different ‘on the ground’ needs of Pacific family caregivers and consumers can be more realistically explored.

### *Theme Fifteen: “Lifting the Spirit”*

The concept of ‘lifting the spirit’ relates to the belief raised by one service worker that if the spirit of a consumer is able to be kept high or positive, then getting that consumer well and keeping them well will eventually come. Working out what helps to lift their spirit is therefore important to working out what will help towards getting consumers well.

A reading of all participant responses finds that there are many different things that might contribute to ‘lifting the spirit’ of a consumer. These include, for example:

- The use of ‘prayers’ to open and close a therapy session;
- The use of ‘humour’ within group therapy;
- Group therapy itself;
- The particular hospitality approaches adopted by many Pacific services;
- The employment of ethnic specific support workers who are competent in their ethnic languages and/or in clinical matters; and
- The ability to find the ‘right’ service worker.

All contribute in different ways to ‘lifting the spirit’.

Here one family member describes how happy her mother is when she attends the group therapy sessions held at her Pacific service provider. Mainly, the daughter attributes this to the fact that the sessions are held in her mother’s native tongue, Samoan, and that tools such as the telling of *fagogo* (Samoan fables) works well for her mother because she can connect with the stories and it reminded her of home. According to this daughter, this approach by this Pacific service provider works very well. She tells:

“In my mind [the Pacific service provider] is an organisation that prioritises family and people. My mother is extremely happy at [the Pacific service provider]. In my observations this is why. My mother, within our own family, often she seems mentally unsettled, but since coming to [the Pacific service provider] she seems to have developed a better understanding of things, she seems happier. This is perhaps because of some of the programmes being run at [the Pacific service provider]. Also [the Pacific service provider] will have someone pick her up every Wednesdays and will take her out, i.e. give her a break from being at home by taking her for a drive, for example. There is also another programme run at [the Pacific service provider] on Thursdays that we come to. It is a programme for Samoans only. Within the programme we sing, we tell *fagogo* or Samoan fables and we have discussions about different topics where anyone can contribute. It is for each of these things that I fully support [the Pacific service provider]. And it is for these reasons that I think [this Pacific service provider] should be opened up to the wider community, its approach should be developed and given greater emphasis (in mental health policies)” (Family member).<sup>7</sup>

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<sup>7</sup> The Samoan verbatim of this quote is as follows: “O, X, o se faalapotopotoga faaea aiga, faaea tagata, i lo’u mafaufau, o le matua fiafia lava lo’u tina ia X. O itu nei e fiafia lava la’u tina: ona la matou mafuta i le matou aiga, e pei e iai a si ona foi ga le, pei e le fiafia tele lona mafaufau, a, ae pei o le ma oo mai i le X, pei ua tele lona malamalama, ua fiafia, aua e iai isi polokalame o le X, e iai le tagata e alu atu e piki ia i aso lulu uma, e pei la o isi idea lena o X e faatafao, pe o mai ave faatafao solo, faati’eti’e, e i ai foi isi polokalame X i aso tofi e matou te omai i ai, e na’o Samoa, e fai o matou pesesega, e fai o matou fagogo, e fai o matou faasoa, e fetufaa’i o matou mafaufauga, e faamatala mafaufauga o lea tagata ma lea tagata. E tusa o se itu lena ou te fiafia ai lava a’u ou te auai i totonus o X, ma ou te support (iga) X. O X o se faalapotopotoga ua tatau ona faalauaitele, ua tatau ona tele ma taua i le ... so’u a ia mafaufau i ai” (Family Member).

If group dynamics are well organised, group therapy can work very well for Pacific consumers. One consumer states that being part of a group can be good because “if people are interested in you, [they help] you to grow and help you get well”.

This theme also relates to the notion of finding meaning in life. One of the older consumers talked of how helping to look after her grandchildren and her nieces and nephews helped to give meaning to her life. She explains that it was not only the dignity she received from being trusted to take responsibility for someone else that helped her to get well, but also the healing she received from the care, affection and trust of her cousin and her niece. She reflects:

“My cousin, she really cares for me, said, ‘can you look after my daughter please, because I have to go to work. Can you take her to school and pick her up?’ But can you trust me, [I said]. ‘Of course’ [she said], I trust you, you looked after me when I was a child, of course I trust you. I know you’. So, anyway I looked after her daughter. [From there] I started to heal. I said [to niece], ‘X you’re healing my broken heart’. And, she said, ‘Aunty, you’re healing *my* broken heart when my daddy left me and my mummy’. So that was alright” (Consumer).

The final point to this theme relates to the issue raised by consumers that having something to do can also help to keep the person well. That is, getting unwell for a number of consumers occurs either as a result of taking the wrong medicine or as a result of being “bored sick”. A number of consumers stated that “a lot of us do nothing” either because they lack the requisite personal motivation to get up and do something for themselves, or they have become dependent on the staff or their family to do most things for them.

One consumer who lived on her own spoke about how the Pacific community support workers who helped her during the week were able to engage her in a routine so that she can motivate herself to get up and do some things for herself. These were simple things, such as making sure that she has a shower and gets dressed before the support workers arrive. Another consumer, whose comments are noted below, affirms the correlation between having something to do and gaining pride. She states:

“There are some [consumers] who just sit and do nothing, and there are some who are busy doing artwork or some playing...the ones who are doing nothing they should be encouraged [to do something], not left to do their own device. They [staff or family] should say, come on, come and do this, come and do the dishes, come...you know, encourage them, but not leave them to their own device, because they won’t grow. ...And, too, when they come in [the home or service], they are dirty, not showered. [You have to say], ‘look, we would like you to shower, you know, take care of yourself and take pride in yourself’. Because there is a lot of people who if you tell them, then they will make an effort, they say, ‘I must have a shower before I go, so I better get up early to have a shower, and that, you know’” (Consumer).

Being able to motivate oneself to do these things, this consumer notes, is not easy, particularly when one is used to having other people do these things for you. However, she encourages that “once [she] got into this routine, [she] was able to help [her]self and [now she] feels good”. Such feelings were expressed as part of what helps to lift the spirit.

Thinking about the value of lifting the spirit of the consumer can, according to these consumers and family members, be more useful as a therapy tool than medication. It can assist them to not only deal with the negative side-effects of the medication, but also with finding coping strategies to deal with the depression of the spirit that can occur with mental illness and/or spiritual warfare.

### *Theme Sixteen: To be treated normally, like everyone else...*

This theme highlights an issue raised by those consumers who spoke about the need to be treated normally. It is a theme that arose out of a discussion between consumers in a couple of focus groups who when talking about issues of stigmatisation and about the value of their different group therapy sessions, raised the point that for them “to be treated normally, like everyone else, like well people”, goes a long way towards making them well.

One consumer iterates that it is in the home that “[they also] need to be treated as well people”. This consumer finds that families and services play an important role in destigmatising mental illness. For him part of this destigmatisation process is to involve consumers (where appropriate) in daily chores instead of letting them laze around. He argues that those consumers that “make a mess” in a service should be made to “clean up their mess” because this instils in these consumers the need to respect other people’s property and the need to recognise the hospitality and goodwill shown to them by services. To not treat them in this way, he suggests, sends them the wrong message that they are different and so should be treated differently. In his words, he states,

“...like if that was a well person just sitting lazing around... [they would be expected to help out]...because in your own family you can’t do some of the things you [used] to do; you make a mess on the bench; they will say, ‘who made the mess, clean it up’, you know. Like, that’s being part of a family – you got to work in with the family. ...We need to bring that into the service, because if the family isn’t doing it, then the service do it; [so] they [consumers] become part of the normal society, instead of labeled as a mental illness [case]” (Consumer).

Furthermore, another consumer suggests that services should not assume that all consumers have a particular (usually low) intelligence level. He tells that his attempts to find a suitable course have been made somewhat difficult by the fact that the mental health service he attends seems to think that he should do ‘introductory’ or ‘bridging’ type courses only. This consumer states:

“...they [service providers] want me to look for my own courses and I thought this is a mental health service which will help me look for something, because they do have courses, but they mean bridging or introductory courses, you know. [But] what happens for the mentally unwell from the educated side of view [like me]...they want to put me in the basics [but] I come from a background of doing computer graphics and like [they don’t give me those] courses...I’m not getting the motivation from them, the services” (Consumer).

It is important therefore to note the caveat raised by some service workers, who often find that although it is important to encourage consumers to do things for themselves, service workers need to be careful about how they do this and about the assumptions they make about consumers generally. Each consumer and family member, they note, is different. Sometimes consumers want people to do things for them even though they are able to do it for themselves. Other times consumers are genuinely unable to engage in various tasks. They argue that this is the same for family involvement. The difficulty lies in determining levels of healthy and unhealthy dependency.

For many of the participants of this study, whether consumer, family member, or service worker, destigmatisation was acknowledged as something that needs to begin in the home. One family member noted that: “We need to teach our kids to love them rather than to be rude”. This family member argues that families should be the first site to practice the ‘Like Minds Like Mine’ destigmatisation message. In many cases for Samoan families like hers, she asserts, this involves reviewing the use of stimatising language. She notes for example, that her Samoan

parents, often say, about her son, “oh yeah, *e valea le tama e le’o sa’o le ulu*’ (the boy is stupid, his brain is not right) and all this sort of thing”. These kinds of comments, she argues, do not help her in her attempt to create a normal environment for her son. Thus, she is fully supportive of the need to deliberately review how to promote the destigmatisation message within our Pacific families, especially she argues, in terms of how to do this using the Samoan ethnic language.

Pacific service providers, particularly the Samoan service providers, had very in-depth discussions during their focus group sessions about the use of stigmatising terms within Samoan language descriptions of mental illness and of mentally unwell people. All those who contributed to this discussion supported the view of the family member above, that a more deliberate review of Pacific mental health ethnic language terms and usages needs to be conducted.

Overall, the ‘Like Minds Like Mine’ campaign has, according to the participants of this study, been very successful in helping to destigmatise mental illness within the wider community. Just how successful this has been within Pacific families themselves is, according to these participants, open to debate.

### *Theme Seventeen: Holding a Job*

This theme highlights the importance of holding a job for consumers in their recovery process. Finding meaningful employment provides consumers with a sense of normality and adds value to their lives in ways that group therapy sessions cannot, according to some of the consumers involved in this study. Group therapy sessions allow consumers the opportunity to reflect on their mental health issues and to be able to discuss these with others who experience similar things. Group therapy sessions also allow consumers to bond and find connections with other consumers and mental health personnel. These consumers argue however that these group therapy sessions are not sessions for normal people and so do not afford them the kind of normality that holding a normal job in society can do. There were a number of consumers who participated in this study who had some type of normal part-time job (i.e. a job that involved working with non-mental health consumers in paid employment). Only a few had full-time jobs. For one consumer, holding a part-time job and being able to look after her grandchildren have both been key factors in her recovery process. She states:

“I’ve got my part-time job and [I] look after my grandchildren and that’s what is making me well. The fact that I’m working, I’m earning a bit of my living and I look after my grandchildren. If I’m not busy I get depressed. But if I am busy, there is something I can do” (Consumer).

Using mental health consumers as “cheap labour” can also occur in the workplace according to another consumer. He argues that it demeans their value in ways that he finds “really disgusting”. This was agreed to by other consumers in his group. They argued that it is sometimes less discriminating to stay on the invalids benefit than to find a job.

For one family caregiver, holding a normal job was for her brother something that he enjoyed but could not keep. This inability to hold a normal job caused him (and her) a lot of stress. She tells:

“And the other thing with my problem, if there is any help from the community to keep him [her brother] in a job. Because he has been working and he’s only been to a job for a month and then they told him to go, if there is any help you know. I’m asking if there is any help to you know, [get him] a job. I think that’s the other thing that stress him, when he goes in the job he’s really interested in it, and then all of a sudden he’s out, because they look at

him and they just, and that's the other thing, if there's any, you know, when he goes in there to look for a job, because he's been in jobs and he's just been in there a month or two and then he rings me he's out of a job and what can I do?" (Family member).

What needs to be realised is that there are different degrees of mental illness or disability amongst mental health consumers, and in the same consumer at different times, and so broad assumptions about their employability (or levels of responsibility) need to be monitored carefully, according to some participants of the study. This is important so as not to unfairly exclude some consumers from gaining meaningful employment and the appropriate remuneration. Moreover, building career pathways are also possible for some consumers but once their consumer status is acknowledged these pathways are usually blocked by support workers who hold discriminatory assumptions. The consumers who raised this point were adamant that like family members, even support workers may need to check their assumptions.

#### *Theme Eighteen: Building Communication, Rapport and Trust with Pacific Consumers*

As already mentioned building rapport and trust with Pacific consumers and family members is key to working effectively with them. According to one consumer helping him with his needs requires getting to know him well, and to do that, he states, "you really need to get into the person to know the person well, to know what's going on". This, he suggests, requires mental health workers (whether doctors, nurses or community support workers) taking time to sit down and to listen to what consumers are saying, rather than just visiting, doing most of the talking themselves and then leaving. He argues that "getting to know the person well, is what helps make a person well, [but] a lot of these nurses just come and talk, you know, blah, blah, blah". Another consumer found the same thing with one of his service support workers. This put this consumer off. He states:

"...like I had this problem with my, you know, my person who comes and looks after me. He'll always talk about the same thing everyday, came with the same old thing, but he's not really, you know, you can tell a person by the way they talk, he doesn't provide the right information, the way, you know, he doesn't give something to look forward to. He's got to express [himself]. He'll just look up your file and just say, blah, blah, blah, but not really getting into the person" (Consumer).

Furthermore, other consumers noted that some acknowledgement by services, especially hospital services, "of where [they as consumers] are from and what [their] background is" would go some way to making them "feel like [they] are people with some dignity, rather than just a number".

Being able to communicate effectively with Pacific consumers and/or build good rapport with them requires, according to service workers, competency in certain key service areas. Language competency was top of the list. This pertained not just to competency in an ethnic language, but also in the languages of certain age or status or professional groups. Communication via appropriate language skills was therefore critical to gaining good rapport and building trust between consumers and/or their families. Each of these skills and attitudes are essential to helping consumers recover.

For many consumers the support of their community support workers is noted as invaluable. They spoke highly of the assistance received from many of these workers, acknowledging the "extra mile" tasks they undertake and the uniquely Pacific flavour of some of their care approaches. One consumer highlighted that the assistance of her community support worker is invaluable, especially during her clinical assessments. She finds that sometimes when she has to have a clinical assessment and she is unwell, she always asks to have her community support

worker present. This is because, she argues, her community support worker “understands me, and she helps me to stay focused”.

Within participant narratives, particularly from consumers and family members, there is some discontent and confusion over the manner in which a hospital discharge occurs. In the experience of one consumer, her discharge, she argues, was “very confusing”, “I did not understand what was happening, nobody told me; I was just told that I can leave”.

Another family member also found that communicating with hospitals can be extremely difficult. This family member notes that with the seemingly high turnover of hospital staff and with the rotating rosters of inpatient staff, finding a hospital staff member or doctor that can help her without her having to repeat her son’s history to them each time is difficult and so very frustrating. This same family member tells that it was not until she was able to find the Pacific service that she currently attends that her communications with the hospital improved. She asserts that without the help of a key worker in this Pacific service she would be having a much more difficult time with the mental health system, especially with the hospital, than she is now. The type of service this worker provides, she states, mostly involves following up the hospital staff and making sure that the communication lines are open between the hospital and herself, her mentally unwell son and her wider Samoan family. She finds that it is because this worker is relatively young, male and New Zealand-born that her son, who is also young and New Zealand-born, has taken to him and to his support in the positive ways in which he has. This worker also speaks Samoan and so he can also bring her parents (who speak little English) on board. This worker has also participated in wider family meetings. It is understandable therefore that this family member is full of praise for this worker and the uniquely Pacific service he provides them.

Making sure that the communication lines are open between service providers (including hospitals), consumers and families is critical to building effective rapport and trust between them. Taking the time to listen to consumers and providing appropriate discharge processes are each factors considered by participants as essential to gaining consumer trust and providing for their meaningful participation in the recovery process. Without this, participants argue, the path towards recovery will inevitably be fraught with difficulties.

#### *Theme Nineteen: Having more interaction between Pacific services*

Some consumers noted that it would “be nice” to have regular interactions with consumers from different Pacific service providers. They noted that there are often sporting, educational and/or cultural events across Auckland for example, where Pacific consumers from different service providers come together. This was, for many consumers, considered a natural Pacific extension of the group therapy approach. It was an approach that pulled on, according to some service workers, the concept of building a *so’otaga* (community connection and spirit) between peoples. It is a connection based on a culture (i.e. an ethnic and/or workplace culture) that values the need for these types of connections and the positive impact they can have on building consumer wellbeing. The value of these types of interactions is affirmed by consumers and family members as essential to finding and maintaining consumer wellbeing.

This type of inter-service interaction (particularly across DHB boundaries) is, according to one service worker, only possible if the delivery of services across these DHB boundaries are able to be read within their core service deliverables. Notwithstanding this constraint, it was generally cited amongst participants as one of the uniquely Pacific approaches to mental health care currently practiced by some Pacific services.

## **2.1.4 How have Pacific families supported family members with mental health problems to ‘get well’?**

There are only three key themes to this question area. These themes are titled:

1. Family Experiences and Perspectives;
2. The Persistence of Pacific Gerontocracies; and
3. Building Competencies and Promoting Destigmatisation through Appropriate Training.

The first theme area mainly reflects views and perspectives of those family caregivers that participated in this study. The latter two theme areas noted above also involve the perspectives of consumers and service providers.

The findings for this question area are discussed in summary form first followed by more detailed discussions under each theme.

### ***Summary of Findings***

According to the participants who responded to this question area, Pacific family members adopt a range of support mechanisms to assist mentally unwell family members to ‘get well’. These ranged from gaining access to key community support workers for their family member; utilising respite care to help themselves ‘stay well’; assisting in the administration of appropriate medication where necessary; engaging and/or transporting their family member to appropriate treatment processes and/or community (or church) support networks; and/or generally helping to keep their family member’s ‘spirit lifted’.

Most family caregivers who participated in the study, whose mentally unwell family member was of the ‘older’ generation (e.g. their mother or aunt), found that the traditional ethnic-specific approach of many Pacific mental health services well suited the needs of their older family members. For younger consumers the ability to find a service and/or service worker who can relate to the consumer at his/her ‘youth’ level was deemed important to the mother of one youth consumer.

Extended family assistance is relatively uncommon and is often more inconvenient for primary family caregivers to organise than it is for them to seek state assistance. For some family members gaining state assistance can assist them to help their mentally unwell family member get well.

Not knowing how to access support mechanisms such as appropriate community support workers, respite care, appropriate medication, treatment processes, and community and/or church support was raised as a common barrier for Pacific consumers and family to receiving these services. It is acknowledged that access to these support mechanisms by Pacific peoples has improved but that more can be done to disseminate information on the availability of these support mechanisms and what they involve as their potential to assist Pacific families in coping with having a mentally unwell family member is huge.

Pacific service models based on traditional gerontocratic hierarchies need to be mindful of changing New Zealand Pacific demographies and the implications of these changes on service needs. The same needs to be kept in the minds of those building appropriate Pacific mental health workforce or consumer and family oriented training programmes. The ultimate goal of such concerns is the ability of these models and/or programmes to meet the various medical and/or culturally-based recovery needs of consumers in ways that allows them to retain their dignity as people.

## ***Findings by Theme Areas***

### ***Theme Twenty: Family Experiences and Perspectives***

There were a range of types of family member(s) with mental health issues that the family caregivers who participated in this study were involved in providing care for. There were a number of family caregivers who were responsible for the care of their mother; a child; a wife; a brother and sister; and even for a cousin-in-law. Each of these family caregivers raised insights into their experiences and perspectives on what has supported their mentally unwell family member to get well.

One family caregiver states that for her mother, attendance at the Pacific service provider she is currently with has been extremely beneficial in terms of helping her to get well. This caregiver finds that the family-like approach adopted by the service has helped both her mother and herself to feel comfortable with her mother's mental illness issues. This family caregiver and her mother are now less conscious of the stigma attached to the illness. The main ingredient for her mother's positive wellbeing, according to this family member, has been the fact that the service is provided in her mother's native tongue. The caregiver explains that although her mother can speak English, she has found that the older her mother gets, the more her mother seems to prefer speaking her native tongue and the more traditional she seems to be in her approach to life. For this caregiver the Pacific service her mother attends adopts the traditional approach preferred by her mother, part of which requires the use of her ethnic language. In the words of the caregiver she states:

“[The Pacific service provider] helps me to understand my mother’s wellness [issues]. The family’s support comes first....[The Pacific service provider] helps me and my mother in our daily lives. My mother does not want anyone else to know about her illness because people might discriminate her. My mother now is coming around and it is a big step to her when she was unwell. It is a big step for her to come to the community. She is no longer scared to come to [the Pacific service provider] to enjoy with her new friends. I have noticed a big improvement with her coming to [the Pacific service provider]. It is not like when we did not have outside support and it’s like just her and me and support from the family. It is a big difference for her now. It is the stepping stone and for her, it’s like she is coming to her own family, who speaks the same language...and she knows it is her people. Participating in [the Pacific service provider’s] activities and [in] compar[ing them] to other people, I have found [the Pacific service provider] not only very supportive but is very vital to Mum’s wellbeing, mental health, spiritually, physically, everything” (Family caregiver).

The importance of finding ways for families to deal with the shame of having a mentally unwell family member is necessary but understandably difficult. Another family member noted that to some degree the stigma attached to older Pacific people with mental illness seems less than that imposed on younger Pacific mental health consumers. This family member advocates for the need to “broaden the education” so that those feelings of shame can be overcome and positive support can be generated instead. She states:

“[The] thing [is] not to feel shame..., because everybody do get sick or have an illness at some stage of their lives, especially our elderly people, the old ones. We need to broaden the education. Some they feel shame and never share their feeling” (Family member).

The on the ground work involved in building positive support networks is often managed by community support workers. The work of community support workers in this area is openly praised by many of the family caregiver members in this study. One family member tells of how if it were not for her mother's community support worker, her mother would not have been as reasonable about her treatment as she is now. Again, this family caregiver notes that it is the

fact that her mother's community support worker was of her mother's age group and able to speak her mother's native tongue that the support worker was able to build good rapport with her mother. This family member tells:

"I notice my mother is very scared to go to hospital. [But when her community support worker] would [then] call around and talk to my mum and I think my mother got her strength from her community support worker. Then afterwards she would go to the hospital for help with her sickness and also medication. My mother was in hospital for more than four months. I found the community support worker's [also] help and support [her] with [her] doctor's appointment and meetings. I always call the community support worker to come and support me. It was very hard for me to make the decision for my mum [to go to hospital], but you know, the community support worker, as well as my sister, that made it [the decision] bearable. The community support worker was a support because she was older; she got an understanding of a *matua*, [because] she is my mother's age" (Family member).

As well as the benefits of language, the importance of familiar surroundings for older consumers, including having traditional food stuffs from their diets 'back home', is recognised by all participants. Family caregivers noted that the approach of many Pacific services and service workers to working with their older unwell family members is to provide them with those familiar surroundings and foods. One family member recalls his mother's delight when one of her community support workers visited her in hospital with a "piece of taro". Such familiar practices and surroundings help to lift the spirit of the consumer, which in turn is believed to help them to get well. Taking their family member to these services is one of the contributions that family members make to help their unwell person get well.

A key point of frustration for many family caregivers in terms of being able to provide good care for their mentally unwell family members, is the difficulties they experience with the follow-up processes adopted by some services, particularly hospitals. One family member asserts that the "work ethics" of one mainstream service "sucks" because the service failed to "follow up for months on end". This family member asserts:

"I didn't like X [mainstream service] and their work ethics, ummm I think when my mum just put on medication, my mum didn't have follow up for months on end. We have to go chasing the psych nurse or who her doctor to follow up and that sucks big time. I mean it was almost like dishing out...It's almost we have to ask all the time of the doctor to follow up mum" (Family member).

Another family member noted that better publicly available user friendly information on the "signs and symptoms" of mental illnesses would go a long way towards gaining better detection of mental illness and developing coping strategies for family, rather than finding out when it is actually happening or after the fact. This family member argues:

"Signs and symptoms, whether they've got the symptoms, we didn't realize that X was ill for a year, we didn't know what it was...we just thought it was just a typical teenager, lazy, sitting there watching TV or partying teenager, you know, all that. We didn't realize until we came back to NZ, we didn't realize that he was. ...If we had detected it earlier, we could've been able to deal with it...we didn't know anything then until the incident happen" (Family member).

A number of family caregivers in two focus groups were also surprised by the fact that support services exist, such as various respite care options, for families who have primary care responsibilities for mentally unwell family members. The availability of these types of services should be better advertised, they argued. Mainly for reasons of fear of cultural shame it is not

easy for Pacific families to utilise these kinds of services, according to one family member. They felt though that families do still need to be made aware that this type of help is available.

As well as asking for help, once help is received, continually asking for clarification of that help is often difficult for many Pacific families. One family member asserts that families have to speak up and say when they do not agree with something. This, she argues, is their right as a family member. She contends:

“Also the family needs to understand the values of the client and the policies that have been set up. To me, if that was my child, I won’t say yes to treatment if I don’t understand. I would say no, you can not treat him/her without my consent. We all understand the importance of that. Because professional people they need consent, but they say they only need the consent of the patient. But to me, if I don’t agree with the medication being prescribed for my child or family member under my care, just stop it, you have the right to ask why” (Family member).

The final key point for this theme is raised by a couple of family members in this study and relates to the issue of utilising traditional healing practices. One family member used both the traditional healing practices and the conventional western medical practices to address the mental health problems of his wife. In the end, he went with the western medicine as it seemed to calm her more. The other family member noted that his family was given the choice by the psychiatrist of whether to access traditional methods of *fofo* for the mental illness of their family member or to have her take the medication he prescribed. Like the family member first, this family also opted to first take their mother to a *fofo* and like the first case also found that that did not really work. Despite this however the second family decided against putting their mother on medication. Instead, they opted to keep their mother at home and to keep her engaged in activities to help distract her from her depression. Church and family support has worked well for this second family, according to their family representative in the study. Both these cases show continuing support for traditional healing methods and varied support for the value of medication towards helping their family members to get well.

In each of the above cases family caregivers note the importance of having a range of support mechanisms available to them to assist them in helping their family members to get well.

### ***Theme Twenty-One: The Persistence of Pacific Gerontocracies***

Throughout participant narratives is a persistent theme about the continued importance of traditional Pacific gerontocracies in New Zealand’s Pacific settings. Part of what makes the Pacific approach uniquely Pacific, some participants argue (mainly the older participants), is the way in which Pacific cultures continue to privilege *tagata matutua* (the elderly) within modern Pacific family settings in New Zealand.

One service worker noted that it is this continued respect for the elderly that makes Pacific peoples unique. He finds that, “having old people around and having kids running around them”, is something that is characteristic of the Pacific family. It is this image of the Pacific family as a communal entity governed by the wisdom of elders that underscores the ideal, if not the reality, of what is often referred to by the older participants of this study as a uniquely Pacific stance on service delivery. This is an ideal that assumes a particular frame of reference. It is a frame of reference that often, perhaps inadvertently, excludes the involvement or experiences of youth, particularly New Zealand-born youth consumers, from being included in definitions of what may help them to get well. A number of participants saw the need to review such frames of reference for their ability to address the realities of the contemporary New Zealand Pacific context.

## *Theme Twenty-Two: Building Competency and Promoting Destigmatisation through Appropriate Training*

This final theme is somewhat broad theme and encompasses a wide range of promotion issues. These ranged from issues of providing specific workforce and family training to issues of providing more culturally nuanced mental health training programmes and/or public campaigns.

Service provider participants advocated for the need to train and/or educate workers (whether a clinical or a cultural worker<sup>8</sup>) on both clinical and cultural matters. They argued that to have a clinically and culturally competent Pacific mental health workforce, that is able to “keep up with the changing times”, Pacific service provider staff, whether NGO or DHB-based, need to have ongoing access to appropriate training. These service providers argued that having this level of clinical and cultural competency would enable staff who have some knowledge and skills to not only work with consumers but also to be able to work with family and wider Pacific community groups.

One participant argued that all clinicians should be educated in what she describes as “*Pasifika*”. She explains that, “there is a compulsory training for Māori models but not for *Pasifika*”, however, there are a lot of requests for training in *Pasifika* models. Ninety percent of doctors who work with Pacific consumers and families, she argues, are from overseas and none of them (in her opinion) have the requisite knowledge or skills to be able to work effectively with Pacific consumers and families. She suggests that the type of training required would include what she describes as “the basic things” such as “family structures” and “differences with mainstream”.

When discussing the Pacific cultural context of post-natal depression, one opinion leader raised the point that this is an area that is often misread or misunderstood by mainstream assessors. She recalls being engaged in a study a number of years ago where she asked questions to Pacific mothers like “when you’re feeling a bit blue after you have your baby do you ever feel like killing yourself?” She recalls that her Pacific mothers laughed and found the question quite “stupid”. Their responses, she tells, was quite telling of the way in which Pacific peoples thought about these things. They responded to her by asking, “Why would we want to kill ourselves for, we’d rather kill our husbands!”.

This “Pacific way” of approaching post-natal depression was also alluded to by another participant, a service worker, who noted that cultural training packages had to pick up on the cultural context in which Pacific responses to post-natal issues, among other things, derive. This participant raised the importance of incorporating humour to address the somewhat sensitive link between the stress of a new mother and the cultural expectations placed on her to continue the conjugal duties often expected of her by her Pacific (island-born) husband. This service worker notes that for newly migrated Pacific mothers living in New Zealand, sometimes it is difficult because of cultural stigmas to talk about these types of stresses. It is important therefore for service workers to know how to address these types of issues in ways that would not offend these Pacific women. Pacific peoples often use humour to address these sensitive issues, she argues. For example, in Niuean, this participant suggests, you can say, “*hu e tau aitu*

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<sup>8</sup> The distinction between a ‘cultural worker’ and a ‘community support worker’ and a ‘clinician’ is somewhat ambiguous and seems dependent on what service setting the title is being used. In the general Auckland region for example, cultural workers are distinguished from clinical workers in WDHB, whilst cultural workers are described as ‘community support workers’ in ADHB. Both DHBs here, however, utilise *matua* and see this role as quite separate to the role of cultural workers and/or community support workers.

*he taane* [loosely translated as ‘the husband gets/will get mad’]” which in its cultural context helps to diffuse the awkwardness of addressing these types of sensitive issues.

Use of these types of ‘cultural’ techniques or approaches requires training in the cultural nuances of Pacific peoples. This is something that is very difficult to pass on in a classroom-based training session, and even more so if the training is not conducted in the ethnic culture’s language of origin. Nevertheless, many of the service workers and opinion leaders interviewed in this study argued that there is the need to build training packages that can alert students to the importance of understanding these cultural contexts when working with Pacific consumers and families.

Such mental health training packages, asserts one family member, are needed not just for service workers but also for families. This family member felt that the training workshops that she had attended were helpful for her in the delivery of her care for her mentally unwell son. She argues that these types of family training programmes should be more widely promoted. In discussing these training packages and/or programmes one participant, who is a student in a tertiary mental health programme, asked whether consumers themselves could also receive training in terms of their mental health issues. This, she argued, might assist consumers “to better explain to their families (especially) what they have” (in terms of their mental illness). Of interest is that her suggestion was challenged by another participant in the group as suggesting that all consumers were intellectually inept however this suggestion for further exploration of whether this would be appropriate was taken on board by the rest of her group.

Furthermore, training on Pacific specific approaches was considered by participants to be something that needs to be provided for all persons, regardless of ethnicity, who might work with Pacific consumers and families. To be able to speak to this potentially wide audience, they argue, training packages need to be pitched at different levels. This raised the point that educators or trainers of such programmes would therefore need to be people who can “walk the talk”. For some Pacific service managers the desire to have all people appropriately culturally trained is something that is the ideal and something that they continue to work towards. In practice however many of these managers argue that the ethnic specific approach often provides the better employment option in today’s limited workforce context. What general cultural training programmes offer for mental health is an ongoing and long-term strategy, but what affirmative action type policies offer, for these managers at least, is both the opportunity to develop the Pacific workforce in this area and the provision of an effective solution to dealing with the need to have culturally competent workers now. Participants argued for the need to look closer into the issues raised here.

## **2.2 Overseas Indigenous and Ethnic Minority Models of Health and/or Service Delivery**

The second part of the key findings of this report involves an analysis of overseas literature and of information gathered through personal correspondences with key indigenous or ethnic minority mental health practitioners both within New Zealand and more notably overseas.

The aim of this part of the report is to explore the ‘indigenous’ aspects of overseas indigenous and/or ethnic minority mental health and/or service delivery models.

This part of the report is therefore divided into two main sections. The first section provides a brief focused literature review highlighting key aspects of New Zealand Māori and overseas indigenous health and/or service delivery models. The second section examines information received through email correspondences from overseas and local indigenous and/or ethnic minority mental health practitioners. These ‘indigenous’ and ‘overseas’ findings, together with

the qualitative Pacific findings of the first section of this part of the report, are then discussed in the third part of the report.

### **2.2.1 Focused Literature Review on Indigenous and/or Ethnic Minority Models of Service Delivery**

The focused literature review drew on a range of publications, from academic texts to public policy documents and service pamphlets. The discussion here is divided into ‘models’ found to exist within different countries. The list of ‘models’ and/or publications cited below is by no means exhaustive. Rather they signal the level of discussion currently available in these different countries on ‘indigenous’ and ‘ethnic minority’ mental health service delivery models, and how these ‘models’ and/or discussions might reflect the type of issues raised by Pacific service providers, family members and consumers earlier about what for them makes for a ‘uniquely Pacific style of health care and service delivery’.

The review begins with the UK then moves to the USA and Canada, followed by Australia. It then ends in New Zealand with an analysis of some indigenous Māori models.

#### ***‘British-based’ Models***

Bhui and Sashidharan (2003) note that many British minority ethnic groups, such as the African-Caribbean ethnic group utilise holistic models of health care that emphasise the importance of interpersonal relationships between patients, family and mental health services. Bhugra et al (1999: 36) further finds that although the ‘holistic’ models of first generation and/or recent ethnic minority migrants in Britain might not be as vigorously adopted by later generations, they nonetheless continue to exist within many of these migrant ethnic minority groups today.

The types of non-western health belief models found in Britain, as noted by Bhugra et al (1999: 36), include: “*supernatural models*” or models based on “spirit intrusion, spiritual possession or soul loss”; “*religious models*” or models based on “moral integrity and ethical conduct”; and “*naturalistic models*” or models based on “principles of balance, such as the ‘yin/yang’ model”. Each of these models presents a world view, commonly referred to as the non-western world view, which configures the relationship between mind, body and soul as one that is either enmeshed or inextricably linked. As Bhugra et al (1999) suggests above, the degree to which second and third African-Caribbean populations might subscribe to these models depends on their level of attachment to the traditional cultural ideologies and/or world view of their ancient forebears from which these non-western models stem.

Given the intergenerational differences within ethnic minority migrant populations, Gluckman (1999: 177) argues that it is important that such population groups “are not forced to use only specialised ‘Black services’”. He contends that it may well “be appropriate for some [Black] people, on occasion, to be in the care of those [specialised] services, but this does not mean that they will never need to make use of generic statutory services” (*ibid*). In other words, Gluckman cautions against the view that culturally ‘specialised’ services will be able to deal with all the needs of ethnic minority populations. Although he does not actually state the view offered by Pacific participants in this study regarding the need for consumers to have the ability to choose the type of service that best suits them, this point can be implicitly read.

Some studies have argued that ethnic minorities in Britain, especially Black African-Caribbean peoples, are more likely than White Britons to be admitted to a mental hospital compulsorily (NIMHE, 2003). Others have argued that this finding is not accurate in that it does not adequately account for the number of ethnic minorities who use hospitals rather than primary

care services as their first port of call to deal with mental health problems (see Bhugra et al, 1999; King et al, 1994). Either way, like Pacific peoples in New Zealand, British ethnic minority admission numbers into hospitals is considerably disproportional compared to Whites and so is thus of relatively similar concern.

Following twelve consultations with Black and African-Caribbean, South Asian, Chinese and Irish communities (between December 2002 and March 2003) and with the evidence laid out in a variety of documents (NIMHE, 2003; Patel, 2003; NIMHE, 2001) a number of disturbing experiences have been identified for Black and minority ethnic communities. Poorer access to services, cultural and language barriers in assessments, over-representation in hospital admissions and higher readmission rates were identified as an example of this. In 2002 the Sainsbury Centre for Mental Health released a document, *Breaking the Circles of Fear*, describing how Black African and Caribbean communities were particularly distrustful that mainstream mental health services could provide them with positive help. This was perceived as the main cause for their delay in making contact and often contributed to the disproportional emergence of crisis situations where more coercive interventions were usually needed.

To examine these ethnic minority issues closer, the National Institute for Mental Health in England (NIMHE), a centrally funded body responsible for supporting local communities to improve mental health and the quality of mental health services for mental health consumers, was established. Through NIMHE the British government developed a programme for public service reform. In the National Health Service (NHS) plan the Secretary of State for Health had outlined four principles or ‘compass points’ to guide the implementation of the plan. These were:

- Services are provided equally to those who need it, free at the point of need;
- Offering to the public a personal service which is truly patient-centred;
- Providing equity of access to care and a fair system; and
- Achieving sufficient increases in capacity to enable choice and diversity to be offered to patients.

Also, under the Race Relations (Amendment) Act 2000 there is a statutory duty to promote race equality and good community relations. This duty underlines both the NIMHE Race Equality Scheme and its recent work (2003) improving mental health services for Black and Ethnic communities in England. In fact the Black and Minority Ethnic (BME) Mental Health workstream is the largest of the current NIMHE programmes emphasising the priority status it has been given.

The stated aims of the NIMHE BME programme are to:

- Enhance quality of life and challenge exclusion through improved mental health services and health outcomes;
- Develop appropriate training and support to staff to deliver culturally competent services with confidence;
- Enhance, or build capacity within black and minority communities and the voluntary sector to deal with mental health and mental ill health; and
- To ensure compliance with statutory obligations; the Race Relations (Amendment) Act 2000 and the Human Rights Act 1998.

The final draft of the document *Delivering Race Equality: A Framework for Action* (DH, 2003) focuses on adults of working age and is available for consultation. This consultation includes communities, service planners, commissioners and providers, and other key stakeholders. The Framework is intended to improve both primary and secondary mental health care for British

minority groups over the next decade. The need for such a framework is based on evidence that these minority groups do not have equitable access to services. The aim of the Framework is to enhance the involvement of mental health consumers and their community. It is also to develop a diverse workforce where the skills and capabilities of all people are maximised thereby increasing the ability of services to offer choices to service consumers and their carers. The Framework has three main objectives which are to improve the use of information related to ethnicity, to work with providers to become more sensitive to the different ethnic needs in their community and to develop a programme for community engagement. These three inter-related and complementary ‘building blocks’ are seen as essential to improving outcomes for Black and other minority groups.

A specific area of concern is the pathways to care for Black and minority communities. As already stated a variety of documents highlight:

- The increased risk of aversive pathways of care;
- Longer time to accessing GP care;
- Lower identification of mental health problems by GPs; and
- Less GP involvement in care.

Black and minority ethnic groups also have:

- Higher risk of involvement with the legal system;
- Increased risk of hospital admissions;
- Increased risk of compulsory admissions;
- Lower access to talking therapies; and
- Higher police involvement with compulsory admission if a GP is not involved in care.

Implementation of the building blocks should achieve better progress in this area.

The British government’s move towards building better quality and more appropriately used information in mental health includes a planned national census; qualitative studies (led by the Mental Health Act Commission) on all Black and minority individuals in inpatient facilities, on pathways to care and suicide prevention, on appropriate and responsive services, and on developing education and training to support culturally competent services.

These recent British developments provide useful sites for making comparative analyses between the operation of New Zealand and British ethnic minority targeted services. Many of the issues raised by the Pacific participants of the qualitative study noted earlier about ‘competencies’ and the ‘holistic’ Pacific relational model of care are echoed in the NIMHE’s discussion of the British ethnic minority mental health sector’s ability to develop “culturally capable services” (NIMHE, 2003: 22). Such services are understood to be those that are able to deal not merely with the cultural issues of these ethnic minority groups but more importantly with “the overall quality” of mental health “assessment, care, support and treatment” of ethnic minority peoples in Britain (*ibid*).

The WHO guidelines of what constitutes a “good primary health care service” was raised by La Grenade (1999: 188) to be just as applicable in the context of determining what constitutes “good mental health” services for ethnic minorities. La Grenade (*ibid*) cites these guidelines as coming under four key principles, those of ‘availability’, ‘accessibility’, ‘adaptability’ and ‘acceptability’. In other words a ‘good’ mental health service is a service that is both available and accessible to ethnic minority consumers or patients who have financial or cultural barriers, and is also a service that is both adaptable to the changing and/or different needs and

circumstances of these consumers or patients and so acceptable of their different cultural and/or intergenerational perspectives.

La Grenade (1999: 189) argues that services catering for Black peoples in Britain should take note to be:

- “Colour-sensitive” rather than “colour-blind”;
- Have an emphasis on community care and collaboration rather than on population control and containment; and
- Recognise that there exists “an inherent mistrust of the formal mental health care system” amongst British Black communities.

In terms of community mental health-based care in Britain, almost two decades ago the ‘dominant theme’ as suggested by Julie Leibrich (1988) was that “there was no ideal model” (*ibid*: 39). Today with the NIMHE (2003) focusing on developing culturally capable services with competent staff and community collaborations, such a model might well be emerging, at least for British ethnic minority populations. To cater for the slow development of such competency models, Bhui and Sashidharan (2003) note that in some psychiatric wards ethnic segregation has become necessary to help alleviate some of the difficulties associated with having language and cultural barriers. Although psychiatric wards do not exist in New Zealand in the same way, the same may be said of the need to have specifically Pacific ethnic services.

Community engagement through capacity building and developing community responses and solutions to identified gaps and weaknesses in services are the focus of the eighty Community Engagement projects to be funded for 2004-2006 by NIMHE. Pilots are currently being identified in each NIMHE Development Centre Area. As part of these community engagement projects, community development workers have been appointed. These are new appointments and are intended to take on various roles in response to the particular or identified needs of their local communities. This is believed to be able to provide a more ‘bottom-up’ approach to ethnic minority community engagement, and so act as a bridge between the Black and ethnic minority mental health user’s community and the services in the area they live. The Frantz Fanon Antenna Centre in Birmingham and the Centre in Haringey are examples of services that provide care mainly for Blacks and Ethnic Minorities, showing better results in terms of lower medication doses and more treatment in the community in comparison to mainstream services (SSHE, 2003).

It is expected that by engaging Black and Minority Ethnic groups in the development of innovative and community informed mental health services that such services will be able to appropriately deliver additional and alternative mental health care. In so far as the development of ethnic specific models of care and service delivery are concerned for Black and ethnic minority peoples, the literature from the UK covered here suggests that this is yet to come.

### ***‘USA-based’ models***

The Department of Health and Human Services (DHHS, 2001) finds similar disparity to that found by the NIMHE in Britain between the health of its indigenous and ethnic minority populations and its White (non-Hispanic) populations. The need to develop culturally relevant, competent and/or sensitive health services is therefore as much an issue in the USA as it is for other metropolitan countries like Britain and New Zealand.

USA-based indigenous or ethnic minority health models include those health frameworks or models offered by Hawaiians, Alaskans and Native American Indian peoples, as well as the frameworks and models offered by American ethnic minorities. In the USA the ethnic minority

populations make up significantly more of the total US population<sup>9</sup> than the indigenous US populations put together<sup>10</sup>. Indigenous American populations generally include American Indians, Alaskans and Hawaiians. The ethnic minority populations include African-Americans, Hispanic Americans, Asian Americans and Pacific Island Americans.

According to the American mental health literature Hispanic and Asian Americans seem to have similar value systems to that held by Pacific Islanders (both those in America and those in New Zealand), at least in terms of adopting more ‘holistic’ models of health belief and service delivery. The Hispanic value-system in particular seems strikingly similar (see Comas-Diaz, 1989).

Many of these values and their explanations resonate with those provided by the Pacific participants of the earlier section. Comas-Diaz (1989) notes that the values important to Hispanics include the following:

- Co-parenting or *compadrazgo* (where baptismal godparents are given responsibility for a child’s welfare if parents were to pass away);
- Respect or *respeto* (where respect governs all positive reciprocal interpersonal relationships and dictates appropriate deferential behaviour between gender groups, age groups, socio-status groups and so forth);
- Interpersonal relationships or *personalismo* (where relationships are formed firstly on a personal basis and then on any other basis – personal in this respect meaning on a basis where building interpersonal rapport is prioritised).
- Spiritual beliefs in both Catholicism and folk healing or *curanderismo* (where massage, prayers and herb treatments are passed down through generations of folk healers who believe that their power of healing is a gift from God);
- An emphasis on extended family or *familismo* (where family unity is emphasised);
- An emphasis on gender specific approaches such as *Marianismo* (female) or *Machismo* (male); and
- Recognition of the importance of *cuento* or folk tales for treating some mental illnesses.

Like the Pacific opinion leaders, Comas-Diaz finds that there is no one single model or method or approach that can be considered best for treating Hispanic peoples. Rather, the models, methods and approaches each come together to form a repertoire from which to tailor-make a suitable service delivery or treatment approach.

The behaviour patterns of Hispanics also seem to resonate with those performed by Pacific consumers. For example, Comas-Diaz (1989: 42-43) notes that whilst Hispanics afford the medical professionals knowledge status and so expect them to be decisive and to provide the patients with sound advice, they also, like Pacific patients, tend to access mental health services as a last resort. In terms of medication, like Pacific patients, many Hispanic patients tend to take medication on a ‘needs only’ basis rather than according to the medical instructions provided. These striking similarities between Hispanic and Pacific value systems suggests that

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<sup>9</sup> In 1996, ethnic minority Americans make up a total of 30% of the total American population. As ‘individual’ pan-ethnic groups, the three main pan-ethnic minority groups break down as follows: Hispanics = 10.5%; African American = 12.1%; Asian and Pacific Islanders = 3.4% (see CMHS, 2000).

<sup>10</sup> In 1996, American Indian, Eskimo, Aleut populations combined totals only 0.7% of the total US population. Even if the Hawaiian ethnic group were included in the American Native counts, the population totals for indigenous Americans would still be lower than the each of the three Hispanic, African-American and Asian/Pacific Islander ethnic minority groups (see CMHS, 2000).

perhaps what is held up to be uniquely Pacific about Pacific services may not in fact necessarily be so, at least in terms of philosophy and world view.

Like Hispanics, Asian Americans also utilise the holistic value-based system of health and health care. Kagawa-Singer and Chung (2002) note that the Asian American ‘cultural systems approach’ is a model that advocates for the need to view mental health as holistic and contextual. The model utilises the concentric circles to show how cultural systems overlap. The model is described as one of “nested layers” whereby the elements of the model function together in an integrated way (*ibid*: 61).

In terms of the models indigenous to the native peoples of America, the Hawaiians, as Pacific Islanders themselves, offer health models based on the common Polynesian value-system shared by Pacific and Māori peoples in New Zealand. Ito’s work on Hawaiian understandings of *hana pono* (appropriate behaviour or performance) is a case in point (Ito, 1987). The Alaskan and American Indian models of health care iterate similar holistic underpinnings (see Bird et al, 2002).

In the Alaskan case (namely the Alaskan Southcentral Foundation and Native Medical Centre case) however the successful development of its indigenous value-based healthcare system has shown to the world that it is indeed possible to move from the indigenous health belief model stage towards developing successful health service delivery models fully integrated into a fully functioning and profitable organisation. The Alaskan prioritisation of the extended family group, of group therapy, of mentoring, of building interpersonal relationships, of creating healing environments that integrate the spiritual, mental, physical and emotional, of the importance of touch and of traditional healers and home remedies, are each values and emphases shared by the Pacific participants involved in the qualitative research work undertaken for this study. This Southcentral Foundation model is one of the key overseas indigenous value-based healthcare models that is working and working well to reduce health disparities between its highly dispersed ethnic communities and its White counterparts.

### ***‘Canadian-based’ Models***

The need for indigenous and/or ethnic minority Canadian-based models of health belief and/or service delivery is recognised by Health Canada in its 2002 report on best practices for concurrent mental health and substance use disorders. In the report Health Canada noted the need to “develop specific strategies and culturally appropriate tools to address the unique needs of small and remote communities” (HC, 2002: 7).

### ***‘Australian-based’ Models***

There was very little published material on Australian Aboriginal health belief models and models of service delivery. The Mildura Aboriginal Corporation’s mental health programme, *From Shame to Pride* offered in the state of Victoria, is promoted as “a culturally acceptable program” through which to “address indigenous mental health issues” (O’Hanlon et al, 2000: 1).

Of the different Australian states, Victoria has the most publicised literature on its indigenous policy initiatives (Ziguras, Stankovska and Minas, 1999). Such policies include the “development and publication of policy statements”, the “altering of funding formulas to account for non-English speaking clients”, the development of “incentive funding mechanisms”, the development of “new funding specifically for ethnic minority mental health”, the development of “service development positions in major public hospital networks” and the “development of a pilot project to employ bilingual staff as psychiatric case managers” (*ibid*).

### **'Japanese' Models**

As a non-western country the Japanese situation provides an interesting contrast with the other countries noted here. Currently Japan's mental health system is based largely on foreign models. Some authors have argued that the hospitalisation model currently adopted and seemingly privileged by Japanese peoples is so because such models cater to the Japanese preference for "tradition-bound institutional structures", to their "tendency to trust somatic rather than psychological models" and for the more practical reasons of having limited numbers of community-based health professionals (Iwata, 1993). In many ways, despite utilising a mental health system based largely on foreign models, the Japanese adoption has by no means been passive. The same can be said of the adoption of many foreign religious practices into Pacific cultures. The Japanese preference for the hospitalisation model could therefore be better understood as an indigenous (Japanese specific) solution to a contemporary problem (that of designing a mental health structure capable of meeting the various needs of modern Japan).

### **'Indigenous Māori' Models**

The work by Mason Durie (1982, 1992, 1995, 1999, 2003, 2004), Lorna Dyall (1997, 1999) and Te Puni Kokiri (1994) have, among many others, been instrumental in articulating and disseminating Māori perspectives and models of health beliefs and service delivery, particularly within mental health.

Mason Durie's *Te Whare Tapa Wha* (cited in Kingi and Durie, 2000) model, like the *Fonofale* model for Pacific mental health, is the most cited Māori model in mental health circles. Like the *Fonofale* model it utilises the metaphor of a house (a *whare* or *fale*) to symbolise the four key cornerstones of a Māori person. These four parts are described as 'the body (*tinana*), the mind (*hinengaro*), the family and community (*whanau*) and the spirit (*wairua*).

In Durie and Kingi's (1997, also cited in Thomas, 2002) discussion of cultural assessments in mental health the *Te Whare Tapa Wha* model is extended to explicitly inform the framing of assessment categories and patient and/or to help make sense of culturally-nuanced consumer responses.

Other Māori models raised by the literature included the *Te Wheke* model (Pere, 1997) and the *Nga Pou Mana* and *Te Ara Ahu Whakamua* models (Te Puni Kokiri, 1994; see also Dyall, 1997).

Māori elders (*Kaumatua* and/or *Kuia*) are given similar status roles as that ascribed by Pacific peoples to their *Matua* (Dew and Kirkman, 2002). Many of these *kaumatua* or *kuia* were also *tohunga* or traditional healers (Lee and Armstrong, 1995). Like Pacific peoples, the types of problems that Māori people consulted their traditional healers for ranged from the physical to the emotional. Like Pacific peoples in today's world, Māori people would see a traditional healer either before or after seeing a *Pakeha* doctor. The healing would involve seeking guidance on what treatment to take as well as seeking spiritual guidance. The healing powers of the Māori *tohunga* were considered, as within Pacific cosmologies, to be a gift bestowed from 'above'.

The Mental Health Commission's current works on core competencies (NMHWDCC, 1999) and on cultural processes for Māori (MHC, 2001) illustrate the growing sophistication of discussion around how to integrate health belief models within service delivery frameworks.

## **Summary of Literature Findings**

From the above literature findings it is clear that other ethnic minority groups overseas have similar value systems to that promoted by Pacific peoples in New Zealand. As a non-Pacific ethnic group the value system of the Hispanic group seems surprisingly similar. The similarities of the indigenous Māori and Hawaiian groups were expected given common Polynesian heritages. There were also points of commonality in the value systems of Pacific peoples and the Alaskan and African-Caribbean peoples. Other than language differences, the value-systems of many of these overseas ethnic minority and indigenous groups therefore seem similar if not the same to that promoted by Pacific peoples in New Zealand.

The Alaskan Southcentral Foundation model of service delivery is the most comprehensive integrated indigenous values-based health service delivery model found within the literature. It is a model that moves from the indigenous and ethnic minority models of health belief towards a sustained model of service delivery that systematically integrates the Alaskan ‘indigenous value system’ into every stage of the service’s delivery, from service philosophy to service structure to service implementation. An exploration of the viability of adopting such a model within New Zealand for Pacific peoples should be conducted.

In terms of literary discussion the cultural competency literature provides the most sustained discussion around how one might think beyond indigenous models of health belief towards indigenous models of service delivery. The cultural competency work is therefore crucial to thinking through what might constitute New Zealand-based Pacific specific models of service delivery.

### **2.2.2 Overseas Correspondences and Individual Interviews**

This section details information received from overseas correspondences and from person to person individual interviews. The discussion begins by detailing information received from Māori correspondents, followed by information from Beth Bowers, Kana Enotomo, Zena Itani, Jill Erickson and John Tuskin in the USA and Poppy Jaman in UK.

#### **Māori Correspondences**

Correspondences were received from Dr Rees Tapsell, a Māori Psychiatrist who works both within a DHB and an NGO provider, and from Bob Elliott, *Kai Waananga*, in the *Runanga*.

Both informants acknowledged that *te reo* (language) was an important part of building Māori specific models of health belief and/or service delivery. Tapsell described the importance of holding on to *whanaungatanga* and *whakapapa* (concepts of family, land and genealogy) and to building pride in being Māori and in things Māori. Like Durie and others Tapsell also noted the importance of understanding Māori concepts of *tinana* (the body), *mana* (power/presence), *tapu* (sacredness), *hinegaro* (which he describes as Māori psychology) and *wairua* (which he states relates to a relationship between the ‘physical individual’ and ‘spiritual individual’) to the project of understanding what is unique about Māori and Māori frameworks of health and service delivery.

Tapsell’s assertion that “each of the different areas of a person’s life especially in health, is like a matrix, [in that] you need a general sense of balance” echoes Pacific assertions that “health is a state in which a person’s physical, mental and spiritual needs are in balance” (Lui, 2003: 1).

Tapsell also notes that, although the process of colonisation is not unique to Māori in that it is a worldwide phenomenon, it is however important to understand its impact on Māori

communities more specifically when reviewing how best to address Māori health needs. The same can be said for understanding the situation of Pacific peoples in New Zealand.

For Bob Elliott “what makes Māori mental health uniquely Māori” lies for him in the following:

- “The ability for Māori services to parallel mainstream”;
- “The adoption of Māori ethos/*kaupapa*/rituals and protocols for work, prayer and healing”;
- “The adoption of Māori concepts of *whakapapa*, *rongoa* or traditional medicine”;
- “Having a Māori specific workforce; especially *kaumatua* and *tohunga* but also Māori medical and health specialists”;
- “Having the use of Māori models of health and practices such as “*Te Whare Tapa Wha*”, “*Te Wheke*”, and “*Te Poutama*”;
- “Having Māori awareness of other indigenous models and practices”;
- “Having a ‘Māorified’ environment – music, artwork, fabric prints, professional tattoos, meals, in-house practices, etc...”; and
- “The ability to ‘decolonise’ *rangatahi* (youth/adolescents) and urbanised (Māori) others”.

Except for perhaps the last point, this list of markers of what makes for a uniquely Māori mental health service for Bob Elliot echoes the points raised by Pacific service providers, consumers and family members earlier. Given the common Polynesian ancestry of Māori and Pacific peoples this similarity in values is not surprising.

### **USA Correspondences**

Beth Bowers is a Social Science Analyst and an expert on ethnic minorities and community engagement for the National Institute of Mental Health (NIMH) in Washington DC. Bowers advocates engaging communities by utilising a community-based participatory model which incorporates both a community-based and a participation-based approach. She believes this model to be comprehensive, effective and ethical in the ways in which it engages service users and their communities. Bowers argues that the providers need to give the institutional perspective during their engagements with community. Those fronting to the community, she believes, should have the authority to keep any assurances they might make to that community. This enables the development of trust between the providers and the community and helps to build meaningful partnerships between key community members, social service agencies and mental health service providers. This is particularly the case for those key community members or social service agencies who might share quite different perspectives to those perspectives held by the service providers.

With regard to researching service delivery models and consumer outcomes Bowers believes that it is important to take the research into the community. In this way, the research team actually presents the importance and value of the research to the community. Bowers was especially mindful of the need to include as many of the key stakeholders as possible in this presentation.

Concerns were raised by other USA correspondents about the growing need to address the ethnic specific requirements of the various ethnic minorities in the USA. Kana Enotomo, Zena Itani, Jill Erickson and John Tuskin all work for the Substance Abuse and Mental Health Services Administration (SAMHSA), a federal agency that researches and supports analysis of service delivery and improvement in the USA. The discussion within this group highlighted the importance of developing competencies for staff working with mental health consumers from ethnic minorities. The discussion raised in particular the difficulties of actually implementing a ethnic specific competency framework in a country that has more than 300 registered Native

American tribes let alone the other ethnic groups. These correspondents raised additional concerns about the how to figure the needs of refugees or illegal immigrants, particularly Cuban and Haitian migrants currently living in the USA, into this equation.

According to H. Westley Clark (Director of SAMHSA's Centre for Substance Abuse Treatment) SAMHSA is aiming to enhance collaboration between the treatment and faith communities. Clark commented that "the faith community is a natural part of our constituency. The faith community can offer us their observed experience and recommendations, just as any other provider of the community". SAMHSA News (2001) and President George W Bush's Faith-Based and Community Initiative represents a new approach to the US government's role in helping those in need. Bush states,

"The indispensable and transforming work of faith-based and other charitable service groups must be encouraged. Government cannot be replaced by charities, but it can and should welcome them as partners. We must heed the growing consensus across America that successful government social programs work in fruitful partnership with community-serving and faith-based organizations." (President George W Bush).

According to these USA correspondents, the goal of these charitable service groups and Centres is to enable grassroots leaders to compete on an equal footing for federal dollars, receive greater private support and face fewer bureaucratic barriers with less red tape and funding restrictions. The need to provide this type of support and to acknowledge the difficulties these groups face as small entities dealing with large bureaucratic processes are needs that also exist for Pacific services within the New Zealand context.

### ***UK Correspondence***

Poppy Jaman is one of the new Race Equality Leads within NIMHE (South West Development Centre). She provided many of the documents relating to the NIMHE used in the earlier literature review section.

### ***Summary of Correspondence Received***

The correspondence came from two main sites, New Zealand Māori and the USA. The commentary received affirmed the literature review findings.

Language, land, family and beliefs in spirituality, traditional healing and the holistic being were promoted by both Māori informants as central to Māori models of health belief and underscored Māori styles and/or systems of service delivery.

For the USA correspondents, the key issues arising were:

- The need to engage communities in research;
- The value of the participatory model to engaging communities in mental health programmes and mental health research;
- The need to include as many of the key stakeholders as possible when making research presentations;
- The development of more awareness of the need to recognise the importance of having different service models, such as those offered by the faith community, to meeting the needs of diverse ethnic groups; and
- The need to work through how to address the real difficulties of actually implementing ethnic specific competency frameworks within a country that has a large volume of different minority ethnic groups.

The Native American peoples alone have 300 different tribes registered as separate ethnic groups. To include illegal immigrants and refugee peoples to the equation makes the task even more difficult for such countries, if not overwhelmingly so.



### 3. Discussion of Findings

your way  
objective  
analytic  
always doubting  
the truth  
until proof comes  
slowly  
quietly  
and it hurts

my way  
subjective  
gut-feeling like  
always sure  
of the truth  
the proof  
is there  
waiting  
and it hurts<sup>11</sup>

This study has been extremely thought-provoking for the research team on a whole range of fronts. In particular it has raised some core questions about how models of health belief inform models of health service delivery. In closely examining the question: “What makes a Pacific mental health service uniquely Pacific?” the research team has been challenged by the number of ambiguities that arise when discussing models. What was clear from Pacific and overseas participant commentaries on different health ‘models’ was that there exists many different types of health models and that often these health models overlap or are used interchangeably. This can give rise to some confusion over what is meant by different respondents when discussing different models of health care. Tracing the evolution of the different health models or explicating in detail each health model is not within the purpose of this research. Rather, the team understands the purpose or aim of the research as documenting what Pacific peoples believe to be their models of health care and what they think is unique about these models.

Thus, the first area for discussion provided below explores some of the issues that arose during an analysis of what was said by the different *fono* participants, the individual Pacific interviewees, and the different overseas and Māori correspondents about different health ‘models’. The discussion here centres on what was common (if anything) in the perspectives of the different participants and what were the points of difference (if any).

There are eight key areas of discussion in this part of the report. The second area for discussion examines the implications of the finding that many of what was articulated to be uniquely Pacific about Pacific services by Pacific *fono* participants or interviewees is, after an analysis of overseas literature and correspondence, in fact not that unique. This second discussion area focuses on what this finding might mean for Pacific services and for Pacific consumers and/or their families or carers.

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<sup>11</sup> This poem was written by Tongan poet/writer/academic Professor Konai Helu-Thaman. It is taken from her address to the Polynesian Society of New Zealand, given 24 July 1996 at the University of Auckland. Her address was titled “Reclaiming a Place: Towards a Pacific concept of education for cultural development”.

The third, fourth and fifth areas of discussion draw out the importance of acknowledging three key issues that arose from *fono* sessions and team discussions on Pacific models of health care. The first issue is in respect to the significance of the Pacific youth voice to the framing and interpretation of future Pacific mental health models of care. The second issue is the acknowledgement of the existence of a new type of spirituality model, the evangelical model, within New Zealand-based Pacific communities today and the impact of this model on Pacific models of service delivery. The third issue is the issue of family versus state assistance.

The sixth area of discussion involves the development of competencies for working with Pacific mental health consumers and their families or carers.

The seventh area of discussion looks at the distinction made between NGO and DHB-based services and highlights some of points of tension.

The final area of discussion in this part of the report reflects on the research process undertaken for this study, in particular highlighting some of the learnings gained in terms of developing culturally sensitive and methodologically rigorous research.

### **3.1 Models of Health-belief and Models of Service Delivery**

As Mandiberg (1996: 6) notes “whole models cannot and should not ever be lifted out of social, cultural and economic contexts and imposed somewhere else”. What can be transported, he argues, are principles of what works. Models themselves do not necessarily influence systems; rather it is the principles upon which models are based that make the difference. When exploring the question of Pacific models of service delivery the research team was struck by the ambiguity associated with what was meant by the concept ‘model of service delivery’. After exploring the literature, closely examining the different Pacific models discussed by the *fono* participants and engaging in team discussions, it became clear that many of the Pacific models that *fono* participants had referred to, including the commonly referenced *Fonofale* model, were more models of health belief rather than models of service delivery. This also includes similar models raised within the literature such as the Cook Island *Tivaevae* model, the Tongan *Kakala* model and the Māori *Wheke* model.

When this point was first raised within one of our reference group meetings the discussion generated was quite interesting. For those members of the research team and reference group who were also mental health clinicians and who were currently working within Pacific mental health service settings, this differentiation gave rise to the need for pause and reflection. The question of what constituted a ‘service delivery model’ as opposed to a ‘health belief model’ framed the discussion. What emerged was the understanding that a Pacific ‘service delivery’ model required address not only of what the health beliefs or values adopted by the Pacific service were but also of how these values or beliefs were to be explicitly implemented within the clinical and service management arms of the service. It was at this point in the discussion that issues of workforce competency and service performance came to light, particularly issues of how competency and/or performance criteria might be defined and/or assessed. Models that failed to address these issues could therefore technically not be considered models of service delivery. They would more accurately be termed models of health belief.

Of the models raised by participants the ‘*faafaleletui* model’ as coined by Tamasese and others (1997), when examined more closely did not fit comfortably within either the definition for a health belief model or a service delivery model. Rather, it seems more accurate to refer to the *faafaleletui* model as a process model. That is, that the Samoan notion of *faafaleletui* (meaning to form a gathering or meeting group to discuss an issue of importance) speaks more to the task of forming an appropriate process or method for discussion and interaction than to the task of

delivering a service. It is of course part of the process of determining the key components of a service and its styles of delivery, but it is not in and of itself a model of service delivery.

The traditional healing model is perhaps the only model of those raised by *fono* participants that might well be perceived as a ‘service delivery’ model. Implicit within traditional healing practices are traditional codes of conduct and service management, as well as accepted ‘treatment’ practices based on cultural and medicinal knowledge that suggest that within the traditional healing model there do exist frames for measuring traditional healing competency and performance (see Macpherson and Macpherson, 1990). More sustained analyses needs to be conducted in order to be able to say conclusively whether this is indeed the case. *Prima facie* the argument seems highly persuasive.

Further theoretical work is required on the significance of these differentiations between health belief, service delivery, process and other types of relevant models, separately and as a whole, to addressing the needs of both Pacific mental health consumers and Pacific mental health services in New Zealand today.

The theoretical work of authors such as Douglas Drosdow-St Christian (2002) who provides indepth ethnographic analyses of Samoan models of health belief, when combined with the findings and analyses of ‘workforce competency’ authors (particularly those examining cultural competencies) and with studies such as this, presents exciting possibilities for future understandings of the complexities of providing culturally appropriate and clinically safe practices.

### **3.2 What is unique about Pacific models of care?**

To talk about ‘what is uniquely’ Pacific about Pacific approaches is inevitably to highlight the philosophical value system adopted by these approaches. This value system is inherent or embodied in many of the different techniques adopted by Pacific service providers interviewed in this study. These techniques include the ‘roundabout’ rapport building approach, understandings of spirituality, the cultural value of group therapy, and the use of Pacific language and hospitality practices. These uniquely Pacific aspects were seen to be more implicit than explicit. Moreover, participants noted that part of what made a Pacific service uniquely Pacific was for them the presence of Pacific motifs, ornaments and/or decorations within service buildings. Interestingly, when these various criteria of uniqueness was placed against those raised by Māori and overseas participants of what were key components of their respective services and/or belief systems, the notions of holistic models of care, of the value of having ethnic motifs and decorations, of wanting culturally and clinically competent staff were the same.

The privileging of interpersonal relations, of building trust and rapport between consumer, families and service workers, of understanding the importance of the spirit of a person to his/her mental health, were, among other things, concepts that were raised both by *fono* participants of this study and by the literature examining indigenous and ethnic minority health issues overseas.

Pacific participant’s assertions of ‘going the extra mile’ was suggested by different studies to be a situation that arose more out of systemic failures to address the holistic needs of consumers than anything else. The Alaskan Southcentral Foundation system provides an excellent example of how, with right support and skills, the holistic value-based service delivery model can operate and operate successfully. Closer analyses of the resource management strategies adopted by the Foundation and its viability for the New Zealand context are strongly encouraged. The claim that ‘going the extra mile’ is a uniquely Pacific phenomenon is therefore, in light of the above, highly debateable.

The implications of the finding ‘that which is perceived by Pacific participants as uniquely Pacific about Pacific services is in fact not necessarily so’ is a finding that in the opinion of the research team, is more positive than negative. As alluded to by Konai Helu-Thaman in the poem that opened this part of the report, the subjective and the objective are metaphorically and emotionally the two sides of the same coin. People are at once both unique and the same. In Pacific philosophy there needs to be balance. The same is espoused in Asian principles of yin and yang. In Pacific philosophy there needs to be *fakalilifu* (respect). The same is espoused in Hispanic principles of *respeto*. Pacific concepts of *kainga* and Māori concepts of *whanau* come from the same family tree. Knowing both what is shared in common and what makes people unique is what provides the balance, the yin and yang, the *tapu* and *mana*, the positive, we argue, in this finding.

Lastly, in terms of this area of discussion, like the need to recognise the difference between a health belief model and a service delivery model, there is also a need to recognise that the ‘Pacific for Pacific by Pacific’ approach to service delivery is more of a strategic tool for political leverage than an ideological goal. The value of the approach has by no means been exhausted. So long as Pacific peoples continue to be over-represented in low socio-economic and health statistics and so long as they continue to privilege their ethno-cultural heritages, keeping the strategy alive is imperative. More work needs to be done however to gain better understanding of how such strategies could be refined to better meet the service needs of future generations of Pacific peoples in New Zealand.

### **3.3 Pacific Youth Consumers and the Pacific Matrix of Care**

This area of discussion arises as a key finding area for this study. For the Pacific mental health sector to admit that there are key differences between New Zealand-born and Island-born peoples and key differences between Pacific youth and Pacific adults, is to suggest that the Pacific mental health service sector has ‘come of age’ in its address of some of the core tensions within. It is a development that reflects the growing integration between New Zealand-born and Island-born Pacific workers within mainstream and Pacific specific services in New Zealand.

With government and sector emphases on Pacific workforce capacity building there today exists a climate where mental health consumers and families, as well as service workers, have become more sophisticated in their knowledge of the demographic evidence associated with Pacific populations in New Zealand. The most notable demographic fact is that the projected future Pacific population is one that will be predominantly young, English-speaking and New Zealand-born. In this case the argument for developing space for addressing Pacific youth mental health consumer issues becomes most pronounced. Whilst the importance of ethnic markers of identity, such as ethnic language and value-system, is acknowledged by all participants in this study, the need to think more carefully about how these ethnic markers play out for youth at that space or time in their lives is today unavoidable for mental health service providers, especially for those who wish to be accessible to Pacific youth. Models of service delivery therefore need to account for this and for the fact that many of these youth live within gerontocratic Pacific family environments. Any Pacific specific matrix of care needs to carefully balance these competing interests.

A final point in this area of discussion relates to the different stigma levels attached to youth mental health consumers compared to older mental health consumers. The suggestion by some participants that there is more stigma attached to younger mental health consumers raises concerns with regard to Pacific mental health consumers who would therefore potentially be ostracised not only by the general community (especially their own youth peers) but also by their own ethnic community. These issues reinforce the need for the mental health sector to

urgently review current models of care for how they address the specific issues of ethnic minority mental health youth consumers such as Pacific youth.

### **3.4 Family versus State Help**

Within Pacific cultures, even in New Zealand, the extended family is touted as the model support network. Responsibility for the care of mentally unwell family members is ideally shared between extended family members. In New Zealand, participants recognise that with travel costs the ideal is often not achievable. The importance placed by Pacific peoples on the extended family as key support networks for unwell members is something also characteristic of non-Polynesian groups such as the Hispanics in the USA.

The low socio-economic status of many Pacific peoples in New Zealand, coupled with the high levels of cultural obligation imposed on some to act as carers/caregivers to immediate and/or extended family members, means that the knowledge and ability of when and how to access help when it is needed is imperative. Ensuring that Pacific communities are well informed of the various respite care services available for families with members who have high caring responsibilities is essential.

### **3.5 The Spirituality of Evangelism and the Pacific Matrix of Care**

Culture and religion are inextricably linked in Pacific communities, whether in the island homelands or in the metropolitan settings of the Pacific communities in New Zealand. Although the study has already raised the significance of ancient Pacific cosmological definitions of spirituality and of traditional Christian missionary definitions of spirituality, there exists another more contemporary type of spirituality that warrants specific mention at this point in the report. This is the evangelical type of spirituality that is growing rapidly in different Pacific population groups, but particularly the youth population group. This was a point specifically raised by one of the Reference Group members of this study.

The spirituality of evangelism is differentiated from the spirituality of ancient Pacific cosmologies and traditional Christianity in terms of how this type of spirituality rationalises the incorporation or not of Pacific practices of family responsibilities and ethnic cosmology. Furthermore, the evangelical movement within Pacific communities is a relatively new phenomenon and so its impact on Pacific peoples generally, let alone their mental health issues, has not yet been fully theorised. Nevertheless, it is a movement that provides yet another dimension to Pacific spirituality that also needs to be factored into the Pacific matrix of care and/or models of health service delivery.

### **3.6 Developing Workforce Competencies**

In developing workforce competencies for health and social service workers who wish to work with New Zealand-based Pacific consumers and their families, the participants of this study argue that there needs to be an integration of key cultural, clinical and management-type skills.

Opinion leaders raised the need to recognise that Pacific peoples are not a homogenous entity. As such, workers need to be careful about making blanket assumptions about Pacific consumers, their families and what would be culturally appropriate for them.

For families one of the key competencies expected of the workforce is the ability of staff to keep the communication pathways open between community support services, hospitals,

families and consumers. A breakdown in these communication pathways is often what lies at the heart of consumer and family dissatisfactions with community and/or hospital services.

For consumers, being fully informed about the side-effects of their medications would go some way towards helping them understand what might be happening to them when they feel unwell. Family would also benefit from being better informed about medication side-effects or even of how to identify when a possible episode of unwellness might be occurring or about to occur.

Moreover, consumers argued that there exists a need to develop a mental health workforce capable of distinguishing between Pacific spiritual warfare and Pacific mental illness. Underlying this is the argument for the need for the medical profession, particularly psychiatry, to give appropriate status to Pacific understandings of spirituality when developing mental health workforce competency frameworks for their staff.

The research team recognises that the development of mental health workforce competencies for working with Pacific consumers and families is far from straightforward. This study however provides a useful starting point from which more specific efforts can be designed. The need to review Pacific practice standards alongside mainstream practice standards, as advocated by a number of participants, is a useful step forward. The importance of recognising Pacific youth issues within future developments of cultural and/or workforce competencies has already been emphasised. The need for better engagement processes and techniques between service staff and their service systems, between service staff and consumers and families and between service staff and other related agencies was also made apparent earlier. Each of these points combine to form a compelling argument for taking the necessary time to tease out the theoretical and practical implications of different workforce competency equations.

Lastly, a point raised by the Reference Group members requires specific mention. From participant narratives there seems to exist two key misperceptions about the clinical. First, that the clinical is synonymous with the bio-medical. Second, that the bio-medical is an actual model of practice and/or is *the* model of practice under which the medical profession train. Both misperceptions underscore the discussion by some participants of the differences between cultural and clinical competencies. These misperceptions need to be addressed in the development of workforce competencies.

To amalgamate all of these points in some meaningful way requires the availability of appropriate analysts, the development of appropriate training programmes and the availability of appropriate facilitators. Within such training programmes, destigmatisation strategies utilising Pacific specific language appropriate for the Pacific home, church and other community contexts need to be developed and incorporated. Moreover, such programmes must also account for the various service and clinical needs of the key ethnic, age, gender, class and cultural sub-groups within the Pacific population as alluded to earlier, not only at the practice level but also at the theoretical level. Integrating theory and practice in meaningful ways should be the catalyst for developing appropriate workforce competencies.

### **3.7 Pacific NGO and DHB-based Mental Health Services**

The discussion around Pacific specific mental health NGO services and Pacific specific DHB-based services centres on the seeming shift from the perception that NGO services were better able, as an institutional organisation, to meet the culturally specific needs of Pacific consumers and their families, to the perception extant today that rather than the better option NGOs are now merely just another option for Pacific consumers. The factors that have contributed to this shift are twofold. First is the development of DHB-based Pacific specific services and the movement of Pacific staff between NGO and DHB-based services. Second is the increased

awareness of Pacific mental health consumers through public mental health destigmatisation campaigns such as the ‘Like Minds Like Mine’ campaign and the development of Pacific specific mental health resources of their rights as mental health consumers in New Zealand.

The main benefit perceived by NGO services to being an NGO is the relative autonomy they feel they have to make budgetary type decisions compared to their DHB-based colleagues. DHB-based services, however, perceive that the benefit of being part of a DHB lies mostly in their access to a potentially larger pool of resources. Both groups acknowledge however that there are advantages and disadvantages for both types of organisational arrangements.

The standard of care received and the differences in use of Pacific models of health belief or care is perceived to be minimal between these two types of Pacific services. Whilst the processes for securing funding for service programmes and operational costs differs and DHB-based services seem to have the advantage over their NGO counterparts on this front, both services face increasing demands for tighter evidence-based practices and service management policies.

Given that the Pacific community is small compared to mainstream and/or Māori populations and/or organisations, the sector and its consumers have been able to work successfully at times on collaborative projects. Encouraging inter-service collaborations and/or group events across DHB and/or NGO sectors or geographical boundaries is argued by some Pacific service workers to be discouraged by service management in that it is not perceived by management to constitute ‘core business’. In this respect the tension lies more in the difficulties associated with finding a service formula that can develop and incorporate such events into core business management strategies. The study advocates for the need to explore the development of such formulas, taking into consideration successful models such as that used by the Alaska Southcentral Foundation.

### **3.8 Developing Culturally Sensitive and Methodologically Rigorous Mental Health Research with Pacific Peoples**

The research team cannot emphasise enough the value of developing good research methods and feedback and consultation processes, both at the outset of the research exercise and throughout. Moreover, the time and resource costs involved in conducting culturally sensitive and methodologically rigorous research with Pacific peoples is severely underestimated by current costing frameworks. The research team found that this is a gap area in Pacific research that needs to be urgently addressed to allow for the realistic design of future Pacific research projects.



## **4. Conclusions**

From the three different types of data the research team makes the following overall conclusions.

- Pacific models of care are informed by Pacific models of health belief. Pacific models of service delivery are also informed by these Pacific models of health belief or health care. Fully developed Pacific models of service delivery exist in implicit rather than explicit forms. To develop more explicit articulations of Pacific models of service delivery, services need to develop written expositions of how these models might be framed, taking into equal account cultural, clinical and service management issues.
- The Pacific styles of service delivery advocated by Pacific *fono* participants to be uniquely Pacific are indeed unique when compared to ‘White’ western styles of delivery. When compared to the service delivery styles of Māori, Hawaiian, Asian-American, British Black and Afro-Caribbean, American Hispanics and Alaskan peoples however this uniqueness becomes highly debatable.
- According to participants and the literature having appropriate family and community support networks, appropriate living environments for consumers, meaningful work for consumers, competent mental health staff are what helps towards getting consumers well and towards assisting families to help.
- The fact that the Pacific population is a significantly young population means that the question of how to incorporate Pacific youth consumer issues in Pacific matrices of care needs to be urgently addressed by the Pacific mental health sector.
- Culturally sensitive and methodologically rigorous Pacific research is severely undercosted.
- Further research is required into the gap areas identified in this study, such as the issues around building a more youth sensitive Pacific matrix of care and into building more effective models of family assistance or involvement in consumer recovery plans.



## **5. Recommendations**

The research team recommends that:

- The findings of the study be appropriately adopted into the development of Pacific mental health service policy statements and service specifications.
- The different models highlighted in this study are researched in more depth to show how these health belief models might inform a national service delivery model for Pacific mental health services in New Zealand.
- The models and matrices of care for Pacific elderly peoples are appropriately designed to reflect Pacific world views.
- The ‘extra mile’ work of community support workers needs to be more clearly defined.
- A systematic investigation into the cultural and clinical efficacy of the ‘extra mile’ claim be undertaken in order to be appropriately recognised in service resourcing formulas.
- The workforce competency findings, particularly discussions on cultural and clinical competencies and personal and professional development be investigated further for how they might inform appropriate models of service delivery and matrices of care.
- The competencies required need to meet the needs of both Pacific Island-born and New Zealand-born consumers and their families.
- Further investigation is undertaken into the rationale and context of Pacific family-based care (i.e. care provided within the family setting as opposed to seeking professional help or incorporating institutional services into care).
- Research is undertaken to investigate the impact that different institutional care settings and management styles have on Pacific admission and committal rates, on family involvement and levels of recovery.
- The findings of the study to be used to inform further research on design and testing of appropriate outcome tools to measure service impact for Pacific consumers and their families.
- That service providers ensure that Pacific communities are well informed of the various respite care services available for families who care for mentally unwell family members.
- Research to scope how Pacific specific destigmatisation messages might be best developed and disseminated in key Pacific sites.
- Research addresses any regional, national and international differences between services and consumers.
- More comparative work to be undertaken between ethnic specific mental health population service requirements nationally and internationally.
- Specific analyses compare mental health indicators, treatment plans and outcomes for Hispanic and Pacific mental health consumers to be undertaken because of the striking similarities found in the literature.

- The Alaska Southcentral Foundation model to be studied more closely for how it could be adopted by New Zealand.
- The research steps noted above would inform the development of a service delivery evaluation framework and dissemination strategy.
- Real-world costings for the successful development, implementation and completion of culturally sensitive and methodologically rigorous research with Pacific peoples to be detailed. This is to inform a costing framework to be used as a baseline for resourcing future research with Pacific peoples in New Zealand.

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# **Appendices**

**Appendix A: Copy of Participant Information Sheet**

**Appendix B: Copy of Participant Consent Form**

**Appendix C: Copy of Qualitative Topic Guide**

**Appendix D: Breakdown of Focus Groups**



## **Appendix A: Copy of Participant Information Sheet**

### **Models of Pacific Mental Health Service Delivery in New Zealand**

#### **Client Information Form**

**Talofa lava, Malo e lelei, Fakalofa lahi atu, Bula Vinaka, Kia orana, Taloha ni**

##### Introduction

You are invited to take part in a national project, looking at the different ways we deliver mental health services to Pacific peoples in New Zealand. We know that the way health services deliver care for you can affect your recovery. As a mental health consumer your opinion is valuable and we are interested in what you think is important for Pacific people affected by mental illness.

The researchers are based in Auckland and over a period of 18 months, we will be talking to 100 consumers and their families from Auckland, Wellington and Christchurch. We will also be talking to a variety of clinicians, support workers, managers and policy makers who provide mental health care for Pacific consumers in New Zealand.

##### What is the purpose of this study?

The purpose of this study is to get a better understanding of what Pacific people believe is meaningful and culturally relevant to the recovery of Pacific people affected by mental illness. You have been asked to participate in this project because of your own unique experience you and your family have had within the mental health field.

We would like to ask you what you think...

- Are important ways that could make your treatment uniquely Pacific
- Mental health services could do to improve your quality of life
- Are general mental health issues that are important or not important
- The value of treatments you have received in order to understand your needs better

The benefit to you as a participant is the opportunity to provide information on how you think mental health services are best delivered to Pacific people. The researchers who will be talking with you are all Pacific people working in the mental health field and will be able to recognise and deal with any issues that cause you discomfort.

##### How will this project be carried out?

Taking part in this project is completely voluntary (your choice). If you choose to take part in this project you will be invited to a small group (8-12 people) meeting with Pacific researchers where you will discuss your views. We believe this will take 1-2 hours and would greatly value your agreeing to be involved.

We will provide refreshments, transport or a petrol voucher for you to attend.

We will also ask you for some demographic information (gender, ethnicity, age group) and type of mental health service you have attended recently. The information collected will not include your name or anything that will identify you. You do not have to take part in this project and you may stop taking part at any time without any negative effect on your health or any other treatment you may be offered.

You may want to take time to decide. If you wish, you can discuss this with your family and friends.

**What about confidentiality?**

The information you provide will be anonymous. No information gathered for this project will contain details that could identify you. By signing this consent form, you agree to the collection of the above information.

This study has received ethical approval from the Auckland Ethics Committee, on behalf of the Wellington and Canterbury Ethics committees. These groups ensure that your rights are protected.

This project is funded by the Ministry of Health with the goal to improve the delivery of mental health services for Pacific peoples. The information collected in this project will be provided to the Ministry in a full report. This report will be published when the project is completed and will be available to Pacific communities and all relevant health services. It will also be available on the Health Research Council of New Zealand website ([www.hrc.govt.nz/MHRD-outcomes.htm](http://www.hrc.govt.nz/MHRD-outcomes.htm)).

**Compensation**

In the unlikely event of a physical injury as a result of your participation in this study, you may be covered by ACC under the Injury Prevention, Rehabilitation and Compensation Act. ACC cover is not automatic and your case will need to be assessed by ACC according to the provisions of the 2002 Injury Prevention Rehabilitation and Compensation Act. If your claim is accepted by ACC, you still might not get any compensation. This depends on a number of factors such as whether you are an earner or non-earner. ACC usually provides only partial reimbursement of costs and expenses and there may be no lump sum compensation payable. There is no cover for mental injury unless it is a result of physical injury. If you have ACC cover, generally this will affect your right to sue the investigators. If you have any questions about ACC, contact your nearest ACC office (freephone 0800 735 566) or the ACC website ([www.acc.co.nz/claims-care/making-a-claim/medical-misadventure/index.html](http://www.acc.co.nz/claims-care/making-a-claim/medical-misadventure/index.html)) or feel free to ask the researcher for more information before you agree to take part in this study.

If any extra appointments are required that are not part of your regular follow up you will not be expected to cover the related travel costs.

**If I have any Questions?**

If you have any queries or concerns regarding your rights as a participant in this project, you may wish to contact a Health and Disability Advocate in your area;

- Northland to Franklin, telephone 0800 555 050
- Mid and lower North Island 0800 423 638 (4ADNET)
- South Island 0800 377 766 or in Christchurch 377 7501.

You could also call collect from a telecom operator the CRRC research team:

Dr Gail Robinson: ph (09) 815 5830 ext 5097 (Principle Investigator)

Tevita Hingano: ph (09) 815 5830 ext 5091

Mali Erick

Helen Schmidt

OR the CRRC Project Coordinator, Heather Stewart: ph (09) 815 5843

Local support contact: Tevita Finau: ph (04) 237 7751 (Wellington);

Manu Sione: ph (03) 366 3900 (Christchurch).

## **Appendix B: Copy of Participant Consent Form**

### **Models of Pacific Mental Health Service Delivery in New Zealand**

#### **Client Consent Form**

Principal Investigator: Dr Gail Robinson

Client Name: \_\_\_\_\_

English:	I wish to have an interpreter	Yes	No
Māori:	E hiahia ana ahau ki tetahi tangata hei korero Māori ki ahau	Ae	Kao
Samoan:	Oute mana'o e iai se fa'amatala upu	Ioe	Leai
Tongan:	'Oku fiema'u ha fakatonulea	Io	Ikai
Cook Island:	Ka inangaro au I tetai tangata uri reo	Ae	Kare
Niuean:	Fia manako au ke fakaaoga e tagata fakahokohoko vagahau	E	Nakai

I have read the information sheet dated 23<sup>rd</sup> April 2004 for volunteers taking part in the project. I understand that this project is designed to collect information on what I believe to be meaningful and culturally relevant to support the recovery for Pacific consumers and their families. As an alcohol or other drug consumer, the researcher is interested in my opinions and attitudes towards alcohol and drug service delivery.

I have had the opportunity to discuss the project and ask questions. I am satisfied with the answers I have been given.

I understand that my taking part in the project is voluntary (my choice) and that I may withdraw from the project at any time and this will in no way affect my ongoing health care/ future health care.

I understand that my taking part in this project is confidential and that no information that could identify me will be used in any reports on this project.

I understand the compensation provisions for this project.

I have had time to consider whether to take part.

I know who to contact if I have any questions about the project.



## **Appendix C: Copy of Qualitative Topic Guide**

### **Pacific Fono Topic Guide (Phase 1 and 4)**

One large forum will be held in each region, Christchurch, Wellington and Auckland. This will be attended by one researcher, the four facilitators and the participants. However, all three researchers will attend the Auckland forum. In the forums the participants will be explained clearly by the researcher:

1. The purpose of the forums
2. The process and time structure such as how each forum will be divided (4 smaller groups each with a facilitator) and the importance of answering each question within the time frame
3. Once the participants are in 4 smaller groups based on their choice of which group to attend (ethnic specific, women, youth, depending on the participants), each facilitator will have a guideline of questions, a tape recorder and a volunteer from each group to take notes. The researcher(s) will co-ordinate each forum to ensure it runs smoothly.
4. Each small group will fill in a demographic characteristics sheet (refer sheet) that will be passed around and collected at the end of the forum.

Each group will discuss the following questions:

**Q1:** What makes a Pacific mental health service uniquely Pacific?

**Q2:** What are the most acceptable models of delivering mental health services to Pacific clients in New Zealand?

**Q3:** What makes Pacific people well?



## Appendix D: Breakdown of Focus Groups

### 1. Christchurch (n=3)

Focus Group Type	Total Participant Numbers	Gender	Ethnicity	Age Band
1. Family (Samoan)	6	4F 2M	All Samoan	41-50 (2) >50 (4)
2. Consumers	7	5F 2M	Samoan (5) Niuean (1) Samoan / Māori (1)	<21 (2) 21-30 (2) 31-40 (2) 41-50 (1)
3. Service Providers	6 (Pacific Canterbury Trust; A&D Pacific Provider; Consultant)	4F 2M	Samoan (4) Cook Islands (1) Niuean (1)	41-50 (4) >50 (2)

### 2. Wellington (n=6)

Focus Group Type	Total Participant Numbers	Gender	Ethnicity	Age Band
1. Consumer – Joint Tongan / Cook Island Group	6	3F 3M	Tongan (3) Niuean (2) Cook Islands (1)	>50 (3) 31-40 (1) ? (2)
2. Consumer – General	1 10	2F 8M	Samoan (6) NZ European (1) Cook Island (3)	<21 (1) 31-40 (3) 41-50 (6)
3. Family – General	2	2F	Niuean (1) Samoan (1)	31-40 (1) 41-50 (6)
4. Youth & Women Group – General	5	All F	Samoan	31-40 (5)
5. Service Provider – Samoan Specific	7 (PaCH; Fagai Care; Tanumafili Trust; Hutt Valley DHB)	4F 3M		31-40 (2) 41-50 (2) >50 (3)
6. Service Provider – General				

### 3. Auckland (n=11)

<b>Focus Group Type</b>	<b>Total Participant Numbers</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Age Band</b>
1. Service Providers – Samoan	7 (Starship; Community Child Health & Disability Service; Laveai Trust; Lotofale; Pacificare Trust)	4F 3M	All Samoan	41-50 (1) >50 (2) ?
2. Service Providers – Tongan	6	4M 2F	All Tongan	?
3. Service Providers – Niuean	3 (Procare; Lotofale)	1M 2F	Both Niuean	41-50 (1) 21-30 (1) >50 (1)
4. Service Providers – Women	4 (Tupu; Faleola Services; Lotofale)	4F	Niuean (1) NZ European (1) Cook Island (2)	21-30 (1) 41-50 (2) >50(1)
5. Service Providers – Youth	5 (Marinoto; Pasifika Healthcare; Tupu)	2F 3F	Samoan (3) Samoan / Tokelau (1) Tuvalu (1)	21-30 (2) 31-40 (1) 41-50 (2)
6. Joint Family & Consumer – Niuean	3	3F	All Niuean	21-30 (1) 41-50 (1) >50 (1)
7. Joint Family & Consumer – Cook Island	2	1F 1M	Both Cook Islands	41-50 (1) >50 (1)
8. Consumer only – Tongan	3	3M	All Tongan	21-30 (3)
9. Consumer only – Samoan	4	2F 2M	All Samoan	21-30 (1) 31-40 (4) >50 (1)
10. Leaders group – general #1	8 (MoH Chief Advisor Pacific; Needs Assessor; Malologa Trust; Lotofale Manager; Consultant; Therapist; Clinical Psychologist; MA student; Clinical Lecturer)	All female	Samoan (6) Tongan (1) Māori (1)	21-30 (1) 31-40 (4) 41-50 (3)
11. Leaders group #2	4 (Senior MH Workers; NGO managers)	3M 1F	All Samoan	41-50 (3) >50 (1)