BARRIERS AND SUPPORTS PACIFIC PEOPLE EXPERIENCE IN USING MENTAL HEALTH SERVICES

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ABSTRACT

Pacific people comprise approximately 7% of the total New Zealand population and with their higher birth rates this percentage is expected to increase in the foreseeable future. Pacific people in New Zealand experience mental disorders at higher prevalence rates than the general population and are also less likely to have accessed mental health services for their mental health problems compared with other ethnic groups in New Zealand. This study investigates the underutilisation of mental health services by Pacific people and the experiences that hinder or support their access and use of mental health services. Interviews were conducted with: 10 service providers (6 of Samoan descent and 4 of Tongan descent); 11 ex-service users (9 of Samoan descent, 1 of Tongan descent and 1 of Niuean descent); and four service providers participants who were also ex-service users (3 of Samoan descent and 1 of Tongan descent); to gain insight into their perceptions and experiences of barriers and supports for service use.

The data were analysed using a process of thematic analysis. In relation to barriers that Pacific people face in accessing and using services, there were two categories of themes. The three themes in the first category: *Barriers to Accessing Services* were *Shame, Stigma and Fear; Lack of Knowledge*; and *Limited Relevance of Services.* The four themes of the second category were: *Lack of Cultural Understanding; Barriers in the Therapeutic Relationship; Other Barriers in Therapeutic Practice and* Socio-economic *Barriers.* Three themes emerged in relation to the supports that assisted Pacific people to access and use services. These themes were: *Supports in Accessing Services*, *Positive Therapeutic Relationships, Family Involvement and Service Support for Family, Other Cultural Support in Services,* and

Other Supports in Using Services. The experiences of stigma, shame and fear; lack of knowledge about mental unwellness symptoms and services; and lack of belief in the usefulness of services appeared to underlie Pacific people's lack of approach to services and could lead to more severe presentations when they eventually entered services. These results also suggest that some Pacific people experience a lack of cultural understanding and support from services. Service providers from mainly western backgrounds were seen as sometimes having limited understanding of the socio-cultural contexts of Pacific service users and their families that impacted on practices in therapeutic relationships, assessment and therapeutic processes. This was particularly relevant in understanding the collectivist and holistic cultural values and practices of Pacific people; the acculturation and identity related challenges; and socioeconomic difficulties that might feature in Pacific service users' presenting problems.

A number of supports were identified that assisted Pacific people to approach and use services more effectively. In accessing services, these included service users drawing on personal strengths; the support of family and friends; and having knowledge of mental unwellness symptoms and services. In using services, positive therapeutic relationships with particular attention to rapport-building based on Pacific approaches were experienced as being helpful. The Pacific service providers and service users who were interviewed emphasized the importance of effective socio-cultural training for staff. They also emphasized the importance of effective psychoeducation for Pacific service users and their families. The implications for mental health services are discussed, along with the limitations of the study, and future research directions.

Dedicated to the memory of my strong and loving grandmother Uapo Tofa Tupuola.

Sa ou aoaoina mai ia te oe le taua le tofa mamao, o le tauivi ma luitau o le olaga

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ACRONYMS AND KEY TERMS IN THIS STUDY

DHB   District Health Board

GP   General Practitioner (medical)

NGO   Non-Government Organisation

SP   Service Provider participant

SU   Service User participant (ex-service user)

Island-born: For the purposes of this study, this term refers to those persons who were born and grew up in a Pacific Island nation and have subsequently migrated and settled in New Zealand.

Mental Health Services: For the purposes of this study, mental health services included inpatient and community mental health services, Pacific-specific services and counselling services.

New Zealand-born: For the purposes of this study, this term refers to those persons who were born and raised in New Zealand, and are descended from migrants from a Pacific Island nation. For the purpose of this study, it also includes those persons who may have been born in a Pacific Island country, but migrated and settled in New Zealand during childhood.

Pacific people: This is a term which refers to people who have migrated to New Zealand from various Pacific Island nations. It also includes their descendants born in New Zealand. The various island nations which these migrants to New Zealand have come from have their own languages, history, beliefs systems and customs. Pacific Islanders, Pasifika peoples, and Tangata Pasifika are alternate terms that also refer to this community in New Zealand.

GLOSSARY OF PACIFIC WORDS IN THIS STUDY

aiga: 53:   family, extended family *(Samoan)*

fa'aaloalo:83:   respect, respectful *(Samoan)*

fa'alavelave: 54:   cultural obligations *(Samoan)*

fa'asamoa: 90:   the Samoan way *(Samoan)*

faitatala: 61:   gossip(y) *(Samoan)*

fiapoto: 55,63:   know-it-all *(Samoan)*

kainga: 53:   family, extended family *(Tongan)*

ma'i aitu: 44:   ghost sickness, ghost disease *(Samoan)*

matai: 84:   chief *(Samoan)*

matua:81:   elder *(Samoan, Tongan)*

palagi/palangi:49,50,64,87,90:   person of European-descent (Samoan/Tongan)

tatalo:99:   prayer *(Samoan)*

teu le va:63:   maintaining harmonious relationships *(Samoan)*

tofa soifua:81:   goodbye *(Samoan)*

ulavale: 90:   naughty *(Samoan)*

va: 63:   relational space *(Samoan/Tongan)*

FOREWORD

This study started out as part of a larger Mental Health Standard Measures Assessment and Recovery (MH-SMART) scoping project, funded by the Health Research Council (HRC). The researcher was part of a team involved in this project. The purpose of this wider project was to provide a preliminary report on mental health outcome research and measures for Pacific people, to the Mental Health and Development Strategy division of the Ministry of Health. The report was based on themes that came out of participating mental health service providers' perspectives on mental health outcomes for Pacific clients and how these outcomes might be measured.

Originally, it was planned that this would constitute my thesis study. However, after contributing to the data collection, and taking into consideration the required timeline for the MH-SMART project, it was decided to expand my thesis topic to focus on the barriers and supports Pacific service users experience using services from the perspectives of Pacific service providers and Pacific service users. This decision was made in consultation with my supervisors and the leader of the MH-SMART scoping project. Once this decision was made, further Pacific service providers were recruited to take part in interviews. A second application was made to the University of Auckland Human Participants Ethics Committee to allow me to also interview service users. This study therefore presents an analysis of the views of 25 Pacific service providers and past service users on the barriers and supports that Pacific service users experience in accessing and using mental health services, including counselling services.

CHAPTER ONE: INTRODUCTION

In New Zealand, the terms Pacific or Pasifika people are used to refer to people who have migrated to New Zealand from a range of Pacific Island nations and communities. It also includes their New Zealand-born descendants (Health Research Council, 2004). Although there is much diversity amongst the Pacific cultures that New Zealand Pacific people identify with, there are still Pan-Pacific commonalities in linguistic, socio-cultural values, beliefs and practices that allow for the use of this collective term (Kingi-Ulu'ave, Faleafa, & Brown, 2007). Pacific people are the fourth largest ethnic minority community in New Zealand, after European, Maori and Asian peoples, comprising almost 7% of the total population (Statistics New Zealand, 2006). The Pacific community is also the fastest naturally increasing ethnic grouping in New Zealand, projected to increase to 12% of the total population by 2051 (Cook, Didham, & Khawaja, 2001). Despite this growing demographic importance, the mental health problems and mental health service use of Pacific people has been under-researched (Foliaki, 2001). Epidemiological research has found that Pacific people experience mental disorders at higher prevalence rates than the general population and are also less likely to have accessed mental health services for their mental health problems compared with the overall population (Oakley Browne, Wells, & Scott, 2006).

A primary aim of this thesis is to better understand the barriers that Pacific people experience in accessing and using services that may be contributing to their underutilisation of mental health services. A second major aim is to investigate the experiences that assist Pacific service users and their families to approach and use services once they have been accessed. This chapter provides the background for this

thesis. The first section of this thesis is entitled *Ethnic Minorities, Mental Health, and Service Use.* It provides a background for examining the mental health needs of Pacific people in services by examining the mental health needs and service use of other ethnic minority migrant groups in western societies. The first section begins by discussing the development of migrant ethnic minority groups in predominantly western countries. It then considers literature pertaining to understanding ethnic minority groups' experiences in adjusting to living in western majority cultures that can hold different cultural worldviews. The research suggests that cultural adjustment may be stressful, and can impact negatively on the wellbeing of ethnic minority group members. Part of this consideration includes examining the concepts of worldview and its dimensions of individualism and collectivism; ethnic identity, acculturation and acculturative stress. The impact of discrimination and low socio-economic-status on ethnic minority wellbeing is also briefly discussed. The final part of the first section examines the mental health status and service use patterns of ethnic minority groups in western countries, and the literature pertaining to barriers and supports ethnic minorities experience in accessing and using mental health services.

The second *section* of this chapter entitled *Pacific People, Mental Health, and Service Use* begins with an overview of Pacific people in New Zealand, before discussing Pacific worldviews and perspectives on wellbeing. It then examines the mental health status and patterns of mental health service use of Pacific people in New Zealand, and ends by looking at identified and hypothesized barriers and supports to their access and use of services.

Ethnic Minorities, Mental Health, and Service Use

Ethnic Minorities and Migration

Although mass migration has always occurred in response to population growth, climatic changes and scarcity of resources, the volume of international migration that took place in the latter half of the twentieth century was unprecedented and occurred over a relatively brief period of time (Castles, 2000; Spellman, 2002). Castles (2000) has identified two distinct phases of this mass migration. The first phase began at the end of the Second World War and lasted till the mid-1970s when a major oil crisis led to a major global economic recession. The migration that occurred during this period was characterised by significant labour migration from non-industrialised nations to predominantly western societies in Western Europe, North America, Australia and New Zealand. The second phase, which spanned the mid-1970s to the mid 1990's, saw the proliferation of transnational economies, and migration to western societies of migrants from mainly professional backgrounds. The migration of people from the Pacific Islands to New Zealand mostly belonged to the first phase (Ongley, 1991).

Individualist and Collectivist Cultural Worldviews

Culture may be defined as a unique and variable set of meanings that is learned and shared by a group, and transmitted across generations to aid survival, wellbeing, and deriving meaning from life (Rohner, 1984; Matsumoto & Juang, 2013). It has external aspects that include social roles, institutions and activities; as well internal aspects that include values, beliefs and epistemology (Marsella, 1982). Culture has been compared to a lens or template through which a person constructs and interprets reality, leading to people from different cultural backgrounds understanding and experiencing reality in diverse ways (Marsella, 1982).

The construct of Worldview and its bipolar dimensions of Individualism and Collectivism have been posited since the late 1970's in multicultural therapeutic literature to describe how different cultures situate a person within their social and physical contexts (Sue, 1978; Williams, 2003). It has been proposed that within collectivist cultures, adult emotional maturity and psychological wellbeing are associated with the capacity to maintain harmonious and interdependent relationships with others (Ho & Chiu, 1994). This is achieved through prioritising group needs and goals over personal ones, and actively engaging in the reciprocal meeting of relational responsibilities and obligations (Markus & Kitayama, 1991). In contrast, it is hypothesized that a more Individualist-oriented worldview highlights the uniqueness of the individual, and places more importance on personal needs and goals over social ones. Accordingly, emotional maturity and wellbeing within an Individualist-oriented worldview are linked to the expression of personal views and uniqueness, and experiencing oneself as separate from others (Markus & Kitayama, 1991).

Many cultures in Asia, Africa, Latin America, southern Europe and Oceania are associated with being collectivist-based, while mainstream North America, Western Europe and Australia and New Zealand societies have been perceived to be more Individualist- oriented (Markus & Kitayama, 1991). Some evidence for this theorizing was found in a study carried out by Hofstede and his colleagues (Hofstede & Bond, 1984). Involving more than 117,000 employees of a large multi-national corporation (IBM), the results of the study indicated that employees from the United States, Canada and Western European countries scored more highly on individualist traits, while employees from Asian, Latin American and African countries scored higher on collectivist dimensions (Hofstede & Bond, 1984). A more recent meta-analysis by Oyserman, Coon, & Kemmelmeier (2002) involving 170 studies, found less systematic

differences between countries and regions that were perceived in the Hofstede study (1984) as being either more collectivist or individualist. However, the researchers did find stronger evidence for individualist and collectivist traits on a more individual level.

For example, the findings of the study indicated that collectivism was associated with the use of social self-descriptors, the need for being part of a group, sensitivity to being rejected by others, and the belief that positive self-esteem was associated more with family life than personal success. Oyserman et al. (2002) also found that collectivism was associated with situational attribution, cooperation in problem solving, strategies of accommodation and negotiation in conflictual social situations, and indirect communication. In contrast, the researchers found that individualism was correlated with an increased use of personal self-descriptors, the belief that positive self-esteem derived more from personal success than family life, dispositional attribution, goal-focussed problem solving, direct communication, and greater use of confrontation as a strategy in conflictual social contexts.

Williams (2003) suggests that the findings from Oyserman et al. (2002) are relevant for mental health service contexts. He suggests that by recognising and understanding the extent of service users' collectivist and individualist values, mental health providers can better understand service users' perspectives on their current problems; how they view and relate within the therapeutic relationship, and their perspectives on solutions for addressing their presenting problems. According to Williams (2003), part of developing this deeper understanding for service providers, is associated with service providers having the capacity to distinguish the differences between their and their clients' worldviews (Williams, 2003). For example, Constantine (2001) found that counselling students who reported higher individualist traits were less able to conceptualise a case from a multicultural perspective, and were less likely to

integrate situational factors into their case formulations than those counselling students who reported having more collectivist traits.

Ethnic Identity

Ethnic identity refers to a person's identity or sense of self as a member of an ethnic group (Phinney, 2003). It is considered a multi-dimensional construct with components that include identifying oneself with a particular ethnic group; experiencing a sense of belonging, pride and commitment to that group; having knowledge of its' history and traditions; sharing values and beliefs that are important to that group; and participating in activities associated with that group (Phinney, 2000; Smith & Silva, 2011; Ashmore, Deaux, & McLaughlin-Volpe, 2004).

Much of the theorizing about the concept of ethnic identity is based on Tajfel and Turner's social identity theory (Tajfel & Turner, 1986). They describe social identity as an individual's sense of belonging to a group and their attitudes and feelings associated with being part of that group. Social identity theory suggests that group identity is an important component of an individual's overall self-concept. This is because individuals typically place value on the groups they have membership in, and derive self-esteem from their sense of belonging to these groups. It is proposed that ethnic identity is one type of group identity that is particularly salient for ethnic minority group members because of their distinctiveness, and therefore their potential to be discriminated against (Phinney, 2003; Tajfel & Turner, 1986). It is suggested a person who identifies with a group that is discriminated against by the majority culture may subsequently accept the negative evaluation of that group and internalize these evaluations (Tajfel & Turner, 1986; Phinney, 2003).

In the face of opposition and marginalization, research indicates that having a strong ethnic identity may help individuals minimise the effects of these negative evaluations by helping them to recognise and affirm the positive attributes of their own ethnic group (Outten, Schmitt, Garcia, & Branscombe, 2009). A strong ethnic identity has been associated with positive self-esteem and personal adjustment (Phinney, Cantu, & Kurtz, 1997). However, some research has also noted that having a strong ethnic identity may potentially heighten distress as individuals are more attuned to inter-ethnic differences and perceived discrimination (Yip, Gee, & Takeuchi, 2008).

Acculturation and Acculturative Stress

Acculturation has been defined as the changes that occur in attitudes, values and behaviours as a result of interaction between two distinct cultures (Berry, Trimble, & Olmedo, 1986; Berry, 2006). It is considered a dynamic and multi-directional process that typically involves ethnic minority individuals and groups negotiating two or more cultures over a period of time (Berry, 2003; Berry, Kim, Minde, & Mok, 1987). Evolving out of a series of research studies, Berry's (1987; 1997) acculturation model describes four adaptation strategies: *Assimilation* which is associated with an individual giving up their cultural identity and values of origin in favour of the cultural values of the dominant culture; *Integration* which involves the maintenance of one's cultural values and identity and participation in the dominant culture's values; *Separation* which is related to valuing one's cultural norms and not participating in the cultural norms of the dominant culture; and *marginalization* in which one does not retain or participate in one's own culture of origin, nor the dominant group's cultural practices.

The term acculturative stress has come to describe both the positive (e.g., new opportunities) and negative (discrimination) aspects of increased stress associated with the acculturation process (Berry & Kim, 1988; Berry, 2003). Many people dealing with acculturation stressors are able to work through these conflicts and challenges with time (Berry, 2006; Rudmin, 2009). However there is evidence that for some ethnic minority individuals and communities, acculturative stress may become problematic with an increased risk for psychological problems (Balls Organista, Organista, & Kurasaki, 2003).

Evidence suggests that the acculturation strategy of marginalisation is the most likely to be associated with poorer mental health and self-esteem, while integration is considered the least stressful strategy, particularly if accommodated by the dominant cultural group (Berry & Kim, 1988; Ward & Kennedy, 1994). Assimilation and separatism are suggested to be situated between the other two strategies, one being more stressful than the other depending on the context (Berry & Kim, 1988; Ward & Kennedy, 1994).

Two models associated with acculturative stress, the *immigration stress* model and the *social stress* model have been posited (Marin, Organista, & Chun, 2003). The *immigration stress* model asserts that recent migrants may experience various cultural and social challenges including isolation from family and social networks, language, employment, and accommodation barriers that heighten susceptibility to psychological and physical health problems (Marin et al., 2003; Chun, Balls Organista, & Marin, 2003). The *social stress* model associates long-term residency and higher acculturation levels with poorer mental and physical health outcomes. For example, one study found that as Latino Americans lived longer in the United States, they were more likely to experience psychiatric and substance use disorders (Ortega, Rosenheck, Algeria, &

Desai, 2000). It is suggested that these findings may relate to the decline of traditional

Latino cultural values including the loss of protective family and social supports,

continual discrimination, and adjustment to new cultural values (Balls Organista et al.,

2003).

Discrimination and Socio-economic Status

Discrimination has been associated with experiencing mental health problems.

One large study that involved three migrant groups within Finland (Jasinskaja-Lahti,

Liebkind, Jaakkola, & Reuter, 2006), and a Spanish study that involved five ethnic

minority groups from South American and Africa (Zlobina, Basabe, Paez & Furnham,

2006) found that perceived discrimination strongly predicted psychological stress.

Experiencing socio-economic hardship has also been linked to increased susceptibility

to psychological problems (Dohrenwend, 2000. One study in the United States, found

that unemployment, poverty and high housing costs were associated with a higher risk

of experiencing a mental disorder (Hudson, 2005).

Mental Health Status and Service Use Patterns

Mental Health Status

Epidemiological studies in the United States suggest that some ethnic minority

groups experience higher rates of mental disorder. African Americans and Latino

Americans were found to have higher prevalence rates than white Americans across a

wide range of disorders including anxiety disorders (Kessler et al., 1994), bipolar

disorder (Breslau, Kendler, Su, Gaxiola-Aguilar, Kessler, 2005) and schizophrenia

(Blow et al., 2004). In the United Kingdom, studies have also reported higher

prevalence rates of psychosis among some ethnic minority groups compared with white

Britons, particularly for Afro-Caribbean Britons (Bhugra et al., 1997), which are not matched by prevalence rates in the Caribbean (Hickling & Rodgers-Johnson, 1995). Furthermore, epidemiological studies have suggested variation in mental disorder prevalence rates within some ethnic minority groups depending on whether ethnic minority individuals were recent migrants or long term residents. For example, Latino people born outside of the United States have been found to experience lower rates of mental disorders than those who were born in, or are long-time residents of the United States (Alegria et al., 2008; Vega et al., 1998).

Service Use Patterns

Despite experiencing higher prevalence rates for psychological disorders, evidence indicates that ethnic minority groups tend to under-utilize mental health services in western countries (Sue, 1998; Snowden & Yamada, 2005). In the United States, Latino Americans, African Americans and Asian Americans attend less visits to community mental health services and utilise psychotherapy less than white Americans (Padgett, Patrick, Burns, & Schlesinger., 1994; Lasser, Himmelstein, Woolhandler, McCormick, & Bor, 2002). This discrepancy remains even after the control of socioeconomic variables (Worthington, 1992). Similarly in Canada, a large epidemiological study has found that Chinese, South Asian and South East Asian minority groups are also less likely than white Canadians to use mental health services (Tiwari & Wang, 2008), as are Vietnamese and Malaysian migrants in Australia (Bruxner, Burvill, Fazio, & Febo, 1997). There is also evidence indicating that some ethnic minority groups are also more likely to terminate treatment early as demonstrated in the United States (Sue, 1998; Gallagher-Thompson, Solano, Coon, & Arean, 2003), and the United Kingdom (Gupta, 1991). Furthermore, some ethnic

minority groups are over-represented in inpatient services with more acute disorders. For example, Afro-Caribbean groups in the United Kingdom (Harrison, Owens, Holton, Neilson, & Boot, 1988) and Sweden (Zolowska, Cantor-Graae, & Mcneil, 2001); and Moroccan and Surinamese ethnic groups in the Netherlands (Selten et al. 2001).

Barriers in Accessing Services

Various explanations have been proposed to account for ethnic minority groups' underutilization of mental health services, with stigma being identified as a significant barrier (Anglin, 2006). Gary (2005) suggests that ethnic minority groups who may already be exposed to discrimination suffer double stigma in experiencing mental illness. One study involving Asian Americans suggested that shame and loss of face may contribute to their low rates of mental health service use (Chow, Jaffee, & Snowden, 2003). Another study in the United States, found that African American and migrant Black Caribbean women were more likely than White American women to identify stigma associated with mental illness as a reason to not seek help from services (Nadeem et al., 2007). The reasons for experiencing shame and stigma also varied. One study indicated that some Mexican Americans avoided seeking help from mental health services because they associated mental unwellness with being 'weak' (Leong, Wagner, & Tata, 1995). Another study found that Arab American women were particularly vulnerable to the stigma of mental unwellness as it could impact on marriage prospects and increase the likelihood of separation or divorce (Al-Krenawi & Graham, 2000).

A further barrier in accessing services has been suggested as the tendency for some cultural groups to source help from more informal supports such as family, medical practitioners, herbal medicine, clergy and church, rather than mental health services (Flaskerud, 1986; Brown, Abe-Kim, & Barrio, 2003) It is suggested that

assistance from these alternative sources may be preferred because of stigma, and the increased likelihood that these sources share similar worldviews (Flaskerud, 1986). Furthermore, in some cultural groups, people may be encouraged to rely on their own inner resources to face problems and 'tough out' challenging situations as was found in one study with African Americans (Snowden, 2001). Another study involving American Puerto Ricans found that individuals with high levels of self-reliance and who met criteria for mental health treatment were much less likely to seek treatment than the overall population (Ortega & Algeria, 2002); while a similar study of Chinese Americans found that those who reported high levels of having a 'hardy' personality were also less likely approach services (Kung, 2003).

Barriers in Using Services

In relation to working with ethnic minorities, western mental health service frameworks have been criticised as euro-centric (Sue, 1998; Fabrega, 2001). This includes the conceptualisation and assessment of presenting problems. One study found that a contributing factor to the under utilization of services by Native Americans may be related to services not accounting for indigenous spiritual beliefs pertaining to mental unwellness (Gone, 2010). There could also be limited awareness in western mental health services of distinct symptom patterns and expression of psychological distress by ethnic minority groups (Baker & Bell, 1999; Brown, Abe-Kim, & Barrio, 2003; Moffic & Kinzie, 1996).

In the United States, Sue (1998) suggests that a lack of cultural understanding has not been helped by the tendency for mental health professionals working with ethnic minority group members to be white Americans. There is evidence that mental health professional not sharing ethnic, worldview, sociocultural or language similarities

with service users they are working with may be a barrier and reason for the underuse of services by ethnic minority groups in the United States (Sue & Sue, 1999; Zaya, Torres, Malcom, & DesRosiers, 1996).

Verbal and non-verbal communication barriers have also been identified as barriers to service use by ethnic minority groups (Moffic & Kinzie, 1996; Sue & Sue, 2003). A review study of mental health services in 16 European countries reported language difficulties as being a significant impediment in service use by ethnic minorities (Watters, 2002). One study also found a lack of understanding regarding variations in communication, such as direct eye contact being disrespectful, could also contribute to cultural misunderstanding (Andrews & Boyle, 2003).

Lack of cultural understanding may lead to culturally insensitive clinical practices in mental health settings (Sue, 1998) and mistrust, (Nickerson, Helms, & Terrell, 1994; &Whaley, 2001). It is suggested that theories and therapeutic practices that are not modified to suit ethnic minority groups may lead to mental health professionals working at odds with ethnic minority service users resulting in early termination from services (Organista, Munoz, & Gonzalez, 1994). Other practical barriers that have been noted include inaccessibility of services and costs associated with psychotherapeutic services (Anglin, Albert, Link & Phelan, 2008).

Supports in Accessing and Using Services

Language support and having mental health providers who share ethnic, cultural, linguistic and similar worldviews have been suggested as important supports to ethnic minority groups using mental health services in western countries (Flaskerud, 1986; Sue, 1998). One study in the United States found ethnic-specific programmes seemed to increase service use for Afro-American, Asian Americans and American

Mexicans in Los Angeles (Takeuchi, Sue, & Yeh, 1995). A similar study in Australia involving Vietnamese migrants, found ethnic matching was positively related to more frequent contact and a longer period of treatment in the use of community mental health services (Ziguras, Klimidis, Lewis & Stuart, 2003). However, similarity of worldviews has been suggested as being a more important aspect than just ethnic matching (Sue & Sue, 2003; Chang & Berk, 2009). Chang and Berk (2009) suggest that ethnic match may be more relevant for service users whose ethnic identification is a particularly salient component of their overall identity. Chang & Berk (2009) also found that mental health service providers that are knowledgeable and sensitive to service users' cultural backgrounds, and who take the time and effort to understand ethnic minority service users and their cultural context can still be very effective in providing useful treatment, despite not sharing the same ethnic and cultural background.

Spirituality is an important aspect in the lives of some cultural groups (Brown, Abe-Kim, & Barrio, 2003), and it is recommended that service providers understand the spiritual beliefs of service users as they can influence compliance to treatment (Abu Raiya & Pargament, 2010). It is further suggested that mental health professionals be open to considering and integrating religious and spiritual aspects into therapeutic interventions as appropriate (Abu Raiya & Pargament, 2010). Finally, Sue and Sue (2003) suggest that in many cultures, the family is perceived as the primary source of support in times of distress. They recommend that mental health professionals need to recognize this aspect, and support family involvement in their affected family member's treatment as appropriate.

There is evidence indicating that some ethnic minority groups such as Latino and Asian Americans prefer active and directive therapeutic approaches over indirective approaches that emphasize self-disclosure and insight (Sue & Morishima,

1982; Sue & Sue, 2003). It is also suggested that multi-systemic approaches are beneficial; for example, the inclusion of social, economic, legal and medical assistance alongside psychotherapeutic services (Flaskerud, 1986). Modification of therapeutic interventions to increase treatment effectiveness for individuals from minority groups has also been suggested (Dowd, 2003; Nagayama & Hall, 2001) as has the placement of community mental health services near targeted populations (e.g., Flaskerud, 1986).

Pacific People, Mental Health and Service Use

This section begins with an overview of Pacific people in New Zealand before discussing traditional Pacific worldview and perspectives on wellbeing. It then provides an overview of Pacific people's mental health status and patterns of mental health service use before examining the literature regarding barriers and supports that Pacific people experience in accessing and using services.

Pacific Migration and Settlement in New Zealand

Since the 1950's Pacific migrants have established communities in countries such as the United States, Australia and New Zealand, that have become increasingly distinctive from those communities in their original Pacific homelands and other migrant communities (Anae, 1997). Large scale settlement from the Pacific Islands to mainly urban centres in New Zealand began in the period immediately after the Second World War (Macpherson, 2004), in response to a demand in New Zealand for workers in the growing manufacturing and service industries (Spoonley, 2001). Prior to this, New Zealand's immigration policy first as a British colony and then as a dominion had been characterised by a marked preference for British and Irish migrants, making New Zealand the most culturally homogenous country for immigration (Spoonley,

Macpherson, & Pearson, 2004). For Pacific people, a primary motivation for migrating to New Zealand was the opportunity to earn income to better support their families back in the islands (Macpherson, 1997). However, the post-war global economic boom that had provided opportunities for migration came to an abrupt halt in the mid-1970s as the global oil crisis and recession led to rising unemployment in countries such as New Zealand (Ongley, 1991). During this time, the New Zealand government began enforcing immigration regulations through dawn raids against Pacific Island 'overstayers' that had been lax while the economic boom lasted (Te Pou, 2010). Since the peak migration of the early 1970's, migration from the Pacific Islands has declined apart from the Cook Islands, Niue and Tokelau whose people have New Zealand citizenship, and from Samoa who has a quota agreement with New Zealand that allows for 1100 people to migrate to New Zealand each year (Te Pou, 2009).

Socio-demographic Status of Pacific People

There is a wide socio-cultural diversity amongst Pacific people in New Zealand with differences not only between Pacific island groups, but also within island groups in relation to language, values and customs (Kokaua, Schaaf, Wells, & Foliaki, 2009). At present, there are over 20 different Pacific cultures and even more Pacific languages in New Zealand (Ministry of Health, 2005). At the 2006 census, Pacific people comprised almost seven percent of the New Zealand population, and this proportion is expected to increase to twelve percent by 2051 (Cook et al., 2001). People of Samoan descent make up the biggest group comprising 49 percent of Pacific people in New Zealand followed by those who identify as Cook Island (22%), Tongan (19%), Niuean (8%), Fijian (4%), Tokelauan (3%) and Tuvaluan (1%) (Statistics New Zealand, 2006). The Pacific population is a much younger population than the overall New Zealand population with a median age of 21.1 years compared with the overall New Zealand

population median at 35.9 years (Statistics New Zealand, 2006). Most Pacific people

live in the main urban regions in the North Island, with two-thirds (66.9 percent) living

in the greater Auckland region (Statistics New Zealand, 2006). At the time of the 2006

Census, sixty percent of people of Pacific ethnicity were born in New Zealand. In

relation to language, a decline has been recorded in the proportion of Pacific people

having the ability to speak their own language (Statistics New Zealand, 2006).

In terms of real median income, Pacific people aged 15 and over, were recorded

as earning $20,500, lower than the median annual income for New Zealand overall

($24,400) (Statistics New Zealand, 2006). Regarding religion, 83 percent of Pacific

people were recorded as having at least one religion, compared to the overall New

Zealand population at 61 percent. A further socio-demographic trend that has been

noted is the growing proportion of Pacific people who identify with more than one

ethnic group (Oakley Brown et al., 2006). In 1997, 54 percent of children of Pacific

ethnicities had multiple ethnicities, with 42 percent having at least one non-Pacific

ethnicity (Cook et al., 2001).

Pacific Worldview and the Relational Self

Although there is diversity amongst Pacific cultures, there is general consensus

that their worldviews and cultural identity formation are relational-based (Helu-

Thaman, 1995; Te Pou, 2010). Bush, Collings, Tamasese, & Waldegrave (2005) have

described the Samoan self as only having meaning in relationships to others, and that

the self cannot be separated from the *va* or relational space occurring between a person

and their family and community. Anae (2007) notes that *va* is a concept that is central

to many Pacific cultures and describes spatially, the appropriate qualities and

boundaries in and around relationships which promote personal and communal well-

being. Wendt (1996) further suggests that *va* is not an empty space that separates, but is a dynamic space that relates, providing context and meaning. According to Autagavaia (2000), the *va* is not to be tainted by disrespectful behaviour. It requires the nurturing and maintaining of relationships, and part of this process involves people meeting their mutual obligations and responsibilities to each other (Mila-Schaaf, 2006; Ka'ili, 2005).

Having harmonious relationships with the spiritual domain, and the importance of spirituality to Pacific people is well documented in the literature (Lui & Schwenke, 2003; Tamasese, Peteru, Waldegrave, & Bush, 2005). From a Samoan perspective, Lui and Schwenke (2003) define spirituality as the feeling of connectedness a person has to the non-physical side of their being. It includes a person's connectedness to their ancestors, their land and God/gods. For many Pacific people, spirituality includes pre-European tapu beliefs as well as Christian beliefs, which according to Samu & Suaalii-Saunui (2009) may appear philosophically incongruent but are generally accepted alongside each other.

Traditional Perspectives on Mental Unwellness and Treatment

In some Pacific cultures there is a belief that mental unwellness has its origins either in traditional Pacific cosmologies or has been "introduced" by outsiders, such as Europeans (Macpherson & Macpherson, 1991; Vaka , Stewart, Foliaki, & Tuitahi, 2009). In relation to traditional causes, Pacific cultures generally do not consider mental unwellness to necessarily originate entirely from within a person (Bathgate & Pulotu-Endemann, 1997). Mental unwellness is often perceived as a 'spiritual' possession resulting from a breach of tapu or sacred covenant by the person or a member of their family against other people or their gods (Suaalii-Sauni et al., 2009; Tamasese et al., 2005). In Tonga, three traditional types of mental unwellness are

'Avanga, *Te'ia* and *Mala. Avanga* and *Te'ia* both refer to the possession of a person typically by bad spirits, while *Mala* refers to a person who has been cursed for breaking cultural norms and values (Puloka, 2009). In Samoa, there is *Fasia*, which according to Tamasese, Peteru , & Waldegrave (1997) occurs when a person has been struck by a spirit, for causing offence to that spirit. *Saua* on the other hand, is when a person is affected by the spell or influence of a spirit, typically for trespassing on tapu ground. *Malaaumatua* and *malaaunuua* refer to a person being cursed by their parents or village chiefs when a particular tapu has been breached (Tamasese et al., 2005). The traditional Pacific approach to healing mental unwellness caused by spiritual possession has been to seek healing from traditional healers who are believed to be able to access supernatural powers necessary to restore balance in affected areas (Suaalii-Sauni et al., 2009).

The Mental Health Status of Pacific people

The Te Rau Hinengaro epidemiological survey (2005) found that Pacific people experienced higher rates of mental disorders than the overall New Zealand population. It was found that over a one-year period, 25% of Pacific people had experienced mental disorder compared with 20.7% of the total New Zealand population, while lifetime prevalence rates suggested 46. 5% of Pacific people had experienced a mental disorder compared with 39.5% of New Zealanders overall (Oakley Browne et al., 2006). For Pacific people, the most commonly reported disorders over a one year period were: anxiety disorders (27.7%) compared to 14.8% for the non-Pacific population; mood disorders (8.6%) compared to 7.9% for the non-Pacific-population; and substance abuse disorders (5.3%) compared to 3.5% for the non-Pacific population. However, once adjustments for age, sex, educational qualifications and household incomes were made,

mental disorder prevalence rates were similar for Pacific people and the non-Pacific population (Oakley Browne et al., 2006). The exceptions to this pattern were the higher prevalence rates for bipolar disorder, substance abuse disorders, and suicidal ideation, planning and attempts, where differences even increased after adjustments (Oakley Browne et al., 2006). Furthermore, the survey found that even after adjusting for the younger age structure of the New Zealand-born population, over a one year period, 31.4% of New Zealand-born Pacific people experienced a mental disorder compared to 15.0% of Pacific people who had migrated to New Zealand after the age of 18 (Browne Oakley et al., 2006).

A further epidemiological study, the New Zealand Mental Health Classification and Outcomes Study (CAOS) (2004) found that Pacific people were more likely to be inpatient service users than the general population, and were more likely to only access services in acute phases of their unwellness. It also found that Pacific people had higher costs of care for inpatient and community care episodes than other ethnic groups (Pulotu-Endemann et al., 2004).

Socioeconomic Risk Factors for Mental Unwellness

Evidence indicates that Pacific people experience poorer health outcomes than the general New Zealand population including shorter life and health expectancies than the overall New Zealand population (Ministry of Health, 2012). They also experience higher rates of chronic diseases including diabetes, cardiovascular problems and diseases of the respiratory system (Te Pou, 2010; Ministry of Health, 2012), and are more likely to live in lower socio-economic areas (Ministry of Health, 2005). Evidence suggests that acute and chronic socioeconomic factors impact significantly on Pacific peoples' poor health status including mental health (Ministry of Health, 2005; Oakley

Browne et al., Foliaki, 2001). These stressors include low income, unemployment, prohibitive housing costs, substance abuse, the breakdown of extended family networks, cultural adjustment difficulties and cultural fragmentation (Foliaki, 2001; Tamasese et al., 2004; Ministry of Health, 2005).

Pacific People and Service Use Patterns

Despite experiencing higher rates of mental health disorder than the general New Zealand population, epidemiological research indicates that Pacific people had lower rates of mental health visits compared with other ethnic groups (Oakley Browne et al., 2006). Over a one year period, and before socioeconomic adjustments, only 24.5% of Pacific people with a mental disorder made a mental health visit compared with 41.1% of non-Pacific New Zealanders. Even after adjusting for socio-economic variables, there was minimal change in these percentages (Oakley Browne et al., 2006). Furthermore, although the Te Rau Hinengaro survey (2005) found there was only a small difference between Pacific people (5.9%) and the overall New Zealand population (4.7%) in relation to experiencing a severe mental disorder; only 25% of the Pacific people who experienced a severe mental disorder visited a mental health service compared to 58% of the overall New Zealand population who had experienced a severe mental disorder. Of Pacific people who had experienced a moderate disorder, only 26.5% had a mental health visit compared with 36.5% of the overall population (Oakley Browne et al., 2006). These patterns of underutilisation of services by Pacific people suggest that there are other reasons that Pacific people do not use services (Oakley Browne et al., 2006).

Accessing and Using Mental Health Services - Barriers and Supports

Accessing Services

A small number of studies and practice recommendations have provided insight into the barriers that might lead to Pacific people not accessing services when there has been a need. One such study by Agnew et al. (2004,) investigated how mental health services might more effectively meet the needs of Pacific people. The researchers examined the perspectives of service providers, service users, family members, and several ethnic minority mental health researchers from overseas, through interviews and focus groups. Their research identified stigma associated with the experience of mental unwellness in Pacific communities, was a significant barrier to approaching services. Samu & Suaalii-Saunui (2009) suggest that this stigma is reflected in Pacific terms for mental unwellness that are often deprecating and reinforce shame for those affected by unwellness.

Traditional Pacific values and beliefs also tend to emphasize the responsibility of Pacific families to care for their own, particularly in times of hardship, and is implicated as a further rationale for Pacific peoples being reluctant to access services (Pulotu-Endemann et al., 2004). A further qualitative study commissioned by Te Pou (National Organization for Mental Health Research, Information and Workforce Development) (2010), found that embarrassment and guilt may also be exacerbated for families when they are not able to meet these expectations. Polotu-Endemann et al. (2004) in a report on Pacific perspectives in the New Zealand Mental Health Classification and Outcomes Study (CAOS) further suggested that for some Pacific service users and their families, having previous negative experiences or hearing about others' negative service experiences could also be a barrier to re-engaging or engaging with services. Pacific families could also have concerns about entrusting their family

member to the care of strangers (Te Pou, 2010). In another small study, Malo (2000) who investigated the perspective of Pacific service users regarding their experience of mental health services, found that a lack of knowledge and general information about mental unwellness, and how to access help, were also implicated in Pacific people not approaching services earlier.

Limited Cultural Competence

Samu & Suaalii-Sauni (2009) conducted a qualitative study to investigate the notion of Pacific cultural competency within the context of mental health services. They interviewed Pacific service providers, Pacific service users and their families, as well as Pacific community leaders. Out of this research, Pacific cultural competency was defined as the ability of service providers and services to be responsive to the cultural needs of Pacific people by having the relevant knowledge, attitudes, skills, and professional judgement. They further suggest that an important component is a service provider's ability to integrate cultural and clinical beliefs and practices. It has been suggested that services and service can demonstrate limited cultural competency in working with Pacific people resulting in their needs being inadequately met (Te Pou, 2009). Specifically, there may be a limited awareness of Pacific cultural worldviews and beliefs associated with the aetiology and treatment of unwellness that often conflict with western understandings (Lui & Schwenke, 2003). Service providers having limited knowledge of historical, social and economic factors that shape the experiences of Pacific people in New Zealand has also been suggested as a barrier to service providers having a better understanding of Pacific service users' problems (Te Pou, 2009; 2010). Furthermore, cultural misunderstanding of Pacific beliefs may lead to

misdiagnosis and inappropriate and invasive treatment, which may contribute to a mistrust of service providers and services (Pulotu-Endemann et al., 2004).

Supportive therapeutic interventions for Pacific people in services requires not only understanding of their cultural beliefs, values and practices, including those associated with mental wellbeing (Samu & Suaalii-Sauni, 2009), but the effective implementation of this understanding into therapeutic practices (Te Pou, 2009). Robinson (2006) suggests that the service providers that are most effective in working with Pacific service users (and their families) are those that have a sufficient knowledge of both mental health principles and Pacific cultures and processes, and are able to integrate both western and Pacific knowledge bases. Following, are the areas that the research and clinical literature highlight as being important to consider in association with the barriers and supports Pacific people may experience in using services.

Family

Involvement of Pacific families, as might be expected of more collectivist and familial-oriented cultures, has been identified as an important component of the healing process, (Pulotu-Endemann, et al., 2004), although this may not always be appropriate depending on individual circumstances (Samu & Suaalii-Saunui, 2009; Te Pou, 2010).

A number of barriers related to a lack of recognition and support by services of Pacific service users' families have been noted. One such barrier concerns the concept and practice of confidentiality. According to Tamasese et al. (2005), whose qualitative study examined Samoan relational concepts of self, confidentiality and privacy issues may be conceived as western concepts that do not account for the importance of family and may marginalise Samoan service users and their families, excluding them from assessment and treatment processes. A further barrier that has been identified is the

inaccessibility of services and limited practical support (e.g., transport, advocacy, respite) to help Pacific people look after their unwell family members (Pulotu-Enemann et al, 2004; Annadale & Instone, 2004). Service approaches that have been suggested as supporting families include service providers working collaboratively with service users and their families (Te Pou, 2010), and the inclusion of effective psychoeducation (Te Pou, 2010; Pulotu-Endemann et al., 2004).

Spirituality

Spirituality is an intrinsic aspect of many Pacific peoples' lives and includes Christian beliefs as well as pre-European spiritual beliefs based on Pacific cosmologies (Agnew et al., 2004). According to a key note address by Lui & Schwenke (2003), published by the Health Commission, the Spiritual dimension is often overlooked when considering the mental health needs of Pacific people, resulting in therapeutic interventions being less appropriate and responsive than is needed. Samu & Saunui-Suaalii (2009) also highlight the importance of service providers understanding the spiritual beliefs of Pacific service users.

Language and Communication Barriers

Language and conceptual barriers in relation to medical and clinical terminology have also been identified as hindering Pacific service users and their families for whom English is not the first language (Malo, 2000; Te Pou, 2010), as has limited understanding of non-verbal body language by service providers with limited Pacific cultural knowledge (Te Pou, 2010).

Therapeutic Relationships and Therapy

Findings from the Te Pou study (2010) suggest that effective initial engagement based on Pacific relational values is important in encouraging Pacific service users and their families to access and continue using services. This is associated with the value that Pacific cultures place on relationships (Mila-Schaaf & Hudson, 2009). It has been recommended that service providers make holistic and authentic connections with Pacific service users, based on respect, humility and treating service users with dignity; and that they have some understanding of the notion and the operation of the v*a* within families Te Pou, 2010). The importance of the practice of hospitality as it is understood within a Pacific cultural context is also recommended (Te Pou, 2010).

In relation to helpful therapeutic interventions for Pacific people, the Te Pou study (2010) suggests the need for flexibility and the modification of western therapeutic approaches to fit Pacific needs. For example, direct questioning could be perceived by some Pacific families as intrusive and rude. Provision of practical rehabilitation programmes with a focus on gaining work experience was also recommended by Malo (2000) as supporting reintegration into the community.

Pacific Services and Providers

Malo (2000) also found that the presence of Pacific service providers could be beneficial for Pacific service users in that Pacific providers were likely to better understand service users' cultural values, belief systems and practices. He also suggests that for some Pacific service users who utilised Pacific mental health services, there could be an appreciation of the family structured environment that these services were often modelled on, encompassing both service users and providers. This model of service could potentially provide for enhanced practical, emotional and spiritual support

for service users. Tamasese et al. (2005) have also recommended the inclusion of cultural advisors and providers in mainstream services. It is argued that cultural advisors not only provide cultural and language support for clinical service providers from non-Pacific backgrounds but are helpful in building connections with Pacific people for whom there may be language and cultural barriers (Te Pou, 2010).

In summary, there is evidence that Pacific people experiencing mental health problems do not access and use mental health services as much as the general population. This chapter has examined the research relevant to ethnic minorities in western countries in relation to their mental health needs and use of mental health services, as well as the research and practice recommendations regarding Pacific peoples' mental health needs and their use of mental health services in New Zealand. Only a small number of studies have investigated Pacific people's experiences in using mental health services. This current study aims to investigate the barriers and the supports for Pacific people accessing and using mental health services. It is a qualitative study that investigates the views and experiences of Pacific service providers and past service users. The methodology and methods of this study are presented in the next chapter.

CHAPTER TWO: METHODOLOGY

Research into the mental health of Pacific people in New Zealand has been scant, and this limited enquiry has extended to Pacific people mental health needs particularly in relation to service use (Health Research Council, 2005). The primary aim of this study was to better understand the barriers and supports that Pacific people face in using mental health services, drawing on the perspectives of Pacific service providers and former Pacific service users. This aim was informed by a real world (or realist) research which supports the notion that a primary by-product of research has beneficial applications in everyday life (Robson, 2002).

This chapter presents the methodology and methods of this thesis study. Silverman (2006) defines methodology as how a researcher goes about researching their study. He suggests that methodology may be defined broadly (e.g., qualitative or quantitative) or more narrowly (interpretative or post-structuralist), while methods are specific research techniques such as surveys or interviews. Silverman (2006) advocates that methodologies and methods not be perceived in terms of being true or false, rather as being more or less useful dependent on the nature of the study.

For the purposes of this research, a qualitative methodology with an interpretative orientation (Merriam, 2002), and the *Talanoa*-a Pacific –based research approach (Vaioleti, 2006), have been selected to inform and ground this research. These approaches are considered to be in harmony in that they are both interested in understanding the meanings participants make of their life experiences (Merriam, 2002; Vaioleti, 2006). The first part of this chapter discusses the qualitative methodology while the second part outlines the methods used in the study including recruitment procedures, data collection and data analysis.

Methodology and the Qualitative Approach of this Study

A quantitative research approach based on the positivist paradigm pervaded social science research for much of the 20th century (Denzin & Lincoln, 2000). The application of this approach particularly in biological-based areas such as medicine and experimental research netted significant knowledge gains in a relatively short space of time, and it was anticipated by researchers in the emerging discipline of social sciences that similar advances might be gained with the application of a quantitative research approach (Fossey, Harvey, McDermott, & Davidson, 2002). The quantitative approach is characterised by the use of deductive logic, measurement and hypothesis testing in order to disprove proposed theories, confirm causal relationships laws between variables (not processes), and make generalizations about the phenomena being studied (Denzin & Lincoln, 2000; Fossey et al., 2002). It aims to be objective and value-free, and suggests that phenomena being studied can be reduced down to 'component parts' allowing for deeper understanding of the phenomena being researched (Denzin & Lincoln, 2000; Fossey, et al., 2002).

However, since the 1970's, there has been a proliferation of criticism in social science research circles regarding the application of a quantitative-positivist approach (Smith, Harre, & Van Langehove, 1995). Guba and Lincoln (1994) suggest it decontextualizes phenomena being studied, omits meaning and purpose, and inappropriately applies outsider (etic) theories on insider (emic) experiences.

In response, the development and diversification of qualitative research approaches has bourgeoned in recent decades (Guba & Lincoln, 1994; Merriam, 2002). However, despite the wide range of approaches on offer, there are underlying commonalities that allow for these approaches to be grouped under the qualitative

methodology banner (Denzin & Lincoln, 2000). According to Merriam (2002), all qualitative research is based on the acceptance of the socially constructed nature of reality in which meaning is constructed by individuals interacting with their environment. Moreover, there is no set or single reality that can be accurately measured as is the aim in quantitative research, instead there are multiple and fluid constructions and interpretations of reality.

From this common foundation, qualitative research shares further characteristics. Firstly, qualitative researchers concur a primary aim of their enquiry is to better understand the meaning and interpretation that people make about their world and their experiences, emphasising that this process be from an emic viewpoint (insider's perspective) rather than an etic (outsider's perspective) (Denzig & Lincoln, 2000; Merriam, 2002). Secondly, there is agreement regarding the intimate relationship between the researcher and what is being researched (Denzin & Lincoln, 2000). This includes the researcher being the primary tool for data collection and analysis, which allows for immediate adaptability and responsivity including the checking and summing of material, and exploration of unanticipated responses (Merriam, 2002). However, biases may arise owing to the subjectivity of the researcher, therefore, transparency and explicitness on the part of the researcher is encouraged (Madill, Jordan, & Shirley, 2000; Merriam, 2002).

A third characteristic of qualitative research is its inductive nature whereby researchers gather data to develop hypotheses as opposed to deductive-based hypotheses favoured in a positivist approach, while a fourth commonality is that qualitative findings are summarised in the form of rich verbal descriptions as opposed to numeric findings (Merriam, 2002). The richness and descriptiveness of qualitative

data facilitates 'discovery' as opposed to merely verifying an existing hypothesis (Ambert, Adler, Adler & Detzner, 1995).

Merriam (2002) suggests there are three broad orientations within qualitative research. Firstly, there is a basic interpretative approach which focuses mainly on understanding and accounting for the meaning of individuals' experiences and actions. Secondly, there is a critical orientation in which researchers emphasize and focus on broader contextual factors that are perceived to influence how participants construct and make sense of their experiences. A third approach is the post-modern or post-structuralist perspective, which stresses the researcher questioning all aspects of reality as constructed by participants.

A basic interpretative approach encompassing the qualitative characteristics outlined above has been selected to guide and inform this research. In choosing an interpretative approach for this research, my focus was in understanding better the perspectives of Pacific service users and providers regarding barriers and supports that Pacific people experience in approaching and using mental health services. This attempt to understand and find meaning has been mediated through myself as the researcher, while the strategy used is inductive and the findings are descriptive.

In conducting an interpretative qualitative study, interviews are a common means for data collection, and data analysis usually involves identifying common patterns or themes across the data set. As discussed above, findings are usually presented in a rich descriptive story which is then discussed with reference to the literature presented as a precursor to the study (Merriam, 2002). This is how the current study has been organized.

Talanoa Approach

      Pacific researchers advocate the use of Pacific research methodologies that are sensitive and responsive to contemporary Pacific contexts and issues (Coxon, Anae, Mara, Wendt-Samu, & Finau, 2002). It is imperative that these Pacific research approaches be grounded in Pacific worldviews, values, knowledge systems and ethical principles (Helu-Thaman, 2003). As Martin (2003) points out, any indigenous researcher doing indigenous research that does not centralise the core structures of their cultures and ontologies risks producing western research carried out on indigenous people. Given that this study examines Pacific service providers and Pacific service users' perspectives on barriers and supports Pacific people experience in using mental health services, it is important that a Pacific -based approach to research gives some guidance to this study. The Talanoa approach was chosen for this purpose.

      According to Vaioleti, a researcher of Tongan-descent (2006), the concept of Talanoa is common to many Pacific nations including Samoa and Fiji. He asserts that Talanoa on a surface level may be defined as a formal or informal conversation or talk; or a sharing of ideas and thoughts that customarily takes place face-to-face. *Tala* has various meanings, such as to inform, tell, relate, direct, ask or apply. *Noa* has been defined as: ordinary, nothing in particular, imaginary or void (Vaioleti, 2006). Talanoa literally translated means talking about nothing in particular or conversing outside of an inflexible agenda, but it can also refer to more significant purposeful discussions and conversations. Vaioleti (2006) further posits that the concept of Talanoa can be understood at a deeper level. He suggests that in a positive talanoa experience the *noa* creates the appropriate space and circumstances to allow for that positive encounter while the *tala* holistically integrates the participants' emotions, knowing and experiences leading to a sense of connectedness and understanding between parties.

The concept and practice of Talanoa is at the heart of the Talanoa research approach, one of the most utilised Pacific qualitative research approaches. Fletcher, Parkhill, Fa'afoi, Taleni, and O'Regan, (2009) suggest that the Talanoa approach's oral and interactive characteristics facilitate cultural authenticity and integrity. Vaioleti (2006) situates the Talanoa approach as both a methodology and method, the aim of which is to understand participants' experiences by talking, chatting or discussing important issues formally or informally, without adhering to a rigid framework. It is embedded in a strong oratory tradition, common to many Pacific cultures, in which verbal mastery, particularly in the art of negotiation and diplomacy is highly valued (Vaioleti, 2003).

The Talanoa approach emphasises the importance of the researcher establishing rapport and building positive relationships with Pacific participants. In Talanoa, researchers and participants are expected to share not only their time and knowledge but also their emotions (Vaioleti, 2003). He suggests that a constructive Talanoa encounter creates the space and opportunity to probe, question, challenge, clarify and realign views if the situation allows (Vaioleti, 2006). According to Vaioleti (2003), Talanoa research is based on an equal and collaborative partnership which aims to remove the distance between researchers and participants, providing participants with a human face they can relate to. He suggests Talanoa principles are similar to the concept of rapport in Western social research with its emphasis on "a face-to-face" interaction which facilitates the establishment of rapport and increases motivation among participants (Vaioleti, 2003; Rew, Bechtel, & Sapp, 1993).

The Talanoa recognises Pacific social values that privilege the collective, and the maintenance and nurturing of relationships in a range of contexts (Mila-Schaaf, 2006). In this way, it is aligned with the New Zealand health research guidelines for

carrying out research with Pacific people (Health Research Council, 2000). These principles include the importance of *fāiā* (building relations through kinship or affinity)*/vā fealoaloa'i* (relationships between people) and *faaaloalo* (respect).

Methods

Ethics

Ethical approval for this research was given by the University of Auckland Human Participants and Ethic Committee (2005/104; 2007/134).

Cultural Supervision

Throughout this research, an advisory group of Pacific mental health providers with research experience was utilised to guide and review this research. They were Epenesa Olo-Whaanga, Dr Monique Faleafa and Pauline Taufa. These advisors made themselves available as the need arose during the research. Having this group of advisors was considered important for several reasons. Firstly, they provided professional guidance, mentorship, and clinical expertise. Secondly, they assisted in issues of safeguarding cultural safety. Finally, having this advisory group provided valuable information on suitable approaches to recruitment, research methods, dissemination and utilization of results.

Recruitment of Participants

For service users, criteria for inclusion were: that they were of Pacific descent and identified as such; that they were aged 18 years and over; and that they had had some recent experience (in the past five years) of using a mental health service or

counselling service and were willing to talk about that. For service providers, criteria for inclusion were: that they were of Pacific descent; that they worked in a mental health or counselling setting; and had experience working with service users of Pacific descent. Participants were recruited mostly through networking and snowballing methods. Advertisements were also placed on noticeboards at the University of Auckland and in two local newspapers. Interested participants were then able to contact the researcher directly or leave contact details for the researcher to initiate contact with them. For those who were interested, a Participation Information Sheet and Consent Form were sent via email or by pre-paid post. If participants were still interested, they were given a choice of location and time that suited them. Service providers and service users had different participation sheets. In the service users' participation sheets attention was drawn to the possibility that talking about their experiences might cause them some distress. They were reminded that if this occurred, they could stop and have a break, or stop altogether. In addition, they could contact my supervisor, Dr Claire Cartwright, a clinical psychologist, if after the interview they needed someone to talk to.

Participants

Twenty-five participants took part in the study. Ten of these participants currently worked as service providers, in a range of clinical and cultural roles. Of these ten participants, two worked in counselling service settings, six worked in District Health Board (DHB) services, and two worked in Non-Governmental Organization (NGO) services. Their ages ranged from the early 30's to the mid 50's. Four of these service provider participants were males and six were females. Six identified as Samoan, while four identified as Tongan. Four of the service provider participants were either born or

raised in New Zealand from childhood, while seven were born and raised in Samoa or Tonga before migrating to New Zealand as teenagers or young adults. All the service provider participants had been working in mental health services for at least three years.

In addition, there were 11 service user participants. Nine had used only counselling services, while two had experience of both community and inpatient services. Of these service user participants, nine identified as being of Samoan descent, one as Tongan and one as Niuean. In this set of participants, there were 11 females and no males, with ages ranging between 19 and 53. They were all either born, or had lived in New Zealand from childhood. Finally, there were four participants who currently worked in service provider roles, but who had also had experience of using community and inpatient services. Three of these participants were male and one was female. Three identified as Samoan and one as Tongan. They were aged between the mid 20's and mid 40's. Previous diagnoses for those who had used services included Bipolar Affective Disorder, Depression, Anxiety, Psychosis-related disorders and Grief-related issues. The three tables (Tables 1-3) below summarise participant gender, ethnicity, and type of service worked in/or used information. Given the small size of the Pacific mental health workforce in Auckland and the issue of confidentiality, participant information has been kept to a minimum.

Table 1
Service provider participant information

Gender		Ethnicity		Service works in		
Male	Female	Samoan	Tongan	DHB	NGO	Counselling
4	6	6	4	6	2	2

Table 2

Service user participant information

Gender		Ethnicity			Service used	
Male	Female	Samoan/Sam/Euro	Tongan	Niuean	DHB/NGO	Counselling
0	11	9	1	1	2	9

Table 3

Service provider/service user participant information

Gender		Ethnicity		Service work in		Service used	
Male	Female	Samoan	Tonga	DHB/NGO	Counselling	DHB/NGO	Counselling
3	1	3	1	4	0	4	0

Data Collection

In keeping with the Talanoa approach and general Pacific approaches to relationship building, it was important for the researcher to take time in establishing connections with each participant. This included sharing general personal and background information as appropriate in an informal conversational manner. Prior to the interview taking place, participants were also able to ask questions about the nature of the research. They were then asked if they wished to continue with the interview to which they all consented and demographic information including ethnicity, age, where participants were born and grew up, and occupation was obtained.

Two interview schedules following a semi-structured format were used; one for service providers and one for service users (see Appendices 7 and 8). This format allowed the interviewer to carry out interviews in a more informal and conversational

manner, while still allowing for predetermined topics to be covered at the same time (Robson, 2002). The semi-structured schedule consisted of gaining participants perspectives' in four main areas of enquiry. These were: the barriers to Pacific people accessing services; the supports to Pacific people accessing services; the barriers Pacific people faced in continuing to use services; and the supports that helped Pacific people in maintaining service use. Apart from a small focus group of three service providers who had been service users who requested a group interview, all participants were interviewed individually. All service providers were interviewed at their place of work. The service user participants were interviewed either at the university, their place of work or home. The interviews generally lasted between 45 minutes to an hour and a half and were audio recorded. At the end of the interview, each participant was presented with a small gift (a petrol voucher), as part of Pacific protocol, to acknowledge the gifting of participants' knowledge for this research. All interviews were conducted in English and subsequently transcribed by the researcher herself.

Data Analysis

The process of data analysis was guided by the thematic data analysis model outlined by Braun and Clarke (2006).

Data familiarisation

Familiarisation with the data is an important feature of qualitative research (Gillham, 2005). This process was enhanced by listening to and transcribing each interview in full. After transcription, each interview was read through several times to ensure more in depth familiarity with the data. Initial thoughts and ideas about what was in the data and what was of interest were also noted down on paper as transcribing took place, as recommended by Braun and Clarke (2006).

Generating initial codes

Once initial familiarisation had taken place, the data was then divided into two sets. The first set included comments relating to barriers Pacific people encounter in using mental health or counselling services. The second category included comments relating to supports that Pacific people found in using services. The two sets of data were then printed out and the generation of initial codes was carried out manually. This involved writing notes on the printouts, as well as the use of coloured pens to highlight potential patterns and relationships.

Thematic searching

Once all the data from the two sets were coded, data extracts demonstrating the identified codes were organised together under the relevant code. This involved cutting and pasting the supporting extracts of data from individual transcripts to a computer file created for the relevant code. Collated codes and associated data extracts were then organized into initial theme groupings and tables were produced to help organize themes and sub-themes. During this phase, several initial codes developed into main themes or sub-themes whilst others were discarded. There were also some codes that appeared not to fit into current themes and subsequently were grouped under a theme entitled 'miscellaneous,' for further consideration later on. By the end of this stage there were several themes and sub-themes.

Thematic review

The next phase involved further revision and synthesizing of these themes and sub-themes. A significant part of this process involved in-depth discussions with my

primary supervisor. Themes and sub-themes were checked to make sure they were relevant to the coded extracts that had been gathered to support them. They were also checked to ascertain their relevance to the data set as whole. Potential thematic maps of the whole analysis were drawn up to aid this process. As a result of this process, some potential themes were excluded, while others were combined with one or more other potential themes. This happened because sometimes there was not enough data to support a theme, or that data gathered in support was too divergent.

Defining and naming of themes

Once it was thought an adequate thematic map had been developed, the next phase consisted of ongoing analysis that involved continual refinement of themes and sub-themes, as well as further development of the story that the analysis told. Themes and sub-themes were also named and more clearly defined.

Writing up the final analysis

This final step was the last opportunity for analysis. Vivid extract examples were chosen and analysed, and related back to the analysis as a whole, as well as the research question and literature.

CHAPTER THREE: BARRIERS IN USING SERVICES

Introduction

A primary aim of this study was to better understand the barriers and supports that Pacific people experience when they engage with mental health services. For the purposes of this study, mental health services included mainstream community mental health services, Pacific-specific services and counselling services. A further aim of the study was that it might contribute to existing Pacific mental health literature aimed at informing and providing practical assistance to Pacific people and their families using services at a challenging time in their lives.

This chapter presents the results of the thematic analyses of data, obtained from interviews carried out with Pacific service providers (SP) and Pacific service users (SU), regarding barriers facing Pacific people in using mental health services. The following chapter outlines the supports that facilitated service use. The process of thematic analysis used in this study was influenced by Braun and Clark (2006) and is described more fully in Chapter Two. It involved familiarization with the data, the generation of initial codes, theme searching, the defining and reviewing of themes, and a write up of the analysis. Owing to the large amount of data pertaining to barriers in using services, it was decided early on in the data analysis process, that this data would be divided into two categories; the first category related more to barriers Pacific service users experience while they are approaching services, while the second category related to barriers identified as being more relevant once services were accessed. In this chapter, the results obtained from these respective data sets were titled: *Barriers in Accessing Services* and *Barriers in Using Services.* In *Barriers in Accessing Services,*

three themes were identified. These were titled: *Shame, Stigma and Fear; Lack of Knowledge;* and *Limited Relevance of Services.* In the *Barriers in Using Services,* four themes were identified. These were: *Lack of Cultural Understanding; Barriers in the Therapeutic Relationship; Other Barriers in Therapeutic Practice,* and *Socio-economic Barriers.* The themes identified throughout this chapter have been summarised for ease of reference in Tables 3-9. Themes are not listed in order of importance. Each theme and sub-theme is illustrated by relevant quotes as well as an approximation of the proportion of participants who contributed comments to that particular theme or sub-theme. However, it is important to keep in mind Braun and Clarke's (2006) caution that a larger proportion of participants commenting on a particular theme does not necessarily make it a stronger theme.

There is also some overlap of themes and sub-themes between the two categories of themes. For example, aspects of the two themes comprising the *Barriers in Accessing Services* category (*Shame, Stigma and Fear* and *Limited Relevance of Services*) continued to be identified as significant barriers for some service users and their families in the *Barriers in Using Services* category of themes. However, to avoid repetition, these themes or sub-themes were placed in the *Barriers in Accessing Services* category as they were first identified at the time of accessing services. Finally, some barriers identified in accessing services were more relevant for service users accessing community mental health services than for service users who were approaching counselling services. For example, family involvement seemed more relevant and important for community mental health service users than for counselling service users. Any differences between the two groups of service users are noted throughout the analysis.

Barriers in Accessing Services

Table 4

Themes in 'Barriers in Accessing Services'

1. Shame, Stigma and Fear
2. Lack of Knowledge
3. Limited Relevance of Services

Three themes were identified in this category. The first theme, *Shame, Stigma and Fear* expressed the emotional distress that service users and their families experienced when the service user became unwell and there was a need for additional assistance outside of family. A second theme, *Lack of Knowledge* concerned limited awareness on the part of service users and their families about either mental unwellness or mental health services in general. The third theme, *Limited Relevance of Services* referred to beliefs held by some service users and/or their families that mental health service use was not relevant or appropriate for their needs. A significant outcome of barriers identified in this category of themes was that there was a delay in service users accessing services which could mean more severe presentations when they did eventually engage with services.

Shame, Stigma and Fear

Table 5

Subthemes in 'Shame, Stigma, and Fear' theme

1. Shame and Stigma
2. Fear

Emotional distress in the form of shame and/or fear was identified by almost all SU and SP respondents as being significant barriers for service users and/or their families in accessing therapeutic services.

Shame and stigma

Shame experienced by service users and/or their families was identified by all SP and some SU participants as a significant barrier in accessing help from services. For most respondents who identified shame as a barrier, they also associated shame with the fear of stigma. Many SP and several SU participants commented about concerns that service users and their families had about being perceived negatively by people they knew. The following SU spoke of the unacceptability and stigma she felt from her community when she became unwell,

> With Pacific Island people, there's such a stigma attached … I mean you can have cancer or something else, but you can't be mentally ill, not acceptable. *(SU)*

The repercussions of stigma within Pacific communities could be profound and long-lasting, with one SP commenting,

> Polynesians will find excuses not to marry into that clan, because that clan has mental illness, and most people know that things are hereditary, so the stigma is very, very profound, and then, even if you move out of the country, it becomes inter-generational. So my parents will tell you about the great grandfather, who acted funny a hundred years ago, in Tonga, Samoa, they won't forget, it'll probably take a hundred years for the memories to start to fade away... it's a huge challenge. *(SP)*

Approximately half the SP and several SU participants explained the presence of stigma in reference to traditional beliefs that viewed mental unwellness as supernatural redress for the breaking of social taboos either by the affected person or a member of their family. This Samoan SP explained,

> From a Samoan perspective, we have a term – ma'i aitu. Ma'i aitu is like a ghost disease … and the reason why it happens is because someone in the family, not necessarily the victim, who is really a representative of the whole family, has done something wrong in the past. So, the aitu or the spirit has come to really avenge something that has been done by the family. So when something like that happens (mental unwellness), people whisper behind the family's back and

say oh, they must have done something terribly wrong, that's why that's happened to their child. *(SP)*

Some SP and SU participants further commented that an individual and/or their family could also experience shame because of perceived failure for allowing themselves to become unwell; or, for not preventing or contributing in some way to the unwellness of their family member. Several SUs and SP participants also noted that shame could be compounded for the service user and/or their family if they were not able to solve or manage their own or family member's distress and unwellness inside their own family. The following SU reflected that in her family, she and her siblings had been raised to look to their own family for help and support if it was ever needed rather than seeking outside help.

> I don't know if it's an island thing, but there's something not right with you and your family if you can't deal with it with the people closest, your family. *(SU)*

In a similar vein, another SU said,

> The ideal is that you keep everything within the family, even if you don't do anything about it, just stays there--and I guess that has a lot to do with bringing shame on the name of the family and shame if you go outside of the family for help. *(SU)*

One SU said that when she told her parents and siblings she was thinking of going to a counselling service to help with marital problems, they said,

> Why are you going to a stranger? You don't need that. This problem should be discussed in the family. *(SU)*

Some SUs also reported they delayed seeking outside or professional help because they had not wanted to embarrass or disappoint their families. Two SUs noted,

> You know, it's almost like you are letting down your family by being unwell. *(SU)*

> So you don't reach out until it's the last resort because you don't want to disappoint your family. *(SU)*

Fear

Fear was identified by some SU and SP participants as a primary barrier for Pacific people accessing services. Several SPs and SUs identified fear of the unknown and of what to expect, as a barrier, especially if families did not have much prior knowledge of mental unwellness and of services. Their perceptions concerning services might also have been influenced by what they had heard from other peoples' experiences, or had gained from a range of media such as television and movies. This SP said,

> There is fear of the unknown cause they don't know a lot about it. What are the processes, and what's going to happen, and of course there's all these stories around about being institutionalized and being put on medication, so there's a lot of misunderstanding, and I guess there's a lot of truth too actually… fear would be a barrier because of unfamiliarity with the process of mental illness, we can relate to being physically sick and going to a GP but not mental illness. *(SP)*

One SP noted that some of the families she had worked with, also feared that engaging with services might exacerbate their service user family members' problems. This could lead to a lack of support and the minimising of the service user's problems.

> You get some families who worry their person will come back worse, so even though you might want to go and check yourself in, your parents or your brothers and sisters might go, no, you know, you don't need to, there's nothing wrong with you, you know, like you're fine. *(SP)*

Feeling anxious and vulnerable about confronting issues that contributed to distress or unwellness was also identified by more than half of the counselling SU participants as a factor in thinking twice about accessing services. This was despite believing that seeing a counsellor might help them. One SU whose husband had left her for someone else, said she had been close to "falling apart," but avoided seeking counselling because she feared the process would leave her emotionally vulnerable and unstable, which she could not afford to be as she had a young child to look after.

> I didn't want to relive the past because I didn't want to be a nervous wreck. I needed to be strong. My son was only a baby ... I decided to leave it. *(SU)*

Hence, shame, stigma and fear were noted as being significant barriers to Pacific people accessing services. They continued to be present for many Pacific service users and their families whilst they used services.

Lack of Knowledge

One further important obstacle identified to accessing services was a lack of knowledge. This limited awareness applied to general knowledge of mental unwellness including triggers, symptoms and maintaining factors to unwellness. Two SPs commented,

> Sometimes, people themselves can't identify they're in trouble. They are not able to recognise it themselves. *(SP)*

> I think it's the lack of insight about the illness. I think that for the person affected by the illness there is a lack of insight and understanding *(SP)*

Lack of awareness could also extend to the existence of services, and/or what they offered.

One SP said,

> Some families don't have awareness that there is a mental health services or exactly what a mental health service does *(SP)*

For some service users and their families, a lack of knowledge continued to be a barrier after engaging with services. This could impact on the quality of support service users received from their families. One SP, an ex-SU said,

> A lot of Pacific people, consumers, are not getting the support cause their aiga (family) don't understand, you know. (*SP/SU*)

A lack of awareness about services including criteria for engagement as well as services offered was not limited to service users and their families. Two SPs commented that sometimes services in the general community such as in educational or medical settings (outside of mental health services) lacked awareness of mental health

service criteria and referral processes. This could impact on Pacific people, who were eligible for service referral not being referred to appropriate services earlier. This SP said,

> People who would normally refer may not have knowledge of the service or what our criteria are for the service *(SP).*

Finally, it is important to note that approximately half of the SPs commented that a significant proportion of Pacific service users who eventually utilised community mental health services often delayed seeking help until their problems were quite severe. This could result in severe and complex presentations to community mental health services, as noted by this SP.

> There's no doubt when you look closely, you can see a whole history of psycho-social stuff that started a long, long time ago, and fixing today's problems away is really, really difficult, because you really need to intervene a lot earlier, you know, in terms of years, before the people we see walking through our door. *(SP)*

According to another SP, severe presentations and delays in seeking help could also result in service users and their families having unrealistic expectations and experiencing potential frustration

> They always get here when it's a bit too late and the problem is too huge you know, and it's almost like they come here with a lot of expectation as well, you know, if they survive through the thing, they get here. *(SP)*

Limited Relevance of Services

Table 6

Sub-themes in 'Limited Relevance of Services' theme

1. Services only for Severe Unwellness
2. Services have Limited Cultural Relevance

The second theme, *Limited Relevance of Services*, consisted of two sub-themes. These were, *Services only for Severe Unwellness* and *Services have Limited Cultural Relevance.*

These two sub-themes correlate to beliefs identified as being obstacles to Pacific people accessing services. The third sub-theme *Lack of Knowledge*, related to service users, their families, and advocates sometimes having limited awareness of aspects of mental unwellness and services available to assist. This lack of knowledge could limit opportunities for Pacific people to engage in services.

Services only for severe unwellness

Several SPs identified the belief that some Pacific people had that services were only for "extreme cases" such as psychosis and bipolar affective disorder. One SP said,

> You know, Pacific islanders believe mental health services are set up for the extremities. You know the extreme cases, the ones that are schizo or the ones that are bipolar, you know. They don't see it as a place for them. *(SP)*

A related perception raised by two SUs and two SPs was that Pacific People were "tough" and hence had more capacity to cope with stress than Palagi (*Europeans)* People. Therefore, problems that Palagi would typically seek help for (especially in using counselling services), Pacific People could handle themselves or within their traditional support circles. One SU said she delayed getting counselling for grief issues despite persistent encouragement from a close friend because she thought,

> Counselling is okay for Palagi but Islanders are tough, they don't need it. (SU)

This SP noted,

> I generally think that Pacific Island people have such a high threshold of tolerance level, of how much you can take of the pain, of the poverty, of the obligations, the stresses in life. They don't see it as abnormal like a Palagi would. *(SP)*

One SU further explained she did not even see herself as having problems that might be helped by going to counselling. She noted that even though she experienced low self-esteem and anxiety, which she linked to abuse in her childhood, she was still able to go to work and raise a family. She said,

> If it hadn't been for my work supervisor, I wouldn't have gone to counselling. I thought I don't need it. I'm alright, I can handle it yet I was always having these thoughts that never stopped but hey I was still able to carry on. *(SU)*

Services not culturally appropriate

A further barrier to engagement with services in general as highlighted by half of the SPs, was that many of the more traditional Pacific service users and/or their families, particularly those who used community mental health services, believed unwellness originated from cultural and/or spiritual factors. Therefore, unwellness needed to be assessed and treated with reference to these causal factors by the appropriate cultural healers. They saw engagement with services as being of limited use. One SP commented,

> Sometimes there's a barrier to access because they don't think it's due to something that can be fixed here, you know when they think that it's a spiritual kind of sickness. *(SP)*

Another SP said,

> I think they sometimes see it as just "Palagi" medicine and that we've got our own. *(SP)*

In a similar vein, this Tongan-born SU commented,

> I went to my doctor. I kept complaining about my chest, I couldn't breathe. They sent me to hospital. I had x-rays, tests. Then, he (the doctor) asked me to see a psychiatrist. And then I said, are you saying that something's wrong with me (pointing to head)? Then he said it's to help you find out what is going on. And that's when my mother said no. Let's go to see the witch doctor. *(SU)*

An additional belief that was identified as influencing Pacific service users and their families' decision to access services was that they already had their own appropriate support systems to help them overcome problems, particularly if problems

were considered not severe. These were notably family, religious and spiritual, and cultural supports. This SP said,

> We think when we are unwell, we have our own support systems. We actually have our own families, friends, we have churches. *(SP)*

Another SP shared similar sentiments,

> Well you know, some of us, we believe in just dealing with it, within our whanau, so sometimes we don't believe in accessing these services because we think we can talk about it or pray about it, or else seek the priest, the pastor to come and pray, and the support of the whanau, so sometimes that way, we believe is better. *(SP)*

One SU agreed with the sentiments expressed above. She also added that counselling, in particular, one-on-one counselling could be viewed as going against the collective nature of Pacific culture, in which problems were collectively addressed amongst those who were personally affected or connected, and not by some stranger. In this way, she considered that counselling could be viewed by Pacific people as being too individualistic and impersonal. Thus a Pacific person engaging with a counselling service could be perceived negatively by other Pacific people.

> There's still a stigma in using services … cause I think from a collective view, you've already got those supports in place where you can talk to people … you know I work mainly with Pacific families, even when I talk to families about using counselling services, I think there's the idea that because you're choosing to leave the collective group and going to talk about things, you know, it's sort of like you're stabbing them in the back, to go and seek that individual type of help. *(SU)*

Barriers in Using Services

Table 7

Themes in 'Barriers in Using Services'

1. Limited Cultural Understanding
2. Barriers in the Therapeutic Relationship
3. Other Barriers to Therapeutic Practice
4. Socio-Economic Barriers

Four themes were identified in the data relating to barriers in using services. These were *Limited Cultural Understanding; Barriers in the Therapeutic Relationship; Other Barriers to Therapeutic Practice;* and *Economic Constraints*.

Limited Cultural Understanding

Table 8

Sub-themes in Limited Cultural Understanding' theme

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1. Pacific Perspectives on the Collective and Family
2. Acculturation and Identity Issues

This theme, *Limited Cultural Understanding* related specifically to service providers having limited cultural awareness of two facets of Pacific living, which mapped on to the two sum-themes comprising this theme. The first sub-theme related to service providers from mostly western backgrounds having limited understanding of the collective values that many Pacific service users and their families held. This included how these values guided Pacific peoples' ways of being and doing, and how they could feature contextually in presenting problems and through various aspects of service use. The second sub-theme focussed on acculturation and identity challenges that could feature as part of the problems that Pacific service users presented with. Lack of a deeper understanding of how these two areas influenced Pacific wellbeing and unwellness could limit understanding of Pacific service users' presenting problems, and limit possibilities for more effective therapeutic relationships and interventions.

Pacific Perspectives on the Collective and Family

Almost all SPs and SUs identified that service providers from mainly western backgrounds, could have limited understanding of Pacific cultural values. This created

a significant barrier in working with Pacific service users. Some SPs thought this was more so for service providers who came from monocultural western backgrounds. She said,

> It's very hard when people are monocultural and ethnocentric to really understand what it's like for these people and their experiences. I feel more passionate about that the longer I do this job. *(SP)*

Some SPs and SUs also commented that although service providers from western backgrounds often had awareness of Pacific cultural values, this could be at a surface level, and lacked a deeper emotional and empathetic connection. One SU said of the Palagi counsellor she was seeing,

> You don't have any understanding of myself or our culture—or the stuff that you do know is very general. (SP)

In particular, some SP and SU participants made reference to a lack of deeper understanding of the collective values of many Pacific service users and their families which guided ways of being and doing in daily life. Some SPs noted that the status of an individual's family was particularly important within traditional Pacific cultures as the primary embodiment of these collective values, and that in Pacific families the interests and needs of the family were often prioritised over individual needs and interests. Moreover, one SP further commented that within a Pacific cultural context,

> The family context is huge because our definition of self is we don't exist without our aiga, without our kaiga (family). *(SP)*

One SU also noted,

> I think the society we live in is quite individual. I think mental health services are used to seeing people as individuals, whereas families are very important to us, it's a bit of an imbalance. *(SU)*

Some SPs and SUs also noted that a significant aspect of belonging to one's family and other close social networks such as church and cultural community groups was to be seen to be fulfilling one's responsibilities and obligations in enhancing the

interests of groups that one was part of. Several SPs commented that for many Pacific

people, meeting these responsibilities and roles was associated with wellbeing. One SP

said,

> I meet my obligations to my immediate family, my extended family, my community, and my
> wellbeing is enhanced through that process. I can't personally be well, unless I'm performing
> those roles. *(SP)*

Some SP and SU participants added that if Pacific people were not able to meet

these responsibilities and expectations, they could experience a range of emotions

including guilt, resentment, frustration, and disappointment, which impacted negatively

on their wellbeing. These problems were accentuated when stress was ongoing, and

combined with other socio-economic challenges. Some SPs working in community

mental health settings, noted that this scenario featured in the problems of a number of

Pacific service users they were engaged with. One SU said,

> We've been through quite a lot with my parents, it's cultural, it's all the faalavelave (family and
> cultural obligations typically involving monetary contributions *)* nearly lost their house, it seems
> like, I don't know, maybe it's just my friends parents, same age, mortgaged themselves to the
> hilt kind of thing. *(SU)*

While another SU commented,

> The cultural expectations, we are expected to perform a certain role, so even though deep down
> you can't or don't want to do it, you do it. I get quite resentful and stressed about it. *(SU)*

A limited understanding of the importance of collective values, and the pull of

meeting family and other collective obligations in the lives of Pacific service users and

their families, could mean that non-Pacific service providers had a limited appreciation

and understanding of the everyday life contexts of their Pacific service user clients, as

well as the context in which their presenting problems arose. It could also lead to

Pacific service users feeling less understood and service providers suggesting

therapeutic interventions that they might not realize were less relevant, had they had

more understanding of Pacific collective perspectives.

A further associated barrier identified by several SP and SU participants, was service providers having a limited awareness of the traditional relational dynamics that could operate in Pacific families, and which guided how respective family members interacted with each other depending on their role and status within the family. For example, children, including adult children, are often expected to defer to their parents and address them with respect. Having limited awareness of such dynamics could mean service providers overlooked aspects of service user problems, or could offer advice that was less helpful. The following SU, an adult university student from a traditional Samoan family, had been experiencing stress over disagreements with her father regarding her university studies. She engaged in a counselling service for help, but disengaged after one session because she felt the counsellor lacked understanding of Pacific cultural values. She said,

> She just pointed out, she just encouraged me to talk about it to my dad, and in time changes would happen. I think for this particular issue, it would have just reinforced to my dad the idea that I was fiapoto (*a know-it-all*) (laughing). I guess it was really hard for the counsellor to understand where I was coming from, about the cultural expectations from my dad, which was quite hard. Yeah it was like you won't understand what I'm talking about. Then that's why I pretty much decided that I wasn't going again. She just won't get me. She wasn't a bad counsellor she just wouldn't get me. *(SU)*

Another SU who also disengaged after one counselling session also related feeling disappointed and angry after a counsellor from a western background said she had a dysfunctional attachment to her mother, which now was a major contributor to her current problems. The SU said she had strongly disagreed with the SU counsellor and believed her attachment to her mother had been appropriate within a Samoan context. She also felt hurt her mother had been criticised and blamed, and in the Pacific cultural context of the importance of respecting parents, this did not sit well with her.

> She was saying my attachment wasn't appropriate. But for my culture, I knew it was appropriate. Her theory was that I hadn't kind of disconnected from my mum when I reached my teenage years and that we still maintained a too close relationship … I just didn't agree with that cause I felt it was really good that I was close to my mum. I didn't agree with the whole attachment thing and I spoke to her about it. She still kind of wanted to work on that attachment

theory and my feeling low kind of turned into anger, yeah, ok bye. Yeah, it was like she gave the impression that my mum was to blame for me, for the way I was now. *(SU)*

Acculturation and Identity Issues

The barriers in this sub-theme were identified by some SPs and SUs, and pertained to acculturation and identity issues being overlooked or inadvertently minimised by service providers working with Pacific service users. Several SPs commented that acculturation and identity issues could feature as main issues in presenting problems or as contextual and ongoing stressors in the background of more pressing problems that many Pacific service users presented with. A number of SP and SU participants commented that a lack of awareness or recognition by western service providers of the potential impact of these factors for ethnic minority service users including Pacific service users, could result in less accurate conceptualisation of presenting problems, as well as less effective therapeutic interventions.

One acculturation-related challenge noted by some SP and SU participants related to the stress of balancing collective-focussed Pacific values with more individual-focussed western values. One SU said,

> I think with being born in New Zealand, there's a conflict. You struggle between the individual and being a "we." In my upbringing I felt so much pressure to go between the two cultures. *(SU)*

Several SPs, noted that the challenge in negotiating two sets of cultural values featured in the presenting problems of many younger Pacific service users and this included isolation from their Pacific cultures of origin and traditional support networks. This SP noted,

> I've seen with a lot of young people that come here with the sense of being isolated not only from their own family, but I think isolated from the community that they've brought up with. *(SP)*

Several SPs commented that these sorts of experiences contributed particularly to younger New Zealand-born Pacific service users experiencing a lack of clarity about who they were, and that such challenges could compromise wellbeing. This SP said,

> What we're finding is that a lot of young people who are the ones most messed up are the ones that have the least clear idea of who it is they are and where they've come from and where they want to go, and those are all sorts of ideas central to having a strong sense of self. *(SP)*

This SP further commented that community and cultural fragmentation also impacted on the mental wellbeing of many Pacific service users they saw. Lack of affirmation and feeling they were being discriminated against within the dominant western culture in New Zealand could also feature as concerns for Pacific service users. This SP said,

> From a Pacific point of view, fragmentation of our communities, fragmentation of our culture, the lack of identity, the lack of a strong, cohesive, support system, and a new environment, I think, are the major determinants of mental illness today. The mainstream society, when they get psychotic they never ever have to think about could this possibly be because I no longer speak English, is this because I no longer participate in day to day activities that helped reaffirm me as an individual, so mainstream never have to worry about those sorts of things, the only people that have these discussions are people like us. *(SP)*

An additional barrier to service use also existed if service providers lacked insight that often younger Pacific service users held a different worldview from their parents who were supporting them. If these differences were overlooked or not acknowledged, service providers risked disengagement by service users or their families. This SP noted,

> I think when clinicians don't understand that sometimes parents have a different cultural worldview than their children, it can be a barrier. They don't feel understood, so basically, parents pull out and there's a higher likelihood of the kids not staying engaged either. *(SP)*

Finally, some SPs commented that a lack of cultural understanding and empathy when working with Pacific service users was not limited to non-Pacific service providers. Some SUs and SP participants commented that some older and more traditional Pacific service providers could assume New Zealand-born service users held

or should hold the same cultural worldview as their parents. This could lead to younger

New Zealand-born service users feeling 'judged' and isolated for their lack of cultural

knowledge and connection to their cultures of origin. It could also be perceived by

younger New Zealand-raised service users that they were being patronised by older

Pacific service providers who thought they knew what was best for them. This SU said,

> I did have contact at one stage with a Pacific support worker. It didn't help me cause I found that they put me into a mould. Yeah, like I'm this island person, but I don't think my upbringing was sort of like traditional Pacific Island, you know what I mean? And in a way this Pacific Island woman, she was more island focused, she already had this image of me oh you're Pacific Island but really she had made assumptions of who I was and what I needed, and I didn't like that and I closed up. *(SU)*

According to the following SP, these sorts of experiences meant,

> There is a huge growing um dissatisfaction amongst Pacific youth about current systems of care, about engaging with Pacific services where there are a lot of mature to older Pacific Island professionals who are quite disengaged and disconnected from who they are and what they represent. *(SP)*

Barriers in the Therapeutic Relationship

Table 9

Sub-themes in 'Barriers in the Therapeutic Relationship' theme

1. Lack of Personal Connection

2. Limited Awareness of Pacific Relational Dynamics

3. Pacific Service Provider and Service User Relationship

This theme focused on barriers identified by SP and SU participants in the

therapeutic relationship. This theme consisted of three sub-themes Lack *of Personal*

Connection, Limited Understanding of Pacific Relational Dynamics and the *Pacific*

Service Provider and Service User Relationship.

Lack of Personal Connection

Pacific service users experiencing a lack of personal connection with service providers was identified by almost all SP and SU participants as a main barrier to Pacific service users continuing to use and benefit from services. Some Pacific SUs reported feeling uncomfortable and disconnected from service providers whom they perceived related to them in an impersonal way. This SU said,

> It's quite a personal thing, your life, but it was like I was being talked to like an object, not a person. *(SU)*

Similarly, one SP, an ex-SU, said some Pacific service users were put off by what they felt were 'cold' and 'calculating' ways of relating by service providers from mostly non-Pacific backgrounds, which contrasted with what was considered warmer and more spontaneous ways of relating in Pacific contexts. Services referring to service users as 'consumers,' highlighted this approach. This SP said,

> They simply see people as consumers. After seeing that person once, they (SUs) say I don't want to see him again, he's not friendly. Simply they do not connect. To them, they seem to be very cold and calculating … showing odd behaviour that Samoan or Pacific people don't relate to. *(SP/SU)*

The following SU also identified a lack of personal connection to service providers as being a barrier while using services. She specifically identified a lack of reciprocity on the part of service providers to share something of themselves. She saw this lack of reciprocity as being 'unnatural,' and thought it contributed to her being less connected to the service providers she was seeing. She commented that it was only when she came into contact with an service provider who shared something personal about herself that she felt more comfortable and connected. She said,

> There could have been more of an emotional connection with something like, oh I have three kids, you know I live in so and so … It's like they expect you to open up but you know it's unnatural to do that, yet for some reason they feel it's so easy for you to do that. They want to hear everything. It's unnatural that it's not coming back to you. You don't want to know all their business, but something like I've done this for thirty years or whatever. And the one person I

found that did this, one of the last doctors, she actually did that and I had some connection with her right from then, I felt more comfortable with her. *(SU)*

One further barrier to personal connection highlighted by several SPs and one SU was when there was a lack of collaboration and negotiation by service providers with service users. This SP said,

> What doesn't help to keep them engaged is when we are not being collaborative, including with the family. Say like when we say oh we think medication would be really beneficial for you to use and the family just don't want to hear it or consider it and we've become quite strong on that this is our position, rather than seeing things from their perspective. *(SP)*

Limited Awareness of Pacific Relational Dynamics

This sub-theme highlighted concern that non-Pacific service providers sometimes lacked awareness of Pacific relational dynamics that could impact negatively on the therapeutic relationship. An aspect of this sub-theme was touched on in the previous sub-theme. This was namely that Pacific service users sometimes felt service providers from mostly western backgrounds related to them in overtly impersonal ways that contrasted with warmer and personally connecting ways that they were accustomed to.

A further dynamic that western service providers could miss was highlighted by several SPs. Showing respect or deference to people in position of authority is common in many Pacific cultures. This could mean that service users and/or their families did not question or give critical feedback regarding approaches to their care. It could also mean 'lip service' to service providers suggestions when in fact there might be no intention to follow through, particularly if they saw no relevance for their situation, in what was being suggested. She said,

> One of the barriers to staying engaged is when Pacific Island parents just go along with sometimes what the professionals are saying, or what the clinicians are saying don't actually believe it. You know they're just saying yes because that's what they perceive the clinicians want to hear, when they don't actually agree, and clinicians who are not Pacific don't

understand that dynamic. I think partly it's cultural, the hierarchy, you know that kind of stuff with you know with professionals always being right, and you don't necessarily have to agree with it, you go home and you do your own thing. *(SP)*

Pacific Service Provider and Service User Relationship

Some SP and SU participants identified additional barriers that were specific to the relationship between Pacific service providers and Pacific service users. The first of these was a concern about whether confidentiality would be guaranteed by Pacific service providers. One SP noted that confidentiality was more of a western concept, and this could be present in the mind of Pacific service users and/or their families who were engaging with services. One SP commented that Pacific service users could worry that their unwellness and service use might be communicated by Pacific service providers to others in their community. He said,

> It's bad enough that their young person has been brought up for referral but even worse having someone of the same ethnic group, you know ringing them, it's another extra person to know about their curse. It's a common reaction because our communities are so small, you know, it's almost like your business is my business, you know, there's no such thing as privacy. You're bound to know somebody that knows that person. *(SP)*

While this SU commented,

> Because of their cultural background, there's a link there ... It's like it could be someone you know, someone from your village … are you going to keep it to yourself? Everybody knows that Polynesians are faitatala (*gossipy*). So to be honest, if it had been a Polynesian I would have done an about face and turned around. *(SU)*

One SU had himself experienced this breach of confidentiality in a Pacific service and said it had led to him disengaging with the service. He said,

> I was ok there, but then I felt my friends were teasing me. There was a guy who worked at X service. His best friend went to the church I go to. They were talking about me at church, and teasing me, talking about "my weakness." *(SU)*

One SP, an ex-SU commented,

> That's probably why most Pacific consumers prefer mainstream mental health services rather than going through Pacific-specific services—worries about confidentiality. *(SU/SP)*

A further barrier identified by several counselling SUs was a concern that they might be 'judged' by a Pacific service provider had they engaged with one. One SU said,

> I know it sounds silly, but don't think I would have gone to a Pacific counsellor. I was critical about a lot of my upbringing … I didn't want the extra burden of worrying about what a Pacific counsellor might be thinking about me …maybe I was not a good Samoan because I was criticising culture and family…I needed a neutral space in which to find my way. *(SU)*

Another SU, who was from a Samoan background also expressed concern about being judged if she had seen a service provider who was Samoan like herself, although she did consider that it was more likely that she would have felt more comfortable with a New Zealand raised service provider, as she herself was. She said,

> I think it might be different if it was a New Zealand born Samoan, I could relate maybe sit and talk. A real Samoan might be too judgemental. *(SU)*

An additional challenge in the Pacific service provider and service user relationship was identified by several SPs. This related to Pacific service users potentially feeling restrained by the need to maintain respectful and appropriate relationships with Pacific service providers within traditional Pacific contexts. In Samoan, this is referred to as knowing how to *Teu le Va,* or cultivating appropriate respectful relationships depending on one's status, role or gender. One SP noted that avoiding conflict or directing criticism particularly towards someone in a position of authority, such as a service provider is often construed as disrespectful. This dynamic was enhanced when both service user and service provider were from Pacific backgrounds and were both aware of these dynamics. This SP noted,

> I think one of the barriers to continuing with a service is sometimes there is a conflict of interest. I've seen this. Let's say you as a client are seeing a counsellor, and you don't think you're fairly treated or you know, you kind of know each other too well, it's hard for you to address any conflict. For us you know one of our values is respect and honouring each other. When something comes up, like a conflict of interest or being unfairly treated, some of us don't disclose it or own up because we don't want to disturb the peace or the relationship and address the issue openly. We rather just leave it, and maybe finish. We don't want to confront, that's the word we don't want to confront the situation. *(SP)*

Furthermore, a feeling of being restricted and having less power, because of the observation of these traditional dynamics could be accentuated for younger Pacific service users who were engaged with older Pacific service providers.

> Sometimes if the therapist is older and I'm the client, of course I'm already down at this level. I'm already in a position that disempowers me, you know, you look up to them, you respect them so yes, you're more disempowered because you're young. Those dynamics are real, and yes they bring conflict and barriers to the work if it's not addressed properly and sometimes it is not addressed. The client feels it is disrespectful to address this with the older therapist. *(SP)*

This dynamic of respect, particularly for one's elders could also play out in the relationship between a younger service provider working with an older more traditional service user. The following SP commented that if this dynamic was not addressed properly, it could lead to the older service user viewing the service provider as a "know-it-all" who did not how to act properly. This included using appropriate language and protocol in working with the older service user. This SP said,

> You know it's different when you talk to someone of your age, you can just say mental health, and mix the language to make it easier for you. You know, when you mix the language with an older person, it's like insulting that person, you know, you're fiapoto *(know-it-all),* who do you think you are! *(SP)*

One final barrier that related to maintaining the 'va' (appropriate relational boundaries) was identified by several SPs. This related to a male service provider being engaged with a female service user, and vice-versa. One SP noted that Pacific service users could find working with a service provider of the opposite gender, uncomfortable and awkward, particularly if personal issues were being discussed in depth. This was accentuated if the service provider and service user were of the same ethnicity. This SP commented,

> You know our people, if a woman has problems, she does not want to talk to a male therapist, and it's the same for a man with a woman therapist, they feel uncomfortable, especially if they are both Tongan or Samoan, or both Pacific. *(SP)*

Other Barriers to Therapeutic Practice

Table 10

Sub-themes in 'Other Barriers to Therapeutic Practice' theme

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1. Communication Barriers
2. Lack of Family Support and Lack of Support for Family
3. Difficulties in Talking Therapy
4. Medication Issues

This theme consisted of four sub-themes which were: *Communication Barriers, Lack of Family Support and Lack of Support for Family, Difficulties in Talking Therapy,* and. *Medication Issues.* These sub-themes represent further barriers to therapeutic practice including practical ones.

Communication Barriers

Many SP participants highlighted that language barriers could be a significant barrier, particularly for some Pacific service users and/or families engaged in community mental health services. Moreover, several SPs noted that although Pacific service users and/or their families might have sufficient everyday language ability, there could be difficulties in either understanding mental health terminology, especially if there were no equivalent terms in Pacific languages. This SP said,

> Sometimes we have only a couple of terms, and of course the palagi (European) have got hundreds of terms to explain the one thing. *(SP)*

Alternative understandings were not limited to mental health contexts but could be present more subtlety in talking about everyday phenomena. For example, the following SP noted how there could be conceptual differences between western and Pacific perspectives, regarding connections between time and the occurrence of

significant events. If service providers from western backgrounds were not aware of

details such as these, there could be some confusion around when and where certain

events occurred in the life of the service user. He said,

> We sometimes have misunderstanding with time. From a Pacific way of looking at things, what's more important is not the time it happened, but what happened, so if it's important, they'll talk about it like it happened yesterday, if it's very, very important, although it happened twenty years ago. So, they'll talk about an incident like yesterday, but it happened last century, because that's more important to them, so that was a bit of a difficulty we had, from Samoan people who came in, the parents especially, when they talk about things, yeah so we had to really figure out in the time frame, where things fall in when they're talking about incidents. *(SP)*

Lack of Family Support and Lack of Support for Family

Lack of family support during engagement with services was identified by many

of the SP and SU participants as being a barrier, particularly for service users using

community mental health services. Some SPs and a few SUs commented that lack of

family support could arise through services not being proactive enough in including

family members in assessment and treatment plans. It could also occur if services were

not providing relevant psychoeducation for families and if services wanted to ensure

confidentiality for service users. The following SU noted that by not getting families

more involved, service providers and services were missing valuable opportunities to

gain additional valuable information from close sources and supports involved with the

service user. She said,

> A lot of sessions I had by myself. I think that maybe they should have looked at including some family, especially because I had home visits. I know it's like a privacy thing but they don't know what you're doing 24 hours of the day, you can pretty much get through the cracks not giving them the real information of what's going on. The family know what's going on *(SU)*.

Another SU, who had been a support person for a close family member who had

also been a service user, spoke in her capacity as a support person. She commented on

the need for service providers to involve family more actively, especially from the start.

I know one of the biggest things was patient confidentiality, but to me, here was a really sick person and it was like here we were as a family trying to support and understand, and knowing what was happening to them, so that we could be there for support. And the medical providers, the psychiatrists were basically saying, oh we can have a family meeting, but only after a number of processes have happened. You know what I mean. I don't think they understood the meaning of, the importance that as Pacific Islanders we should have been involved at the beginning. *(SU and family support person for SU family member)*

Several SPs also stated that services needed to actively involve family members where appropriate. As one SP said,

Where we don't engage the families, I think, there is a huge barrier to engagement, like when we're not doing family therapy, we're actually not including the parents as part of the treatment which is you know can be for a variety of reasons. Yeah so when they're less involved I think it's quite different. *(SP)*

This SU recounted how a non-Pacific service provider had come to visit her at home to see how she was. She reported a family member had been home at the time who was willing and waiting to be part of the update, but was not invited by the service provider to take part. The SU commented she had downplayed the problems she had been experiencing that week, but that her family member was aware of this. She commented had the service provider been more proactive in involving and including her family member in discussions she would have gained a clearer picture of her situation. She said,

There was one time when a family member came in. She was clued on that I wasn't giving them a true indication of what was going on, whereas I suppose if they had said oh you can sit in—the family's waiting to be invited, but they let things run their course. And I think the family they're waiting for someone to say you can come in, they wait to be asked which is normal. *(SU)*

Lack of family support could also occur when there was disagreement between a service user and family members about ways forward. Disagreement could be accentuated if parents had more traditional views to their New Zealand-raised children who might emphasize more individualistic views. This SP said,

There's conflict with the parents. They think that's the way of showing their love, and they care, but it's totally different from the client's perspective, they say I know I have my rights, and I am an adult, I got the right to do whatever I want. *(SP)*

Limited family support for their loved one's service use could also be due to fear. The following SP commented that sometimes families were worried about the safety of their loved one or concerns that others in their community might find out about their service user family member's problems and need to use services. She said,

> There is a barrier from some families ... we go there, we say we would like your son to come to the programme to come out from the house ... The barrier is that the family is not supportive, they don't their son to come out. They worry if he will be safe, they worry about other people finding out their son has a mental illness. *(SP)*

An additional barrier that was identified by a few SP participants was that sometimes family members could become over-burdened by the level of care and vigilance required to take care of their loved one. This could lead to emotional, mental and physical burn-out, particularly if the responsibility to oversee aspects of care such as appointment attendance, medication, and warning signs fell on only one or two people in a family, who often had other responsibilities such as employment and other family obligations. One SP commented, that this barrier was important to note, because of the cultural expectations that family members look after their own. Lack of support for the family, in these sorts of situations could mean that the wellbeing of family members of service users was also compromised. Furthermore, they were then not able to maintain support for their service user family member as before.

Difficulties in Talking Therapy

A set of barriers was identified by some SP and SU participants that were related to barriers in talking as part of therapy. One area identified by some SPs and SUs concerned the difficulty associated with talking about one's problems. A few SP and SU participants commented that it was not the Pacific way to talk at length about one's feelings and that it could be considered as being too individualistic. This SU from a Samoan background said,

> As a Samoan you're not taught to talk about yourself or to validate your feelings. A lot of the way we're brought up is that we're told we're not allowed to voice our own personal feelings. *(SU)*

One SP also noted that some Pacific service users and/or their families, especially those that were older and from more traditional backgrounds, could perceive the 'talking' that took place in therapeutic settings as a waste of time, and that it had limited relevance for their situation. He said,

> Some people especially our older generation, they think sometimes that it's just a waste of time. You know, they come to the service, we talk and talk, and they start asking why is there a lot of talking going on. What's happening? But, it's because they don't understand that this is a part of our therapy that we talk about stuff. *(SP)*

A further barrier identified by two SPs working in community mental health services was that Pacific service users and/or family members could sometimes open up at initial sessions about their problems, and after reflecting on this experience, feel shame and embarrassment at having exposed their problems and their vulnerabilities to strangers. This could lead to them not wanting to come back again for further sessions. One SP said,

> I think sometimes when they talk about stuff that is going on, and their families, I think some of that stuff is very emotional, there's a lot of emotional hurt, and so when they talk about it, maybe after that, they go home and they think about it, there's a lot of stuff that they didn't really intend to talk about it, and actually poured it out in front of strangers who they don't really know, and I think, sometimes they probably feel shy and ashamed and so they don't come back. *(SP)*

Feeling vulnerable was also identified by these two counselling SUs as being a hindrance to continuing counselling. In particular, they identified talking about past experiences as being particularly challenging. It led the second of these SUs to disengage from counselling, while the first SU agreed to continue for several more sessions as long as the counsellor did not revisit earlier childhood experiences. They said,

> She made me go right back to when I was 15, and I didn't like it, and then she backed off. *(SU)*

> She wanted to talk about my childhood and I thought no way am I going there. *(SU)*

A further aspect of talking therapy that was identified as being a limitation by several counselling SUs was what was perceived as a lack of a more directive approach on the part of counselling SPs. This was associated with a preference for quicker practical interventions. This SU commented,

> She was really nice, just allowing me to talk, asking me questions, but I wanted someone direct telling me, hold on this is what I see. I like to talk, but I like to be directed. It's like I'm having a problem I would like to have a solution, you know, so to get past the feelings and get to an answer. *(SU)*

A second set of barriers in this sub-theme was associated with assessment processes that could sometimes frustrate Pacific service users and/or their families. The establishing of genograms was noted by three SPs working in community mental health as being potentially problematic. For many Pacific people, discussing one's genealogy and family connections and history is considered to be privileged information. One SP commented that genograms could be seen as being overly intrusive, requesting personal information that was to be shared with strangers in a short space of time. She said,

> One of the things that I was not very happy with, you know is how we do the genogram. One of the very first things they have to do this the genogram, you know, and some of the Pacific Island genograms it's almost like a maze, you know and we know how we feel about it, it's almost an invasion, having your while life story up there on the board for strangers to see. It's hard to do without offending them. You know. It's almost like demanding, you know, the people, how old are they, you know and how educated are they, you know. *(SP)*

Another SP in a similar vein added,

> You know the first time that we meet, and we do your genograms, you're asking them how they got from A to Z, you know it is quite fast process, within the first hour, two hours of meeting. *(SP)*

Another barrier identified by several SPs was what could be perceived by Pacific service users as repetitive questioning. This could result in irritation, disinterest and disengagement by service users. One SP commented,

> They'd come to our meetings and they have meetings with the families and they ask and they ask them the same questions, probably the same questions they asked the last time. I think the psychologists wanted to know whether there was any change from last time, and they, the families are thinking that's the same question they asked the last time, they're asking them

again. Sometimes, they get bored with the whole thing, and sometimes they don't want to come back. *(SP)*

Repetitive questioning could also occur in printed formats such as forms and questionnaires. This SP said,

> Some of the forms that we give people to answer, they look at, and some of them even told me, you know, all these questions here they all sort of like the same questions here. Why are they asking the same questions over and over again? *(SP)*

One SU also felt frustrated at what she perceived as being the repetitive nature of questions that her service provider asked as she went through her checklist during home visits. She said,

> The next couple of weeks they'd ask me the same questions again. And you know, I used to think, oh no, not again. It seemed clinical. I couldn't understand why they kept asking me the same questions if they already knew. I already knew what they were going to say or do before they started, and I just started thinking oh they're running through the motions. *(SU)*

Medication Issues

Challenges with medication in terms of regular and prescribed dosage were identified briefly and in passing by several SPs working in community mental health settings as being barriers in helping service users to manage their unwellness. One SP noted that often Pacific service users did not like to take medication because of side effects or their beliefs. He said,

> Most Pacific people don't like to take medication ... one is the side effects, number two comes back to the holistic approach. They believe that the medication doesn't help them, the only medication that they have is God. *(SP)*

Another SP noted the benefits that some Pacific service users gained from taking medication, but commented that for some service users, particularly young people, it was a challenge to maintain their medication routine. This could also be related to concerns about side effects, but could also because due to limitations on being able to drink alcohol.

> I've actually found the biggest problem is not becoming unwell, it's maintaining the wellness. Maintaining wellness is the hardest part for most people ... Medication helps maintain the wellness but they have to take medication on a very regular basis. The young people especially don't want to take the medication ... there's the side effects, and as well as they can't take it with alcohol. *(SP)*

This SP participant further noted that sometimes medication issues could arise from service users and/or their family lacking understanding about important aspects of the service user's medication regime including why it was important to take medication and how it worked. This SP also commented that irregularity and incorrect dosages in medication usage could arise if the main responsibility for overseeing medication compliance resided with one person and that person was already over-burdened with other concerns and responsibilities. She said,

> We've got this client, but it's really hard because mum, she is a solo mum ....and she's having a lot of her own problems ... she thinks she's doing the right thing, but we've her son to have a blood test and from the blood test, we found out that there is not enough medication. *(SP)*

Socio-economic Barriers

Socio-Economic barriers were also identified by some SP and SU participants as being contributing factors in service users presenting problems, and then continuing to be barriers when Pacific service users engaged with services. One main area highlighted by participants was the ongoing experience of financial hardship experienced by Pacific service users and their families as they used services. This could impact on their ability to meet transport costs, particularly if it was considered that there were more pressing essential costs to be met, such as for food and utility expenses. This SP said,

> You're already poor and you just struggle get to an appointment, bus fare to get to your appointment, or food on the table, so yeah, that's going to be a barriers. *(SP)*

Further challenges for Pacific service users getting to appointment at services were raised by several SPs working in community mental health services. These

included difficulty in service users and their families being able to make appointments during services' opening hours and the limited accessibility to the location of some services. Appointments could also be missed by Pacific service users were dependent on family or friends to get them to appointments. This could happen if friend or family members could not get time off work. This SP said,

> Mum or dad will have to take time off work, and that's the other quite hard part, that most of them can't afford to take time off work. *(SP)*

Some counselling SUs also commented on the prohibitive cost of paying for counselling as being a barrier to maintaining service use. The following SU reported that her GP recommended she get counselling to help with depression. The SU said she was only able to access counselling as her workplace offered three free sessions for counselling. She commented she otherwise would not have been able to afford private counselling. She said,

> I couldn't afford to go to private counselling. Initially, my doctor said there was private counselling just down the road, but then I heard about EAP scheme at work, and that you got three counselling sessions for free, and so I thought I'd use that because I wouldn't have the money to pay this other lady. *(SP)*

Another SU reported that she had been going to counselling for several months and it had helped her with anxiety related issues, but she had to stop going because she could not afford it.

> I was getting a lot out of it, you know, I was learning stuff , made me see why I was doing things and feeling stressed. But in the end, I couldn't afford it. It was like, ok, what you're paying to see the counsellor, you could be paying the petrol that week or buying a pair of shoes your kid needs. *(SU)*

Several SPs also highlighted that sometime 'therapy' as might normally be expected in a western context needed to be put on hold as some Pacific service users came with more pressing concerns. This SP commented,

> When you're sitting there and your client is just thinking how the hell am I going to eat tonight? So, if it means I'll hop in the car and take her down to get some food parcels so her kids can eat.

This SP noted that such financial hardship was often chronic and ongoing for some Pacific service users and their families, and that these experiences contributed to service users becoming unwell in the first place. He said,

> Not being able to meet your obligations, just basic survival stuff, you can't feed your kids, can't feed yourself, you're not sleeping because of it. One woman was even too busy to be depressed, but obviously you know, it's really sad, that's the reality of some of the families that I have seen come that through here. The socio-economic factors are very strong. *(SP)*

Another SP said,

> I find myself writing letters to WINZ, please help this family get their power on cause it's been cut for a week and the kids have not had a nice shower, so mental health it can be a big broad thing. *(SP)*

One other area identified by several SP participants as a significant barrier in therapy for some of the service users they worked with, was when service users also presented with co-morbid alcohol and drug problems. This following SP noted that this was a major problem affecting a significant number of service users who utilised the service he worked in. He said,

> There's a drug and alcohol component. Over two thirds of our patients have a drug or alcohol related issue and if you remove the drug and alcohol related-issue, you could cope with the mental health issue. You know a large percentage of the mental health problem is made up of the drug and alcohol abuse, if you took that away, their bipolar illness, their schizophrenic illness, their depressive illness, their anxiety illness, a lot of that would be resolved, purely by dealing with the drug and alcohol issues. *(SP)*

Summary

This chapter examined the results concerning the themes that emerged in regard to the barriers Pacific service users experienced in using services. The results suggest a number of barriers which were organised into four themes. The first theme identified barriers that were associated with service providers from mostly western backgrounds having limited cultural understanding in two significant areas. This lack of

understanding could influence service providers' interpretations of Pacific service users' life experiences and presenting problems, as well as impacting on choice of therapeutic interventions. The first of these areas related to a lack of understanding of the collective worldview many Pacific people held, including the importance of the family unit. The second area of focus related to limited awareness of how acculturation and identity challenges could impact on the wellbeing of Pacific people living as en ethnic minority in New Zealand. A second set of barriers highlighted challenges to the therapeutic relationship. These included Pacific service users experiencing a lack of personal connection with service providers, mainly non-Pacific service providers having limited awareness of Pacific relational dynamics, and obstacles specific to the Pacific service provider and Pacific service user relationship.

A third group of barriers related to challenges that were perceived to hinder aspects of therapeutic practice. These included language and conceptual barriers, lack of family support for the Pacific service user, as well as lack of service support for family. It also highlighted barriers that were associated with talking as part of therapy as well as challenges associated with medication as a therapeutic intervention. Finally, a fourth set of themes discussed socio-economic barriers, namely financial hardship, which were obstacles to Pacific service users attending appointments regularly, and which were often precipitating and maintaining factors in Pacific service users' problems.

CHAPTER FOUR: SUPPORTS IN USING SERVICES

Introduction

This chapter presents the results of the thematic analyses from data obtained from interviews carried out with Pacific service providers (SP) and Pacific service users (SU) regarding supports that helped Pacific people to use services. This process of thematic analysis has been already described in Chapters Two and Three. Data pertaining to supports in using therapeutic services were extracted from interviews and organised into five themes. These were*: Supports in Accessing Services, Positive Therapeutic Relationships, Family Involvement and Service Support for Family, Other Cultural Support in Services,* and *Other Supports in Using Services.*

As with the themes outlined in Chapter Three, the themes in this chapter are not listed in order of importance, nor does it follow that when particular aspects of themes have been highlighted by a greater number of participants, that that particular aspect is more relevant than other aspects, which are commented upon by less participants. Each theme has been illustrated by relevant quotes as well as an approximation of the proportion of participants who contributed comments to that particular theme or sub-theme. For ease of reference, themes and sub-themes are summarised in Tables 10-15.

Supports in Using Services

Table 11

Themes in 'Supports in Using Services'

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1. Supports in Accessing Services
2. Positive Therapeutic Relationships
3. Family Involvement and Service Support for Family
4. Other Cultural Supports in Services
5. Other Supports in Using Services

Supports in Accessing Services

Table 12

Sub-themes in 'Supports in Accessing Services' theme

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4. Personal and Motivational Factors
5. Support of Close Others
6. Knowledge about Services
7. Pre-Engagement Support from Services

This theme identified a range of supports that assisted Pacific service users and their families to access services. This theme consisted of four sub-themes. The first sub-theme *Personal and Motivational Factors* concerns inner supports that service user participants drew on in making the decision to engage with services, while the second sub-theme *Support of Close Others* noted the benefit service users gained from having the encouragement and help of family and friends to access services. The third sub-theme, *Knowledge about Services* pertained to service users or others who had their interests in mind, having awareness of services including how to access them. The fourth and final sub-theme *Pre-Engagement Support from Services* related to the support that Pacific service users using community mental health services and their

families gained from having services make contact with them before any therapeutic work was begun. This assisted relationship building and provided the opportunity for service providers to give information and address concerns that service users and their families might raise. It was suggested by participants that such supports could help service users and their families to decide in favour of accessing services.

Personal and Motivational Factors

This sub-theme consisted of inner supports that some SU participants identified as helping them make the decision to access services and try and make the most of what services had to offer. These inner supports could be beliefs, attitudes, thoughts, self-talk, or insight that encouraged and motivated the service user to seek help despite fears or sense of apathy that the service users might have had about service use. Several SUs commented that recognising and accepting within themselves they had problems which they needed help with outside the support of their families, friends and other close circles, helped them to be more open and willing to try services. One SU participant commented it had helped her to think of service use in the following terms,

> I knew that my doctor wasn't going to be able to help me, my dentist wasn't going to be able to help me. There was something going on in my head, I'm just out of control, and it's a psychotherapist that I need to see. *(SU)*

Several SU participants noted that believing services might be able to help them was important. This SU said,

> If you're going to get help, you have to want that help, and you've got to be open to getting help I knew these people could help me fix this thing that was broken inside me. *(SU)*

Some counselling SUs also noted that reflecting and focussing on personal goals helped them decide to engage with services. For some SU participants, goals were more orientated to the alleviation of distressing emotions and the prevention of symptoms getting worse. One SU who had used counselling services several times noted,

I felt at my lowest each time I went. I had to find help of else I don't know where it would have taken me. *(SU)*

While another SU participant, with a recent diagnosis of depression had been motivated to engage with a counselling service earlier rather than later because she had seen at close hand a family member's prolonged experience of depression and did not want to repeat this experience for herself. She said,

I was aware of what depression was, what the signs were from a family member's experiences and knew I had to do something before it got worse. *(SU)*

Some SU participants were motivated to use services because they wanted to enjoy life more and lead more fulfilling lives. Two counselling SUs said,

I wanted to be a person who enjoyed life, not pretend to enjoy life or feel guilty about enjoying life. *(SU)*

I wanted a more fulfilling life and to have less fear *(SU).*

Furthermore several SUs reported being motivated to engage with services by a desire to make positive changes for their families' sakes. One SU who had sought counselling to help her cope with the breakup of a relationship commented that thinking about her son and being a better parent had been a primary factor in her deciding to go to counselling.

Several counselling SUs also commented that they had experienced a lack of support from family members when they had decided to use counselling services. One of these participants reported it had helped her to put some emotional space between her and these family members when she was starting counselling to strengthen her resolve to go through it. She commented that when her family saw she meant to go through with it, and then a little while later saw the positive changes in her as a result of her counselling sessions, they changed their outlook and supported her decision without reservations. She said they had said,

> Why are you going there for? And I just had to say I am going…but then when I went through that, they could see the difference in me. I actually had to make some emotional distance between me and them—and it actually helped. They saw me in a different way. Oh you're going, this is a decision that you made. *(SU)*

Finally, one other counselling SU reported she had felt uncomfortable about engaging with a counselling service because it felt selfish. She said it helped her when she was able to give herself permission to do something for herself. She said,

> When I decided to do the counselling it was like I had given myself the permission to just think about me. *(SU)*

Support of Close Others

Some SP and SU participants highlighted how important the emotional support and encouragement from family members and friends was in helping then engage with services. One counselling SU related how anxiety and grief associated with the death of a close family member had impacted significantly on her life. She reported her best friend kept encouraging her to get counselling help which she avoided. After some months, she finally agreed to give counselling a go, partly out of respect for her friend. She found it a positive experience and one that helped her overcome her problems. She reported being grateful to her friend. She said,

> I didn't want to go, I just refused. My best friend was the one that said you should go. She said you've got to go and get some counselling. We talked about it. She even helped me make the appointment.

Knowledge about Services

Several SPs and SU participants noted that a further support in being able to access services, was if a service user or a close other had awareness and knowledge of services including how to access them. Some counselling SUs commented they had recognised themselves that they were experiencing problems they needed help with, and were able and willing to source information about counselling through various

media, and initiate contact with counselling services themselves. Other SUs who had used either community mental health services or counselling services, and who did not have much knowledge about services, noted the importance of the support from close others who encouraged them to get help and helped them in the process of approaching services. One counselling SU reported getting such help from a work supervisor. This SU related how having low self-esteem was manifesting itself in her work environment. She reported not even being aware of it until her work supervisor pointed out the effect it was having on her professional development. Her supervisor had then helped her get in touch with a private counsellor who the supervisor knew. She said,

> I had gone to external supervision for work. I was having some problems with things to do with work, feeling not good enough about taking up responsibility. My supervisor pointed out that it had to do with my past. And then she said she knew someone that could help me. She could see that I needed helping because it was a deeper issue than she could deal with and that it was personal, and then that's when I went to my counsellor for the first time. *(SU)*

One SP also noted the importance of non-mental health community agencies and organizations having knowledge of referral processes to mental health services. This could assist service users who met service criteria to access services earlier rather than later. She said,

> Something I've directly observed is actually having people who know how the service operates and what make an appropriate referral, so that if they're seeing things early on, when people, especially young kids are falling behind academically, when there's been a marked change in their functioning, they pick up on it, they know that it's an appropriate referral to here, I think that's really quite supportive of them being able to access services. *(SP)*

Pre-Engagement Support from Services

Some SPs working in community mental health noted that service providers meeting with Pacific service users and their families before 'clinical work' began was often beneficial in helping Pacific service users and their families. These meetings provided opportunities for building rapport, imparting psychoeducation as well as the addressing of service users and their families' concerns in a neutral environment. It

could also provide additional contextual information for service providers about the service user in their home environment. This SU said,

> We try and make that contact as soon as possible, and if that means we go by ourselves, then we're quite happy to do that, there's no clinical stuff happening there, all we're doing is to make the contact first and start straight away to establish a working relationship… we'll say hello and introduce ourselves, and I think by the time they come here for the first assessment, they know us and when we meet them at reception, they know who they are talking to, because we've already seen them, so the apprehension of coming to a mental health service is taken away a little bit. *(SP)*

This SP also supported such meetings and highlighted the importance in Pacific cultures of 'face to face' dialogue. She said,

> To be Pacific, it's really good to have a face-to-face… introduce yourself, before you meet at the service. *(SP)*

A further support in helping Pacific service users and their families to engage with services was raised by one SP participant. She noted that sometimes initial appointment letters sent out by services to Pacific service users were not responded to, and this could be construed by services as disinterest on the part of service users and their families regarding their wellbeing and care. She said,

> The service, they just send the letters and if they don't respond, that's it, case closed, you obviously don't want your care maintained, Good luck, tofa soifua *(Goodbye)*.

This SP highlighted that non-response from potential service users could be for a number of reasons, many of which have been outlined in the previous chapter. In such cases, this SP noted that in the Pacific service she worked in, there was perseverance in following up non-response with visits to homes. Furthermore, she reported that if and when contact was made, exploring and addressing potential barriers to service use could also be embarked upon with service and their families. This process could include the presence and support of matua *(elder).* She said,

> Here, we will not only write you, we will ring you, and if you don't come, then we'll go there with the matua and say, what is it that stops you from coming? *(SP)*

Positive Therapeutic Relationships

Table 13

Sub-themes in 'Positive Therapeutic Relationships' theme

1. Personal Connection
2. Other Helpful Service Provider Approaches
3. Pacific Service Providers

Service users and their families experiencing a positive relationship with the service providers they were engaged with, was identified by all SP and SU participants as being a significant factor in service users and their families continuing to use services. One SP commented,

> If they have a positive relationship with the clinician that's working with them, they will come back again. If not, they won't come back again, unless they're so desperate, but having a positive relationship is a big onus for them to come back again. *(SP)*

Personal Connection

Most SP and SU participants identified service users experiencing a personal connection with service providers they were engaged as a primary feature of a positive therapeutic relationship. This SP noted,

> I think just the whole people connectedness, just ongoing consistent relationships with people is so important, you know there is no magic wand or cure, it's about people connecting. *(SP)*

Another SP commenting on the nature of this connection reflected that personal connecting was more effective when in keeping with Pacific holistic approaches. In particular, he noted the importance of service providers connecting at a deeper level with people's hearts and spirits. Such connections lead to a stronger relationship in which service users and their families were able to trust and respect the service providers they were engaged with. He said,

> Can you connect with these individuals in a way that are connecting hearts and minds? You know you connect with peoples' minds if you first engage their hearts. If you connect deeply with people at that level you gain their trust, their respect, their compliance, then you're far more likely to get positive outcomes… if we don't connect with people's hearts, we don't get them better. *(SP)*

Service users and their families being able to trust the service providers they were engaged with was noted by some SPs and SUs as an important aspect of personal connection in the therapeutic relationship. This included service users and their families believing that service providers would keep their personal information confidential (with the exception of safety issues). The following SP said it was a real concern for many Pacific families he had worked with and it was an aspect he stressed whenever he engaged with Pacific service users and their families. He commented,

> We make sure that they understand that whatever they talk about here won't get out of this service, and that we won't talk to anyone, about it unless of course there are safety issues and stuff like that. We make sure that they understand that, right at the beginning. *(SP)*

This was especially important when Pacific service users were engaging with Pacific service providers and services as noted by several SP and SU participants. This SP said,

> We make sure that they know about confidentiality and that things will stop here. When they come here for the first time, they're ashamed or shy when they see another person whom looks the same as them and they say, oh no, shall I talk to these people or not? And so that will be their first reaction, and when they come here. *(SP)*

Some SPs also highlighted service providers treating service users and their families with dignity and respect as an important feature in enhancing personal connection. One SP noted that service providers showing respect and treating the service user as an equal was paramount. She said,

> It's those basic tenants of fa'aaloalo (*respect),* equal respect for people. If you have that right, you'll never go wrong. *(SP)*

Another service provider noted this was particularly relevant at this vulnerable time in the lives of service users and their families. This SP said,

> You know how you talk to them and how you treat them, you know with dignity. It's something I always remember when they walk in with their mana. I always make sure when they leave the room you know that everything is still intact you know, or maybe more, rather than walking out feeling stripped to the max, in a way that they've been exposed, you know and humiliated. *(SP)*

Several SPs further raised an additional aspect of showing respect. This was particularly in relation to Pacific service providers (if they were aware) acknowledging the appropriate status within their communities, of either the service user or a member of their family who had come to support them. According to the following SP this could mean a lot to some Pacific families, and demonstrated the respect that service providers had for the service user and their family. He said,

> So for example, if we have a matai *(Samoan chief)* that comes in with the family, we acknowledge his title and where he comes from and that's a big thing to a lot of our people. *(SP)*

Personal connection was enhanced and manifested through a variety of other ways. Most SU and some SP participants commented they responded better to service providers who were friendly, warm and welcoming. One SP noted that this aspect was a 'big deal' for some Pacific service users and could make a difference in whether and how Pacific service users and their families engaged with a service. She commented half-jokingly that this even included the receptionist who was usually the first point of personal contact when service users came into services. She said,

> Even the receptionist, you know how it's like with our people, you're walking to a palagi place the receptionist can be really friendly, oh she's nice, we can go back just for the receptionist (laughing). But can you imagine it if she's frowning you know it's like something major to us. *(SP)*

Several SPs and SUs also commented that service users and their families felt more connected to service providers when they believed they were being heard by service providers and having their experiences validated. Moreover, several SU and SP participants commented that service users wanted to feel that the service provider working with them 'cared' for them, and saw them first and foremost as people who needed help rather than being characterised by their unwellness. This SU participant

commented that she had wanted to feel that the service provider she was seeing chose

to be there to help her and was not just going through the motions of carrying out their

job. She said,

> Be more of a friend, rather than a doctor or just staff. Not giving that feeling like you are ill,
> they have to be there that sort of thing. *(SU)*

The following SP expressed similar sentiments.

> See them for who they are, you don't see them as sick as such. You see them as a
> person who needs help.

An additional quality that was identified by several SP participants as enhancing

the connection between a service provider and a service user and their family, and that

was noted by several SP participants as a value in keeping with Pacific ideals was the

practice of humility on the part of the service provider. This was particularly important

with the power differential between the service provider and service user. This Samoan

SP commented,

> There's a way of approaching Samoans, you have to come from down here, (indicating lower
> level) and make your way from there to whatever the issue is. *(SP)*

Another SP said,

> It's a Pacific practice, the practice of humility where we acknowledge that we don't have all the
> answers, but that we are willing to support them to help find the answers. *(SP)*

Several SUs and SPs also noted that service providers sharing something

personal and appropriate about themselves helped service users to connect personally

with service providers. One of the SU participants noted that this would normally be

expected in the normal course of relationships in general. The following SU reported

that having her counsellor share some personal background information helped her

relate to, and feel more comfortable with the counsellor. She said,

> She talked a bit about her past, about how she grew up in X. Her parents were X and she'd
> travelled around the islands. I felt I could relate to her. She made me feel comfortable by sharing
> something about herself. It started from there. *(SU)*

One final feature identified by one SP as enhancing therapeutic relationships, as well as being good for wellbeing, was the presence of humour and laughter where appropriate. He noted that many Pacific service users he had worked with had responded to humour and laughter. He said,

> If you sit in on our clinical interviews, sometimes it's a hell of a laugh. We have a hell of a scream. It's the funniest thing because the problems are really serious but you wouldn't even believe the amount of laughter and humour and banter that goes on even with depressed people. If you were to go across the road to my (non-Pacific) colleagues you'd find that there's a real sort of absence of humour… I started to recognise that that how much laughter and sense of connection there is between us and our patients, how beneficial that is, how important *(SP)*

Other Helpful Service Provider Approaches

Participants highlighted other attributes that contributed to a positive therapeutic relationship. Some SP and SU participants also commented that service users were encouraged and strengthened when service providers highlighted and reminded them about their existing strengths and the positive features that were present currently in their daily lives. This counselling SU said,

> The counsellor actually showed me to look at what was going on for me. She helped me see my own strengths *(SU)*

Several SPs and SU participants also noted that service users were strengthened when they saw that service providers had a belief in their ability to get better and encouraged hope. This SP said of one of her service user clients,

> It helped her that I came with a positive attitude, that YES you can be well again. *(SP)*

While this SU participant said of the service provider she was engaged with,

> She talked about the future, what we could look forward to. *(SU)*

A further quality that several SPs working in community mental health services noted was service providers practicing patience in their work with Pacific service users and their families. Some SPs working in community mental health services noted that

often more time was needed with Pacific service users and their families. Several SPs commented it was worth the additional time and effort as it enhanced rapport based on Pacific values and approaches, and gave the opportunity for service providers to gain a deeper understanding of service users and their presenting problems. This SP said,

> The first thing before you start to assess a client or ask about their history or their medical history is to try and respect the person. The palagi way is for you to go and meet a client do the assessment straight away. We find that is not going to happen because you don't even know the person, you don't know the family, but from a Pacific perspective we have to go and sit down and start talking and introduce yourself and maybe you talk a little bit about my village and so son. That will be a few days before you come again and say now we have to complete this form because you know it is part of the requirement of my work. *(SP)*

This SP similarly added,

> With our people you need to be EXTREMELY EXTREMELY patient. So in terms of assessment, you might just be able to meet, get to know each other, you wouldn't go into your assessment proper unless of course it's a crisis and there are safety issues, but in terms of doing a proper comprehensive assessment, it's going to be at least three or four sessions before you can get all the information. So just be patient and expect not to get all your assessment done in one go. *(SP)*

One SP who worked in the a mainstream community mental health setting, reflected that patience was needed as it was almost like many Pacific service users had further to travel in the journey to recovery because of exposure to additional social and cultural challenges. He said,

> You need more patience, more time to work with them, because it's almost like they need to come a long way, or we need to go a long way to meet them. *(SP)*

An additional related support for Pacific service users and their families was noted by a few SPs. This was associated with service providers being able and willing to give additional time, support and care if needed to service users and their families. This was sometimes over and above their prescribed roles, particularly as set out in mainstream services. One SP suggested this approach was a 'Pacific approach' and that some Pacific SPs sometimes went beyond the western-based professional boundaries of their professional roles. The SP said,

> If I stick to my role as a Pacific Island cultural worker there is no way I could do the transport, pick up clients and spend extra time with them. But because I know as a Pacific Island person how important it is to spend extra time with them. *(SP)*

However, several SPs further noted that Pacific SPs could experience burnout by practising this way over a sustained period. It could lead to their own needs and wellbeing being compromised. This SP said,

> I used to try and do everything, but it's not wise ... cause we're a heart people, we're so loving, giving people, we can give and give, but burnout is one of the results if we're not careful. *(SP)*

Several SP and SU participants also commented that Pacific service users sometimes did not like therapy where there was 'too much talking,' particularly if it involved what was viewed as too much talk about feelings. Several SP and SU participants also commented that some Pacific service users had a preference for a more directive approach from service providers. This SU said,

> I like to talk, but I like to be directed. If I'm having a problem, I would like to have a solution, to get past the feelings and get to an answer. *(SU)*

Some other SP and SU participants noted that some Pacific service users had preferences for practical and visual strategies. Several SUs reported being visual people who had found it useful when counselling service providers had utilised whiteboards, pictures and other objects. The two following counselling SUs said,

> I just like the way we had our sessions because I'm a visual person. She had lots of objects where I could express emotions using objects symbolising a thought or anger or happiness. *(SU)*

> Well, she would pinpoint things on the white board and I found it easier visually to relate to what was causing some type of stress, and she would direct me back to that. *(SU)*

These two counselling SUs found that writing helped them therapeutically. This counselling SU commented,

> She gave me a diary…I would come back to her and I would share and discuss with her. And that really helped me. *(SU)*

One final practice highlighted by several SPs and SUs as enhancing the

relationship between service providers and Pacific service users was the demonstration

of hospitality in the form of offering refreshments. This SP noted,

> You know having a nice person to greet us with a beautiful big smile, making us feel welcome, making coffee, tea available, you know those little things matter to us, so the client will just keeping going to the service just for the biscuits (laughing) *(SP).*

Pacific Service Providers

This sub-theme, *Pacific* Service *Providers* highlighted the support that Pacific

service users and their families gained from being engaged with Pacific service

providers who shared a Pacific heritage with common beliefs, values and experiences.

One SP noted in her work inside a mainstream service, that although some Pacific

service users and their families were embarrassed at seeing Pacific service providers in

services, other Pacific service users and their families were relieved and felt more

supported when they saw Pacific service providers in services. This Tongan SP said,

> I had this Cook Island client comment on how glad she was when she walked through the door to see me there. She felt understood…and that she could talk and tell us everything and be understood and not undermined. *(SP)*

Several SPs noted that the connection between a Pacific service provider and

service user particularly of the same ethnicity could be strengthened by shared

genealogical connections, values and ways of thinking, doing and being. These deeper

connections potentially facilitated a stronger and supportive therapeutic relationship. It

potentially allowed for Pacific service users to feel they were better understood, and

were able to tell their stories without having to educate and provide additional

explanations to clarify what were cultural norms for them. This counselling SU said,

> I think it would have helped if I had seen a PI counsellor. There's just that feeling of being relaxed, being able to share what came to mind because they would have clicked on, and me not having to explain the reasons for what happened. *(SU)*

Another counselling SU also expressed similar sentiments. She said,

> If you said something about family and how they did things, or of their values and beliefs, you wouldn't have to explain. You would have just said a statement; I'm expected to do this, that and the other. And instead of turning around and saying no, and why do you think that was. They'd know cause that's just the way it is. And someone from the same culture would have understood it without asking, and the flow would have just continued. *(SU)*

A related aspect was noted by this SP participant. She commented that sometimes western diagnoses were applied to Pacific people by service providers from western backgrounds to explain symptoms which from a Pacific perspective might not be abnormal, and might have been accounted for differently. This SP said,

> I'm thinking of some children in my own head who get labelled as ulavale (naughty) in our settings. They're always here, there and everywhere. You just can't keep them still. In the palagi setting, oh there's definitely something wrong with that kid, ADHD, they're just a rocket, and yet in the heart of the Pacific person it's just ulavale, that's just typical of a kid, you know. The emotion behind that is that they could just be really happy, overzealous with life. *(SP)*

Service providers sharing ethnic, cultural and village and kinship connection with service users was also seen as potentially useful in building rapport as related by this SP.

> There was a Samoan guy who was strongly psychotic and violent. He was threatening whoever was near him and I didn't know if he'd accept me. The first thing that I thought about was the approach. I had to find a connection, some connection to connect with this person. To me that is one of the important things in the fa'asamoa, *(the Samoan way)* like where is your village? Who is your father, your mother? So I introduced myself and said I'm from X village and he said, oh, my brother-in-law is from there ... that helped calm him down. *(SP)*

Moreover, some SPs working in community mental health settings noted the importance of service providers understanding Pacific relational values and approaches, and the impact they had on the relationship with Pacific service users. These values were seen as being better understood and appreciated by Pacific service providers who were more likely to share these values and were able to apply them to benefit the therapeutic relationship and improve therapeutic outcomes. For example, the following SP commented on how she viewed older people coming into their services, whether as service users or supporting family members, as like her own parents. She would then

interact and treat them accordingly. She believed that the incorporation of such Pacific

values and approaches in her work greatly validated and supported Pacific service users

and their families. She also noted how a western colleague had commented positively

on her approach. She said,

> One of them recommended me on wonderful work and so I said that's therapeutic work. When this mother comes through that door, she looks at me, I'm the daughter, (laughing), and likewise for me, when she walked in through the door, she's my mother (laughing). *(SP)*

Some SP participants also noted the usefulness of mainstream services having

Pacific cultural support providers. Their roles included providing a range of supports

for Pacific service users and their families; helping educate service providers from

western backgrounds who had limited knowledge of Pacific ways; and serving as

facilitators, translators and advocates for Pacific service users and their families. Such

help could help strengthen understanding and the relationship between western SP

clinicians and Pacific service users and their families. The following SP believed

having the presence of cultural support teams made a positive difference in the

mainstream service in which he worked and in which there was lack of Pacific service

provider clinicians. He noted that the cultural support offered by such cultural support

workers was particularly crucial in the early stages of rapport building and in helping

Pacific service users to access services. He said,

> I think having the cultural team has really helped. I think having the team has sort of facilitated the accessibility of our people here better. I think one of the things is the process of referral. We are the first point of contact, ring up the family and then sometimes we actually make the face to face contact. We actually turn up and introduce ourselves and actually explain what we do here face to face. *(SP)*

In a similar vein, this SP noted,

> Having cultural workers making the first contact with families where they can explain what the service is. They can do some of that destigmitization. *(SP)*

However, on the other hand, one SP commented that the provision of cultural

support workers particularly for relationship building with Pacific service users and

their families needed to be monitored. She suggested it could lead to a sense of complacency on the part of service providers from western backgrounds and in their not making an honest effort to engage, build and strengthen their own 'bridges' with Pacific service providers they were engaged with. She said,

> The practice of building bridges to connect, for people to walk along, to walk across, and start communicating- I guess needs to happen in a lot of our mainstream settings. There is the assumption that you just get Pacific cultural liaison person and that bridge will be built, but it's not like that, there's a skill to building those bridges. It's not just by putting a brown face on your organisation that will do. Not enough just to get Pacific liaison people. Non-Pacific clinicians need to practice the art of building bridges themselves *(SP)*

Family Involvement and Service Support for Family

Table 14

Sub-themes in 'Family Involvement and Service Support for Family' theme

1. Services Supporting Family Involvement
2. Services Providing Support for Family

This theme discussed the importance where appropriate, of services facilitating positive family involvement and support for their service user family member while they were using services. It also discussed the need for services to help support the families of SUs. The two sub-themes were: *Services Supporting Family Involvement* and *Service Support for Family.*

Services Supporting Family Involvement

As discussed earlier, many SPs and SU participants noted the collective worldview many Pacific families have and live by, and the important status families hold as a manifestation of this worldview. Consequently, many SP and SU participants commented that services users experiencing positive family support was a key factor

throughout all aspects of service use. This was seen as particularly relevant to those Pacific service users who were engaged with community mental health services. One SP noted,

> You definitely have to work with family… It's just appreciating and respecting the fact that "I" is always a "we." *(SP)*

Moreover, services facilitating family involvement where appropriate, was seen by many SP and SU participants as in keeping with Pacific values and approaches. This approach also took into account traditional beliefs around family taking care of their family members in times of need. This SP suggested that from this perspective it was important for service providers to encourage and create an environment in which families were able to feel they could be involved and work with service providers and their service user family towards the goal of helping the service user to get better.

> Get the family involved, so there's a shared responsibility. *(SP)*

Moreover, participants highlighted further reasons why it was important for service providers to get active family involvement. Several SPs and SUs noted family members were potentially able to provide additional information and alternative perspectives of service users' presenting problems in order to gain a fuller picture. This SP said,

> There may be things that the family see differently from how we see it, you know, and so it's very helpful to have that open communication. *(SP)*

While another SP noted,

> You would obviously have to work hand in hand with the family … If you're just going in after the individual, you're not really bringing everyone in on the picture … you might be missing some really vital elements to the person's ongoing journey. *(SP)*

One SP also commented that family dynamics could be a primary part of a service user's presenting problems and from this perspective it was often beneficial

when family members were present and were involved in therapeutic interventions as a family. She said,

> The emphasis is on the family. I think is very important because that's where it all starts.

Some SP and SU participants noted that having families actively involved with their service family member in services was also beneficial in that it could mean additional support to see that interventions were being put into place outside the service in the daily life of the service users. Several SPs also commented that sometimes getting families more involved with services could be difficult to achieve for a variety of reasons. However, it was seen by these SPs as being worth the effort to get service users' families involved as often, once families had 'bought' into the idea of therapy and understood the benefits that their family member and the family as a unit might gain, they were more likely to engage more whole heartedly. This SP said,

> I think sometimes work needs to be done to involve the family … I know a lot of our families are very hard to get engaged, but once they are engaged and they know that we're actually doing this for the benefit, not only for the young person, but also for the whole family, I think they'll come to the party, and engage with the services. *(SP)*

On the other hand, several SPs also noted that although it was generally a positive occurrence when families were actively involved in supporting their loved ones, it was also important to be mindful of potential conflict between the service user and their family in terms of goals and approaches. One SP noted that this sometimes could occur when New Zealand-born Pacific service users who could sometimes have more individualistic outlooks disagreed with their more traditional parents as to ways forward. This SP commented,

> I feel sometimes parents need to move back and just be there to support our clients make their own decision and be supportive, but not to be against what her choice or his choices are. *(SP)*

Services Providing Support for Family

It was suggested by some SP and SU participants that services having additional support for service users' families was important. Better supported families meant that family members were better able to support their service user family member. It also could mean that family members were better placed to recognise and address their own wellbeing needs which often were negatively impacted on by the burden of caring for their service user family member.

Several SU participants who had experience of community mental health services commented on a lack of support from services for their family and friends when they had been unwell. The following SU user felt that in the mainstream service she had used, the focus had been entirely on her as the 'sick one' and that there was a lack of effective information from services on how her family could cope better with what was happening to her as a result of her unwellness. She said the following.

> Support services for my family and friends, information for them where they could turn to, because it was more focused on the sick person. Because mental illness is quite hard to deal with, families don't have the strategies to cope within themselves so that they seem to deal with it themselves in their own way. *(SU)*

Participants further identified other supports in services that helped Pacific families. One such support was noted by many of the SP participants who worked in community mental health settings and several SU participants. This was services being able to offer home visits when service users and their families found it difficult to make appointments in services through a variety of reasons including a lack of transport and shift work. Several SPs also noted that home visits provided the opportunity to gain additional information about the service user's home environment and potentially make recommendations to better support service users and their families. This SP said.

> I think from visiting the family, we can then sort of suss out what is happening, of what the environment is like at home, whether it's chaotic or whether it's a nice place for young people

to be brought up in there, or if it's horrible, you know with about 10 other relatives living in the house which usually is what we see there. Grandparents live at home sometimes and people living and sleeping in the sitting room because it's only two bedroom house, all those sorts of things we start seeing then. *(SP)*

According to one SP participant, being able to accommodate home visits was also evidence to service users and their families that service providers respected and cared for them. She said,

> We do more home visits now than we used to and so that gives them the feeling that we actually care about them and so we've made the effort to come and visit them in their homes, and all those other things. *(SP)*

Being able to access services in urgent situations was also noted by this SU participant as being important in the time she was engaged with a community mental health service. She said,

> I could ring them at any time of the day, they were accessible. They knew who I was. I didn't have to go to them. They could come to me, maybe because my case was quite extreme. *(SP)*

Two other SPs identified Pacific-specific family support groups as being useful in supporting families. The service these two SPs worked in, had run such a support group which provided psychoeducation and provided a forum whereby family members of service users could meet and talk with each other about their experiences. This also assisted in normalising the experience their families were living through. One of these SPs said,

> When we had that Pacific Island parent support group, I think, what really came out of it is that parents start to think and say, we never knew that was happening with our child, we never knew that what we were doing was causing that effect on young people, or we didn't know we were thinking that way. Also the other thing is that parents and families get support from other parents and families who are in the same boat. *(SP)*

Finally, one SP noted that often the families of service users using community mental health services were over-burdened with the responsibility of caring for their loved one in addition to their other daily responsibilities. She suggested that services being able to provide Pacific support workers outside of the family to offer respite for affected family members would be beneficial to those families. She commented that not

only would this give respite for those family members, but could also help alleviate

strained relationships between service users and family members. She said,

> Having that Pacific Island support person, you know I'd rather have that role provided by the services rather than the family. You know we've got these families that live with the client…it's a huge responsibility, on top of everyone else you know. You may be working, you may have a mother, a brother who has mental health issues, and you may be working full-time, you see this person seven days of your life. But to have somebody whose paid to do that job, that independent person, it's his role, his job to provide for that person, to support that mental health client, rather than having, Oh, I'm looking after my stupid cousin, it becomes like a real barrier, because you still want to have a relationship outside of that relationship, rather than just having a cousin, and a sick cousin to look after, you know, and they (the family member looking after the unwell person) may not understand or appreciate their mental health problems. *(SP)*

Other Cultural Support in Services

Table 15

Sub-themes in 'Other Cultural Supports in Services' theme

1. Cultural Training in Services

2. Recognising Spiritual Supports

In this theme, participants identified cultural supports within services that could

assist Pacific service providers and their families in using services. The sub-themes

were: *Cultural Training in Services* and *Recognising Spiritual Supports.*

Cultural Training in Services

Several SPs and SUs identified the importance of services having ongoing

cultural training for service providers from western backgrounds. The following SP

who was involved in providing this type of training commented on the positive

difference such training made his workplace,

> I think we've helped change the culture of the place. It has become more accommodating of people from other cultures, especially our own Pacific Island people. *(SP)*

However, one SP noted that although such training had its merits, it was still inevitably limited. She suggested that a deeper understanding and appreciation of a culture was intrinsically linked to being raised and immersed in that culture's values and practices from an early age, and that it was important not to lose sight of this. She said,

> I strongly believe that that's something that you can't teach in cultural competence training. *(SP)*

As previously mentioned, many SUs and SPs, noted the significance of holistic and collective perspectives in the lives of Pacific people. Several SP and SU participants suggested it was important that service providers from western backgrounds, had some understanding of these values and how they manifested in Pacific people's daily lives as well as in therapeutic relationships. Cultural training was seen by several SPs as being beneficial in developing a deeper understanding among service providers from western backgrounds. This SP said,

> We've exposed a lot of staff who have come from different backgrounds and also different ways of training to see things in different ways, to working within different frameworks when working with our Pacific Island people. *(SP)*

Recognising Spiritual Supports

A significant aspect of a holistic perspective for many Pacific people was noted by many SP and SU participants to be the spiritual domain. As one SU put it,

> I think with us Pacific Islanders, we're strong on the spiritual side.

Several SPs and SUs commented on the support that Pacific service users and their families gained from their spiritual beliefs and practices. One SP participant further noted that spiritual beliefs could often provide a framework within which Pacific service users were able to contextualise current problems. Spiritual supports such as prayers also provided strength and encouragement to help some Pacific service

users to address and overcome their problems. Several SPs and SUs commented that it was important for service providers who did not share these spiritual beliefs to recognize the support that some Pacific service users and their families gained from utilizing these spiritual supports, in conjunction with service- related therapeutic interventions. The importance of prayer in particular was noted by several SP participants. One Samoan SP who worked in a Pacific service, reflected that as a Christian working in a Pacific service he offered Pacific service users and their families the choice of starting a session with a prayer. He commented on the significance of a prayer at the beginning of a session with Pacific service users who shared similar spiritual beliefs.

> A tatalo (*prayer)* serves a very crucial role. It reminds the person and you of how genuine the transaction is We're also asking the higher being to give his blessing. It also helps create rapport because as a Samoan I believe that once you say tatalo, it's like you open up all of who you are, your wishes and wants. In prayer you are also asking God for guidance and strength, to facilitate the process and it go easier. *(SP)*

Another SP who was also a Christian emphasized the importance of service users having a choice as to whether or not they wanted to begin and/or end sessions with a prayer. He said,

> We offer them the help of prayer at the start, because it's quite important to us. We give them a choice, it's not forced.

One Tongan service provider from a Christian background, related how her praying with a service user had helped support the service user who had not been able to pray for some time, due to grief over the death of a close relative. The service provider understood the importance of this woman's spiritual beliefs before the death of her close family member, and was aware that her inability to pray was a significant problem for this woman. It had disconnected her from the support, guidance and protection that prayer offered. It also had disconnected her from the support of her

church community. This SP noted that this aspect had gone unnoticed by her western co-workers. She said of the SU,

> She said to me, I can't even say my prayer because I get too upset and I cry when I pray and I just cry. You know when she mentioned prayer, it was not a big deal to them (western SPs), but it was to me and I case noted it. And I said to myself, this is how she's been surviving, and I was thinking, oh gosh, and I said to her, okay, we will pray, and so I prayed for her. *(SP)*

Several counselling SUs also noted that working with a service provider who shared similar spiritual beliefs was or could have been beneficial in working through their problems. One counselling SU who reported she experiencing negative experiences with three counsellors from western backgrounds in terms of how they conceptualised her problems eported it was not until she went to a fourth counsellor that she felt more comfortable and connected. She reported this although this counsellor was a New Zealand European it made a difference that she shared the same Christian values and beliefs as herself. She said,

> It was only when I got to the fourth counsellor; she was Christian-based that I just felt a lot more at ease. Because I was raised in a Christian family, it was just about bringing God into the whole session. It was something that I could relate to, the other stuff I couldn't pick up straight away. *(SU)*

A further counselling SU who was also a Christian commented that although she had benefited from her counselling experience, she believed she might have gained more benefit had she gone to a Christian-based counselling service which reflected her own beliefs and met her spiritual needs. She said,

> You know, when I think about it now, seeking out counselling that's meets my needs spiritually might have been better. *(SU)*

Other Supports in Using Services

Table 16

Sub-themes in 'Other Supports in Using Services' theme

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1. Psychoeducation
2. Recognising Individual Differences and Needs of Pacific Service Users
3. Recognising Impact of Socio-economic Issues

This theme presented further supports which helped Pacific service users and their families to continue to engage with services and gain benefit from this use. Four sub-themes were identified. The first subtheme *Psychoeducation* noted the importance of making sure effective psychoeducation was provided for Pacific service users and their families. The second sub-theme *Recognising Individual Differences and Needs of Pacific Service Users* highlighted the importance of service providers continuing to be mindful of the unique individual difference and needs of Pacific service users they were working with. The third sub-theme *Recognising Impact of Socio-Economic Issues* related to service providers recognising the impact of the socio-economic factors in the presenting problems of Pacific service users and their families, and the need for therapeutic interventions to address some of these wider contributing issues.

Psychoeducation

The importance of services providing effective and clear psychoeducation for both individuals and their families was highlighted by many SPs and several SU participants. It was seen by some SPs as being particularly relevant in community mental health services. It could play a significant part in helping service users and their families understand precipitating factors to service users' presenting problems, as well as how they could support their family member. As previously noted by one SP, when

Pacific service users and their families had better understanding of the service user's problems, this could lead to a deeper commitment and involvement in supporting their family member to use services. This SP said,

> I think education is the bottom line, if we want Pacific people to overcome the fear of entering services like this. *(SP)*

Two SPs, who had both been SUs, noted how having knowledge about their problems helped them to manage their unwellness. It also gave them a sense of being in control of their own lives. One of these participants said,

> I believe that knowledge is power and so that helps me to stay well and so I'm very much self-aware with regards to my own health and I know what my triggers are. *(SU/SP)*

Several SPs commented that psychoeducation could be accessed and presented in a range of ways. For example, it could be presented in printed format, including in various Pacific languages which Pacific SUs and their families could keep referring back to as needed. This SP said,

> Having knowledge by way of pamphlets and brochures that are written in their own languages would help. *(SP)*

Broader community level psychoeducation was also seen by some SP and SU participants as being important to help destigmitize mental health unwellness. For example, as part of Pacific radio programmes and television advertisement campaigns. This SP commented,

> Like the radio programme. Because people don't like to go anywhere but they still like listen to the radio. That is another way of promoting and letting people know there are service around. *(SP)*

Several SPs also commented on the importance of ongoing and clear psychoeducation on relation to medication usage. They noted that sometimes there could be issues of non-compliance. This SP commented,

A lot of education has to be done with things like non-compliance with medication, and that's probably one of the main issues in my experience. Most Pacific people don't like to take medication. *(SP)*

Finally, several SP participants highlighted the importance of making sure that service users and their families understood their rights. This was seen as being important in giving service users and their families a sense of some control in what was a vulnerable time in their lives. This SP said,

Whoever is seeing them has the authority or the power in that situation so they need to help that person understand that they have rights. They can ask questions, or that things can be explained to them. *(SP)*

Recognising Individual Differences and Needs of Pacific Service Users

Several SPs and SUs commented that although it was important to acknowledge the collective and holistic values many Pacific cultures had in common, it was also important not to lose sight of the individuality and diversity amongst Pacific service users they saw. This could be in terms of their varying Pacific Island backgrounds (e.g., Samoan, Tongan, Fijian) and the diversity within those cultural groups themselves. It could also be in the differences between more traditional service users or families and New Zealand raised service users and/or family members who could hold what might be seen as more western values and outlooks. It was also important to note differences in personality, education, and religious beliefs amongst other variables factors, and for service providers to formulate interventions accordingly. This SP, a former SU said,

People are individuals—there's not going to be one model that suits one person—it's going to be a mix and match of things. And so I'm very resistant to being locked into—one model that this is the way to go. *(SU/SP)*

Recognising Impact of Socio-economic Issues

Finally, many SPs who worked in community mental health services commented it was important for services to keep in mind socio-economic challenges

that Pacific service users and their families might currently be experiencing and which were likely to have contributed to their presenting problems. Some of these SPs supported a holistic and multi-disciplinary therapeutic approach that included the addressing of these socio-economic challenges. This SP said,

> The context of the problem is important---say for example in meeting a woman with post-natal depression---it's not just depression itself—it could be the relationship she has with her partner, violence, financial problems—there's all these kinds of issues to address. The successful outcome would be that not only had we treated the depression say with CBT interventions, but also that they've learned to manage their finances, that the partner has gone to a 'Stopping Violence' programme and maybe there's been parenting issues solved. *(SP)*

Another SP said,

> I think the most the most utilized service here is social work, because despite the fact that these people have experienced psychotic episodes—the source of the problem—the most urgent thing for them—cause once you give them medication they think that they're well, but the problems at home never go away. There are financial issues, social issues, family issues. *(SP)*

While another SP said,

> This is a multidisciplinary service. We're offering housing New Zealand House, if they are not getting what they are entitled from WINZ, we try to help transition them on to a school, a job or a course. And when they do come here and are offered that and they think, oh, you know, wow these people are really trying hard to help us and so they keep coming back. *(SP)*

Summary

This chapter discussed supports identified by SP and SU participants as assisting service users and their families in accessing and using services. These supports were outlined in five themes. The first theme *Supports in Accessing Services* highlighted factors that assisted service users and their families to access services. These included service users utilising inner resources, experiencing the encouragement and support of family and friends, and the service user or a close other having knowledge of access to services. The second theme *Positive Therapeutic Relationships* highlighted the support that service users and their families gained from having a

positive relationship with service providers. This theme discussed attitudes and practices that service providers had, that were perceived to be helpful to Pacific service users and their families. The third theme *Family Involvement and Service Support for the Family* noted the benefit service users generally gained when their family was able to actively support them in service use. Services support for family was also seen as being an important feature in both assisting the family to support their service user family member as well as make sure that their own needs wer prefer active and directive approaches to therapy instead of inactive and indirect approaches that emphasize self-disclosure, insight such as in "talk" therapy (Sue & Sue, 2003).e being recognised and addressed.

The fourth theme *Other Cultural Supports in Services* outlined the importance of services having cultural support for service users and their families, as well as for service providers from western backgrounds who had limited understanding of Pacific values and practices. Having cultural support workers and training were seen as being important supports.

The fifth theme *Other Supports for Using Services* noted the importance of psychoeducation for service users and their families. It also noted that some Pacific service users had a preference for practical and directive approaches particularly in talking therapy settings. This theme also discussed the importance of service providers being mindful of service users' individual differences. Finally, it highlighted the importance of service providers recognising and addressing the impact that socio-economic factors had on service users presenting problems. The supports in services outlined in this chapter were perceived as being useful in assisting Pacific service users and their families to engage with services, and to get the most out of services in their journey to achieving better wellbeing.

CHAPTER FIVE: DISCUSSION

Overview of this Study

This study had two primary aims. The first aim was to gain a deeper understanding of the barriers that Pacific people experience in accessing and using mental health services. The second aim was to attain a better understanding of the supports that assist Pacific people to access and use mental health services. Interviews were conducted with service providers and service users of Pacific descent to gain their insights and experiences in relation to the study aims. This chapter examines the results of this study in light of previous research into the experiences of mental health service use by ethnic minority service users, and especially the research that is relevant to the experiences of use of mental services by Pacific people in New Zealand. The implications for the provision of mental health services, clinical practice and future research directions are also discussed, along with the limitations of the study.

Barriers to Accessing and Using Services

As has been found in previous ethnic minority mental health-related research both overseas (Anglin, 2006) and in New Zealand (Samu & Suaalii-Saunui, 2009; Te Pou, 2010), this study found that stigmatization and shame associated with mental illness posed a major barrier for Pacific people and their families in accessing and using services. In line with traditional perspectives (Lui & Schwenke, 2003; Vaka et al., 2009), the experience of stigma and shame typically related to being perceived by others as facing retribution and consequences for the breaching of spiritual and social taboos (Vaka et al., 2009; Tamasese et al., 2005). The results, similar to a study

involving Mexican Americans (Leong et al., 1995) suggest that stigma can also be associated with perceptions that a person was 'weak' when they had a need for mental health service treatment. Moreover in the context of this current study, shame and guilt could also occur when Pacific service users felt they had let their family down by being unwell and not being able to solve problems within their family. Furthermore, in accessing services, the results from this study indicate that apart from fear of stigmatization, there was also fear of the unknown, and concerns that inappropriate treatment might exacerbate symptoms of mental unwellness. Service users and their families having limited of knowledge of mental unwellness symptoms and triggers, and of services in general, was also noted in this study as a barrier to access. Having limited knowledge could also apply to community services and organisations, including medical practitioners and schools that were in a position to refer potential service users, but who were not fully informed about criteria and referral processes.

Similar to results demonstrated in international ethnic minority mental health and Pacific mental health research in New Zealand (e.g., Sue & Sue, 1999; Agnew et al., 2004; Tamasese et al., 2005), this study found that a significant barrier to accessing and using services was the perception that services were based on western conceptualisations and practices, and therefore were not culturally relevant for Pacific needs. In addition, this study found that as with some ethnic minority groups in the United States (Flaskerud, 1986), Pacific people could prefer to use their own informal support systems such as family, spiritual supports (e.g., clergy and prayer), and traditional healers to help overcome problems rather than access services.

This study also found that service providers having a lack of insight into Pacific service users' socio-cultural contexts, could limit understanding of their problems.

Relevant socio-cultural areas identified included Pacific collective and holistic values, acculturation and identity issues, and socio-economic challenges. Limited understanding on the part of service providers of Pacific service users' socio-cultural backgrounds could also impact on the quality of therapeutic relationships, assessment and therapeutic processes. Referring to the assessment process and the importance of service providers recognising the impact of differing worldviews on conceptualising presenting problems, Constantine (2001) found that counselling trainees with more individualist orientations found it more difficult than trainees with more collectivist tendencies, to conceptualise cases from multicultural perspectives. They were also less likely to integrate situational factors into their case formulation than trainees who had a more collectivist orientation.

In addition, this study also found that the realities and socio-cultural contexts of New Zealand-born service users could be overlooked as Island-born perspective could take precedence in services. This could be particularly relevant if younger New Zealand- born service users were engaged with Pacific service providers who held more traditional perspectives, and if service providers from non-Pacific backgrounds were not aware of the diversity within Pacific families.

Regarding the therapeutic relationship, this study further found that limited understanding and integration of Pacific relational approaches could be a significant barrier. The result suggests that Pacific service users and their families may find some service providers (particularly from western backgrounds) as "clinical" and "impersonal". It also found that service providers could misinterpret situations and intentions if they did not have a deeper understanding of Pacific relational dynamic (e.g., showing respect for 'experts' and therefore not wanting to contradict them). These situations could be further exacerbated by language and communication

difficulties. A lack of fit between Pacific users' cultural beliefs and those of service providers were also evident in western therapeutic strategies (e.g. use of genograms, aspects of talking therapy approaches), as well as aspects of medication use. Furthermore, this study found that different understandings around the status and role of family including their involvement with services and the therapeutic process, could lead to service users feeling isolated and families feeling marginalised. A related finding, that was similar to the findings of Annandale & Instone (2004), was associated with families perceiving a lack of service support, including practical support, to help them support their family member, and facilitate self-care for themselves (e.g., assistance to access respite care).

This study also identified additional barriers that were specific to the relationship between Pacific service providers and Pacific service users. The issue of different cultural understandings around the concept of confidentiality was identified as a potential barrier for some service users and/or their families. There were concerns that Pacific service providers might relay information about service users to others outside the service, despite confidentiality assurances, and based on the premise that confidentiality might be viewed as a western concept with limited relevance within Pacific communities. A further potential barrier located within the context of the Pacific service user-Pacific service provider relationship was the challenge and potential conflict in negotiating two different ways of relating; a therapeutic relational context based on western principles, and observing Pacific relational values associated with maintaining the appropriate *va,* depending on the age, gender, status, and role of the service and service provider.

Supports in Accessing and Using Services

This study found that service users and their families' experiencing positive therapeutic relationships with service providers was a significant support in using services. Part of this positive experience related to the use of relational approaches that connected with Pacific service users and their families, and were valued in Pacific cultures, such as connecting not only on an intellectual level, but as one service provider said, with "people's hearts and spirits." It also entailed treating service users and their families with respect and being perceived as committed to their care. Similar to the conclusions of the Te Pou study (2010), this study found that initial contact and rapport-building was particularly important in developing and sustaining a positive therapeutic relationship. This process was seen as often needing more time than in western contexts, and might take place in peoples' homes as appropriate, but was noted as being worth the effort. Meeting with families before clinical work commenced, could also provide opportunities for psychoeducation, addressing concerns, and giving additional information. These were all strategies that were seen as supporting Pacific service users and their families.

This study also found that positive and affirming family support helped service users to access and use services. This was noted as particularly important given the collectivist and family-focussed values of Pacific cultures, and that family is often the primary support for service users engaged with community mental health services (Pulotu-Endemann et al., 2004). Having families actively involved could mean additional support was at hand to help facilitate therapeutic interventions in daily life outside of services. The results from this study also suggest the importance of services supporting families who are often over-burdened in caring for unwell family members by providing information and facilitating access to respite and other government and

non-government agency supports that might be relevant to their situation. Family support groups were also noted as providing additional support including the normalisation of their experiences, when these worked well.

One further significant area of support highlighted by this study was services having effective cultural competency training programmes for service providers, and having cultural support in the form of translators and trained cultural support providers to assist service users and their families as needed. Similar to Malo's (2000) findings, this study also found that having Pacific service providers who held similar worldviews and values, and were able to communicate with service users in their first language were also valuable supports, particularly where language and cultural barriers were more pronounced.

In relation to supports in accessing services, the results of this study suggest that personal internal strengths helped and gave courage to some Pacific individuals to make the decision to access services, particularly for counselling service users. These inner supports included affirming beliefs, attitudes, and reflecting on the potential benefits of engaging with services. These inner strengths assisted service users to be open to accessing services despite experiencing fear or apathy. These internal motivations and strengths, including spiritual faith, continued to be important throughout service use and were also noted by Malo (2000). As might be expected in Pacific cultures, the emotional and practical support of family and friends was also seen as being a significant support in assisting Pacific people, particularly in accessing community mental health services, as was having knowledge of mental unwellness symptoms and services. Similar to the Pulotu-Endemann et al. (2004) recommendations, the results further suggest the importance of non-mental health community agencies and organizations having knowledge of referral processes to

mental health services and being co-ordinated with each other, as this could assist service users who met service criteria to access services earlier rather than later. Finally, this study found that effective psycho-education for service users and their families throughout the process of accessing and using services could be important to help support families to use services and gain benefit from them. Psychoeducation programmes were also seen as relevant for the wider Pacific and general communities in order to address stigma associated with mental unwellness and provide education on recognising the early signs of mental unwellness.

Clinical Implications

Pacific people experience stigma and discrimination in a range of settings and this poses significant barriers to their access and use of mental health services (Pulotu-Endemann et al., 2004; Samu & Suaalii-Saunui, 2009). As recommended in previous studies and practice recommendations (Te Pou, 2010; Pulotu-Endemann et al., 2004), it may be desirable to have effective educational programmes aimed at families, mental health services and organisations, and Pacific communities to assist in destigmatizing mental unwellness. A lack of knowledge has also been posited as a barrier in accessing and using services. On a personal and family level, there needs to be effective psychoeducation in all aspects of mental unwellness. This is particularly relevant for the family and other close support people as they are often the primary support for their unwell member. On a general government and community agency level, as suggested by Pulotu-Endemann et al. (2004), and supported by this study, effective co-ordination between relevant services may help prevent delays in Pacific people accessing services if they are deemed to meet service criteria. Finally, mental health related-issues could

be promoted to Pacific communities so that they recognise the symptoms of mental unwellness and are aware of the benefits of seeking help early.

In addressing barriers more specifically related to therapeutic work in services, there is a need for comprehensive cultural competency training for mental health service providers. A significant component of this training could be focussed on promoting deeper understanding of traditional Pacific cultural values and practices, particularly, of the collective and holistic-based nature of Pacific cultures in general, and the emphasis on the importance of relationships and the spiritual dimension. Implementing this understanding, as appropriate to therapeutic work with Pacific service users and their families, could also be an important aspect of this cultural competency training. A second important component of this cultural competency training could be aimed at promoting better understanding of acculturation and identity-related issues that may be particularly salient for New Zealand-born Pacific service users. This is important as more traditional island-born perspectives may be prioritised in mental health frameworks and practices in services over younger New Zealand-born perspectives (Suaalii-Sauni et al., 2009). Training also needs to emphasize the diversity that exists within Pacific communities and the need to safeguard against stereotyping Pacific service users. There is also the need for assessment and formulation practices to encompass information on Pacific service users and their families' spiritual beliefs, acculturation levels, and identity beliefs. These aspects provide additional information that are likely to provide a more complete contextual picture of the service user and the problems they are experiencing and give guidance to more effective therapeutic interventions.

In relation to the therapeutic relationship, there is a need to incorporate more Pacific approaches to relationship building. This includes taking more time to build

rapport if needed and having a better understanding of Pacific relational dynamics that may be present, such as respect for authority. Furthermore, it is important that Pacific service providers are aware of relational dynamics that may be operating between them and Pacific service users in the course of respecting and maintaining relationships within a Pacific context. These need to be acknowledged and addressed openly. Finally, it is suggested that multi-systemic approaches to addressing Pacific service users' problems may be useful. These approaches are in line with Pacific holistic perspectives, and address needs in the inter-related areas of service users' lives that impact on mental, emotional and overall wellbeing. For example, this might include co-ordinated services that not only provide psychotherapeutic interventions, but also budgeting and social advocacy services.

Limitations of the Study

This study has a number of limitations. Firstly, the current study was Auckland-based and thus may not represent the experiences of Pacific service users and Pacific service providers in other parts of New Zealand. While the Auckland region has the biggest Pacific population in New Zealand, exploring the experiences of Pacific service users and Pacific service providers from other regions would be useful to examine any differences in experiences. Secondly, there were two distinct groups of service user participants; those who utilised community mental health or inpatient services, and those who used counselling services. Although there are common themes in experience of services, there were also aspects of service use that appeared to be more or less relevant for each group. For example, having family support was identified as being more relevant to community mental health service users than counselling service users, several whom had chosen to keep from their immediate family that they were going to

counselling. Part of this decision may have been due to perceptions (their own and close others) that counselling was a 'palagi' (*European)* practice. A third limitation identified was the wide range of occupational experience in the service provider group. Their backgrounds ranged from clinical, cultural and peer-focussed roles. Although this allowed for a wide range of valuable information to be gained, it may also have led to less depth of understanding of specific areas. This was partly due to the small Pacific mental health workforce across the range of mental health occupational roles.

A fourth limitation was the lack of service user participants who were male. This included not having male counselling service users. It would have been useful to explore the experiences of more Pacific male participants, particularly within a counselling context to see whether there were discrepancies between their experiences and those of Pacific women service users. A fifth limitation was a lack of Pacific ethnic diversity with almost all participants being either of Samoan or Tongan descent. For example, it would have been useful to gain the perspectives of participants of Cook Island descent who comprise the second largest Pacific group in New Zealand, as well as those from smaller Pacific communities such as Niue and Tokelau to investigate if there were any discrepancies in their experiences because of the small size of their communities. Finally, a sixth and significant limitation was that almost all the service user participants were New Zealand born or had migrated to New Zealand at an early age. It would have added to the study if the perspective of more Island-born service users had been gained. Island-born Pacific people currently comprise about 40 percent of the Pacific population in New Zealand.

Directions for Future Research

There are a wide range of possibilities for future research in relation to understanding the mental health service needs of Pacific people in New Zealand. Firstly, there needs to be more research on the experience of different types of services used by Pacific people. For example, mainstream community services, Pacific-specific services, inpatient services and counselling services. Secondly, the 'Pacific' pan-ethnic label is likely to conceal the diversity that exists among distinct ethnic island groups. Therefore, there is a need for research on the ethnic-specific needs of distinct island groups (e.g., Samoan, Cook Islands, Tongan, Niue).Thirdly, there is a significant need for further research on the impact of acculturation and identity issues on the wellbeing of Pacific people, particularly New Zealand-born Pacific people. A further related aspect of this particular sub-population is the rapidly increasing proportion that identify with more than one ethnic group. A fourth possibility for future research is to understand better the impact of western therapeutic interventions on Pacific people. This research would help to define the aspects of these therapies that are helpful and those aspects that are problematic. Further, it is important that future clinical research look at integrating aspects of Pacific and western approaches as appropriate and beneficial to needs. In the long-term, it may be important to develop evidence based practices that are designed specifically for Pacific people.

Conclusion

This study set out to investigate the barriers that hindered Pacific people to access and use mental health services, as well as the supports that assisted them in engaging and using these services. Interviews were conducted with former mental

health service users and mental health service providers of Pacific descent to gain their perceptions and experiences in relation to the aims of this research. The data were then analysed using thematic analysis.

This study found the experiences of stigma, shame and fear; lack of knowledge about mental unwellness symptoms and services; and lack of belief in the usefulness of services appeared to underlie Pacific people's lack of approach to services and could lead to more severe presentations when they eventually entered services. These results also suggest that some Pacific people experience a lack of cultural understanding and support from services. Service providers from mainly western backgrounds were seen as sometimes having limited understanding of the socio-cultural contexts of Pacific service users and their families that impacted on therapeutic relationships, assessment and therapeutic processes. A number of supports were identified that assisted Pacific people to approach and use services more effectively. In accessing services, these included service users drawing on personal strengths; the support of family and friends; and having knowledge of mental unwellness symptoms and services. In using services, positive therapeutic relationships with particular attention to rapport-building based on Pacific approaches were experienced as being helpful. The Pacific service providers and service users who were interviewed emphasized the importance of effective socio-cultural training for staff. They also emphasized the importance of effective psychoeducation for Pacific service users and their families. The implications for mental health services were discussed, as were the limitations of the study, and future research directions.

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APPENDICES

Appendix 1

Participant Information Sheet

Project Title: Mental Health Service providers' perceptions on an Outcome measure for Pacific Island clients

Researcher: Christina Fa'alogo-Lilo, Clinical Psychology Doctoral student, University of Auckland

Supervisors: Dr Claire Cartwright, Dr Ian Lambie

To: Mental health service providers working with Pacific Island consumers

What is the study about?

This research is part of a larger Mental Health Standard Measures Assessment and Recovery (MH-SMART) scoping project, funded by the Health Research Council (HRC). The purpose of this wider project is to provide a preliminary report on mental health outcome research and measures for Pacific Island people, to the Mental Health and Development Strategy division of the Ministry of Health. Wide consultation with various Pacific Island mental health stakeholders has been identified as an essential component in the formation of this report.

The purpose of this study is to specifically focus on one group of stakeholders - mental health service providers; and find out what their perceptions are on mental health outcomes for Pacific clients and how these outcomes might be measured.

Who is carrying out the study?

This study is being carried out by a team of three Pacific Island researchers; a clinical psychologist, a mental health consultant and a University of Auckland Clinical Psychology Doctoral student.

Who do we want to talk to?

With your permission, we would like to talk with mental health service providers who work with Pacific consumers in your agency. The first study is a Focus Group study while the second study   involves individual interviews. Service providers may include psychiatrists, psychologists, nurses, social workers, support workers and cultural advisors who work with mental health consumers.

How long will it take?

It is expected that the Focus groups will run for about an hour, and that the interviews will last between 45-60 minutes.

Meaalofa (gift)

In keeping with Pacific protocol a small meaalofa will be presented to participants in recognition and acknowledgement of the gifting of their valuable knowledge.

What happens to the information?

All consent forms will be assigned an identity code and locked in a filing cabinet. The corresponding audiotapes and the interviews transcribed from them will be assigned the same identity code as the corresponding consent forms. After they are used, the audiotapes and transcribed interviews will also be locked away in separate filing cabinets. Audiotapes and transcribed interviews will be kept for six years before being destroyed. The information is kept for this duration in the event that it is used in peer-reviewed publications or that research might be further developed. All data will be stored at the University of Auckland.

Every attempt will be made by the researchers to transcribe the audiotapes themselves. However, in the event that this is not possible, a transcriber will be employed to assist. He or she will be required to sign a confidentiality agreement.

Regarding confidentiality in Focus groups, every endeavour will be taken to maintain confidentiality of the group, but we cannot guarantee this on behalf of the other participants.

If the information you provide is reported or published, this will be done in a way that does not identify you as its source. After completion of the study, information on the findings of this research will be made available to you if you wish it.

Participants will be given the choice of receiving a written summary of the study results as well as receiving a copy of their individual interview. Participants taking part in the Focus groups will not be offered the choice of receiving a copy of the audiotape as it also contains other individuals' input.

Can I change my mind and withdraw from the study?

You may withdraw from the study at any time, and withdraw any information traceable to you up to two weeks after the conclusion of the Focus Groups and interviews without giving a reason. You are under no obligation to participate. Participation is purely voluntary.

If you have any questions about this project at any time, please contact:

Christina Fa'alogo-Lilo at the Psychology Department, University of Auckland. Prviate Bag 92019. Auckland or on 373-7599 ext 84479.
OR
Dr Claire Cartwright (Doctoral supervisor), at the above address or on 373-7599 ext 86535
OR
Associate-Professor Fred Seymour (Head of Psychology Department), at the above address or on 373-7599 ext 88414

For any queries regarding ethical concerns please contact:
The Chair,
The University of Auckland Human Participants Ethics Committee,
The University of Auckland, Private Bag 92019, Auckland.
      Phone: 373-7599 Ext. 87830

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 21.9.2005 for 3 years from 21.9.2005 to 21.9.2008. Reference Number 2005/104

Appendix 2

[Printed on University of Auckland Psychology department letterhead]

Participation Information Sheet

Pacific people perspectives on having a problem that required some counselling or support.

Researcher
- o This study is being carried out by Christina Fa'alogo-Lilo, a student in the Doctorate of Clinical Psychology Programme at the University of Auckland. This study forms part of the basis for her doctoral thesis.

- o Her primary supervisor is Dr Claire Cartwright; PhD, DipClinPsych (Auck.), a senior lecturer in the Clinical Psychology programme at the University of Auckland. Her secondary supervisor is Dr Ian Lambie; PhD, DipClinPsych (Auck.), who is also from the University of Auckland.

Invitation
- o You are invited to take part in this study what will investigate Pacific people '
  retrospective perspectives on experiencing psychological distress that required some counselling or support.

- o To participate in this study you will:
    - Be of Pacific Island descent
    - Self-identify as being a Pacific Island person
    - Be at least 18 years of age
    - Have had some recent past experience (within the past five years) of using a mental health or counselling service.

Purpose of Research
- o The purpose of this research is to investigate the experiences and perspectives of Pacific people who have experienced psychological distress in the past that required counselling or other forms of support. The aim of this research is to contribute to a better understanding of supports that may help Pacific People when facing such distress.

The Participation Process
- o Your participation is entirely voluntary (your choice). You do not have to take part in this study.
- o If you do agree to take part, you can choose to withdraw from the study at any time. This also includes the right to withdraw the information that you have given me up to two weeks after the conclusion of your interview without giving a reason.
- o It is expected that the interview will last around 60 minutes and be audiotaped.

o In keeping with Pacific protocol, a small meaalofa (gift) will be presented to participants in acknowledgement of the gifting of their valuable knowledge.

Storage of Information
o All consent forms will be assigned an identity code and locked in a filing cabinet. The corresponding audiotapes and the interviews transcribed from these audiotapes will be assigned the same identity code as the corresponding consent forms.
o After they are used, the audiotapes and transcribed interviews will be kept for six years before being destroyed. The information is kept for this duration in the event that it is used in peer-reviewed publications or that research might be further developed. All data will be stored at the University of Auckland.

What happens to the Information
o Every attempt will be made by the researcher to transcribe the audiotape herself. However, in the event that this is not possible, a transciber will be employed to assist. He or she will be required to sign a confidentiality agreement.
o If the information you provide is reported or published, this will be done in away that does not identify you as its source.
o After completion of the study, information on the findings of this research will be made available to you if you wish it. Participants will be given the choice of either receiving a written summary or electronic mail copy of the study results.

Potential Risks
o Given that participants will be interviewed regarding a distressing time in their lives, it is possible that you might become upset. There is a risk of bringing back the thoughts and feelings that you were experiencing at that time. If you think it may be a problem for you, it may be better that you do not take part in this study. Alternatively, we can begin, and then stop if you feel uncomfortable. You can have a break and then continue, or stop altogether.
o If you feel the need to talk to someone you may contact Dr Claire Cartwright (my supervisor, a registered clinical psychologist).

If there are any questions about this project, please feel free to contact:

Primary Researcher
Name: Christina Fa'alogo-Lilo,
Position: Clinical Psychology Doctoral student
Address: Psychology Department, University of Auckland.
                Private Bag 92019, Auckland
e-mail: ctup001@aucklanduni.ac.nz
Telephone: 027-32311575

Supervisor
Name: Dr Claire Cartwright
Address: Psychology Department, University of Auckland
                Private Bag 92019, Auckland
e-mail: c.cartwright@auckland.ac.nz
Telephone: 09 3737599 Ext 86269

Head of Psychology Department

Name: Associate-Professor Fred Seymour
Address: Psychology Department, University of Auckland
                  Private Bag 92019, Auckland
e-mail: f.seymour@auckland.ac.nz
Telephone: 09 3737599 Ext 88414

For any queries regarding ethical concerns you may contact:
The Chair,
The University of Auckland Human Participants Ethics Committee,
The University of Auckland, Office of the Vice Chancellor, Private Bag 92019,
Auckland 1142.
Telephone 09 373-7599 extn. 87830.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANT
ETHICS COMMITTEE ON 9.5.2007 for 3 years from 9.5.2007 to 9.5.2010. Reference
Number 2007/134.

Appendix 3

[Printed on University of Auckland Psychology department letterhead]

Participant Consent Form

Project Title: Mental Health Service providers' perceptions on an Outcome measure for Pacific Island clients

Researcher: Christina Fa'alogo-Lilo, Clinical Psychology Doctoral student, University of Auckland

Supervisors: Dr Claire Cartwright, Dr Ian Lambie

To: Mental health service providers working with Pacific Island consumers

I have read and I understand the Information for Participants sheet for volunteers taking part in this study designed to explore mental health service providers' perceptions on an outcome measure for Pacific Island clients.

I understand that my participation is voluntary and that I can withdraw from it at any time.

I understand that my interview will be audiotaped.

I understand that my interview may be transcribed by someone other than the investigators who has signed a confidentiality agreement.

I have had time to consider whether to take part and I know whom to contact if I have any questions about the study.

- I wish to receive a written summary of the results   YES/NO
- I wish to receive a copy of my audiotaped individual interview   YES/NO

If YES to one or both of the above, Address to be sent to: _____

_____

Contact phone number: _____

I _____ (name) hereby consent to take part in this study.

Signature of Participant: _____Date: _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE ON 21.9.2005 for 3 years from 21.9.2005 to 21.9.2008.
Reference Number 2005/104

Appendix 4

[Printed on University of Auckland Psychology department letterhead]

Participant Consent Form

This consent form will be held for a period of 6 years

Pacific people ' perspectives on having a problem that required some counselling or support.

Researcher: Christina Fa'alogo-Lilo

- o I have read and I understand the Information for Participants sheet for volunteers taking part in this study designed to explore Pacific people ' retrospective perspectives on having a problem that required some counselling or support.

- o I have had the opportunity to discuss this study with the researcher and I am satisfied with the answers I have been given.

- o I understand that taking part in this study is voluntary (my choice).

- o I understand that I can choose to withdraw from the study at any time. This includes the right to withdraw any information I have given up to two weeks after the conclusion of my interview without giving a reason.

- o I understand that my participation in this study is confidential and that no material that could identify me will be used in the final report.

- o I consent to my interview being audiotaped.

- o I understand that my interview may be transcribed by someone other than the researcher who has signed confidentiality agreement.

- o I have had time to consider whether to take part in this study. I know whom to contact if I have any questions or concerns about the study.

- o I wish to receive either a written or electronic summary of the results
        YES/NO

Postal/Email Address summary to be sent to if YES to the above:

_____
_____
_____

I agree to take part in this research.

    Signed: _____

    Name: _____
       (Please print clearly)

    Date: _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANT
ETHICS COMMITTEE ON 9.5.2007 for 3 years from 9.5.2007 to 9.5.2010. Reference
Number 2007/134.

Appendix 5

Semi-structured Interview Schedule for Service Providers

1(a) What does 'mental wellbeing' mean to you as a Pacific person?
  (b) What does 'mental un-wellness' mean to you as a Pacific person?

2. (a) What do you perceive are some of the barriers to Pacific clients accessing mental health services?

    (b) What do you perceive are some of the supports to Pacific clients accessing mental health services?

     © Once accessed, what do you perceive are some of the barriers to Pacific clients using mental health services?

    (d) Once accessed, what do you perceive are some of the supports that Pacific clients draw on, in using metal health services?

3. What have you found to be useful interventions or approaches in helping Pacific clients to recovery?

4. What do you think are successful outcomes for Pacific clients of mental health services?

5. What do you know about the use of mental health outcome measures for Pacific clients?

Prompt: e.g., general measure like the HoNOS etc., (including usefulness and effectiveness)

Prompt: Foundation work has already been carried out on a Pacific Mental Health Outcome Measure, based on the Fonofale model. Do you know much about it?

6. What do you think are the pros and cons of having a Pacific Island Outcomes measure?

7. What are some (other) ways to assess or measure positive change resulting from mental health service interventions?

Appendix 6

Semi-structured Interview Schedule for Service Users

Part One

To gain demographic information: Age, occupation, ethnicity, Country of birth (and if not New Zealand, the length of time participant has lived in New Zealand, diagnosis if relevant.

Part Two

A. What does being well mean for you? What was unwellness like for you?

B. Do you think you identity as a Pacific person was important to your problem of concern? If so, how?

C. Can you tell me about the type of service(s) you used?

Can you tell me what it was like going there?

What were the good things/things that helped?

Were there things that you did not like/that were not helpful?

What was your relationship with the counsellor/therapist/support people like?

What were some of the things that you did with them? That you liked, didn't like? What might have been different?

In your life in general, what were some of the supports that you found helpful in getting better? What were some things that were not so helpful?

D. When you got better, what was important? How did it feel different in your life form what you had been experiencing before? (How did you know in yourself that you were better?)

Appendix 7

[Printed on University of Auckland Psychology department letterhead]

Talofa Lava, Malo E Lelei, Kia Orana, Fakaalofa Lahi Atu, Ni Sa Bula, Taloha Ni.

Are you an adult person of Pacific descent who has received counselling or support from a mental health service in the past?

I am looking for participants to take part in a study exploring the experiences and perspectives of Pacific people who have experienced psychological distress in the past that required counselling or other forms of support from a mental health service. Participants would no longer be using a service and be able to talk about their experiences.

The aim of this research is to contribute to a better understanding of supports that may help Pacific People when facing such distress.

Participating will mean taking part in one interview of up to 90 minutes.

This study is being undertaken by Christina Fa'alogo-Lilo, a mature student of Samoan descent, as part of a Doctorate in Clinical Psychology.

If you are interested in participating, or would like more information, please contact:

Christina: on 027-3211575

or e-mail: ctup001@aucklanduni.ac.nz