Samoan families experience and interpretation of the person- and family-centred model of care in adult community mental health services.

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Abstract

This doctoral study explored Samoans’ experiences and interpretation of the person- and family-centred model of care delivery in specific mental health services in Aotearoa, New Zealand. The literature review presented here highlights the core principles of the approach; however, there is no clear definition of its application to care practice. A succinct history of healthcare in New Zealand, including an overview of the mental health services, provides an outline of the healthcare system as well as the establishment of specialised mental health services for Pacific people. In addition, a brief history of the foundation of Samoans’ ancient beliefs, values and existence provides an overview of participants’ worldviews and offers a rationale for their experiences of the research topic. The fa’afaletui cultural lens was applied to guide the study, and feedback was collected from six semi-structured talanoa group discussions with families who had been previously or were at the time engaged with mental health services. Moreover, a local stakeholder group was recruited to guide stages of the fa’afaletui. A total of 13 individual participants from six families participated. Participants consisted of four mothers, two fathers, five sisters, one son, and one husband. The research aim *What does the person and family centred care mean for Samoan families accessing mental health services?* was answered via the qualitative exploration and five themes were identified: (i) Fa‘atuatua ile Atua; Spiritual faith in God; (ii) It’s a hush-hush topic; stigma of mental illness; (iii) We are in the dark with our communication and dealings with the services; (iv) Practice what you preach; clinical service delivery misaligned with the model of care aim and vision; and (v) The values of alofa (love) and fa‘aaloalo (respect); enablers of positive experience. The findings overall highlight spirituality and religion as core to a Samoan’s faith in fostering resilience and healing when facing adverse mental health events with their family members. Also, the findings revealed spirituality as the foundation of the

Samoan culture where the person is identified with family, village, community, and others. In addition, the role of church affiliation is vital to nurture social connection and cultural wellbeing for Samoans. Moreover, there is a need to build up capacity for Pacific-staffed specialist services and a Pacific model to achieve equity and holistic care for Samoans and other Pacific populations at risk of adverse mental health outcomes. Also recommended is the need to raise awareness and to educate future and current mental health professionals about Samoan/Pacific cultural beliefs and values and how these can promote and strengthen quality of care for the person and their families.

Contents

List of Figures

List of Tables

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), 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.

Signed:

Date: 2nd December 2022

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Chapter 1: Background and rationale of study

1.1 Introduction

A popular expression both within Samoa and elsewhere is that there are just as many Samoans living overseas as in Samoa (Meleisea & Schoeffel, 2015). Widespread Samoan migration started in the early 1960s through to the 1970s, mostly to Aotearoa New Zealand (NZ) (Liki, 1994). As the number of Samoans increases in NZ, the demand for healthcare rises and, correspondingly, the need for mental healthcare services. This has created pressure on health authorities to formulate future planning and policy that recognise and embrace Samoan culture to accommodate the expected growth of Samoans needing mental healthcare. This study focusses on Samoan experiences of a family-centred model of care practice in adult community mental healthcare settings in Aotearoa, NZ.

Pacific people constitute 7% of the population of Aotearoa, NZ (Statistics NZ, 2018), and are a key section of society who have shaped the country's culture through sport, arts, music, academic, political, and types of social engagement (Samu & Suaalii-Sauni, 2009). Almost two-thirds of Pacific people are NZ born and the highest proportion of the population consists of those who are younger than 25 years old (Statistics NZ, 2018). Pacific people constitutes 16% of Auckland metro population in the Counties Manukau, Auckland, and Waitemata District Health Board (DHB) regions (Jackson & Minster, 2012). District Health Boards are now replaced by Te Whatu Ora Health, a nationwide healthcare organisation since July 2022 (Te Whatu Ora, n.d.). Samoans currently constitute the largest (47.9%) Pacific ethnic group in Aotearoa, impacting considerably on the characteristics of the overall NZ Pacific population (Ministry of Pacific Peoples, 2021). Half of the Pacific people residing in the Counties Manukau area are Samoans (50%), with 25% Tongan, 21% Cook Islands Māori, 8% Niuean, 4% Fijian, and other

Pacific being 3% (Counties Manukau Health, 2021). Counties Manukau is part of Auckland city and is divided into four localities: Māngere/Ōtara, Manukau, Eastern and the Franklin area (Counties Manukau Health, 2021).

Importantly, in 2018 the Pacific population was identified as having high health disparities, mortality rate and metabolic complications, and poor health outcomes when compared with the general population (Ministry of Health, 2020). In addition, in NZ, life expectancy for mental health services users is 20 years shorter than the general population from natural and external causes, and 70% of participants were younger under the age of 45 (Cunningham et al., 2014). The participants in Cunningham et al.'s (2014) study were 6.5% Pacific. Therefore, due to the Samoans being the highest ethnic Pacific group in NZ, the voices of Samoan families are invaluable in understanding the core cultural factors that both enable and pose barriers to Samoan/Pacific families seeking, engaging with, and experiencing long-term benefits from the mental healthcare services in Aotearoa, NZ.

This chapter presents the background to the study. The first part presents the rationale and significance of the study, challenges for Samoans accessing mental health services (MHSs), the aim and scope and the area of focus, and the researcher's positionality. This is followed by a brief introduction to the Aotearoa, NZ healthcare system and the history of the development of MHSs nationally and in Auckland. The third part describes the current Pacific cultural MHS delivery model. The fourth part provides an overview of the theoretical and methodological framework guiding the study and concludes with the study's contribution to Samoans in NZ and brief summaries of the thesis chapters to follow.

1.2 Rationale and significance of the study

World Health Organization (WHO) (2015) strategy has identified ‘person- and family-centred care’ and integrated health services as the guiding principles in the way health services are funded, managed, and delivered to meet the current global health needs. As a result, in NZ, healthcare reports and plans have prioritised person- and family-centred care as the focus of healthcare delivery in the region (Counties Manukau Health, 2019b; Taranaki District Health Board, 2014). Likewise, in MHSs, *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (Government Inquiry into Mental Health and Addiction, 2018) recommended care to be person and family centred to achieve quality outcome for consumers, which aligned with the *Blueprint II* focus for services in the region (Mental Health Commission, 2012). The incorporation of the WHO concept into healthcare, especially in mental health, indicates the preparedness of services to have a person-centred focus to address the increasing demands for healthcare and to reduce the health disparities of services users and their families. In fact, the Mental Health & Wellbeing Commission (2021) *Annual Report*’s strategic framework, in response to the Mental Health and Addiction Inquiry 2018 reinforced this change to ensure the voices of Pacific people are heard and their cultural holistic needs rightly addressed (Mental Health & Wellbeing Commission, 2021).

The Mental Health Survey 2003-2004 reported the Pacific population in NZ has the highest prevalence of mental illness (25%) compared to 20.7% of non-Pacific people. Cook Island Māori are most affected at 29.3%, followed by other Pacific at 25.5%, and Samoans at 24.5% (Foliaki et al., 2006). Furthermore, Pacific people also suffer the highest burden of the illness in NZ, with 25% reported to have a severe mental disorder that required a visit to a healthcare service (Baxter et al., 2006). In addition to this, life expectancy for Pacific is 76.6 years of age compared to 84.4 years of age of the general population. Socio-economic and demographic differences in accessing quality care contribute to the differences in mortality rate for this group when compared to the general NZ population (Mental Health & Addiction, 2017). Altogether, these statistics have highlighted the major challenges Pacific people encounter in Aotearoa, NZ that contribute to their health disparities and poor health outcomes.

Five years ago, MHSs in an urban Auckland region made a change to whole-system integration with the aim of taking the service to a 'new place'. The vision for service transformation was for the service user and family to be at the centre of care delivery to provide holistic health and wellbeing across the life course. Also, the change was to highlight the person and family as equal partners with health in care (Mental Health & Addiction, 2017). As a result, the demographic boundaries were shifted; new teams were created as well as major changes being made to the Pacific MHS role. Interestingly, these changes promised to integrate services, community, people, whānau, and family to achieve the goal of 'Healthy Together' which specifically targeted vulnerable populations such as Māori and Pacific as outlined in the *NZ Health Strategy* theme (Mental Health & Addiction, 2017). Hence, the purpose of this study is to explore and understand qualitatively the experience of this change from the perspectives of Samoan family consumers.

1.3 Background: Challenges for Samoans accessing mental health services.

Cultural values, beliefs and worldviews on health have considerable influences on Samoans' health-seeking behaviour and the utilisation of healthcare (Ministry of Pacific Island Affairs, 2011). The importance of respect and humility deeply influences Samoans' perceptions, experiences, and interactions with health professionals (Efi, 2009). In my experience as a Samoan, demonstrating these values during interactions and communication can be extremely challenging, especially when the dialogue is mostly conducted in English. In addition, a lack of understanding between non-Pacific health professionals and Samoan lay people in their encounters has been well documented, particularly how oral language is commonly misinterpreted (Fa‘alogo-Lilo & Cartwright, 2021; Taueetia-Su‘a, 2017). According to Efi (2009), Samoan language can use deliberate ambiguity or doublespeak intended to camouflage meaning and intentions. Therefore, the complexity of the Samoan way of communication is a challenge for Aotearoa health services in how to combine bio-medical, and largely westernised terms and understandings with more allusive and allegorical discussions expected and respected by the Samoan population in their clinical encounters (Efi, 2009; Mo‘a, 2015). This further poses an issue for Samoans in Aotearoa engaging in psychological therapy such as cognitive behavioural therapy (CBT) and counselling approaches (Ioane & Tudor, 2017).

Working in mental health, I have experienced and observed the challenges facing Samoans and their families, especially when assessed and case managed by non-Samoans, and this is an on-going concern for me. The ‘person- and family-centred care’ model (Mental Health & Addiction, 2017) was introduced with the intention of providing a Samoan/Pacific cultural normalisation of the collective and relational relationship between a person and family, extended family, village, community, and church (Efi, 2009; Suaalii-Sauni et al., 2009). Therefore, the culturally located voices, participation, needs and input of family should be included, heard, and accommodated and respected throughout the service users’ journey in services.

1.4 Aim and scope of study

This study is grounded in the fa’afaletui methodology approach (Tamasese et al., 2004), and conducted in urban MHS settings (in both adult community MHSs and allied Pacific non-government organisations (NGOs)) in Auckland, Aotearoa (see Figure 1). This study provides an opportunity to obtain Samoan family members’ perspectives on how the current ‘person- and family-centred care’ has been integrated into the care and what more is needed to transform the current MHS approach to Samoan service users and their families. Most importantly, a focus on what the cultural lens of the ‘self’ and family means for Samoans will help determine any barriers and enablers for Samoan-centred MHS delivery.

1.5 Researcher’s positionality

I was born and raised in Samoa and my sense of self was shaped in the village of Vailu’utai. Within my village there are systems in place, such as aualuma (ladies of the village) looking after the health and wellbeing, the leadership and decision making of Matai (chiefs), taulele’a (untitled men) serving the chiefs and the village, faletua ma tausi (wives of chiefs) for advice and guidance, faifeau (church priests) responsible for the village spiritual wellbeing, and tupulaga (youth). Importantly, health and wellbeing were a collective aspiration of the village, and collectivism, therefore, was a ‘way of life’ that helped me make sense of overall health and wellbeing.

Furthermore, my father was a devout Catholic. I attended Catholic schools from primary to secondary levels and attended mass consistently with my family. My father always offered the best produce of his plantation to our parish priests and offered to look after the church compound despite there being many available members. Catholicism has a very strong place in my life. My mother, on the other hand, was a traditional healer for infants and children called the fofo o le ‘ila’ (healing for the ila). Many parents not only from my village but also nearby always came to seek my mother’s healing before they consulted a medical doctor. My mother’s medicine was the juice of a young green coconut’s husk and body massages using a fagu‘u (coconut oil), and parents always came back the next day satisfied that their children had been cured. The co-existence of both religion and old Samoan traditions formed the foundation of how I understand spirituality and how pervasive this is in Samoan-born and raised people.

As a Samoan migrant, I understand the challenges of the way of life in NZ and how it conflicts with the traditional beliefs and upbringing of Samoan people, especially those from the islands. Samoans may find it difficult to communicate especially when seeking healthcare, not only due to understanding and speaking the English language but also for different perspectives on what ill-health means to them (Fa'alogo-Lilo & Cartwright, 2021). Also, before seeking healthcare, Samoans prefer to consult with each other first within extended families, friends, and church community for advice and support as they can relate to and understand each other. Therefore, cultural values and fundamental beliefs are very important to Samoans, and this has great influence on people's overall health and wellbeing (Suaalii-Sauni et al., 2009).

Working in mental health, my professional success has been grounded in my culture. However, within my 15 years' nursing experience, MHS has lacked the cultural support to strengthen cultural worldviews and beliefs in clinical practice for an Indigenous population such as Samoans/Pacific people. Throughout my clinical experiences, Pacific models of care were often mentioned and pledged in services' strategic plans and visions for Pacific people; however, there was no direct influence of this on outcome statistics and quality of care for Pacific mental health consumers. My profession and cultural experiences have enabled me to see models of care delivery that do not relate to or understand the nuances of the Samoan 'self and family'.

Therefore, this study is an opportunity to utilise my cultural and clinical experience to advocate for improved mental healthcare for Samoan and Pacific consumers, such as incorporating cultural worldviews and practices into care resonating with the Samoan/Pacific way of life. The experiences of the Samoan families participating in this study would bear witness to the fact that cultural values and beliefs are core to Samoans' holistic wellbeing, as well as the inseparable connection between the person and the family, village, community, and country.

Figure 1. Area of study: Map of Counties Manukau DHB region

Source: Boundary Maps: www.countiesmanukau.health.nz

1.6 Healthcare in Aotearoa, New Zealand

In Aotearoa, the recent *NZ Health Strategy* was set up as a platform for the government to identify its priority areas and goals in ensuring health services are focused and directed at areas with the highest need, to address health inequalities (Ministry of Health, 2000). A major focus was to acknowledge the Treaty of Waitangi principles, to improve the health status of those who are disadvantaged, and the active involvement of consumers and communities at all levels (see Table 1) (Ministry of Health, 2000).

Table 1. The *New Zealand Health Strategy*'s seven underlying fundamental principles, goals and objectives

1. Acknowledging the special relationship between Maori and Crown under the Treaty of Waitangi
2. Good health and wellbeing for all New Zealanders throughout their lives
3. An improvement in health status of those currently disadvantaged
4. Collaborative health promotion and disease and injury prevention by all sectors
5. Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
6. A high-performing system in which people have confidence
7. Active involvement of consumers and communities at all levels

Source: Ministry of Health, 2000, p. VII.

In addition, seven broad goals and objectives framework have been structured to address the broad range of determining factors in health (see Table 2), such as ensuring accessible and appropriate services for Pacific people, improving the responsiveness of MHSs, ensuring care is coordinated by health services with consumers and family preferences, and ensuring care that is safe in respecting people's rights (Ministry of Health, 2000). The goals and objectives revealed the government has finally identified Pacific people as a priority population, and the ministry's focus is to improve MHSs with an emphasis on care coordination with the person and family at the centre of healthcare delivery.

Table 2. The *New Zealand Health Strategy*'s seven goals and objectives framework

Goal	Objective
1. A healthy social environment	Eliminate social exclusion or discrimination against people based on their health status or disability.
2. Reducing inequalities in health status	Ensure accessible and appropriate services for Pacific peoples.
3. Maori development in health	Build the capacity for Maori participation in the health sector at all levels.
4. A healthy physical environment	Reduce the adverse health effects of environmental hazards.
5. Healthy communities, families, and individuals	Support and promote community development.
6. Healthy lifestyles	Minimise harm caused by alcohol and illicit and other drug use to individuals and the community.
7. Better mental health	Improve the health status of people with severe mental illness

Source: Ministry of Health, 2000, p. 18.

1.7 Overview of the structure of mental health services in Aotearoa

Over the past two decades, the mental health and addiction sector in Aotearoa, New Zealand has been guided by continuous national strategies and policies improving approaches to addressing the needs of service users and family (Mental Health Commission, 2012). Three core documents were published in the 1990s, the two versions of the National Mental Health Strategy in 1994 and 1997, and the Mental Health Commission's *Blueprint I* in 1998. These reports have influenced changes whereby mental health and addiction started to become the priority for the government. As a result, five core focus areas were identified as priorities: increase access to specialist services and grow sector capacity and infrastructure; strengthen the voice of service users in service development; shift of care with fewer people in institutions and more in recovery within the community; grow NGOs including Māori and Pacific providers; and put more funding into MHSs (Mental Health Commission, 2012).

From 1994-2005, the sectors focus was on 3% of people most severely affected and their specialist service providers (Mental Health Commission, 2012). Eventually, the focus was broadened beyond the severely affected and Te Tahuhu (2005-2015) mental health strategy and its action plan Te Kokiri (2006-2015) were published. As a result, the need for MHSs to be integrated into the wider health system and across social services was highlighted (Ministry of Health, 2021). This new model extends beyond the 3% of people who are severely unwell to include treating 5% with moderate to severe and 12% experiencing mild to moderate mental health issues (Williams et al., 2017). In addition, primary mental health and culturally appropriate services for Māori and Pacific were developed around this time (Williams et al., 2017), as well as Health Promotion campaign such as 'Like Minds Like Mine' and the Depression helpline (featuring John Kirwan) (Ministry of Health, 2021). These progressions and the growth of the MHSs showed services are adapted and moulded according to community need and the recognition of the need for cultural appropriate services, accessibility, and the individual rights of service users.

Indeed, Professor Mason Durie (as cited in Williams et al., 2017) signalled the progression of the mental health system as a series of waves: the first wave treated people in psychiatric institutions out of community sight, and the second wave (1960s-1980s) shifted toward the transition from institutionalisation to community care, thereby ending large psychiatric hospitals. The third wave (mid-90s to early 2000s) saw the development of community MHSs and the establishment of several NGOs (Williams et al., 2017). The fourth 'new wave', according to *Blueprint II*, raised the concept of an integrated healthcare approach covering mental health and addiction, physical health, and a person's social environment (Mental Health Commission, 2012; Ministry of Health, 2021). Overall, with prevention and early intervention as cornerstones of current MHSs, the aim of this change was to improve and support mild to moderate psychological conditions, preventing deteriorating mental wellbeing (Williams et al., 2017).

1.8 He Ara Oranga: Mental health and addiction inquiry

In 2018, the government published *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* from an inquiry which took place as a result of the widespread concern about services within the mental health sector (Government Inquiry into Mental Health and Addiction, 2018). The purpose was to hear the voices of the community on the government's current approach to mental health and addiction and what needs to change. In this review, Pacific peoples spoke of the lack of quality and described services they found to be hostile, coercive, culturally incompetent, individualistic, cold, and clinical. Pacific people suggest specific services delivered in 'Pacific ways' as a solution to many existing problems in supporting people and their families (Government Inquiry into Mental Health and Addiction, 2018). As a result, recommendations 20 to 25 of the inquiry highlighted people-centred care delivery (see Table 3). The recommendations direct the Ministry of Health to undertake initiatives that include service users with lived experiences, and to promote care delivery that support families and whanau to be active participants in care (Government Inquiry into Mental Health and Addiction, 2018). Altogether, these recommendations presented core strategies to promote person- and family-centred care; not only has it the potential to address concerns about MHSs but also to resonate with 'Pacific ways' addressing the holistic needs of Pacific people accessing MHSs.

Table 3: He Ara Oranga: Mental health and addictions recommendations 20-25

Place people at the centre **Strengthen consumer voice and experience in mental health and addiction services**
20. Direct DHBs to report to the Ministry of Health on how they are including people with lived experiences and consumer advisory groups into governance, planning, policy and service development.
21. Direct the Ministry of Health to work with people with lived experience, the Health Quality and Safety Commission and DHBs on how the consumer voice and role can be strengthened.
22. Direct the Health and Disability Commissioner to undertake specific initiatives to promote respect for and observance of the Code of Health and Disability Services Consumers' Rights by providers, and awareness of their rights on the part of consumers, in relation to mental health and addiction services.
Support families and whānau to be active participants in the care and treatment of their family member
23. Direct the Ministry of Health to lead the development and communication of consolidated and updated guidance on sharing information and partnering with families and whānau.
24. Direct the Ministry of Health to ensure the updated information-sharing and partnering guidance is integrated into: training across the mental health and addiction workforce, [and] all relevant contracts, standards, guidelines, quality improvement processes and accountability arrangements.
Support the wellbeing of families and whānau

25. Direct the Ministry of Health working with other agencies, including the Ministry of Education, Te Puni Kōkiri and Ministry of Social Development to: lead a review of the support provided to families and whānau of people with mental health and addiction needs and where gaps exist, [and] report to the Government with firm proposals to fill any gaps identified in the review with supports that enhance access.

Source: Government Inquiry into Mental Health and Addiction, 2018.

In fact, the recommendations aligned well with one of the Mental Health Commission's (2012) *Blueprint II* principles of a people-centred and people-directed approach in MHSs. This was focused on those who are not severely affected with the illness, but the impact of mental illness and addiction has significantly affected their ability to function normally in their usual environment. *Blueprint II*'s vision, 'Mental health and wellbeing is everyone's businesses', highlighted that every individual has a responsibility for protecting and improving their mental wellbeing. The implementation of this vision saw people and their family/whānau as active participants in planning and coordinating care that resonates with their need rather than the needs of those providing services (Mental Health Commission, 2012). Therefore, the Blueprint II person-centred principles and vision, and the recommendations from *He Ara Oranga* (Government Inquiry into Mental Health and Addiction, 2018) should be at the core of all MHSs' direction and should be reflected in the quality of care experienced by Pacific consumers.

1.9 Health and Disability Consumers' Rights

The Health and Disability Commissioner (HDC) is New Zealand Crown entity responsible for advancing and protecting health and disability consumers' rights. It is an independent custodian, providing a voice for consumers by resolving complaints and holding providers responsible for improving their practices at an individual and system-wide level. Also, its vision is for all healthcare services to deliver services with consumers at the centre, as highlighted by the ten rights of the Code of Health and Disability Services

Consumers' Rights (Health and Disability Commissioner, 2022) (see Figure 2). Therefore, the Code not only clearly highlights interconnectedness with the principles of person- and family-centred care, but also reaffirms the NZ Health Strategy, *He Ara Oranga*, and *Blueprint II*'s current core focus for all NZ healthcare providers, especially MHSs.

Figure 2: Ten rights of the Code of Health and Disability Services Consumers' Rights

1. To be treated with respect
2. To be treated fairly
3. To dignity and independence
4. To receive good care and support that suits your needs
5. To be told things in a way you understand
6. To be told everything you need to know about your care and support
7. To make choices about your care and support
8. To have support
9. To decide if you want to be part of training, teaching or research
10. To make a complaint

3

Source: Health and Disability Commissioner, 2022.

1.10 Mental health service delivery models

In 2017-2018, MHSs in urban Auckland developed a new integrated model of care enabling the workforce to respond to the needs of the population utilising their specialist skills and expertise. The aim of integration is for specialist mental health teams to work collaboratively and effectively in partnership with primary care providers and NGOs as part of the bigger virtual team (Mental Health & Addiction, 2017). Service transformation aims to provide for service users' and families' holistic health and wellbeing across the life course, as demonstrated by centring the service user, family, and whānau in care delivery. The development of integrated locality care roles was a key part of this movement with the focus on supporting primary care to provide holistic care that better responds to the wider health and wellbeing needs of the population in their communities. This was done with the hope that the integrated care model would enable specialist mental health providers and others to respond better to the needs of local communities (Mental Health & Addiction, 2017).

For instance, the *NZ Health Strategy* statement about being 'people powered and partners in health' (Mental Health & Addiction, 2017; Ministry of Health, 2000), and the regional healthcare organisation's Healthy Together 2020 strategy 'working with others to achieve equity in key health indicators for Māori and Pacific communities by 2020' has inspired the mental health and addiction whole-of-system strategy to identify four aims – see Table 4 (Mental Health & Addiction, 2017).

Table 4: Mental health and addictions whole-of-system strategy 2017-2018

Four Main Aims
1. An integrated model of care for mental health and addictions;
2. Locality-based integrated MH & Addictions care teams working alongside primary care to support physical and mental wellbeing;

3. Specialist district wide MH & Addictions services working with other parts of the health system;
4. Timely acute response with an improved service user experience, including family and whanau engagement, implement MH & A new after-hours triage and warm line service, and implement actions to reduce health disparity for Maaori and Pacific

Source: MH & A Business Plan, 2017-2018.

These strategies of the new service transformation have shown mental health and addiction services were committed to centralising person- and family-centred care and prioritising quality outcomes for Māori and Pacific people.

1.10.1 Current care delivery in community adult mental health services

The changes outlined above saw a new services configuration in the mental health structure including adult community services, with the services divided to serve community mental health (CMHC), acute, and district wide. As a result, in CMHC, major changes were introduced to the demographic care coverage of the teams, and a new adult CMHC was set up in the outer rural area as teams' catchment areas and boundaries were shifted. The main goal for this change was for services to be closer to people's homes, providing earlier intervention in a timely manner and improving equity for disadvantage population. People in need of services were to be referred from primary care (the GP), police, community organisations, emergency departments, and other healthcare services through the single point of entry managed by an acute team (Counties Manukau. n.d.). Overall, these changes were intended to ensure the new integrated model approach was more responsive to community need at the right place in a timely manner.

1.10.2 Transition of care between community mental health teams

Another process happening in the current service transformation in the community is the transition of care (TOC). The TOC occurs between all mental health acute community and integrated care teams across the age continuum. There are several reasons for TOC to happen (see Table 5).

Table 5: Purpose for transfer of care

1. SU [service user] is moved or placed to a different geographical area outside his/her service catchment boundaries,
2. When SU is discharged from inpatient unit to a new address,
3. Transitioning of care from child and adolescent to adult services,
4. Transitioning of care from specialised services who have specific timeframes of engagement.

Source: Counties Manukau Health: Transfer of Care Procedure (2017).

This process needs to be driven by the service user's need, goals, and aspiration. Meetings prior to this process need to be organised with the service user, family/whānau, clinical team, and others who are involved in care, and the decisions for transition need to be agreed by all. Successful transition includes appropriate support that needs to be in place ensuring the service user adjusts and adapts to their new situation (Counties Manukau Health, 2017). Therefore, all mental health practitioners are guided by the TOC policy and procedure ensuring CMH's agreed standards and best practice are maintained throughout the process.

1.10.3 The role of non-government organisations

In addition, the new MHS integration saw a major role for NGOs that operate independently from the government (Mental Health & Addiction, 2017). NGOs are set up on community, national and international levels to serve social, political, and humanitarian causes. Although not part of the government, NGOs rely heavily on public funds to support and fund their services. In NZ, NGOs have become an important part of healthcare organisations in providing social and political support for the community (Mental Health Commission, 2012). Examples of these groups are the Mental Health Foundation, Heart Foundation, Pathways, and various Pacific NGOs.

Examples of Pacific NGOs are Penina Health Trust, Emerge Aotearoa, Vaka Tautua, and others serving the Pacific population in Auckland, Waitematā, Waikato and other regions. Some are integrated partners with MHS and primary care practices, while others provide support to the wider Pacific community (Emerge Aotearoa, n.d.; Pathways, n.d.; Penina Trust, n.d.). The Pacific NGOs' role includes social and housing support for MHS consumers and their families, transport, food parcels, housing and accommodation, family support workshops, peer support, engagement, finding employment (Emerge Aotearoa, n.d.; Penina Trust, n.d.), support for older people, and people living with disability (Vaka Tautua, n.d.). Most support workers are Pacific who are also fluent in their ethnic Pacific languages. The vital contribution of the Pacific NGOs' role in providing social support for mental health consumers has made them valuable partners in health with MHSs. Importantly, the incorporation of cultural knowledge and languages contributes person- and family-centred values to the partnership.

1.10.4 The role of Pacific cultural specialist mental health services

As mentioned above, the person-centred care focus from *Blueprint II* saw the establishment of specialised mental health services for Pacific during 1980-1990s (Mental Health Commission, 2012). As a result, Pacific cultural specialist services were developed within District Health Boards nationwide, such as the Pacific service in the Auckland central area, and in west Auckland, and one service in the south Auckland catchment area. These cultural specialist services focus on providing holistic Pacific cultural and clinical services (Auckland District Health Board, 2019; Mental Health Commission, 2012; Waitematā District Health Board, 2019). Pacific MHSs have been set up for a range of reasons: improving access rates to healthcare for mental disorders (Kokaua et al., 2009), and addressing a gap in service provision that the mainstream MHS approach does not meet, especially in relation to children and youth (Bush et al., 2005). The development of Pacific services within MHSs in the 1990s was purposely fabricated to address gaps for Pacific, therefore, these Pacific services should be strengthened, allowed to flourish, and developed to fully meet Pacific consumers' needs. However, the new service integration change altered the role and direction of the current Pacific MHSs to providing cultural liaison support only.

In addition, the 1990s saw the introduction of the cultural safety movement by nurses in response to poor health outcomes for Māori, and the call for healthcare to recognise cultural worldviews of Indigenous people in care (Papps & Ramsden, 1996). The Pacific Fonofale health model was introduced around the same era, in 1995 (see Figure 3, below) (Pulotu-Endemann & Tu‘itahi, 2009). The Fonofale health model was developed due to the Pacific communities' consultation with the Ministry of Pacific Islands Affairs alongside the development of strategic directions for MHSs for Pacific Island people (Pulotu-Endemann & Faleafa, 2017). Pacific community leaders in this consultation identified the need for Samoan/Pacific people to access culturally based MHSs addressing key cultural factors (Suaalii-Sauni et al., 2009; Tamasese et al., 2004) underscored by the key principles of the Fonofale model.

1.11 The Fonofale health model

The Samoan traditional house concept is incorporated in to the Fonofale model with the floor, posts and circular roof promoting the holistic and continuity philosophy (Pulotu-Endemann & Tu‘itahi, 2009), based on the value of a Samoan's connection with self, family, and the universe (Efi, 2009). The foundation or floor represents the family, the roof represents cultural values and beliefs, the four posts (spiritual, physical, mental, and other – gender, sexuality, age, socio-economic status) connect the culture and family which are continuous and interactive with each other. Environment, time, and context represent the dimensions surrounding the Fonofale model that may have direct or indirect influences on people's views on health (Pulotu-Endemann & Tu‘itahi, 2009). What is demonstrated here is the vital role of family connectedness and the interrelated relationship of a Samoan individual when supported and encouraged in any relationship, concordant with the aim of person- and family-centred care.

Figure 3: Fonofale model

Source: Pulotu-Endemann & Tu‘itahi, 2009.

1.12 Matalafi matrix: A Pacific cultural formulation/assessment

In addition to this, a Pacific cultural assessment tool, the Matalafi matrix, a Pacific cultural formulation, is incorporated into MHS in Auckland. The Matalafi matrix was established from a project by Takanga a Fohe (Pacific mental health and addiction services) at Waitematā District Health Board in 2008 (Suaalii-Sauni & Dash, 2009). The project included a stocktake of available Pacific cultural assessment tools, assessed how Matalafi matrix domains align with DSM-IV, and conducted staff focus groups and interviews with key people. The Matalafi matrix Pacific cultural tool is accessible online and is part of the scope of practice of all mental health clinicians, being expected to be utilised for all Pacific consumers (Suaalii-Sauni & Dash, 2009). The Matalafi matrix Pacific cultural formulation tool is available in the mental health clinical records (HCC) electronic platform and is accessible for all health professionals.

The Matalafi matrix Pacific formulation tool focuses on six domains (see Appendix I). The first domain is aiga (family); this section focuses on any factors that have contributed to the person’s problem in their life. Second is tino atoa (physical); this section focuses on physical and medical reasons for presenting issues (effecting factors), such as physical presentations, changes in behaviours, and changes in interactions with others. Third is lagona (emotions); this section focuses on emotions and wellbeing, identifying any decline in emotional wellbeing, any changes in emotions and feelings, and ongoing negative symptoms of an illness. The fourth domain focused on aganu‘u (cultural); this domain links in with family but more traditional behaviours and ways of thinking including the values and beliefs of that ethnic group. The fifth domain is fa‘aleagaga (spirituality and religious beliefs); this domain focused on the impact of beliefs for a service user and their family, or the absence of spirituality, as not all Pacific families have religious views. The sixth domain is recommendations; this provides a summary of the assessment and come from the above summary and better engagement with Pacific (Suaalii-Sauni & Dash, 2009). Overall, the Matalafi matrix and the Fonofale health model are Pacific tools available to support clinicians and mental health professionals to identify and address the cultural issues of Pacific people, ensuring their holistic cultural needs are rightly addressed.

1.13 Current Pacific mental health services

Importantly, the adaptation of the Fonofale model approach and the Matalafi matrix tool have remained at the core of the new Pacific MHS despite changes brought about by the new service transformation. In addition, the vision for this new team was for it to be a centre of cultural clinical excellence in delivering evidence-based best practice for Pacific mental health. While aiming to increase engagement and participation of Pacific service users and their families, the Pacific service is also expected to support the integrated model of care by working effectively with primary care and NGOs. Also, the new Pacific team is responsible for enhancing the Pacific cultural clinical competence framework, supporting Pacific staff, and contributing to the strategy of growing Pacific workforce capacity and capability. In sum, the change in focus in 2017 of the Pacific MHS brought about by the new service transformation revealed major gaps for Pacific. This is due to the reduced capability of the Pacific team in terms of resources and clinical involvement in care versus the magnificent expectations and vision for the MHS to achieve for Pacific people.

1.14 The study's contribution to Samoan health and mental wellbeing

This study's aims were to benefit Samoan and Pacific people and their families accessing MHSs in Aotearoa, New Zealand. In addition, the study provided an opportunity to obtain Samoan family perspectives on how the current 'person- and family-centred care' has been integrated (if at all) and what more is needed to transform the current MHS approach to provide optimal care for Samoan service users and their families. Most importantly, a focus on what the cultural lens of the 'self' and family means for Samoans has helped determine barriers and enablers for engagement with the current Samoan MHS delivery. Moreover, the findings contribute Pacific-based empirical knowledge to inform healthcare services policy, structure, and care delivery on core cultural practices to be incorporated to benefit Samoan and Pacific people and their families accessing and engaging with mental healthcare in Aotearoa, NZ.

Importantly, the study provided an opportunity to develop and increase my knowledge and skills in research, in which I will continue to contribute to and advocate for quality mental healthcare for vulnerable populations such as Samoans/Pacific. Undoubtedly, this study will be a reward for me professionally as I will achieve a doctorate qualification when it is completed.

1.15 Theoretical and methodological framework of the study

This study has been guided by the fa‘afaletui methodology. Fa‘afaletui is a Samoan concept of communication where different representatives within the community come together to consult and discuss issues to find a consensus outcome that benefit the collective (Tamasese et al., 2004). Moreover, fa‘afaletui was an ancient Samoan school system of mentoring where the knowledge and mana of the mentor were transferred in the process (Efi, 2009). Fa‘afaletui is a way of life for Samoans, a way to connect and validate cultural knowledge within family, village and community facilitated by the values of alofa and fa‘aaloalo. Importantly, the fa‘afaletui concept is a Samoan cultural taonga shared equally by the researcher and participants; it has not only safeguarded the research process, but also added value to the findings to benefit current and future Samoan mental health consumers.

1.16 Summary

To summarise, this chapter provided background information about the study, including the history of the NZ healthcare system as well as the MHS delivery models; however, the content included was relevant and contextually linked to the research topic which provides the landscape of what is to follow. Also, the new MHS transformation of 2017 highlighted the changes and how the MHS has evolved and adopted the current person- and family-centred model. This study has explored and provided novel data on the experience of Samoan families’ engagement with adult community services with the aim of improving the person- and family-centred care model for Samoans and Pacific people, which is the focus of the recommendations.

1.17 Thesis chapter summary

This thesis consists of seven chapters. Chapter one has introduced the study topic and explained the rationale and significance of the research. In addition, a brief overview of the previous models of NZ mental healthcare delivery and a description of NZ MHS development has been provided. Also, an outline of services within adult community MHSs including Pacific mental health was included.

Chapter two includes contextual background information on Samoan ancestral spiritual and religious beliefs, the arrival and influence of Christianity in the Samoan culture, and how this has influenced Christianity today. It also provides a brief history of the development of Samoan aiga and Samoan migration to Aotearoa, NZ.

Chapter three is the literature review. Highlighted is the literature search approach and framework used to identify the literature that was included. Also mentioned is the identification of the gap in the literature and how the current study is relevant in addressing this.

Chapter four describes the fa‘afaletui methodology that was used to guide this study. The rationale in selecting this method including cultural epistemology and relevance is described in this chapter. The latter section of the chapter outlines the process of securing ethics approval, and the key approaches to collecting data, the analysis process and ensuring rigour.

Chapter five presents the findings including the demographic descriptions of each family fa‘afaletui and participants, and the key themes and subthemes. Chapter six is the discussion of the study’s main themes in detail, critiqued in the context of the relevant local, regional, and international literature.

Chapter seven includes the recommendations and conclusion of the study. It provides recommendations for practice improvement that include organisation and services leadership, policies, and professional improvement. Strengths and weaknesses are outlined as well as implications for future research and a personal reflection on my research journey.

Chapter 2: The Samoan cultural context

2.1 Introduction

This chapter presents a brief overview of Samoan cultural beliefs and traditions to provide the link between the research topic and study participants' worldviews. The chapter is presented in two parts. Part one outlines the foundation of Samoan contemporary beliefs, worldviews, and mental illness. Part two presents a brief description of Christianity influences on Samoan ancient tradition, and an outline of the key changes to the Samoan family in contemporary times, as well as outlines of Samoan migration to NZ.

2.2 Samoans' beliefs, worldviews, customs, and traditions

Samoa has been an independent state since 1962 with a population of approximately 169,000 people. Samoa is made up of two large islands, Savai'i and Upolu, and two small islands, Manono and Apolima (see Figure 4), and eight other small islands are also inhabited (Meleisea & Meleisea, 1987).

In Samoan ancestral history, God is Tagaloa-Lagi who was the progenitor of all living things. According to Samoan history, man is God-descended and there is a genealogical relationship between man and everything above and below the sky and earth. The relationship between these elements are governed by kin/family (Efi, 2005). In the origin of Samoans, according to the Tagaloa mythology, earth and all living organisms emerged from a 'big bang', the stirring division of Lagi (heaven) and Papa (earth). After the division, Lagi ascended to the heavens, Papa remained beneath Lagi. The Samoan name for planet earth is 'Lalolagi' referring to being beneath Lagi of the heavens (Filipo, 2014). Furthermore, Tagaloa, who made Papa and Lagi, also created man (Efi, 2009). In the creation of man, God Tagaloa first created the spirit, heart, will and thought, and jointly these made man intelligent (Meleisea & Meleisea, 1987). This mythology revealed the sacredness of a Samoan person’s connection and relationship with self, cosmos, environment, and the creator of his/her universe.

Figure 4: Samoa main islands Upolu and Savaii & small islands Manono and Apolima

Source: Istockphoto.com.

Importantly, as God Tagaloa’s creation, man and all living creatures (plants, moon, cosmos, animals, mountains, and others) are equal and are complementary of each other. There is sacredness and tapu in the boundary between man and all living things because of their shared divinity with God Tagaloa. In this way, man’s connectedness with the universe, with the environment and to each other is the foundation of collectivism and the holistic concept of wellbeing of Samoans (Efi, 2009). Overall, this ideology emphasises Samoan spiritual concept and practice that dominate every aspect of ancient Samoan life (Efi, 2009; Filipo, 2014; Mo‘a, 2015).

2.2.1 Ten levels of Samoan Indigenous religion and spirituality

In ancient history, Samoans’ spiritual heaven has 10 levels that people can aspire to achieve. Tagaloa-Lagi’s daughter Amoa resides in the ninth heaven and personifies the ‘feagaiga’ (covenant), and in the 10th heaven resides God Tagaloa the progenitor of all living creatures. In their quest for spiritual growth, Samoans can only attain the first nine heavens. To aspire to reach the 10th heaven demonstrates a lack of humility and wanting to be equal with the absolute God Tagaloa (Efi, 2014). Humility (loto maualalo) is a foundational value of the fa‘a Samoa, and to be humble is to have mental and emotional acceptance of a lower status, a concept important in the process of searching for peace and harmony (Efi, 2009).

Importantly, peace and harmony are seen when achieving the equilibrium of the four harmonious peace with self, cosmos, environment, and others (Efi, 2009). This concept describes man’s constant search for the greatest harmony of peace and humility, where Samoan Indigenous religion locates balance in all living creatures (Efi, 2014). It is the searching for these harmonies that gives significance, meaning and purpose to the self and to life for Samoans. To achieve peace and equilibrium with oneself means having good relationships, contributing to and playing one’s role within family, church, and community; and their absence can cause psychological disturbance and ill-health (Efi, 2009). Overall, the essence of peace and harmony deriving from the feeling of being connected, included, and contributing to the wider community is core to Samoans’ health and wellbeing.

Furthermore, to reinforce Samoans’ harmonious relationships, there are sacred concepts that fortify and affirm relationships. These concepts are tapu (taboo), feagaiga (sacred covenant) and tuaoi (boundaries); collectively, they create a persona of peace as understood by Indigenous Samoans who assume their significance in searching for harmony with self and others. The three concepts are the cultural protocols and ethics guarding and protecting the three core relationships of Indigenous Samoans (Filipo, 2014). These core relationships are firstly, between a parent and a child; second, between the brother and sister; and, thirdly, between the offender and the offended (Efi, 2009). In this case, peace and harmony are achieved for a Samoan when core cultural relationships are respected and protected by understanding and adhering to cultural protocols.

To demonstrate, firstly, consider the relationship between a parent and a child. The parents share a sacred relationship with their children that should be in harmony underpinned by love. For instance, the sacred spiritual bond between a mother and child shared from the womb, ‘O le au o matua fanau’ (the pinnacle of parent’s love is their children). Parents provide love and care and are responsible for their child’s affairs; on the other hand, the child is to obey, listen and respect. A parent and child relationship is shown by the power given to the parents to give blessings (fa‘amanuiaga) or enforce curses (malamatua) on their children (Efi, 2009) if they step out of line.

The second relationship is between a brother and a sister. This relationship is sacred, where brothers consider their sister the most important member of the family. She is treated with respect and words considered as rude and disrespectful are strictly forbidden in her presence. The sister is given the status of feagaiga (covenant), a role in keeping peace and harmony in the family (Efi, 2009). If angered and wrongly treated, the sister is likely to curse the brother and his children and, as a rule, her curses will be fulfilled (Steubel et al., 2010). Women’s status is special and different, and their roles are complementary to men in Indigenous Samoa. Child-bearing women produce new life and are sharing divinity with God (Efi, 2014). Therefore, the respect between the brother and sister in protecting this relationship is paramount and an important practice continued and protected within Samoan families nowadays.

The last relationship is between the offender and offended. This relationship is where the boundary between right/wrong, harm/good is pronounced. In Indigenous Samoa, justice is intended to restore family, village, and personal harmony. Punishments for committing offences were not directed towards inflicting any pain on the physical being but towards spiritual pain and suffering (Efi, 2009). Without a doubt, justice for Samoans through restoring culturally severed boundaries by forgiveness is spiritual healing where inner peace and harmony are facilitated by tofa fa‘amagalo (wisdom in forgiveness) (Filipo, 2014). In addition, there is the Samoan traditional practice of ‘ifoga’ (practice of seeking forgiveness), which seeks forgiveness and obtains formal apologies after an unfavourable event involving injury, death, or the verbal degrading of personal character or family honour (Efi, 2009; Filoiali‘i & Knowles, 1983). The ifoga usually happens at dawn and the perpetrator(s) covers their head(s) with fine mats and sit outside the victim’s house. When the victim or representative for the victim asks the perpetrator(s) to come into their house and the ifoga is received, the act is forgiven, and harsh punishment minimises (Filoiali‘i & Knowles, 1983). Importantly, the willingness of the supplicants to accept responsibility for the act and accusations are all at the core of a successful outcome of an agreement on the terms of forgiveness that undoubtedly anticipate the fa‘aleleiga (reconciliation) (Macpherson, 2005).

Altogether, the harmony of these three core relationships is the foundations of achieving the wholeness, peace, health, and wellbeing of every Samoan, and this should be understood, acknowledged, and addressed in healthcare assessments, especially in MHS.

2.3 Achieving individual spiritual holistic wellbeing.

For a Samoan, peace and self-actualisation is the harmony of three parts, the tino (body), mafaufau (mind) and agaga (soul), and this is facilitated by the practice of self-reflection of anapogi (self-denial) and moe manatunatu (dream dialogue) (Filipo, 2014). Tatalo and self-reflection/meditation through anapogi were tools favoured by Indigenous Samoan religion for encouraging mindset on the harmony of holistic wellbeing (Efi, 2009). The process of anapogi involves rituals of the evening, of self-denial, prayer, and meditation. One need to self-isolate from the village and family often in the stillness of the forest and evening; as a result, the person can reflect the harmonies gained from spiritual insight (Efi, 2009). In moe manatunatu, one would hold a dream dialogue with ancestors and family gods, and this would made available to man depending on the spiritual levels attained in the process of anapogi (Kelly, 2014). Indigenous Samoan beliefs know that through moe manatunatu and anapogi, the soul is fed. It is spiritual insight that helps to attain mental and physical harmony. The harmony of mind, body and soul helps the Samoan ‘self’ to achieve levels of spiritual harmony, personal peace, and healing (Efi, 2009; Mo‘a, 2015). In short, anapogi and moe manatunatu are spiritual healing processes to facilitate Samoans’ own personal healing without medical interventions, and this should be encouraged and incorporated in treatment plans for Samoans.

2.4 Traditional healing

Samoans have unique Indigenous healing practices and, according to ancestral history, healing is a process that is underpinned by the complementary relationship between man, gods, cosmos, sea, land, and environment (Salesa, 2014). Another form of traditional healing pertains to the treatment of laoa (choking on a fishbone), one of the common complaints of Samoans in the past due to their established fish diet. According to Efi (2014), the common treatment for this ailment involved the taulasea (healer) chanting to his/her significant god, facing the patient towards the wind or the sea or creating wind by fanning the patient’s face. The healing in this process identifies the spiritual and collective relationship between man, the sea, and the wind (Efi, 2014). I remembered as a child my father would tell the person with the laoa to place the fish backbone on top centre of the head and look towards the direction of the sea. A few minutes later, the laoa was healed. It was normal practice, and I never questioned the rationale around it; however, there was an expectation that this treatment would work. Now I realise that we placed a lot of faith in the absolute healing power of the complementary relationship between people, environment, and living things in Samoan traditional healing practices. Traditional healing practice shows not only how Indigenous religious beliefs are placed and manifest in traditional Samoan healing practice, but how religion fuelled daily Samoan wellbeing and how everyday Samoan existence filtered through religion (Salesa, 2014).

Importantly, the relational practice and collectivism of traditional healing are embedded in Samoan's psyche and widely practiced today. My mother was a traditional healer of children for many years until recently. I remember when parents brought their children over mornings and afternoons to our house. The treatment included body massage, my mother's chant and making a circle around the child's head while giving the child the liquid from a young coconut's husk. Her other healing treatment was the dispensing of the bark of a 'vi' tree for children's mouth burns, gutu malu. The following day, parents came back with positive feedback that the ailment of their children has been healed. At the time I was not paying attention but now I realise how the relational and collective spiritual practice of healing was performed by my mother and seen in the faith and trust shown by the parents. This relational mindset, I believe, enhanced the powerful healing relationship between the healer and the patient (Lui, 2007).

2.5 Samoan deities and divinities

In the Samoan belief system, spiritual deities have a history of nearly 200 years back into ancestral Samoa (Salesa, 2014). These are in the forms of ghosts, taula aitu (anchors of aitu), vaa o aitu (vessels of aitu), birds, fish, and animals. They travelled the wider cosmos forming unions, marriages, and close relationships with each other (Efi, 2009). Deities have specific roles and functions; for example, there is a god for the rain, guidance for war, and one who predicts the future. Special houses and spaces known as temples of the aitu were created for purposes of offering sacrifices. People offer gifts such as food by way of a request to aitu to keep diseases away, and for guidance and strength to fight wars (Steubel et al., 2010).

Additionally, there were/are deities specific to families and villages, tapu a fanua (taboo of the land) and they guard and look after the wellbeing of the family and village (Salesa, 2014; Steubel et al., 2010). The villages of Falelima and Palauli in Savaii have a male aitu (ghost) Nifoloa (long tooth); anyone pricked with this tooth will die unless a specific Samoan medication is applied (Macpherson & Macpherson, 2003; Mageo, 2012). This aitu wanders around Samoa and people who disrespect him will become his victims. Nowadays, Samoans still believe in the presence of Nifoloa and are very much frightened by it (Steubel et al., 2010). Interestingly, the presence of the Nifoloa is believed to have existed in other Pacific islands.

Moreover, the village of Manono used to worship the bird Matu'u and the village of Saleimoa worshiped the owl. These birds were tapu and not to be killed. As observed by one missionary, Samoan deities' wisdom could have great influence on people's social life over matters of restoring relationships, distributing, and receiving gifts, sense of direction or communicating with each other on matters pertaining to specific deities (Salesa, 2014). Altogether, deities played a vital role in Samoan ancient tradition and way of life, they were guardians with absolute wisdom to safeguard the health and wellbeing of Samoans. However, their presence gradually diminished after the arrival of the missionaries in Samoa (Gabbard, 2014; Macpherson & Macpherson, 2003).

2.6 Christianity and Samoans

Samoans' Christian conversion was established from within a profound and continuing dedication to the belief that supernatural beings had inhibited Samoa for a long time. Deliberate efforts were made by early Christians, Samoan converters, and foreigners to destroy images of Samoan gods and their sacred knowledge, practices, and places, to destroy and diminish their value (Efi, 2009; Macpherson & Macpherson, 2003). Accordingly, this was purposefully done to show the powerful presence of the Christian God (Salesa, 2014). Since then, Samoan gods and deities have become less common, and their role has changed within Samoan families and communities since 1830. Christians view Samoan divinities as obsolete, and not to be acknowledged, and have classified them as devils (Salesa, 2014). As a result, these deities' presence has become less frequent, and their roles devalued in Samoan societies.

Views brought by Christianity were integrated into the already established living and structural universe of Samoan contexts. As such, Samoan contemporary religion is based on the complementary relationship between Samoan Christianity and ancestral Samoan divinities. Samoan Atua and Christian God are both divinely inspired (Efi, 2009). The Christian church at first seemed strange to Samoans but the familiarity of the key principle of different churches to people already established belief in their gods aided the conversion (Salesa, 2014). He further described the interface between ancestral spirituality and Samoan Christianity as "Samoan became Christian and Christianity becomes Samoans" (Salesa, 2014; page 157). To Samoans, the relationship between church and God is the most sacred and the cornerstone of Samoans relationship known as feagaiga (the sacred covenant between brother and sister). The feagaiga also describes the relationship and connection between a faifeau (pastor) and the congregation (Salesa, 2014).

Nowadays, Christianity has a profound influence in Samoan culture and politics. In fact, the allegiance of God, customs and traditions are the three core values that are written into and pledged in the Constitution of Samoa (Meleisea et al., 2012). Also it is noted in Samoa's official government emblem motto 'Fa'avae ile Atua Samoa' (Samoa is founded in God) (see Figure 5), which signifies the fact that at the time of becoming an independent state in 1962, every Samoan belonged to an extended family and a village as well as having an association with a church or religious denomination (Meleisea et al., 2012).

Figure 5: Samoan independence state emblem and motto

2.7 The heart and soul of the fa'a Samoa

As mentioned elsewhere, Samoans do not view themselves as individuals; rather each person represents the many faces of self, parents, ancestors, village, extended family, church, and nation (Efi, 2014). Samoans are accountable not only to the living but to the dead (Efi, 2009). This essence of connection and belongings is explained by Tui Atua below.

> *I am not an individual; I am an integral part of the cosmos. I share divinity with my ancestors, the land, the seas, and the skies. I am not an individual, because I share a tofi (an inheritance) with my family, my village, and my nation. I belong to my family and my family belongs to me. I belong to my nation and my nation belongs to me. This is the essence of my sense of belonging. (Efi, 2009, p. 2)*

2.7.1 Saving face

In the Samoan culture, the notion of saving and protecting face is crucial to a Samoan person. As such, a Samoan individual is responsible and obligated to honour and protect not only his/her face, but those of parents, family, village, church, community, and country during interactions and conversation with others. These are facilitated by two important values of the Samoan culture: alofa (love) and fa‘aaloalo (respect) (Kelly, 2014). Fa‘aaloalo is a combination of fa‘a (the way of), and the two words alo and alo. Alo is a Samoan formal word for stomach, so alo alo is stomach to stomach or meetings of the frontal part of the body. Fa‘aaloalo therefore means, face meeting face, seeing face to face, alo atu (face towards), alo mai (face inwards) (Va‘ai, 2014). It is alofa and fa‘aaloalo that helps Samoans to maintain their responsibility in keeping the many faces that they are obliged to save and keep (Efi, 2009).

Samoan language possesses many meanings where allusion is used in social interactions with the intention of saving face (Efi, 2009). Individuals are responsible not only to self but also in protecting the mana of and respect for the people he/she represents (Efi, 2014). Samoans use humour and ridicule as a culturally acceptable way of ‘saving face’ in handling rejection or managing challenging situations. Tui Atua has identified the complexity of Samoan communication as a challenge for mental health services in how to combine westernised understandings with the objectives of allusive and allegorical discussions in clinical assessments (Efi, 2009).

Without a face-to-face meeting the essence of fa‘aaloalo disappears, resulted in a loss of face. Experiencing a loss of face during confrontations and challenging situations is stressful. Therefore, ongoing exposure to this experience can caused psychological distress, and a loss of face for Samoans cannot be taken lightly as losing face is a trauma which causes ongoing discomfort and psychological pain (Va‘ai, 2014).

In addition, to Samoans, experiencing mental illness is to be possessed by the spirits/ghosts (Suaalii-Sauni et al., 2009) as the consequences of disrespecting relationship boundaries and covenants with others, village, church, and family. Samoans as well as other Pacific groups often view mental illness and sufferings as a form of spiritual possession caused by disrespecting the ‘va’ (space) or breaching a sacred relationship and commitment between peoples or between peoples and their gods (Efi, 2009; Suaalii-Sauni et al., 2009). The sufferings/symptoms are often viewed as karma from the spirits and the universe teaching people lessons for disrespecting this sacred covenant with others (Efi, 2009). Overall, culture has a strong influence on how Samoans describe and comprehend ill health and leads them perceive certain signs, feelings, and symptoms of illness (Macpherson, 1990). Therefore, they view mental illness as shameful and un-Christian and as something that should not be openly discussed for fear of being ridiculed, judged, and stigmatised.

2.7.2 Courtesy and caregiving

The core demonstration of the Samoan values of alofa and fa‘aaloalo is the respect and courtesy given to their elders. This is shown by a young person giving up his seat for an older person on the bus, the older matai being given the chance to speak in meetings, or the elders of the family being served first at the table before younger family members. Nowadays, new ways of life and the change within the family and community dynamic has influenced how courtesy is played out for some contemporary Samoans (Efi, 2014). In addition is the essence of caregiving in the fa‘a Samoa**.** This describes the commitment of parents and family members in providing ongoing care and support for their loved ones with debilitating illnesses or disabilities. ‘E pele i upu, pele i a‘i, pele i aga, pele i foliga’ meaning fondly in spoken word, in feeding, in gesture, and in body language. The loyalty of family members to provide loving care despite the burdensome nature of such tasks is something Samoans willingly takes to heart (Efi, 2009). These Samoan practices reveal the commitment and obligation of people to show respect and love for the elders as well as providing care for their sick family members, as seen with families supporting their family members in mental health services.

2.8 The contemporary Samoan family

Although there are visible changes within family dynamics in Samoa, such as families owning freehold lands, nuclear families, single parents, and divorce, due to capitalism, the essence of relational practices and collectivism is still strong where people are identified with family, extended families, villages, and church. Some families are now residing in urban areas, but they remain attached to their usual familial communities in the villages.

However, for migrants Samoans living in New Zealand the family dynamic has changed profoundly. In the absence of villages and the lack of proximity of extended families, a Samoan family in NZ is mostly nuclear, consisting of parents and their children, with very few families living with relatives and grandparents. Instead of the usual connection and living side by side, families are now separated and have drifted away from each other. Without the presence of the village, church has now become the major connection for mostly migrant Samoan families where they can worship and practice their faith in Samoan language as they have done in the islands. Church provides a space for Samoan families to connect with other Samoans from their own or nearby villages. The sense of relational practices and collectivism of Samoans is observed by the attendance of people at church services on Sundays in most Auckland suburbs where Samoan and Pacific people reside. These behaviours reveal that the connections and communal lifestyles offered and found in the churches have provided comfort and sense of belonging for Samoans back home.

However, despite living away from home, Samoans in NZ and other countries overseas contribute considerably to Samoa’s economy through sending overseas remittances (Le De et al., 2016,). Samoans send remittances to support their families in so many ways, whether to support their immediate family, extended family affairs, or contribute to the village or church projects. This was further evidenced in a study of Samoans living in NZ by Le De et al. (2016) during and after the tsunami in 2009. The findings identified a sense of obligation and responsibility to assist families in crisis as the number one factor. Also, reinforcing social connections with the affected community was more rewarding than the struggle to meet their need financially. This is a notion that Albert Wendt described as a ‘double edge sword’ as one side affirms family and community ties whilst the other brought stressful circumstances (Wendt & Hunter, 1982). These practices, according to Efi (2009), are fulfilling the perception of life dominated by change in society driven by globalisation.

2.9 Samoan migration to New Zealand

Migrations of Samoans to Aotearoa, NZ is believed to have started during and after World War II, going by the minute increases to 164 people recorded in Census 1921, 592 recorded in Census 1945 and 2,995 according to Census 1956 (Fairbairn, 1961). According to Fairbairn (1961), Samoan migrants originally consisted of more of females than males, which related to the availability of light employment in textile manufacturing and food processing work at the time, but this had changed by 1951, and most migrants had a single status (Fairbairn, 1961). From 1960 there was an influx of more Samoans until 1970 (Wendt & Hunter, 1982) encouraged by the Treaty of Friendship between Samoa and New Zealand that was signed and formalised in 1962. During that time, Samoans did not need to register as ‘aliens’ when arrived in NZ. As a result, more than 2000 Samoans departed with six-months and three-month visas, and during this time in the 1960s the NZ economy was able to accommodate many Samoan workers (Meleisea & Meleisea, 1987).

Samoans concentrated mostly in urban Auckland where 82.3% of Samoans were recorded in 1956 (Fairbairn, 1961) and settled in areas of Grey Lynn and Karangahape Road

(Wendt & Hunter, 1982). Most worked as labourers in manufacturing industries such as textiles, food processing and machinery (Fairbairn, 1961). They were hard-working and worked from early hours of the morning and, according to a documentary made by Albert Wendt in the 1980s, Samoans had no idea what to expect when they migrated – all they knew was “New Zealand need us and we need to work” (Meleisea, 1987; Wendt & Hunter, 1982).

Consequently, Samoans craved familiarity and a sense of belonging in a new environment, and the church began to serve as a secure cultural base. Religion was central to their way of life and a chance for them to maintain dignity and a sense of self-control. With the absence of the village structure, the pastor became the leader and church became a community and held a crucial role in bringing people together. Church and ‘aiga’ (family) served as two anchors for Samoan settlement into their new-found home (Wendt & Hunter, 1982). Additionally, an intergenerational difference emerged between migrant Samoans and their NZ-born children. Young people started to experience a sense of rejection from society and from their own community, and often found their parents’ fa’a Samoa too strict. A notable event was the Dawn Raids of 1974 to 1976 which saw institutional racism blatantly inflicted upon Pasifika families (Anae, 1997). The Dawn Raids were series of operations by police where they randomly checked Pacific people on the street demanding their visa status, or the invasion of houses of alleged ‘overstayers’ at dawn (Fresno-Calleja, 2016). NZ-born youth began to feel anger towards society, creating their own aiga on the streets and joining gangs (Wendt & Hunter, 1982; Anae. 1997). The Polynesian Panthers are an example of how NZ-born youth mobilised based on this shared experience (Anae, 1997). Unfortunately, finding a sense of belonging and cultural identity is an ongoing challenge that our Samoan and Pacific youth face today.

2.10 Summary

In summary, this chapter has described the development of Indigenous Samoan cultural beliefs in brief, specifically in areas directly relevant to the research topic. Highlighted are the impact of the arrival of Christianity, migration, and capitalism that altered the landscape of Samoa's cultural practices and protocols. However, despite these influences, the strength of the bond of family and community connection through love, support and respect for others is paramount. The obligations to uphold these values are not only crucial to the health, mental health, and wellbeing of Samoans, but may also cause stressors and psychological unrest. Therefore, having an understanding and awareness of these cultural beliefs and their impact on Samoans' behaviour and engagement is vital for effective mental healthcare service delivery such as MHS.

The next chapter outlines the literature review. This includes the search process, and the methods used to collect and select the material, and the synthesis of the literature.

Chapter 3: Literature/Past Research Review

3.1 Introduction

This chapter presents a review of the relevant local and global literature on the person- and family-centred care approach in MHS. Also, highlighted in this review are the healthcare and health-seeking experiences of Samoan and Pacific consumers of healthcare in Aotearoa. The chapter is presented in three parts. Firstly, the person-centred care concept is introduced, based on the WHO and other available literature, and an outline of the applied research in this field. Secondly, the evolution of person-centred care from its inception to current theoretical framing in international healthcare and in healthcare in Aotearoa, NZ is reviewed. This is followed by a review of the emerging inductive research and more holistic access to person-centred care from Samoan, Pacific and other Indigenous first-nation perspectives. Lastly, there is a review of culturally based literature on what constitutes a Samoan person-centred 'self' and how this influences knowledge, health seeking and healthcare engagement.

The aim is to critically examine existing studies that explored, analysed, and evaluated the research topic to identified gaps in the knowledge. Due to the scarcity of studies conducted exclusively with Samoans both those living in Samoa and on Samoan migrant populations, the review includes on the general population, both migrant and non-migrant and on Pacific people, as well as grey literature to support a more comprehensive understanding and highlighting gaps in the literature.

3.2 Integrative review approach

This literature review follows an integrative review approach. Selecting this method allows the inclusion of experimental and non-experimental research to support a more comprehensive understanding of the review topic. There are five stages of the integrative review which are: problem identification, literature search, data evaluation, data analysis, and presentation. Firstly, the problem identification stage requires clarity on the problem that the study is addressing and the review purpose, considering the variables of interest and relevant sampling method (Whittemore & Knafl, 2005). This is followed by the literature search. The reviewer needs a well-defined strategy to enhance the search for literature to avoid bias and an incomplete search which can result in inaccurate outcomes. This stage needs to be focused on the review purpose and topic to enable the sorting of identified literature (Whittemore & Knafl, 2005). Thirdly, in regard to data evaluation, Whittemore and Knafl (2005) suggested that there is no gold standard for evaluating and explaining quality in research reviews; therefore, quality for an integrated review depends on the sampling frame of the study. The fourth stage is data analysis in data from primary sources is categorised and compared into an integrated outcome about a problem. The final stage is presentation and conclusion (Whittemore & Knafl, 2005). Overall, using the integrative approach allows the combination of data from theoretical and empirical literature to define purposes and the review of evidence on person- and family-centred care practice in mental health nationally and internationally (Whittemore & Knafl, 2005).

3.3 Approach to literature search

Literature was selected if it met the inclusion criteria of English language texts only, with the full text available and the text written within the past 15 years. Topics included were mental health, inpatient and community mental health settings, person/patient-centred care, family-centred care, schizophrenia, depression and anxiety, or mental illness; Samoan worldviews or perspectives, view, focus, ideas, concepts; cultural worldviews, health, and wellbeing; Samoan family or aiga, whānau; and Pacific Island family, Pacific family in Aotearoa, NZ. Items were excluded if they focused on other areas of mental health such as alcohol and drugs, intellectual impairment, healthcare development and other Pacific Islanders as opposed to generalised health.

After a comprehensive search of the literature and following the second step of the integrative review process, 37 empirical studies were selected from 462 papers identified from established databases that included the EBSCO Health database (CINAHL, Ovid Medline), Scopus, PsycINFO, and Google Scholar. Thirty of the articles were quantitative studies and six were qualitative studies. A total of 18 studies were conducted in Canada, UK, Finland, Sweden, United States, China, Taiwan, and Australia, three in Hawaii, two in Samoa, one combined study in Canada and New Zealand, and 13 in New Zealand. In addition, a comprehensive search was conducted of the grey literature appearing on the websites of the Ministry of Health, healthcare organisations, and Pacific health service providers, and hard-copy reports were searched for manually and obtained from healthcare organisations and New Zealand libraries. As a result, WHO reports as well as Ministry of Health and other NZ publications, and Pacific health reports are included in the review.

Three main themes supported by sub-themes emerged from the selected literature and health reports after following the third and fourth stages of the integrative review process: see Table 5. These themes are described and discussed in detail below.

Table 6: Themes and sub-themes in the literature

Theme One	**Theme Two**	**Theme Three**
The concept of person-centred care and application to mental health care.	The person-centred care approach in healthcare Aotearoa, NZ.	Collectivism, relationship, and social connection epitomise person- and family-centred care approach for Pacific people.
Sub-themes:	**Sub-themes**	**Sub-themes**
1. Good communication and inclusion vital to person-centred care approach.	1. Person-centred care approach in healthcare Aotearoa, NZ.	1. A sense of belonging and family wellbeing vital to Samoan/Pacific holistic health.
2. Training and support crucial to promote person- and family-centred care in mental health practice.	2. Human connection and understanding illness imperative to person-centred experiences in NZ healthcare practice.	2. The fundamental role of family and community involvement for Samoan/Pacific-centred approach.

3. Healthcare structure and systems need to be in place to support person- and family-centred practice.		3. Family knowledge and cultural status are important consideration in the person-centred care approach for Samoan/Pacific.
4. Positive outcome of person- and family-centred care in healthcare practice.		

3.4 The concept of person-centred care and application to mental health practice

The WHO’s (2015) strategy identified person- and family-centred care and integrated health services as the guiding principles in the way health services are funded, managed, and delivered to meet current global health needs. Central to this strategy is a vision of the future where healthcare is delivered and coordinated according to people and their families’ needs and preferences (WHO, 2015). More recently, WHO added key recommendations to promote a person-centred and rights-based approach to community MHS requiring services and systems to be more inclusive of the person’s holistic needs and to extend their focus beyond the biomedical model of care (WHO, 2021). In addition, in Aotearoa, NZ, *He Ara Oranga: Report of the Government Inquiry to Mental Health and Addiction* recommended placing consumers at the centre of care delivery (Government Inquiry into Mental Health and Addiction, 2018). In recent healthcare reports, various terms are increasingly used to describe this concept, such as person-centred care, patient and family/whānau-centred care, partnership in care, negotiated care and participation/involvement in care (O’Connor et al., 2019). However, there is lack of a universally accepted definition of what this concept means in practice, resulting in inconsistencies in its implementation (O’Connor et al., 2019). Finset (2011) suggested that when the clarification and elements of a concept are not clearly understood, the consequences are that practice is greatly flawed. Overall, person-centred care approaches seem to lack universal agreement are open to individual healthcare organisations' interpretation and application into their policies, procedures, and structures, as well as there being a lack of guidance on practical application to clinical care practices.

3.4.1 Good communication and inclusion vital to person-centred care approach.

Despite this, the selected literature illustrated that person- and family-centred care has been well incorporated into healthcare globally. For instance, a study conducted in the UK to explore the experiences of patients with dementia and their caregivers during hospitalisation for acute illness found although there were examples of good person-centred practices such as attachments and inclusion, the continuity of staff, lack of professional engagement and lack of time spent with patients prevented therapeutic relationship in care (Clissett et al., 2013). Another study, conducted at the developmental services at a children's hospital in Alberta, Canada, by MacKean et al. (2005), aimed to endorse the findings from a recent research project that challenge the growing common view of conceptualising family-centred care as shifting responsibilities to the family. Data was collected from focus groups and individual interviews with 37 parents and 16 health professionals. The results revealed parents preferred to be included and work collaboratively with health professionals to discuss and implement the care plan that addresses the child's holistic needs (MacKean et al., 2005). In addition, a study to evaluate the implementation of a family-centred care Baby One Programme (BOP), an Indigenous health worker-led programme for Aboriginals in Australia, was conducted by Campbell et al. (2018). Data was collected from semi-structured interviews with four families enrolled in the programme, 24 professionals, and focus group of 20 community members and two programme users. The findings highlighted that the value of the relationship formed between health professionals, especially that between Indigenous health workers and families, was core to the BOP programme (Campbell et al., 2018).

Collectively, these studies revealed that although there was no clear guidance as to the practice of the person- and family-centred care approach, the principles of person-centred care were clearly highlighted by healthcare consumers as core to their experiences of care.

3.4.2 Training and support crucial to promote person- and family-centred care in mental health practice.

Importantly, person-centred care has begun to be applied and critically evaluated in mental health research and practice. In this review, eight studies reported findings on the quality of the person-centred care delivered in various mental health settings: Beckett et al. (2013), Cheng et al. (2020), Gondek et al. (2017), Hsiao et al. (2019), Korhonen et al. (2008), Korhonen et al. (2010), Lee et al. (2018), and White and Unruh (2013). Firstly, while person- and family-centred care was considered the focus of care in clinical practice, especially when caring for children of service users, Korhonen et al. (2008) in Finland discovered that supporting families depended on the nurses' individual characteristics such as being a parent themselves and any further education completed on family therapy and family work. These factors were influential in the positive attitudes among nurses toward accepting and incorporating family-centred care in their practice. However, Korhonen et al. (2010) later argued that the reality of applying person- and family-centred care through including and meeting children face-to-face was problematic. In this case, the person- and family-centred approach was mostly limited to information discussed amongst the nurses involved and during professional meetings without the involvement of patients and their families. Therefore, these two studies suggested that family-centred care depends on health professionals' attitudes and, while it was documented on clinical records, the family and the person in care were omitted in practice (Korhonen et al., 2008; Korhonen et al., 2010).

Secondly, these studies by Korhonen et al. (2008) and Korhonen et al. (2010) suggested the importance of health professionals accessing relevant training such as family therapy, education, professional development, and ongoing support. Also, it was contended that there was an urgent need for the additional resources, such as nurses trained in family therapy, to strengthen and maintain initiatives that already promote patient- and family-centred care in practice to be present in mental healthcare to ensure quality health outcomes (Beckett et al., 2013; Lee et al., 2018; Hsiao et al., 2019, White & Unruh, 2013).

Moreover, a study focusing on child and youth mental health settings in the UK by Gondek et al. (2017) found an urgent need to implement person-centred care into professional development, and education programmes for all mental health professionals. This was supported by research into the first episode young adults' family members experienced as caregivers in the United States, with the findings highlighting the critical role of health professionals in supporting families to make sense of the unpredictable and non-specific nature of the illness, and to develop knowledge and skills in identifying and monitoring symptoms (Cheng et al., 2020). Overall, the studies supported the vital role of health professionals in promoting person-centred principles and incorporating them in their practices.

Furthermore, a study of families living with family members experiencing schizophrenia by Hsiao et al. (2019) in China identified that the levels of education of caregivers influenced the level of relapse and hospitalisation and overall family functioning. This suggests the need for evidence-based family interventions for nurses in assisting families vulnerable to the sequalae of mental illness (Hsiao et al., 2019). Similar findings were obtained in White and Unruh's (2013) study using semi-structured interviews with eight mothers of schizophrenia clients in Canada in which they discussed the devastating experiences such as seeing an adult child being tied down, repeated experiences of trauma, chronic sorrow and being tormented by what their children has been through. Although the authors recommended more research on this issue due to their small sample, they suggested the need for an improved method of knowledge translation to improve services for families (White & Unruh, 2013). Overall, this study has revealed important role of communication, information sharing and education to achieve a person-centred approach for consumers.

Another study comparing the views of adult patients with ADHD and bipolar disorder on aspect of ‘good care’ with scholarly viewpoints on person-centred care in the Netherlands found feedback from a patient focus group corresponded with the four intersecting dimensions of person-centred care found in the literature, namely ‘patient’, ‘health professionals’, ‘patient-professional interaction’ and ‘healthcare organisation’ (Maassen et al., 2017). The study highlighted the value of family inclusion, a non-judgemental attitude from health professionals, and patients’ holistic needs and strengths being included in care planning (Maassen et al., 2017). This was supported by an integrative review focused on the patient’s viewpoint on the meaning of person-centred care in perioperative nursing context in Sweden (Arakelian et al., 2016). Although the review’s focal point was not on mental health, the results are complementary with regard to respecting patients’ wishes, the presence of health professionals in attending to patients’ needs, and being allowed to be the person you are. These findings highlight that a training and professional development focus on the core principles of the person- and family-centred approach would add value in achieving equity and addressing health disparities for mental health consumers.

3.4.3 Healthcare structure and systems need to be in place to support person- and family-centred practice.

A key study explored the experiences of mental health staff in a specialist dementia unit within a substantial National Health Service Trust, assisting a metropolitan mixed ethnic population in the UK, to examine participants’ views about the improvement of person-centred care skills in practice (Smythe et al., 2015). Seventy staff members participated in a focus group to explore experiences on staff roles and dementia training, and 16 family members' observations of the quality of effective person-centred care from staff were explored to supplement staff feedback. The findings revealed that staff felt person-centred skills are already ingrained and part of their personal qualities. Moreover, successful means of learning were connected to learning on the job, from others and from experiences (Smythe et al., 2015). The findings have confirmed the success of the person-centred approach in practice depends upon health professionals' attitudes, choices, and collaboration with others, and this should be further supported by professional development and training programmes. This was endorsed by the findings of a multilevel study of mental health professionals and managers of mental health teams perceptions of patient-centred care in Québec, Canada. The study found the success of patient-centred care in mental health teams depends on effective interprofessional collaboration relationships (Durand & Fleury, 2021). However, a qualitative study to explore eight acute psychiatric nurses' approaches to and logical views of care of self-harmed patients in Ireland found the structure, nature and operation of the acute units prevented a patient-centred care approach despite their best efforts (O'Donovan, 2007). Overall, these studies have highlighted that, despite health professionals' optimal efforts to promote person-centred care in practice, the relationship with other providers and the structure, protocols and services guidelines are the barriers to incorporating its principles into practice.

3.4.4 Positive outcome of person- and family-centred care in healthcare practice

The literature review identified studies that evaluated person- and family-centred initiatives in MHSs in Taiwan (Lee et al., 2018), and Australia (Beckett et al., 2013), and assessed the importance of learning from patient- and family-centred care in services as achieving good outcomes for people. The study by Lee et al. (2018) in northern Taiwan compared a brief family-centred mental health programme (BFCC) with usual treatment for 47 hospitalised patients with bipolar and their families. The programme includes a 60-minute family discussion group about violence and suicide prevention, while the BFCC group provided individually tailored interventions through psychoeducation, and social and emotional support. The results showed the BFCC approach had positive benefits in family function (Lee et al., 2018). Another initiative was trialled in Australia by Beckett et al. (2013), in preparation for the opening of a new integrated MHS focusing on developing a patient/family-centred culture. This programme was facilitated by a series of 'away days' for the nursing team and the multi-disciplinary team. Five priority themes for family-centred care were outlined in the findings – person-centred care, personal recovery, strengths-based principles, evidence-based practice, and value-based care – and these are incorporated in a development plan (Beckett et al., 2013). Collectively, these studies highlight the key benefits of incorporating person- and family-centred care core principles into practice, such as involving family in clinical discussions, providing education and information, plus the active participation of patient and family in care. These factors have been shown to significantly impact service users' recovery, positively influences the level of relapse, and holistically address consumers' mental health needs.

3.5 Person-centred care approach in Aotearoa, New Zealand

While there is an absence of a globally established definition of the practical application of the term, the core elements of person-centred care are identified most frequently in NZ health publications and reports in ways such as: treating people with dignity and respect; good communication including access to information; involvement and participation of family, significant others and friends; access to care; emotional and physical support, collaboration; and coordination of care (Ministry of Health, 2000). Importantly, *Whanau Ora: Report of the Taskforce on Whanau-Centred Initiatives,* published in 2010 in NZ, developed the whānau-centred framework with the intention of providing opportunities for effective working relationship between government and Māori. The framework was an evidence-based plan aiming to strengthen whānau capabilities and an integrated approach to whānau wellbeing (Durie et al., 2010). However, an article by Boulton and

Gifford (2014) presenting the findings of two qualitative studies of Māori communities, which aimed to define the term ‘whānau ora’ and provide an analysis of the whānau ora outcome goals outlined by the Taskforce on Whānau-Centred Initiatives (2010), revealed a discrepancy between Māori whānau’s definition of what whānau ora represents and those of the policy document. The overriding Māori definition of whānau ora was achieving wellbeing of children and wider family members, such as being healthy and happy, incorporating cultural values, connection with others, a sense of duty and support (Boulton & Gifford, 2014). These reports and literature provided evidence that although the person- and family-centred care approach is recognised in Aotearoa, NZ, gaps are visible despite best efforts to incorporate its principles into healthcare structures, especially for Indigenous populations, if the voices of the person and families are not included.

Person- and family-centred care has been adopted in MHS in Aotearoa. For instance, recommendation 12 of *He Ara Oranga* (Government Inquiry into Mental Health and Addiction, 2018) proposed to improve MHSs by upgrading access and choice including designing and implementing improvements to create more people-centred and integrated services, and to support families and whānau to be active participants in the care and to understand their family member’s treatment (Government Inquiry into Mental Health and Addiction, 2018). Furthermore, the *Blueprint II* vision saw that ‘mental health is everyone’s business’ and, when incorporated in practice, saw people and their whānau as partners in care and support to be designed around their needs (Mental Health Commission, 2012). This is also aligned with the Health and Disability Commissioner’s vision that ‘consumers are at the centre of services’ and the 10-point Code of Health and Disability Services Consumers' Rights is in place to promote and protect the rights of consumers (Health and Disability Commissioner, 2022). Collectively, these NZ health reports showed support for a whānau-centred approach to be incorporated into healthcare practices where the patient and family's right to quality care that accords to their need should be at the core of healthcare service delivery in Aotearoa, NZ.

3.5.1 Human connection and understanding illness imperative to person-centred experiences in NZ healthcare practice.

As mentioned, a gap is recognised in the NZ literature in terms of studies that relate to person- and family-centred care in MHSs, whereas the international literature contains significant research in that area. However, several studies of person- and family-centred care exist in areas of older adults, dementia, and diabetes. An example is a qualitative descriptive study conducted in Canada and New Zealand and aimed at exploring the essence of care in older people and caregivers to identify the attributes of person-centred care (Kuluski et al., 2019). The attributes found were being heard, feeling comfortable and appreciated, easy access to health and social care, feeling safe, and being valued as meaningful. Participants were 172 older adults with multimorbidities who received community based primary healthcare. The study concluded that the quality of person- and family-centred care identified stretched beyond the management of disease, where being provided with clear treatment information, treated like a friend, and connected to a responsive provider were valuable to participants (Kuluski et al., 2019). This was supported by findings of a pilot study to evaluate person-centred care and dementia care mapping for long-term residents in a psycho-geriatric hospital in NZ (Bone et al., 2010). The pilot was intended to assess the effectiveness of the interventions, including daily activities, staff education, and environment adaptation. These were administered in four stages: baseline, pre-intervention, post-intervention, and one-month post-intervention. The findings revealed occupational and psycho-social interventions can enhance the quality of care and wellbeing of consumers living with dementia (Bone et al., 2010).

Moreover, similar results was found by a clinical audit to determine the effectiveness of the specific patient-centred intervention (GPSI Diabetes Service) that aimed to improve adults' diabetes care in a community-based clinic in NZ between 2008 and 2010 (Titchener, 2014). Participants attended 30-minute weekly appointments with a general practitioner and a nurse where they participated in a relatively diabetes-specific patient-centred framework consisting of six components. These six components are all focused on consumer education, one-on-one communication with health providers, and consumer empowerment. The findings were that NZ Europeans and Māori with type 1 and type 2 diabetes experienced an actual and sustained change in HbA1c (Titchener, 2014). Overall, these studies have highlighted human connections and education as major benefits in achieving person-centred care of patients and their families. Importantly, these NZ studies correspond with findings in international literature in identifying the core values of the person-centred care are related to the quality of care for healthcare consumers.

3.6 Foundation of Samoan/Pacific person- and family-centred care approach

As well as the lack of research on person- and family-centred care in mental health in NZ, studies focused on the Samoan/Pacific population are also limited. However, several Pacific-focused population studies have explored the general experiences of Samoan/Pacific people using mental health and other healthcare services (Bush et al., 2005; Enoka et al., 2014; Tiatia-Seath, 2014). Also, there has been research on cultural models of health (Samu & Suaalii-Sauni, 2009; Tamasese et al., 2004; Vaka, 2016), and on Pacific perspectives on healthcare and exploring the 'Samoan self' (Bush et al., 2005). These studies collectively highlighted core Pacific cultural values and beliefs that have a major impact on Samoan and Pacific people's relationships and connections with others. Importantly, the studies demonstrated that the person and family is an inseparable entity in the Samoan/Pacific cultural belief and consequently these studies are included in this review.

For instance, to investigate the influences of the Samoan culture and the appropriateness of mental health services in meeting people's needs, researchers Bush et al. (2005) and Tamasese et al. (2004) conducted focus groups with European psychiatrists working in adult community MHSs and exposed to Pacific cultural issues in clinical settings. In one of the studies, a detailed view of the Samoan 'self' titled in Samoan Ole Taeao Afua (the new morning) (Tamasese et al., 2004) was examined using a Samoan-centred mental health study to compare psychiatrists' and Samoans' perspectives on 'self'. The findings highlight distinct cultural differences between the Samoan perspective and the models of care in western-based psychiatry. As previously mentioned, Samoans value relationships with others highly. Individuals were found in this survey to be inseparable from the 'va' or relational space that manifests itself between self and parents, siblings, grandparents, uncles, aunts and extended family and wider community members (Tamasese et al., 2004). Therefore, Bush et al. (2005) pointed out that these surveyed psychiatrists felt incompetent in addressing Samoan holistic cultural needs such as spirituality and religion, which can hinder quality care for this group.

In fact, the role of spirituality in achieving wellness is central to the bio-psycho-social health beliefs of the Samoans, as found by Ihara and Vakalahi (2011) drawing from 20 Samoan and Tongan elders in Hawai'i who discovered that spirituality was a driving force in people's lives, providing strength to look after oneself and to serve others (Ihara & Vakalahi, 2011). The same researchers examined the effect of Samoans' collective worldviews and health (Ihara & Vakalahi, 2012), with the findings suggesting that health and fulfilment for the participants occurred when community norms of shared responsibility and reciprocity within their community were in sync. Church activities and senior groups are formed not only for social support but to support Pacific cultural groups and play a significant role in achieving good health (Ihara & Vakalahi, 2012). It was clearly demonstrated that although participants were from different Pacific ethnic groups, their views on health and wellbeing are similar and there are strong cultural influences on daily functioning (Ihara & Vakalahi, 2011, 2012).

In addition, to find appropriate cultural means to provide mental health interventions, Tamasese and his team in NZ not only developed a culturally based research method to examine Samoan views on mental health concerns but applied this approach to pinpoint cultural values and impressions that are crucial in clinical practice for Samoans using MHSs. Tamasese et al. (2004) contended that MHSs would need to change their current model of care to competently address Samoan fundamental ways of being – the relational self and spirituality (Tamasese et al., 2004). The authors suggested services need to incorporate Samoan beliefs and customs, the use of traditional healers and inclusion of family, churches and the communities where Samoan people reside (Tamasese et al., 2004). This was later supported by Suaalii-Sauni et al. (2009) when conducting focus groups on Pacific Islanders' experience on theory, practice, and the use of Pacific MHSs in NZ. It was also supported by Enoka et al. (2014) when exploring Samoan nurses' views about the Samoan philosophy of nursing; this study suggested that Samoans, no matter where they reside, need to access culturally appropriate care that facilitates health education and health-seeking behaviours to improve health outcomes. Altogether, these studies have supported the benefits of valuing and incorporating cultural approaches in care delivery for Samoans and Pacific consumers in NZ.

Indeed, this has highlighted the concept of cultural competency, as confirmed by Samu and Suaalii-Sauni (2009) in a study of 200 Pacific Island participants in which they collectively identify this competency as necessary to construct and strengthen the capability of MHSs to become culturally responsive services. Tiatia-Seath (2014), in her exploration of Pacific people's engagement with MHSs in NZ and Pacific strategies for suicide prevention, drew on Samoans aged between 18-59 years of age who had attempted suicide and/or held a suicide ideation and were registered with MHSs. The study found participants preferred a culturally based, family-centred approach rather than a clinical focus in the first instance of seeking help. This ensured a secure and effective engagement with Samoan/Pacific people. Overall, the findings raise issues about the cultural competency preparedness of health professionals when caring for Samoans, and the important role of families (Tiatia-Seath, 2014).

3.6.1 A sense of belonging and family wellbeing vital to Samoan/Pacific holistic health.

In the Samoan Indigenous context, health and wellbeing is achieved when peace and harmony are present through the balance of four key harmonies: harmony with the cosmos, harmony with the environment, harmony with others, and harmony with self. All four need to be in balance and complementary to each other and all living things to ensure equilibrium and sense of self-actualisation (Efi, 2009). However, stressful situations, anxiety and trauma can disrupt this balance such as the effect of migration and the loss of identity. Research by Kokaua et al. (2009) investigated the differences in the 12-month prevalence of mental disorders and 12-month treatment contact among NZ-born Pacific people and Pacific migrants in the NZ Mental Health Survey. Results showed that those who migrated as adults had a lower prevalence of mental disorders when compared with NZ-born Pacific people and those who migrated as young children (Kokaua et al., 2009).

In addition, there is the burden of increased responsibility for immediate and wider family obligations for young Pacific fathers in NZ, as outlined by Tautolo et al. (2009) in their investigation. The authors investigated the prevalence of potential psychological disorder amongst new Pacific fathers over their child’s first six years of life. The team were motivated by the lack of research and data concerning the health and wellbeing of fathers, specifically Pacific fathers. The results suggested that although most fathers reported good health and wellbeing at 12 months, symptoms increased at two years and six years which was significantly associated with the risk of developing mental disorder for this group (Tautolo et al., 2009). The study highlighted the need for support for this group as positive fathering promotes resiliency and improves mental wellbeing amongst the young Pacific generation, resulting in improving mental health statistics for this population. In sum, these studies confirmed a Samoan/Pacific person's connection and obligation to family and community has a major impact on the individual's holistic wellness and health. It has indicated while person-centred care was developed in western-centric contexts globally, the Samoan and Pacific interpretation is collective, communal, and connection- and relationship-based, and the person represents the family, extended family, church, and the wider community.

3.6.2 The fundamental role of family, community, and church involvement for a Samoan/Pacific-centred approach

Importantly, the literature review also revealed how Samoans living in host countries such as NZ navigate between different worlds when it comes to ill-health. In their phenomenological study, Norris et al. (2009) examined the experiences of Samoans living in NZ in navigating ill-health between western and cultural patterns. The results suggested that Samoans used to experiment between the two systems to establish the kind of illness they possessed. The authors implied that the interpretation of symptoms for Samoans and proposed treatment needed to involve family as the consensus of the family often overruled what an individual believed about his/her illness (Norris et al., 2009). This suggests important implications for Samoans and people from other cultures where family plays a vital role in decision making, thus influencing quality of care (Norris et al., 2009). Norris et al. (2011) explored Samoan views about antibiotics, showing that Samoans surveyed were confused between the nature of pain and of infection, and believed antibiotics were painkillers, which may reflect the clash between western biomedical and cultural views on illness (Norris et al., 2011). The findings revealed culture beliefs and family shared knowledge about health have very strong influence in how people interpret ill health despite of where they are in the world. Therefore, having awareness and understanding about ‘person- and family-centred care’ core principles were vital in addressing health disparities for this population group.

In addition, to explore the influence of the Samoan culture in health promotion, McCarthy et al. (2011) utilised the fa‘afaletui framework in one Samoan community in Australia to address language and culture barriers, as well as to increase awareness of factors contributing to kidney disease, by way of semi-structured group interviews which were conducted with Samoan families. Findings showed that diet and exercise were of concern, and health promotion was needed to focus on the collective interventions such as incorporating the village, church and family and seeking leaders such as ‘matai’ within these communities for support. Awareness of cultural protocols, ‘tapu’, such as leaving shoes at the door when entering Samoan houses and always taking a seat before speaking, are vital. Additionally, the use of Samoan language in workshops in churches or community gatherings or the use of local Samoan radio to deliver health messages was important to improve health outcomes (McCarthy et al., 2011).

Likewise, this notion was supported by another Australian study by Ndwiga et al. (2020) when evaluating the outcomes of a church-based lifestyle intervention amongst Samoans in Sydney in a study titled the “Le Taeao Afua Diabetes Prevention Program.” The programme was facilitated and delivered by community coaching and peer support to prevent Type 2 diabetes and promote self-management, and HbA1c was measured before delivery and 3-8 months post-intervention. Results showed a structured church-based and culturally tailored lifestyle programme produced some improvement in diabetes risk among Samoans (Ndwiga et al., 2020). Similar findings were obtained by Puaina et al. (2008) in the United States, in a study to exploring whether traditional aspects of Samoan practices might influence cancer prevention and also whether specific elements of the culture could be incorporated into screening programmes to improve compliance. The findings showed that knowledge of disease prevention was lacking and not a priority for

Samoans. What they suggested was that any prevention programmes targeting this group should seek the input and influences of matai (chief) and faifeau (pastor) in engaging with cancer prevention (Puaina et al., 2008). Collectively, these studies have highlighted the positive influences of incorporating cultural approaches and community involvement to connect, communicate with and educate Samoan/Pacific people about ill-health. These findings resonate with the way Samoan/Pacific people think, act, behave, and respond to any given context, which are core characteristics of person- and family-centred care for Samoans.

3.6.3 Family knowledge and cultural status are important considerations in the person-centred care approach for Samoan/Pacific people.

The literature also explores Samoan views on ill-health and cultural influences on how they interact with and accept treatment within healthcare. A study in Australia by Shahab et al. (2019) explored the experiences and perceptions of Samoans living with diabetes and their families. Twenty Samoan migrants took part in interviews with findings showing that Samoan culture plays a significant role in how people behave and respond to their health risks. Food was part of the social structure of Samoan community and communal eating, where providing large portions of calorie-dense food during important events such as weddings and church occasions is often associated with flaunting the self-worth and pride of the family hosting the event. Additionally, due to the pride inherent in the Samoan culture, a diagnosis of diabetes could be a threat to their standing in the community. However, in contrast, feelings of shame and failure to provide for the wellbeing of families and status within the community can be barriers to seeking healthcare for those with diabetes (Shahab et al., 2019).

Similarly, a study in NZ by Schmidt-Bushby et al. (2019) of 16 Pacific Islanders that included five Samoans with type 2 diabetes and end-stage renal disease (ESRD) explored their understanding of disease. In-depth interviews with participants revealed that a diagnosis of ESRD served as a prompt to change behaviour due to the invisibility of diabetes symptoms, a misunderstanding of the health risks when communicating with health services and a misunderstanding of the management of the conditions (Schmidt-Bushby et al., 2019). Participants disclosed the negative effect of the lack of education and information of the earlier generation which have influenced the actions and attitudes of future generations towards diabetes (Schmidt-Bushby et al., 2019). Evidently, culture has a great influence on Samoan health beliefs and manifests in the way they respond, behave, and seek healthcare. More importantly, a family's knowledge and information is passed between generations, which affects positive decision making on health.

Additionally, a study in Hawai'i that focused on health beliefs drew on a population of 22 native Hawai'ians and 10 Samoans (three adults with heart failure and seven caregivers) in order to identify key family and social relationships. It found that inadequate knowledge was a barrier to quality healthcare, with denial and avoidance of illness being their way of coping with hopelessness and despair (Kaholokula et al., 2008). The study concluded that having a supportive family together with competent knowledge about their illness allowed them to better assist with caregiving (Kaholokula et al., 2008). Also, in a study to explore the value of using a health belief model, Allen et al. (2017) evaluated Samoan caregiver perceptions of rheumatic heart disease follow-up care. The study was conducted at district hospitals and clinics in Samoa over a 12-month period. A total of 64 caregivers of children diagnosed with rheumatic fever responded to the questionnaire which was supported and guided by local staff. Results showed that a caregiver's knowledge and perceptions of their child being sick has a critical link with trying to seek relevant follow-up treatments. These findings demonstrated the vital role of health education, involvement of family and providing appropriate information for Samoans – a core value of the person- and family-centred care concepts.

3.7 Chapter summary

In summary, this integrated critical literature review focused on ‘person- and family-centred care’. The three main themes and their sub-themes highlighted good communication and inclusion of the person and family in care coordination were vital to the person-centred care approach. In addition, training and support were crucial to promoting person- and family-centred care in mental health practice. Moreover, the human connection and understanding illness imperative to person-centred experiences were found to be important in NZ healthcare practice. Importantly, a sense of belonging and family wellbeing were found to be vital to Samoan/Pacific holistic health, as well as the fundamental role of family, community, and church involvement for a Samoan/Pacific-centred approach. In particular, family knowledge and cultural status are important considerations in the person-centred care approach for Samoan/Pacific people. However, there is a gap in the literature on the experience and influences of Samoan family and cultural beliefs in current person-centred MHS delivery models. The review also identified the need for such an approach to be centralised in MHSs. This slogan of ‘person- and family-centred care’, while widely advocated, needs to ensure holistic care and equity for mental health outcomes by addressing health inequalities for this population.

Moreover, while Samoan and Pacific academics have researched and explored the Samoan ‘self’, perspectives on mental illness (Suaalii-Sauni et al., 2009), views on culturally appropriate mental health services (Tamasese et al., 2004), Pacific models of care in mental health (Samu & Suaalii-Sauni et al., 2009; Vaka, 2016), no studies to date have investigated the perspectives of Samoan family and caregivers on their understanding and experiences of the person- and family-centred care that drives the current NZ model of mental health practice. Furthermore, the literature review shed light on the lack of research on the application of a Fonofale model for Pacific people in MHSs.

The next chapter presents the methodology that was used to guide the study and address the research questions as well as ethics approval, data analysis, and steps taken to achieve study rigour.

Chapter 4: Methodology

4.1 Introduction

This chapter describes the key steps in the methodology that addresses the research question on how Samoan families experienced the current person- and family-centred care in MHS. The Pacific fa‘afaletui methodology sat alongside the premises of a descriptive qualitative research, and the analysis used Braun and Clarke’s (2012) thematic analysis to draw out a focus on the Samoan interpretation of person- and family-centred care in adult MHSs in Aotearoa, NZ.

The chapter is divided into three parts. First is the summary of Pacific research methodologies, namely teu le va and talanoa, as well as a description of the fa‘afaletui methodology. Part two includes the study settings, recruitment and sampling, rigour, and ethics considerations. The final section outlines the process of data collection, analysis process and steps taken to address bias, cultural credibility, and the validity of the study.

4.2 Pacific research methodology

In the last two decades, research frameworks for Pacific studies have been developed and utilised by Pacific researchers to explore, interpret, and evaluate Pacific issues. Since then, Pacific Indigenous methodology has become popular in the national and international academic field. Unlike western and mainstream methodologies, Indigenous methodologies can highlight and identify cultural nuances, meanings, understandings, and beliefs of ethnic populations such as Pacific (Anae, 2010; Suaalii-Sauni & Fulu-Aiolupotea, 2014; Vaioleti, 2006). For instance, Pacific studies published in NZ using Pacific methodologies within education and health (Anae, 2010; McCarthy et al., 2011; Suaalii-Sauni & Fulu-Aiolupotea, 2014; Vaka, 2016) have presented the needs and issues pertaining to Pacific populations in the public arena for consideration in government policies and funding. Overall, Pacific methodologies offer a unique contribution in addressing the disparities experienced by Pacific populations in NZ and around the globe (Violeti, 2006), and they should continue to take centre stage for current and future Pacific studies as described in the following.

An important Pacific research methodology is teu le va (safe space) developed by the Samoan scholar Melani Anae (2010). The teu le va approach emphasises respectful relationships and equal partnership between the researcher and participants underpinned by the Samoan values of love and reciprocity (Anae, 2010; Efi, 2009). This concept also affirms the value of relationships and creates a pathway for good working between different stakeholders. Anae applied teu le va in Pasifika education research; however, core values such as love, reciprocity, and respectful relationship are applicable to other Pacific research fields and disciplines as well (Anae, 2010).

Additionally, the talanoa methodology symbolises the mean of oral communication for Tongan, Tokelauan, Fijian, and Samoan peoples (Tunufai, 2016). Tala means to tell, inform, relate, and announce; noa means nothing, undefined purpose, and without value (Vaioleti, 2006; Vaka et al., 2016). Talanoa means talking about an unspecified topic in a moment and time without a fixed plan (Suaalii-Sauni & Fulu-Aiolupotea, 2014; Vaioleti, 2006; Vaka, 2016). Talanoa is a respectful and reciprocal interaction in which people take turns to speak and listen, and the flow of conversation determines what the other has to say (Vaioleti, 2006) in a formal or informal situation that removes barriers between participants (Vaioleti, 2006; Vaka et al., 2016). Talanoa is both an epistemology and approach in which human connection and relationships are important to Pacific people on all levels (Anae, 2010; Suaalii-Sauni & Fulu-Aiolupotea, 2014; Vaioleti, 2006). The unique features of connection and face-to-face interaction are shared characteristics of teu le va, talanoa and the fa‘afaletui methodologies (Suaalii-Sauni & Fulu-Aiolupotea, 2014).

4.3 Fa‘afaletui methodology

Fa‘afaletui is a Samoan word for conversation. It is derived from Samoan philosophies of connection and collective approaches of different social groups to achieve a consensus for decision making (Goodyear-Smith & ‘Ofanoa, 2022). Fa‘afaletui is the combination of three Samoan words: faa (the ways of), fale (a Samoan house) and tui (the process of weaving) (Tamasese et al., 2004). Through interactive discourse, issues are comprehensively discussed and tui (woven) to achieve pertinent resolutions of individuals and communities and reflecting the fa‘a Samoa (McCarthy et al., 2011).

Fa‘afaletui is a Pacific methodology developed and utilised by Pacific researchers to identify and highlight the cultural nuances, meanings, understanding, and beliefs of ethnic populations such as Samoan/Pacific (McCarthy et al., 2011; Sualii-Sauni & Fulu-Aiolupotea, 2014; Tamasese et al., 2004). Fa‘afaletui methodology is grounded by Samoan values of fa‘aaloalo and alofa (Goodyear-Smith & ‘Ofanoa, 2022). Alofa is the combination of two words alo (to face) and fa (the four posts of the fale, the Samoan house representing chiefs, talking chiefs, aumaga and aualuma (untitled men and women); alofa is shown when all four posts work in unison (Muaiava, 2022). Fa‘aaloalo is alo mai (face inwards) and alo atu (face forward), literally meaning ‘face to face’ or ‘face meeting face’ in relationships (Va‘ai, 2014). Alofa and fa‘aaloalo are two important Samoan cultural values used in conversation help to save and keep face. A loss of face is traumatising for Samoans, as faces represents those of both the living and the dead, and persistent exposure to confrontation and misunderstanding causes distress of the mind and psychological imbalances (Efi, 2014). Therefore, when alofa is achieved, fa‘aaloalo is shown (Muaiava, 2022). In addition to this is understanding the Samoan language, as it holds the key to comprehending meanings of important cultural concepts and ways of knowing. These Samoan values and language are the foundation and core ethics of the fa‘afaletui framework (Tamasese et al., 2004).

The success of the fa‘afaletui framework depends on the skills and available resources of the researcher to highlight significant issues even when views are controversial and differ from each other (Goodyear-Smith & ‘Ofanoa, 2022). The Pacific researcher uses a variety of these skills and cultural expertise as a weaver to collect all perspectives in which different views are woven together, and the collective feedback is then co-analysed for collective and consensus decision making (Goodyear-Smith & ‘Ofanoa, 2022; Tamasese et al., 2004).

4.4 Using the fa‘afaletui methodology

A major advantage of the fa‘afaletui framework is enabling an emic understanding of the Samoan perspective of the person- and family-centred care concept in MHSs in NZ. It also helps to identify key service delivery areas that could be improved to influence the quality of clinical care for Samoan people. Samoan and Pacific academics have researched and explored the Samoan ‘self’ and perspectives on mental illness (Suaalii-Sauni et al., 2009; Vaka et al., 2016), and also, culturally appropriate MHSs (Tamasese et al., 2004) and Pacific models of care in mental health (Suaalii-Sauni et al., 2009; Vaka, 2016). However, none to date have investigated the perspectives of Samoan families’ and caregivers’ understandings of the framework that drives the NZ model of clinical practice in mental health.

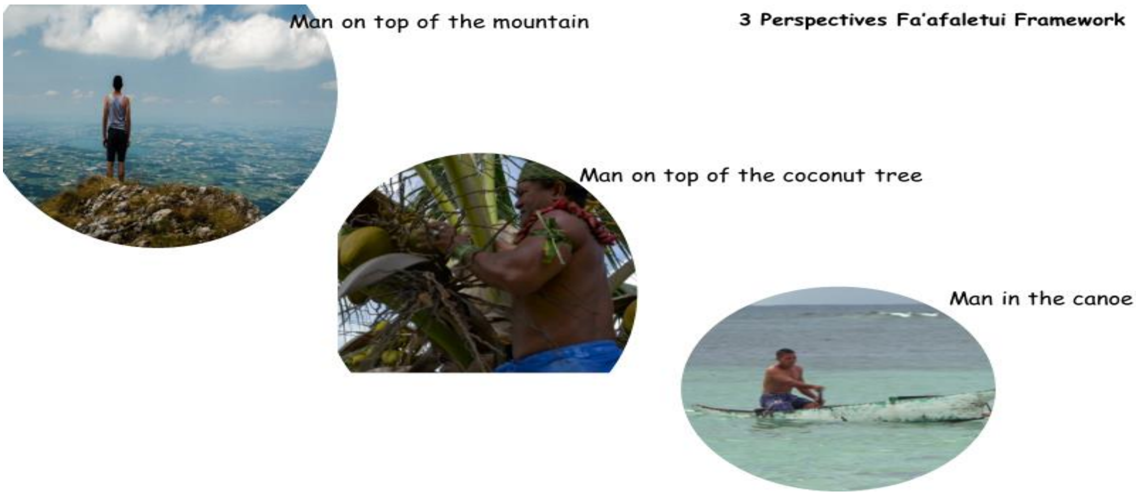
In addition, the fa‘afaletui framework was chosen for three primary reasons. First, the main participants for this study are all Samoans, so the focus of the approach would be familiar. In particular, fa‘afaletui is a way of life in the Samoan culture, villages, and citizens (Mulipola et al., 2022). Second, this framework was developed to specifically address the gap in the interpretation of experience and understanding of mental illness between non-Samoans and Samoans in MHSs in NZ (Tamasese et al., 2004. For instance, the fa‘afaletui's three perspectives from various representations within families, services and communities are facilitated by Samoan values of alofa and fa‘aaloalo. This approach resonates with Samoan and Pacific peoples' communication and connection with others. As a result, it creates a non-threatening environment and encourages people to share meaningful experiences and cultural worldviews addressing the research topic. Third, the topic of this research is to explore family members' experiences with MHSs' model of care; therefore, the issue for discussion is already identified and discussions would be more focused. Overall, this method is particularly useful in studying serious issues concerning Samoans using MHSs. Consequently, employing the fa‘afaletui methodology avoids the risk of a western interpretation of Samoan experiences and understanding in clinical practice and allows space for a culturally specialised approach in care (Tamasese et al., 2004). Fa‘afaletui in this context brings to the fore a sense of accountability for MHSs, to understand the reasons behind a Samoan's behaviour (Mulipola et al., 2022; Suaalii-Sauni et al., 2009).

4.4.1 Theoretical perspective

Indeed, Samoans are relational people where the ‘self’ is identified with their family, extended family, village, and environment (Efi, 2009; Tamasese et al., 2004). Health and wellbeing for Samoans is achieved through the complementary relationship between the ‘self’, others and environment underpinned by alofa and fa‘aaloalo (Efi, 2009). These Samoan values are major influences on an individual's obligations to family, village, church, and wider community. Therefore, health and wellbeing for Samoans is not only about gaining and maintaining good relationships, but also respecting cultural boundaries and connection with self and others (Suaalii-Sauni et al., 2009; Efi, 2009). These Samoan values are the foundation and core ethics of the three perspectives of the fa‘afaletui framework.

4.4.2 Three perspectives of the fa‘afaletui framework

Figure 6: The three perspectives of the fa‘afaletui framework (Tamasese et al., 2004)



The three perspectives involve: the person on top of the mountain who has a comprehensive view of the issue; the person on top of the tree, who has some understanding of the issue but lacks the wider and immediate knowledge of the issue; and the person in the canoe, who most affected by what is going on (Suaalii-Sauni et al., 2009; Tamasese et al., 2004). These perspectives form groups of diverse sources of expertise and knowledge such as Matai (chiefs), Faletua ma Tausi (wives of chiefs), Aualuma (women’s guild), Taule‘ale ‘a (untitled men), and Tupulaga (youth) representing the collective voices of the wider community, and in any substantial issue the three perspectives are equally important (Efi, 2009). The three perspectives allow a comprehensive evaluation of a topic by the collective and encourage a response that reflects Samoan culture (Tamasese et al., 2004).

To demonstrate, the view from top of the mountain represents one’s mother/father; they are aware of the issue and worried about the implications of mental illness on the service user's future in relation to family land, matai (family chiefly titles), and surviving in NZ. The view from top of the tree represents the siblings who understand the issue but have limited awareness of the impact that mental illness might have on the service user's future. The person in the canoe represents the wife or husband of the service user a person who has close contact with the service user and understands the impact of the illness not only on the service user, but also on family wellbeing (Mulipola et al., 2022). Hence a chain of interconnectivity is created.

4.5 Study aim

The focus of the study was on the Samoan interpretation of person- and family-centred care in adult MHSs in NZ. In addition, exploring Samoans cultural interpretation of MHS care delivery was guided by the overarching research aim: What does person-centred care mean for Samoans accessing MHS?

4.5.1 Study objectives

- To explore the meaning of 'aiga' (social and cultural support) in relation to the delivery of person- and family-centred care in adult MHSs.
- To explore retrospective experiences of Samoan families on their dealings with the MHSs and their interpretation, understanding, and experiences of what a cultural model of care delivery within NZ MHSs means.
- To recommend culturally targeted improvements for the more effective delivery of person- and family-centred care in MHSs that incorporate Samoan ethnic belief systems.

4.5.2 Inclusion criteria for family members

The participants chosen were core family members' 'aiga' who live with or have regular contact with the service users, or identify as family, and may include parents, siblings, partners, children, friends, cousins, aunties, uncles, roommates, landlords, caregivers, and grandparents.

Core family members of service users aged between 18-65 years were included if they were:

- family members of service users who are currently registered with the adult community services or discharged from the services within the last 12 months.
- family members with service users with an Axis I diagnosis of mental disorders; and
- family members who can speak both Samoan or/and English.

4.5.3 Exclusion criteria

Family members of service users are excluded from the study if they were 17 years old or younger.

4.5.4 Recruitment

Phase one

a) Flyers were available in Samoan and English and distributed in adult mental health community services and Pacific NGOs in Auckland. Handouts were also available at reception and waiting room areas, and on walls in areas which people could access. These resources were sent via email to the leadership and management team and wider MHSs.

b) Information sessions were presented in English and Samoan language face to face and via Zoom to community MHSs and Pacific NGOs. Case managers were advised to share only the research information with Samoan people in their caseloads, and they were advised not to share the contacts of any potential participants with the researcher. Advice for any potentially interested people was to contact the researcher directly for more information.

c) The researcher met with Faletoa Pacific mental health team to present the study proposal and aim, and also to secure the team’s support in identifying possible candidates who fitted the inclusion criteria.
d) The researcher also approached service managers and services in the community to discuss study aim and securing support in recruitment.

Phase two

Two weeks was given to potential candidates to consider accepting or rejecting study the invitation and they were able to contact primary researcher by email, phone, or text messages. Afterwards a follow-up phone call was made to chase the progress of the invitation to ensure people had received the information and, additionally, to renew the invitation for those who had forgotten and to follow-up on availability. An informed consent form was prepared for all family members before family group fa‘afaletui started.

4.6 How data was gathered.

Data collection for this study was guided by the process described in the Auckland University of Technology Ethics Committee (AUTEC) data management plan (see Appendix A. When families gave their approval and indicated that they were willing to participate in this research, an appointment was booked for a time and date that was appropriate for them. A private room in the local library, MHS site, and local community services was offered, and five families chose to hold their family group fa‘afaletuis at home. One family group fa’afaletui was held at a local tertiary organisation facility as this was more accessible and comfortable for them.

4.6.1 Approach to family group fa‘afaletui

Most families preferred to have their fa‘afaletuis completed at their family homes by the researcher during April–May 2021. Following Samoan protocols for visiting families, the researcher brought a cake as appreciation and to reaffirm connections. All the fa‘afaletuis were started and concluded with a prayer led by the researcher or a family member. Establishing connection is fundamental in commencing relationship, such as friendly and positive body language, respectful, appropriate clothes that cover below the knees, sitting down with face-to-face engagement, and hospitality (Efi, 2009). The fa'afaletui sessions started when the family were ready and gave permission to begin. Importantly, the Samoan language was valuable in this space as there was warmth, love and respect felt by everyone involved. This was evident in participants' willingness to engage, share and ask questions, and some offered food and warm drinks. Each fa'afaletui lasted for between 60 and 90 minutes.

Initially, participants were briefed in the Samoan language on the purposes of the fa'afaletui to ensure they fully comprehend the informed consent sheet. All participants consented to the fa'afaletui being audio recorded. Also, processes and plans were in place ensuring that all Samoan cultural protocols are followed. Participants were well informed of their rights to withdraw at any stage if they felt uncomfortable, and confidentiality of information shared and discussed throughout the process and stages of the fa'afaletui family group was assured. The participants were required to sign a consent form if they agreed to participate in the study.

4.6.2 Research setting and sampling

This study was conducted in urban MHS settings (both adult community MHS and allied Pacific NGOs) in Auckland, Aotearoa.

4.6.3 Main research questions

The fa'afaletui family group discussions were guided by the following main fa'afaletui questions. This semi-structured interview guide was given to the Samoan advisory group to translate prior to family group fa'afaletuis to check for any issues in the researcher's translation. The feedback was that only minor changes were needed to the main questions.

The advisory group feedback helps confirm the researcher’s Samoan translation was according to the nuances of the Samoan language.

1. Can you tell us more about what kind of services and what you know about the services you or your family member has been receiving from mental health services to date?
2. Have you heard of the term person-centred care? If so, what does this mean to you?
3. Have you heard of the term family-centred care? If so, what does this means to you?
4. How are you experiencing your interactions with the community mental health service? What is working well and what does not work currently?
5. How could Samoan families be best supported with their dealings with the mental health services in NZ? What aspects, any examples please.
6. Was the Pacific service offered to you? Were your cultural needs understood, respected addressed – language, religion, health beliefs? What was your experience with the Pacific cultural liaison team support? What worked, what could have been improved?
7. Anything else you might want to add?

Additional questions were added when new topics emerged that needed to reach saturation.

To provide robust triangulation at each step of data collection, a local stakeholder group was recruited to guide stages of the fa‘afaletui ensuring the interest of the community was maintained. The Samoan Advisory Group is a steering committee of three Samoan cultural experts providing insight into the Matai (chief) and power structures within families (Efi, 2009) and to further advise on how the principles of the fa‘afaletui methodology ensures Samoan values and protocols were sustained. The advisory group had no access to data collection or analysis. A set of criteria for reporting qualitative research was used to prepare this thesis (Tong et al., 2007).

Moreover, in keeping with the va-fealoaloa‘i‘ (sacred space), fa‘aaloalo (respect) and humility in the Samoan culture and the fa‘afaletui framework, participants were offered a cake for light refreshments and a $100 supermarket voucher per family. Also, petrol vouchers was provided for family group fa‘afaletuis held outside of family homes. Obviously, the practice of offering goods is showing reciprocity in Samoan culture where the participants share their experiences and knowledge, and the researcher offers gifts in whatever form as a token of love, appreciation, and humility.

To conclude the family group fa‘afaletuis, the researcher talked about and acknowledged what participants contributed to the research. A family member reciprocated according to Samoan culture protocols and offered appreciation for the opportunity the study has provided to have their voices heard. Participants were offered the opportunity to be provided with a copy of the findings summary to keep at the completion of the study. To sum up this process, families imparted words of encouragement and blessings for the researcher’s work, and the family group fa‘afaletui were formally concluded with a tatalo (prayer).

4.7 COVID-19

Much consideration was given at the time of data gathering to what was currently happening globally with COVID-19 and how this changed communication channels in NZ. This change had a huge impact on the fa‘afaletui method of data collection where face-to-face and personal connection is important. As a result, there was a possibility of taking a modern approach to the fa‘afaletui framework with the use of technology and online methods to hold family group fa‘afaletuis if it was deemed necessary.

However, Zoom was not utilised for data collection of this research as family group fa‘afaletuis were completed while the community was in alert Level 1. The alert levels were determined by the Government and specify the public health and social measures to be taken in the fight against COVID-19. Level 1 was to prepare and signalling the disease was contained; level 2 was low risk of community transmission; level 3 presents medium risk of community transmission- managed in clusters; and level 4 suggests the disease was not contained with widespread outbreaks and lockdown measures introduced (COVID19, n.d.). At level 1, face-to-face communication and visiting other people's homes were allowed. Although this was a challenging time for the country and communities, the willingness of the six families to accept the opportunity to describe their experiences was immense. The study was not only a chance for them to connect with other Samoans, but also provided moments for therapeutic alleviation by sharing common experiences with the researcher about the pandemic.

4.8 Rigour

The study followed Lincoln and Guba's (1990) approach to rigour as providing appropriate criteria to judge the quality of the study. This included participant member checking and method triangulation. The researcher and supervisory team were involved in reviewing the data and study documents. Dependability involved consistency in categorising data, and by having a Pacific primary researcher and the Samoan Advisory Group to promote recruitment and provide feedback on the emergent themes for each fa‘afaletui family group. A detailed description of the study context, access, and action was documented for transferability (Polit & Beck, 2010). Importantly, an independent bilingual Samoan community member forward- and back-translated one data transcript for accuracy of interpretation (Wong et al., 2019), with such changes as omitting certain information and some descriptive verbs due to the many meanings of the Samoan language modified accordingly.

Five months was spent analysing the data, with scripts and data records reviewed repeatedly, including listening to the audio recordings to ensure important family feedback was recorded. In addition, the researcher's field notes, and observational records were looked at, reviewed, and compared to data scripts and audio recordings to ensure vital information was captured. Also, there were ongoing discussions and meetings with the supervisory team to elaborate further on possible themes and identify new topics that arose from the data. Altogether, these steps ensured sufficient time was spent in reviewing and being familiar with the data to achieve credibility.

In addition, the researcher planned and followed the process of triangulation. Firstly, a reflexive journal was used to keep records of the researcher's preparations and fa‘afaletui processes. It also includes personal reflections on learning opportunities and possible changes in approach for the next fa‘afaletui. Secondly, family group fa‘afaletui audio recordings were used to clarify discussions and emotions observed during interview sessions. Thirdly, three-monthly meetings were held with the Samoan Advisory Group. The group provided feedback on the Samoan translation of the fa‘afaletui family group questions, and minor differences were identified due to the many meaning of Samoan words. Therefore, different words were used but had the same meaning as the researcher's translation. For example, ‘person-centred care’ was translated as ‘fa‘atauaina ole tagata ile auaunaga’ and the advisory group translation was ‘ole tagata ma lona fa‘atauaina ise auaunaga’. This showed the group uses more words in translation, but the wording has the same meaning in Samoan as the translation of the researcher. The Samoan Advisory Group asked to provide feedback on theme tables with all data and places de-identified. Their input were specifically focused on cultural practices such as spiritual faith and traditional healing and how Samoan values of alofa and fa‘aaloalo are core to how people behave and communicate with others.

Moreover, ongoing progress review meetings with the supervisory team were held fortnightly. These recurring meetings provide space for the researcher to debrief and reflect on the research progress. A prepared draft of possible themes was presented to the supervisory team for discussion and to identify possible links between themes, and also to uncover additional topics to explore further with the next group to reach saturation. As a result, additional topic questions were added as the research progressed. Additionally, the researcher had ongoing catchups with her peers who were students of the same doctoral programme. This space was invaluable for students to debrief and share learning while supporting each other along the way. Overall, the steps followed demonstrated careful consideration in maintaining the study rigour and credibility. Also, peer review offered the opportunity for learning and a therapeutic space for the researcher to reflect, grow, and recharge throughout the learning process.

4.9 Potential for subjectivity

Admittedly, the researcher's profession as a nurse and residing in the community in Auckland may have had an influence on participants' shared feedback and experiences. In this case, the researcher has established awareness and understanding of the current model of care and how this affects Samoans within MHSs. Also, she has personal experience and awareness of the community dynamic plus a familiar relationship with the Samoan community in south Auckland. Therefore, a pre-suppositions interview was undertaken with the supervisory team to check on and address any imbalances that could arise, and also to withhold any personal cultural assumptions that could arise from participants' responses and allow them the space to clarify their own answers. In addition, regular meetings with the Samoan Advisory Group provided cultural peer support and clarified boundaries and awareness of any deviation of opinions from the study focus.

4.10 Ethics

Ethics for this study was approved by AUTEC 20/365, on December 17, 2020, and Counties Manukau DHB Research Ethics 1351, February 26, 2021. Also, an exception letter from Health and Disability Ethics Committees was received in January 2021.

In fact, ethical consideration required the researcher to request participants to refrain from sharing any legal matters or sensitive information before family group interviews began. The researcher has an obligation under Health Practitioners Competency Assurance Act 2003 to respond and act accordingly and to report any safety concerns and illegal behaviours to the statutory entities such as the police.

4.11 Data collection and analysis

To collect and analyse data, the three perspectives of the fa‘afaletui methodology and Braun and Clarke’s (2006) thematic analysis were used. Thematic analysis is a systematic approach used in identifying, arranging, and providing an understanding of patterns of keynote ideas across the data set (Braun & Clarke, 2006). In earlier decades, thematic analysis was lacking in popularity during the time where qualitative analysis was widely use in psychology (Braun & Clarke, 2006). However, more recently, thematic analysis has been recognised as a method in its own right (Joffee, 2012). Nowadays, there is a new wave of interest for the method, and it is now centre stage in writing on qualitative research across academic disciplines (Terry & Hayfield, 2020).

However, Samoan and other Pacific methodologies such as fa‘afaletui lack key analytical features; also, researching cultural issues is often led by the community and can take several years to reach an outcome. By contrast, this study was intended to provide professional outcomes to improve clinical practices. All interviews were transcribed and, subsequently, audio recordings were coded, read, reread, categorised, and reviewed to identify recurring themes emerging from family group fa‘afaletui by the first author, guided by the primary and secondary supervisors. Feedback was transcribed and checked following the fa‘afaletui framework and Braun and Clarke’s (2006) thematic analysis.

4.11.1 A six-phase approach to thematic analysis

This section contains a brief overview of Braun and Clarke’s (2012) six phases of thematic analysis, specifically the phases borrowed for the analysis reported here, and the three perspectives of the fa‘afaletui approach.

- Phase 1: Familiarising oneself with the data.
- Phase 2: Generating initial codes.
- Phase 3: Searching for themes – fa‘afaletui.
- Phase 4: Reviewing potential themes – fa‘afaletui.
- Phase 5: Defining and naming themes – fa‘afaletui.
- Phase 6: Producing the report.

Phase 1: Familiarising oneself with the data.

This step requires the researcher to engage with the gathered data by reading and re-reading textual data (interview transcripts) and listening to audio recordings. In this study, this meant firstly listening to the audio recordings then starting to transcribe. Four out of five audio recordings were transcribed and translated from Samoan to the English language. While listening, data was sorted into categories consistent with the three perspectives of fa‘afaletui such as the voices of fathers (Matai), mothers, and siblings. Further listening to the audio recordings and checking transcripts made sure important data were captured and noted with every discussion and word that was said. During this process, notes were made, portions of the data highlighted or items potentially of interest underlined. The aim was to become familiar with data contents and to start observing items that might be relevant to the research question (Braun & Clarke, 2012).

Phase 2: Generating initial codes.

This phase starts to organise data into a coding system. This creates the building blocks of the analysis (Braun & Clarke, 2012). In this study, a list was created with grouped codes that had a similar focus. Codes representing Samoan beliefs were brought to the Samoan Advisory Group to discuss and to clarify culture meanings for correct code allocation. A list of codes was prepared for discussion with the supervisors, and after discussions some codes were dropped, merged with other codes, or became a new code. The coding process ended when data were fully coded and data relevant to each code collected (Braun & Clarke, 2012).

Phase 3: Searching for themes.

This phase involves shifting from codes to themes. A theme recognises important aspects of the data relevant to the research question and represents some level of patterned response within the data set (Braun & Clarke, 2012). At this stage of the fa‘afaletui, the links between ideas and levels of knowledge within families were examined and woven together to formulate an interim collective interpretation (Tamasese et al., 2004). A preliminary draft list of themes was then formulated and prepared for discussion and review with supervisors. The plan was to continue to read and review data to clarify and defined themes.

Phase 5: Defining and naming themes.

In this phase, a summary of preliminary themes was first given to the Samoan Advisory Group for their feedback. The group was asked to clarify the cultural meanings of themes and the themes’ consistency with participants’ explanations. They were pleased with and supportive of the themes; their feedback were based on their cultural knowledge as well their roles as clinicians of MHSs. Importantly, the Samoan Advisory Group supported the view that the issues mentioned in the themes provided answers to the research questions.

In addition, the applied learning from the Thematic Analysis Workshop, August 3-4, 2021 was helpful in this phase.

A total of five themes were identified: 1. Fa‘atuatua ile Atua (Our faith in God): Spirituality and religion; 2. It’s a hush-hush topic: Stigma of mental illness; 3. We are in the dark with our communication and dealings with MHS; 4. Practice what you preach – clinical service delivery misaligned with MHS model of care aim and vision; 5. The values of alofa (love) and fa‘aaloalo (respect): Enablers of positive experiences. These themes were informative, concise, and catchy, as using quotes in titles can provide a sense of the theme while maintaining participants’ language and concepts (Braun & Clarke, 2012). See Table 8

Phase 6: Producing the report.

This is presented in this thesis including summary of the study report offered to participants.

4.12 Summary

In conclusion, this chapter has described the fa‘afaletui methodology, along with its history and theoretical relevance to the study. Also, the chapter has given a summary of teu le va and talanoa was included and their relation to the principles of the fa‘afaletui approach. In addition, the steps the researcher followed to guide recruitment, family groups fa‘afaletuis and ethical considerations was described in detail. In particular, the phases of Braun and Clarke’s (2012) thematic analysis with the fa‘afaletui approach to analysing data were described. Overall, this chapter has detailed the methodological steps taken to address the gap in the knowledge and the study focus. The following chapter presents the demographic description of the participants and the study findings.

Chapter 5: Findings

5.1 Introduction

The findings from the family group fa‘afaletui are presented in this chapter. The first part outlines participants’ demographic details. The second part includes the descriptive detail of the five main themes. These are: 1. Fa’atuatua ile Atua (Our faith in God): Spirituality and religion; 2. It’s a hush-hush topic: Stigma of mental illness; 3. We are in the dark with our communication and dealings with MHS; 4. Practice what you preach- clinical service delivery misaligned with MHS model of care aim and vision; 5. The values of alofa (love) and fa’aaloalo (respect): Enablers of positive experiences. The final section of the chapter is the summary and also a preview of the flow of the following chapter. A table of findings is presented to further show the relationship of themes.

5.2 Participants’ demographics

A total of six aiga (families) participated with a total number of 13 individual participants (see Table 6). The aiga are identified using Samoan words for numbers: Aiga Tasi (one), Lua (two), Tolu (three), Fa (four), Lima (five) and Ono (six), all core family members who had previously or were currently engaged with MHS. Participants consisted of four mothers, two fathers, five sisters, one son, and one husband. Samoan language was the primary language spoken for eleven participants, and two identified English as their primary language). Four families had resided in NZ for 15 years or more. One family had lived in NZ for 10 years, and one family for five years. In addition, schizophrenia and mood disorders were the most common diagnosis for family members of all participants. See Table 7.

Of note is that all bar one participant belonged to a church. In respect to work and income, two mothers were in full-time employment, sister number one of Aiga Lua worked part-time, and the remaining sisters of Aiga Lua and of Aiga Lima are unemployed.

Additionally, both parents of Aiga Tolu are on pensions as well as the fathers of Aiga Ono and Aiga Fa, and the mother of Aiga Lima. Two of the participants are students, one was NZ-born, and the other was born in Samoa but raised in NZ.

Two families represents the intergenerational Samoan family dynamic of migrant parents, and NZ-born and raised young people, and four families represent different levels of Samoan migration. In fact, the number of years in NZ was shown by the level of confidence and awareness of families about services and seeking support.

The following sections describe the five main themes and sub-themes of the study as described above – see also Table 8.

Table 7: Demographic characteristics of participants

Aiga - Family	Family members	Pseudonyms	Church affiliation	Years living in NZ	Social background	Family member diagnosis	Family member role & relationship to participants	Years with MH
Tasi (One)	Mother	Alofa	Yes	10	F/T	Bipolar disorder	Son	5
Tasi	Sister	Vao	Yes	10 NZ raised	Student	Bipolar disorder	Brother	5
Lua (Two)	Sister 1	Rula	Yes	5	P/T	Schizophrenia	Brother	5
Lua	Sister 2	Vine	Yes	5	Unemployed	Schizophrenia	Brother	5
Tolu (Three)	Father	Toma	Yes	25	Pension	Schizophrenia	Son	4
Tolu	Mother	Ata	Yes	25	F/T	Schizophrenia	Son	4
Fa (Four)	Father	Fala	Yes	35	Pension	Mood disorder	Daughter	5
Fa	Mother	Lina	Yes	30	Pension	Mood disorder	Daughter	5
Lima (Five)	Mother	Sina	Yes	15	Pension	Schizophrenia	Son	10
Lima	Sister 1	Tina	Yes	15	Unemployed	Schizophrenia	Brother	10
Lima	Sister 2	Mia	No	15	F/T	Schizophrenia	Brother	10
Ono (Six)	Husband/ Partner	Fatu	Yes	20	Pension	Schizoaffective disorder	Wife/partner	15
Ono	Son	Tama	Yes	20 (NZ born)	Student	Schizoaffective disorder	Mother	15

Note. MH mental health, F/T full-time employment, P/T part-time employment

Table 8: Main themes, sub-themes, and examples

1. Fa’atuatua ile Atua (Faith in God): Spirituality and Religion	2. It’s a hush-hush topic: Stigma of mental illness	3. We are in the dark with our communication & dealings with MHS	4. Practice what you preach: clinical service delivery misaligned with MHS model of care aim & vision	5. Alofa (love) & fa’aaloalo (respect): Enablers of positive experiences
Sub-theme 1.1: Tatalo & spiritual faith O le Atua e moni ma fa’amaoni (God is true and honest). A sense of strength and hope. He is intimate, close, and compassionate. Faith in God keeps family going and able to cope. God always answer my prayers. All I can do was praying to God. I believe that God saw my sufferings and this incident with my son was the answer so I can have a rest. There was no one else that we can turned to yeah and thank you Lord for his amazing grace yeah, we have lost a lot of people	**Sub-theme 2.1: It’s a cursed: Stigma of mental illness** It’s like a hush-hush subject when people said oh yeah, it’s a cursed or kind of because I’ve been condemned of that. You reach out to your own people wanting support and yet you are like your parenting skills was like you get condemned and persecuted. Fia Palagi (thinking like a Pākehā) and not believe in Fofo Samoa. We have lost family relationships because of this.	**Sub-theme 3.1: Problems with access to care** I literally went through the phone directory for any mental health support coz I was desperate. Not answering the phone- goes straight to voicemail and never responded. I kept on ringing and ringing no answer, I left message, and they never reply. Another healthcare organisation mobile service came to our rescue but not own local services.	**Sub-theme 4.1: Model of care misalignment: We do not get person-centred care from them** We get this from another healthcare organisation. We do not get that from them because my son is now in prison. As recipients of care, we are not experiencing any outcome of resources poured into MHS budget 2019. We relate this to our brother’s IMI [intramuscular injection]. I relate this to my wife receiving free services – seeing the doctor and her IMI, also free pick-up to do her injection so that was good.	**Sub-theme 5.1: We get more support from Pacific NGO** The strength of the Pacific NGO. If it wasn’t for X services, our family have no connection with MHS. The staff at Y service were mostly Samoans they explained things to us in the Samoan language and we understand.

along the way, but you know it's been one hell of a journey. Even though my son humiliated me but as parents I could not denied my love for my son and wanted him to come home.				
Sub-theme 1.2: Anapogi I fasted because of my wife's illness. God can bring healing and answers to my prayers. God gives me hope.	Belief that authoritarian discipline role of parents is the treatment for MI. 'Bring him here so I can crack his head as we did not send him there to do those behaviours.'	**Sub-theme 3.2: Police don't do anything** • We called police and the police were saying we won't move if the crisis is not going to be there. • When we contacted MHS that we really needed help with my brother, they said to contact police – and police don't do anything. I don't know. • We were informed by police that MHS will visited us the following day, so up to this day no-one contacted us or visited us at home to follow-up, then I said oh well… • Keyworker said that police should help your son not MHS – caused family confusion.	**Sub-theme 4.2: Not understanding clinical practice and processes** We were got told oh he's coming home and I'm like pardon no family meeting no nothing, oh boy I was angry. There is a lot that we do not know, and services should be automatically available to us when we engage with MHS. They only mentioned the voices, but we do not know where it came from.	**Sub-theme 5.2: O le Gagana Samoa- value of the Samoan language** The Samoan interpreter was very helpful it helps me understand what was discussed in my daughter's medical review. Only Samoans can understand Samoans 'o lau tu ma le aganu'u fa'a Samoa' (Samoan cultural values). Radio Samoa – value of the Samoan community radio programme. I was listening to Vaka Tautua's programme on the radio and I contacted them immediately – they were very helpful. The interpreter was very helpful, we always request for an

				interpreter when we have a meeting with MHS.
Sub-theme 1.3: Religion & church Beliefs that growing up in church and participating in church activities should not be associated with bad outcomes. We are a strong Christian family and smoking and alcohol is not allowed. At church we always offer prayers for my son. I'm ashamed and humiliated by my son in front of the church. I breached the word of God. And we are deacons, and my husband was next in line to our pastor.	Belief that Samoan family norms in the island-environment and cultural values can change behaviours and help with treatment of mental illness.	**Sub-theme 3.3: Crisis care access difficult** He was damaging a lot of stuff but when we reached out for help, they said unless he is causing harm to himself or to the public – that was woah yeah that was a mission. Access crisis support was even difficult for service user and family already within services caused confusion and hopelessness. Difficulty in navigating health services and understanding processes and protocols.	**Sub-theme 4.3: Lack of understanding and awareness about medical reviews** He went to review his WINZ [Work & Income] benefit I saw his form when he came back. They asked a lot of questions- I do not know, it was a waste of time compared to the care we received. Maybe they just record and then throw it in the rubbish. We do not know we can attend; I thought his support worker always go with him.	**Sub-theme 5.3 Pacific staff provides warmth and love** A Samoan person provides warmth and comfortable environment. The Pacific nurse was approachable and kind, she visited us at home and that was good. Pacific vibes (Pacific administrators) in services waiting rooms. The ladies at reception were friendly and they call me by name.
	My sister is from Samoa she does not understand mental illness, she tried to discipline service user at the wrong time. His father in Samoa would throw away the medications he does not believe in mental illness.	**Sub-theme 3.4: Poor communication** It was the very first-time experience for us we would have appreciated some sort of guidance you know; we kept asking a lot of questions but there was no-one to support us.	**Sub-theme 4.4: Lack of understanding about diagnosis and treatment** • It was easier to read about the diagnosis than being a sibling of someone who was going through the illness. • He was under a lot of medications but there wasn't a lot of talk around it. • She was sleeping a lot.	**Sub-theme 5.4: O lo'u ivi ma a'ano: My flesh and blood** O lo'u ivi, toto ma a'ano (my flesh and blood). Strength of the aiga Samoa. We take care of our brother and family together; we cannot neglect him because he is our flesh and blood. Whatever stress he caused us with his behaviour and attitude we always have

		Lack of understanding about MHS and what is available for families.	- His eyes rolled up from his medications and I was worried. - Her hands and feet were shaking, and we do not know why. - She was eating a lot and putting on a lot of weight. Oute le malamalama ile gagana faigata. I need to understand deep hard English. Even if I know how to speak English but I do not understand deep hard English especially with mental illness and treatments.	patient and continue to provide love and care**.**
	My son is close to his papa he kept saying that he is hearing his voice, then you tried to explain to them, and they looked at you – thinking that you are weird.	We contacted acute services that my brother self-discharged and came home, but they do not know he left – we were not sure what to do as we feared him.	**Sub-theme 4.5: Gaps in transfer of care** COVID-19 lockdown caused seven months gap in care, service user and family felt forgotten and neglected by MHS, resulted in service user assaulted his father at church witnessed by the congregation.	
			Sub-theme 4.6: Our voices do matter: Lack of family inclusion in care Not checking if people need an interpreter.	

			When they visited my brother, they only talked to him even if I'm around. I always home when they visited my son, but they never talked to me, maybe it's because of the Samoan language. **Sub-theme 4.7: They talk to the support worker/NGO, not us** I'm sure the keyworker is talking to NGO and arrange transport and plan for my brother, but he never talks to us.	
			Sub theme 4.8: we do not know about Pacific Mental health services available. We need more than prayers and moral support. We need a cultural-clinician support. Pacific service should be the voice for the people – the support was not deep enough.	
			Sub theme 4.9: issues encountered with clinicians' attitudes and behaviours: Lack of compassion and care. • Clinicians' attitudes and behaviours, bio-medically driven and lack of human compassion for reality of circumstances.	

			• We are here to get help and yet you already discounted us. • There was no love, honesty, and care, they are not doing what they supposed to do. • They were looking at their screens and talked to us. They looked at each other and shrugged their shoulders as if we were not there. From the first time we entered we looked at them doctor/ keyworker I can see they do not really acknowledge our presence.	
			Sub-theme 4.10: We haven't met the keyworker: Inconsistent contact with mental health clinician. Inconsistent key-worker contact and support. We have not seen the keyworker for months, I met the keyworker once, but I do not know her name.	

5.3 Theme 1: Fa’atuatua ile Atua (our faith in God): Spirituality and religion

A substantive theme in the interviews was a sense amongst participants that they had a significant bond with God. Family group discussions related this connection as intimate and loving, especially when situations are tough. In this context, the fa‘afaletui has identified how participants use the practice of tatalo (prayers) and anapogi (fasting) to connect and communicate with their Gods. Indeed, participants believed that engaging in these practices provided them with a sense of hope, peace, clarity, and strength. As a result, they could cope and continue to offer ongoing care and support for their family members.

5.3.1 Tatalo (prayer) and spiritual faith

Tatalo is a spiritual practice for Samoans. It is an important practice that often takes place at the beginning and end of most Samoans’ daily activities. Some traditional Samoans practice tatalo ala (prayers in the morning) and tatalo moe/lotu moe (bedtime prayers), and tatalo for blessings of food before and after meals. Tatalo is a spiritual tool that Samoans use to communicate with God, whether that is to ask for blessings, healing or guidance, or for comfort in difficult situations.

> *‘God is true and honest. God always answers my prayers’ (O le Atua e moni ma fa‘amaoni. E tali mai le Atua I la‘u tatalo). – Husband, Aiga Ono*

Obviously, this fa‘afaletui shows the strength of the participant’s faith in God. Through prayers, God gave him strength and hope. The feedback showed the participant’s conviction that God answered prayers and was an indication that other people do not listen and pay attention to his needs. His feedback showed he has limited knowledge about his wife's illness and since no-one in the MHS offered him an explanation that he could understand, his only hope was from God. Overall, prayers provided comfort that the participant was not alone when caring for his wife and family.

Other participants described how prayers provided them with comfort and hope when there was no response from or getting through to the MHS.

> *'I believe God saw my sufferings and this incident with my son being taken away by police was the answer so I can have a rest. All I can do was praying to God.'– Mother, Aiga Tolu*

In the Aiga Tolu discussion, the participant described her frustration with the MHS's lack of response. She revealed ongoing barriers that she encountered with supporting her son, and not getting through to the MHS. Her spiritual faith and belief helped her cope when her son was removed by police. This was her answer from God. Through her faith, she believed that someone was listening and attended to her sufferings. This fa'afaletui describes feelings of disappointment, sadness, and anger towards the failure of the MHS to provide care and support to her son and family:

> *'There was no one else that we can turn to and thank you Lord for your amazing grace and it's been one hell of a journey. I failed all my resources, but my Lord has not failed me.' – Mother, Aiga Tasi*

A similar experience was shared by a participant in Aiga Tasi. The participant talked about the difficulties that she encountered in managing her son's illness at home, as well as her persistent phone contacts to the MHS. She was a first-time consumer and desperate for help, but there was no connection with the MHS. Her sense of strength came from her belief in the loving care and protection from God.

When enduring these challenges, the families confirmed that prayers and spiritual faith have a tremendous force in their resilience. It showed strong bonds between Samoans and their spiritual faith. Through prayers, God provided healing and comfort not only for the service user but also for the family. Overall, spiritual faith is important to Samoans, and this should be core of the person- and family-centred care for this population because this helps with healing and maintaining mental wellbeing for family.

Prayers were also believed to influence healing in treatment and medication. The discussion below was a conversation between parents in family fa‘afaletui Aiga Fa:

> *‘There were lot of things that were going on and as parents we provided the best we could for our daughter plus our ongoing prayers to God. I believe that’s why she was making a great recovery.’ – Mother, Aiga Fa*
>
> *‘I agree with my wife, I’m thankful to the love of God that my daughter recovered plus our ongoing prayers and attending church.’ – Father, Aiga Fa*

In this family fa‘afaletui, participants disclosed their coping strategies to overcome challenges while supporting their daughter. The parents placed their trust and faith in God’s blessings for their daughter’s recovery. They focused on faith, prayers and attending church as enablers of healing. The parents believed that positive outcomes from MHS treatments were made possible by the presence and healing power of God. Their strengths, and ability to make good decisions for the service user, were not possible without God’s guidance. Overall, faith and prayers were an indication that God is always around, the giver of healing and hope that enabled this family to be good caregivers.

5.3.2 Anapogi (practice of fasting and meditation)

As well as tatalo, participants mentioned the spiritual practice of anapogi they engaged with to provide comfort and hope. Anapogi is the practice of fasting or abstinence from food and water. When in the process of anapogi, worshippers isolate themselves from their family, village, or community and engage in prayers and meditate in silence (Efi, 2009). The practice of anapogi includes self-reflection, mindfulness, and soul-searching. It is a space in which to search for confirmation, direction, and healing. Anapogi is a spiritual ritual to help people cope especially when they are not in control of their situation.

Feedback from one participant showed how he was able to cope due to his engagement with anapogi:

> *'I fasted because of my wife's illness, and I don't tell her that I'm fasting. I followed the Holy Bible's teaching to help others. I fasted if I encountered difficulties with my children, and if I know I'm not able to handle a situation, I fasted for three days without food and water. Eventually, God answered my prayers, God is real and answered prayers.' – Husband, Aiga Ono*

In this discussion, the participant described how his commitment to anapogi practice empowered him. He asked for God's healing for his wife and wisdom to address matters pertaining to his children. Through his faith he was never alone. God is always present to guide, support, and counsel him. He fasted according to the extent of his needs. The feedback indicated that the participant's desperation for information, knowledge, and patience to perform his many roles for his family. Overall, the fa'afaletui showed that the participant has more connection, support, and guidance from his God than from the MHS.

5.3.3 Importance of religion and church

Most participants were affiliated with church/religion. Church is a sacred place and has strong connections with participants, and all Samoans. Church is God's residence and only appropriate and godly behaviours are endorsed, such as peace, kindness, caring and compassion. Violence and aggression of any form are not allowed and are disrespectful to the presence of God. Church is a significant place which all Samoans have an obligation to respect and safeguard.

The following fa'afaletui reveals an ordeal one family experienced at church:

> *'My son assaulted me at church. I'm ashamed and humiliated by my son in-front of the congregation. I preached the word of God, that was the other thing that caused me shame. I felt shamed and humiliated because of the church and the tapu relationship of the Samoan culture.'*
> *– Father, Aiga Tolu*

His wife added:

> *'Can I add to what my husband was saying. We are deacons for our church and my husband assists the pastor, so only God knows the 'va fealoa'i' sacred space between us and the church.' – Mother, Aiga Tolu*

The fa'afaletui describes the feelings of shame and humiliation the parents experienced when their son assaulted his father at church. For instance, the father described church as a sacred place where violence and anger were condemned. Also, he was humiliated when the assault was witnessed by the congregation of Samoans. In addition, his son's behaviour brought shame to his role as the church preacher. However, the participant was also angry and frustrated with the MHS's lack of care. Because his son was without medications, he was not able to control his anger. Overall, to this family, this incident has shown the lack of care, understanding, and respect from the MHS in not protecting cultural significant dynamic of Samoan family. Family are at the core of the person- and family-centred care model. However, this was not reflected in this case, causing trauma and psychological pain for the service user and family.

Another church matter was shared by one family member:

> *'We are a strong Christian followers and smoking cannabis and drinking alcohol is not allowed.' – Sister 1, Aiga Lua*

This fa'afaletui describes how the participant shows her disapproval of the service user's behaviour, as what they observed was not acceptable according to their religion's beliefs. These inappropriate behaviours not only brought shame but also reflected badly on their family, especially their parents. The disappointment was based on the service user being raised in the religion; however, his behaviour showed not only that he was neglecting his faith but also dishonouring his family. In this case, the participant's feedback showed her expectations for service user to follow rules without considering his altered mental capability due to the illness. It showed her lack of awareness and understanding about mental illness, which showed her cultural lens's expectation for family members to respect and uphold their religion's rules. Such beliefs could contribute to developing resentment and unhealthy patterns of behaviour that might hinder the quality of family support for the service user.

This family support was shared by the following participant:

> *'My son humiliate me in-front of the church but when I came home, and he was taken by police I felt sorry for him. I can't remove my love for my son like all parents feel for their children, right now I want my son back home where he belongs.' – Father, Aiga Tolu*

The fa'afaletui above describes how the participant was humiliated in front of his church. In fact, this incident is tapu in the Samoan culture. It showed disrespect and violation of the sacred space (va) of the relationship not only between a parent and a child but also the relationship between the family and the church. The discussion has also revealed an example of how the sacred space between Samoan parents and their children was restored as shown by the father's willingness to forgive his son. It has shown the sacred culture dynamic of a Samoan family that should be protected. However, this was violated due to the lack of response and follow-up by the MHS causing emotional distress and shame. Overall, cultural values and beliefs around families should be at the core of the person- and family-centred care model for Samoans. However, this was not the case as endured by this family.

One participant shared her disbelief at what was unfolding for her son:

> *'That was not my son assaulting his father, he was raised in church and participate in church activities; he should not be ending up like this – he is now in jail.' – Mother, Aiga Tolu*

In this discussion, the participant has expressed her disappointment and sadness with what was happening to her son. In her belief, participating and serving church should not be associated with bad outcomes because serving church is serving God and people who served God are blessed with whatever they pursued in life. The feedback also showed the participant's disappointment with the MHS's lack of response and care. Obviously, she blamed the MHS for her son's unfortunate circumstances because, based on participants' experience, the lack of care from MHSs clearly suggests inconsistency of theory and practice. The experience also highlighted that the service user and family were not the priorities or at the core in the plan of care as pledged by the MHS model.

Overall, family discussions revealed the significant connection participants had with their spiritual and religious beliefs. In particular, the belief was that God's love was consistent, compassionate and honest for those who are in need. Also, God is family, intimate and close. This trust has impacted participants' resilience in coping with the challenges they have encountered. Also, the conversation described participants' disappointment, confusion, anger, and frustration at the lack of support from the MHS.

Altogether, spiritual faith and religion has a major impact on participants’ way of being, indicating how this factor should be core to the person- and family-centred care approach for Samoans.

5.4 Theme 2: It’s a hush-hush topic: Stigma of mental illness

Samoans also believed that ma‘i Samoa or Samoan sickness is the possession of someone by the spirits or ghosts stemming from traditional cultural beliefs. In this case, the spirits are assumed to communicate through the possessed, whether to correct behaviour or provide guidance (Efi, 2009). In most cases, and from personal experience, possession by the spirits often related to bad or negative energy.

Indeed, the presence of the spirits was mentioned by participants when they interpreted symptoms of mental illness, as well as the challenges they encountered when explaining and sharing this phenomenon with MHS clinicians. The following conversation described one participant’s experience at her son’s psychiatric assessment:

> *‘My son was very close to his grandpa, and he kept saying he was hearing his papa’s voice, then you tried to explain, and they looked at you and thinking that you are weird.’ – Mother, Aiga Tasi*

The discussion above explains an experience the participant encountered when she disclosed cultural explanations of mental illness to a non-Samoan health professional in the MHS. She was frustrated with the lack of acknowledgment and acceptance of her explanations as valid interpretations and instead was being judged. The participant was concerned that the misunderstanding of her viewpoints might have consequences for her son’s treatment, consequently resulting in misdiagnosis and wrong treatment. Clearly, this fa‘afaletui indicates gaps between the MHS model of care and Samoan people, as understanding and awareness about cultural interpretations should be at the core of the assessments.

5.4.1 It’s a curse: Stigma of mental illness

Family fa‘afaletuis have identified different ways families have experienced stigma. Some families were more aware about stigma than others. Also, it caused disagreement within families and was a barrier to the service user’s recovery. There was strong indication from the discussions that mental illness was someone’s undoing, and traditional healing was the only cure. The following family members in Aiga Tolu and Tasi described how stigma was played out within families as well as Samoan beliefs associated with mental illness.

> *‘It's like a hush hush subject when people said oh yeah, it’s a curse or kind of because I’ve been condemned of that.’ – Mother, Aiga Tolu*
>
> *‘My mum was right, because she was saying my brother really needed mental health but then our whole family was telling her that she should not be ‘fia Palagi’ and should consider ‘fofo Samoa’’ – Sister, Aiga Tasi*
>
> *‘You reach out to your own family wanting support and yet your parenting skills was blamed, and I got condemned and persecuted’ – Mother, Aiga Tasi*

These fa‘afaletuis describe different perspectives and interpretations of mental illness. Instead of support, the mother in Aiga Tasi was judged and ridiculed for not believing in ‘fofo Samoa’ (the traditional healer) and was ‘fia Palagi’ (acting like a Pākehā). This has caused disagreement and created a barrier to the family support that was needed at the time. Also, the mother’s parental skills have been scrutinised and blamed for her son’s mental illness. This was unnecessary and unhelpful, causing more stress and discomfort. Alternatively, the fa‘afaletui has identified the lack of MHS programmes to educate Samoan and other Pacific communities about mental illness in their own ethnic languages. In fact, community engagement and the community understanding of mental illness is a core principle of the person- and family-centred care model, which was clearly not what happened in this case.

Additionally, family discussions revealed that wherever Samoans reside in the world, their view about mental illness were the same. As mentioned, hearing and responding to voices are associated with negative forces brought about by someone, perhaps people within the family. The dscussions below are examples of how Samoans are detached from associating with mental illness:

> *'My sister was from Samoa and does not understand mental illness, she tried to discipline service user at the wrong time causing the incident at church.' – Mother, Aiga Tolu*
>
> *'His father in Samoa would throw away the medications he does not believe in mental illness.' – Mother, Aiga Tasi*

These fa'afaletuis recount participants' frustration with what they have observed from their family members. For instance, a family's lack of awareness and understanding of mental illness can become an obstruction to a service user's recovery. As a result, this can create stress and discomfort for everyone involved. Also, this example showed the significant need for mental health education and information for families, especially those who are registered in services. Admittedly, community education and involvement was one aim the person- and family-centred care approach set out to achieve. However, discussions with the family indicate gaps in practice, and misaligned approaches in the MHS person- and family-centred care model.

Furthermore, Samoans often send family members back home with the hope of healing and recovery from illness or discomfort. In fact, for MHS users, the usual cultural control environment within villages and family provides a low stimulus for behaviour, as well as limited access to drugs and substances. In addition, the authoritarian roles of parents are more pronounced in some families in Samoa where strict discipline rules are in place.

Therefore, parents and cultural values are believed to have some control over the behaviours that are most associated with mental illness.

The discussion below demonstrates this belief where the family was considering sending the service user back home:

> *Our parents said, "send him to Samoa so I can smash his head as we did not send him there to do those behaviours"' – Sister 2, Aiga Lua*
>
> *'I agree with my sister, because in Samoa it's hard to find money to buy cannabis and there are some controls on his behaviour, we wanted him to learn and stop smoking.' – Sister 1, Aiga Lua*

In their accounts of the events surrounding the service user's behaviour, smoking cannabis, drinking alcohol, and mental illness can be controlled in Samoa. The conversation shows the belief that the authoritarian role of parents can have some control on mental illness, as well as the family environment in Samoa being therapeutic and healing. This example indicates the need for family education and awareness, not only about the illness but also information on coping techniques for health and wellbeing, because caregiving can be exhausting and unhelpful if family are not supported and well-informed. Indeed, this can be addressed if families are involved and their needs centralised in the plan of care, as dictated by the aim of the MHS model of care.

Overall, this theme has highlighted factors that contribute to Samoans' views on mental illness and the stigma associated with it. In fact, cultural values and the usual family environment indicate that, for Samoans, healing and peace were found at home. In addition, family discussion highlights gaps in MHS clinical assessments because important cultural information that has a strong influence on how a family operates was not explored. This shows miscommunication and practices that are misaligned with the MHS person- and family-centred care model.

5.5 Theme 3: We are in the dark with our communication and dealings with the mental health service

Participants believed that barriers existed which prevented them from gaining access to MHSs, such as accessing care at the right time, not answering the phone, confused police response, and poor communication. In addition, families often felt neglected and unsupported, especially during urgent circumstances. The following sub-themes describe the barriers as experienced by participants.

5.5.1 Problems with access to care

Concerns were expressed about MHSs not answering and returning phone calls. Examples include participants' desperate efforts to get hold of case manager/keyworkers, but instead being directed to leave messages. These experiences were shared by new referrals and families who were already registered and using services.

The following discussion explains these examples in detail:

> *'It was very hard to get through MHS. I keep calling all community support services and even NGO and try to get help. I literally went through the phone directory for any MHS support because I was desperate.' – Mother, Aiga Tasi*

The discussion above shows a mother's desperation to get urgent MHS support for her son. While describing her experience, she was emotional, her voice was raised showing anger and frustration. Clearly, she was confused that this incident occurred in the area where most Samoans/Pacific people reside. Therefore, she was hopeless and felt neglected.

Another family shared similar experiences:

> *'I tried to ring them no answer only the answer machine. I kept on ringing and ringing no answer, I left messages and they never replied.'*
> *– Mother, Aiga Tolu*

Obviously, the participant expressed disappointment and frustration with the MHS's lack of response to her call. In this case, the service user has already registered with the MHS; however, the mother struggled to get hold of the MHS for her son's medications. She was describing feelings of hopelessness when her appeal for help went unanswered because what she has observed with her son was beyond her ability to cope with and she was depending on the service for support. In this context, accessing care was difficult even for families already within services. This lack of access contradict the aim and purpose of the person- and family-centred care model.

In addition to this, one family described how another healthcare organisation came to her rescue instead of her responsible service.

> *'We literally had to go to another healthcare organisation – they have a mobile service, and they were the one who responded and came through. This organisation mobile service came to our rescue. Because I tried to get through to our healthcare organisation crisis team with no help.' – Mother, Aiga Tasi*

In this discussion, the participant was confused that another service outside of her catchment area came to her rescue instead of her own. This family's experiences revealed challenges for Samoan families in accessing care, and the system in place has already discouraged them. Person- and family-centred care is aiming to improve communities' access to care but the experiences shared by participants showed otherwise, raising major concerns for Samoan and Pacific populations.

Family group fa'afaletuis also identified difficulties experienced with the police because, when families contacted MHSs, they were always advised to contact the police.

5.5.2 Police don't do anything

These views surfaced mainly in relation to the role emergency services such as the police played in acute care episodes because, when families contacted MHS for acute or crisis support, they were directed to contact the police; however, the police redirected them back to MHS. This sub-theme describes incidents where participants were caught between the two systems which created more confusion instead of prviding the care they urgently needed.

> *'When we contacted MHS we were told to contact police and when we contacted police, they said we are not coming unless MHS was present.'*
> *– Mother, Aiga Tasi*

> *'We contacted MHS that we really needed help with my brother, they said to contact police – and police do not do anything, so I don't know.'*
> *– Sister 2, Aiga Lima*

In the conversations reported above, participants were bewildered and frustrated at what they have experienced during urgent situations. The experiences were unhelpful, causing despair and hopelessness as families were unsure who to turn to for help. In fa'afaletui in Aiga Tasi there was an example of MHS and police involvement; however, the two systems were waiting on each other instead of helping the family in need. Clearly, MHS processes and criteria were the priority without considering the suffering and trauma experienced by the family while awaiting help. This has contradicted the purpose of the person- and family-centred care model where access to care is timely and closer to communities. Also, the need of the service user and family were clearly not the priority in this case.

Moreover, this experience was shared by the fa'afaletui in Aiga Lima. In this case, being told to contact the police seemed to be a regular response received by this family when they urgently needed help. As a result, the participants seems to have given up hope about contacting the MHS, and instead preferred to manage the service user home at the expense of their peace of mind and comfort. In fact, from the family discussion, it was easier for the family to live with discomfort than trying to get through to MHS. All the same, participants in both fa'afaletuis felt they were let down by MHS. Also, the involvement of police, although helpful in some ways, was delaying the care they desperately needed at the time.

Another family shared their version of interacting with police. In this case, the police informed the family that the MHS would be in contact the following day.

> *'We were informed by police that MHS will visited us the following day, so up to this day no one contacted or visited us at home to follow-up, then I said to my sister ... oh well!' – Sister 2, Aiga Lua*

This fa'afaletui shows the participants' confusion at the lack of care by the MHS because there was no follow-up to check and to assess and review the service user's treatments as promised by police. While the participants were annoyed, there was no indication from them of a challenge to the MHS failure to follow-up. Instead, the family seems to accept this as 'the way things are' but their facial expressions revealed this story 'was not okay'. Important to note that this family migrated to NZ less than five years ago, and this might influence their awareness and confidence level about challenging and asking questions.

In fact, this fa'afaletui is an example of the different stages of Samoan family dynamics in Aotearoa. Samoan migrations vary from recent to those who migrated over 30 to 50 years. Therefore, the number of years a Samoan family has been settled in NZ should be noted, and considered in their interactions with MHS. Also, it should be highlighted in the person and family centred care model for Samoan families as this has great influence in people's confidence level in seeking help.

Alternatively, one family group discussion shared an experience where the keyworker/case manager was confused with the police role. Moreover, the family were unsure if this was an excuse for the keyworker's lack of commitment and care.

> *'I was telling them at our meeting that we contacted police and the keyworker asked did the police helped you? And I said no police said to contact you and she said no the police should helped your son not us,*

> *and I said my son has a mental illness that supposed to be you guys not police' – Mother, Aiga Tolu*

This fa'afaletui recounts a mother's frustration with the keyworker's unhelpful attitude. The keyworker's response has shown either her lack of experience, ignorance, or negligence. Here was an example of an MHS clinician avoiding their responsibility and duty of care by giving the family misinformation. It also shows the possibility of the MHS using the police role for their own agendas without providing quality care for people. This family's experience has demonstrated an example of practices that are clearly centralised on the clinicians' and the service's need rather than on the service user and family, which is obviously not aligned with the MHS's aim of providing person- and family-centred care for the population.

5.5.3 Crisis care access difficult

In addition, one fa'afaletui described a mother's frustration when she contacted the MHS for urgent support, but instead was informed that care was only warranted upon meeting certain criteria.

> *'My son was damaging a lot of stuff but when we reached out for help, they said unless he was causing harm to himself or to the public – that was woah! that was a mission!' – Mother, Aiga Tasi*

Clearly, the participant was frustrated with the MHS as her desperate contact was denied due to a criterion proposed by the MHS. She recounted the impact of coping with her son's illness for days without help from the MHS. While her son was not a threat to himself and others, the trauma experienced by his siblings and family was immense. In fact, she was disappointed when the MHS response was determined by criteria without considering the psychological need of the service user and family. Obviously, this experience has shown an example of the MHS prioritizing its need instead of the service user and family, which indicate practices are misaligned with the person- and family-centred care model.

5.5.5 Poor communication

Another reported problem by families was their lack of knowledge about MHS, and available support services for Pacific people. For instance, participants' family members were registered with the MHS for over five years; however, they were still 'in the dark' in regard to understanding services and their role in care. Therefore, families were relying on themselves and NGOs for support to navigate their way through the MHS.

For example, one family describes their first contact as lonely and unwelcome because they were expecting a face-to-face meeting, information, and guidance as this was new territory for them; however, there was none.

> *'It was the very first-time experience for us in MHS, we would have appreciated some sort of guidance you know, we kept asking a lot of questions but there was no one to support us.' – Mother, Aiga Tasi*

This discussion explained the participant's disappointment with the unwelcome attitude of the MHS. In fact, she was expecting information about services, mental illness, Pacific support, language, and all relevant family resources for people new to the MHS. In this case, the family appears to have been neglected while the focus of care was on the service user. Obviously, the family were not encouraged to engage and participate as highlighted by the aim of the MHS's person- and family-centred care model. As a result, the family were discouraged and felt disrespected by the service. Overall, first impressions are key to fostering a good relationship as this has major influence on the quality of care and experience of consumers.

In addition to this, another family were surprised to learn about available Pacific services in the MHS, although they had been registered with the MHS for over five years.

> *'It seems like there are services that we were not aware of, and these services should be automatically available to us.'* – Sister 1, Aiga Lima

> *'Like what my sister was saying, I want to learn and understand things about MHS that's why I participate in this study because for our family we are in the dark with our dealings with MHS.'* – Sister 2, Aiga Lima

This family were confused and disappointed at their lack of awareness about available services in the MHS. From their perspectives, support services should be available to every family at the initial contact with services. This family has been registered with the MHS for over five years and their feedback has shown their limited awareness. In this case, the family indicating that they were 'in the dark' has revealed the quality of their relationship with the MHS.

Overall, this theme has described the lack of accessibility and poor communication experienced by families. As a result, families were confused and uncertain, with no sense of connection and relationship with the MHS.

5.6 Theme 4: "Practice what you preach": Clinical service delivery misaligned with the mental health service model of care aim and vision.

In family group fa'afaletuis, families were first asked to describe what person- and family-centred care means to them. This was followed by an invitation for them to compare their interpretations with what they have encountered with MHS. Participants' interpretations and understandings of what the integrated person- and family-centred care are combined and described below:

> *'Person- and family-centred care means care, and support centralised on the need of the service user and family. Including practises of making sure the person and family can understand what is going on, explaining the treatment and side effects, providing information about support services, to be included in care planning, provides ongoing follow-up, and services to be available and respond to requests in a timely manner.*

> *The more understanding the family become, the more we understand and provide better care for the service user.' – All family fa'afaletuis*

Importantly, the collective interpretation from participants was aligned with the aim and goal of the MHS integrated model of care. However, thereafter, changes in the experience of care were apparent.

The following sub-themes describe the insights of families highlighting the incongruency of their interpretations and clinical approaches that were in breach of the model of care delivery.

5.6.1 We don't get that from them: Model of care misalignment

This fa'afaletui describes the interpretation of two families when asked to rate the MHS care they received according to their interpretations of the model of care.

> *'I think the only time that we ever felt this was from another healthcare organisation mental health mobile service, this was from T and S. They sat us all down in that room and we talked and explained things to us.'*
> *– Mother, Aiga Tasi*

The discussion above explained why the participant and her family have failed to experience the person- and family-centred approach from her own MHS. Instead, she expressed her disappointment and frustration with the lack of care when it was urgently needed. The feedback has revealed the incongruency of what the model of care sets out to achieve and the quality of care that was experienced by families. This clearly highlights the mismatch between the model of care and the awareness of health professionals causing major concern.

Additionally, another participant's interpretations was clouded by experiences of sadness and frustration with the lack of care and commitment by the MHS. Instead, she overtly confirmed that the care her family received from the MHS has failed to represent the core values of the model of care.

> *'I don't experience this from X service because my son was placed in jail. I still contacting that lady (keyworker), the police contacted us about my son's court hearing, and I contacted X service they said they will be attending. I'm sure they were lying they never turned up at court, same as yesterday we went there, and they don't.' – Mother, Aiga Tolu*

As stated above, the participant denied any relatedness of her interpretation to her current service. Instead, she was disappointed at their lack of care which resulted in her son being out in jail. Also, the fa'afaletui has shown the participants distrust the services, for they make promises that they do not care to keep. Additionally, the family was not informed of changes, which showed the lack of respect. Indeed, this family experience has revealed a poor standard of care which is misaligned with the purpose of the MHS integrated person- and family-centred care model.

In addition, the participant from Aiga Lua related her interpretations to the support and care from the NGO.

> *'I can relate this to X service as there are lots of support from them. They gave us food parcels especially during COVID19, the NGO contacted us by phone and visited us at home, we got more contact from NGO than MHS.' – Sister 1, Aiga Lua*

Three of the families in this study shared similar feedback with Aiga Lua above. The participants found NGO support helpful and caring. Not only does the NGO make home visits but it also provides food parcels. In addition, support workers were approachable and empathetic. The NGO also provides monthly family workshops for mental illness. This fa'afaletui has revealed that participants valued their family relationships with the NGO more than with the MHS because the qualities shown by NGOs are more aligned with the purpose of the person- and family-centred care model.

Another Aiga fa'afaletui related their experiences to a different Pacific NGO. This NGO allocates a Samoan-speaking support worker. The family described this NGO support as care that went ‘above and beyond’ their expectations, which creates feelings of hope and encouragement during difficult times. This approach, according to the participants, was a true reflection of a service providing care that centralised on the person and family need.

As well as families relating their interpretations of NGOs, other family’s interpretations were related to Pacific people working in the MHS and other support services. One family related their interpretation to the intramuscular injection (IMI), and another family to the free services from the MHS. The following discussion describes these interpretations further.

The first interpretation is from Aiga Fa. The participant shared her interpretations of Pacific health professionals:

> *‘I don’t experience this from a Pākehā, I only get this from a Pacific person like S and the Samoan interpreter. There was no comparison between the love and care from a Pacific person with that of a Pākehā.’ – Mother, Aiga Fa*

This interpretation was related to the Pacific nurse and a Samoan interpreter. In this case, the support, attitude, and manner of the two professionals as experienced by the family were centralised on the needs of the person and the family. The participant’s understanding of Pacific professionals was that they were caring and compassionate in comparison to others in the field. Importantly, this interpretation suggests that service from the heart is the true reflection of the person- and family-centred model.

The second family relates their interpretation to the fortnightly IMI.

> *‘As far as I know I can relate this to my brother’s injection because the IMI helps him focus and able to do his normal routines.’ – Sister 2, Aiga Lua*

In this Aiga Lua, the participant’s interpretation of the model was related to her brother’s treatment. The IMI not only manages the service user’s symptoms but also maintains the family's wellbeing and peace of mind. The injection was also the only regular connection the family had with the MHS. Therefore, the IMI represents care that supports the person- and family-centred care by preserving the peace and wellbeing of the family.

The third interpretation was from Aiga Ono. In this group, the participant related his interpretation to the free services that his wife received from the MHS.

> *'I can relate this to my wife's receiving free services from MHS and the staff were looking after her well. I should also provide support and not rely entirely on your service.' – Husband, Aiga Ono*

In this feedback, the free public care from the MHS was beneficial for Aiga Ono. The free MHS services helped support the family's financial position. Therefore, some aspects of person- and family-centred was achieved for this family by minimising financial pressure.

Unlike Aiga Tolu, the participants failed to identify any form of person- and family-centred approach to their experience with MHS. This was due to an incident which involved the service user assaulting his father and being removed by police. This family believed the lack of care and follow-up was unacceptable. Moreover, they were disappointed with health professionals' negative attitudes as they observed and sensed the lack of care and honesty in fulfilling their roles.

To summarise, findings in this sub-theme have revealed participants' interpretations of the MHS person- and family-centred model. Collectively, the interpretations show that participants rate human connection, good communication, honesty, and respect as core to the person- and family-centred care approach. Overall, the focal point of this sub-theme reveals inconsistencies and miscommunication reflecting a misalignment between the model of care and the actual application of clinical practice in the MHS.

5.6.2 Not understanding clinical practice & processes

Concerns were expressed that participants lacked understanding about clinical processes and their role in the mental health delivery model of care. The fa‘afaletui in this sub-theme describes challenges families experienced in understanding clinical processes, medical terms, diagnosis, and treatment.

For instance, Aiga Fa described disappointment in the psychiatric assessment. This family went through an extensive process of questioning, but this was not reflected in the service user's outcome.

> *'You know about doing the assessments they ask everything from the beginning before my son went to Australia, including his school history and our family environment. Also included information about my husband and me. Some of the question they asked were confidential and I don't want to answer but I must because I thought this would benefit my son. So, when I think of my son's current situation it sounds like that assessment was done for nothing and my son's life is destroyed, he's in jail and not supposed to be there.' – Mother, Aiga Tolu*
>
> *'I agree with my wife, maybe they just record our answers down and then threw it in the rubbish.'– Father, Aiga Tolu*

In this family fa‘afaletui, the parents were disappointment and angry with the MHS's complex clinical processes. The mother was frustrated as she was placing her trust with clinicians by not withholding confidential information; however, there was no value in it based on her son's current situation. There was pain and anger expressed by the participants as, in their view, the negligence by MHS clinicians has ruined their son's future. In addition, the father's discussion shows his lack of trust with clinicians' lack of professionalism, honesty, and love. Overall, these would be the qualities that reflect care centralised on the need of the person and the family, and which has failed to be shown with this family.

Another family also shared an experience where the participant was explaining her son’s situation; however, clinicians were looking at her as if she was not sensible. The participant was frustrated and annoyed as she appeared to be judged by clinicians despite her efforts to answer their many questions. Additionally, the assessment process and questions were stressful and emotionally draining for the family. Such processes should contribute to identifying specific strategies and cultural patterns to manage illness and not to add more stress for the family.

5.6.3 Work & Income benefit review: Lack of understanding and awareness about medical reviews

Another clinical process that was identified in the family fa‘afaletuis was the medical review. A variety of perspectives were expressed when participants were asked about their experiences. One family shared positive feedback while most families were either confused or showed a lack of awareness about the process.

Aiga Fa shared positive experiences, where they were included and actively participated in their daughter’s medical reviews. The contributing factors were the Samoan interpreter and the Pacific keyworker who contributed to the family’s confidence by asking questions and focusing clinical discussions on their daughter’s illness that helped empower them to support their daughter’s recovery. These cultural supports are important as they form the core of the person- and family-centred care reflected by this family’s positive experience.

However, Aiga Lima’s family fa‘afaletui revealed confusion and a lack understanding of the medical review process:

> *‘My brother attends medical review with his support worker. I asked him what he was doing at his review, and he said he went to review his WINZ [Work & Income New Zealand] benefit.’ – Sister 1, Aiga Lima*
>
> *‘Yes, I thought that’s what the support worker’s job to pick up my son and attends the appointment with him.’ – Mothe,r Aiga Lima*

> *'But for me, I do not know, because we haven't attended medical review as we are not aware we can.' – Sister 2, Aiga Lima*

This family has been registered with the MHS for over five years; however, in their feedback, they were not involved in or attended any medical reviews for their family member. While one participant thought the medical review process was to review the WINZ benefit, the other family member were not sure if the family could attend this process with their mother thinking that attending medical reviews was the role of the support worker. Obviously, this family was not included in care despite being registered with the MHS for years. The fa'afaletui also revealed that care was mostly coordinated between the MHS and an NGO without the family's involvement. These events have begun to provide insight into how practices are inconsistent with the purpose of the person- and family-centred care model.

5.6.4 Lack of understanding about diagnosis and treatment

Furthermore, participants believe they lack knowledge and understanding about the diagnosis and treatment of their family members, such as information about the diagnosis, the rationale of prescribed treatments, side effects and the therapeutic effects of medications. A variety of perspectives were expressed and these are described below:

> *'He was under a lot of medications but there wasn't a lot of talk around it.' – Sister, Aiga Tasi*
>
> *'She was sleeping a lot; I don't know why. Sometimes she slept nearly a whole day.' Husband, Aiga Ono*
>
> *'There was a time when his eyes rolled up and showed only the white part and he can't see, so when his eyes were like that, and the medications ran out I was ringing them but there was no response.' – Mother, Aiga Tolu*
>
> *'Her hands and feet were shaking, and we do not know why.' – Father, Aiga Fa*

> *'Oh yes, and she was eating a lot and putting on a lot of weight.' – Mother, Aiga Fa*

> *'The doctor said to my brother, I'm giving you the injection, but my sister and I do not understand the reason for the treatment and what it does for my brother.' – Sister 1, Aiga Lua*

Discussions revealed that participants were uncertain when they observed changes with their family members' mannerisms and body changes. In fact, these changes were disheartening when limited knowledge and information were available to them. Additionally, clinical information and discussion were mostly delivered in English which most families do not understand. Therefore, families were left to seek answers and to make sense of their situations alone. Clearly, the family role was not at the core of the MHS model of care as demonstrated by participants' experiences. Also, there was a lack of responsibility from the MHS to provide information and to educate families about medications. In short, these experiences have begun to show examples of practices that are not aligned with the purpose of the person- and family-centred model for Samoans.

In addition, families admit they lack awareness about diagnoses given to their family members. One participant's version of her brother's diagnosis is as follows:

> *'They only mentioned the voices, but we do not know where it came from and why my brother was hearing voices, so we came back home not sure about the cause of his illness.' – Sister 2, Aiga Lua*

This fa'afaletui from Aiga Lua revealed an example where the mental health diagnosis was not explained to the family in a language they understood. Also, there was no effort from the MHS to educate and provide information since, for this family, talking to the spirits was a normal occurrence for Samoans; however, they needed clarification from medical professionals to help differentiate between the illness and their beliefs. Without a doubt, this experience has shown major gaps in MHS understanding and acceptance of cultural influences on mental illness. Samoans need information and education to fully understand mental illness, especially in the community where stigma is more pronounced. Overall, these findings could contribute to revealing distinct approach to align the person- and family-centred care to be more culturally in tune to Samoans.

In addition to this, one participant for whom English language was her first language recounts her experience in questioning her brother’s diagnosis.

> *‘When he first went in, they diagnosed him with drug-induced psychosis, then after that they said it was depression and when it got worst then he was diagnosed with bipolar, and I was like oh okay.’ – Sister, Aiga Tasi*

The participant was frustrated by clinicians constantly changing her brother’s diagnosis. This practice was unhelpful for the family while they were trying to adjust to their family member’s ordeal. Additionally, the family was not provided with information about the clinicians’ rationale for their clinical decisions to help alleviate fears and uncertainty. This example shows that families were left to investigate clinical information on their own when English was not the first language for most families. Also, families were not included, nor was their level of understanding addressed by clinicians. As a result, family were not centralised in care, which contradicts the MHS person- and family-centred care goal.

5.6.5 Gaps in transfer of care between services

As well as not understanding diagnoses, the fa‘afaletui uncovered gaps in the transfer of care (TOC) between MHSs. One family believed they suffered the consequences of substandard MHS processes. Participants shared their frustration and despair with the lack of adequate care coordination and communication which left them lost and ignored for seven months. As a result, their son was without medication, relapsed, threatened young children, and assaulted his father at church. The mother expressed her sadness and disappointment with the TOC process that was executed during COVID-19 level 4 restrictions. For this reason, her son and family were left vulnerable during the crisis period for the community and the country. She accepted and understood the need for no face-to-face contact; however, there was no response to her ongoing phone calls for help either. In addition, when she tried to contact the previous service, she was redirected back to the current service as her son was no longer with them. This incident caused the family confusion, anger, and frustration due to the lack of care and love involved in the TOC process.

> *'There were so many things going on with my son, he was stressed, he needs help but at that time help was so far away and no-one was helping my son.' – Mother, Aiga Tolu*

In this experience, the participant believed that getting help for her son was impossible. She saw 'help so far away' indicating her hopelessness when she realised that help was beyond her reach. The MHS was the only support, and she had nowhere else to turn. This experience shows a vulnerable family being isolated without proper support. Such experience could contribute to identifying practices that lack care and compassion and are inconsistent with the MHS person- and family-centred care model.

Overall, this fa'afaletui revealed barriers experienced by families using MHSs. In this case, the incident happened when the community was at the highest level of restrictions in the pandemic crisis. This family ordeal has shown the lack of flexibility and consideration of services, not only in the current situation for the family but also in the community. In fact, the TOC should not go ahead. These decisions demonstrate services that are unresponsive to the family and their living situation, and instead are focused on fulfilling their processes. Consequently, this has highlighted decision-making and practices that cater to meeting services' needs without regard for the family. Clearly, it has shown inconsistent practices and a mismatch with the person- and family-centred model of care, causing heartbreak and sadness for the family.

5.6.6 Our voices do matter: Lack of family inclusion in care.

Families believed they were not included in care planning and discussions. Discussions revealed experiences where family members were not included in discussions even if they were present and visible. Younger family members shared their feelings of being neglected, and clinicians assumed they understand and that their feelings do not matter.

> *Whenever we have sessions, they only talk to mum and they would like 'how's your daughter's feeling', while I was sitting there, and I was like – I don't have a voice –* coz *I wasn't that young I was 18 or 19 years old at the time.' – Sister, Aiga Tasi*

The family member in Aiga Tasi shared occasions where she felt invisible to MHS clinicians. On one occasion, clinicians visited her brother at home, and they only talked to him without acknowledging her. Also, clinicians were aware that she was studying psychology, therefore, they assumed that she knows about mental illness and were saying,

> *'Oh, you should know about what was going on with your brother' and I thought 'It was easier to read about the diagnosis that being a sibling of someone who was going through the illness.'' – Sister, Aiga Tasi*

Additionally,

> *'I am aware my mother has mental illness that's all I know but they never talked to me maybe because I'm at school most of the time, so I do not know a lot about her illness.' – Son, Aiga Ono*

Overall, discussions have revealed that younger family members were discounted by MHS. There was an assumption that siblings and younger members are okay without acknowledging that service user's actions affects every family member. Such practices could contribute to establishing patterns that contribute negatively to the person- and family-centred care for Samoan families.

A similar experience was shared by Aiga Lima. The mother shared that the clinicians only addressed her son despite her presence at home. However, she was not overtly concerned because she understands the language barrier. This barrier also has prevented the family from engaging and contributing fully to the service user's recovery progress. Clearly, this has shown a mismatch of the core purpose of the model of care and the reality for Samoan families using MHS.

Additionally, other participants believed that the MHS has poor communication. One mother was informed over the phone to pick up her son from respite without any explanations or family involvement in follow-up care planning. The communication was short notice as the participant needed to plan and organise her family. Also, she wanted to know about the medications and get an update on the service user's progress and mental wellbeing before discharge. The participant was annoyed and frustrated with the MHS's processes as she was informed without any discussions or involvement in planning. This incident has identified explicit areas in clinical practice that are inconsistent with person- and family-centred care.

Overall, this sub-theme has identified the lack of family participation and involvement in all areas of the MHS. This has shown major gaps and barriers between MHS and health professionals' expectations and their understanding of the aim of person- and family-centred care.

5.6.7 They talk to the support worker not us.

Along with not being included in care, some families revealed that the coordination of care was mostly happening between the MHS and NGOs. Some of these NGOs are partners with the MHS in supporting the person- and family-centred care model. The following findings reveals how participants saw their role being replaced by an NGO when coordinating care with MHS.

> *'I'm sure the keyworker is talking to NGO to arrange transport and plan for my brother, but he never talks to us.' – Sister 1, Aiga Lima*

In this fa‘afaletui, care coordination between MHS and NGO was normal practice for participants, indicating the nonexistence of the family role in care. Also, it shows disconnection of the MHS person- and family-centred care model from the actual application to practice. Moreover, family support and connection have significant meanings to Samoans as outlined in Chapter 2, so families are always present and involved. This should be encouraged and empowered to reflect true representations of family in the MHS model of care.

Another family shared how the NGO represented the MHS role in their interactions.

> *‘NGO visited my brother weekly, and as far as I know no one visited him at home from MHS, it would be good for them to communicate with NGO, this could be a way for MHS to have close contact with my brother if they are not listening to us the family.’ – Sister 1, Aiga Lima*

The participants’ appreciation of NGO support was shared in the above fa‘afaletui. The participant believed that the MHS care should be of same quality as the NGO approach, and there was clinical information she wanted to discuss that the NGO does not provide. Also, her brother needed regular contact with clinicians to review his mental state. Although social support was important to this family, having the important clinical information they demanded was even more important. The participants valued the support from the NGO and often it went beyond expectations. This support could add value to identify positive communication factors in person- and family-centred care for Samoan families.

5.6.8 We don’t know about the Pacific service: Lack of awareness about Pacific MHS and language support.

Some participants shared they were not aware of the Pacific service in the MHS. Out of the six families, only one family was referred to the Pacific service, and two families used language support. However, the other families were either unaware of the services or Pacific support services were not offered to them.

In the following fa‘afaletui, the Aiga Tasi participant considered the quality of service she received from the Pacific service as poor.

> *‘They were okay, it was almost felt as if it was just the support – not a clinician support kind you know, there was no therapy, they would come in and do a prayer and that is moral support and they would bring in the culture, but to me it was not deep enough like it doesn’t form part of the diagnosis and what you know, and from where we were and how far could we go and the follow-up.’ – Mother Aiga Tasi*

The participant was expecting more from the Pacific service. She was aware that prayer was important to Samoan culture; however, she wanted an explanation of the illness, treatments, and processes in a language that she can understand. In fact, she needed a Pacific clinician to provide information so she can better understand and support her son. She was disappointed to learn that the Pacific service has limited ability to support her because she was requesting support services, and instead she was informed that the Pacific service can only liaise with keyworkers and was not actively involved in referrals. The participant was confused and was questioning the quality of cultural support due to the limitations placed on Pacific service roles. Overall, this fa‘afaletui has revealed the limited function of Pacific services to cater for Pacific people. It also indicates the misalignment of the model of care and the lack of responsiveness of the existing Pacific MHS to Samoan and Pacific people’s holistic needs.

From most family fa‘afaletuis, it seems that Pacific services were not offered despite families being registered with MHSs for many years. There were clear mechanisms for deciding if the families needed cultural support. Most families identified Samoan as their first language, indicating the need for language support; however, this was not addressed. In addition, Samoans are more at ease when interacting with people from their own culture. And despite these obvious demands, services were not offered or discussed. This has shown examples of care that lacks a holistic consideration of people's need and is not meeting the purpose of the MHS model.

Participants identified the Samoan language as being very important. Families shared that they struggle to converse in or understand the English language, especially understanding medical terms and jargon. One participant describes his experience in the following fa‘afaletui:

> *'I need to understand deep hard English (gagana faigata ma loloto), even though I can follow but I do not understand deep hard English especially with learning mental illness and the medications.' – Father, Aiga Fa*

In this discussion, the participant described his struggles to understand medical terms and jargon used by clinicians. The reference to 'deep hard' English revealed a language in which he was out of his depth, and which was too much for him to comprehend. He needed to understand information so he could better support his daughter. This example shows the need for language support to be available to all Samoan families to ensure their full participation in care. This family experience provides an insight into how health literacy and language barriers may be unfavourable to efforts to meet the core purpose of person- and family-centred care for Samoans.

5.6.9 Issues encountered with clinicians' attitudes and behaviours: Lack of compassion and care.

Families reported health professionals were not doing their job properly. They reported, for example, lack of care attitudes, negative body language, inconsistent practices, and disrespectful behaviours.

One family recounted an experience where they were immediately dismissed by the assessing clinician without proper assessment.

> *'We got told to go home that my son was okay, and he doesn't need help, and I'm like what the hell – we were here to get help and yet you already discounted us and said we were okay.' – Mother, Aiga Tasi*

This mother was struggling for a week to get support for her son, but the clinician immediately discharged him. The participant was desperate to get help but was discounted by the system that was supposed to alleviate her family ordeal. This experience has demonstrated the lack of connection between families' sufferings and MHS expectations and criteria for admission. It shows different interpretations of urgency where the MHS is focusing on available resources more than acknowledging the psychological pain and sufferings of the family. Overall, it indicates the lack of consideration for the need of families which is misaligned with the aim of the MHS's person- and family-centred care model.

Also, participants acknowledged that health professionals were not following through with their promises. Participants shared occasions where the service user was told to prepare for outings but there was no follow-through to pick up their son. The family were sad as their son was looking forward to going but were annoyed with the staff not following through. Staff sometimes informed the family about changes but often there was no communication, leaving the service user and family feeling angry and deflated. This clearly indicates services and care that are misaligned with the MHS's person- and family-centred model of care, causing disappointment for and distrust from families.

5.6.10 We haven't met the keyworker: Inconsistent keyworker contact.

In addition, families confirmed they struggle to connect and interact with keyworkers/case managers. Out of the six family groups, one reported a positive experience with their keyworker. A keyworker/mental health clinician is the responsible mental health clinician allocated to oversee, manage, coordinate care, and provide ongoing follow-up for the service users and families in his/her caseload. One other family reported they have not seen the keyworker for several months. Another family met their keyworker once but does not know her name, while yet another family reported that they do not know the keyworker's name nor have they met them, and the last family said that although they know the keyworker's name, they found her unhelpful. In short, the inconsistency in keyworkers' contacts could contribute to identifying specific areas that need to improve for the successful application of the person- and family-centred care for Samoans.

Furthermore, participants believed that keyworkers were coordinating care plans with NGO providers without involving them. The communication and connection with the MHS was often facilitated thorough NGOs. Some families were confused as they are unable to differentiate between the support worker and the keyworker role. In fact, discussions revealed that NGOs have played a dual role in taking responsibilities for families and this highlights the lack of accountability of health professionals. Mental health professionals/keyworkers are pivotal in supporting the model of care; however, the feedback from families shows that they creates barrier to connection and communication with families. These experiences have begun to provide observations of how health professionals' performance may hinder positive results for person- and family-centred care for Samoans.

On the other hand, discussions with one family show a positive experience. This family has developed a good connection with the Pacific keyworker.

> *'The other thing I liked she visited us at home so we can talk and for her to see us in our family environment.' – Father, Aiga Fa*
>
> *'Yes, I agree with my husband she was a good person. Even she can't speak Samoan, but she was always there, and we saw she was trying her best to explain everything that we don't understand and what was best for my daughter.' – Mother, Aiga Fa*

The fa‘afaletui above has described the support and care from the keyworker that was deemed valuable by the family. This family appreciated the keyworker’s effort, seeing that even the language barrier does not prevent her providing the best care for them. The keyworker’s attitude and approach has created a positive experience and has contributed to the service user’s recovery. The experience of this family has demonstrated a clinician performing her keyworker role in alignment with the MHS person- and family-centred care model and contributing to the mental wellbeing of the family.

However, this experience was not shared by one family who was also allocated a Pacific keyworker. In this case, the family expressed their frustration at the lack of contact and follow-up, as it had been several months since their last contact. Also, most of their connections were through the support worker. The experience from this family has demonstrated that not all Pacific staff possessed qualities that are favourable to Pacific families. In fact, this has shown the level of clinical experience, knowledge, and confidence of Pacific staff in working with families. Briefly, this inconsistency in practice from Pacific health professionals should be supported to ensure Pacific staff are confident in delivering practices that are aligned with MHS model, because the combination of clinical competence plus cultural qualities has potential benefits for Samoan and Pacific families using the MHS.

5.6.11 They don’t care I can tell: Poor communication skills and attitude.

Most families considered their interactions with health professionals’ behaviours as showing those people to be disrespectful and aloof. These behaviours were manifested through negative body language, poor communication, and a lack of professionalism. One participant shared that she was in the waiting room and observed staff walked past with heads down without acknowledging her presence. Another family reported an experience in which the participant was trying to explain her son’s situation in English and the clinician asked if she needed an interpreter. There was no relevance of this offer as the participant was speaking in simple English. She was sad and annoyed as the clinicians were judgmental, as shown by their facial and body language, and their failure to listen and understand her explanations.

Further examples were shared by another family whose participants shared their disappointment at what they observed in the clinicians' body language:

> *'At my son's assessment they (psychiatrist and keyworker) were looking at each other and at their screen when they realised there was no follow-up for my son. They just looked at each other and shrugging their shoulders while we were sitting there in the room.' – Mother, Aiga Tolu*
>
> *'Can I add to what my wife was saying. The first time we entered we looked at the doctor and I can see they don't really acknowledge our presence I can tell. There was no love and commitment involved in doing their job.' – Father, Aiga Tolu*

This family were frustrated and angry as what they saw showed a lack of care and compassion. The family struggled with the lack of response from the MHS, and their ordeal was not reflected by the lack of empathy they observed in the clinic. They were disheartened to realise there was no respect and love involved in their interactions with the MHS. This fa‘afaletui has provided an insight into the impact of clinicians' negative attitudes and behaviour on consumer's experiences. This family's experience has revealed practices that are provided without the person and family in mind and the behaviours observed are an indication that the MHS model of care did not exist in the clinicians' frame of reference.

5.7 Theme 5: The values of alofa and fa‘aaloalo: Enablers of positive experiences

This finding showed participants aspirations for more cultural representation and authenticity in current service delivery models.

5.7.1 We got more support from the Pacific NGO

Three families reported Pacific NGO services as helpful with, for example, good communication with support workers that was regular and ongoing. Most of the support workers were Samoans and fluent speakers of the language. The communication in the Samoan language was valuable because participants were able to communicate and expressed themselves clearly. Moreover, the support workers were approachable, caring, loving, and compassionate. Such positive attitudes have shown the value NGOs contribute to the person- and family-centred model for Samoan/Pacific families.

However, Aiga Tasi shared a different experience. At the initial meeting, the family were pleased to learn about available support services the NGO could offer the service user; however, the communication stopped there. The family was not informed when the allocated support worker had changed. And when the NGO was approached, the family went through the whole referral process again. Overall, this experience was unnecessary and unpleasant, and the family found it unhelpful.

A similar experience was shared by another family about another Pacific NGO. The family recounted incidents where the support worker failed to pick up the service user for her appointments. On many occasions the family stepped in to provide transport as they wanted to avoid relapses. Also, the family sometimes needed help with food, and they were not aware that this NGO was able to provide this support. The unreliable attitude of this NGO was shown in the inconsistent approach and lack of commitment to do their part to support the MHS’s person- and family-centred care.

These two examples reveal inconsistencies in NGO approaches that families found unhelpful. Family group discussions showed that although most staff are good, some workers may need to be reminded of their responsibility as NGO partners in achieving person- and family-centred care for Samoan and Pacific families.

As well as providing social support for Pacific people, another NGO that was associated with participants was a different Pacific NGO. Unlike the previous NGOs, this one provides mental health and disability support for Pacific communities in the region. In this case, the family were appreciative of this NGO, because their interactions were all conducted in the Samoan language. Also, available support services were explained at their first contact. This has provided the family with confidence and peace of mind. Eventually, the family was provided with a Samoan-speaking social worker, and the social worker helped support the service user to attend a peer support workshop. This workshop has enabled the service user to find part-time employment as a peer support specialist with the MHS. Although this Pacific NGO is not an integrated care partner with the MHS, the social and moral support they have provided shows the quality that the person- and family-centred care model needs for Samoan and Pacific families.

5.7.2 Gagana Samoa (Samoan language)

The family group fa‘afaletui discussions have identified the valuable contribution of the Samoan language to families' positive experiences. Discussions recounted occasions where families were able to involve and actively participate in care planning, for example the experience from Aiga Fa. However, other families shared experiences of hopelessness with the lack of communication or connection due to language barriers.

Aiga Fa described an experience where an NGO mental health programme was delivered over the Samoan local radio. Impressed with what he heard; the participant visited this service with his daughter to find out more.

> *'I was listening to the radio and this lady working for this Pacific NGO was delivering her programme, she was explaining support that were available for people like my daughter. The lady said to contact her office if in need of support.' – Father, Aiga Fa*

The fa‘afaletui shows how information delivered in Samoan language helped this family to engage with the MHS. The combination of the health promotion programme delivered in Samoan language plus a Samoan local radio station has provided a positive outcome for this family. The experience was positive for this family, and they credited this to Radio Samoa.

In addition, the Samoan language was used throughout their interactions with the Pacific NGO service. This has enabled them to communicate and express their daughter’s need fully. Discussions show how the family appreciated the language but also valued the support from Samoan staff who were present at the service and attended to their needs.

> *‘A Samoan person creates a feeling of warmth and always asks to clarify if I fully understand information like the social worker.’ – Mother, Aiga Fa*

This fa‘afaletui points out a family member’s experience with the Samoan-speaking social worker. Discussions revealed that warmth and care existed when a Samoan person took time to explain and clarify information. It was clear from the discussion that the positive experience was achieved when services are provided by Samoans for Samoans.

In addition, other family group discussions identified the positive influences of Samoan interpreters on their experiences. Families found interpreters as helpful by explaining discussions and conversations with health professionals in the Samoan language. Also, interpreters helped support the family to ask questions and to provide feedback about their family member’s recovery progress.

Overall, fa‘afaletuis for this sub-theme has highlighted the value of the Samoan language to the health and wellbeing of Samoan people and also the importance of informed and culturally targeted support available through NGO service providers, Pacific health professionals and interpreting services. Discussions with families have indicated that the success of the integrated person- and family-centred care should be delivered and provided in a language that Samoan/Pacific people can understand.

5.7.3 Pacific clinicians and staff provides ‘warmth and love’.

The fa‘afaletui identified the contributions of Pacific clinicians and staff to participants’ positive experiences. They are Pacific keyworkers, support workers, social workers, and administrators. One family shared their experience with a Pacific nurse, describing her as being kind, caring and compassionate. The nurse visited the family at home and was always available when needed.

> *‘The Pacific ladies at the front desk always called out to me by name when I dropped off my wife for her injection, that was always good.’ – Husband, Aiga Ono*

Aiga Ono described occasions where the husband was acknowledged by Pacific staff at the front desk. Discussions showed that Pacific administrators were friendly, and they addressed family members by name. The positive attitudes from Pacific staff have created a welcoming environment for this family which helps support their ongoing engagement with the MHS. The fa‘afaletui has identified that most Pacific staff are approachable, kind, caring and responsive to families’ needs. Pacific staff and clinicians contributed positive vibes to participants’ experiences which enabled them to endure their interactions with the MHS. The positive outcomes from these engagements indicate the vital role of Pacific health professionals in promoting and leading the integrated person- and family-centred care for Samoan/Pacific people in MHSs.

5.7.4 O lo‘u ivi ma a‘ano (my flesh and blood): Family support

As well as the positive influence of Pacific staff, the fa‘afaletui also highlighted the important role of family during challenging times. The fa‘afaletui provides an opportunity for families to explore and reflect on experiences and to point out positive enforcers of their journey with the MHS. Family group discussions have identified extended family support as one major force that keeps them going. This support derives from the responsibility and obligation of a Samoan family's expectations that members tolerate, accept, and provide continuous care for each other.

> *'We take care of our brother and family together we can't neglect him because he is our flesh and blood. We always put family and love first so whatever stress he caused us with his behaviour we always have patient and provided care and love.' – Sister 2, Aiga Lua*

The discussion above shows an example of a Samoan family's commitment and obligation to provide care and support for their family members. The participant is the main caregiver for her brother as well as having her own family. She shared the challenges she encountered daily with the service user but the commitment to care for her family was stronger.

This commitment was shared by all families where participants are obligated to support their family member. In fact, this was a normal expectation for a Samoan family. One family reported an incident where the service user was angry, and she left the house with her children to allow him space to calm down. Another family reported occasions where family members were threatened by the service user's behaviour, but the support and ongoing care remained. Importantly, family discussions have demonstrated the cultural connection that binds Samoan families together. This connection is underlined by commitment, obligation, and responsibilities to each other. Clearly, this connection has highlighted that the person- and family-centred care model resonates with Samoan families when the right support and guidance are in place.

Overall, the fa'afaletuis for this sub-theme have revealed the significant connection of a Samoan family. There are strong cultural links between individuals and their family that are relational and complementary to each other. Family discussions have identified this as source of strength in continuous support for the service user. Family group discussions have highlighted that, with the right support, the integrated person- and family-centred care model can provide a positive outcome for Samoan people. Therefore, family feedback and the right advice should offer guidance on how cultural practices can improve person- and family-centred care for Samoan/Pacific people.

5.8 Summary

The study findings were outlined in this chapter. The main structure of the chapter included an overview of the demographic description of participants, and the five main themes. The five themes were described in detail as well as the associated sub-themes. The main objective of this study was to explore Samoan family experience with the current MHS person- and family-centred model of care. The following chapter discusses these issues in detail and provides a comparison with the literature.

Chapter 6: Discussion

6.1 Introduction

This chapter presents and critically discusses the findings presented in the previous chapter relating to Samoan families' experiences of MHS delivery in Aotearoa, New Zealand. It also provides comparison and contrast with the current literature to address the key research question: *What does person-centred care mean for Samoan families accessing MHSs?*

This critical discussion addresses what is known about the services received from MHSs, the meaning and experiences of person-centred care for the family participants, and the extent to which the cultural needs of the families were understood, respected, and addressed. Moreover, while the discussion presents a critique of the findings in respect to addressing the main research question, also highlighted are what constitute novel and unique findings from our participants, and how these findings compare with the current local and global literature.

The current discussion is presented in two sections. The first section describes how spirituality and religion promoted Samoan families' resiliency while dealing with their family member's mental illness, yet this was not offered in the current models of service provision despite the services claiming to be person- and family-centred. In addition, the importance of drawing on cultural and religious beliefs in making sense of mental illness and treatments by Samoan families is highlighted. Moreover, this section also captures the participants' experiences of some of the positive impacts of the current involvement of Pacific health professionals in these services, in particular engagement with Samoan values, language, and Pacific approaches as enabling genuine and culturally congruent experiences. The second section includes the Samoan's family participants' interpretations of how a MHS person-centred model should operate, drawing from their experiences as service users, as well as outlining emic examples of how targeted and culturally appropriate person-centred care and clinical practices and processes might be best delivered.

6.2 Data summary

Foremost, the findings show the deep importance of spirituality and religion as core to Samoans' conceptualisation of healing and wellbeing. Also, highlighted was participants' perceived need for enhanced Pacific approaches in the current MHS provision. The former was evident in participants' testimonies of their faith in God and cultural/spiritual ritual practices helping them cope with and withstand the challenges of their family member's illness. Additionally, cultural beliefs strongly influenced participants' perspectives on mental illness and had been a source of family disagreements, for example with Aiga Tasi and Aiga Tolu. Also, a significant factor for these Samoan participants was the conviction that traditional healing and restoring family relationships were fundamental remedies for protection and family healing from mental illness, as seen with Aiga Tasi, Tolu, Fa, and Ono. Further, the importance of the Samoan values of alofa and fa‘aaloalo to participants' overall experiences was apparent, as evidenced by Aiga Lua, Tolu, Fa, Lima, and Ono. Overall, the findings provided insight into how the accommodation of spirituality, cultural values and beliefs had the potential to positively affect Samoan families' experiences of and dealings with mental health, yet the findings also showed how these factors were seldom centralised in their prior dealings with the MHS.

6.2.1 Samoan concepts of spirituality, harmonious relationship, and the essence of wellness.

Themes one and two showed God and faith signify spiritual belief at an elevated level for these Samoan families (Efi, 2009). Spirituality here refers to faith and the personal relationship of participants with their Christian or ancestral God. These concepts had a significant impact on maintaining wellness in the face of adversity and hardship. Spirituality is the heart of Samoan and Pacific culture and is embodied and imparted through everyday traditional cultural customs, ceremonies, and rituals (Ihara & Vakalahi, 2011) as seen in participants who viewed prayers, faith and attending church as vital practices to revitalise strength and hope when facing adversity. Significant evidence of the connection to God and religion was felt by all participants, especially Aiga Tasi, Tolu, Fa, and Ono, where their faith in God provided the pillars of hope and reassurance to withstand the challenges of their family member's mental illness and the system further signified that spirituality as the essence of strength, balance, and wellness and was at the core of the holistic bio-psycho-social health of Samoans (Efi, 2009). As mentioned in my outline of Samoan ancestral history, God is Tagaloalagi, the progenitor of man and all living things. There is sacredness and tapu in the boundary between man and all living things because of their shared divinity with God Tagaloa. In this way man's connectedness with the universe, the environment and each other is the foundation of collectivism and the holistic concept of wellbeing of Samoans (Efi, 2009).

In the Pacific, similar results to the current findings were found by a grounded theory study in Hawai‘i that sought to describe Samoan and Tongan elders' perspectives on spirituality, and how this concept contributed to their essence of wellness (Ihara & Vakalahi, 2011). The authors discovered that the elders attributed their wellness to their faith in God, and prayers and devotions helped them to cope with difficult situations (Ihara & Vakalahi, 2011). Therefore, the practice of prayers offered healing and comfort for Samoans, indicating their strong faith that God will never forsake them in life. This serves to illustrate that spirituality is at the core of person-centred relationships for Samoans and Pacific families.

Similarly, spirituality or wairua defined Māori identity, as confirmed by Valentine's (2009) study into the relationship between wairua and Māori wellbeing. The findings revealed spirituality expressed aspects of the Māori reality in which people and their universe are inclusive and interconnected with each other. It is where relationship, balance and healing for Māori are created and maintained. The current findings also compare to a qualitative study by Grieves (2009), with Australian Aboriginals finding spiritual faith was core to their social and emotional wellbeing. Therefore, like Māori (Valentine, 2009) and Samoans (Efi, 2009), spirituality can be observed to outline the deep integration, wholeness, a sense of the inter-relatedness of all life for all Indigenous populations (Grieves, 2009).

Theme 1 also identified tatalo (prayers) and anapogi (fasting) are practices Samoans engage with to connect with God and their spiritual faith, as outlined in Aiga Fa and Ono with participants sharing how they sought guidance and connection with God through anapogi. The husband in Aiga Ono described occasions where he carried out anapogi for three days with his strong conviction that God would heal his wife and so respond to his prayers. Participants showed the trust and faith placed in prayers to provide them with the courage to endure life challenges such an acute mental illness in their family member, as outlined by Aiga Tasi and Fa. The husband's experience in Aiga Ono was paralleled with the findings from a qualitative explorative Australian study on the role of religion, spirituality and fasting in coping with diabetes by Indian migrants, where participants preferred to fast while having diabetes. This shows the strong conviction that healing through their faith was imperative and took precedence over bio-medical approaches to healing (Ahmad et al., 2022). Therefore, these findings confirmed spiritual healing for ethnic migrant populations such as Samoans is crucial to their holistic wellbeing and that of their communities (Ihara & Vakalahi, 2011).

As seen for Aiga Lua, Tolu, and Fa, the church played an important role in their communities. For these migrant participants living in Aotearoa, in the absence of the village, church provided new networks for their faith-based community groups (Connell, 2002). It provided a place of worship where respectful and proper behaviours were expected and sanctioned; for example, in Aiga Lua, participants spoke of their disapproval of their service user’s behaviour in drinking alcohol and smoking cannabis. There was considerable family pressure, as seen with Aiga Tasi and Aiga Lua, when supporting a family member with mental illness, about the imperative to also conform to cultural rules and protocols around church. In fact, appropriate behaviours around church were bound by the Samoan concept of ‘va’ (sacred space in-between), and protecting these spaces are cultural boundaries to guide and keep people and their environment safe (Mila-Schaaf & Hudson, 2009a). This was seen to be violated when in Aiga Tolu’s son was not himself in church, bringing shame on the family. The church is expected to maintain and sustain relationships between self, people, family, extended family, villages, districts, and communities (Ropeti, 2016). A major struggle for families was to find the balance in managing mental illness and respecting cultural boundaries while at the same time saving face within their communities. Overall, the findings revealed the current person- and family-centred approach lacks a good understanding, awareness, and sense of the cultural imperatives to best support these families.

Also, most Samoans interviewed commented on the importance of their faith and serving the church, and the associated pressures this caused when a family member was mentally ill. One family disclosed an incident in which they were humiliated, and their cultural values violated due to the lack of support and care for their son from the MHS. That incident was seen to have violated Samoan cultural ‘va taupuai‘a’ (sacred space) between the family and church, by other Samoans. The incident of the father assaulted at church by his son shattered a Samoan core relationship boundary – the relationship boundary between a parent and a child (Efi, 2009), resulting in extreme distress. Moreover, the process of fa‘afaletui enabled this family to comprehend and reveal the impact this incident had on their wellbeing. This serves to further highlight the limitations and shortcomings of the current approach in relation to respecting and protecting Samoan key religious cultural practices and identities.

Importantly, balance was seen to be restored, and healing took place when tatalo, fa‘afaletui and restoring the va tapuai‘a were drawn upon, which reconnected the family with the church. In our findings, despite being publicly humiliated, the father in Aiga Tolu wanted his son home. In this case, restorative justice through forgiveness and renewed family relationships enabled healing and re-established boundaries (Efi, 2009). The fa‘afaletui framework and the understanding of the nuances of the Samoan language has uncovered this vital aspect of the Samoan culture (Goodyear-Smith & ‘Ofanoa, 2022). The father’s decision drew on the Samoan traditional practice of ‘ifoga’ (practice of seeking forgiveness), in which forgiveness is sought and formal apologies obtained after an unfavourable event involving injury, death, or the verbal degrading of personal character or family honour (Efi, 2009; Filoiali‘i & Knowles, 1983). The ifoga usually happens at dawn; the perpetrator covers their head with fine mats and sits outside the victim’s house. When the victim or representative for the victim asks the perpetrator to come into their house and the is received, the act is forgiven, and harsh punishment avoids (Filoiali‘i & Knowles, 1983). Importantly, the willingness of the supplicants to accept responsibility for the act and accusations are all core to the successful outcome of an agreement on the terms of forgiveness that undoubtedly anticipates the fa‘aleleiga (reconciliation) (Macpherson & Macpherson, 2003). As Efi (2009) mentioned, justice for Samoans is spiritual not physical, which highlights the fundamental Samoan practice of healing through forgiveness, which should be adopted as a core aspect of assessment and treatment in the MHS’s person-centred care approach for Samoans.

Indeed, spiritual healing is shared by Māori, Aboriginal and other Indigenous cultures. Research by Waldram (1993) at a Canadian forensic prison, which aimed to develop a better understanding of Aboriginal offenders' spirituality and symbolic healing, has confirmed this concept. Two spiritual awareness programmes, one focused on spirituality and religion, the other on native knowledge, were attended by participants supported by Aboriginal elders. The findings showed spirituality programmes helped participants to cope and provide them with new perspectives on their situation. Also, talking and sharing cultural knowledge with elders allowed them to facilitate the process of symbolic healing (Waldram, 1993). In Māori culture, Wairua existed within the individual and signifies wellness and health (Furbish & Reid, 2003). Holistic health and wellbeing for Māori are conceptualised in te whare tapa whā model, which relies on the balance and connection between the four walls: taha wairua, taha tinana, taha hinegaro, and taha whānau (Durie, 1997). While the harmony and reciprocity of the four walls are crucial, taha wairua enabled Māori to have faith and to recognise the interconnection between life, ancestors, living creatures, and the environment (Durie, 1997). Therefore, wairua is core to Māori wellbeing, as the failure to recognise its value is to expect Māori to divide and fragment their lives and values (Fraser, 2004) with implications to be drawn for Pacific models of health and healing for targeted service delivery.

Overall, theme 1 revealed church, faith, and the practices of prayer and fasting have confirmed spirituality is at the core of holistic wellbeing for Indigenous populations, such as Samoans, Pacific, Aboriginal and Māori. It is considered an intricate expression of identity and culture (Fraser, 2004). Importantly, it has highlighted that healing and restoring inner peace is achieved when cultural connection and boundaries are balanced and repaired. It has revealed cultural healing through spiritual equilibrium should be the initial treatment option for Samoans and Pacific people. However, these cultural practices are not supported in MHSs or found in western and modern approaches. Consequently, the findings suggests that Aiga Fa had their cultural integrity violated and disrespected due to the disconnection with MHSs experienced cultural incongruity highlighting major gaps in the current person-centred care model and causing considerable concerns for equity and the addressing of health disparities for Samoans/Pacific people.

6.2.2 It's a hush-hush topic, we do not talk about mental illness.

Additionally, themes one and two revealed Samoans believed that a diagnosis of mental illness was secondary to disrespecting the 'va' and overstepping cultural boundaries (Efi, 2009; Suaalii-Sauni et al., 2009), as well as being deeply rooted in an association with spirits and a topic people preferred to culturally disassociate from (Suaalii-Sauni et al., 2009). As a result, anything affiliated with mental illness is not talked about, as identified by Aiga Tasi and Tolu. Moreover, Samoans believed traditional healing was the first line of treatment. This belief caused family disagreement as experienced by Aiga Tasi where the extended family accused a participant of thinking like a Pākehā for opting to accept westernised treatment over fofo Samoa. Although this has caused unnecessary stress and strains for family relationships, it also demonstrated the strongly held cultural beliefs of Samoans in spiritual healing. This was consistent with the findings of a qualitative study of Tongan traditional healers and mental health workers that aimed to explore beliefs on traditional and western practices and found that traditional healing played an integral role in mental health recovery for Tongans (Vaka et al., 2009). However, despite traditional therapies' potential benefit for Pacific people, westernised treatment models remain the primary line of treatment available in NZ. Therefore, until the NZ health reforms of July 2022 under the newly established Te Whatu Ora address the lack of traditional choices in MHSs, the families interviewed that have been directly affected by mental illness will continue to experience uncertainty due to their cultural alienation from bio-medical approaches, as their options to pursue traditional approaches were not promoted in previous MHS delivery.

Also, the findings showed that older and migrant Samoans amongst these participants were more strongly linked to traditional practices than the younger generations and those already residing in NZ. This was highlighted by Aiga Tolu and Aiga Tasi stating that their family members back in Samoa had no awareness of the scientific basis of mental illness and medications when deciding to discipline the service user when quite unwell, and the father refused to accept his son's medications. This push and pull between traditional belief systems and bio-medical approaches was accelerated for these Aotearoa-based Samoans migrants who faced the constant dilemma of family conflict due to this dichotomy around cultural appropriateness. It has shown the vital role of the Pacific-centred MHSs in care to advocate, provide information and health education through professionals in appropriate ethnic languages for families to mitigate disagreements in positionality (Suaalii-Sauni et al., 2009) and strengthen cultural family support to enable positive recovery experiences for families directly affected by mental illness.

Importantly, a recent literature review focusing on Pacific and mental health services in NZ by Kapeli et al. (2020) found Pacific communities need culturally appropriate services to support and serve their needs due to the disconnection between western and other cultural perspectives preventing access to care. This was also supported by Parsonage et al. (2009) when they developed a Mental Health and Addiction Pacific Practice Framework for the Auckland region. The framework presented the vital involvement of three core cultural roles of a Matua (a Matua has a strong cultural identity and fluency in one or more Pacific languages and cultures), specialist Pacific worker and a Pacific cultural worker. Their aim was to promote cultural expertise in mental health that is visible, valued and understood (Parsonage et al., 2009). However, despite the existence of the Mental Health and Addiction Pacific Practice Framework in MHSs, its application has had minimum influence on quality care outcomes for the participants. A similar concept was behind the drive to develop the Pacific child, adolescent, and family services in Wellington, NZ by Bush et al. (2009). In sum, cultural specialists' services has been, researched, advocated, and evaluated as the appropriate approach for Samoan and Pacific people. However, despite available evidence of its utility for Pacific people, fully embedded culturally centralised approaches are still lacking in formal mental health practice, as indicated by the experiences of the families that participated in the present study.

Moreover, the findings have outlined how parents were often blamed for their child's mental illness. This was evidenced in Aiga Tasi, where the mother's parenting skills were scrutinised and condemned by the extended family. In fact, this 'family stigmatisation', where the blame is mainly conferred on inadequate parenting skills causing the child's mental illness (Larson & Corrigan, 2008). In the findings, where Aiga Lua reported their father's message to send the service user to Samoa so he can correct his behaviour, an underlying admission was made about his parenting shortcomings and the cultural power of the community of origin to impact health. Overall, the findings revealed a great need for mental health education and promotion for families, and major gaps in Samoan families' awareness of the illness, coping techniques, recovery, and supportive language to aid family members' understanding and recovery.

Importantly, the data identified some positive influences of being informed about mental illness and support being available in a language people understand. As experienced by Aiga Fa, the father was listening to Pacific NGO mental health programme in the Samoan language on a local radio station for Samoans in Auckland. As a result, the family was linked to the right NGO service and provided with all relevant health information. This connection with a Pacific NGO was seen to have contributed to the family's positive experience with MHSs. Indeed, the finding provided an example of the potential for the successful communication of health promotion messages that resonate with Samoans belief systems, which compares to the 'Like Minds Like Mine' NZ project where the success was due to the involvement of famous people with lived experience of mental illness (Vaughan & Hansen, 2004) such as Sir John Kirwan. The point of difference in these approaches was to find the connection and relatedness of content to the population's experiences. As confirmed by Aiga Fa, the use of the Samoan language and Radio Samoa, which most Samoans access and understand, was valuable. This feedback highlighted a positive approach for Samoans/Pacific that should be at the core of the person-centred care, communication, and connection with consumers.

6.2.3 The values of alofa and fa‘aaloalo: Enablers of friendly and respectful relationships.

In Samoan culture, alofa and fa‘aaloalo are the two core values and principles upheld in communication that helps to keep or save face (Efi, 2009), as seen in all participants especially Aiga, Tolu, Fa, and Ono. Fa‘aaloalo is based on respect and reciprocity; it is greater than a feeling, it symbolises a relationship. The ethics of fa‘aaloalo emphasises that one must protect the mana and wellbeing of others and, if possible, never put them in a position of embarrassment or loss of face (Va‘ai, 2014). These Samoan foundational values were central to participants' interpretations and experiences. In fact, these values shaped their views and expectations, as shared by participants of Aiga Ono and Fa when they reported fond memories of being respected and valued due to the alofa and fa‘aaloalo shown by Pacific MHS staff and the use of the Samoan language in care delivery.

Aiga Fa shared that a Samoan person creates warmth and comfort, indicating the value of cultural respect and authority in connecting and in forming genuine relationships with others, as validated by other research findings from Pacific populations (Suaalii-Sauni et al., 2009; Tamasese et al., 2004). Indeed, our results again endorse Pacific models of care as the blueprint for achieving equity for Pacific (Bush et al., 2009; Samu & Suaalii-Sauni, 2009; Suaalii-Sauni et al., 2009). These models include Te Vaka Atafaga, a holistic mental health assessment model for Tokelau peoples in NZ (Kupa, 2009); Uloa, a mental health practice model for Tongans (Vaka, 2016); and the Fonofale Model, a Samoan health and wellbeing model (Ioane & Tudor, 2017; Suaalii-Sauni et al., 2009).

In fact, the Fonofale Model and allied Pacific health models, were occasionally employed (Suaalii-Sauni et al., 2009; Tamasese et al., 2004) while the intended centralised in-service delivery has been found to have flaws in this application, which creates the potential to exacerbate the health disparities of the Pacific population (Ministry of Health, 2015). A qualitative study by Suaalii-Sauni et al. (2009) exploring Pacific perspectives found Pacific models of care were often used for consultation only rather than being deeply incorporated into practice. This highlighted the multi-level inconsistencies of the person-centred care model in efforts to acknowledge and include quality cultural representation so as to advocate Pacific interests at decision-making levels.

Importantly, the support for cultural approaches in mental health was reiterated in the Movement of Global Mental Health, the review of the use of Māori Indigenous psychologies (Kopua et al., 2020) which found an Indigenous process as the legitimate alternative to western psychiatry, due to it being relatable to an Indigenous worldview and spiritual healing (Kopua et al., 2020). In fact, Durie (1999) suggested that improvements in Māori mental health require an integrated care approach across sectors and disciplines which is consistent with Māori beliefs. Indeed, this needs Māori leadership to lead and to uphold cultural knowledge within the contemporary healthcare climate (Durie, 1999). Without a doubt, models of care that targeted Māori, Samoan and Pacific peoples should be lead and guided by people from this group, as not only do these people themselves have cultural insights into their own Indigenous culture, but also they are able to help non-Indigenous to make sense of their cultural nature (Durie, 1999; Mental Health Commission, 2012). However, a qualitative study to explore the experiences of Māori and Pacific leaders on health policy committees by Came et al. (2018) found inequalities in the health system also existed in advisory committees where participants experienced racism and their appointment was tokenistic. Altogether, these studies further highlighted considerable discrepancies of delivery of person-centred care to achieve equity for Indigenous and ethnic populations.

Overall, this section has explained and explored the place of spirituality in Samoan culture and the lives of Samoan people. God and church represent participants’ spiritual beliefs, where tatalo and anapogi brought them closer to and made them more intimate with their faith. Spiritual healing for Samoans reconnects, restores, reconstructs, and rebuilds relationships and boundaries to achieve justice. Importantly, spirituality has a great influence in Samoans’ view of mental illness and recovery, and the resistance and disagreement between family members shows a lack of available culturally appropriate services in NZ. Therefore, the findings reveal the heightened need for Pacific specialist services as well as community education and awareness utilising Pacific/Samoan ethnic languages and resources.

Additionally, this section has described and highlighted the inadequacy of the current MHSs in regard to being culturally responsive to Samoan and Pacific consumer’s needs. Participants’ feedback has indicated considerable gaps in the cultural awareness and knowledge of the system that is required to address the holistic needs of disadvantaged populations. In fact, it has revealed shortcomings in the current person-centred care approaches to addressing equity objectives for Pacific population. To conclude, the findings of the current study have confirmed previous study findings and health reports that advocated for Pacific cultural MHSs and Pacific models of care as core to address Samoans and Pacific holistic needs.

Importantly, the findings have identified novel findings on the values of alofa and fa‘aaloalo as core to Samoans’ engagement, connection and relationship formation with others. These values have kept Samoan cultural boundaries intact and communities safe and are key to maintaining and sustaining spiritual balance to achieve holistic wellbeing.

6.3 Samoans' interpretation of the person- and family-centred model and the experience of this model of care in mental health clinical practice.

6.3.1 Overview

The findings revealed that the families interviewed are 'in the dark' about their dealings with MHSs, even though many had engaged with the services for number of years. One major challenge identified was the lack of communication. This concern included not answering or returning phone calls, non-response when urgently needed, no care follow-up, and no information or guidance for families to enable them to navigate MHSs. Also, families were not informed about available Pacific and culture services, nor were those services offered to them. This was despite most of the participants being first-generation migrants with Samoan as their main language. Furthermore, communication and the coordination of care was often organised with allied NGO services and bypassed families. These issues raised by participants indicated lack of family inclusion in care and indicates practice that are not according to the principles of the person- and family-centred care approach.

Moreover, the findings revealed most of the current mental health clinical practices were not inclusive of family. These practices meant that families did not understand their family member's diagnosis and treatments, clinical assessments, and processes. Participants reported occasions where clinicians prioritised service delivery over their needs. In addition, families were informed of clinicians' decisions made without their involvement, as well as some family members being seen but not heard. Overall, these findings have shown that mental healthcare for Samoans lacks targeted family-centred delivery approaches and is not congruent with the mental health needs of Pacific people.

Therefore, they revealed inconsistency, miscommunication, and a misalignment of the person-centred model of care philosophy and the actual delivery of the person-centred care model for community mental health.

This following section discusses participants’ interpretations of what person-centred care means, drawing on theme 3, ‘We are in the dark with our communication and dealings with MHS’, and theme 4, ‘Practice what you preach: Clinical service delivery misaligned with MHS model of care aim and vision’, describing the clinical practices of medical assessments, transfer of care, health professionals’ contact, and care coordination as they were experienced by my participants.

6.3.2 Samoan families lay interpretation of ‘fa‘atauaina ole tagata ma‘i – person-centred care’

The findings revealed that while migrant Samoans had adjusted to the Aotearoa, New Zealand way of life, their experiences, expectations, and interpretations of care remained firmly influenced by their personal cultural and religious perspectives. Participants described the importance of alofa (love), fa‘amaoni (honesty), fa‘aaloalo (respect), feso‘otaiga lelei (good communication), and tausa‘afia (being approachable). These attributes indicate compassion, caring and love for others, which clearly highlights relational and human connections were at the core of Samoans’ interpretations what person-centred care means to them (Efi, 2009; WHO, 2021).

A range of terms was used by participants to describe their experience with MHS person-centred care delivery, with favourable experiences commonly related to services other than community MHSs, for example, the face-to-face support from another healthcare organisation, the warmth and caring attitudes of Pacific NGOs, Samoan language support from the interpreting service, and free public services. Some were specific in identifying the treatment such as the IMI, which indicated the IMI was the only connection Aiga Lua has with the MHS, the engagement of a Pacific nurse, and the Samoan social worker.

Collectively, participants' interpretations showed that when they experienced face-to-face engagement when they felt supported, included, and informed of their family member's care. These participants' interpretation were parallel by the core principle of a person-centred approach (Mental Health Commission, 2012), in which services are required to form a genuine partnership between services and consumers. This differs from focusing on processes, protocols, structure, and guidelines without human connections and relationships.

Importantly, most participants identified some strengths in the person-centred approach when it occurred in receiving health and social care from Pacific NGOs, where Samoan language was respected and used, and where Samoan social workers and Pacific nurses were employed. They reported a genuine connection and mutual understanding was established with Samoan and Pacific healthcare professionals. Undoubtedly, the services identified by participants supported services 'by Pacific for Pacific' where only cultural approaches resonate and address Samoans and Pacific peoples' holistic needs (Bush et al., 2009; Ministry of Pacific Island Affairs & Statistics New Zealand, 2011; Suaalii-Sauni et al., 2009). Ihara and Vakalahi's (2012) study on the collective worldviews and health of Samoan, Tongan, and Hawai'ian American elders found that engaging with community norms such as language and culture was valuable. Similar findings were obtained in a study of church-based and culturally focus lifestyle interventions employed in the Australian Samoans' diabetes programme (Ndwiga et al., 2020). The same study found cultural approaches were vital to Samoans' health and wellbeing no matter where they resided globally. Collectively, the findings highlighted the vital role of Pacific health staff and services in addressing the holistic needs of Samoans/Pacific people in care.

In Aotearoa, Pacific people proposed the need for 'by Pacific for Pacific' services in response to the Mental Health and Addiction Inquiry 2018 as their solution to address culturally incompetent services, coercive practice and undesirable first impressions and manner in MHSs (Government Inquiry into Mental Health and Addiction, 2018). This notion was also supported by Tiatia-Seath (2014) in her study investigating Pacific engagement in mental health and suicide prevention in NZ. The study found that successful engagement with Pacific people involves cultural approaches instead of a clinical focus at initial contact. Similarly, support for cultural approaches was the foundation of the Pacific child and adolescent MHS in Wellington in a study a decade earlier by Bush et al. (2009) to improve access of Pacific families to services when needed. These studies and reports have reiterated that culturally confirmatory interactions are of key significance in the person-centred care approach for Samoans and Pacific accessing MHSs.

6.3.3 Barriers to accessing care.

The current findings have shown a mismatch between MHS expectations and our participants' experiences. The most prominent barrier to family engagement was the lack of communication and this was shared by new referrals and established consumers, as outlined by Aiga Tasi, Lua, Tolu, and Lima stating that there are barriers to their communication with MHS. This experience was not aligned with MHS integrated-care aim in which care was promised to be accessible and timely (Mental Health & Addiction, 2017; Mental Health Commission, 2012). Indeed, such cultural misunderstanding was found to be a key barrier to MHS care for Pacific people by Fa‘alogo-Lilo and Cartwright (2021). A similar finding was reported in Canada with diverse ethnic seniors in Toronto (Sadavoy et al., 2004), and sub-Saharan refugees living in Australia (Sheikh-Mohammed et al., 2006), confirming how cultural incongruity and poor and ineffective communication have impacted access and engagement with healthcare service providers for a diverse ethnic population.

Another barrier to accessing clinical care was the delay in acute responses whereby instead of responding, participants were told to initially contact the police; however, the police redirected them back to acute services. Participants were confused and frustrated when they were caught between two systems without any support during urgent situations. This has revealed major concerns as the memorandum of understanding signed in 2000 between the police and the MHS dictates that the provision of care is the MHS's sole responsibility (Ministry of Health, 2000). Also, police are not trained to assess and triage mental illness, a leading factor in the criminalisation of the mentally ill person (Lamb et al., 2002). This finding is further highlighted in the NZ Mental Health Survey report which indicates a high number of Pacific people access MHSs via the justice system (Oakely Browne et al., 2006). These barriers have shown health service approaches and practices involving the police do not support timely and equitable non-criminalised nor stigmatised access to service provision for Samoans.

Furthermore, the findings revealed that during urgent situations, families needed to meet specific criteria to access care. This was experienced by Aiga Tasi where the participant was informed during an urgent contact that MHS support depended on the service user's current level of risk to self or others. As confirmed by participants, although the service user was not a threat to the public, he was damaging the house and causing psychological trauma to the family. This criterion was drawn from the Mental Health (Compulsory Assessment and Treatment) Act 1992, which has as its primary role the protection of the mentally ill person and the public from harm, when this person lacks the capacity to care and think for him/herself (Ministry of Health, 2000). In this case, the removal of the capacity criteria without focus on the mental health need at hand, and the ability to treat solely for the protection of others, is an abuse of power (Szmukler & Holloway, 2000). It has presented major concerns over the usage of the MH Act criteria (Ministry of Health, 2000) to delay care urgently needed by families. The participant described the magnitude of sacrifice and the tribulations they went through on a mission to get help. This feedback showed the MHS has been deflected from the purpose of a 'no wait' system mentioned in *Blueprint II*, where responses are early and timely, ensuring fast access during crisis or relapse events (Mental Health Commission, 2012). It also indicated a misalignment with the MHS integrated person-centred care vision where, it was noted, the whole of system integration aim is for early intervention and promotion of positive mental health (Mental Health & Addiction, 2017).

Additionally, the findings also showed most family groups had no understanding of what to expect from clinical/medical review processes despite some participants being engaged with services for many years. For instance, one family went through the assessment and shared sensitive information they thought may benefit service user's care. However, they were disappointed when the service user relapsed and was removed from their home by police. In this case, police introduced what Bittner (1967) coined 'psychiatric first aid' when the mentally ill person was contained but not placed in hospital; however, police are not trained to assess and handle mental illness (Lamb et al., 2002). On the other hand, currently, in the community MHS, the Matalafi Matrix: Pacific cultural assessment tool is available (Counties Manukau Mental Health Clinical Records-HCC, 2022); however, the findings revealed these family participants did not see the tool being used to assess them. The Matalafi Matrix: Pacific cultural assessment tool (Suaalii-Sauni & Dash, 2009) was developed to specifically assess the cultural needs of Pacific people accessing mental health services – see Chapter 1, section 1.12, "Matalafi Matrix". Overall, these findings showed that these participants did not see any valuable benefits in the current clinical processes. In addition, assessment tools for Pacific people were not incorporated into and utilised in care. As a result, families were confronted with unwanted challenges beyond their control, suggesting that the MHS was unresponsive to the holistic needs of Samoans and the Pacific population as promised by the person-centred care vision and purpose (Mental Health & Addiction, 2017).

Moreover, the findings identified concerns about health literacy. The fa‘afaletui has revealed one participant struggled with understanding the medical terms and definitions used to describe diagnosis and treatments and highlighted in professional care workers' use of specific language at family meetings and medical reviews. The findings have confirmed issues highlighted by Pacific research by Bush et al., (2005) and Suaalii-Sauni et al. (2009) where the use of both English and highly medicalised language created barriers and had a major impact on the quality of communication with and understanding of Samoans and Pacific mental health consumers. These studies provide insights into how incorporating Samoan language and other Pacific ethnic languages in person-centred care has potential benefits for Samoans and Pacific people. Furthermore, the findings revealed considerable concerns with current cultural support offered, in that it was more a form of tokenism. Participants expected to be told of symptoms of their illness, treatments, and coping strategies in a language and in terms they understand, and then linked with community support services. However, a Pacific service experienced by Aiga Tasi provided cultural liaison support without active involvement in the clinical care. This approach not only disadvantaged these Samoan families and further highlighted the incongruencies in the links with Samoan and Pacific epistemologies (Suaalii-Sauni et al., 2009; Tamasese et al., 2004), while highlighting major gaps in the current person-centred care model's capacity to address health disparities in access to the MHS.

Additionally, participants shared mixed experiences of medical review processes. While Aiga Fa reported a positive experience, due to the attendance of a Samoan interpreter, most families interviewed did not understand the process or had not attended a medical review, as confirmed by Aiga Lima, who thought medical review was the role of an NGO. Alarmingly, most participants were not only unaware of the process and its purpose but also did not understand the significance of this review in regard to their family role. Lack of health information about clinical processes was also discovered in Aotearoa by

Fa‘alogo-Lilo and Cartwright (2021) and in Australia (Sheikh-Mohammed et al (2004) in their studies on barriers to ethnic populations accessing mental healthcare. In the current study, Aiga Lima thought medical reviews were only for reviewing WINZ benefits. WINZ is part of NZ’s Ministry of Social Development tasked with assisting people looking for work and providing financial support for people to buy what they need (Ministry of Social Development, n.d.). These benefits are reviewed three- or six-monthly depending on the benefit category and require a valid signature from a responsible clinician. The findings provided insight into the disconnection between the MHS’s current clinical processes and WHO expectations of the key components of people-centred practices, and arguably family-centred practices, in which individuals, families and their communities are seen as active participants of care (WHO, 2015). Also, what is apparent is a powerful disconnect between the reality and the MHS vision for person-centred care, in which it pledges that the service user and family are at the core of service delivery to ensure holistic health and wellbeing across the life course (Mental Health & Addiction, 2017).

In addition to this, participants did not understand their family members’ diagnosis and treatments. The findings showed that families were not informed about treatments or had them explained, as evidenced by Aiga Tasi, Lua, Tolu, Fa, Lima, and Ono where participants questioned the changes, they observed in their family member’s presentations. The feedback showed participants were not aware of or understood the rationale, therapeutic benefits, and side effects of their treatments. Studies of barriers to quality mental healthcare have identified lack of knowledge about medications and treatment as a major disparity for migrant populations (Sadavoy et al., 2004; Sheikh-Mohammed et al., 2006). This was also a barrier confirmed by a recent study of Pacific people’s mental health experience in NZ (Fa‘alogo-Lilo & Cartwright, 2021). Such barriers were not helpful for Samoans when they were already confused between treatments/medications, as confirmed by a study on Samoan people's views about antibiotics (Norris et al., 2011). The authors went on to highlight the confusion arising from a struggle between western and Samoan concepts of illness (Norris et al., 2011). This was supported by Macpherson (1990) who reported that Samoans' interpretation of ill-health and perception of signs and symptoms of illness are strongly influences by their cultural worldviews.

Overall, the lack of understanding of treatment and medications, as highlighted in the data, poses a considerable risk for migrant population such as Samoans and Pacific people. The lack of congruence between Pacific people's cultural health and social belief system and the scientific approach of Aotearoa's medicalised services can be seen as contributing to health disparities and resulting health inequity. Moreover, these findings revealed consumers' rights to health information were not respected and protected as they ought to be according to the Health and Disability Commissioner Act 1994 (Health and Disability Commissioner, 2022). Also, the findings highlighted concerns with professionalism and the accountability of health professionals in their duty of care as indicated in the Health Practitioners Competence Assurance Act 2003 (Health Practitioners Competence Act 2003, n.d.), and clinical and cultural competencies framework (Le Va, 2009; Pulotu-Endemann & Faleafa, 2017).

6.3.4 Clinical processes not inclusive and lack flexibility.

The findings identified challenges with clinical process such as the process of TOC between services and those of co-ordinating care with families, as confirmed by Aiga Tolu; with care coordination, as experienced by Aiga Lima and Aiga Lua; and with home visiting by clinicians, as described by Aiga Tasi and Aiga Lima. Firstly, in the TOC experience, Aiga Tolu reported the TOC happened during the COVID-19 level four restrictions when connections with the MHS were restricted to phone and online contacts. As a result, the service user was left without treatment and follow-up for seven months.

Participants shared their hopelessness and despair when there was no contact from the current service or the previous service during this time. Importantly, this process was not aligned with what is written in the organisation's TOC policy and procedure where, in the process outlined, the key direction is to provide sound clinical practice and person-centred care and to avoid TOC during period of crisis (Counties Manukau Health, 2017). In addition, the findings have revealed misalignment of the TOC process with *Blueprint II* principles (Mental Health Commission, 2012), as the TOC appeared to satisfy the service's needs rather than the person and family's needs. As a result, the findings have presented a misalignment of the current person-centred care processes in achieving quality outcomes for Samoans and other mental health consumers.

Secondly, Aiga Lua and Aiga Lima revealed the current care coordination had not involved them in any aspect of treatment decision-making. Interestingly, participants seemed to view the service delivery as 'the way things are', suggesting a sense of hopelessness. Samoan cultural values of humility and respect given to people in authority (Efi, 2009) may have contributed to the view that questioning and complaining is seen as disrespectful and ungrateful. As outlined by Aiga Lima and Lua, participants assumed the NGO's role was to attend medical reviews instead of the family, as their responses suggest this was supposed to be the community support worker's role. Clearly, the findings have shown practice misalignment between the reality and the coordinated care planning procedure, in which family involvement in care is crucial, as it is not working for these families (Counties Manukau Health, 2020). Also, the lack of involvement exposed the violation of families' rights to access information and participate in quality care (Health and Disability Commissioner, 2022), furthering the inequity that disadvantages Samoans and potentially other Pacific populations in mental health care.

Thirdly, feedback from Aiga Tasi and Aiga Lima was that they were felt invisible to mental health professionals whether at home or in clinical meetings. In the data, the mother in Aiga Lima believed that professionals did not include nor acknowledge her due to the language barrier, (see section 6.2.3, “The value of alofa and fa‘aaloalo: Enablers of friendly and respectful relationships”). The participant in Aiga Tasi considered that, because she was a sibling, her feelings and input did not count. In her feedback, she highlighted an important point in observing that clinical assessments are often directed at the service user and parents without acknowledging that the siblings and their input in clinical discussions are equally valuable. This feedback demonstrates inconsistency with the *Blueprint II* principles (Mental Health Commission, 2012) where family are active participants in care. In this case, the data highlighted major gaps between the theory and the practice of the person-centred care approach which disadvantage Samoans and Pacific consumers in care.

6.3.5 Health professionals lack person-centred care training.

Another important finding that was highlighted was the inconsistent attitudes and behaviours of mental health professionals, as experienced by Aiga Tasi, Aiga Lua, Aiga Tolu, and Aiga Lima. The mother in Aiga Tasi shared how her family was discounted by a mental health clinician immediately after a quick assessment, without understanding difficulties they encountered for weeks to get help. Also, Aiga Tolu experienced clinicians who failed to follow through with scheduled plans without informing them, as well as providing them with conflicting and wrong information. In addition, at first impression, Aiga Tolu reported professionals’ body language that was disrespectful, and described how they lacked connectedness. They described an incident in which they observed health professionals looking at computers while talking to them, not listening, and uncaring body language such as shrugging shoulders. Participants felt there was a lack of love, honesty, and respect received from their encounter. Importantly, participants’ feedback was based on Samoan concept of fa‘aaloalo where, at initial contact, the essential importance of ‘face meeting face’ (Va‘ai, 2014) is seen in showing respect and genuine care for others. Moreover, the findings also highlighted further connection issues with health professionals in the community. Aiga Lima reported they never met the mental health clinician in person, Aiga Lua claimed they had not seen the mental health clinician in two years, and Aiga Tolu revealed they do not have a good connection with their mental health clinician. Therefore, understanding Samoan cultural concepts in forming connections and genuine relationships should be at the core of person-centred care, as face-to-face, verbal and non-verbal cues have great influence on the quality of Samoans communication, connection, and engagement with others. As such, they should be incorporated in training and professional development for all mental health professionals.

6.3.6 Inconsistent access to Pacific-centred NGO services

The findings revealed additional Pacific-based mental health and NGO services were not offered routinely to families nor were the families aware of them, despite the fact most were migrants and Samoan speakers. Aiga Lima were amazed to realise there are Pacific services available especially within mental health, but they were not accessible to them. By contrast, Aiga Fa and Aiga Lua reported they had a positive experience with accessing the Samoan interpreting services. The finding has shown there are inconsistent practices since, for Samoans, gaining access to cultural support depends on health professional different attitudes. Research by Suaalii-Sauni et al. (2009) exploring Pacific peoples' view of Pacific practices found access to culturally competent health professionals to be invaluable to Pacific people. The findings in the present study revealed a lack of responsiveness and awareness of services to meet the holistic needs of consumers and a disregard for the vision of the person-centred care model (Mental Health and Addiction, 2017). Moreover, the findings highlighted the limitations of many current health professionals' cultural awareness and capability to assess and address the holistic needs of Samoan people.

Of note, however, was the participant families' positive experiences arising from the Pacific support workers providing not only connection with the MHS but also specifically catering to participants' socio-cultural needs. The findings affirm that the use of the Samoan language and respecting cultural values of alofa, fa'aaloalo and loto maualalo (humility) by the support workers enables productive and quality relationships with families, as well as regular contact and support. These results have shown the positive contribution of Pacific NGOs to person-centred delivery when offered to families. The findings also highlighted the roles NGOs performed in their integrated partnership with the MHS, as not only were they community support workers but also mental health clinicians. It was not surprising most participants preferred mental health support from Pacific NGOs than from the MHS. The finding has confirmed that although NGO services created more options, they compounded service fragmentation which made it difficult to monitor and to hold one service responsible for service outcomes (Mental Health Commission, 2010).

One NGO went beyond cultural support as seen in the testimony from Aiga Fa. This NGO provided a health promotion programme aired over Radio Samoa in Auckland which supported this family's positive experience with the MHS. In this case, the Samoan language was used throughout Aiga Fa's engagement with the NGO, and the service user was supported to attend peer-support training which resulted in the service user securing part-time employment as a peer-support specialist in mental health. This finding provided novel and first-time evidence of the value of Pacific-based and led services, as this NGO has demonstrated the commitment and engaged delivery of person-centred care practices for Samoan people. Altogether, these findings have shown a lack of consistency within other NGOs' service delivery models and highlights the need to monitor and regularly evaluate to ensure objectives pertaining to person-centred care social support are addressed and met.

6.4 Summary

In sum, this chapter has critically discussed the participant Samoan families' interpretations and experiences of the person-centred model of care delivery by considering the research questions and providing a critique in the context of the relevant literature. The findings have highlighted strong cultural and religious influences on expectations for care and missed service opportunities in this area of care delivery. There was culturally incongruent care delivery in participants' experiences of person-centred clinical care, communication, and engagement with the MHS. Alternatively, the findings highlighted how Pacific health professionals, the use of Samoan language, and Pacific approaches from the associated NGOs were seen as core enabling factors of the person-centred model while seldom being seen in the present care delivery model for migrant populations and those having English as a second language. Although a Pacific mental health liaison service is currently available, access depended on health professionals' decisions and these consultations did not commonly involve the family. Moreover, the findings presented here and other findings from the literature have highlighted the valuable contribution of Pacific NGOs, NGOs in general, and targeted and appropriate support for mental health. Not only did associated NGOs support the integrated person-centred care model, but also confirmed that social and community support demonstrates the real essence of cultural approaches addressing Pacific communities' holistic health and wellbeing.

The next chapter concludes this thesis. A summary of the study is outlined and recommendations for mental health service policy, research, education, and delivery are presented. Also, included are the strengths and limitations of the study, and further recommendations for future mental health research and methodologies.

Chapter 7: Conclusion and Recommendations

7.1 Introduction

This chapter presents the conclusion of the thesis and recommendations for mental health education, service policy and delivery for Samoan and Pacific families engaging with MHSs in Aotearoa, NZ. The chapter further outlines the study's strengths and limitations. Also, implications for cultural clinical practices are highlighted. Overall, this chapter firstly summarises the key findings that are both unique and novel, as identified by participants in addressing the research objective. This is then followed by key recommendations for clinical practice. To conclude, the study offers further recommendations for further mental health research, health professional education and policy, and a brief personal journey reflection.

7.2 Summary of key findings.

The findings have revealed spirituality and religion as core to Samoans families' conceptualisation of healing and wellbeing. Also highlighted was participants' desire for enhanced Pacific approaches in MHS provision. The five main themes highlighted, firstly, participants' faith in God and this was evident in the cultural/spiritual ritual practices participants engaged with to help them withstand the challenges of their family member's illness. Secondly, the themes revealed the stigma of mental illness remains an issue with the Samoan community and has strongly influenced Samoans' perspectives on mental illness and how they engaged with and accepted treatment. Thirdly, participants revealed they were in the dark in their dealings with the MHS, and this revealed challenges in accessing and engaging with the MHS. The fourth theme presented how the clinical practice model was misaligned with the MHS model of care, including families not understanding their family member's diagnosis and treatments, clinical assessments, and processes. The last theme revealed the Samoan values of alofa and fa‘aaloalo as enablers of friendly and positive relationships and highlighted how these values were linked to feeling respected and loved, with examples given of how they were displayed by some Samoan and Pacific staff. Overall, these findings have shown that current mental healthcare for these study participants lacked social connectedness. These findings reveal considerable inconsistencies, miscommunications, and misalignment in the current model of care for Samoan families facing community mental health concerns with their family members. Importantly, the results of this study may be transferrable to areas where Indigenous and migrant populations reside, such in Australia, Canada, and Hawai‘i.

7.3 Strengths of the study.

The strengths of this study includes the soliciting, in-depth and for the first time, of the experiences of Samoan families during COVID-19 and their unique cultural view of mental healthcare delivery as migrant families living in NZ. In addition, the fa‘afaletui methodology has provided an opportunity for participants to speak openly about their experiences and enabled a depth of conversation that reveals core cultural matters addressing the research topic. Also, the fa‘afaletui methodology offered a Samoan way of engagement, communication, and connection which added cultural congruence to the study. In addition, the use of the Samoan language was seen as valuable to engaging with families where nuances of participants’ experiences were clearly articulated and understood without constraint. Importantly, the researcher is a clinician and a Samoan national, therefore, her cultural and clinical knowledge and awareness helped facilitate the investigation on core cultural and clinical issues addressing the research topic. Additionally, regular supervision meetings were held to check on theme development and address possible inherent biases. Furthermore, having a Tongan primary supervisor and the involvement of the Samoan Advisory Group helped guide cultural themes and provided assistance in clarifying the fa‘afaletui methodology and the nuances of the Samoan language and culture.

7.4 Limitations.

This study has several limitations. The small sample size does not reflect a general representation of the experience of the person-centred MHS in Auckland. Also, COVID-19 restrictions restricted the time available to meet people face to face. Additionally, most participants were older migrants, therefore, feedback were not inclusive of the contemporary Samoan family dynamic of mixed ethnicities, and NZ-born and 17 years old and younger family members. Also, NGO staff were not included and seeking their feedback on the topic could have provided further insight. Most importantly, the need to translate between Samoan and English languages was challenging and took time. Furthermore, patients/service users were not directly included in this study, and their views might be different from their families and could offer a source of data triangulation.

7.5 Implications for mental health service delivery.

This study presented views from six Samoan families regarding their experiences of the MHS person-centred care model of delivery. These perspectives reveal that the MHS’s approach was not aligned with the principles of person-centred care, nor did it address the holistic needs of Samoans/Pacific families. Importantly, the findings highlighted a misalignment of services that goes beyond the particular experience of the participants to represent those of migrants and Indigenous MHS consumers.

The following presents key recommendations that have potential benefits in achieving quality person- and family-centred care for Samoan family consumers.

- Re-orientate person-centred care models to reflect Pacific models of cultural beliefs and practices.

- Recruit and retain Pacific healthcare staff.
- Implement Pacific cultural awareness in MHS training/orientation programmes and undergraduate tertiary curriculum is urgently needed for current and future mental health professionals.
- Implement mental health promotion and community awareness using the Radio Samoa and the Samoan language is needed.

7.5.1 Re-orientate person-centred current care models to reflect Pacific models of cultural beliefs and practices.

This recommendation addresses the following themes: Fa‘atuatua ile Atua (our faith in God); It’s a hush-hush topic: Stigma of mental illness; and The values of alofa and fa‘aaloalo: Enablers of positive experiences. These three themes have highlighted Samoan cultural values and beliefs as well as spirituality as being at the core of these participants’ worldviews and engagement with others. Therefore, the following recommendations are suggested for consideration.

Firstly, to re-orientate person-centred care models to reflect Pacific models of cultural practices. This would involve the inclusion of key social actors such as church leaders, family/community elders and spiritual/traditional healers. Culturally based care would first and foremost need to engage with these key players throughout all the steps of Samoan/Pacific engagement with the MHS. For example, church pastors would be able to offer blessings and counselling and facilitate conversations on forgiveness and healing based on Christian religious beliefs for the service user and within the family.

Secondly, family/community elders such as the cultural health navigator or community support worker now available for Māori services (Goh, 2019) can provide a link to cultural traditions of respect and can facilitate meetings and talanoa to counsel, offer guidance and suggest culturally appropriate ways to resolve severed cultural boundaries. Thirdly, the inclusion of spiritual healing into practice to promote the practice of ifoga and fa‘aleleiga (reconciliation) would be an initial treatment option on its own or with medication, as well as including traditional healers. These three extra approaches should be offered at the initial contact with Pacific people and on an ongoing basis. In addition, it is important to strengthen the role of Pacific NGOs, as outlined by participants in the current study, as knowledge of their role and functions should be accessible to all Pacific families.

Also, importantly, there must be enhanced use of Samoan and ethnic Pacific languages in all clinical processes, medical reviews, therapy sessions and cultural assessments at initial contact, and in medication and treatment information. In addition, Pacific health professionals should be available at all point of access for Samoans and Pacific people, especially in acute settings and police contacts. Overall, these Samoan cultural approaches are based in alofa and fa‘aaloalo and are appropriate to solve and heal any conflicts, misunderstandings and ailments in any situations, no matter where Samoans reside in the world.

Lastly, the findings revealed the primary importance of core cultural practices as conducive to Samoans/Pacific quality care delivery systems. As such, mental health policy, structure, and guidelines should reflect Pacific cultural practices and worldviews that are managed and led by Pacific people. In addition, Pacific elders, health professionals, community leaders, and church leaders should be represented and involved in reviewing and influencing current MHS policy and clinical practice, and this should be the core role of the Pacific MHS.

7.5.2 Recruiting, training, and retention of Pacific healthcare staff.

The last three recommendations pertain to theme 3, We are in the dark with our communication and dealings with the MHS; and theme 4, “Practice what you preach”:

clinical service misaligned with the mental health service model of care aim and vision care.

Firstly, this study proposes the ongoing employment, training, and retention of Pacific healthcare staff to meet the demands of Samoan and other Pacific populations' mental health needs. There must be an active role for the Pacific MHSs to work in partnership with tertiary education to promote mental health careers to future members of the Pacific workforce such as the students in the Pacific nursing programmes at Manukau Institute of Technology (MIT) in Auckland and Whitireia in Wellington (MIT, 2022; Whitireia, 2022). Pacific-focused courses need to be added to the current tertiary health professional curriculum, as well the NZ Nursing Council providing guidelines supporting a Pacific focus whereby a Bachelor of Pacific Nursing will be offered in all tertiary institutions in the region.

Secondly, undergraduate nursing programmes should be revised to include Pacific worldviews in all programmes, and to put more emphasis into mental health nursing and Pacific mental health compared with physical and general health course content.

Thirdly, Pacific MHS should be involved in the recruitment programmes that currently operate within healthcare organisations supporting local high school students to consider careers in health. The Pacific MHS can support this and be visible at local high schools to promote students' interests in recognising Pacific mental health as a career and profession.

7.5.3 Pacific cultural awareness workshop and training for all mental health professionals' continuing education and all undergraduate mental health curricula.

There must me a Pacific cultural awareness workshop/training available and mandatory in training and orientation programmes in MHSs, highlighting these core cultural elements: key Samoan/Pacific terms, Pacific belief system, the role of church, worldviews, epistemology, communication and engagement styles, and cultural values. This annual training should target all health professionals working in MHSs, such as nurses, the allied workforce, medical practitioners, leadership, and management teams. This workshop can further promote safe practice within services as professionals, leadership and management are held accountable and responsible, according to their dedicated professional competencies and codes of conduct, to provide quality safe care for Samoan/Pacific consumers. Altogether, MHSs and healthcare organisations are responsible and accountable to the health strategy, goals, and vision they pledge to deliver and achieve for Pacific population.

Importantly, Pacific cultural awareness training for mental health leadership and management would provide an appreciation of the cultural influences of the Samoan/Pacific worldviews on mental illness and engagement with services. As a result, they would engage Pacific people to lead, develop, and implement policy and procedures to guide, evaluate and monitor the quality of service/care for Pacific people; and also to implement policy and processes to promote and encourage Pacific cultural supervision for all mental health professionals.

Not only should this programme be available in MHSs, but the content of this workshop should also be included in undergraduate tertiary curricula in programmes targeting the future community and healthcare workforce. Importantly, cultural awareness education at undergraduate level can plant the seed into the future workforce’s frame of reference about the value of understanding Pacific worldviews and culturally appropriate approaches that are respectful and provide quality and safety in healthcare for Samoan and Pacific people.

7.5.4 Mental health promotion and community awareness.

As confirmed by our data, mental health education delivered in the Samoan language via the most popular Samoan radio station in Auckland was valuable and in keeping with person- and family-centred care. There is an urgent need for MHSs to recognise this positive engagement pathway for Samoans, as this platform has been well utilised by other healthcare agencies such as heart foundation, and those operating in field such as diabetes, cardiovascular disease, and public health. In addition, mental health promotion programmes need to be accessible in churches and Samoan/Pacific community groups. Collectively, Radio Samoa, churches and community groups resonate with Samoan people; therefore, mental health promotion should accompany other healthcare agencies in using these channels to connect with the Samoan and Pacific community and raise mental health awareness.

7.6 Future research.

Further research is needed to explore the views of diasporic Samoan populations and other multi-ethnic Samoans as their views might differ from those of these migrants in the current study. Also, a comparative study with MHSs in other locations in NZ, or in Samoa and other parts of the Pacific is recommended. In addition, future co-design projects with Pacific patients, families, churches, and community leaders are needed to further explore Samoan/Pacific experiences with healthcare approaches in NZ.

In addition, future research is recommended to conduct a pilot intervention study to address the lack of cultural awareness and the shortage of Pacific staff and support structures in MHSs. This intervention would consist of a cultural awareness workshop/training for all mental health professionals, and in the undergraduate curriculum for future health professionals including nurses, psychologists, social workers, occupational therapists, doctors, and peer support and support workers. This training should be developed with pre- and post-test surveys to examine knowledge, attitudes, and beliefs before and after training and to determine its effectiveness. The plan is to extend this training to NGOs, police, housing, and community service workforces supporting Samoan/Pacific people in the community.

7.7 Conclusion

In conclusion this study has revealed the misalignment of the current MHS person-centred care objectives, vision and goals with the experiences and worldviews of the six Samoan families interviewed. Importantly, it has confirmed the significant value of cultural practices in the MHS. Additionally, this study revealed the strengths and validity of deeply engaging with the fa‘afaletui methodology to explore issues pertaining to Samoans in westernised contexts. It has highlighted how Samoans’ worldviews are underpinned by the collective and inter-relational relationship with self, family, village, and the universe. As such, it has provided the guidance that person-centred care for Samoans should include the voices of families and communities, and those they are connected with. Also, the study highlighted the Samoan values of fa‘aaloalo and alofa at the core of Samoans’ engagement and connection, as well as the pivotal role of spirituality and language to Samoans’ health and wellbeing. However, mental health practices remain constrained by organisational expectations and westernised models of care delivery that are not fit for purpose for Samoans and other Pacific populations. Indeed, the study has offered a reminder to review the mental health system as recommended by *He Ara Oranga* (Government Inquiry into Mental Health and Addiction, 2018), and the strategic framework from the Mental Health and Wellbeing Commission (2021) framework reinforces this change to ensure Pacific-centred MHSs are reinforced and more responsive to the holistic need of the population.

Additionally, the current study of Samoan families aims to inspire other ethnic and Indigenous populations to participate and share their cultural experiences of mental health practices to further inform healthcare organisations, health authorities, health providers, and society in general, and remind them that other voices exist.

7.8 Final remarks and self-reflection.

This study has generated new knowledge on Samoan migrant families' experiences of mental health care in Aotearoa. Importantly, the emphasis on cultural values and beliefs in Samoans' interpretations of care is, under the current system, under recognised and this poses barriers to the optimal family care outcome. In fact, despite the small sample size, this study has provided an in-depth view on the experiences of mental healthcare and highlighted gaps in the fully person-centred model for Samoan families.

Additionally, the findings presented several inconsistencies in mental healthcare delivery. The study revealed the need for a Pacific-centred monitoring and evaluation tool for Pacific mental health services, and Pacific NGO social support providers. Therefore, this study is an opportunity to further remind healthcare organisations and MHSs in Aotearoa that 'for Pacific by Pacific' means not only services led by Pacific, but also incorporating cultural practices into clinical care delivery that address and resonate with Samoan/Pacific service users and families' holistic needs.

Undertaking the DHSs study has provided me space to reflect on the leadership qualities I developed during my personal and professional life. Growing up in a traditional Samoan family, there were clear roles and responsibilities for every person. The leadership roles within Samoan families are always assumed to be male. Despite that, there were opportunities where I led major family circumstances with success and where I discovered my innate leadership qualities that were dormant due to the cultural expectation of the roles of women. Moreover, in my professional role, there were successful outcomes from various leadership positions I held during my nursing career in Aotearoa. I utilised both (western and Samoan) leadership styles in my approach, and self-awareness is very important, so I know when to step out of one into the next or when to use both to achieve the best outcome relevant to a particular situation and time. Meanwhile, feedback from family, friends and colleagues suggested that my style was more relaxing, respectful, friendly, genuine, firm, clear, straight to the point and fair. Therefore, this study has provided insight into my personal and professional growth and realised the potential benefits of utilising both cultural and western leadership qualities in leading and managing change for Pacific mental health in NZ.

In this case, the research topic was selected after the MHS transformation and integration change which saw a major remodelling of the Pacific MHSs. The study was an opportunity to evaluate and review this change, to see if is fit for purpose for the population. Therefore, it was a personal commitment to advocate for quality care for current and future Samoans and Pacific families accessing MHSs.

Using the fa‘afaletui methodology to guide this research into Samoan families' experiences was a privileged experience for the researcher. The fa‘afaletui methodology has reminded me of the privileges of being Samoan and the vital role of alofa and fa‘aaloalo in fostering connection, relationship, and bonds with self, others, and the environment. Indeed, the fa‘afaletui concept belongs to the Samoan culture, and it was my responsibility as a custodian to guard this approach and ensure our values and culture protocols were rightly adhered to. Importantly, the fa‘afaletui methodology was a taonga belonging to me and the six Samoan families that participated in this study. This project was an enjoyable journey filled with blessings and opportunities for professional and personal growth. Importantly, there was warmth and genuine connections developed with participants, and it was an honour to be allowed into their sensitive and vulnerable life experiences with MHSs. These were not light decisions for Samoans to make unless reciprocity, trust and care was in play. Additionally, this study was evidence that anything is possible, and that persistence, determination, and self-belief really do actualise dreams and goals that were once deemed impossible to achieve.

Importantly, the value of this study was summarised by a closing prayer by one participant when he prayed: *'fa'afetai le Atua mo lenei galuega ona ua faia i luga o le alofa mo tagata' (Dear God, thank you for the researcher's work as we believe it was done based on love for the people).* These words confirmed that the study purpose was felt and acknowledged by participants. Most definitely, this study was encouraged by love and commitment to serve. As stated in a verse in the Christian Bible: '*afai oute tautala I gagana a tagata atoa ai ma agelu ae leai so'u alofa, ua na'o a'u o se sumepalo tagitagi' (if I can speak different languages including the language of angels but I do not have love, then I am only an empty vessel in the wind).*

With a grateful heart. Thank you so much.

O le agaga ma le loto ua fa'agae'etia.

Fa'afetai, fa'afetai tele lava, Fa'amanuia le Atua

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Glossary of Samoan Terms

Aiga	A family, a relative; a nuclear or extended or household
Aitu	A spirit or God; a ghost
Alofa	Love/compassion/caring
Aualuma	The unmarried women’s guild of a village
Aumaga	The untitled men’s guild of a village
Anapogi	To fast, fasting, meditate
Atua	God
Fa	Four
Fa‘aaloalo	Respect
Fale	Samoan house
Faletua	A pastor’s wife
Faletua ma tausi	Wives of chiefs
fanau	Children
Fofo	Treating a disease
Laoa	To have something lodged in the throat
Lagi	The sky, heaven
Lua	Two
Matai	Chief of a Samoan family
Matua	Parents
Moe manatunatu	Dream dialogue with ancestors
Tagaloa-Lagi	Samoan ancient God
Talanoa	To chat
Tama	Father
Tasi	One
Tatalo	Prayer
Taule‘ale ‘a	Untitled men
Tolu	Three
Va	Space
Va tapua‘ia	Sacred culture boundaries

Appendices

Appendix A: AUTEC ethics approval

17 December 2020

Sione Vaka
Faculty of Health and Environmental Sciences

Dear Sione

Re Ethics Application: **20/365 Exploring Samoan families' understanding and experiences of New Zealand's current mental health family focused/model of care.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 17 December 2023.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat **Auckland University of Technology Ethics Committee**

Cc: ioanamulipola@yahoo.co.nz; Eleanor Holroyd

Appendix B: Flyer

Aiga Samoa – Tatou Talanoa

Do you have a story to share about your experience in Community Mental Health Services? We would love to hear!

We are conducting a research project on exploring experiences of Samoan families on their dealings with community adult mental health services when supporting their family members in care.

We are interested in your experiences as a Samoan family member at various levels of your interaction with services, including any challenges or difficulties you experienced, or any positive experiences you had.

If you are identified by the service user (patient) as a family member and you reside with and provides some form of caregiving, can speak, and understand Samoan or English, we want to hear from you.

Please contact Ioana Mulipola if you are interested in sharing your story.

Please note that families that I (Ioana Mulipola) have personal or professional relationship with are excluded from participation.

You can email or call us & hope to hear from you soon.

Contact: ioanamulipola@yahoo.co.nz, 021 1836855

Appendix C: Study information

Participant Information Sheet

Project Title: Exploring Samoan families' understanding and experiences of New Zealand's current mental health family focused model of care.

An Invitation

Talofa lava, Malo le Soifua. My name is Ioana Mulipola. I am a New Zealand Registered Nurse and have been working for 13 years between Counties Manukau Health and Auckland District Health Board. Currently, I am working in Counties Manukau Mental Health Services in the Clinical Quality Coordinator role.

I was born and raised in Samoa and lived in Mangere. I am completing a Doctorate study at Auckland University of Technology and part of my study is completing a research. My research title '**Exploring Samoan families' understanding and experiences of New Zealand's current mental health person and family focused model of care'.** The aim is to explore Samoan families understanding and experiences of the current model of care when accessing services with their family members.

I would like to invite you to consider volunteering to participate in a family focus group interview for my research. I am interested to explore your experience with your family with your dealings with the mental health services. This is a chance to understand the opportunities and challenges that Samoans families perceive due to their cultural interpretation of the care received and interactions with the mental health services.

Your participation is totally voluntary (your choice) and will in no way disadvantage your current or future dealings with mental health services. This invitation is your opportunity to contribute to enhancing and supporting our mental health approach and care for current and future Samoan people using adult mental health services.

What is the purpose of this research?

Purpose of this study

- To explore your perceptions and experiences as a Samoan about the mental health services
- To explore cultural opportunities and challenges
- The findings may be used for academic and professional publications or presentations both nationally and internationally.
- To enhance and support culturally approach in mental health services that are more responsive to the need of Samoans and Pacific people accessing services.

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

You are invited to participate in this research if you are

- Identified by a service user (patient) as family member, resides with and provides some form of caregiving
- Ages between 18-65 years
- Identified as Samoan
- Speak both Samoan and English
- Your family member (patient) is currently or has been using adult mental health services for the last 12 months

Please note that you are in no way obliged to participate in this research project after receiving this information sheet. This information has been sent out to you so you can gain further understanding of what this research is about and if you require more information or have some questions before you make any decisions, you are welcomed to contact me. My information is outlined in this information sheet.

How do I agree to participate in this research?

Please contact me Ioana Mulipola if you are interested in participating in this study. My contacts is included at the end of this information sheet. I will invite you to sign the consent form before interviews begins.

What will happen in this research?

The data collecting period involves me interviewing you in a family focus group. Which means that you will be interviewed together face to face with (2 or more) adult members of your family for approximately 90 minutes. Family focus group session can be organised at a place that is safe and accessible to you. I will contact you to set a time for your interview if you agree to participate in the study. I can meet you at your family home or at a public venue that offers some area for private conversation. You decided which is more convenient for you and your family. In case of COVID-19 Alert levels restriction (2-4) at the time of our interview then online technology Zoom will be used for our family focus groups interviews. If this happens, I will support and guide you with organising Zoom connections and setting up prior to the interviews.

Our interview will be audio recorded and some notes will also be taken to accurately document your story. I have prepared some questions that can guide and prompt our interview and you are welcomed to have a copy of this prior to the focus group session, alternatively I will bring a copy for you during the interview. Please note that these prepared questions' is only a means of prompting our interview and I understand that the protocol of true 'faafaletui' will be shaped and guided by what information you think will be important for discussion to benefit this project.

Following our interview, I will have the audio recordings transcribed. Your identity will not form any part of our recorded interview, and I undertake to maintain your privacy and confidentiality throughout this research. I undertake to only use the information for the purpose as stated in your consent form. My primary and secondary research supervisors and myself will be the only people that have access to your data and no third parties will have access to the information that you have provided as part of this research project.

What are the discomforts and risks?

Talking about your experience may trigger some emotional issues for you and this may cause discomfort. I hope the discomforts and risk caused to you will be minimal since the interview will be a form that is like a daily conversation causes little pressure.

How will these discomforts and risks be alleviated?

I will advise and remind you at the start of our interview that you can refrain from answering a question should you prefer not to, and this will in no way affect your continued participation in the research project. Also, at the beginning of family focus interviews I will ask you to refrain from sharing any illegal behaviours or sensitive information, and in case you do, and if someone's safety is at risk, and in consultation with you I will intervene. I have an obligation under Health Practitioners Competency Assurance Act 2003 (HPCA) to respond and act accordingly and to report any safety concerns and illegal behaviours to the statutory entities - police.

Any potential participant discomfort or psychological disturbance is unintended, and should this be noted, then the option of psychological support such as free services:

Healthline 0800 611 116, www.healthpoint.co.nz

Health Point 08005676666, www.cmh.org.nz/vagus-centre.aspx

Faletoa Pacific Cultural Liaison Services 09 2709090

You can withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What are the benefits?

Having the opportunity to talk and sharing your experience with your family may discover some new perspectives and learning. The information you obtained from this study increases your awareness and knowledge about accessing healthcare and mental health services in the future. Also, this experience might give you the self-awareness on your own Samoan culture in the New Zealand context. And according with our Samoan culture protocols I will provide $100 supermarket voucher for your family as token of appreciation of your participation. I understand that there may be some travel (if family focus groups will be held outside of family home) that you might have to undertake to participate in this research and fuel vouchers totalling $20.00 will be made available to compensate for your travel costs.

Also, completing this study will benefits me in completing my qualification Doctor of Health Science.

How will my privacy be protected?

Your privacy and confidentiality of your information will also be protected, your stored interview data, signed consent forms and your contact details will all be stored and kept separately from each other. If the information is stored electronically this will be password protected. Only the primary and secondary research supervisors and I, will have access to your information and this will only be accessed for the purpose of this research. As mentioned no third parties will be given access to your information. As a Samoan nurse researcher, I understand and acknowledge that our Samoan culture underpins by 'alofa' (love) and fa'aaloalo (respect) therefore protecting your privacy and confidentially is the culturally appropriate way to reciprocate your support and participation for this project.

What are the costs of participating in this research?

There is no financial cost for you apart from the time that is required for our focus group session and interview information validation.

What opportunity do I have to consider this invitation?

Time will be given prior to data collection for you to read the information sheet and consent form. There will be a chance to meet if you want to discuss and clarify this information in Samoan and this session is optional (your choice). There is no obligation for you to participate in the study after attending this meeting or affect your dealings with mental health services. You have up to four weeks to consider this information once you have received this information sheet however if you make up your mind earlier, you can always contact me. Again please be aware that your non participation or engagment will in not advantage or disadvantage you in any way.

Will I receive feedback on the results of this research?

You will receive a copy of summary of this study if you are interested. As part of my commitment to this project, I undertake to provide all participants with a summarised report of this research once the report has been finalised. Alternatively, if you prefer a face-to-face feedback session, then please let me know at the family focus interview session and I will schedule this meeting after the report is finalised.

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 Sione Vaka

Contacts: sione.vaka@aut.ac.nz,

Work phone contact: 09 9219999

Professor Eleanor Holroyd

Contacts: Eleanor.holroyd@aut.ac.nz

09 9219999 ext 6745

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Ioana Mulipola

ioanamulipola@yahoo.co.nz, 0211836855

Project Supervisor Contact Details:

Dr Sione Vaka

Sione.vaka@aut.ac.nz

Professor Eleanor Holroyd

Contacts: Eleanor.holroyd@aut.ac.nz

09 9219999 ext 6745

Approved by the Auckland University of Technology Ethics Committee on 17/12/2020, AUTEC Reference number 20/365.

Appendix D: Ethics approval- Counties Manukau

Level 1, Ko Awatea, Middlemore Hospital Research & Evaluation Office
100 Hospital Road, Otahuhu; Private Bag 93311, Auckland – 1640
cmdhb.org.nz – koawatea.co.nz

26 February 2021

For the attention of: Ioana Mulipola and Irene Zeng

Thank you for the information you have supplied to the CM Health Research Office regarding the following research proposal:

CM Health Research Registration Number: 1351

Ethics Approval Reference Number: AUTEC: 20/365

Research Project Title: Exploring Samoan families' understanding and experiences of New Zealand current mental health focused and model of care

I am pleased to inform you that the CM Health Research Office has received all the required service lead approvals and the Chief Medical Officer's final sign-off for the above research project, which has Ioana Mulipola named as the Principal Investigator and Irene Zeng named as the CM Health Facilitator.

This CM Health locality approval is valid until 18 September 2023, which is the Final Reporting Date specified on your registration information.

All external reporting requirements must be adhered to. Please note that failure to notify us of amendments, and/or submit copies of annual Progress Reports and annual Ethics renewal letters may result in the withdrawal of ethical and CM Health organisational approval.

FINAL REPORT: It is a requirement of the CM Health Research Policy that all research and audit projects conducted within CM Health should complete the CM Health Final Report Template and submit no later than 3 months following completion of the study. This report is to be uploaded to your study file on the Registry and is viewable by CM Health staff. Contact us for the report template or download it from the Registry. **Please Note** that having an overdue Final Report will impact your application for locality approval of any new studies.

Yours sincerely

A Bennett.

Angela Bennett

Research Coordinator
Counties Manukau Health

Under delegated authority from CM Health Research Committee and the Chief Medical Officer

Appendix E: HRC scholarship funding

hrc nz
Health Research Council
of New Zealand
Te Kaunihera Rangahau Hauora o Aotearoa

8 October 2020

Mrs Ioana Mulipola

Auckland University of Technology

ioanamulipola@yahoo.co.nz

Mālō e lelei Ioana

Pacific Health Clinical Research Training Fellowship: Application for Health Research Council Funding
HRC Reference: 21/216
Samoan Families Experience with Mental Health Services

The Health Research Council of New Zealand (HRC) has evaluated all Pacific Health Career Development Award applications for the 2021 funding round. I am pleased to inform you that the Council has approved your application for a Pacific Clinical Research Training Fellowship.

As you know, the health research sector has been severely affected by COVID-19. The HRC recognises that your original proposal, as submitted and assessed, may need to be updated due to this situation. This may include start dates and milestones, key personnel, research location and other aspects of the proposed research, provided the overarching aims or intent and total budget remain the same. Alternatively, if this research is no longer possible, this offer can be declined with regret.

Upon your acceptance of the award, a start date will be negotiated, and a contract finalised with your host institution, clarifying administrative and funding arrangements on the terms and conditions outlined on the enclosed draft Third and Fourth Schedules of the HRC Research Contract. Your research office will contact you regarding contract details.

The Fellowship will provide 100% of your salary support (unless your application specified a part-time FTE). If other salary support is obtained, the HRC must be advised, and the award will be adjusted accordingly. It is a condition of receiving the Fellowship that you cannot hold other awards without the permission of the HRC.

Enquiries relating to the administrative aspects of your funding should be directed to your Research Office. Once any changes have been agreed, a contract will be sent to your host institution for execution.

Some key conditions of the contract include best efforts to complete the proposed research, fulfilment of reporting requirements noting problems or delays as soon as they occur, changes or significant absences of key staff, and significant changes to research objectives/milestones (Fourth Schedule)

Regular reporting aims to identify any issues or concerns as well as highlight positive outcomes of the research. All research reports are to be submitted on HRC Gateway. Please let us know directly of any newsworthy impacts of our funding, as our Communications team may be able to assist in sharing these results.

Contract variations, such as time extensions, must be submitted to the HRC by your Research Office.

In your acceptance of this offer, please indicate for our records whether an ethical approval is required for the planned research.

Please note that all investigators receiving contract funding from the HRC must make themselves available as reviewers or assessing committee members whenever possible. Please update your HRC Gateway profile to nominate yourself for HRC assessing committee membership.

Your Research Office has been requested to return the draft Third and Fourth Schedules and signed Staff Declaration form by 23 October 2020. The Staff Declaration form should include timeonly staff and their FTE on the contract.

Your Research Office is required to return the signed contract to the HRC by 6 November 2020. Unless your Research Office has received written authority from the HRC, your contract must commence no later than 1 February 2021. The funding may be withdrawn and returned to the HRC funding pool if this condition is not met.

Please note that the HRC will be making a media announcement about the outcome of this round in late October 2020. Media activities initiated by your institution may follow the HRC's announcement but must not be before this announcement. This includes posting any result details on your websites. Please contact the HRC if you would like us to provide comment for your institution’s media funding announcements as we would be happy to do so.

Please note due to unforeseen circumstances the review summary for your application is not currently available and will be sent to your research office as soon as it becomes available. The review summary notes some of the points raised during the assessment of your application.

I would like to offer you my personal congratulations on your success and to wish you every success with your research. Should you have any specific questions regarding your award, please do not hesitate to contact Ms Tolotea Lanumata, Manager of Pacific Health Research, at the HRC.

Mālō ‘aupito

Mr Stacey Pene
Director of Equity, Māori and Pacific Health Research

encs Draft Third Schedule

Draft Fourth Schedule

cc Auckland University of Technology Research Office

Appendix F: HDEC Out of Scope Letter

5 June 2023

Mrs Ioana Mulipola

Counties Manukau Health

ioanamulipola@yahoo.co.nz

Dear Mrs Mulipola,

Study title:	Exploring Samoan families' understanding, and experiences of New Zealand current mental health focused and model of care.

Thank you for emailing HDEC a completed scope of review form on 02 January 2021. The Secretariat has assessed the information provided in your form and supporting documents against the Standard Operating Procedures.

Your study will not require submission to HDEC as, on the basis of the information you have submitted, it does not appear to be within the scope of HDEC review. This scope is described in section three of the Standard Operating Procedures for Health and Disability Ethics Committees.

An observational study requires HDEC review only if the study involves more than minimal risk (that is, potential participants could reasonably be expected to regard the probability and magnitude of possible harms resulting from their participation in the study to be greater than those encountered in those aspects of their everyday life that relate to the study).

For the avoidance of doubt, an observational study always involves more than minimal risk if it involves one or more of the following:

- one or more participants who will not have given informed consent to participate, or
- one or more participants who are vulnerable (that is, who have restricted capability to make independent decisions about their participation in the study), or
- standard treatment being withheld from one or more participants, or
- the storage, preservation or use of identifiable human tissue without consent, or
- the disclosure of identifiable health information without authorisation.

As you have already received AUTEC approval, HDEC does not need to review these issues.

If you consider that our advice on your project being out of scope is in incorrect please contact us as soon as possible giving reasons for this.

This letter does not constitute ethical approval or endorsement for the activity described in your application, but may be used as evidence that HDEC review is not required for it.

Please note, your locality may have additional ethical review policies, please check with your locality. If your study involves a DHB, you must contact the DHB's research office before you begin. If your study involves a university or polytechnic, you must contact its institutional ethics committee before you begin.

Please don't hesitate to contact us for further information.

Yours sincerely,

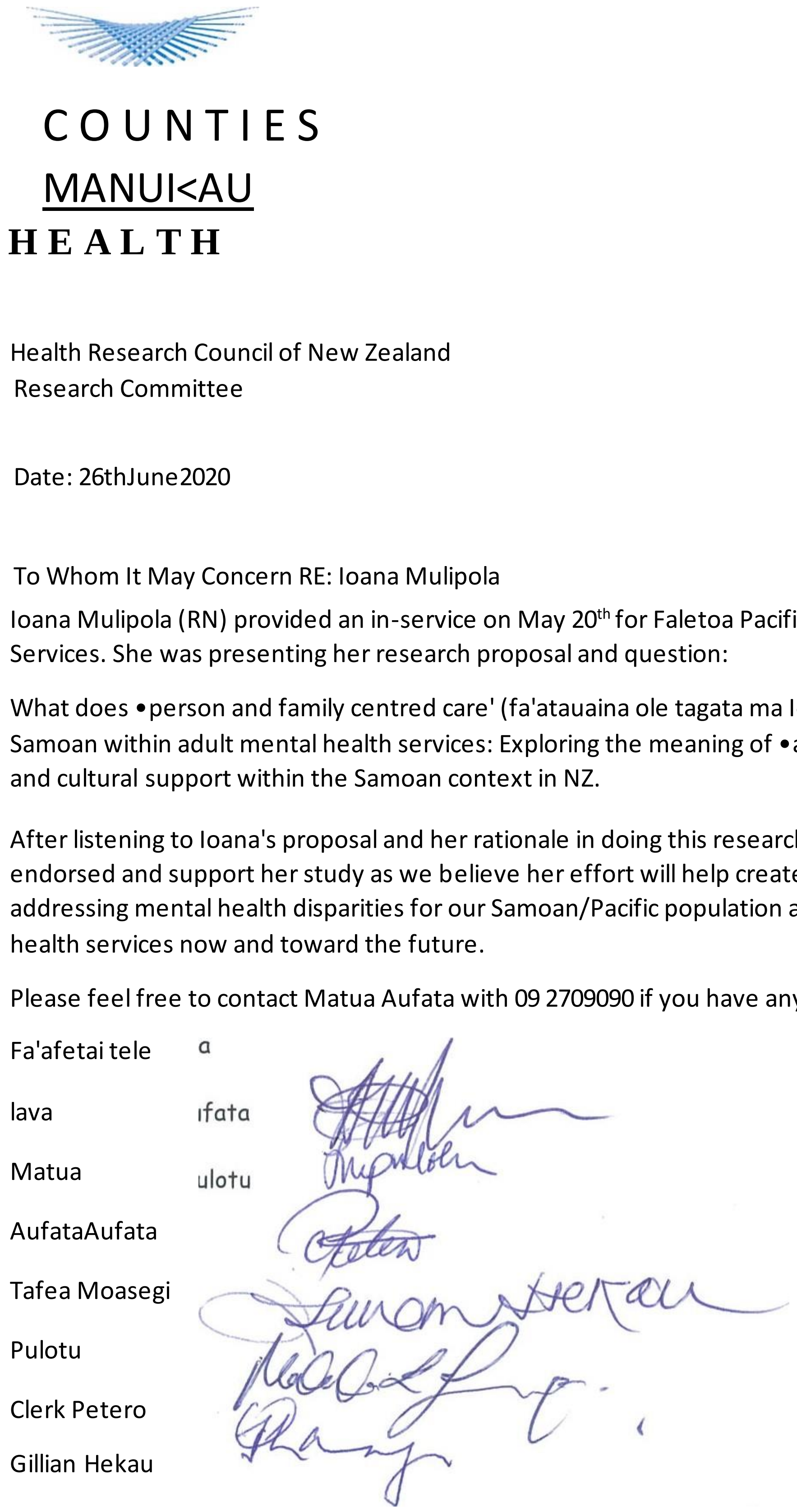
Zoe Benge

Assistant Advisor

Health and Disability Ethics Committees

hdecs@moh.govt.nz

Appendix G: Support letters for study



COUNTIES
MANUI<AU
HEALTH

Health Research Council of New Zealand
Research Committee

Date: 26thJune2020

To Whom It May Concern RE: Ioana Mulipola

Ioana Mulipola (RN) provided an in-service on May 20th for Faletoa Pacific Mental Health Services. She was presenting her research proposal and question:

What does •person and family centred care' (fa'atauaina ole tagata ma Iona aiga) means for Samoan within adult mental health services: Exploring the meaning of •aiga' including social and cultural support within the Samoan context in NZ.

After listening to Ioana's proposal and her rationale in doing this research, we hereby endorsed and support her study as we believe her effort will help create a difference and addressing mental health disparities for our Samoan/Pacific population accessing mental health services now and toward the future.

Please feel free to contact Matua Aufata with 09 2709090 if you have any questions.

Fa'afetai tele a
lava ıfata
Matua ulotu
AufataAufata
Tafea Moasegi
Pulotu
Clerk Petero
Gillian Hekau

COUNTIES
HEALTH

26 June 2020

Health Research Council of New Zealand

Level 3 - ProCARE Building

Grafton
Mews,
110
Stanley
Street

Auckland 1010

RE: Ioana Mulipola Research Study

To whom it may concern,

Ioana has informed me about her research and I have reviewed a copy of her research proposal summary.

Cultural values and beliefs influence how Samoan/pacific people engage with Health Services. Samoan people living in New Zealand currently have the highest representation within mental health services. I believe that research such as the one proposed by Ms Mulipola can create a difference, and would contribute to the knowledge base very much needed to improve the design of mental health services appropriate for our New Zealand Pacific population.

Ioana has over 12 years of experience in various areas of mental health and has competent knowledge of the Samoan language and cultural values. I'm fully supportive of her research and hereby offer my endorsement and good wishes for her studies.

Please feel free to contact me by email Charles.tutagalevao@middlemore.co.nz if you have any questions.

Fa'afetai tele lava,

Charles Tu agalevao

Service Manager

Pacific Mental Health & Integrated Care North

Counties Manukau Health

Pacific Island Mental Health Professionals Association

13 May 2020

To Whom It May Concern:

I am Leota Dr Lisi Petaia, Consultant Forensic Psychiatrist, Waitemata District Health Board (WDHB), and President of the Pacific Islands Mental Health Professional Association (PIMHPA) in New Zealand.

I have been asked to provide a supporting reference for Registered Nurse, Ioana Mulipola, who is undertaking a Doctorate study at the Auckland University of Technology (AUT), and is in the process of submitting her research proposal.

Ms Mulipola's research question is:

What does 'person and family centered care' (fa'atauaina o le tagata ma lona aiga) means to Samoans within adult mental health services. Exploring the meaning of 'aiga' including social and cultural support within the Samoan context

The proposed participants for the research will be Samoan family members of service users' who are currently registered in adult community services, and those who are already discharged.

Ms Mulipola's study will critically explore the current mental health practice as mentioned in strategic & development plans, policy and guidelines regarding; person/whanau centered care and integrated care. Ms Mulipola hopes to explore the Samoan cultural views and social supports that are appropriate in addressing their needs whilst involved with mental health services.

Mental health disorders are highly prevalent amongst the Pacific community in New Zealand so I fully support any research initiative to increase the cultural knowledge and competency of its community to deal with mental health issues.

I believe that research such as the one proposed by Ms Mulipola can create a difference, and would contribute to the knowledge base very much needed to improve the design of mental health services appropriate for our New Zealand Pasifika population.

Ms Mulipola is a respectable member of our Pacific Island community in Auckland and I am very proud of her achievements thus far, as well as her continuous efforts to improve mental health care for our Pacific people.

I wish to warmly state my full support and endorsement for her proposed research and wish her all the best for her work.

Please feel free to contact me if you have any questions about this reference.

Yours faithfully,

Leo Dr Lisi Petaia
BSc, MBBS, PGrad.ForSci, FRANZCP, Cert Forensic Psych.
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Appendix H: Consent form

For use when focus groups are involved.

Project title: Exploring Samoan families' understanding and experiences of New Zealand's current mental health family focused/model of care.

Project Supervisor: *Dr Sione Vaka*

Researcher: *Ta'avale Ioana Mulipola*

○ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.

○ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.

○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○ I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the focus group discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○ I agree to take part in this research.

○ I wish to receive a summary of the research findings (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 17/12/2020 AUTEC Reference number 20/365

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

Appendix I: Matalafi Matrix Pacific Cultural Formulation Tool

[redacted] [redacted]

Faletoa Clinical Cultural Liaison Team - CMDHB

MATALAFI MATRIX - Pacific Cultural Formulation

[redacted]

Client's identified ethnicity			
Client's first language		**Interpreter required**	☐ Yes ☐ No
Who is present at the assessment			
Assessment date			
Cultural Assessor			

Aiga / Famili / Kainga / Kopu tangata / Magafaoa - Family, relationships:
(Peers, roles, responsibilities, education, affiliations, sexual orientation, social interactions etc)

Tino Atoa / Sino / Oraanga Kopapa / Tino Katoa - Physical
(General health, physical disorders and problems)

Lagona / Ongo / Oraanga aroa, inangaro / Loto Haau - Emotional and psychological wellbeing
(impact of culture, cultural identity, etc on emotions and mood related to how the person feels about their current situations, e.g. depression, anxiety, guilt etc)

Aganu'u / Ulungaanga faka-fonua / Peu Tupuna, Peu Kopulangata / Mosi faka Niue - Cultural
(Cultural or ethnic meanings & considerations, how they explain what is happening (attributions), perceived causes of abnormal thoughts, beliefs or experiences (perceptual abnormalities))

Fa'aleagaga / faka-laumalie / Oraanga Vaerua / Fakaagaaga - Spirituality
(What does spirituality mean to the individual and how does it impact on wellbeing ?)

Recommendations

[redacted]

Appendix J: Demographic Questions

Key Demographic Questions

1. What is your relationship to the MH service user?
    a) Parent
    b) Grandparent
    c) Siblings
    d) Friend
    e) Other

2. How long has your family member being cared for by MH services?
    a) Less than 12 months
    b) 1-5 years
    c) 5-10 years
    d) 10+ years

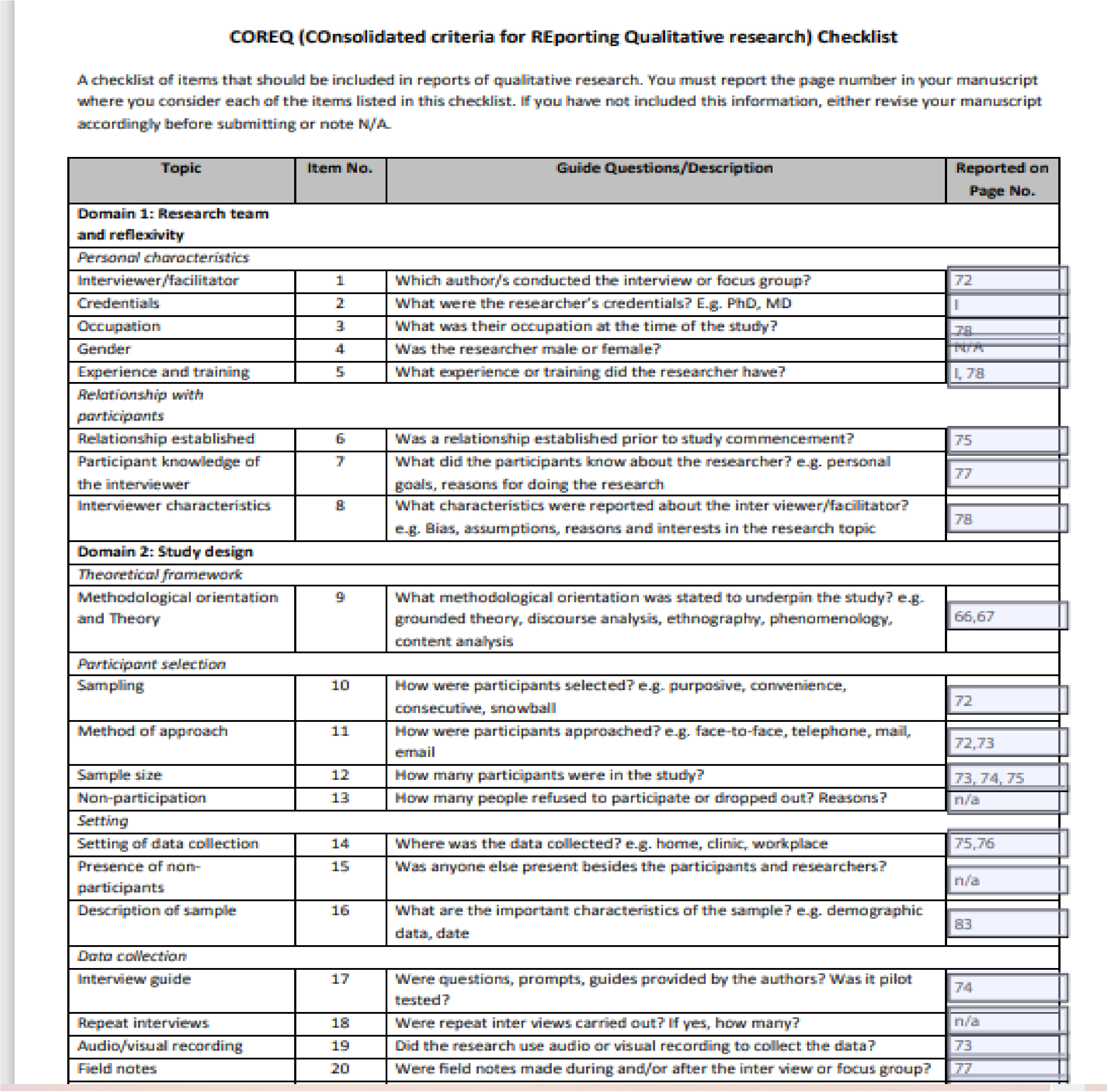
3. How long have you been living in NZ?
    a) 1-5 years
    b) 5-10 years
    c) 10-15 years
    d) 15+ years

4. What is your main language?
    a) Samoan
    b) English

5. What is your employment status?
    a) Full time employment
    b) Part time employment
    c) Self employed
    d) Student
    e) Other

6. Do you belong to a church?
    a) Yes
    b) no

Appendix K: CQEC



COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	72
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	I
Occupation	3	What was their occupation at the time of the study?	78
Gender	4	Was the researcher male or female?	N/A
Experience and training	5	What experience or training did the researcher have?	I, 78
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	75
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	77
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	78
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	66,67
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	72
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	72,73
Sample size	12	How many participants were in the study?	73, 74, 75
Non-participation	13	How many people refused to participate or dropped out? Reasons?	n/a
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	75,76
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	n/a
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	83
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	74
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	n/a
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	73
Field notes	20	Were field notes made during and/or after the inter view or focus group?	77

Duration	21	What was the duration of the inter views or focus group?	73
Data saturation	22	Was data saturation discussed?	77
Transcripts returned	23	Were transcripts returned to participants for comment and/or	n/a

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	79
Description of the coding tree	25	Did authors provide a description of the coding tree?	79,80
Derivation of themes	26	Were themes identified in advance or derived from the data?	82
Software	27	What software, if applicable, was used to manage the data?	n/a
Participant checking	28	Did participants provide feedback on the findings?	n/a
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	86-134
Data and findings consistent	30	Was there consistency between the data presented and the findings?	136
Clarity of major themes	31	Were major themes clearly presented in the findings?	136
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	89

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Appendix L: Fa'afaletui family group questions English/Samoan

Family Focus Group Questions

English Version

1. Can you tell us more about what kind of services and what you know about the services you or your family member has been receiving from Matariki to date?
2. Have you heard of the term (person centred care) if so, what does this mean to you?
3. Have you heard of the term (family centred care) if so, what does this means to you?
4. 4How are you experiencing your interactions with the community mental health service? what is working well and what does not work currently?
5. How could Samoan families be best supported with their dealings with the mental health services in NZ? - what aspects, any examples please
6. Was the Pacific service offered to you? Where your cultural needs understood, respected addressed, language, religion, health beliefs What was your experience with the Pacific cultural liaison team support? what worked what could have been approved
7. Anything else you might want to add?

Family Focus Group Questions
Samoan Version

1. O lea sou finagalo fa'aalia ile auaunaga sa/po'o lo'o fa'atinoina e Matariki/Rapua/Manukau mo, lou alo po'o seisi o lou aiga.

2. Sa e fa'afofoga ile fa'aupuga lea 'fa'ataua le o lo'o gasegase i auaunaga' fa'a le soifua maloloina? O le'a sona uiga ia te oe?

3. Sa e fa'afofoga ile fa'aupuga lea 'fa'ataua le aiga ole o loo gasegase I auaunaga fa'ale soifua maloloina? O le'a sona uiga ia te oe?

4. Oa ni vaega ole matou auaunaga o e maitauina lo'o fa'atauina ai nei fa'aupuga? Oa ni vaega lelei? Oa fo'I ni vaega e fia fa'aleleia?

5. Oa ni auala e sili ona mo'omia e faia e le matou auaunaga e fesoasoani atu ai mo tatou tagata ma aiga Samoa e autova'a mai ile matou matagaluega?

6. Sa ofoina atu le auaunaga ale pasefika mo le tou aiga? Ea la sau maitau ile a'ua'unaga a Faletoa? Na e lagonaina sa malamalama le matou matagaluega I ou manaoga fa'aleaganuu, gagana, ma ou talitonuga fa'a le soifua maloloina?

7. E iai seisi vaega po'o se manatu mulimuli e fia fa'aalia I lenei mataupu?