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ORIGINAL ARTICLE

Using *Fa'afaletui* to explore Samoan consumers' experience and interpretation of mental health person-centred care in Aotearoa, New Zealand

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ABSTRACT: *This study applied a* fa'afaletui *cultural lens to an exploratory qualitative study examining Samoan families' experiences and engagement with a person-centred care model employed in specific mental health services in Aotearoa. Six semi-structured* talanoa *group discussions with families who had been previously or currently engaged with mental health services. In addition, 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. Five themes were identified: (i) Fa'atuatua ile Atua; Spiritual faith in God; (ii) It is a hush hush topic; stigma of mental illness; (iii) We are in the dark with our communication and dealings with the services; (v) Practice what you preach; clinical service delivery misaligned with the model of care; and (vi) Alofa (love) and fa'aaloalo (respect); enablers of positive experience. The findings overall highlight spirituality and religion as core to a Samoan's faith to foster resilience and healing when facing adverse mental health events with their family members. In addition, the need to build up capacity for Pacific staffed specialist services and Pacific model to achieve equity and holistic care for Samoans and other Pacific populations at risk of adverse mental health outcomes are recommended.*

KEY WORDS: *family, mental health services, Pacific people, person-centred care, Samoan people.*

BACKGROUND

Pacific people constitute 7% of Aotearoa, NZ population (Statistics New Zealand 2018), and are a lively part of society who have shaped the country's culture through sport, arts, music, academic, political, and other forms (Samu & Suaalii-Sauni 2009). Almost two-thirds of Pacific people are New Zealand born, and the highest proportion of the population is younger than 25 years old (Statistics New Zealand 2018). 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). Most Samoans 50% reside in the Counties Manukau area, followed by 25% Tongan, 21% Cook Islands Maori, 8% Niuean, 4% Fijian, and other Pacific 3% (Counties Manukau 2021).

In Aotearoa, the prevalence of mental disorder sits 24.4% with Pacific peoples compared to a rate of 19% in the general population (Mental Health Commission 2012; Browne *et al*. 2006). Cook Island Maori are most affected at 29.3%, followed by other Pacific 25.5%, and Samoans are 24.5% (Foliaki *et al*. 2006). A high burden of mental health problems are correlated to young Pacific populations attributed in part to relative socio-economic disadvantage when compared with the general population (Browne *et al*. 2006).

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The World Health Organization (2015) strategy identified 'person-centred care' and integrated health services as key guiding principles that dictate how health services are funded, managed, and delivered to meet the current global health needs. Person-centred approach is more than a set of techniques, skills, and procedures (Edvardsson 2010), it is a personalized approach of developing genuine relationship, connection, and partnership with patients and families underlined by respect and compassionate care (Santana *et al*. 2018). These person-centred principles have been shown to play a vital role in healthcare systems of creating a culturally centred approach using co-design processes, and structures to promote and implement this socially and culturally congruent care delivery.

In Aotearoa in recent years, mental health services (MHS; adult community MHS and allied Pacific non-government organizations (NGO) social support providers) in Auckland, Aotearoa's largest city have undergone a whole system integration change with the aim of taking the service to a 'new place'. This was intended to align with the World Health Organization (2015) strategy, as well as the He Ara Oranga, Mental Health (MH), and Addiction Government Inquiry (2018) recommendations for the person and family to form the core of service delivery. Additionally, this approach was planned to coordinate with the wider organization strategy to prioritize 'person and family centred care' as the focus of healthcare delivery in the region (Auckland District Health Board 2019; Counties Manukau Health 2019; MH & Addiction Business Plan 2017). In fact, the Mental Health & Wellbeing Commission Annual Report 2021 strategic framework in response to the MH & A Inquiry 2018 reinforced this change ensuring the voices of Pacific people are heard and their cultural holistic need rightly addressed (MH Commission 2021).

According to ancient Samoans, 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 2014). Importantly, as the creation of God Tagaloa, Samoans, and all living creatures are equal and are complementary of each other. There is sacredness within the cultural boundaries (Va tapua'ia) between man and all living things because of their shared divinity with God Tagaloa (Efi 2009).

Furthermore, to reinforce Samoans harmonious relationship with the earth, the sky, and one another, there are sacred concepts that fortify and affirm relationships. These concepts are coined Tapu (taboo), Feagaiga (sacred covenant), and Tuaoi (boundaries), collectively, they create a presence of peace as understood by indigenous Samoans. These three concepts are cultural protocols and ethics to guard and protect the three core relationships (Efi 2009). These core relationships are firstly between a parent and a child, second is between a brother and a sister, and thirdly between an offender and the offended (Efi 2009). In this case, achieving peace and harmony for a Samoan is a core cultural relationship to be respected and protected through understanding and adhering to shared cultural protocols (Mila-Shaaf & Hudson 2009). The Va tapua'ia or Va is a culturally inspired notion that is managed by virtue of balance, respect, and mutual relationship with others (Efi 2014; Mila-Shaaf & Hudson 2009). This ideology emphasizes Samoan spiritual connectedness and practice that dominate every aspect of Samoan life (Efi 2009; Mo'a 2015).

Importantly, cultural values, beliefs, and worldviews on health have considerable influences on Samoans' health seeking behaviours and how they engage with health care (Ministry of Pacific Island Affairs 2011). Samoans believe that a diagnosis of mental illness (MI) is secondary to disrespecting and overstepping cultural boundaries (Efi 2009; Suaalii-Sauni *et al*. 2009), that are deeply rooted in an association with spirits believed to be a major cause of stigma (Suaalii-Sauni *et al*. 2009). In addition, a lack of understanding between non-Pacific health professionals and Samoan lay people 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 westernized 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).

Within the framing of these cultural prescriptions and considerations, the Samoan methodology of *fa'afaletui* was employed to explore how Samoan consumers' engaged and experienced person-centred care in MHS in Aotearoa.

A Fa'afaletui approach

Fa'afaletui is a Samoan word for conversation. It is derived by Samoan philosophies of connection and collective approaches of different social groups to achieve a consensus for decision making (Goodyear-Smith & 'Ofanoa 2021). *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*. 2005). 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 methodology is grounded by Samoan values of *fa'aaloalo (respect)* and *alofa (love/compassion*; Goodyear-Smith & 'Ofanoa 2021). Alofa is the combination of two words alo (to face) and fa (the four posts of the fale- 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) 'alo atu' (face forward), literally means 'face to face' or 'face meeting face' in relationships (Va'ai 2014). Alofa and fa'aaloalo are two important Samoan culture values used in conversation to help save face. A loss of face is traumatizing for Samoans, as faces represent 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, is understanding the Samoan language, as it holds the key to comprehend 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*. 2005).

Fa'afaletui is a Pacific methodology developed and utilized by Pacific researchers to highlight and identify cultural nuances, meanings, understanding, and beliefs of ethnic populations such as Samoan/Pacific (McCarthy *et al*. 2011; Suaalii-Sauni *et al*. 2014; Tamasese *et al*. 2005). It is a collective approach where different levels of knowledge are shared and consolidated as expressed by the three perspectives framework (Tamasese *et al*. 2005). The three perspectives include the person on top of the mountain who has a comprehensive view of the issue. The person on top of the tree has some understanding of the issue but lacks the wider and immediate knowledge of the issue, and the person in the canoe who is most affected by what is going on (Suaalii-Sauni *et al*. 2009; Tamasese *et al*. 2005). These perspectives form groups of diverse sources of expertise and knowledge, such as Matai (chiefs), Faletua ma Tausi (wives of chiefs), Aualuma (women guild), Taule'ale'a (untitled men), and Tupulaga (youth) representing the collective voices of the wider community (Efi 2009). The perspectives allow a comprehensive evaluation of a topic by the collective and encourage a response that reflects Samoan culture (Tamasese *et al*. 2005). 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 MI might have on the service user's future. The person in the canoe represents the wife or husband of the service user who has close contact with the SU and understands the impact of the illness not only to the SU but also to the family well-being; hence, a chain of interconnectivity is created.

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 2021). 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 2021; Tamasese *et al*. 2005).

Study aim

In this study, we critically discuss the use of *fa'afaletui* in an exploratory qualitative study examining Samoan families' experiences and engagement with the person-centred care model in MHS. In addition, exploring Samoans' cultural interpretation of MHS care delivery was guided by the overarching research question – What does person-centred care mean for Samoans accessing MHS?

METHODS

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

recruited through invitation and flyers, as well as information sessions presented in English and Samoan language by face to face and via Zoom.

Approach to family group fa'afaletui

Most families preferred their *fa'afaletuis* completed at their family homes by the first author during April–May 2021. Following Samoan protocols for visiting families, the researcher brought a cake as appreciation and to reaffirm connections. All the f*a'afaletuis* were started and concluded with a prayer led by the researcher or a family member. Establishing connection is fundamental in commencing relationships, 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 asked questions, and some offered food and warm drinks. Each *fa'afaletuis* lasted for between 60 and 90 min.

Initially, participants were briefed in the Samoan language on the purposes of f*a'afaletuis* to ensure they fully comprehend the informed consent sheet. All participants consented to *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 feeling uncomfortable, and confidentiality of information shared and discussed through-out the process and stages of the *fa'afaletui* family group. The participants were required to sign a consent form if they agreed to participate in the study.

The first author is Samoan, a MH nurse clinician as well as a Samoan fluent speaker and was not known to the participants. Seven semi-structured questions guided family discussions and incorporated these issues: Have you heard of the term 'person-centred' care? If so, what does that phrase mean to you? And how are you experiencing this phrase in MHS? Also, exploring awareness and experience of Pacific MHS; and areas of improvement to address cultural needs.

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 consisted of three Samoan cultural experts (two Matai's (chiefs), and a Faletua - pastor's wife) providing cultural insight into the Matai and power structures within families, 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 the data. Criteria for Reporting Qualitative Research was used to prepare the paper (Tong *et al*. 2007).

Ethics

The study was approved by the university and relevant health organization on 26 February 2021, and permission to recruit was given by Auckland University of Technology Ethics Committee (AUTEC) 20/365 on 17 December 2020.

Data analysis

All interviews were transcribed, and subsequently audio recordings were coded, read, reread, categorized, and reviewed to identify recurring themes emerging from family group *fa'afaletui* by the first author, guided by the second and third author. Feedback was transcribed and checked following the *fa'afaletui* framework and Braun and Clarke (2006) thematic analysis.

Rigour

The study followed Lincoln and Guba (1990) criteria to establish rigour as appropriate criteria to judge the quality of the study. In the current study, this included participant member checking and method triangulation. All authors were involved in reviewing the data and study documents. Dependability involved consistency in categorizing 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 f*a'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.

Findings

A total of six Aiga (families) participated with a total number of 13 individual participants. 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 (see Table 1).

After six family fa'afaletuis' and the analysis process, five main themes were identified.

Theme One: Fa'atuatua ile Atua: Spirituality and religion

Spirituality and religious beliefs as cornerstones of the Samoan culture were seen by the participants to have enabled them to cope with challenges, they endured with the MH care system and were important in their healing.

> 'There was no one else that we can turn to, 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. Additionally, 'I'm thankful to the love of God that my daughter is recovering plus our ongoing prayers and attending church' – Father Aiga Fa

Similarly, tatalo (prayers) and anapogi (fasting) are Samoan practices that enabled them to be more connected and closer to their God.

> I fasted because of my wife's illness, also when I'm not able to handle a situation, I fasted for three days. God is real and answered prayers Husband Aiga Ono

Importantly, the church was associated with God's presence and a place of worship. Participants felt obligated to honour and respect this space at all costs.

> My son assaulted me at church. I'm ashamed and humiliated in-front of the congregation. I felt ashamed because of our Samoan culture. – Father Aiga Tolu

With sadness his wife added, 'that was not my son assaulting his father'.

This feedback shows the parents disbelief and shock at what was unfolding was culturally devastating and heart-breaking due to the lack of support from services.

However, the strength of the Samoan culture was seen to enable forgiveness and spiritual healing despite the unfolding crisis.

> When my son was taken by police, I felt sorry for him. Although I was ashamed and humiliated, I cannot deny my son, now I wanted him home. Father Aiga Tolu

Theme two: Stigma of mental illness: It's a hush hush topic

Mental illness and the stigma associated with it was identified by some participants as an issue.

> My mum was saying my brother really needed MH but our whole family said she should not be 'fia palagi' (thinking like a pakeha) and consider 'fofo Samoa (Samoan healing)' Sister Aiga Tasi

Similarly, *It's like a hush-hush subject when people say it's a curse because I've been condemned of that. Mother Aiga Tolu*.

The role of the strongly held cultural belief on traditional healing for curing MI was seen in opposition to clinical services and caused many family disagreements

TABLE 1 *Demographic characteristics of participants*

Aiga-Family	Family members	Pseudonyms	Years living in NZ	Family member role & relationship to participants	Years with MH
Tasi (One)	Mother	Alofa	10	Son	5
Tasi	Sister	Vao	10	Brother	5
Lua (Two)	Sister 1	Rula	5	Brother	5
Lua	Sister 2	Vine	5	Brother	5
Tolu (Three)	Father	Toma	25	Son	4
Tolu	Mother	Ata	25	Son	4
Fa (Four)	Father	Fala	35	Daughter	5
Fa	Mother	Lina	30	Daughter	5
Lima (Five)	Mother	Sina	15	Son	10
Lima	Sister 1	Tina	15	Brother	10
Lima	Sister 2	Mia	15	Brother	10
Ono (Six)	Husband	Fatu	20	Wife/partner	15
Ono	Son	Tama	20	Mother	15

MH, mental health.

which impacted on the family support unit in times of stress. Also, the feedback shows parental role was blamed and criticized for causing MI.

Theme three: We are in the dark with our communication and dealings with MHS

Participants believe there are barriers that prevent them accessing MHS.

> I rang them no answer, only the answer machine. I kept on ringing and left messages, and they never replied – Mother Aiga Tolu

In addition, participants identified challenges with needing urgent support from MHS.

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

Furthermore, communication barriers were identified in the lack of information about services and inclusion of families in care-planning.

> I want to learn and understand MHS. That's why I participated in this study because for our family we are in the dark with our dealings with MHS – Sister 2 Aiga Lima

Theme four: Practice what you preach – clinical service misalignment with the MHS model of care

This theme revealed a mismatch of the person-centred care and the experience of care as confirmed by our participants.

> I need to understand gagana faigata ma loloto (deep hard English), even though I can follow but I do not understand MI and the medications – Father Aiga Fa

Also, feedback on the nature of Pacific MH support offered was disappointing.

> They were okay, it was just a support- not a clinician support. There was no therapy, they came and do a prayer and that was moral support, it was not deep enough it doesn't form part of the diagnosis and what you know and the follow-up – Mother Aiga Tasi

Similar disappointment was expressed with feedback on the clinical assessments.

> Some of the questions 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 that assessment was done for nothing, my son's life was destroyed, he's not supposed to be in jail. – Mother Aiga Tolu

Her husband added '*Maybe after they wrote it down then throw it in the rubbish*'.

Also, one family was not aware they could attend medical reviews.

> I thought the support worker attends the appointment with him. – Mother Aiga Lima

Theme five: Featured Samoan values of alofa *and* fa'aaloalo *demonstrated through positive relationships and genuine connections*

This finding showed participants aspirations for more cultural representation and authentication in current service delivery models with examples provided.

> A Samoan person creates a feeling of warmth and always asks to clarify if I fully understand' Mother Aiga Fa. Additionally, '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

Their engagement with Samoan and Pacific health service professionals, and the use of Samoan language, or at the minimum some Samoan terms created a positive experience for these participants.

DISCUSSION

Spirituality as core to Samoan culture and healing

Importantly, as seen in our data, spiritual beliefs had a significant impact in maintaining Samoan's wellness in the face of adversity and hardship (Efi 2009). Participants shared how they sought guidance and connection with God. One participant outlined how he engaged in anapogi (fasting, meditating) for 3 days and that his strong conviction that God would heal his wife and so responds to his needs. Spirituality here referred to faith and the personal relationship participants had with their God. As mentioned, in Samoan ancestral history, God is Tagaloa-Lagi, who was 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 the God Tagaloa. In this way connectedness with the universe, environment and to each other is the foundation of collectivism and holistic concept of well-being of Samoans (Efi 2009). Significant evidence of this connection was felt by all participants, especially Aiga Tasi, Tolu, Fa, and Ono, where their faith

in God were the pillars of hope and reassurance to withstand challenges of their family members' illness within the MH system.

These findings have shown faith and trust in spiritual healing was not merely physical healing but rich and diverse, *tatalo* and *anapogi* practices that were engaged to connect with God and acclaim their spiritual faith. Tatalo and self- reflection/meditation through anapogi were tools favoured by indigenous Samoan religion for encouraging mindset on the harmony of holistic well-being (Efi 2009). Research on spiritual faith to the well-being of Pacific elders in Hawaii supported these spiritual practices (Ihara & Vakalahi 2011), and how Indian migrants in Australia preferred to fast over their diabetes (Ahmad *et al*. 2022). It provides holistic wellness of mind, body, and soul (Ihara & Vakalahi 2011). These cultural practices have significance to Samoans' well-being and should be core of person-centred care for this group.

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 where they were humiliated, and their cultural values violated due to the lack of support and care for their son from MHS. That incident was seen to have violated Samoan cultural *'va taupuai'a'* (sacred space), between the family and church, and by other Samoans. The incidence of the father assaulted at church by his son has shattered 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 person-centred care delivery in relation to respecting and protecting Samoan cultural practices and identities.

Importantly, balance was seen to be restored, and healing took place when *tatalo*, *fa'afaletui* and restoring the *va tapua'ia* 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 understanding nuances of the Samoan language has uncovered this vital aspect of the Samoan culture (Goodyear-Smith & 'Ofanoa 2021). The father's decision drew on the Samoan traditional practice of *'ifoga'* (practice of seeking forgiveness), which seeks forgiveness and obtains formal apologies after unfavourable event involving injury, death, or 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 prevailed (Filoiali'i & Knowles 1983). Importantly, the willingness of the supplicants to accept responsibility for the act and accusations are all core to successful outcome of an agreement on the terms of forgiveness that undoubtedly anticipate the fa'aleleiga (reconciliation; MacPherson 2005). As Efi (2009) aforementioned, justice for Samoans is spiritual not physical. Importantly, it has highlighted the fundamental Samoan practice of healing through forgiveness, which should be adopted as core of assessment and treatment of the person-centred care MHS approach for Samoans.

Additionally, the findings revealed Samoans believed that a diagnosis of MI was secondary in importance to disrespecting the *'Va'* and overstepping cultural boundaries (Efi 2009), due to the deeply rooted association with spirits and a preference to culturally dis-associate from (Suaalii-Sauni *et al*. 2009). As a result, anything affiliated with MI was not spoken about as identified by some participants. Moreover, some participants interviewed believed their extended family considered traditional healing as the first line of treatment. This belief caused a family disagreement, as experienced by Aiga Tasi, where the extended family accused her of thinking like a pakeha for opting to accept westernized treatment over *fofo* Samoa. Although this has caused unnecessary stress and strains on family relationships, it also demonstrated the strongly held cultural beliefs of Samoans around the importance of spiritual healing. This was consistent with findings of a qualitative study of Tongan traditional healers and MH workers that aimed to explore beliefs on traditional and western practices (Vaka *et al*. 2009) found traditional healing to have an integral role in MH healing. However, despite an established potential benefit for Pacific people, western treatment was always the first line of treatment available in NZ. Therefore, the lack of traditional choices left families directly affected with mental illness with uncertainty and pressure, as their options to pursue traditional approaches are not overtly promoted in MHS.

The values of fa'aaloalo and alofa

As aforementioned, *alofa* and *fa'aaloalo* are the two core Samoan values and principles upheld in communication that helps to keep or save face (Efi 2009). The ethics of *fa'aaloalo* emphasizes that one must protect the mana and well-being of others, and to never put them in a position of embarrassment or lose face (Va'ai 2014). The failure to acknowledge and reciprocate this results in a loss of face, and this causes mental stress and may cause psychological disturbances (Efi 2009). These Samoan foundational values were imminent to participants' interpretations and experiences. In fact, these values shaped their views and expectations as shared by participants of Aiga Ono and Fa where they reported fond memories of being respected and valued due to the *alofa* and *fa'aaloalo* shown by Pacific MHS staff and use of the Samoan language in care delivery.

Aiga Fa shared that a Samoan person creates warmth and comfort indicated the value of cultural respect and authority to connect and to form genuine relationships with others as validated by other Pacific population research findings (Suaalii-Sauni *et al*. 2009; Tamasese *et al*. 2005). Indeed, our results again endorse Pacific models of care as the blueprint to achieve equity for Pacific (Bush *et al*. 2009; Samu & Suaalii-Sauni 2009; Suaalii-Sauni *et al*. 2009). Such as, Te Vaka Atafaga, a holistic mental health assessment model for Tokelau peoples in NZ (Kupa 2009); Uloa, a MH practice model for Tongans (Vaka 2016); and 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, while having become centralized in-service delivery models; has also resulted in health disparities of the Pacific population (Ministry of Health 2010). A qualitative study by Suaalii-Sauni *et al*. (2009) exploring Pacific perspectives found Pacific models of care were often used for consultation rather than deeply incorporated into practice highlighting inconsistencies of the person-centred care model to acknowledge and include cultural representation to advocate for Pacific interests at decision making levels.

Barriers in accessing care

The findings indicated that participants believed there were many barriers for them to access MH services. The most prominent barrier to family engagement was the lack of communication as shared by new referrals and established consumers, as outlined by Aiga Tolu and Tasi. This lack of communication was misaligned with MHS integrated-care aim where access to care was promised to be accessible and timely (MH & Addiction Business Plan 2017–2018; Mental Health Commission 2012). Indeed, such cultural misunderstanding was found to be a key barrier to MHS care for Pacific people in a study 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, poor, and ineffective communication have impacted access and engagement with healthcare service providers for a diverse ethnic population.

Another barrier to accessing care was the delay in acute responses whereby instead of responding, participants were told to contact police; however, the police commonly redirect them back to acute services. Participants were confused and frustrated when they were caught between two systems without any support during emergency situations. This has revealed major concerns as the Memorandum of Understanding cited in the Ministry of Health Compulsory Assessment and Treatment (2000) between the police and MHS dictates that the provision of care is MHS sole responsibility. Also, police are not trained to assess and triage mental illness, a leading factor in the criminalization of the person with mental illness (Lamb *et al*. 2002). This finding is further highlighted in the NZ MH Survey report where a high number of Pacific people access MHS via the justice system (Oakley-Browne *et al*. 2006). These barriers have shown practices involving the police does not support timely and equitable non-criminalized nor stigmatized access to services provision for Samoans.

Furthermore, the findings also showed most family groups did not have any 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 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 MI (Lamb *et al*. 2002). Overall, these findings show that these participants did not see any valuable benefits in the clinical interventions when they were confronted with challenges, suggesting that MHS was

unresponsive in addressing the holistic need of Samoans and Pacific populations as promised by the person-centred care vision and purpose (MH & Addiction Business Plan 2017–2018).

Moreover, the findings identified that some families had limited health literacy. The f*a'afaletui* revealed one participant struggled in understanding medical terms and definitions to describe diagnosis and treatments highlighted in professional care workers' use of specific languages at family meetings and medical reviews. The findings have confirmed issues highlighted by Pacific researchers Bush *et al*. (2009) and Suaalii-Sauni *et al*. (2009) where a language barrier has a major impact to the quality of communication and understanding of Samoans and Pacific MH consumers.

Additionally, the findings revealed considerable concerns with cultural support offered. Participants were expected to have the symptoms of the MIs, treatments, coping strategies explained in a language they understood, and provided links to community support services. However, while the service provided cultural liaison support there was no active involvement in care as in most participants' feedback. The system integration changes 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*. 2005) but also showing major gaps in the person-centred care models' capacity to address inequities to accessing MHS.

Relevance to clinical practice

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 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 misalignment of services goes beyond the confinement of our participants to represent those of migrants and indigenous MH consumers'. The ongoing employment of more Pacific healthcare staff and use of Pacific language terms should be adopted. Also, attention to co-design participation in developing and monitoring policies to re-orientate person-centred care models to reflect Pacific models of cultural practices. This might include engaging church pastors, traditional healers, family elders, Pacific NGOs, Pacific police support, and Pacific ethnic languages in all clinical processes. Additionally, Pacific cultural awareness in MHS training/orientation programmes and undergraduate tertiary curriculum is urgently needed for current and future MH professionals.

Study limitations

The study has some limitations. The small sample size does not reflect general representation of the issue within MHS in Auckland. Also, most participants were first-generation migrants, therefore, feedback was not inclusive of the diaspora Samoan family dynamics, as well as younger family members. Furthermore, service users were not included and their views on the topic may differ from their families.

Future research

Further research is needed to explore views of diaspora Samoan populations and other multi-ethnic Samoans as their views might differ from those of these migrants in the current study. Also, results of this study may be transferable to areas where indigenous and migrant population resides such in Australia, Canada, and Hawaii. Additionally, a comparative study with MHS in other locations in NZ, or Samoa and of the Pacific is recommended.

CONCLUSION

This study revealed the strengths and validity of the *fa'afaletui* methodology to explore issues pertaining Samoans in westernized contexts. Our findings have highlighted how Samoans worldviews are underpinned by the collective and inter-relational with self, family, village, God, and the universe. Therefore, provision of person-centred mental health care for Samoans should include the voices of families, communities, and those they connect with. Importantly, the results confirm the significant value of religio-cultural practices within MHS. However, MH practices remain constrained by organizational expectations and westernized models of care delivery that are not fit for purpose for Samoans and other Pacific populations. Particularly, the findings have revealed the primary importance of core cultural practices as conducive to Samoans/Pacific quality care delivery systems, and the importance of reviewing and influencing current MHS policy and clinical practice. Indeed, the study has offered a reminder to review the MH system as recommended by The Government Inquiry (2018), to ensure Pacific centre MHS are reinforced and more responsive to the holistic need of the population.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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