

**An investigation of Pasefika access to the Child and Adolescent
Mental Health Service within Counties Manukau District Health
Board - the influence of health beliefs and attitudes.**

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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

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Abstract

Pasefika rates of access to Counties Manukau District Health Board's (CMDHB) Child and Adolescent Mental Health Services (CAMHS) have been below the 3% per annum expectation set by the Ministry of Health. In an effort to address this discrepancy CMDHB established a Pasefika specific CAMHS in 2008, Vaka Toa (VT). Since the establishment of VT our clinical experience is; self-referral by Pasefika is unusual, and often when introducing the service to referred Pasefika young people and their family the family will respond with "our [young person] is not mental". The questions raised from these experiences are; what are Pasefika beliefs and attitudes in relation to child and adolescent mental health and, how do these beliefs and attitudes influence decisions to access CAMHS. An understanding of these beliefs and attitudes will provide opportunities to apply Public Health activities of organised community effort aimed at the prevention of mental health issues and health promotion as interventions to increase Pasefika access to CAMHS in the CMDHB catchment. Descriptive statistics have been provided by CMDHB Research, Evaluation and Audit of Mental Health Services for Period 1, pre establishment of VT, (1/4/2005 to 31/3/2008) and Period 2, post establishment of VT, (1/4/2009 to 31/3/2012) to mark the context of this research. This piece of qualitative research's epistemological foundation is Qualitative Description (QD). QD is recognised as the methodology of choice when a straight description of phenomena is sought, in this instance Pasefika health beliefs and attitudes. Interviews were arranged with Pasefika naïve to mental health services (MHS) and past service users from Period 1 and Period 2. The behavioural model of health service use recognises that experience of a health service has an influence upon the service users' health beliefs and attitudes hence the decision to interview Pasefika naïve to MHS. Interviewing past service users from Period 1 and Period 2 provides the opportunity to learn how the provision of CAMHS via mainstream and Pasefika specific teams is experienced by the service users. Semi-structured interview schedules were developed, all interviews were digitally recorded, transcribed then analysed using the Thematic Analysis technique. A total of seven in depth interviews occurred with 3 adults and 1 adolescent naïve to MHS and 1 adult and 2 adolescents who were past CMDHB CAMHS service users. All interviewees were resident in the CMDHB catchment at the time of interview. Findings indicate that the Pasefika holistic health belief model that clinicians are introduced to as a basis for cultural competence is not readily recognised by Pasefika of the 1.5 and subsequent generations, the term mental health is synonymous with mental illness, and stigma remains a significant barrier to MHS access. In order to increase Pasefika awareness of child and adolescent mental health issues messages need to be in accessible language that describes behaviours and reflects parental concerns in conjunction with the promotion of CAMHS as an everyday aspect of overall health care similar to a GP.

Chapter 1: Introduction

1.1. Purpose and background to the thesis/research problem

This study seeks to shed light upon the nature of health beliefs that people of Pasefika ethnicity hold in relation to Child and Adolescent mental health. Prior to embarking on this journey, as documented in this study, I will introduce myself and how my interest in this area has been piqued.

I am a 52yo New Zealand born male of Samoan and New Zealand European ethnicity. Within my family of origin I am the oldest child of four, I have a younger sister then two younger brothers. My father is Samoan and I can trace my lineage back to the villages of Sale'a'aumua on Upolu and Safune on Savai'i. My mother is a third generation New Zealander from Timaru and her lineage is a mix of English, Welsh and Danish ancestry. Within the acculturation literature I would be classified as being of the 2.5 generation. The 2.5 generation refers to children born in the host country of a migrant parent and a native-born parent (Montazer & Wheaton, 2011).

My father arrived in New Zealand in the late 1950s; he was a hardworking man and was employed all my life. He worked at night and when I was an adolescent he became a business owner, running his business during the day and continuing to work at night. My mother returned to work as the care needs of her children allowed; she has financial nous and together my parents purchased several investment properties.

I believe my father considered that it was more important for his children to learn the New Zealand way of living. My father maintained his involvement with the Samoan community and responsibilities toward extended family members. Berry's (2005) model of acculturation strategies suggests that my father's personal acculturation strategy was one of integration; that is he engaged with New Zealand culture whilst at the same time maintaining connections and involvement with his Samoan culture. Looking back and applying Berry's model of acculturation it appears that my father's acculturation strategy for his children was that of assimilation; a process whereby my father allowed the dominant New Zealand culture to become absorbed by his children

supported by our negligible involvement in, and understanding of, things Samoan. My father's strategy for his children was congruent with the wider societal "imperative of assimilation" (Walker, 1990a, p.198) which was dominant at that time.

Therefore I am a product of my times. I have a poor understanding of things Samoan and a reasonable understanding of things Kiwi, English is my first and only language. I am married to a New Zealand European woman; we have 3 adult children and a grandchild. Six people and three generations live in the home we own, the average house occupancy for Pasefika families is six people in a 3 bedroom house (Schluter, Carter, & Kokaua, 2007).

My curiosity about how Pasefika think of child and adolescent mental health has prompted me to think about the beliefs and attitudes towards mental health that were evident when I was a child and adolescent.

Looking back I now realise that I was largely unaware of mental health issues; I am also unsure about my parents' awareness of and thoughts about these issues back then. The closest I came to learning about mental health issues was when I went and saw the film 'One flew over the cuckoo's nest'®. My view then was; mental health issues are extreme and occurred to others. Yet when I think about my adolescence I recollect that I was very unhappy and angry, I had begun to use alcohol and drugs and my academic functioning decreased markedly half way through my 6th form year. I completed the school year however did not achieve University Entrance which I was capable of doing given my very successful School Certificate Examination results and my 6th form results for the first half of that year. In essence I drifted out of school and into adulthood with no clear goals or purpose and my use of alcohol and drugs increased, becoming an integral part of my life for the next 16 years. I'm not sure how much my parents noticed a change in my adolescent mood or behaviour and if they did notice, how they made sense of it. I did not see a health professional for these issues and had I seen a health professional it would be difficult to predict how this may have influenced my future. Certainly as an adolescent I was likely to have met criteria for a mood disorder and a substance abuse disorder. Over the next 16 years I did not contribute much to society in terms of gainful employment and paying tax. It is

difficult to know if over those latter years I would have met criteria for a mood disorder; however my substance abuse continued and I would have met DSM-IV- TR (American Psychiatric Association, 2000) criteria for diagnoses of alcohol abuse disorder and a [name of substance] dependence disorder. Over this period, on one occasion, I approached a health service about my substance abuse and as the experience was unsatisfactory I did not enter into treatment. The law eventually intervened and I was coerced into entering an alcohol and other drug treatment facility which proved to be a turning point for me and my family.

I came to Tertiary education late in life, graduating with a Diploma in Social Work in 1996 after two years of full time study, I was 35 years old. My employment since then has been with District Health Boards (DHB) working within mainstream services. In 2008 I changed my role and employer to that of Social Worker within Counties Manukau DHB (CMDHB) mental health services, a mainstream service. After a year with CMDHB I was 'shoulder tapped' to move from the Service I was with to a Pasefika specific Child and Adolescent Mental Health Service (CAMHS), Vaka Toa (VT), that was being set up by CMDHB. I accepted the invitation and since working in VT I have become acutely aware of the challenges that Pasefika fanau experience. Some of these challenges include negotiating the cultural transition from their homeland to the New Zealand way of doing things (for new migrants) and, for 73% of Pasefika who live in the CMDHB catchment area, the on-going sequelae from occupying a low socioeconomic status and living in New Zealand Deprivation scale decile 9 and decile 10 areas (Wang & Jackson, 2008). Each generation struggles with this burden which is added to by the on-going process of acculturation and the impact this has upon fanau functioning.

As a mental health clinician, with an extensive Western education which informs my practice, I am a member of a team that has been assigned the task of 'helping' referred Pasefika young people and their fanau. Our team is developing a curiosity about our effectiveness because we have noticed that we have become busier seeing the Pasefika young people referred to us. What we think is happening is: the number of referrals has increased; the young people and their fanau are being retained in treatment longer; we are more responsive, that is time from receipt of referral to first

face-to-face contact is happening sooner. All these ‘improvements’ are as compared to the level of service delivery for Pasefika referrals prior to the establishment of a Pasefika specific team.

In spite of this perceived ‘improvement’ in service provision we have noticed two ‘anomalies’

- the number of self-referrals from Pasefika young people and/or their fanau does not appear to have increased,
- it is not unusual when we meet with the fanau of a referred young person and explain who we are, CAMHS, that the fanau respond with “our [young person] is not mental”.

It is these anomalies that has piqued my interest, what is it about the word ‘mental’ that triggers this response? What are the health beliefs that fanau have about their young person’s behaviour that precludes seeking support from a mental health service. After all I’m trained and employed to ‘help’.... These musings have led me to attempt to develop a greater understanding of the phenomena described above by embarking upon:

- An investigation of Pasefika access to the Child and Adolescent Mental Health Service within Counties Manukau District Health Board - the influence of health beliefs and attitudes.

1.2. Why Public Health?

The Ottawa Charter stipulates that the fundamental conditions and resources of; “peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity” need to be present in order for peoples’ health to improve (World Health Organization, 1986, para.4). Within New Zealand (NZ), public health is the activity of ensuring the conditions exist for people to be healthy. This is achieved through “organised community effort aimed at the prevention of disease and the promotion of health” (Public Health Association of New Zealand, 2010, “What’s Public Health about?”) to ensure that the fundamental conditions and resources exist and are available to all. The expected outcomes from this activity are; “raised health status

and quality of life, reduced health inequalities, increased safeguards for the health of the public, and reduced number of people with acute or chronic disease or disability” (Public Health Association of New Zealand, 2010, “What’s Public Health about?”). Therefore Public Health is a two pronged approach that focuses upon both disease prevention activities and health promotion activities.

The behavioural model of health service use contends that there are a number of factors that influence decisions to access health services (further discussion of this model occurs in Chapter 2 pp.9-11) including personal health beliefs (Andersen, 1995). This model of health service use also posits that one’s personal health beliefs comprising of values, attitudes, and knowledge of health services can act to impede or facilitate access to health services (Andersen, 1995); however these beliefs are not fixed and have a medium degree of mutability. This means that health beliefs and attitudes are amenable to change, either positively or negatively, through the provision of information, a health promotion activity, and from the experience of having engaged with a particular health service (Aday & Andersen, 1974).

As indicated earlier the CMDHB CAMHS Pasefika team, VT, have noticed; a lack of self-referral by Pasefika to the Service and, the response from referred families that their young person is not mental. This suggests that Pasefika beliefs, knowledge and understanding of mental health issues need to be better understood in order to:

- identify how to present the Service in a way that is acceptable to Pasefika
- develop appropriate health promotion strategies that will increase Pasefika knowledge and understanding of child and adolescent mental health issues.

1.3. Structure of thesis

This segment describes how this study unfolds. The introduction is followed by Chapter 2, the literature review. This review presents not only what the extant literature has to say about Pasefika health beliefs and attitudes, in general and in relation to mental health, it also describes the multivarious factors that interact; in relation to the formation of health beliefs and attitudes, and contribute to the mental

health status of Pasefika in CMDHB. These factors include acculturation, migration and generation. This chapter also includes a synopsis of the current mental health status of Pasefika children and adolescents within CMDHB. Chapter 3 describes the methodology, the philosophical basis for this qualitative study, and the method of data analysis. Included is a description of the criteria for participation, the process of recruitment, the ethical approval, and a proposal about how to judge the validity of the knowledge claims made. Chapter 4 presents the Data analysis which contains some statistical information to provide a 'context by the numbers' for this study and an analysis of the participant interviews. Chapter 5 is the discussion; a critical analysis of the findings from the Data analysis in relation to the information presented in the literature review. Included in this chapter are recommendations about how to address the barriers to service access and commentary about the limitations of this study.

Chapter 2: Literature Review

2.1. Introduction

The focus of this study is to investigate the influence of Pasefika health beliefs and attitudes upon access to the Child and Adolescent Mental Health Service within Counties Manukau District Health Board [CMDHB]; however it is important to acknowledge that the social context is the climate that surrounds peoples' health beliefs and attitudes. This chapter seeks to set the scene for this study by bringing to the fore several interrelated aspects that influence ethnic minorities' and migrants' access to the health system.

This chapter will: present an explanatory model of access to health services; describe the barriers to accessing health services; discuss how migration, acculturation and generation influence mental health and health beliefs; discuss the extant literature on Pasefika health beliefs and attitudes and identify any potential gaps in the literature; describe the current situation for Pasefika in New Zealand and for Pasefika living within the CMDHB catchment area.

2.2. Search Strategy

The search for literature related to this study was conducted from March to July 2012. The web-based search engines utilised for the literature review were Google and the AUT library SUMMON search bar, found on the AUT Library home page and also at the top of the AUT Library Search Results page.

This study is an investigation into the health beliefs and attitudes of Pasefika and how these influence access to mental health services. An initial literature search of the AUT library databases using the search terms; 'Pacific', 'health belief', 'mental health', 'New Zealand', produced one result that contained information about Samoan Traditional mental health beliefs. Therefore a Google search utilising the same terms was run and this produced literature that contained information describing Pacific health beliefs.

This literature included Governmental reports, DHB reports and information available on NGO web pages. The reference lists contained in this literature were also used to identify specific Pasefika ethno-cultural health belief information; searches using the specific titles were run.

As the initial AUT library search with the term 'Pacific' produced one useful result further searches did not use the term 'Pacific' due to the paucity of Pasefika specific results that were returned. With the identification of literature describing Pasefika health beliefs further searches were run to identify factors associated with access to mental health services. An initial search was run using the terms: 'access', 'mental health', 'children', and 'adolescents'. The review of these search results highlighted other concepts that come to bear upon decisions to access mental health services; 'acculturation', 'migration', 'generation', 'minority status', 'health literacy', and 'ethnic preference'. As the scope of the literature related to this study became evident four search strategies were developed with the following terms:

1. 'Acculturation' interchangeably – singly and in combination, with; 'migration', 'immigra/nt/tion', 'generation', 'mental health', 'child/ren', 'adolescen/t/ce', 'youth', 'ethnic minority'.

Articles were selected that described: the process of acculturation; the impact of migration upon the migrant and their family; the protective factors and the challenges associated with migration; what generation is and how this impacts upon migrants and their family functioning.

2. 'Barriers' interchangeably - singly and in combination, with: 'healthcare access', 'mental health', 'health', 'ethnic minority', 'child/ren', 'adolescen/t/ce', 'youth', 'help-seeking', 'utilisation/utilization'.

Articles were selected that were specific to children and adolescents, preferably they were systematic reviews, described the experiences of ethnic minorities, and also described the role health beliefs and attitudes played in relation to health service access.

3. 'Counsel/or/lor preference' interchangeably - singly and in combination, with: 'ethnic matching', 'ethnic minority', 'mental health'.

Articles were selected that provided a description of the effect of ethnic matching in relation to access to treatment – as a facilitator or barrier.

4. 'Health literacy' and 'problem recognition', this search developed from the literature on barriers to mental health service access which identified 'problem recognition' as an issue and 'health literacy' as a possible solution. Therefore two minor searches were run using the terms: 'health literacy' and 'migrants'; and, 'problem recognition' and 'mental health'. A few articles were selected that provided an overview of these factors in relation to access to mental health services.

These searches were repeated on Google to ascertain if there were any articles that were not available via the AUT library's search engine.

A review of the reference lists of the selected literature occurred. Cited articles were accessed by title and author when this information was required in order for the researcher to better understand the concepts being discussed and the relevance of these concepts to the present study.

2.3. Barriers to access to mental health services for migrant populations and their young people

The decision to migrate from one's home country can be triggered by a number of reasons, such as seeking asylum, seeking refuge or seeking better opportunities (Stevens & Vollebergh, 2008). With the increasing level of international migration that is occurring the attention of researchers and policy makers has been drawn to the impact of migration and subsequent resettlement upon the migrants' mental well-being and to the task of identifying and understanding potential barriers of access to mental health services (Harker, 2001; Khanlou, 2010; Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006).

In the 1960s, Andersen (1995) developed a model of access to health services that sought to causally order the factors that influence health service use. The initial model posited that 'predisposing characteristics' plus the presence of 'enabling resources' and 'need for health services' led to the use of health services (Aday & Andersen, 1974). The model in its current rendition has developed beyond the linear approach of the initial model by adopting a systemic approach that recognises the influence of the

health care system and external environment upon how people view their health and their ability to use health services. Their experience of using health services creates a feedback loop that influences their health-beliefs, health behaviour and subsequent health service utilisation (see Figure 1) (Andersen, 1995).

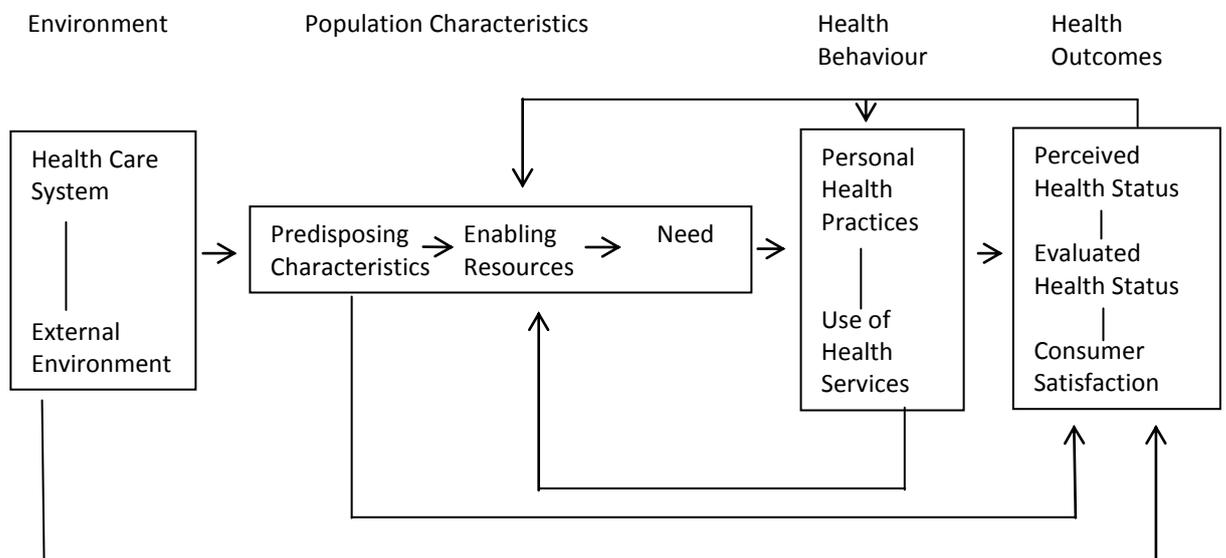


Figure 1: Behavioural model of health service use – Phase 4 (Andersen, 1995, p.8)

Although Phase 4 of the model has become more sophisticated and is cognisant of the range of internal and external influences and the recursive nature of these influences upon health service utilisation; at the core of the model are the three factors identified in the initial model ‘predisposing characteristics’, ‘enabling resources’, and ‘need’. ‘Predisposing characteristics’ describe the propensity of an individual to use health services and comprise personal properties that exist before the onset of health issues. These include age, sex, ethnicity, religion and health beliefs - attitudes and values concerning wellness and illness (Aday & Andersen, 1974). ‘Enabling resources’ refer to the resources a person has that will enable them to access health services, such as their income, and it also includes how the community a person lives in enables them to access health services, e.g. rural or urban, the location of health services and their proximity to home and work (Andersen, 1995). ‘Need’ refers to an individual’s perception of their health, informed by their health beliefs, with ill health indicating a pressing need; however, ‘need’ also incorporates evaluated need as assessed and recommended by health professionals (Aday & Andersen, 1974; Andersen, 1995).

Andersen (1995) contends that health beliefs have a medium degree of mutability, meaning that they can be altered and therefore effect health behaviour change. One way that health beliefs may be altered, as suggested in Andersen's (1995) model, is from the actual experience of accessing a health service

There are a range of health beliefs, defined as attitudes and values concerning wellness and illness (Aday & Andersen, 1974), which have been identified in the literature as acting as barriers to accessing health services. When thinking about health beliefs it needs to be acknowledged that culture, the learned beliefs, values, attitudes, social norms and behaviours shared by a group (Cauce et al., 2002; Jacobs & Giarelli, 2001), provides the context within which health beliefs form and are transmitted from generation to generation.

Health beliefs that can act as barriers to accessing health services include:

- illness perceptions, that is, how the problem is recognised, identified and defined, who recognises it as a problem, and how the problem is described and explained (Cauce et al., 2002; Copeland, 2005; Gulliver, Griffiths, & Christensen, 2010);
- a distrust of the health service provider in their understanding and explanation of the illness (Copeland, 2005), and negative perceptions about the characteristics of the health provider i.e. their race, credibility and their ability to maintain confidentiality (Gulliver et al., 2010; Scheppers et al., 2006);
- stigma and embarrassment about seeking help from a mental health service, which can be reinforced by the public's response to mental health issues as well as being self-induced and reinforced culturally through beliefs such as the notion that the use of external supports is a 'loss of face' (Cauce et al., 2002; Gulliver et al., 2010);
- cultural explanatory models that conceptualise problems as being caused by external forces which can be natural or supernatural, or the belief that health is holistic and includes the mind, body, spiritual and social dimensions which differ from the service providers explanatory models (Scheppers et al, 2010);
- cultural approaches to dealing with difficulties such as, being self-reliant, avoiding thinking about problems and, toughing it out (Cauce et al., 2002; Copeland, 2005).

Improving health literacy for migrants (Simich, 2010) and adolescents (Gulliver et al., 2010; Reavley & Jorm, 2011) is an intervention that is being employed to improve

problem recognition and reduce stigma in order to increase mental health service utilisation by these populations. Mental health literacy is defined as “knowledge and beliefs about mental disorders which aid in their recognition, management or prevention” (Jorm, 2000, as cited in Simich, 2010, p.19). The impetus to improve health literacy is based upon the awareness that the general public and young people have difficulty identifying mental health disorders and have incorrect beliefs about treatment, and these factors interfere with help-seeking behaviours and access to appropriate treatment whereas the recognition of a mental disorder is associated with access to treatment (Reavley & Jorm, 2011; Simich, 2010).

The issue of problem recognition and its action as a barrier to access has been identified as a factor among parents/care-givers of preschool children that negatively impacts upon mental health service utilisation (Pavuluri & Luk, 1998). Pavuluri and Luk (1998) posit that parents/care-givers beliefs that the problems will resolve by themselves, or that they should be able to handle them, underpin this issue. The education of parents about these disorders by mental health professionals who can recognise the problems in these children and uniformly describe them is suggested as a solution (Pavuluri & Luk, 1998).

2.4. Migration, Acculturation and Generation, facets of the context for Pasefika in New Zealand

2.4.1. Migration

Migration is recognised as a significant life event that impacts upon a person’s health behaviour and their health outcomes. This impact is due to the interaction of factors related to; the migrant’s culture and society of origin, the process of migration, and the culture of the society of settlement (Borrows, Williams, Schluter, Paterson, & Helu, 2011).

For Pasefika the main impetus for migration to New Zealand since the 1960s has been the population pressures in the Pacific nations and the desire to seek an improved standard of living and vocational opportunities (McPherson, 1981, as cited in Paterson,

Fairburn-Dunlop, Cowley-Malcolm, & Schluter, 2007; Statistics New Zealand [SNZ] & Ministry of Pacific Island Affairs [MPIA], 2010), they migrate with the hope of realising the dream of living in the land of milk and honey.

Internationally migrating peoples that move from countries of lower gross national product (GNP) to a host country that has a higher GNP have a greater likelihood of conflict between the private arena of family practices and the public arena of social and employment responsibilities (Montazer & Wheaton, 2011). This conflict can be a source of stress that negatively impacts upon the mental health and well-being of the individual and the family. Additionally, the greater the cultural distance (differences in language, values and beliefs) between the country of origin and the host country, the greater the risk to migrants of experiencing significant stress and mental health problems (Alati, Najman, Shuttlewood, Williams & Bor, 2003; Montazer & Wheaton, 2011). Furthermore, this migration pathway, from a poorer country to a wealthier country, tends to result in migrants living in the host country in the poorer areas of major cities and having to deal with poverty, underemployment and housing difficulties (Masaud, McNicholas, & Skokauskas, 2010; Scheppers et al, 2006; Stevens & Vollebergh, 2008).

2.4.2. *Acculturation*

With migration comes the process of acculturation. Acculturation is described as a bi-directional process in which cultural and psychological change occurs in response to prolonged contact with a different culture (Berry, 2005). This means that both the migrant culture and the host/dominant culture can experience adaptation to their norms, values, beliefs and, behaviour as a result of this prolonged contact, dependent upon the acculturation strategy that each party utilises. The impact of the acculturation process, which is influenced by the acculturation strategy that is adopted by the host country, upon the migrant has been termed acculturative stress. If there is a significant level of acculturative stress then the migrant can experience mental health problems (Berry, 1997, 2005).

Berry's (2005) acculturation model describes four acculturation strategies that the host country and the migrant can each use. However the acculturation strategies that the host country utilises can limit the type of acculturation strategy the migrant has access to. There are four acculturation strategies that a host country can adopt, as follows:

- multiculturalism, in which the host country signals to migrants that cultural maintenance is important in conjunction with the migrants involvement as an integral part of the wider society;
- melting-pot, which is the term that describes the acculturation strategy of assimilation – the host country signals the societal expectation that the migrant will shed their cultural identity and become absorbed into the host country's culture;
- segregation is the strategy whereby the host country endorses the migrant's maintenance of their cultural heritage but does not support their involvement and interaction in the wider society;
- exclusion is the strategy whereby the maintenance of cultural heritage is not endorsed nor is the migrant's involvement in the wider society, this is experienced by the migrant as enforced cultural loss and discrimination (Berry, 2005).

Therefore the acculturation strategies present in the host country determine the acculturation strategies available to the migrant.

The four acculturation strategies available to migrants are: integration, assimilation, separation and marginalization. Assimilation is the maintenance of cultural heritage and cultural integrity as well as participation as a valued member of the society. This strategy is optimally available within a host society that utilises the multiculturalism acculturation strategy. Assimilation is the acculturation strategy that a migrant may choose if he or she does not wish to maintain their cultural heritage but they do wish to participate fully in the host society's culture. This strategy can be chosen within a host society that utilises the multiculturalism strategy; however if the country has a melting-pot strategy then this strategy becomes imposed upon the migrant with the two remaining acculturation strategies as options. Separation is the acculturation strategy used when a migrant choses to hold on to his or her cultural heritage and does not seek involvement or interaction with the host country's society.

Marginalization is the acculturation strategy in use when a migrant has neither interest

in maintaining his or her cultural heritage nor any interest in involvement in the host country's society (Berry, 2005).

Acculturative stress results from intercultural contact and the migrant's recognition of cultural conflict that cannot be addressed by adjusting to, or assimilating to, the issues. Each acculturation strategy incurs acculturative stress. Typically: integration is the least stressful strategy, if the host society has a multicultural approach; marginalisation is the most stressful with separation and assimilation holding the middle ground with either being more or less stressful. The greater the level of acculturative stress the greater the impact upon the mental health of migrants (Berry, 2005).

Berry's (2005) concepts have developed from studying contemporary migration and the acculturation process; however the study of acculturation "grew out of concern for the effects of European domination of indigenous peoples" (p.700). Berry's typology is able to be applied retrospectively as acculturation occurs when two culturally different groups come into contact with ideas about what they intend to do; implementing colonial imperatives, achieving the goal of migration, or having ideas about what is being done to them during contact.

When considering NZ's history of race relations through the lens of Berry's (2005) typology of acculturation strategies, it would appear that at least three of these strategies have been utilised. After the signing of the Treaty of Waitangi and with a decline in the Maori population there was an expectation that Maori were going to die out. Berry's typology suggests that a strategy of exclusion was implemented and reinforced by legislation that; stopped Maori speaking their language, disenfranchised Maori from their productive lands and, forced Maori to live in more remote rural areas (Walker, 1990b). After the Second World War and to fill labour shortages, both Maori and Pakeha (Borrows et al., 2011) were encouraged to migrate, Maori from their rural home lands and Pakeha from their Island home lands, to the urban areas of NZ. At this time NZ society as the host society/culture utilised a melting-pot assimilation strategy supported structurally through policies such as 'pepper-potting' and institutions such as the education system (Walker, 1990a). Nowadays NZ society is recognised as utilising a strategy of multiculturalism (Sang & Ward, 2006, as cited in

Borrows et al., 2011), and is a society in which cultural diversity is celebrated and official policy acknowledges that cultural maintenance is vital to health outcomes (Borrows et al., 2011).

As migrants settle into and become established within the host society the cultural and psychological changes that occur from prolonged contact with a different culture continues in parallel with typical family developmental processes, births, deaths and marriages. Birth, or generation, is of particular interest when considered in relation to acculturation as it has been identified that as subsequent generations of migrant settlers lose their language and adopt the values and norms of the host country, there are poorer mental health outcomes for the children and young people of these generations (Alati et al, 2003; Harker, 2001).

2.4.3. *Generation*

Generation is a family developmental process that occurs in conjunction with the process of acculturation. Generation and acculturation are processes that continue over time, length of time in the country of settlement is recognised as having a negative influence on the mental health status of migrants (Alati et al., 2003; Montazer & Wheaton, 2011).

Generation is classified as:

- 1st generation refers to those born in the home country that have migrated and settled into a host country. Young children in this category are often referred to as the 1.5 generation, that is they have the cultural imprint of their homeland however are exposed to a greater level of cultural influences within the host country because of their involvement in the education system and greater level of exposure to a culturally diverse peer group.
- 2nd generation describes children born in the host country (also called native-born) of migrant parents,
- 3rd generation describes native-born children of native-born parents with immigrant grandparents (Harker, K. 2001).

- There is also a group known as the 2.5 generation which describes native-born children who have a migrant parent and a native-born parent of any ethnicity (Montazer & Wheaton, 2011).

Initially the literature on migration considered that the stress of migration resulted in migrants experiencing poorer mental health in part due to the process of adapting to a new society and culture as well as from the stress of living in poorer areas, experiencing difficulties with language, finding employment and housing and, disconnection from familial and community support networks (Alati et al., 2003; Stevens & Vollebergh, 2008; Rothe, Tzuang, & Pumariega, 2010). This view has modified with the recognition that those who migrate with the aim of improving their lifestyle have a mental health advantage over those in the host country who occupy a similar socio-economic-status.

This mental health advantage is known as the healthy migrant effect (Alati et al, 2003; Harker, 2001), the migrants' resiliency is conceptualised as deriving from their hope for a better future and the opportunity to achieve it. This resiliency acts to protect the migrant, and their family, from the difficulties associated with settlement in the host society. However migrants that do not achieve upward mobility and remain within the lower socio-economic-status segment of the population go on to experience poorer mental health (Driscoll, Russell, & Crockett, 2008; Harker, 2001; Khanlou, 2010) that is, their rates of mental health problems converge with those of the host country.

The convergence in rates of mental health disorder in migrants to match those of the host population is termed the transitional effect (Alati et al, 2003; Harker, 2001). The transitional effect has been observed to affect the 2nd generation onward and is considered to be a consequence of; the process of acculturation, and intergenerational conflict. The conflict between migrant parents and their children is a response to the children's adaptation of the cultural values of the homeland with the cultural values of the host country and a behavioural repertoire that does not fit with their parent's culture bound expectations. The children's cultural adaption is the result of how he or she negotiates the influences of the private world of family with the public world of

school and peers; their cultural values, attitudes and behaviours begin to mirror those of the host society (Harker, 2001; Montazer & Wheaton, 2011).

The protective factors that reduce the likelihood of 2nd and subsequent generation children developing mental health disorders include; parental supervision, low levels of parent-child conflict, church attendance and social/community support; however for 2nd and subsequent generations whose families do not experience upward mobility then the stress related to socio-economic deprivation undermines the parents ability to adequately provide an environment that supports their children's psychological well-being (Harker, 2001).

The areas of migration, acculturation and generation are relevant to understanding the context of Pasefika mental health outcomes and involvement in mental health services within NZ. Pasefika migration tends to be motivated by the desire to improve the family's situation, therefore 1st generation Pasefika migrants could be characterised as being protected with the mantle of the 'healthy migrant effect'. The combined factors of cultural-distance and migration from countries of lower GNP result in Pasefika migrants experiencing socio-economic hardship and acculturative stress. This stress is a risk factor for mental health problems for 1st generation migrants if upward mobility is not achieved and also for 2nd and subsequent generations.

Although Pasefika migrants to NZ arrive in a society that 'officially' embraces cultural diversity the migrant and their family experience the cultural and psychological changes that occur from contact with NZ culture. This adaptation of cultural norms, values, beliefs and behaviours is likely to be more evident in the 2nd and subsequent generations and will influence their health beliefs and attitudes.

As Pasefika families settle within NZ and grow we can assume that any healthy-migrant benefit erodes due to two factors, generation and length of time in NZ. The transitional effect suggests that the rate of Pasefika mental health disorder will converge with that of the mainstream population as subsequent generations move further from the cultural values of their migrant parents and closer to the cultural values, beliefs and attitudes of mainstream NZ. The convergence in the rate of Pasefika mental health disorder with that of the NZ population may be exacerbated by;

intergenerational conflict, socio-economic deprivation, poor housing and poor educational achievement. Lower socio-economic status is a recognised risk factor for the development of health disorders and mental health disorders in particular (Beiser, Hou, Hyman, & Tousignant, 2002; Collings & Ellis, 1997).

2.5. Pasefika Health Beliefs

The term Pasefika is an umbrella concept that embraces all peoples whose ancestry connects them to a Pacific ethnic group and culture and who self-identify as being a member of at least one Pacific ethnic group. This term is not meant to imply that those of Pasefika ethnicity comprise a homogenous group nor is it meant to imply that Pasefika health beliefs and attitudes are interchangeable across ethnic groups and cultures. Despite this caveat there is some similarity in health beliefs across the Pasefika ethnic groups, this similarity is in the notion that health is holistic and incorporates the spiritual which sits alongside the physical (Suaalii-Sauni et al., 2009).

Within New Zealand the recognition that culture plays an important role in well-being has allowed for indigenous models of health-beliefs to be articulated and introduced to mental health services. The intention of introducing Pasefika models to mental health service delivery has been to increase Pasefika access to mental health services at an earlier stage rather than coming to the attention of services when in crisis (Agnew et al., 2004; Bathgate & Pulotu-Endemann, 1997; Tamasese, Peteru, Waldegrave, & Bush. 2005).

Pasefika participants in Agnew and colleague's (2004) study identified eight models of mental health care that are being practiced in the New Zealand Pacific mental health sector. Of these eight models identified in the study three can be described as being Pasefika specific health-belief models which are metaphors that convey Pasefika understandings of how health and wellbeing are maintained. One model was a Pasefika health treatment model and is embedded with beliefs about the nature and treatment of health problems. The remaining model mentioned by participants in the Agnew and colleagues study was called the 'illness model', this was the term used to

describe mainstream mental health service approaches to the assessment and treatment of mental health issues. Pasefika experience this model as alienating and as a barrier to treatment as the ‘illness model’ gives primacy to the medical professions assessment, description of the problem and, treatment (Agnew et al., 2004).

Scheppers and colleagues (2006) identified that a difference in explanatory models of illness between the service provider and the service user acts as a barrier to service access. The term ‘mental health’ is acknowledged as marginalising non-Western health beliefs as the term is “not inclusive of a holistic approach, it is a reductionist palagi western paradigm in which mental health is seen as separate from anything else.” (Merry, Wouldes, Elder, Guy, Faleafa, & Cargo, 2008, p.97).

Table 1 provides a list of the models participants identified in Agnew and colleagues (2004) study.

Table 1: Pasefika Health-belief models.

<p>Fonofale model, recognised as epitomising the holistic notion of health and the most cited model by participants in Agnew et al.’s (2004) study.</p>	<p>Recognised as being a Samoan health-belief model (Kupa, 2009). This model points to the importance of focusing on the process of interventions and understanding of Pacific concepts such as the use of Pacific languages, spirituality, gender, responsibilities and intergenerational concepts (Agnew, et al., 2004).</p>
<p>Te Vaka model, participants in the Agnew et al. (2004) study did not offer any discussion upon how it differed from other Pasefika health-belief models.</p>	<p>A Tokelauan health-belief model more fully described as Te Vaka Atafaga (Kupa, 2009) and clearly demonstrates a holistic notion of health</p>
<p>Strands or Pandanus mat, a health-belief model based on the notion that the key strands of a person’s life need to be well thatched to withstand the test of time and different elements (Agnew et al., 2004).</p>	<p>Within Agnew et al.’s (2004) study this model was not attributed to any specific Pasefika ethno-cultural group and is therefore possibly considered to be a pan-Pacific model.</p>
<p>Traditional Healing treatment model (Agnew et al., 2004). A Pasefika approach to the treatment of health problems by specialised healers whose skill and knowledge have been handed down to them. The treatment is based in the spirituality of old, the cosmological beliefs of Pasefika ancestors.</p>	<p>The traditional Pacific approach to healing is to seek the input of traditional healers believed to have the spiritual powers necessary to restore spiritual, physical, mental and social balance (Suaalii-Sauni et al., 2009).</p>

<p>Kakala model, the development of which is attributed to Konai Helu-Thaman in 1999. The model appears to have been developed as a research methodology which describes the research process from data collection, to weaving the data to create the report then presenting the information back to the community¹.</p>	<p>A Tongan health-belief model acknowledged by both Agnew et al. (2004) and Suaalii-Sauni et al. (2009). This model points to the importance of focusing on the process of interventions and understanding of Pacific concepts such as the use of Pacific languages, spirituality, gender, responsibilities and intergenerational concepts (Agnew, et al., 2004).</p>
<p>Faafaletui model. Although this model was identified by participants in Agnew et al. (2004) study it is unclear how this model metaphorically represents Pasefika health-beliefs. Agnew et al. (2004) acknowledged that further work needed to occur to ascertain its meaning and application as a mental health service delivery model.</p>	<p>Recognised as being a Samoan model (Agnew et al., 2004) however it appears to have been initially presented as a “culturally appropriate research method to investigate Samoan perspectives on mental health issues.” (Tamasese et al., 2005). This model points to the importance of focusing on the process of interventions and understanding of Pacific concepts such as the use of Pacific languages, spirituality, gender, responsibilities and intergenerational concepts (Agnew, et al., 2004).</p>
<p>Cook Islands Tivaevae model, the development of which is attributed to Teremoana MaUa-Hodges in 2000². It appears that this model may also have been initially developed as a research methodology as referenced by Koloto and Sharma (nd)³.</p>	<p>A Cook Island health belief model acknowledged by both Agnew t al. (2004) and Suaalii-Sauni et al. (2009). This model points to the importance of focusing on the process of interventions and understanding of Pacific concepts such as the use of Pacific languages, spirituality, gender, responsibilities and intergenerational concepts (Agnew, et al., 2004).</p>

In my attempt to understand how these Pasefika health-belief models conceptualise health and well-being what I have discovered is the dearth of literature about the models and, the difficulty accessing the source information that fully explains how each of these models describe health and well-being.

When looking into the literature that describes Pasefika mental health beliefs what becomes apparent is the lack of information from all the Pasefika populations although

¹ http://www.arphs.govt.nz/Portals/0/Health%20Information/Pacific%20Health/Chapter_Four.pdf

² MaUa-Hodges, Teremoana (2000) *Ako Pai Ki Aitutaki: Transporting or Weaving Cultures: Research Report of Field Experiences to the Cook Islands*, Wellington College of Education, Wellington.

³ Koloto, 'A., Sharma, S. (nd). *The needs of Pacific women when they are victims of family violence*. Retrieved from <http://www.google.co.nz/webhp?hl=en#hl=en&sclient=psy-ab&q=www.msd.govt.nz%2Fdocuments%2Fabout-msd...%2F26-pages84-96.doc&fp=75678be52d69e8d5>

Samoan views are the most common and most often cited (Bathgate & Pulotu-Endemann, 1997). Despite the paucity of ethno-specific information related to health-beliefs, the holistic concept of well-being: the maintenance of equilibrium between mind, body, spirituality, family, and the environment; is deemed to be shared by Pasefika along with similar views about the development of mental illness.

Traditional Pasefika beliefs about the development of mental illnesses, expressed as disturbed behaviour, attribute the behaviour to possession by an ancestral spiritual force in response to either the individual or the individual's family having offended the spirits by breaching a sacred custom or a tapu (Bathgate & Pulotu-Endemann, 1997). Traditional Tongan beliefs appear to be similar and also explain the cause of mental illness as the result of a breach of tapu (Foliaki, 1999). Also important to both Samoan (Tamasese et al., 2005) and Tongan (Foliaki, 1999) causal understandings of disturbed behaviour is; the sacred nature of relationships and, the ability to meet one's social obligations and responsibilities. Therefore; the inability to meet one's social obligations, the breach of a sacred or forbidden relationship, spiritual possession, breaking a tapu, are both Samoan and Tongan traditional explanations for disturbed behaviour and mental illness.

Although the literature about the cause of mental illness is scarce for other Pasefika ethnic groups what is documented indicates that similar beliefs are held by Tokelauans, Niueans and Cook Island Maori. Kupa (2009) documents that "kaiga – families and traditional sacred relationships between members" (p.158), is a key aspect of the Tokelauan definition of health and, a traditional Tokelauan belief about the cause of mental illness is possession by evil spirits. Bathgate and Pulotu-Endemann (1997) note that within the Cook Islands some mental illness is considered to be a spiritual sickness due to the breakdown of social relations and, within Niue upsetting spiritual forces is believed to cause mental illness.

The similarity in causal explanations for disturbed behaviour may suggest there is a 'pan-Pacific' understanding of mental illness however each ethno-cultural group will have their own culture specific: breaches of custom and tapu as causes of disturbed

behaviour; descriptions and meanings of disturbed behaviours; interventions to address the disturbed behaviour (Bathgate & Pulotu-Endemann, 1997).

These traditional understandings of the cause of mental illness described above are more likely to be endorsed by first generation Pasefika migrants as compared to New Zealand born Pasefika (Bathgate & Pulotu-Endemann, 1997; Foliaki, 1999; Tamasese et al., 2005).

The stigma that is associated with mental illness is identified as a significant issue for Pasefika. Ramage and colleagues (2005) report that stigma acts as a significant barrier to Pasefika access to CAMH Services however generationally there may be different understandings of the nature of the stigma. First generation Pasefika parents and young people may consider that involvement with a Mental Health service is shameful as their understanding of the behavioural disturbance is based upon traditional explanations (Ramage et al., 2005) whereas second generation Pasefika young people may be concerned about ostracism not only from their ethnic community but also their peer group (Agnew et al., 2004) as a result of their contact with a Mental Health service.

Another belief that may act as a barrier to accessing mental health services is concern about the characteristics of the provider (Gulliver et al., 2010; Scheppers, et al., 2006). This refers to perceptions Pasefika may have about the mental health service provider. The NZ mainstream MHS approach is often viewed as separating the Pasefika person into parts and treating the physical aspect and this is at odds with the Pasefika belief of a holistic approach to assessment and intervention (Tamasese et al., 2005). To address the influence of negative beliefs about the service provider upon access to MH Services by indigenous populations the importance of providing culturally responsive services has been acknowledged (Mental Health Commission [MHC], 2012a). Therefore in areas where there is a large Pasefika population the 'Pacific for Pacific by Pacific' model of service delivery (Agnew et al., 2004; MHC, 2012b) is championed as the appropriate response. International literature documents that minority populations prefer service providers of the same ethnicity; this supports retention in treatment and positive treatment outcomes (Abreu & Gabarain, 2000; Duncan &

Johnson, 2007; Farsimadan, Draghi-Lorenz, & Ellis, 2007; Jerrell, 1998; Ziguras, Klimidis, Lewis, & Stuart, 2003).

Language is another factor that may influence how Pasefika perceive and understand mental health services. It is recognised that languages of migrant populations may not have specific terms for mental illness or it may be taboo to speak about mental illness because of the associated stigma (Simich, 2010).

The Pasefika languages do not appear to have words that translate easily into the term 'mental illness' possibly because Pasefika notions of holistic health do not separate out the 'mental health' aspect of the person (Bathgate & Pulotu-Endemann, 1997; Ministry of Health [MoH], 2008). Without this specificity of language the Pasefika words that are available may prove to be difficult to accept by a Pasefika person attending a mental health service due to the imprecise meanings being conveyed. Examples of this include: the Cook Island Maori word *neneva* which can mean 'intellectual disability' or 'illness in the head'; within the Tongan language *fakasesele* can translate as 'stupid, retard, crazy' (Crawley et al., 1995, as cited in Bathgate & Pulotu-Endemann, 1997). Within the Samoan language there are specific terms related to illnesses attributed to spiritual possession or being cursed which are explanations for a person's disturbed behaviour however they do not convey Western Psychiatric understandings of mental illness (Bathgate & Pulotu-Endemann, 1997). Another aspect related to language is how the Palagi term 'mental health' is understood. Crawley et al. (1995, as cited in Bathgate & Pulotu-Endemann, 1997) when seeking a Samoan understanding of the term 'mental health' received the following response; a third of the participants offered a phrase that translated as 'calmness of the mind' and another third offered a term that translated as spiritual illness or possession by spirits. This second response suggests that for a reasonable proportion of the Pasefika community the term mental health is synonymous with mental illness.

The behaviours that can manifest as a consequence of spiritual possession or, the breach of sacred relationships or *tapu* or, failing to meet one's familial and societal roles and obligations, can include: impulsiveness; foul language; bad-tempered; behaving out of character; hallucinations; 'emotional sickness'; being aimless, despairing and without purpose; isolating oneself; not talking; becoming unkempt;

violent, murderous or suicidal (Bathgate & Pulotu-Endemann, 1997). The display of these behaviours by a family member are likely to be a cause of serious concern for any family irrespective of their ethno-cultural background, the behaviours can also be present when a person is experiencing an episode of mental illness. The behaviours described above suggest that spiritually based illnesses, or what could also be described as mental illnesses, from a traditional perspective are serious disorders. This notion of severity seems to extend to Pasefika views about child and adolescent mental illness also. Participants in the Tamasese and colleagues (2005) study commented about the benefits of hospitalisation for their child who has a mental illness and others commented that hospital is the appropriate place to treat some illnesses, hospital was viewed as a strength of mental health services. Within Whirinaki CAMHS hospitalisation is an intervention that is used when there are serious concerns about a person's mental state and safety.

The information presented in this section illustrates that the traditional Pasefika understanding of well-being is holistic and traditional explanations of behavioural disturbances include spiritual possession and relational breaches as causes. The descriptions of the behavioural disturbances indicate that these afflictions are serious and a traditional treatment approach requires a person with the appropriate spiritual knowledge and skill to restore the spiritual, physical, mental and social balance of the affected person. A Western medical approach is likely to treat these behaviours as symptoms of a mental disorder, if a physiological explanation could not be identified. In either treatment approach stigma will be a factor, stigma associated with the family having offended the spiritual realm or from having a family member with a mental disorder.

There appear to be some significant gaps in the literature related to Pasefika health beliefs. One gap is in regard to the health beliefs of second and subsequent generation Pasefika in relation to well-being, mental health and mental illness. Another gap is in terms of Pasefika health beliefs and attitudes in relation to child and adolescent mental health. There is a traditional explanation for behavioural disturbances in Samoan children, fear of Moso - God of the land below, which can cause behavioural disturbances for a period of time; however the children then return

to their normal state (Bathgate & Pulotu-Endemann, 1997). Again this is a Samoan belief and the beliefs from other Pasefika cultures are not readily available. Masoe and Bush's (2009) paper on Samoan infant mental health appears to bring together Western attachment literature with Samoan relational and spiritual understandings of child development as a starting point to inform culturally appropriate infant mental health interventions with Samoan families.

Apart from these writings there does not appear to be a lot written about Pasefika explanations for behavioural disturbances in children and adolescents except by inference to the overarching concept of holistic beliefs that ascribes Pasefika well-being to the maintenance of equilibrium between; mind, body, spirituality, family and the environment. Therefore the question remains, what are Pasefika beliefs and attitudes in relation to child and adolescent mental health?

2.6. The current situation for Pasefika nationally and within Counties Manukau District Health Board's catchment area

The NZ Government is aware that Pasefika carry a greater burden of mental disorder as compared to other ethnic groups within the population, apart from Maori, and have directed that the provision of mental health services aims to address this burden (MHC, 2012a; MoH, 2008). Pasefika are also over represented with regard to socio-economic deprivation as compared to the general population (MoH, 2005).

At a population level, nationally Pasefika number 266,000 or 6.9% of the total NZ population and are the second fastest growing ethnic group in New Zealand (SNZ & MPIA, 2010). Within the Pasefika population children, 0-14 years, make up 38% and youth, 15 – 24 years, make up 18% of the total population (MPIA, n.d.). Pasefika are a youthful population with a median age of 21 years and 56% of the population is under 25 years, 60% of the population is NZ born and 36% identify with more than one ethnic group (MPIA, n.d.).

In terms of the mental health burden that Pasefika carry, Pasefika have lifetime prevalence rates of 46.5% for any mental disorder compared to 39.5% for the NZ population and 12 month prevalence rates of 25% as compared to 20.7% for the NZ population (MoH, 2008). Within the Pasefika population there are different rates of mental disorder for each Pasefika ethnic group and this information is available in the MoH publications *Te Rau Hinengaro* and *Pacific Peoples and Mental Health*. For this study it is useful to report on; the mental health burden of young Pasefika, rates of access to mental health services by Pasefika, the relationship of migration and mental health burden:

- younger Pasefika are more likely than older Pasefika to experience a serious mental disorder
- 25% of Pasefika with a mental disorder received treatment from mental health services as compared to 58% of all people with a serious disorder. When adjustment for demographics, age, sex, education and income, was made there was minimal change in these figures suggesting that some variable other than demographics is inhibiting Pasefika access to mental health services
- NZ-born Pasefika have a 12 month prevalence rate of 31.9% for any mental disorder as compared to 15.9% for Pasefika who were 18 years and older at time of migration
- Pasefika who were 12-17 years at time of migration have a 20.7% 12 month prevalence rate and those under 12 years at time of migration have a 32.1% prevalence rate
- 13.3% of NZ-born Pasefika visited a mental health service; 1.6% are under 12 years; 10.8% are 12 to 17 years and 3.6% are 18 years and over. Overall in 2003 2.9% of Pasefika under the age of 20 accessed a mental health service (MoH, 2008).

This information indicates that the process of acculturation will be having a significant impact upon the Pasefika community given that 60% of the population are NZ born and therefore are of the 2nd and subsequent generations. It is difficult to know how the acculturation process has influenced NZ born Pasefika views on mental health or their involvement with traditional health beliefs, values and practices. There also appears to be a healthy migrant effect which is protective for those that migrate at 18 years or older however this effect does not appear to hold for those that migrate as;

adolescents, children, or are NZ born. This suggests that there is a significant number of migrant and NZ born Pasefika children and adolescents that are at risk of developing a mental health disorder. As younger Pasefika are at risk of experiencing a serious mental disorder, this in combination with the low rates of overall service access (2.9% for those under 20 years) indicates that there is a high level of unmet need; demographic variables do not appear to account for these low levels of access to mental health services.

Counties Manukau District Health Board [CMDHB] have an expressed commitment to address the mental health burden of Pasefika living within the CMDHB catchment (Counties Manukau District Health Board, 2008), this is in line with the Government's directive (MoH, 2012a).

The CMDHB catchment area covers nearly 3000 square kilometres and comprises the territorial authorities of Franklin District, Manukau District and Papakura District. CMDHB has the fastest growing general population and the largest Pasefika population of any DHB nationally. Within the CMDHB catchment there is an estimated 98,000 Pasefika who make up 21% of the CMDHB population and 37% of all NZ's Pasefika population (Wang & Jackson, 2008). The age distribution for Pasefika within CMDHB is similar to that for New Zealand, Pasefika are a youthful population with an estimated 33,400 children under 15 years living in the catchment area which can also be expressed as 2 out of 5 Pasefika children in NZ live in CMDHB (Wang & Jackson, 2008).

Within the CMDHB catchment area 73% of Pasefika live in NZ Deprivation Index 2006 [NZDep06] decile 9 and 10 areas. The NZDep06 rates decile 10 as the most deprived and decile 1 as the least deprived (Wang & Jackson, 2008). Deprivation is determined by the following variables: being in receipt of a benefit; income below a certain threshold; home ownership; living in a single parent household; unemployment; education level; house size; access to a telephone; access to a car. The areas within CMDHB that have the highest NZDep06 deprivation scores are Otara, Mangere, Manurewa and Papatoetoe. Areas of high Pasefika populations are Mangere (35%), Otara (24%), and Manurewa (17%) (Wang & Jackson, 2008) and as Pasefika are a youthful population a significant number of Pasefika children and adolescents will also

be living in these areas of highest socio-economic deprivation. Socio-economic deprivation is a recognised risk factor for the development of mental health disorders (Beiser et al., 2002; Collings & Ellis, 1997).

The national information about prevalence rates for mental illness within the Pasefika population indicate that within CMDHB there is likely to be a significant percentage of those under 20 years who will experience a mental health disorder possibly as a result of acculturation and its impact upon the family combined with the impact of socio-economic deprivation. The national findings indicate that this young Pasefika population are less likely to present to mental health services as compared with the general population, and socio-economic deprivation does not appear to explain this low level of access. This suggests that there is likely to be a high level of unmet mental health need within the CMDHB Pasefika community. The question remains with regard to, what is it that acts as a barrier to Pasefika access of mental health services?

2.7. Conclusion

Pasefika as migrants and as acculturating individuals face increased risk of mental health problems. The impact of acculturation is possibly mitigated by NZ's multicultural acculturation strategy which supports the migrants' integration upon settlement; however the migrant still has to manage the day to day realities of living in a new country with a different culture.

Pasefika migrate from nations that have lower GNPs and a significant cultural distance between the home society and NZ. As migrants from countries of lower GNP, upon arrival in NZ Pasefika tend to obtain housing in areas of high social deprivation and struggle with underemployment, adapting to a new culture and negotiating how private family practices fit with social and employment responsibilities. The healthy migrant effect posits that the hope of a better life and the opportunity to achieve it enables the migrant to better tolerate the stresses associated with resettlement and acculturation; however the fact that 73% of Pasefika within the CMDHB catchment live in NZDep06 decile 9 and 10 areas suggests that a significant number of Pasefika families are not achieving the dream associated with living in the land of milk and

honey. This socio-economic stress in conjunction with the 'transitional effect' may account for the prevalence of mental health problems in NZ born Pasefika who are recognised as having higher rates of mental health disorder.

Pasefika health beliefs appear to attach stigma to behavioural disturbances due to traditional understandings of how the disturbance has been caused – spiritual possession which suggests a person/family have behaved in an 'offensive' manner; or, because the person has a mental illness which also carries a stigma. The impact of stigma may be to delay help-seeking which could contribute to the acknowledged late presentation of Pasefika to services. Late presentation could be exacerbated by other factors such as; language, how a problem is described and, perceptions about the health service provider and their approach to assessment and treatment.

Despite the official stance that cultural maintenance is important to maintaining positive health outcomes Pasefika children and adolescents and NZ born Pasefika children and adolescents are the group that appears to be most vulnerable to mental health problems possibly due to the interaction of; socio-economic deprivation, intra-familial conflict, and negotiating the influences of traditional cultural 'practices' and NZ cultural 'practices'.

Given the identified stressors that the Pasefika community in CMDHB are experiencing and the risk factors for the development of a mental health problem for Pasefika children and adolescents it is clear that they, or their families are not accessing services, there is a high level of unmet need. What remains unclear is the specific factors that contribute to these low access rates. This study seeks to investigate the influence of Pasefika health beliefs and attitudes in relation to child and adolescent mental health.

Chapter 3: Research Design

3.1. Introduction

This chapter will detail the research and subsequent data analysis process. The research methodology and its epistemological foundation will be described, the research method which includes criteria for participation and the data collection will be outlined, the researcher's position in the study will be discussed and the method of data analysis will be presented. A discussion proposing how rigour is established for this study is also included. Although this study is primarily a qualitative research project some descriptive statistics will be provided in the following data analysis chapter as a means of providing context to the study.

3.2. Methodology

This study: An investigation of Pasefika access to the Child and Adolescent Mental Health Service (CAMHS) within Counties Manukau District Health Board (CMDHB) - the influence of health beliefs and attitudes, aims to identify these health beliefs and attitudes by interviewing Pasefika and hearing their description of reality.

Qualitative research methodologies are utilised in studies founded on the intention to understand the meaning people attribute to their experience with the aim of generating knowledge that conceptualises how these meanings shape a person's attitudes and social reality (Hesse-Biber & Leavy, 2011).

The epistemological and philosophical basis of a research paradigm is important to understand because this is what shapes the research process, how the research question is framed, how the data is collected and, how it is analysed; the selection of a particular methodology occurs because the paradigm that it rests on is recognised for "its ability to solve a particular problem, or address a particular question" (Kuhn, 1970, as cited in Grant & Giddings, 2002, p.12).

As my intention is to understand Pasefika health beliefs and attitudes in relation to CAMHS I have decided to use Qualitative Description (QD), as described by Sandelowski (2000; 2010) and others (Neergaard, Olesen, Andersen, & Sondergaard,

2009; Sullivan-Bolyai, Bova, & Harper, 2005). QD is recognised as the methodology of choice when a straight description of phenomena is sought (Neergard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005) and it appears to have a good fit with the research question that is being asked. The interview schedules that have been developed (refer to Appendices H to K) are intended to elicit from the participants their beliefs and attitudes, their knowledge and their reality.

QD takes a pragmatic and naturalistic approach to inquiry into people's perceptions and experiences (Sandelowski, 2000; Sullivan-Bolyai et al., 2005). Both pragmatism and naturalism are philosophical approaches to understanding the world. Naturalism contends that nature is observable, knowable, patterned and predictable; nature is reality ("Naturalism", n.d.). Although Sandelowski's (2000) initial use of the term naturalistic implies studying something in its natural state as much as is practicable when conducting qualitative research interviews, she also acknowledged that QD is theoretically founded upon naturalism (Sandelowski, 2010).

Pragmatism contends that "language and knowledge do not copy reality but are means of coping with a changing world" (Kvale & Brinkman, 2009a, p.51) therefore knowledge does not mirror nature but develops from conversation and action, knowledge is the ability to perform effective actions that transform; good research is determined by the use-value of the knowledge that it produces (Kvale & Brinkman, 2009a).

The philosophical underpinnings of QD, naturalism and pragmatism, situate this research methodology within what is known as the postpositivist epistemology. Postpositivism is an extension of the positivist epistemology which contends that the cause of an effect can be determined and actions have predictable outcomes (Giddings & Grant, 2006; Ryan, 2006). Therefore "knowledge is to be discovered so people can explain, predict or control events" (Grant & Giddings, 2002, p.14). Postpositivism eschews a linear cause and effect explanation for an outcome and recognises that an outcome occurs in response to the interaction of a complex array of causal factors. Postpositivism maintains the assumption that outcomes can be predicted, and controlled, once the factors have been discovered and the pattern of interaction is understood (Grant & Giddings, 2002; Ryan, 2006).

The QD data collection process seeks a rich straight description of the phenomena from the participants; the analysis of this data assumes that the participants' descriptive information is more or less an accurate reflection of reality. These descriptions contain documentary excerpts of beliefs and behaviours that convey what is 'really' going on (Sandelowski, 2010). In this sense QD remains close to the data due to its low inference level of interpretation which is in contrast to other qualitative research methodologies that, for example, seek to develop theory from the data or seek an interpretative meaning of an experience (Neergaard et al., 2009).

Data analysis will be discussed more fully in a later section within this chapter however it is germane to comment at this stage that although content analysis is reportedly the analysis strategy of choice when using QD (Neergaard et al., 2009, Sandelowski, 2000; Sullivan-Bolyai et al., 2005) thematic analysis is also acknowledged as an analysis technique typically used in QD studies (Sandelowski, 2010). The data analysis technique that is employed in this study is Thematic Analysis (TA) as described by Braun and Clarke (2006).

3.3. Researcher positionality and background

Positionality refers to the researcher's position in relation to; the research topic, the process of the research, the literature, and the participants (Laing, 1996). Giving consideration to one's positionality requires an examination and understanding of one's own characteristics; sex, sexual orientation, education, socio-economic status, ethnicity, attitudes and biases, and the influence they have upon the research process when researching within one's culture or across cultures (Merriam et al., 2001). This examination of one's positionality is also deemed to be an aspect that demonstrates methodological rigour (Ritchie, Zwi, Blignault, Bunde-Birouste, & Silove, 2009).

Initially the researcher's position was defined as that of insider or outsider. These terms described:

- insider; a researcher seeking an experiential understanding of the phenomena being studied (Louis & Bartunek, 1992) or, someone who is part of, that is indigenous, native, inside, the social group being studied (Moore, 2012)
- outsider; the detached observer, an onlooker gathering factual data (Louis & Bartunek, 1992) or, a non-member of the social group being studied and just beginning to relate to the phenomenon being studied (Moore, 2012; Ritchie et al., 2009).

As the discussion to understand and define positionality has progressed it is now recognised that the characteristics of the researcher in combination with the characteristics of the researched mean that positionality is accepted as a continuum. That is, the researcher can occupy both insider and outsider positions in relation to the community of participants being researched due to the social and cultural variance that exists within communities (Merriam et al., 2001; Ritchie, et al., 2009). This notion of an insider/outsider continuum is exemplified by a proposed typology of positionality

- indigenous-insider is a researcher who embraces the cultural values, beliefs and behaviours of his or her indigenous community and can speak with authority about it,
- indigenous-outsider is a researcher who has experienced cultural assimilation to another culture but remains connected with his or her indigenous culture
- external-insider is a researcher who has minimal experience of his or her indigenous culture and is imbued with the values of another culture but is viewed as an 'adopted insider'
- external-outsider is a researcher who has been socialised outside of the community he or she is researching (Banks, 1998, as cited in Merriam et al., 2001).

The current thinking in relation to positionality, as indicated by the typology above, takes cognisance of the researcher's socio-cultural connection to the community being researched. Another perspective proposes that insider and outsider can be defined as the researcher's physical and psychological distance from the research setting (Louis & Bartunek, 1992; Moore, 2012; Ritchie et al., 2009). Therefore outsider refers to a researcher who is detached from the setting of the research and interested in uncovering knowledge that can be generalised and, insider refers to a researcher who

is within the research setting and is interested in a particular situation and developing knowledge which is of practical use (Louis & Bartunek, 1992).

Based upon the understandings of insider/outsider described above, what is my position in terms of this study?

As presented in the introduction to this study, I am a 52 year old Samoan/NZE male born in Wellington, of the 2.5 generation and imbued with 'Kiwi' cultural values. English is my first and only language. I come from a 'working class' background where my parents worked hard and achieved upward mobility and could be described as 'middle-class'. Socio-economically I would now be a member of the 'middle-class', we are home owners, I have a tertiary education, am employed and our household income is above the NZ average income. I am married to a NZE woman whose parents are 'working-class', however they also achieved upward mobility; we have three adult children, a NZ-born Pasefika step-grandchild and a biological grandchild. My daughter married a man of Pasefika parentage who, although born in NZ, spent his early years, up until Intermediate school age, moving between NZ and the Pasefika nation his family are from. My daughter's family live with us. I am a Registered Social Worker working within the CMDHB CAMHS Pasefika specific Team, VT, however I am not resident within the CMDHB catchment. I have lived on the fringes of society and associated with sub-cultural groups as an adolescent and young adult. My history and experiences inform my values, attitudes and biases and who I am today.

When considering my positionality using Bank's (1998, as cited in Merriam et al., 2001) typology my movement along the insider/outsider continuum and the heterogeneity of the Pasefika community becomes apparent. When interviewing

- Island-born Pasefika and NZ-born Pasefika adults whose parents are both Island-born migrants I 'feel' as if I am the external-insider.
- NZ-born Pasefika adolescents, the 2.5 and 3 generation, I probably could be positioned as the external-outsider, although we share some characteristics our experiences are separated by a generation, I am the same age or older than these young people's parents.

The characteristics of the Pasefika community: Island-born, NZ-born, generation, level of acculturation, socio-economic status, education, sexual orientation, sex, social and

familial role, are varied across individuals; therefore we may share some characteristics but there will also be significant differences, my position in relation to each participant will differ. Based upon earlier definitions of positionality am I the 'outsider', the onlooker, seeking the 'facts' of the situation and benignly tolerated by the participants? Or, from the perspective of physical and psychological distance; am I the 'insider', within the research setting and interested in developing knowledge that has use-value.

In essence, the concept of positionality requires the researcher to take responsibility for the 'self' - one's attitudes, biases, and experiences, as an instrument; in the interview interaction, in the collection of data, in the interpretation of data, and then reflexively consider how the 'self' influences the research process. This reflexive rigour is integral to well-conducted research (Ritchie et al., 2009).

What position do I occupy in relation to the methodology of this study? As a mental health clinician my therapeutic orientation aligns with systems theory and post-modernism; there is a circular causality to social phenomena and reality is socially constructed through language and meaning making, therefore there are multiple ways to understand social phenomena. This suggests that a post-positivist research paradigm may not sit comfortably with such a therapeutic orientation. As the intention of my study is to find out what people know, what their reality is, as opposed to discovering the power imbalances inherent in the participants' discourse and how the discourse is socially influenced; then QD fits the purpose of this study - a straight description of the phenomena being studied.

3.4. Field study – including selection of participants and data collection

Participants for this study have been recruited from the Pasefika population resident in the CMDHB catchment, which includes the territorial authorities of Franklin District, Manukau District and Papakura District covering an area of slightly less than 3000 square kilometres.

The selection of participants for this study occurred as approved by Auckland University of Technology Ethics Committee (AUTEK), see Appendix A and CMDHB Research Committee, see Appendix B.

In brief, the following research criteria was approved:

- participants self-identified as being of Pasefika ethnicity and were 16 years or older at the time of the interview.
- participants had to have reasonable English language skills. The Principal researcher does not have Pasefika language ability and the cost of an interpreter for the interviews and the subsequent transcription was prohibitive – this is an acknowledged limitation of this study
- participants were drawn from 2 groups
 1. Pasefika adults and adolescents who have not been involved with Mental Health Services (MHS) nor any of their close family members. Purposive sampling was used to identify these interviewees. Purposive sampling ensures that interviews occur with those who have had experience of the phenomena being researched (Kane, 2003).
 2. Pasefika who were past clients of CMDHB CAMHS. Participants from this group were either; 16 years or older at the time of their referral to CAMHS, or were the Pasefika parents/care-givers of a referred young person. Participants were drawn from 2 distinct time periods: Period 1 (1/4/2005 to 31/3/2008), this group represents referred young people and their family who received a clinical service from mainstream CAMHS Teams as a Pasefika specific team was not in existence at that time; Period 2 (1/4/2009 to 31/3/2012), this group of young people and their family/caregiver will have received a clinical service from VT. VT was officially launched in October 2008; the launch signalled that all referrals for Pasefika adolescents would go to VT for clinical intervention.
- participants had a closed referral as at 31/3/2012. This was to ensure that interviewees felt able to speak freely and not be concerned about how their responses could affect their treatment.
- participants had no previous clinical contact with myself, the Principal researcher. This was to reduce the potential impact of either, coerced involvement and responding, or socially desirable responding.

Group 1 participants were recruited by my colleagues in VT who used their informal networks to approach those who met the criteria and would be appropriate to interview.

Group 2 participants were identified via a randomised stratified sample of those that met the criteria above. This sample was drawn by the CMDHB Research Evaluation and Audit of Mental Health Services team (REAMHS). Stratified sampling ensures that minority groups are represented in the sample (Kane, 2003). This is of particular relevance as Pasefika are a heterogeneous group; Samoans comprise the largest group then Cook Island peoples, Tongans, Niueans, Fijians, Tokelauans and Other Pacific – those from Tuvalu, I-Kiribati and Tahiti (SNZ & MPIA, 2010).

The recruitment of Group 2 participants was undertaken by the VT clinical team and Matua. AUTEK made this a requirement for ethical approval to be granted. This ensured that young people approached to participate were not being targeted inappropriately, for example, if they were in crisis or unwell, and to provide some 'distance' between themselves and the researcher so they did not feel coerced. The clinicians would make a brief assessment to ensure the young person was able to participate in an interview; I was informed if they agreed.

Information sheets and consent forms (refer to Appendices C to F) were given to those that agreed to an interview and I would follow up and contact them to arrange the interview. At this contact I would offer participants a thirty dollar voucher that could be redeemable for food, petrol or music/electronic goods. Information about a voucher as a gift for participation was not disclosed prior to my contact with those that volunteered. All interview participants received a thirty dollar voucher of their choice.

All participants signed their consent (refer to Appendix E) to participate in the interview and for the interview to be digitally recorded. AUTEK requires signed parental consent for those under 20 years old to participate in research; adolescent volunteers obtained their parents signed consent (refer to Appendix F) prior to our scheduled interview. Interviews occurred at locations convenient for the participant. Interviews were held at; at a CMDHB facility, at a school, at participants' homes.

Participants were able to have support people present and one participant chose to have a friend.

An aspect of my clinical role involves interviewing therefore I feel comfortable in my ability to engage and develop rapport in an interview setting. I believe that good clinical interviewing is based on the ability to impart the Rogerian concepts of unconditional positive regard, genuineness, and empathy (Rogers, 1980); this context supports people to talk of difficult experiences and not to feel as if they are being judged. My ability as a clinical interviewer provides a sound platform to base my research interviewing upon. Although I have the skills for successful interviewing it is my responsibility to manage the dual roles of researcher/clinician and to be mindful that I am not conducting a clinical interview (Adams, 2010; DiCocco-Bloom & Crabtree, 2006). This requires that I maintain appropriate boundaries by managing the interviewees' distress if it is triggered during the interview then offer them psychological support via AUT Student Services (refer to Appendix G). Although both therapeutic interviews and research interviews can result in increased understanding and change the intent of the research interview is knowledge production rather than achieving personal change (Kvale & Brinkman, 2009b).

Semi-structured interview schedules were developed for Group 1 and Group 2 participants (see Appendices H to K). All of the interview schedules contained vignettes, based upon typical referral concerns, and were made relevant to the interviewee's age and the group they were part of (see Appendices H to K). Vignettes are recognised as a useful tool within qualitative research because they access people's knowledge, attitudes, perceptions and opinions based upon the situation presented (Wilson & White, 1998). Vignettes also provide concrete examples of situations that interviewees may not have had personal experience of and allows the interviewee to come up with their own responses as they would if facing that situation (Leighton, 2010).

The internal validity of the vignettes is established by; basing them on clinical cases, presenting them to a panel of experts to verify and comment upon, and pre-testing them (Gould, 1996, as cited in Leighton 2010). I followed this process for establishing the vignettes internal validity. The vignettes are based upon clinical cases, were

presented for review and comment by the VT clinical team as experts, and pre-tested as part of an assignment for the AUT Integrated Research Methods paper 588632 completed in 2012.

Interviews occurred with four Group 1 participants and three Group 2 participants, further demographics describing the participants is provided in the Data Analysis chapter. All interviews began with the Pasefika 'roundabout approach' (Agnew et al., 2004) a process of making connections and warming the context before getting to the issue, the research interview.

Completed interviews were transcribed verbatim over the course of the data collection period. During this period I was also completing the Literature Review for this study and I began see connections between the literature and what my informants were telling me. Although this did not specifically change the interview schedules I did consciously probe those who had specific experience of CAMHS about that experience in order to understand the impact of 'provider characteristics'. Provider characteristics will be described further in the Data Analysis chapter.

3.5. Ethics

Ethical approval for this study was obtained from AUTEK with Conditional approval obtained on 2/11/2012 and Full Ethical approval confirmed on 26/11/2012 (see Appendix A). The AUTEK application number that identifies this study is 12/276. Approval for this study from CMDHB was also required and this was confirmed by the CMDHB Research Committee on 21/12/2012 (see Appendix B). CMDHB identify this study by the Research Registration Number: 1315.

Health and Disability Ethics Committee [HDEC] approval was not sought as the study did not appear to meet the criteria for this requirement. It was confirmed by the CMDHB Research office that HDEC approval was not required (S. Everitt, personal communication, December 20, 2013).

The process of gaining ethical approval entailed discussing the study and how it would be implemented with a variety of stakeholders as described below:

- the semi-structured interview schedules for adolescent participants were reviewed by the CMDHB Youth Consumer Advisor for comment upon the language and appropriateness of the questions for young people.
- The study, the information sheets, and the semi-structured interview schedules – for parents, adolescents, past service users and those naïve to MHS, were presented to the Pasefika members of the CMDHB Foafao Committee. The Foafao committee brought cultural purview to the study design. The committee members questioned the language ability exclusion as a possible limitation of the study; however they accepted the rationale for this decision. They also commented about the term ‘well-being’ in the interview schedules and suggested that Pasefika with a traditional belief system may provide behavioural descriptions of well-being. Pasefika with traditional understandings recognise well-being through behaviour; the individual is meeting their age appropriate responsibilities both within the family and the community. The committee gave their blessing to the study.
- The study, the information sheets, and the semi-structured interview schedules were reviewed by the Counties Manukau Maaori Research Review Committee [MRRC], a committee of CMDHB. The MRRC represent the interests of Tainui, the mana whenua of the CMDHB rohe. Although this study is in relation to Pasefika, Pasefika are increasingly of multi-ethnic origin as the result of inter-marriage with other ethnic groups in the community (SNZ & MPIA, 2010). It is appropriate to seek review for this study from mana whenua via the MRRC given that CMDHB, as an instrument of the Crown, has the responsibility to ensure that it is meeting its obligations to Maaori as defined by the Treaty of Waitangi.

3.6. Data analysis

Statistics of referrals to Whirinaki have been provided by CMDHB REAMHS for Period 1 and Period 2. The CMDHB data-warehouse has been able to provide information for the following variables: total number of referrals for each period by; ethnicity, age at referral, gender and, length of referral.

The variable; 'number of face to face contacts' for each Period was requested however information for Period 1 was not available in the data-warehouse. 'Referral source' was another variable not available in the data-warehouse. Access to this information would have required a manual file review which is beyond the scope of this study. Descriptive statistics are presented in the Data Analysis Chapter along with inferences based upon the available information.

Qualitative interview data underwent Thematic Analysis (TA) as described by Braun and Clarke (2006). TA supports the use of either an inductive or deductive approach to analysing the interview data. Inductive analysis means that the themes identified in the data do not develop from the researcher's preconceived theory about the phenomena being studied; codes and themes are identified from the data. Whereas deductive analysis actively involves the researcher's theoretical stance in relation to the phenomena being studied and the development of codes and themes is driven by the existing knowledge of the phenomena (Braun & Clarke, 2006).

TA requires the researcher to actively decide if they will use an inductive or deductive approach to the data analysis and they also need to decide if they are seeking a semantic or latent approach to the interpretation of the data. A semantic approach to the data is based upon the surface or explicit meaning of what has been said (Braun & Clarke, 2006), the participant's comments reflect his or her reality no further interpretation of the information by the researcher is required. A latent approach to the data seeks to examine the underlying meaning of what has been said, the assumptions, philosophies and social influences that shape the semantic meaning of the data (Braun & Clarke, 2006). This study takes a semantic approach to the data as this is a good fit with the postpositivist stance of QD; that language reflects people's knowledge and experience of the world.

TA occurs in six phases beginning with familiarising oneself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and finally producing the report (Braun & Clarke, 2006).

Familiarisation with the data began with my transcription of the recorded interviews. All the transcripts were created as MS Word[®] documents. Once the transcripts were in hardcopy I read each transcript several times looking for patterns and similarities across them; this is known as immersing oneself in the data (Braun & Clarke, 2006).

During the data immersion stage and with knowledge from the Literature Review I recognised the data contained comments that mirrored what has been written about barriers to health service access. These comments did not necessarily reflect ideas related to cultural based understandings of mental health however they were beliefs and attitudes in relation to service access. Therefore the data analysis that I have conducted has been a combination of inductive and deductive approaches. Inductive in that the interview data has informed me about Pasefika health beliefs and attitudes and, deductive in that the literature has informed me about barriers to access and I have recognised some of these ideas within the interview data.

As I immersed myself in the data, developed codes and identified matching text excerpts, I then developed themes and grouped the coded excerpts accordingly. Through a process of constant review and refinement of the themes the data analysis stage was completed and I began to prepare the final report.

3.7. Rigour

Within qualitative research rigour is the term used to describe the process of establishing trust or confidence in the study's findings; this is known as reliability/validity within quantitative research (Thomas & Magilvy, 2011). The process for demonstrating rigour within a qualitative study is a topic of significant debate among scholars. This debate stems from perceptions held about how valid knowledge is legitimised and the argument by the quantitative research camp that the subjectivity of qualitative studies invalidates any knowledge claims that are made (Angen, 2000). The initial attempts to legitimise qualitative research resulted in the development of criteria that were analogues of quantitative methods for the establishment of a study's rigour (Angen, 2000). These analogues, based upon the quantitative approach to

rigour, are now recognised as being poor instruments for the evaluation of qualitative research (Davies & Dodd, 2002).

The approach to the establishment of rigour that I have adopted from the plethora of literature on the subject is that suggested by Angen (2000), the evaluation of qualitative research rests upon the notions of ethical validation and substantive validation.

Ethical validation asks several things of the researcher. Firstly, it requires of the researcher to be mindful that they are not an objective observer, to be cognisant of their shared humanity with the researched, and establish an equitable context in which all voices can be heard. Secondly, it asks of the researcher to ensure that the topic of research and the approach is pragmatic so that there is real-world usefulness to the results. This may mean that the validation of a study, its practical usefulness, may not be realised until its results inform the practice of others. Kvale and Brinkman (2009c, p.256) share a similar position and consider that “in the pragmatic validation of a knowledge claim, justification is replaced by application”. Thirdly that the researcher provides “practical, generative, possibly transformative, and hopefully non-dogmatic answers” (Angen, 2000, p.389) to the questions posed in the research.

Substantive validation requires of the researcher to demonstrate their just treatment of the complexity of the research topic by acknowledging the various understandings that exist about the topic; current understandings, historical understandings, personal understandings of the phenomena being studied and accounting for this within the written report. This involves a self-reflexive process throughout the course of the study that is evident in the final report, and the resultant knowledge claims within the report resonate with the intended audience who feel convinced by what they have read (Angen, 2000).

3.8. Concluding remarks

Ethical approval from AUTEK and CMDHB Research Committee for this study was granted based upon an Ethics Application that included an abridged version of the

study's methodology as outlined above. The selection of QD as the methodology and TA as the analysis technique was based upon the suitability of these approaches to achieving the aims of this study, the generation of knowledge about Pasefika health beliefs and attitudes in relation to CAMHS. The generation of this knowledge requires hearing what the participants are saying and ensuring this is accurately represented, their voices are heard. The adoption of this approach in this study forms the basis of rigour it rests upon. That is; the complexity of this topic is presented in the literature review, and a pragmatic approach is used to generate knowledge that has real-world usefulness with the intent to inform practice in the future. This is undertaken with an awareness of the researcher's position in relation to the participants, the setting and the literature.

Chapter 4. Data presentation and analysis

4.1. Introduction

This chapter will present a combination of statistical data and qualitative data. The statistical data, drawn from the CMDHB data warehouse and provided by REAMHS, will provide a broad brush strokes picture of the context for this study by the numbers. Participants for the study were drawn from 1/4/2005 to 31/3/2008 [Period 1] and 1/4/2009 to 31/3/2012 [Period 2]. Period 1 represents provision of CAMHS to Pasefika prior to the establishment of VT; during, and prior to, this period Pasefika referrals were managed within mainstream teams. Period 2 represents the provision of CAMHS to Pasefika by VT – Pasefika specific team, which was formally launched in October 2008 although the team had been functioning since April 2008. Statistical information relating to these periods for the variables of; total number of referrals by ethnicity, gender, age at referral, and length of referral is provided below. Length of referral, which is the amount of time in days that a person had an open referral with the service, does not necessarily equate to the referred young person receiving active intervention as referrals remain open until the administrative processes to close the referral are completed. The variable ‘total number of face to face contacts’ which is a more accurate indicator of active intervention was requested; however this information was not available from the CMDHB database for Period 1, accessing the information would have required a manual file review which is beyond the scope of this study.

The statistical data and inferences about what it may describe will be followed by a presentation of the qualitative data.

Qualitative data was obtained via semi-structured interviews until the data was saturated. The interviews sought to elicit Pasefika health beliefs and attitudes in relation to child and adolescent mental health. The interview data of verbatim transcriptions underwent the process of TA (Braun & Clarke, 2006) by the researcher. The outcome of this analysis has been the identification of five themes that convey Pasefika health beliefs and attitudes in relation to child and adolescent mental health. Each theme will be defined and accompanied by excerpts from the transcripts to

illustrate these health beliefs and attitudes. The themes will be presented in the following sequence: well-being and mental health; causation; solutions; mental health as mental illness; provider characteristics.

4.2. Statistical information, the context by the numbers

AUTEC required that statistical data for this study was provided in an aggregated de-identified form. Therefore I am able to present descriptive statistics and make inferences based upon this information.

Table 2

Period	Total number of referrals to Whirinaki - all ethnic groups	Total number of referrals for Pasefika	Pasefika referrals as a percentage of Total referrals
1/4/2005 – 31/3/2008 [Period 1]	3811	529	13.9
1/4/2009 – 31/3/2012 [Period 2]	5699	960	16.8
Percentage increase: Period 2 over Period 1	49.5	81.5	

529 referrals for Pasefika children and adolescents were received for Period 1 which averages out to 176.3 referrals per year. Pasefika made up 13.9% of the total number of referrals received for this period.

960 referrals for Pasefika children and adolescents were received for Period 2 which averages out to 320 referrals per year. Pasefika made up 16.8% of the total number of referrals received for this period, refer to Table 2 above.

Although it is difficult to identify the number of 4 to 18 year old Pasefika young people in the CMDHB catchment, access rates can be approximated by comparing them to the number of 0 to 14 year olds in the general population. In 2007 it was estimated that there were approximately 33,400 Pasefika 0-14 year olds in the catchment and it is estimated that the Pasefika population will grow by 3.2% per annum (Wang & Jackson, 2008); therefore in 2011 there would have been approximately 37, 884 Pasefika 0-14 year olds. Based upon these figures the 'average' access rates for both periods was; 0.53% per annum for Period 1 and, 0.84% per annum for Period 2. These figures

suggest that Pasefika children and adolescents residing within the CMDHB catchment are underserved by Whirinaki given the MoH expectation that 3% per annum of the child and adolescent population will access child and adolescent mental health services (Ramage et al., 2005).

Table 3

Total number of Pasefika referrals to Whirinaki by Ethnicity Period 1.

1/4/2005 to 31/3/2008 [Period 1]		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Cook Island Maori	130	24.5	24.5	24.5
	Fijian	22	4.2	4.2	28.7
	Niuean	26	4.9	4.9	33.6
	Other Pacific Island	21	4.0	4.0	37.6
	Samoan	231	43.7	43.7	81.3
	Tokelauan	5	0.9	0.9	82.2
	Tongan	94	17.8	17.8	100.0
Total		529	100.0	100.0	

Table 4

Total number of Pasefika referrals to Whirinaki by Ethnicity Period 2.

1/4/2009 to 31/3/2012 [Period 2]		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Cook Island Maori	222	23.1	23.1	23.1
	Fijian	52	5.4	5.4	28.5
	Niuean	56	5.8	5.8	34.3
	Other Pacific Island	8	0.8	0.8	35.1
	Pacific Island not further defined	2	0.2	0.2	35.3
	Samoan	436	45.5	45.5	80.8
	Tokelauan	3	0.3	0.3	81.1
	Tongan	181	18.9	18.9	100.0
Total		960	100.0	100.0	

The break-down of referrals by Pasefika ethnicity is provided in Tables 3 and 4. There was an 81.5% increase in Pasefika referrals between the two periods with a corresponding increase of 49.5% in total referrals to Whirinaki, refer to Table 2.

Table 5

Average age at Referral by Pasefika Ethnicity		
Ethnicity	1/4/2005 to 31/3/2008	1/4/2009 to 31/3/2012
	[Period 1]	[Period 2]
Cook Island Maori	12y 9mo	12y 7mo
Fijian	14y 1mo	14y 2mo
Niuean	11y 1mo	12y 8mo
Other Pacific Island	13y 7mo	12y 5mo
Pacific Island not further defined		16y
Samoan	12y 10mo	13y 7mo
Tokelauan	12y 9mo	14y
Tongan	12y 1mo	13y 2mo
Average age for combined Pasefika ethnicity	12y 8mo	13y 4mo

The average age of Pasefika being referred to Whirinaki for Period 1 was 12 years 8 months and 13 years 4 months for Period 2. Average age by Pasefika ethnicity is provided in Table 5.

Table 6

1/4/2005 to 31/3/2008 [Period 1]	Gender by Pasefika Ethnicity				Total
	F	%	M	%	
Cook Island Maori	54	41.5	76	58.5	130
Fijian	12	54.5	10	45.5	22
Niuean	11	42.3	15	57.7	26
Other Pacific Island	9	42.9	12	57.1	21
Samoan	106	45.9	125	54.1	231
Tokelauan	1	20	4	80	5
Tongan	37	39.4	57	60.6	94
Total	230	43.5	299	56.5	529

Table 7

1/4/2009 to 31/3/2012 [Period 2]	Gender by Pasefika Ethnicity				Total
	F	%	M	%	
Cook Island Maori	99	44.6	123	55.4	222
Fijian	33	63.5	19	36.5	52
Niuean	23	41.1	33	58.9	56
Other Pacific Island	1	12.5	7	87.5	8
Pacific Island not further defined	0		2	100	2
Samoan	190	43.6	246	56.4	436
Tokelauan	2	66.6	1	33.3	3

Tongan	63	34.8	118	65.2	181
Total	411	42.8	549	57.2	960

The gender ratio of referrals for either period seems similar between the two groups with 56.5% of all Pasefika referrals during 2005-2008 were males, and 57.2% of all Pasefika referrals for 2009-2012 were males. Further break down of gender by Pasefika ethnicity is provided in Tables 6 and 7 above.

Table 8

1/4/2005 to 31/3/2008 [Period 1]	Length of Referral by Pasefika Ethnicity										Total
	30 days or less	%	31- 90 days	%	91- 180 days	%	181- 365 days	%	more than 365 days	%	
Cook Island Maori	32	24.6	26	20	29	22.3	31	23.8	12	9.2	130
Fijian	9	40.9	4	18.1	8	36.4	1	4.5	0	0	22
Niuean	1	3.8	4	15.4	7	26.9	14	53.8	0	0	26
Other Pacific Island	2	9.5	3	14.3	6	28.6	5	23.8	5	23.8	21
Samoaan	47	20.3	57	24.7	62	26.8	50	21.6	15	6.5	231
Tokelauan	2	40	0	0	0	0	3	60	0	0	5
Tongan	24	25.5	22	23.4	22	23.4	16	17	10	10.6	94
Total	117	22.1	116	21.9	134	25.3	120	22.7	42	7.9	529

Table 9

1/4/2009 to 31/3/2012 [Period 2]	Length of Referral by Pasefika Ethnicity										Total
	30 days or less	%	31- 90 days	%	91- 180 days	%	181- 365 days	%	more than 365 days	%	
Cook Island Maori	37	16.7	56	25.2	58	26.1	56	25.2	15	6.8	222
Fijian	17	32.7	12	23.1	13	25	10	19.2	0	0	52
Niuean	11	19.6	10	17.9	15	26.8	14	25	6	10.7	56
Other Pacific Island	0	0	1	12.5	4	50	3	37.5	0	0	8
Pacific Island not further defined	2	100	0	0	0	0	0	0	0	0	2
Samoaan	68	15.6	96	22	124	28.4	109	25	39	8.9	436
Tokelauan	0	0	0	0	1	33.3	1	33.3	1	33.3	3
Tongan	24	13.3	35	19.3	51	28.2	55	30.4	16	8.8	181
Total	159	16.6	210	21.9	266	27.7	248	25.8	77	8	960

The number of Pasefika engaged in treatment as defined by length of referral (Tables 8 & 9) showed an increase for the periods; 3 months to 6 months and, 6 months to 12 months in Period 2 over Period 1. A total of 514 Pasefika, 53.5%, remained in

treatment for a period of 3 to 12 months in Period 2 whereas for the same time in Period 1 only 48% remained in treatment. Percentages for the '1 to 3 months' and the 'greater than 1 year' periods seem similar for both groups. The '30 days or less' period showed a decrease in the number of referrals being closed within 30 days when comparing Period 1 at 22.1% with Period 2 at 16.6%.

4.3. Thematic analysis: what the participants are telling us?

4.3.1. Participant demographics

There were seven participants who identify as being Pasefika, four people naïve to mental health services and three people who were past service users of Whirinaki CAMHS.

Socio-economic situation

The average household size was 6 people; the average number of bedrooms was 4; the minimum number of years education was 12 – the equivalent of 6th form secondary school and 3 participants had undertaken tertiary study; combined family income per household was reported to be greater than \$79k with nobody in receipt of a Work and Income benefit, participants had telephone and internet access in their homes. Home ownership was not clarified neither was the level of employment. The overall impression is that although this group of people reside in CMDHB areas of high socio-economic deprivation these families do not meet the NZDep06 decile 9 and 10 criteria for socio-economic deprivation.

Generation and household structure

Three participants were of the 1.5 generation, they had migrated to NZ with their parents at 13 years of age or younger; three participants were of the 2nd generation and one participant was of the 2.5 generation. One of the 1.5 generation adult participants was living with extended family including her parents; another of the 1.5 generation adult participants was living as a blended family without her parents in the home. The remaining respondents were living as nuclear families.

Generation, age and ethnic mix

Four participants were adults and three participants were adolescents, two adolescents – one 2nd generation the other 2.5 generation, had previous involvement with Whirinaki and one adult – 1.5 generation, was the parent of an adolescent who had been involved with Whirinaki.

The ethnic mix of the interviewees reflects the diversity of the Pasefika population within the CMDHB catchment: the 3 respondents of the 1.5 generation are Tongan, Tongan/Samoan, Samoan; the 3 respondents of the 2nd generation are Samoan/Niuean, Samoan/Indian (both parents are migrants), Tongan; and the respondent of the 2.5 generation is Samoan/NZE. All respondents self-identify as Pasefika.

4.3.2. Well-being and mental health

The interview schedules directly enquired about participants' beliefs of well-being in relation to, children and adolescents and, mental health. Participants often used behavioural descriptions to explain and illustrate how they understand well-being. This response was not unanticipated as the Fofoa Committee, to whom I presented this study, advised me that using the term well-being may evoke descriptions of behaviour. Whilst discussing with participants' their views about well-being they also commented on how their views have been influenced by the media and education.

Well-being

“how do you describe child and adolescent well-being, what does that mean to you?”

“...well-being I just think the type of up-bringing, healthy up-bringing...”

“...just growing up in a good environment...” (Gp1Inv1)

“I would describe it is being able to look after your children properly educational wise and mentally, physically”

“...wellbeing for me is making sure my family is safe in all aspects...” (Gp1Inv2)

“I guess it would be happy, healthy, of mind and of body” (Gp1Inv3)

“child well-being is children that are physically well and spiritually well” (Gp2Inv6)

“well-being, I would say having balance in all aspects of your life, being ok in health, mentally, physically, culturally...” (Gp1Inv4)

The interviewees' concepts of well-being do not appear to draw upon Pasefika notions of holistic well-being as documented by Agnew and colleagues (2004) and Bathgate and Pulotu-Endemann (1997). As the excerpts identify, variously interviewees acknowledged; the physical and spiritual aspects of well-being and, the physical, mental, and cultural aspects of well-being. The majority of respondents recognised well-being as comprising of mental, emotional, and physical aspects, and acknowledged the family environment and role of parents as factors that influence well-being.

One adolescent interviewee's explanation seems to incorporate ideas about developmental stages by commenting that adolescents can take more responsibility for their well-being "...where I'm at, I can say what well-being is, and I can partially ensure that I'm ok..." as compared to children who are more reliant upon their parents "...a child, they're very dependent on whoever is looking after them..." (Gp1Inv4). This young person is of the 2nd generation and has recently completed High School. Another adolescent interviewee seemed to have difficulty articulating ideas about well-being and commented that "I think it's like the emotions, I'm not really sure" (Gp2Inv7) and suggested that it is to do with what goes on inside one's head.

The general impression garnered from the interviewees' responses is that well-being is contextual; the environment and quality of relationships has a direct bearing upon children and adolescents mental, emotional, physical, spiritual and cultural selves. This composite rendering of the interviewees' descriptions of well-being is congruent with the Pasefika notion of holistic well-being.

As I understand it the elucidation of Pasefika models of well-being have occurred via the process of fono, talanoa, and consensus often among people who are considered to have cultural expertise related to their specific ethnic group [refer to Kupa's, (2009) description of developing the Te Vaka Atafaga model]. It is interesting to note that within the 'general population' people do not readily describe their understanding of well-being as succinctly as it is described within the documented Pasefika models, is

this because 'it goes without saying', is it because of people's 'cultural education', or some other reason?

Cultural education is a term I have used to refer to the transmission of cultural knowledge; cultural explanations of well-being and mental health were not reported by the interviewees as something that was talked about within their families-of-origin and any references to mental health tended to be pejorative.

Well-being and mental health

“how would you describe the connection between well-being and mental health?”

“I think mental health is an aspect of having balance...I think...when you're balanced you have the ability to reach your full potential and so, if one aspect of you being balanced, like your mental health, is down you can't reach your potential, your full potential, and I think mental health is one of the most important aspects because it controls the way you think, the way you feel, mostly the way you express yourself...the brain...is the most important organ...without your brain being fully functional...how are you yourself”
(Gp1Inv4)

This respondent acknowledges that mental health is one aspect of well-being and balance in all aspects including mental health is important to well-being. The respondent is the 2nd generation who has recently completed secondary school and was introduced to the holistic model of health through the health curriculum and the subject 'Hauora'.

A respondent of the 1.5 generation described mental health as detracting from well-being, by commenting “...if a happy child all of a sudden became withdrawn not being their normal self...” (Gp1Inv3). This suggests that well-being is a state of normality and mental health is a deficit. This idea that mental health detracts from well-being was echoed by an interviewee of the 2nd generation who gave an example of poor decision-making resulting in her brother being in an unsafe situation, “...gotten beaten up somewhere...then it would have been...his own fault for not thinking straight...” (Gp2Inv5). Another interviewee's reply was also suggestive that mental health

detracts from well-being however her answer could also be construed as mental health is the ability to 'deal with things' which is important to the maintenance of well-being. The interviewee is of the 1.5 generation.

"...if we cannot deal with things that is in our mind and what we're going through we cannot become a well-being person and do well because once we have all these things loaded up in our minds we cannot concentrate then children will not be able to function they won't be able to think properly of what they are doing..." (Gp2Inv6).

The notion of mental health as mental illness is picked up as a theme in its own right later in this chapter.

Well-being as behaviour

"what sort of behaviours would you expect to see from either a child or adolescent that would tell you that they have good well-being?"

"it's when I'm happy, on track, and not doing silly things just talking to people and not being snobby yeah" (Gp2Inv5)

"physically children are able to get along with others and also spiritually get along with others this is what the normal teenager would do, they don't get angry fast, or be [im]patient, they don't get involved, don't encourage others to do bad stuff to people..." (Gp2Inv6)

"...at home the kids they get to share things, a 12year old will still do as they are told at home and they do their chores and everything yeah" (Gp2Inv6)

In essence interviewees considered that behaviours associated with well-being demonstrate that children and adolescents are happy, are meeting their age appropriate responsibilities, are co-operative and, engage with their parents. One adolescent respondent's perception of how her mother would describe her behaviours when she is 'well' gave a description similar to the responses provided by the other adult interviewees "...she would probably [say] 'oh she washes dishes now, comes out of her room, talks to us, comes to Church'..." (Gp2Inv5). Another young person reiterated the developmental aspect of well-being, describing children as happy and adolescents as having greater autonomy and the ability to be confident in the decisions they make. An adult respondent acknowledged her role as a parent to support children and adolescents in their well-being through educating and nurturing them in the home.

These behavioural descriptions appear to parallel Pasefika notions of relationships and social responsibilities and the importance of these to the maintenance of well-being. The idea of adolescent autonomy in relation to decision making, mentioned by a 2nd generation interviewee, seems to fit alongside the Western psychological concept of individuation. This interviewee also commented that compromise is important when making decisions and giving consideration to the impact of one's behaviour upon those that care for you. Again this suggests an acknowledgement of the importance of maintaining relationships.

Influences on beliefs about well-being and mental health

“where has that idea about mental health and well-being, where has that come from?”

“...once you see someone that hasn't got it all there [I] think ok mental health right there, so a lot of it is perception...” (Gp1Inv1)

“...mostly just by reading, I read the paper and you see the things that are happening, television news and hearing and reading, when we have our Tongan papers as well...” (Gp1Inv2)

“...the huge exposure on TV about it has given me a heads up and it's good, it's good to have that sort of understanding and that sort of knowledge, yeah.” (Gp1Inv3)

“...when I watch the movies and they are raped or something and then after they start hallucinating about things that happened and then that's when they go all mental yeah” (Gp2Inv5)

The comments from the interviewees suggest that views about well-being and mental health tend to develop from one's own observations and assumptions about behaviour and from representations in mainstream media; movies, television programmes, books, and newspapers. These 'dramatic' representations of mental health appear to skew respondents' perceptions to consider that mental health issues are severe and develop from traumatic events. The interviewees were aware of the Like Minds, Like Mine television campaign (Mental Health Foundation [MHF], n.d.) and the John Kirwan depression campaign (The New Zealand Herald, 6/8/2010). These campaigns appear to have increased the participants' awareness of mental health issues. Adolescent

respondents seem to be able to better articulate their views on well-being based upon what they had learnt through the high school health curriculum.

What has been pleasing to hear is how involvement with a mental health service has been positive. The young person commented that "...they helped us not do anything stupid and now I know that it's not all about mental people, they helped us mentally...about how we think of solving our problems..."(Gp2Inv5). This experience may have altered her perception of mental health services; to view mental health services as a support option for issues that are not the result of a 'traumatic incident' or manifest as severely disturbed behaviour.

4.3.3. Causation

Causation refers to the respondents' beliefs that explain the cause of problem behaviours. These explanations are provided in response to the vignettes that were used in the semi-structured interviews (refer to Appendices H to K). Past clients of the Service provided explanations for their referral to the Service and also to a vignette. Respondents' answers have been categorised as personal beliefs and traditional beliefs. Personal beliefs refer to what the respondent believes is the explanation for, or cause of, the behaviours. Traditional beliefs refer to ideas that explain the cause of the behaviours which the respondent attributes to the previous generations or to a specific ethnic group. Within this theme are ideas associated with problem recognition, as well as, tolerance of age-appropriate behaviour that is; at what age does a behaviour become seen as a problem? Problem recognition and tolerance have been identified in the literature as factors that influence access to health services and are embedded in cultural understandings of behaviour.

Personal beliefs

Vignette – 6yo boy

“what's your explanation for this behaviour?”

“...he's got a lot of energy, needs to be focused...” (Gp1Inv1)

“...if he's...beat up at home that's what he might be doing at school...”
(Gp1Inv1)

“...hyperactive...very spoilt sometimes they can be born...with a disability with the mind, maybe he’s abused as well, not enough love and not enough discipline, education, you’ve got to be educated from an early age...” (Gp1Inv2)
 “...there might be something happen or has been physically abused at home...” (Gp2Inv6)

Vignette – 14yo girl

“what is your explanation for this change in her behaviour?”

“...someone’s hurt her in a physical way, violated her or something...” (Gp1Inv1)

“...she can be bullied at school at the same time she could be bullied at home and it depends on the friends that they hang around with ...” (Gp1Inv2)

“...she’s being bullied at school or somebody’s doing something not right with her or...she’s sexually active...” (Gp1Inv3)

Adult interviewees’ personal explanations for the cause of problems for the 6yo boy and 14yo girl vignettes tended to focus upon what was happening in the home. In general the respondents considered that some form of abuse was occurring in the home in both vignettes with the additional factors of; wanting attention for the 6yo boy and, peer influences for the 14yo girl, as causal explanations. These explanations seem to be cognisant of developmental factors. The 6yo boy is dependent upon the home environment for getting his needs met and his behaviour is a reflection of what is happening at home. The 14yo girl has to negotiate her home situation and her involvement in the community and with peers; these factors may influence her behaviour. Two adults, one naive to mental health services and the other the mother of a VT client, suggested that the 6yo boy may have a mental problem however did not say much more than that.

Vignette – adolescent female respondents

“what do you think is happening for your friend?”

“I think she’s had far too much restriction, her parents keep holding her back telling her you can’t do this can’t do that...” “...it’s just rebelling” (Gp2Inv7).

All of the adolescent respondents when commenting about their vignette explained the behaviour as being a response to restrictive parenting rather than considering that there could be a mental health issue.

The two previous clients of the service explained maladaptive behaviours as being an attempt to improve one's mood "...they think that it feels good when they cut themselves..." or to cope with what they had been through "...always cut themselves and...think of committing suicide coz of things they've been through..." (Gp2Inv5) and, mental illness as "...a state of mind that you just can't really get out of...you've brain washed yourself to believe something that's not true..." (Gp2Inv7) and therefore can't get out of on your own. These interviewees did not seem to apply their personal experience of psychological difficulties as a way of understanding the adolescent's situation in the vignette.

Traditional beliefs

Traditional explanations tended to locate the problem within the young person with descriptions of

"...he's naughty doesn't sit still..." (Gp1Inv1)

"...she has an attitude...she is being stubborn...[she's] hard-headed, they would say that in a typical Island way..." (Gp1Inv2)

"...they'd probably say she's stupid..." (Gp2Inv7).

All of these explanations suggest discipline as a solution.

An adolescent interviewee commented that her mother said "...it was good coz she thought I was a[n] egg coz the Principal said I had anger issues..." when being informed about her daughter's referral to Whirinaki. This response is suggestive of a belief that involvement with a mental health service is a disciplinary consequence. She also considered that her mother would identify there was a problem when she stopped meeting her responsibilities "...where is that little girl, the one that hides in her room, where's the lazy girl who doesn't wash the dishes..." (Gp2Inv5). However she did not comment upon how her mother would address this problem.

An adult respondent of the 1.5 generation indicated that her parents might say "...your kid's gone mental..." however the use of the word in this context seemed to be pejorative. Her mother's fuller explanation for the young person's behaviour was described as "...it's just an Island thing if your child is not behaving it's a reflection of your own bad behaviour when you were growing up with them..." (Gp1Inv3).

Another interviewee of the 1.5 generation acknowledged that although extended family would say "...there is something wrong with that kid..." their suggestions as to how to deal with the problem is influenced by "...how you explaining it and then their feedback will depends on what kind of words you use but it means something else or something deeper it's how you explain to people what's going on with that child" (Gp2Inv6).

Traditional views were varied and attributed the manifestation of problem behaviours: to the young person evident by their actions such as not attending to their role responsibilities; as recompense for the adult's poor behaviour as a child or; "... she hasn't met God...she doesn't know what's out there for her...she's blind..." (Gp1Inv4). All of these 'traditional' ways of explaining problem behaviour are likely to be contingent upon how the behaviour is described and the language used. The overall impression from the interviewees' responses is that there is an implied solution to address the problem. None of these explanations easily lend themselves to a solution that involves mental health services.

Problem-recognition

All respondents identified the behaviour presented in the vignettes as being a problem for the young person; however the problem was framed by the interviewees' causal explanations. Despite this recognition that a problem was present the involvement of a mental health service was not a readily identified response to the problem. Respondents' considered more 'traditional' members of the family would not necessarily describe the behaviours as a problem; although if they did deem the behaviour to be a problem seeking support would not be a suggestion from these family members

"...definitely wouldn't say go get some help, call these people, nah they just don't know..." (Gp1Inv1).

There was also a sense that 'traditional' family members would normalise the behaviours,

"...if the child is knocking other child on the street, it's a macho thing, so my dad 'yeah, yeah, you're a good boy' that's normal, even if my daughter was

doing the same thing to dad ‘yeah, yeah, that’s my granddaughter’...”
(Gp1Inv3).

Normalising also seemed to be a way that some respondents used to explain changes in behaviour,

“...I suppose it would be [a problem] if it was a recurring thing...if it just kept happening...” (Gp1Inv1)

“...I think everybody has problems” and “...if that was me I wouldn’t get professional help...” (Gp1Inv4).

A mother whose daughter was involved with Vaka Toa commented in relation to her daughter

“...it was just normal [I was] thinking ‘oh nah she’s probably in her room doing some work, school stuff’ but it’s just that I notice the change when my daughter goes and [name] is not going with her that’s the only thing I notice...”
(Gp2Inv6).

As this was an existing pattern of behaviour between sisters the change, although noticeable, was not considered to be unusual, despite the school reporting problems and the involvement of VT. This respondent and an adolescent interviewee, naïve to mental health services, both remarked that aggressive behaviour would need to be present before it was deemed to be appropriate to seek further assistance

“...once it hits self-harm or abuse, she starts to become abusive not only to herself but to others or her friends...they’re aggressive towards her...”
(Gp1Inv4).

Tolerance

“...the 6 year old you’d probably just put it down as a ‘ula vale kid’...breaking out, whereas a 14 year old as they get older and they are still doing the same thing then it becomes a problem...in my own way of thinking and even in my mum and dad’s way of thinking, it’s a problem...” (Gp1Inv3).

Although an excerpt from one respondent has been produced to illustrate the concept of tolerance as a Pasefika belief the effect of normalising problem behaviours that respondents’ used would also increase their tolerance toward these behaviours. In conjunction with the process of normalising is the way interviewees’ causal explanations of the problem behaviour may also increase tolerance; the explanation of

attention seeking in relation to the '6yo boy vignette' demonstrates a level of tolerance for hitting and being off task with an implied solution being the provision of attention. However if as a 14 year old the behaviour is unchanged, culturally this is not acceptable. The behaviour would interfere with the young person's roles and responsibilities which is then a problem; however defining the problem in this way does not suggest mental health service involvement.

Our, VT, clinical experience is that parents often do not express the same level of concern about their child's behaviour as that expressed by the referrer which is often the school for children under 12 years old. Even for referred adolescents their parents do not express the level of concern that the referrer has. It is not unusual for parents to express surprise and sometimes anger or disagreement, when informed by VT clinicians that a referral to a mental health service has been received. The parents of referred adolescents seem to more readily accept there is a problem, although their description and explanation of the problem may differ from the referrers.

4.3.4. Solutions

Respondents recognised that the behaviours in the vignettes or their own behaviours which resulted in referral to Whirinaki were problematic. In general interviewees indicated if their approach to the issues in the vignettes was not successful they would engage in help-seeking behaviours; however mental health services was not readily identified as an option unless prompted for, even from those who'd had contact with Whirinaki. It appeared that the interviewees did not recognise that the vignettes, or their own behaviours, would be appropriate for assessment by a mental health service. Respondents also offered ideas about how the previous generation would address the issues; these are referred to as traditional solutions. Within the literature on barriers to service access self-reliance – managing the problem yourself, is described as an approach that some cultural groups utilise in response to challenges. Respondents indicated that self-reliance was an approach that they utilised themselves or something that they understood as being endorsed by their family of origin.

*Help-seeking***“what ideas do you have about how to address the behaviour, how to sort it out?”**

“...I suppose being educated...I would go find help” (Gp1Inv1)

“I would go to the social workers, get Government help...” “I would ask around...and even with the Doctor” (Gp1Inv2)

“...sitting down with her and talking to her if I don’t get any answers I’d probably try and get some help for her” (Gp1Inv3)

“I think you can just talk to your family Doctor about it and then find out some specialist for mental health out there and seek help” (Gp2Inv6)

Respondents recognised that the vignettes portrayed problems which if not resolved through their actions the next step would be to seek help. Help-seeking would occur via: informal networks – friends, pastor, friends in the community who are helping-professionals; utilising the internet and phone directory; seeing a general practitioner or school counsellor. There was a varied response from the adolescent respondents, one of whom considered the school guidance counselling system to be ineffective, whereas the other two adolescents described the school guidance counselling system as an accepted source of support by the student body; although she also expressed some dissatisfaction about the type of support she had received. Both adolescent interviewees who had previous involvement with VT indicated that it would be acceptable to approach “your guys team, I’d probably drag her down and go talk to someone” (Gp2Inv5).

Two other views were offered about how to address the behaviours in the vignettes. Two adult respondents, one who is 1.5 generation and the other 2nd generation, acknowledged that an ideal home environment and good relationships with the children would mean that as parents they would be available to their children as supports and also be able to approach their children and raise their concerns. The other view was to talk to the young people about what might be behind the problem. The adolescent interviewees also commented that they would talk directly to their ‘friend’ in the vignette.

An interviewee who had been seen by VT clinicians described this experience as educating her to the idea that “...it’s ok to talk about this kind of stuff there’s a lot of

understanding people that have gone through the exact same thing..." (Gp2Inv7) this has hopefully increased the range of solutions available to her.

Traditional solutions

"what advice would they [migrant parents] give you then about how to manage the behaviour?"

"they would have the same idea as myself, if we are helping them at home and that is the best we can do then we will go further outside..." (Gp1Inv2)

"...she would just say 'po le nuku' slap them across the face discipline them in the old fashioned Samoan way..." (Gp1Inv3)

"my mum would tell me to invite her over to have dinner or...my mum would say 'oh invite her to Church', or, 'you guys should introduce her to Jesus'..." (Gp1Inv4)

The majority of adult respondents of the 1.5 and 2nd generation indicated that approaching their parents or extended family for support about the behavioural issues would not be useful as the 'traditional' response would be to treat the behaviour as naughty, tell the children off and / or apply discipline which would be physical. One of the 1.5 generation interviewees offered a counter-view in which she considered that her parents would suggest seeking outside support if the family had done their best. This respondent also indicated that 'telling off' would be an idea suggested by her parents; the assumption is that outside support would be sought if everything the family did, including discipline, was unsuccessful. A 2nd generation adolescent interviewee indicated she would approach her Island born mother who would advise her to befriend the young person in the vignette and invite her to Church. This is not an unreasonable solution as engagement in pro-social activities has the potential to improve mood and promote behavioural changes in young people.

Self-reliance

The notion of self-reliance seemed implicit in adult interviewees' responses to the behaviours presented in the vignettes, in that they would try to address the behaviours themselves by talking to the young person, then seeking information from their informal support networks and the internet. If this was not successful they would

then look for professional assistance. What was surprising to notice in the interviews was the adolescent interviewees' belief that they have to deal with things on their own

“...problems like these how do we prevent it...but I think it's been planted in our heads 'you can fix it yourself'...” “...it's just floating in the air, nobody wants to share their problem or everyone wants to be independent, nobody wants to look weak” (Gp1Inv4)

“it's in my family, if I go to any of my Samoan cousins or households they don't talk about emotions and problems and everything, it's just something you deal with on our own...” (Gp2Inv7)

The excerpts suggest that self-reliance, dealing with it on your own, is a message that influences how people think about addressing the challenges in their lives.

Explanations for this appear to attribute the attitude of self-reliance as being: culturally based – it's a Samoan thing; from society in general – ‘you can fix it yourself’; a response to how the family-of-origin has responded to challenges in the past “...they'd be in denial...which is part of the reason why I would never talk to them about the problem and I would try and deal with it...” (Gp1Inv3).

One respondent who had contact with VT said her coping response now would be to “...just keep it inside...” (Gp2Inv5), this would not have been a strategy espoused by the clinical team.

4.3.5. Mental Health as Mental Illness

This theme of mental health as mental illness captures the interviewees' thoughts about the relationship between mental health and mental illness. Associated with this relationship is stigma, the embarrassment and shame, that can occur as a consequence of being recognised as having a problem or, being known to be involved with a helping service.

Mental health as mental illness

“what does mental health mean to you?”

“wow, mental, back in the Islands or even, when you talk to someone about mental or when you talk about someone with that title ‘mental’ it means someone is crazy, is not all there, disability comes under that title and because there is no proper translation or description for that word mental in Tongan often people take it the other way and take the meaning off from the word and

change it into something totally bad and often when you hear people ‘oh they are going to a mental health’ the mind-set is ‘oh he or she, they’re crazy, you know, they’re mentally ill’, and often if that person has been named or referred to you guys the mind-set is ‘oh she’s crazy that’s why she goes there’ people just need to understand fully what that really means, it doesn’t mean that you are totally crazy and run around wild” (Gp2Inv6).

This was a consistent response from all the interviewees when asked to say what mental health means to them, mental health was universally referred to as mental illness or described as an impairment. A 2nd generation adolescent naive to mental health services when I responded to her comment “like mental illness” by suggesting that was the flipside of mental health was able to say

“it’s just like your physical health...mental health...it involves your brain, that needs to be cared for just like every other part of your body and mental health is more or as important as every other part of yourself, your well-being” (Gp1Inv4)

The impression I am left with after the interviewees’ responses are; if the term mental health has such negative connotations for Pasefika, of any generation, it is not surprising then that mental health services are not a support option people consider when faced with their own psychological distress or challenging behaviours from family members.

Stigma

Given the association of mental health with impairment and disability expressed by the interviewees, there was an underlying impression that involvement with a mental health service would be viewed negatively by the referred young person and by the community. In particular, family members with a more traditional outlook may find the issue extremely difficult to deal with or they could reinforce the sense of shame.

“I guess it’s just the way that they [Samoan migrant parents] were brought up, that sort of thing is makanga or not something to be in the family, it’s an embarrassment to them...shameful to have somebody with what they say ‘leaga le ulu’, mental...I’ve heard my mum talk “that one over there grew up leaga le ulu” so we all kept away...that person was ex-communicated, shunned that’s how they were brought up...” (Gp1Inv3)

“...I have no idea what they think but he’d [Tongan migrant father] probably mock me like ‘oh mental blah blah blah’” (Gp2Inv5)

Two interviewees (adults, one of the 1.5 generation and the other of the 2nd generation) expressed concern about; how the referred young person would see themselves, the potential impact of a mental health problem upon them as parents, and also how others would view the young person

“...if I was just blunt about it they’re not fully there...and I think we’re probably going to have a hard time trying to figure out what to do...” “...I’d be thinking...is he going to be a bit slower than his peers, does that include him getting bullied a lot, coz he’s not going to get accepted and stuff” (Gp1Inv1)
 “...when the rest of the kids at home found out even the school, [name] friends found out that he was referred to a mental health counsellor, it was a huge thing, then [name] felt that he’s mental, he felt that he’s not suitable to hang out with his friend he felt that he’s different...as soon as you say...she’s been referred to a mental health service...the kids will say ‘mental are you mental’” (Gp2Inv6)

These comments clearly demonstrate that being identified as having a mental health problem or being involved with a mental health service is considered to be embarrassing or shameful and if known by the wider community could result in the identified person being marginalised. Awareness of the societal stigma attached to mental health issues meant that respondents recognised the potential for self-stigmatisation, the young people’s perception of themselves as flawed being confirmed by their involvement with a mental health service.

Traditional perspectives view those with mental health issues as people that should be shunned. This suggests that stigma is likely to be a significant barrier to accessing mental health services for, in particular, first generation Pasefika families. It also means that clinicians need to be mindful of the influence these beliefs may have upon engagement when Pasefika young people and their families, of any generation, are referred for assessment.

It was pleasing to hear from those young people that were involved with VT that it was a positive experience despite their initial thoughts that things were very serious.

“what did you think about being referred to a Mental Health service?”

“I felt weird, when they said that I was, ‘do youse think I’m mental or something?’ but then after that I found out its really cool and they actually help...” (Gp2Inv5)

“I thought I was crazy, when she said that to me I was like, ‘oh my god I’m going insane’ I remember, I just thought I was going insane” “...once I got talking to Whirinaki I was able to talk to others about it as well, I felt more confident in myself...” (Gp2Inv7)

4.3.6. Provider Characteristics

Andersen’s (1995) model of health service access recognises the recursive nature of health service utilisation upon the service user’s health beliefs and attitudes. The user’s experience of the health service can be positive, negative or neutral and this will influence their future health-management decisions. Prior to engaging with a health service, especially when people from ethnic minorities are considering accessing a mainstream service, the beliefs and attitudes they hold about the health service provider will inform their decisions about engaging with the service.

The theme of provider characteristics refers to the ideas that the interviewees’ have expressed about service providers that may influence their decisions to access a service and, their experience of the service provided by VT.

Responses from the adolescent interviewee who was naïve to mental health services mirrored some of the ideas in the literature that are reported to be barriers to mental health service access by young people

“I have so many friends who have cut themselves...and they don’t seek help, they go to their friends and their secrets are just held between that close circle...how are we supposed to get all these close secrets to you guys without the fear of being judged without the fear of you telling our parents without the fear of you knowing anyone who was involved in whatever has happened...there’s always that fear of nothing’s actually going to happen and I’m just going to be let down again and I’m just going to end up hurting even more” (Gp1Inv4)

This interviewee also considered that the school guidance counselling system was ineffectual

“...to a majority of the school it’s a joke...I went to the counsellor once, there was a certain situation and I told the school counsellor in confidence that she would keep it confidential and then she told me ‘you have two choices, go and tell the principal or I will’ and I just think that it wasn’t helpful at all...”

“...confidentiality is a really tricky situation and it can easily be broken unintentionally and intentionally” (Gp1Inv4)

These comments represent the dilemmas that young people face when considering accessing support for their distress; will it help or will I feel worse, can I trust the person I am talking to, will I be judged because of what I am telling them. These are powerful impediments to taking the first step to seek support.

Once having made the decision to see the school counsellor and talk about their worries having an experience as described below is likely to have a negative influence upon seeking further support

“she didn’t really listen, it felt like she was controlling me, she kept telling me ‘you gotta do this, you gotta do that and then you’ll come out feeling like this’ and I didn’t like that” (Gp2Inv7).

The past clients of VT that were interviewed indicated that the cultural knowledge and ethnicity of the clinicians supported their positive engagement and experience of the service.

“...they help us and they always had snacks...they were really cool, the ladies that came, it was easy talking to them” “...some of them were young and they were Islanders and it didn’t seem like they judge us...they were cool.” (Gp2Inv5)
 “I’d say...the whole cultural thing, Pacific Islander Maori they’re more understanding of your culture...they get the strictness of the Pacific culture and everything...” “...I did feel much more accepted yeah” (Gp2Inv7)

This interviewee also acknowledged that she could have had a similar experience with a clinician from another ethnic group however she considered that “...I would have to explain more...” (Gp2Inv7) in reference to educating the ‘other’ clinician to Pasefika cultural mores.

The mother of the young person who was a client of VT also indicated a positive view of mental health services by commenting “I just want to say...keep up...these services... because there are a lot of kids out there that needs help...” (Gp2Inv6). Although this endorsement does not necessarily indicate that she would access support if she had concerns about any of her children. An adult interviewee of the 1.5 generation

indicated she would "...be in agreement of it [a referral to CAMHS], it all comes from wanting to see my child better, to finding out where the problem is..." which is motivated by her parental responsibility toward her children. Although mental health services would not be her first step due to her lack of knowledge about the types of helping services available, if this was suggested to her by somebody with the appropriate authority she would accept the decision.

The information above suggests that it can be difficult for young people to access helping services due to concerns about; confidentiality, being judged and, the helpers ability to listen and respond in a manner that is congruent with the young person's needs at the time. These issues reflect what the literature describes as barriers to accessing mental health services by young people, and the concerns ethnic minorities have about mainstream treatment providers.

What the respondents have identified as helpful characteristics of service provision that promoted engagement are: a thorough explanation of the service and individual time spent with both the parent and the young person; ethnic matching, meeting with Pasefika clinicians; being youthful and having food seemed to facilitate engagement with the helping process. Although it was acknowledged that a similarly successful helping experience could have occurred with a clinician from a different ethnic group, shared experience and understanding of things Pasefika seemed to enhance the experience. Similar themes are evident in the literature about ethnic matching.

4.4. Conclusion

The statistical information presented indicates that the number of Pasefika being referred to CAMHS is growing however not at a rate that is expected, this along with the increase in the average age of Pasefika at referral is a concern. The apparent increase of referred Pasefika remaining in treatment over 3 to 12 months is encouraging.

It appears that the qualitative data indicates MH is not readily recognised as an aspect of well-being and well-being is often recognised by how a person is behaving. Despite the media increasing participants' awareness of MH issues it does not appear to be

informing participants that MH and well-being are connected. Other findings in the data indicate that the causes of difficulties tended to be explained from a social perspective; the impact of intra-familial behaviours or social difficulties whereas traditional beliefs were assumed to locate the problem within the individual. The data also indicates that problem-recognition is a significant issue which is exacerbated by normalising beliefs that increase one's tolerance to the behaviour. If a problem was recognised solutions involving MHS were not identified, in part due to a lack of knowledge but also due to a belief about being self-reliant and the role and influence of informal networks. A traditional solution of discipline was also offered by participants. Another belief identified in the data is the role stigma plays in regard to the type of solution that would be acceptable, for both traditional and NZ born Pasefika this appears to be a significant issue in terms of access to MHS. However once engagement with a MHS has occurred ethnic-matching, being non-judgmental, youthful and employing cultural practices of engagement supported a positive treatment experience.

Chapter 5: Discussion and Conclusion

5.1. Introduction

The purpose of this study is to investigate Pasefika health beliefs and attitudes in regard to child and adolescent mental health in order to understand more about the relationship between beliefs, attitudes and decisions to access Whirinaki CAMHS. Statistical data has been provided by CMDHB REAMHS, in an aggregated format, and inferences drawn from this data are presented. Qualitative data obtained from interviews with volunteer participants has undergone thematic analysis and the findings discussed in relation to the extant literature as reviewed in Chapter 2. This discussion is a critical analysis of the qualitative data findings and the extant literature in order to further our understanding of the influence Pasefika health beliefs and attitudes have upon access to child and adolescent mental health services. The limitations of this study and recommendations based upon the findings of this study and for further research will also be presented.

5.2. Summary of findings

5.2.1. Inferences drawn from the statistical data

Inferences drawn from the descriptive statistics indicate that the rate of Pasefika referrals increased over the 2009-2012 period at a rate greater than all referrals to Whirinaki for the same period. This result would be expected given that Pasefika within the CMDHB catchment are recognised as a youthful and fast growing population with 73% living in areas of high socio-demographic deprivation which is a significant risk factor for the development of mental health issues.

Also evident is the low access rates of Pasefika young people and their families to Whirinaki, approximately 0.53% per annum for the 2005-2008 period (Period 1) and 0.84% per annum for the 2009-2012 period (Period 2). This is significantly less than the expectation set by the MoH of 3% per annum of the CMDHB Pasefika child and

adolescent population. These low access rates demonstrate the importance of understanding this phenomenon in order for CMDHB CAMHS to meet the need of this population given the recognised mental health burden that Pasefika carry.

There was an increase of 8 months in the average age of Pasefika at referral from 12 years 8 months in Period 1 to 13 years 4 months in Period 2. This increase in age at referral is of concern as research specific to the mental health of Pasefika in New Zealand has identified that Pasefika have a tendency to present late to services, often when in crisis, and with a more severe form of disorder (Agnew et al., 2004; Bathgate & Pulou-Endemann, 1997; Tamasese et al., 2005).

The low rate of access to Whirinaki and the increase in age at referral between the groups suggests that despite the impact of; education, anti-stigma campaigns, increasing generation and acculturation, Pasefika beliefs and attitudes in relation to mental health may be largely unchanged. This factor along with how Pasefika recognise and define a problem may be factors contributing to the increase in age at referral and the low access rates.

It is pleasing to observe; a reduction in the percentage of referrals seen for 30 days or less and, an increase in the percentage of referrals that remained in treatment from 3 months to 12 months in the Period 2 data. 53.5% remained in treatment over Period 2 as compared to 48% over Period 1 for the 3 to 12 month time frame.

The reduction in the number of referrals seen for 30 days or less and the equivalence in the number remaining in treatment for 31 to 90 days between Period 1 and Period 2 further strengthens the assertion that more Pasefika have remained in treatment from 3 to 12 months in Period 2. Despite the data not being in a form that enabled further statistical analysis what can be inferred is that Pasefika engaged for a longer period of treatment with a Pasefika specific service provider, VT. This is not an unexpected result given the recognition that minority populations remain in treatment longer and have better outcomes when service providers are of the same ethnicity (Abreu & Gabarain, 2000; Duncan & Johnson, 2007; Farsimadan et al., 2007; Jerrell, 1997, Ziguras et al., 2003). This increased retention in treatment also suggests that the 'Pacific for Pacific by Pacific' approach to service delivery is having a positive impact.

The inference that the increase in treatment retention is due to service provision by an ethnically and culturally matched service provider needs to be considered with caution as there are other variables that may also account for this increase:

- Administrative processes to close a referral become lower priority for clinicians when there are high numbers of new referrals each week, this can artificially inflate the length of time in treatment. The 81.5% increase in Pasefika referrals for the 2009-2012 period over the 2005-2008 period suggests an increase in workload for VT clinicians. If there was an administrative delay one would expect to see an increase in the percentage of referrals for the 31-90 day time frame in the Period 2 data, a percentage increase in the Period 2 data over the Period 1 data for the 31-90 day time frame was not found.
- VT have an assertive approach to engaging referred Pasefika young people in treatment however an assertive engagement approach by culturally competent non-Pasefika clinicians may also be as effective. An assertive engagement approach was not a core aspect of treatment provision over the 2005-2008 period as Whirinaki provided a predominantly clinic based service. If families did not attend their arranged appointment or were unable to be contacted by telephone letters, in English, would be sent out. The lack of response to these letters would result in the referral being closed. The closure of a referral could occur within 30 days of the referral being received without the young person or their family having been seen.

5.2.2. What has been learnt?

Acculturation

The acculturation literature suggests that the process of acculturation causes an adaption to both the cultural values of the migrant and the cultural values of the host country. How adaption occurs is in part due to the acculturation strategy of the host country which determines the availability of acculturation strategies that the migrant can adopt. Migrants of the 1.5 and subsequent generations, on balance, have increased involvement with the host country's cultural values and acculturation agents as compared to the 1st generation migrants and therefore are exposed to factors that

significantly influence their rate of cultural adaptation. The impact of this rate of cultural adaptation can create intra-familial stress as 1st generation parents perceive behavioural and attitudinal changes within their children that are at odds with their cultural values from the homeland. Whilst not a causative factor on its own, intergenerational stress can contribute significantly to poorer mental health outcomes (Harker, 2001).

Migration and generation

The literature on migration and generation suggests that there is a healthy migrant effect, resilience to the potential mental health impact from the migration and resettlement process, for the 1st generation migrant however for the 1.5 and subsequent generations there is a gradual movement in their rates of mental health disorder to match those of the host population. This convergence in rates of mental health disorder becomes more evident in the 2nd and subsequent generations. Challenges associated with migration are increased when there is significant cultural distance, differences in language and social practices, between the homeland and the host country. These challenges are further exacerbated when the country of origin has a lower GNP to the country of settlement as migrants from poorer countries end up being housed in areas of high socio-economic need and are often not equipped educationally to obtain skilled positions in the workforce, or their qualifications are not recognised in the host country. Having a higher level of education at the time of migration is a protective factor against the development of a mental health issue for migrants and their children from countries of lower GNP (Harker, 2001; Montazer & Wheaton, 2011).

The participants for this study were of the 1.5, 2nd and 2.5 generations and self-identified as being of Pasefika ethnicity. The adult interviewees were of the 1.5 and 2nd generation and the adolescent interviewees were of the 2nd and 2.5 generation.

Pasefika holistic health belief model

The responses to the interviews suggest that the participants' collective understanding of well-being is congruent with Traditional Pasefika holistic health belief models

espoused in the literature (Chapter 2, pp.19-22), their combined responses identified the physical, mental, emotional, spiritual, cultural and relational aspects of health and well-being. Individually their responses seemed to be a step removed from these models.

Adult interviewees tended to comment about aspects of the models; the physical and mental, the physical and spiritual, the quality of the family environment. The adult that commented on the spiritual aspect of well-being has a position of responsibility within a Church whereas the other respondents who also attend Church did not acknowledge this aspect. These responses demonstrate the differences that are present in relation to how well-being is conceptualised among Pasefika and in relation to the literature.

The adolescent interviewees had a description of well-being that was introduced through the NZ secondary school health curriculum and seemed to be informed by Te Whare Tapa Wha, a Maaori holistic health model, which has close parallels to Pasefika holistic health models. The adolescents' responses did not include an understanding of the spirituality that underpins the model. An example of this spirituality within the Pasefika health belief models, from a Samoan perspective, is the concept of feagaiga, a sacred covenant that informs the nature of relationships between siblings and others (Efi, 2005).

Although interviewees acknowledged that well-being includes a mental aspect their notion of this mental aspect did not appear to be related to their concept of mental health; for them mental health was synonymous with mental illness.

Traditional beliefs

Traditional Pasefika beliefs ascribe the cause of behavioural problems to a breach of sacred covenants, feagaiga, which includes abuse within the family, or due to a spiritual transgression. Behaviours associated with Samoan spiritual illnesses or a relational breach can include; impulsiveness, behaving out of character; isolating oneself, violence (Bathegate & Polutu-Endemann, 1997). Although similar behaviours were described in the vignettes and interviewees' explanations included abuse within the home, none of the interviewees proffered Traditional beliefs as an explanation from their own or their parents' perspective. Equally none of the past service users

considered that their own referral to CAMHS could be explained from the perspective of Traditional beliefs.

This information suggests that through the process of acculturation and generation there appears to be a movement away from traditional understandings of problem behaviours and a disconnection from Traditional health belief models by the 1.5 and 2nd generation adults. This movement away may possibly be offset by the inclusion of the holistic health belief model as part of the secondary school health curriculum.

Even though adult interviewees did not provide explanations that fully aligned with Pasefika health belief models to explain the behaviours in the vignettes when asked how the older generation, their parents, would explain the behaviours these explanations did not appear to draw from these models either. The perception was the older generation would understand the behaviours to be discipline problems and address them as such. Although the adult interviewees recognised the vignettes described difficulties that would interfere with the young person's functioning the solutions to addressing the issues did not readily include referral to a CAMHS as an option.

Stigma

Traditional attitudes toward mental health issues were described by the interviewees as evoking feelings of embarrassment and shame because they are heavily imbued with stigma; therefore mental health issues were not something that would be easily accepted by their parents' generation. This idea is congruent with the literature which reports that Pasefika with traditional views experience mental health issues as stigmatising given the shame associated with a spiritual or relational offence as the causal explanation for the behaviour. Adult interviewees acknowledged the way their parents would explain and respond to the issues in the vignettes was not an approach that they considered useful and they also expressed views that stigmatised mental health issues. All interviewees perceived mental health as synonymous with mental illness.

This suggests that for Pasefika the concept of mental health is stigmatised, which may explain why mental health was not included in definitions of well-being and why CAMHS is not a readily recognised support option. The pervasive influence of stigma related to mental health issues does not appear to be solely transmitted via the family; societal stigma about mental health and mental illness appears to also play a role especially for the 2nd and later generations.

Barriers to access

All of the interviewees recognised that the young person portrayed in the vignettes was experiencing problems. For the adult interviewees the beliefs and attitudes that seemed to get in the way of making a decision to approach a CAMHS were influenced by:

- **Tolerance:** this appears to be an acceptance of a child's behaviours based upon the idea that they are just being a child. If over time there is no age appropriate modification of the behaviour then this is recognised as a problem however how it is explained informs the parent/family response. Explanations included 'its normal', 'naughty' or 'attitude'. Even 'excessive' behaviour when the child is younger can be explained in similar terms. These explanations are suggestive of solutions such as; doing nothing as it is normal, and using discipline if it is naughty or attitude, to address the behaviour. If these solutions are not effective then options for help, other than through informal networks, did not seem to be readily available to the interviewees. Family members with traditional views were considered more likely to 'normalise' the behaviour and if living within an extended family the influence of these family members may delay decisions to seek help.
- **Problem recognition:** despite the interviewees recognising the vignettes or their own behaviours, which resulted in referral to CAMHS, as being problematic the idea of CAMHS involvement was either not considered or came as a surprise when suggested by others. The decision to seek help is informed by the context of the problem, how it is defined and recognised, and the response from informal networks which can facilitate or impede the decision to access 'professional' services (Cauce et al., 2002). Beliefs about behaviour are informed by culture, personal experience and tolerance levels, children play up and adolescents develop 'attitude', there appears to be a gap in knowledge about what is 'normal' and when

to seek a 'professional' opinion. This suggests that CAMHS may be viewed as a place to go to for serious problems rather than for problems that are presenting at an earlier stage or lower level of severity but are still having a negative impact upon the child or adolescents functioning.

For those that were naïve to mental health services they did not seem to know that CAMHS was an option for support.

If CAMHS was suggested as an intervention by a person with appropriate authority such as a GP, Social Worker or, School counsellor and they provided a logical explanation then this suggestion is likely to be accepted.

- Self-reliance is a belief that interacts along with tolerance and problem recognition to influence the decision to seek help. The adult interviewees indicated that they would attempt to address the issues themselves; if they were having difficulty with this approach they would seek support from their informal networks which would have an influence upon what they would do next. It appeared that the notion of seeking professional assistance was a last resort and would likely occur via an approach to their GP, teacher or counsellor. Adolescent interviewees also expressed a belief that they had to deal with their problems themselves which was an idea that came from their family and from the wider society.
- Judgement and confidentiality was identified by adolescent interviewees as barriers to accessing psychological support. Their concerns about; being judged, how assured confidentiality is, will it work, will I feel better after meeting with a 'professional', act to inhibit decisions to seek support. These concerns are exacerbated by the notion of being self-reliant, having to deal with things themselves. What the adolescent interviewees have described mirrors what is reported in the literature about perceived barriers to mental health service access by young people (Gulliver et al., 2010). This suggests that the messages adolescents receive from society need to; counter the cultural messages in the family, reflect that help-seeking is acceptable and, endorse 'professional' helpers as being trustworthy.

Provider characteristics

As suggested by Andersen's (1995) model of health service access experience of the health service has an influence upon people's health beliefs and attitudes. The past

service users who were interviewed expressed concern about being referred to a MHS, which appeared to be informed by stigma; however once they had experienced the service their views changed. What appears to have supported a positive change in their beliefs and attitudes toward CAMHS has been an improvement in their well-being. They have experienced a successful treatment outcome and this was supported by interventions provided by Pasefika clinicians who demonstrated a non-judgemental approach and with whom the young people could identify. The mother of the adolescent client also acknowledged the improvement in her daughter and although she held reservations about MHS, prior to her daughter's involvement, she did endorse the service that her daughter received and opined that there are other young people who could benefit from this service.

5.3. Mental health as a Public Health issue

The World Health Organization (1998, p.3) defines public health as “the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society.” This definition does not place the role of ensuring public health solely with health services but includes the wider society, or community. It is clear from the participants' responses that increasing health literacy; the ability of Pasefika to recognise, manage, and prevent mental health issues, would address the health beliefs and attitudes that impact upon access to mental health issues identified in this study. The challenge with increasing health literacy again lies in the interaction of migration, culture, existing health knowledge, socio-economics, and language (Simich, 2010) although with the increasing number of NZ born Pasefika language is less of a barrier. Despite the challenges related to increasing health literacy for migrant populations what has been found to be effective is “using clear and multiple forms of communication, community-based development and delivery methods, and increasing cultural competence in providers of health and social services” (Simich, 2010, p.18).

The findings from this study suggest that mental health, well-being, and mental health issues are aspects of human experience that are not generally discussed within Pasefika families nor do these aspects appear to be well defined and understood. All

interviewees indicated these were not topics of general conversation within their families, if comments were made about mental health they tended to be pejorative. This again supports the idea of developing Pasefika specific mental health promotion and increasing health literacy.

Interviewees considered that 1st generation migrants tend to conceptualise problems in their children in terms of observed behavioural changes. Changes in behaviour that negatively impact upon the young person's role functioning and their relationships with others, tend to be explained as 'naughty' or 'attitude' and therefore deemed to require a disciplinary solution rather than involvement of a mental health service. The difficulty with this belief system is that for chronic behaviours such as the 'ula vale kid' the parents may not agree to access help when it is recommended because of this belief system. If the problem is seen as a sudden change in behaviour and explained similarly then a disciplinary response may exacerbate the young person's distress and also delay help-seeking. This suggests that definition and recognition of what constitutes a problem appropriate for a mental health service to assess is poorly understood in this sector of the community. Health promotion and health literacy that specifically targets this sector of the Pasefika population may begin to address the issue. This 'traditional' sector is more likely to be engaged in cultural systems of support and therefore accessible via these cultural institutions.

The adult interviewees' personal approach was less inclined to adopt an explanation that located the problem within the young person and they expressed a willingness to find out more and better understand what was going on. This suggests that Pasefika who have had a greater exposure to NZ acculturating agents are open to information about other ways of 'sorting things out', this is promising in terms of health promotion and health literacy strategies and interventions bringing about change.

What this study has added is the provision of 2nd and subsequent generation adolescent Pasefika beliefs and attitudes to mental health as well as the views of Pasefika elicited in response to vignettes about children and adolescents. Stigma and equating mental health with mental illness are issues that have as big an impact upon migrants with more traditional belief systems as it does upon NZ born Pasefika. The source of the stigma may have a different genesis for each group however its impact is

just as debilitating given it appears to be a pervasive belief across these generations. For those of the 2nd and subsequent generation the education system would appear to be the place for this sector of the Pasefika population to further develop their understanding of well-being, mental health and mental illness.

5.4. Recommendations

How a problem is explained and types of solutions offered may be a factor that is contributing to the low access rates and the increase in age at referral which has been identified.

Given the description provided by the adolescent interviewees about how their parents reacted to the suggestion of intervention from a MHS and in light of the information above; professionals need to be cognisant of how the suggestion of a referral to a MHS may be received. Rather than relying upon their authority to convince a family to engage with a CAMHS it is recommended that professionals:

- clarify with the family what their concerns are and how they explain the cause for the behaviour of concern
- explore with the family what it would mean to them to be involved with a MHS, address the stigmatising beliefs
- educate the family about what the behaviour may mean and the possible consequences, how it may impact upon their young person in the future, if it is not addressed.

It is our clinical experience that often families do not understand who we are, the explanation they have is vague, and often the referrer has not mentioned that we are a CAMHS; we get to be the bearers of 'bad news'.

This study has identified that the Pasefika holistic health models may not be as readily recognised in the community as they are among mental health professionals who have had it introduced as a basis for developing their cultural competence when working with Pasefika. That a holistic health belief model is being taught in the secondary school health curriculum is possibly a response that will reduce the rate at which this understanding of well-being is being eroded through the process of generation and

acculturation. Based upon information from the adolescent interviewees it appears that the relationship between mental health and well-being is not well understood and it is recommended that:

- holistic models of well-being taught via the health curriculum at secondary school include models from other ethnic groups as well as information about the spiritual foundations to these models along with information about what constitutes a spiritual breach and the attendant behaviours when someone is 'unwell'.
- the relationship between well-being, mental health and mental illness is explicated.

Given the participants' awareness of both the John Kirwan depression campaign (The New Zealand Herald, 6/8/2010) and the Like Minds Like Mine campaign (MHF, n.d.) it appears that these health promotion techniques are increasing peoples' knowledge of mental health issues, including Pasefika, although the impression from the interviewees is that these campaigns did not seem to strike a chord with them. This suggests that messages need to be tailored to engage with Pasefika and reflect mental health issues for children and adolescents as both of the aforementioned campaigns have an adult focus and convey an impression that mental health issues are serious. Therefore it is recommended that health promotion strategies and health literacy information that will increase Pasefika recognition, management and prevention of child and adolescent mental health issues:

- clearly articulates the relationship between mental health and well-being
- refrain from the use of academic language and diagnostic terms, and use "colloquial, values-driven, emotionally compelling language" as these messages are more effective (Robert Wood Johnson Foundation, Carger, & Western, 2010, p.5)
- develop messages that: describe behaviours; describe the impact of these behaviours upon others; mirror the family's concerns. This will assist with problem recognition and hopefully engage Pasefika as they will see themselves and their worries reflected in the messages.
- develop messages that promote mental health services as a normal aspect of health care, similar to and as important as a GP, as places of support and assessment if somebody is concerned or unsure.

What do the findings from this study suggest as a better way to present VT or CAMHS in a manner that is acceptable to Pasefika? As stigma remains a significant issue, could it be as simple as removing the word 'mental' from the title of name of the Service? The MoH (2012) identifies that challenges in a young persons' life are a risk factor for the development of mental health issues at a later stage. CAMHS is an early intervention that aims to change the developmental trajectory of vulnerable young populations away from one linked to later MH issues. As Pasefika have significant risk factors/vulnerabilities for the development of MH issues (MoH, 2012), letting parents/families know that it is ok to come in for a 'routine' check-up may enable early identification of potential issues and an appropriate intervention. It is recommended that:

- the word mental is not used to identify the Service
- Vaka Toa is located in the community with other Pasefika NGO providers in 'One-stop-shop' facilities which have drop in capacity for adolescents and fanau and are youth friendly
- Pasefika mental health clinicians provide a consultation and liaison role for community based services as a resource to discuss children and adolescents whose behaviour or social situation raises a concern for the other professionals involved. Examples of the types of community services include; Well Child Public Health nurses, Early Childhood Education Centres, Social Workers in Schools and Social Workers in Secondary schools, School Guidance Counsellors, Child Youth and Family Services.
- This type of service development occurs in conjunction with health promotion and health literacy strategies

5.5. Limitations

The limitations of this study include:

- being unable to recruit Pasefika who had received a service from Whirinaki from the 2005-2008 period to ascertain their views in relation to this study

- the language exclusion criteria, this meant that the views of new migrants and those migrants who had chosen a separation or marginalization acculturation strategy were not ascertained
- not recruiting any 1st generation Pasefika who had involvement with the Service in order to understand their experience and the impact of contact with a MHS upon their beliefs and attitudes in relation to mental health
- not recruiting any 3rd and subsequent generation Pasefika which will have provided information about how much attitudes and beliefs may have shifted toward mainstream views.
- the overall size of the sample, a larger sample over a longer time frame may have addressed some of the limitations above.
- being a member of the Clinical Team that has had clinical contact with the research population; has that created a bias in the analysis and the findings?

5.6. Concluding remarks – way forward and further research

Although health beliefs and attitudes, at an individual and family level, act to facilitate or inhibit access to health services the overall impression is that Pasefika are at significant risk of developing a mental health disorder due to the interaction of; migration, acculturation, generation, and cultural distance. It is unclear how prepared Pasefika migrants are for the actuality of migration and re-settlement especially in relation to their understanding of how acculturation may impact upon their born and yet to be born children. Although protective factors such as; education, connection with community supports, a nurturing parental style, good communication, employment, pro-active engagement with NZ culture and lifestyle, an integrating acculturation strategy, can mitigate the stresses of migration and settlement, being able to tolerate the behavioural and attitudinal changes that the children and grandchildren will undergo is something that may be difficult to prepare oneself for (Beiser et al., 2002).

The other significant stressor associated with migration would appear to be not achieving the goals of migration. These goals include better opportunities for self and

family and achieving upward mobility. The non-achievement of these goals will compound the psycho-socio-cultural stress for the migrant and their children, this increase in stressors can undermine the efficacy of any protective factors as well as hastening the transitional effect (Beiser et al., 2002).

Given the risk from migration and generation and, the stigma associated with mental health from both a traditional and generational perspective what are ways forward? Health literacy is touted as a response to address a number of health issues impacting upon Pasefika and engagement with Churches and other groups in which Pasefika are involved are strategies that have been utilised with some success (Northern DHB Support Agency Ltd, 2010). The strategy of accessing Churches and community groups however does not address how to increase the literacy of the segment of the Pasefika population that do not engage in this manner. This is possibly the most at risk Pasefika group, those potentially marginalised within both mainstream and Pasefika communities. In addition to these issues overcoming the stigma associated with MH issues still remains a significant challenge.

Ideas for further research include:

- Research that increases our understanding of the impact of migration, acculturation and generation upon Pasefika, what are the protective factors, what are the risk factors, in order to identify interventions that target new migrants to mitigate the impact of migration, acculturation and generation in relation to intra-familial and inter-generational stress.
- Repeating this study's methodology over a longer time frame with a team of interviewers and a larger nationally drawn sample to increase our knowledge of Pasefika health beliefs and attitudes in relation to child and adolescent mental health. This will build upon the knowledge that this study contributes to our understanding and identify other interventions and strategies to increase Pasefika access to mental health services.
- If any recommendations from this study are implemented then 'pre' and 'post' studies are undertaken in order accurately measure the effectiveness of the recommendation.

- Research to identify the factors that supported Pasefika young people and their families to remain in treatment, what worked and what didn't.

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Glossary

Assertive engagement – an active approach that Vaka Toa uses to engage with referred Pasefika. It entails use of Matua and Cultural advisors to broker first contact with the referred young person’s family. The preferred Pasefika method for doing this is face-to-face therefore Matua and clinicians go out into the community to meet with families, this may be done as an unplanned visit if the referral contact details are unclear. It is a process of engaging that seeks to reduce the socio-demographic and cultural factors that can act as barriers to service access such as; the lack of telephone, English as a second language, the lack of transport, indigenous beliefs in relation to mental health.

AUTEC – Auckland University of Technology Ethics Committee

CAMHS – Child and Adolescent Mental Health Service

CMDHB – Counties Manukau District Health Board

CMDHB Fofoa Committee – Pasefika clinical governance committee comprising of Pasefika clinicians, Pasefika Adult and CAMHS Mental Health management, and Matua from both Pasefika Adult and CAMHS; as well as the Mental Health Services General Manager and Mental Health Services Clinical Director.

CMDHB REAMHS - CMDHB’s Research Evaluation Audit of Mental Health Services team who provided the randomised sample of past service users to be approached to participate in the study and provided the statistical information for this study.

DHB – District Health Board

Fanau – Samoan word for family

GP – General practitioner, doctor.

Mana whenua – Maaori with a genealogical connection to a specific region

Matua – Pasefika elders who are respected members of their community

MHS – Mental Health service

NGO – Non- Governmental Organisation, community based organisations that provide services to the community that are not directly under the auspices of the Government.

NZE – New Zealand European – the dominant cultural group within New Zealand.

Pasefika – generic term to describe a person whose heritage links them to an ethno-cultural group from the Pacific region. This is also a term of self-identification people of mixed ethno-cultural heritage, Pasefika and ‘other’, may not identify as Pasefika. Variant of the word Pasifika.

Palagi – NZ/European

QD – Qualitative Description – methodology of the study

Rohe – geographical region defined by Iwi (Maaori tribal) boundaries

TA – Thematic analysis – method of data analysis

Talanoa – Pasefika process of discussion and debate to reach a point of understanding and agreement

Tapu – Taboo, sacred

VT - Vaka Toa, Pasefika specific CAMHS, a Team within Whirinaki – CAMDHB CAMHS. Vaka Toa is a multidisciplinary team staffed with Registered Nurses, Occupational Therapists, Registered Social Workers, Psychologists, a Pasefika Consultant Psychiatrist, a Cook Island Cultural Advisor, and a Pasefika Matua for cultural oversight and support of the Team

Whirinaki – CMDHB CAMHS, that consists of 2 mainstream child teams for those 4-12 years of age; 2 mainstream adolescent teams for those 13-19 years of age; 1 Maaori specific child and adolescent team; 1 Pasefika specific child and adolescent team. Both the Maaori and the Pasefika Teams are fairly recent developments over the past 5 – 6 years. Prior to the establishment of these ethnic specific teams all referred young people were seen by mainstream teams, Maaori and Pasefika clinicians will have been members of the mainstream teams.

Appendices

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Appendix A



27 November 2012

Helen Warren
Faculty of Health and Environmental Sciences

Dear Helen

Re Ethics Application: **12/276 An investigation of Pasefika access to the Child and Adolescent Mental Health Service within Counties Manuka District Health Board - The influence of health beliefs and attitudes.**

Thank you for providing evidence as requested, which satisfies the points raised by the AUT University Ethics Committee (AUTE C).

Your ethics application has been approved for three years until 26 November 2015.

As part of the ethics approval process, you are required to submit the following to AUTE C:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 26 November 2015;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 26 November 2015 or on completion of the project.

It is a condition of approval that AUTE C is notified of any adverse events or if the research does not commence. AUTE C approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTE C grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

A handwritten signature in black ink, appearing to read 'Rosemary Godbold'.

Dr Rosemary Godbold
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Fa'alia

Vaeau

vaeauf1@middlemore.co.nz

Appendix B

CMDHB Research Office
Room 253, Level 2
Clinical Support Building
Middlemore Hospital

21 December 2012

Dear Fa'alia

Thank you for the information you supplied to the Research Committee regarding your research proposal:

Research Registration Number: 1315

Research Project Title: An Investigation of Pasefika Access to the Child and Adolescent Mental Health Service Within Counties Manukau District Health Board – the Influence of Health Beliefs and Attitudes

Ethics Approval: Auckland University of Technology Ethics Committee

I am pleased to inform you that the Counties Manukau District Health Board Research Committee has approved this research with you as CMDHB investigator.

We wish you well in your project and require an update on how it is progressing. A copy of the progress report that is required by the Ethics Committee is sufficient, and should be submitted electronically to the **Research Office**.

Please note failure to submit the progress report may result in the withdrawal of institutional approval.

Yours Sincerely,

A handwritten signature in black ink that reads "S. Everitt." with a period at the end.

Dr Samantha Everitt

Manager Research Office

Counties Manukau District Health Board

Appendix C

Participant Information Sheet


Date Information Sheet Produced:

28/09/2012

Project Title

An investigation of Pasefika access to the Child and Adolescent Mental Health Service within Counties Manukau District Health Board - the influence of health beliefs and attitudes.

An Invitation

Kia ora, Talofa lava, Kiaorana, Malo e lelei, Fakalofa lahi atu, Bula vi naka, warm Pacific greetings.

My name is Fa'alia Vaeau, I am of Samoan / Palagi descent and born in Wellington New Zealand. I am a Masters in Public Health student with Auckland University of Technology (AUT).

I am inviting you to be interviewed by me to discuss your thoughts, beliefs, ideas and, attitudes about the mental health of children and teenagers.

Your participation in this interview is voluntary and you can withdraw from the interview and study at any time up until the last interview. If you decide to withdraw from this study all the information you have given me will be destroyed.

What is the purpose of this research?

The purpose of this research is to write a Thesis that meets the requirements of the Masters in Public Health offered at AUT.

There is also the possibility that the study will be published in an academic journal.

I hope that what we learn from what you and others have told us, about child and adolescent mental health, will help with the development of services for Pacific people that are more inviting to come to when people want help.

How was I identified and why am I being invited to participate in this research?

If you have been given this information sheet then you are known by someone I have talked to about my project and they think you would be a good person for me to talk to.

I want to talk with Pacific people who have not had to use mental health services. I want to hear what your thoughts are about this topic.

If you agree to be involved you can call me on 265 4043 or text me on 021 823 976 and I will call you to arrange a time to meet. Otherwise you can tell the person that gave you this information sheet and they will pass your contact details on to me.

What will happen in this research?

I will arrange to meet you at a time and place that is convenient for you. You are able to have support people with you at this meeting.

I will have some prepared questions that I want to ask you about your thoughts, ideas beliefs and attitudes about child and adolescent mental health. I will also ask you for some information about your ethnicity, where you were born and if not in New Zealand how long you have been in the country and what level of education you achieved.

I will ask for your permission to audio-record our interview.

I will also be interviewing other people and asking them the same questions. Once I have collected enough information I will review the information and then begin to write up what I have learned from what people have told me. The information you give me will only be used for this study. When I write my report you personally will not be identified however I may use the ideas you have shared with me in my report.

What are the discomforts and risks?

For some people, talking about mental health may bring up some unpleasant memories if this happens please let me know and we can stop the interview.

If you tell me anything about an individual or child being at risk of physical or emotional harm, I have an obligation to notify the appropriate authorities. In these cases, the process will be as transparent as possible and I will talk with the individual/s involved first.

How will these discomforts and risks be alleviated?

If any memories that have come up from our discussion continue to bother you, you can contact Whirinaki 09 265 4000 for free counselling or AUT Counselling Services 09 921 9992 for 3 free counselling sessions.

What are the benefits?

Potential benefits of this study are: increased understanding of Pacific beliefs and attitudes about child and adolescent mental health. This understanding may help in designing health services that are more inviting to Pacific people.

A personal benefit is that if I do this well I will achieve the qualification of Masters in Public Health.

How will my privacy be protected?

Apart from my Research supervisor, nobody else is involved in this study. I will be listening to the recording of our interview and I will be transcribing our words into a Word document. The computer file will be copied onto a memory stick and kept in locked storage.

Your written consent to be involved in this interview will be kept in locked storage with the Project supervisor at AUT North Shore Campus.

The audio-recording and the transcript of that recording will also be kept in locked storage with the Project supervisor at AUT North Shore Campus.

The Consent forms and the transcript of the recording and the audio-recording will be kept for 10 years. At the end of 10 years the papers will be shredded, the audio-recording will be erased and the computer file will be deleted.

I will not tell anybody that I have interviewed you for this study. I will not personally identify you when I write my report. I may use some of what we discuss 'word-for-word' in the report however I will not identify you specifically when I do this.

You are able to withdraw your consent to be involved in this study up until the completion of the last interview, all the information you have provided can either be returned to you or I can destroy it.

What are the costs of participating in this research?

On average I would expect an interview to take 1 hour it may take longer especially if you have a lot to say. If we do not finish in time I will negotiate with you how we can finish the interview.

What opportunity do I have to consider this invitation?

If you agree to be involved you can call me on 265 4043 or text me on 021 823 976 and I will call you to arrange a time to meet

I need to hear from you if you are willing to be involved. I will have completed my information gathering by 31 March 2013. I will not require any more volunteers after that date. Thank you.

How do I agree to participate in this research?

At our arranged meeting I will ask you to sign a consent form. I will also ask you to verbally confirm your consent to participate and record this on a voice-recorder.

Will I receive feedback on the results of this research?

If you wish to receive feedback on the results of this study I am happy to provide this to you. We can discuss the options how you would like the feedback when we meet for your interview.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Dr Helen Warren*, helen.warren@aut.ac.nz 921 9999 extn. 9679.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Dr Rosemary Godbold, rosemary.godbold@aut.ac.nz , 921 9999 ext 6902.

Whom do I contact for further information about this research?***Researcher Contact Details:***

Fa'alia Vaeau, vaeauf1@middlemore.co.nz 265 4043

Project Supervisor Contact Details:

Dr Helen Warren, helen.warren@aut.ac.nz 921 9999 extn. 9679..

Approved by the Auckland University of Technology Ethics Committee on 29 October 2012
AUTEK Reference number 12/276.

Appendix D

Participant Information Sheet


Date Information Sheet Produced:

28/09/2012

Project Title

An investigation of Pasefika access to the Child and Adolescent Mental Health Service within Counties Manukau District Health Board - the influence of health beliefs and attitudes.

An Invitation

Kia ora, Talofa lava, Kiaorana, Malo e lelei, Fakalofa lahi atu, Bula vi naka, warm Pacific greetings.

My name is Fa'alia Vaeau, I am of Samoan / Palagi descent and born in Wellington New Zealand. I am a Masters in Public Health student with Auckland University of Technology (AUT).

I am inviting you to be interviewed by me to discuss your thoughts, beliefs, ideas and, attitudes about the mental health of children and teenagers.

Your participation in this interview is voluntary and you can withdraw from the interview and study at any time up until the last interview. If you decide to withdraw from this study all the information you have given me will be destroyed.

What is the purpose of this research?

The purpose of this research is to write a Thesis that meets the requirements of the Masters in Public Health offered at AUT.

There is also the possibility that the study will be published in an academic journal.

I hope that what we learn from what you and others have told us, about child and adolescent mental health, will help with the development of services for Pacific people that are more inviting to come to when people want help.

How was I identified and why am I being invited to participate in this research?

You were identified as having previously been a client of Whirinaki Child and Adolescent Mental Health Services of Counties Manukau District Health Board before 31/3/2012. The CMDHB research department has randomly drawn your name from this group of past service users and you are being approached to participate in this research.

You are being invited to tell me about your beliefs, ideas, thoughts and attitudes about child and adolescent mental health because you were seeing somebody from Whirinaki. It is important for me to hear what you have to say.

If you agree to be involved you can call me on 265 4043 or text me on 021 823 976 and I will call you to arrange a time to meet.

What will happen in this research?

I will arrange to meet you at a time and place that is convenient for you. You are able to have support people with you at this meeting.

I will have some prepared questions that I want to ask you about your thoughts, ideas beliefs and attitudes about child and adolescent mental health. I will also ask you for some information about your ethnicity, where you were born and if not in New Zealand how long you have been in the country and what level of education you achieved.

I will ask for your permission to audio-record our interview.

I will also be interviewing other people and asking them the same questions. Once I have collected enough information I will review the information and then begin to write up what I have learned from what people have told me. The information you give me will only be used for this study. When I write my report you personally will not be identified however I may use the ideas you have shared with me in my report.

What are the discomforts and risks?

For some people, talking about mental health may bring up some unpleasant memories if this happens please let me know and we can stop the interview.

If you tell me anything about an individual or child being at risk of physical or emotional harm, I have an obligation to notify the appropriate authorities. In these cases, the process will be as transparent as possible and I will talk with the individual/s involved first.

How will these discomforts and risks be alleviated?

If any memories that have come up from our discussion continue to bother you, you can contact Whirinaki 09 265 40003 for free counselling or AUT Counselling Services 09 921 9992 for 3 free counselling sessions.

What are the benefits?

Potential benefits of this study are: increased understanding of Pacific beliefs and attitudes about child and adolescent mental health. This understanding may help in designing health services that are more inviting to Pacific people.

A personal benefit is that if I do this well I will achieve the qualification of Masters in Public Health.

How will my privacy be protected?

Apart from my Research supervisor, nobody else is involved in this study. I will be listening to the recording of our interview and I will be transcribing our words into a Word document. The computer file will be copied onto a memory stick and kept in locked storage.

Your written consent to be involved in this interview will be kept in locked storage with the Project supervisor at AUT North Shore Campus.

The audio-recording and the transcript of that recording will also be kept in locked storage with the Project supervisor at AUT North Shore Campus.

The Consent forms and the transcript of the recording and the audio-recording will be kept for 10 years. At the end of 10 years the papers will be shredded, the audio-recording will be erased and the computer file will be deleted.

I will not tell anybody that I have interviewed you for this study. I will not personally identify you when I write my report. I may use some of what we discuss 'word-for-word' in the report however I will not identify you specifically when I do this.

You are able to withdraw your consent to be involved in this study up until the completion of the last interview and all the information you have provided can either be returned to you or I can destroy it.

What are the costs of participating in this research?

On average I would expect an interview to take 1 hour it may take longer especially if you have a lot to say. If we do not finish in time I will negotiate with you how we can finish the interview.

What opportunity do I have to consider this invitation?

If you agree to be involved you can call me on 265 4043 or text me on 021 823 976 and I will call you to arrange a time to meet.

I need to hear from you if you are willing to be involved. I will have completed my information gathering by 31 March 2013. I will not require any more volunteers after that date. Thank you.

How do I agree to participate in this research?

At our arranged meeting I will ask you to sign a consent form. I will also ask you to verbally confirm your consent to participate and record this on a voice-recorder.

Will I receive feedback on the results of this research?

If you wish to receive feedback on the results of this study I am happy to provide this to you. We can discuss the options how you would like the feedback when we meet for your interview.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Dr Helen Warren*, helen.warren@aut.ac.nz 921 9999 extn. 9679.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, *Dr Rosemary Godbold*, rosemary.godbold@aut.ac.nz , 921 9999 ext 6902.

Whom do I contact for further information about this research?

Researcher Contact Details:

Fa'alia Vaeau, vaeauf1@middlemore.co.nz 265 4043.

Project Supervisor Contact Details:

Dr Helen Warren, helen.warren@aut.ac.nz 921 9999 extn. 9679..

Appendix E

Consent Form



*Project title: **An investigation of Pasefika access to the Child and Adolescent Mental Health Service within Counties Manukau District Health Board - the influence of health beliefs and attitudes.***

*Project Supervisor: **Dr Helen Warren***

*Researcher: **Fa’alia Vaeau***

- I have read and understood the information provided about this research project in the Information Sheet dated 11 February 2013.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-recorded and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including recordings and transcripts, or parts thereof, will be destroyed.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research (please tick one): Yes No

Participant’s signature:

Participant’s name:

Participant’s Contact Details (if appropriate):

.....

.....

.....

.....

Date:

**Approved by the Auckland University of Technology Ethics Committee on 27 November 2012
AUTEK Reference number 12/276**

Note: The Participant should retain a copy of this form.

Appendix F

Parent/Guardian Consent Form



Project title: *An investigation of Pasefika access to the Child and Adolescent Mental Health Service within Counties Manukau District Health Board - the influence of health beliefs and attitudes.*

Project Supervisor: *Dr Helen Warren*

Researcher: *Fa’alia Vaeaeu*

- I have read and understood the information provided about this research project in the Information Sheet dated 11 February 2013.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that I may withdraw my child/children and/or myself or any information that we have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If my child/children and/or I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I agree to my child/children taking part in this research.
- I wish to receive a copy of the report from the research (please tick one): Yes No

Child/children’s name/s :

.....

Parent/Guardian’s signature:

Parent/Guardian’s name:

Parent/Guardian’s Contact Details (if appropriate):

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 27 November 2012
AUTEC Reference number 12/276

Note: The Participant should retain a copy of this form.

Appendix G

**MEMORANDUM**

TO Fa'alia Vaeau

FROM Kevin Baker

SUBJECT Psychological support for research participants

DATE 9 August 2012

Dear Fa'alia

I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled:

An investigation of Pasifika access to the Child and Adolescent Mental Health Service within Counties Manukau District Health Board - the influence of health beliefs and attitudes.

The free counselling will be provided by our professional counsellors for a maximum of **three** sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to contact our centres at WB219 or AS104 or phone **09 921 9992 City Campus** or **09 921 9998 North Shore campus** to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and the option of online counselling on our website:
http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Yours sincerely

Kevin Baker
Head of Counselling
Health, Counselling and Wellbeing

Appendix H

Group 1 - Parents

Indicative questions

- How do you describe child well-being and adolescent well-being? What behaviours would you see that would demonstrate well-being?
- What does mental health mean to you?
- Describe for me the relationship between mental health and well-being?
- Where did this idea come from?
- You are contacted by the school for the second time, your 6yo son has not been doing as he is asked, he walks round the classroom and annoys other children, he does not listen to the teacher and he does not pay attention, at interval he has been involved in incidents where he has pushed or punched other children and made them cry.
 - What is your explanation for this behaviour?
 - Where do your ideas come from?
 - Are there any other possible ideas that might explain your son's behaviour?
 - Do you think his behaviour is a problem?
 - What are your ideas about how to address this behaviour?
 - How would your mother, father, g/mother, g/father, extended family explain your son's behaviour?
 - What advice would they give you about what to do?
 - If you did not like the advice from family and were unsure about what to do where would you go to get some advice?
 - If it is not a problem what would need to happen for you to think it could be a problem?
- Your 14yo daughter seems to be moodier than usual it seems that one minute she is happy and laughing the next minute she is crying, she has been like this for a couple of months. She gets irritated easily – has more arguments with her siblings, gets annoyed when asked to help round the house - previously she would help without fuss, her friends aren't coming round as often and she spends more time in her room, often she is asleep when you have looked in, she is eating more and is still going to school.
 - What is your explanation for this change in her behaviour?
 - Where do your ideas come from?
 - Are there any other possible ideas that might explain your daughter's behaviour?
 - Do you think how she is behaving is a problem?
 - What are your ideas about how to address this behaviour?
 - How would your mother, father, g/mother, g/father, extended family explain your daughter's behaviour?
 - What advice would they give you about what to do?
 - If you did not like the advice from family and were unsure about what to do where would you go to get some advice?
 - If it is not a problem what would need to happen for you to think it could be a problem?
- How does your child / adolescent behave for you consider there is a problem?

- What do you understand is the reason for this behaviour? Why do you think they act this way?
- Has the school ever contacted you about your child's behaviour in school?
- What do you think about the school's worries about your child's behaviour?
- When the school contacts you with worries about your child's behaviour what do you think is behind your child's behaviour?
- Do you think that they behave this way because of a mental health issue if not what is your explanation?

Demographics *(Participants are able to decline to answer any of these questions)*

Ethnicity	Number in the household		
Age	Adults 19 >		
Gender	Adolescents 13 - 18		
Number of years of education	Children 0 - 12		
Where born?	Number of bedrooms		
Number of years in NZ	Household Income > \$79,159	Y	N
	WINZ benefit	Y	N

Appendix I

Group 1 – Adolescents - female

Indicative questions

- What does the term well-being mean to you?
- How do you describe child well-being and adolescent well-being? What behaviours would you see that would demonstrate well-being?
- What does mental health mean to you?
- Describe for me the relationship/connection between mental health and well-being
- Where did this meaning/idea come from?

Your friend has strict parents who don't want her to have a boyfriend and they don't let her go out with her friends. She has told you that she is unhappy at home, she has big arguments with her parents about the way they treat her and she has started sneaking out of the house at night to meet up with other girls from the neighbourhood to drink in the park and meet up with her boyfriend. You have noticed that she has changed – she isn't focusing on her school work and generally seems unhappy.

- What do you think is happening for your friend? How would you explain it?
- Where do these ideas come from?
- Who would you talk to about what is happening for her?
- If you were to talk about this with your parents, g/parents, Aunts or Uncles how do you think they would explain your friend's behaviour?
- What advice would they give you?
- What explanation would your other friends have for your friend's behaviour?
- What would you do for your friend?
- Do you think your friend has got a problem? If she has got a problem where could she go for help?

Demographics *(Participants are able to decline to answer these questions)*

Ethnicity	Number in the household
Age	Adults 19 >
Gender	Adolescents 13 - 18
Number of years of education	Children 0 - 12
Where born?	Number of bedrooms
Number of years in NZ	Household Income > \$79,159 Y N
	WINZ benefit Y N

Appendix J

Group 2 – Parents

Indicative questions

- How would you describe child well-being and adolescent well-being?
- What does MH mean to you?
- What does child Mh and adolescent MH meant to you?
- What is the r/ship/connection between MH and well-being?
- Tell me about how your young person was referred to Whirinaki?
- What did you think about being referred to Whirinaki/Campbell Lodge? What did it mean to be referred to Whirinaki/Campbell Lodge?
- What did you understand the referral meant? What was the referrer concerned about?
- What is your understanding of child and adolescent mental health now?
- How does this understanding differ from your views of child and adolescent mental health before your involvement with Whirinaki/Campbell Lodge?
- How did your extended family and friends react when they knew Whirinaki/Campbell Lodge was involved? What did they say?
- What was their explanation for the reason of the referral? (A question about the communities understanding of the family's referral and explanation for the referral concerns)
- How would your child/adolescent be acting (what would they be doing) for you to consider there was a problem?
- What would be your explanation for this behaviour?
- Who would you talk to about your concerns?

Demographics (*Participants are able to decline to answer these questions*).

Ethnicity	Number in the household		
Age	Adults 19 >		
Gender	Adolescents 13 - 18		
Number of years of education	Children 0 - 12		
Where born?	Number of bedrooms		
Number of years in NZ	Household Income > \$79,159	Y	N
	WINZ benefit	Y	N

You are contacted by the school for the second time, your 6yo son has not been doing as he is asked, he walks round the classroom and annoys other children, he does not listen to the teacher and he does not pay attention, at interval he has been involved in incidents where he has pushed or punched other children and made them cry.

- What is your explanation for this behaviour?
- Where do your ideas come from?
- Are there any other possible ideas that might explain your son's behaviour?
- Do you think his behaviour is a problem?
- What are your ideas about how to address this behaviour?
- How would your mother, father, g/mother, g/father, extended family explain your son's behaviour?
- What advice would they give you about what to do?
- If you did not like the advice from family and were unsure about what to do where would you go to get some advice?
- If is not a problem what would need to happen for you to think it could be a problem?

Appendix K

Group 2 – Adolescent females

- How would you describe child well-being and adolescent well-being?
- Before you were referred to Whirinaki / Campbell Lodge what did MH mean to you?
- What is the r/ship / connection between MH and well-being?
- Tell me about how you came to be referred to Whirinaki / Campbell Lodge?
- What did you think about being referred to Whirinaki / Campbell Lodge? What did it mean to be referred to Whirinaki / Campbell Lodge?
- What did you understand the referral meant? What was the referrer concerned about?
- What is your understanding of child and adolescent mental health now?
- How does this understanding differ from your views of child and adolescent mental health before your involvement with Whirinaki?
- How did your extended family and friends react when they knew Whirinaki was involved? What did they say?
- What was their explanation for the reason of the referral? (A question about the communities understanding of the family's referral and explanation for the referral concerns)
- How would your friends be acting / behaving for you to consider they might have a problem?
- What would be your explanation for this behaviour?
- Who would you talk to about your concerns?

Demographics *(Participants are able to decline to answer these questions)*

Ethnicity	Number in the household		
Age	Adults 19 >		
Gender	Adolescents 13 - 18		
Number of years of education	Children 0 - 12		
Where born?	Number of bedrooms		
Number of years in NZ	Household Income > \$79,159	Y	N
	WINZ benefit	Y	N

Your friend has strict parents who don't want her to have a boyfriend and they don't let her go out with her friends. She has told you that she is unhappy at home, she has big arguments with her parents about the way they treat her and she has started sneaking out of the house at night to meet up with other girls from the neighbourhood to drink in the park and meet up with her boyfriend. You have noticed that she has changed – she isn't focusing on her school work and generally seems unhappy.

- What do you think is going on for your friend? What is your explanation for the change in her?
- Where do these ideas come from?
- Who would you talk to about what is happening for her?
- If you were to talk about this with your parents, g/parents, Aunts or Uncles how do you think they would explain your friend's behaviour?
- What advice would they give you?
- What explanation would your other friends have for your friend's behaviour?
- What would you do for your friend?
- Do you think your friend has got a problem? If she has got a problem where could she go for help? What comments do you have about being seen by a Pacific clinician, would you have preferred to be seen by a mainstream clinician?