Mariana Ribeiro Garcia de Rezende

Exploring Latin American women migrant's experiences of accessing and utilising primary health care for mental health care needs in Aotearoa, New Zealand.

2023

School of Clinical Sciences

A thesis submitted to Auckland University
of Technology in partial fulfilment of the
requirements for the degree of
Master of Health Science

Abstract

What barriers and facilitators do Latin American women migrants face when accessing and utilising primary health services for mental health care needs in Aotearoa New Zealand, and how do these experiences affect their perception of mental health care in the country? New Zealand has experienced an increased influx of Latin American migrants. The migration process is recognised as a significant source of stress, and various factors associated with the migrant status contribute to an increased risk of mental health issues. Migrants usually face multiple barriers to accessing healthcare services in the host country. Women migrants may accumulate risk factors for mental distress and face more challenges in accessing healthcare services than men, Ensuring that effective mental health support is offered to this population is crucial. A qualitative descriptive approach underpinned by a transnational feminist theoretical framework was used in this study to explore the barriers and facilitators faced by Latin American women migrants when accessing and utilising primary health services for mental health care in New Zealand. The analysis also investigates how these experiences shape their perception of mental health care in their host country. Through semi-structured in-depth interviews, eight Latin American women currently living in New Zealand shared their experiences. A thematic analysis of the data was conducted, and the findings were organised into three themes: "Accessing Primary Health Services for Mental Health Needs", "Engaging with Primary Health Services for Mental Health Needs", and "Connecting with Primary Health Services for Mental Health Needs". The subtheme *"Obtaining mental health information as a migrant"* offered findings that aligned with existing literature, as it suggested that globally Latin American women migrants have low mental health literacy regarding available support services to receive and continue to receive mental health assistance. The subtheme *"Seeing the GP as a condition to accessing psychological therapy services"* revealed that the requirement to see the general practitioner (GP) to obtain a referral for psychological services was seen as a barrier to accessing timely and efficient mental health care, besides also being viewed as being invasive. Other findings included the perception that non-comprehensive medical assessments are inadequate for mental health support and that dismissive responses to mental distress complaints are due to a lack of empathy and mental health skills among GPs. Lastly, primary healthcare services are perceived as unreliable in addressing mental health needs for this population. Recommendations that can be applied to guide improvements for the mental health support of these women in New Zealand include the promotion of mental health information; facilitating direct access to psychological services; fostering collaborative participation of mental health care professionals to discuss their subjectivities and intervention plans; offering a better quality of mental health assessments with extended duration consultations; and

educating professionals that show sufficient cultural sensitivity and recognition of the population’s vulnerabilities, and who encourage their active participation in care planning.

Contents

Acknowledgements

Firstly, I would like to thank the Brazilian women who participated in this study. I appreciate your trust in me to share your experiences so openly. I acknowledge how hard it might be to talk about such sensitive subjects, so I admire how brave you were in trying to make a difference in our realities as migrant women in New Zealand.

I also would like to thank my supervisors, Professor Eleanor Holroyd and Dr Tula Brannelly, for providing me with a delicate balance of guidance throughout the research process. Your skilful supervision encouraged my active involvement in the research and facilitated my understanding of each step. Thank you for making this research possible.

The unwavering support and encouragement from my parents, Ligia and Mario Cristiano, have always been the driving force behind my educational journey. I am deeply grateful to them for instilling in me the importance of studying for personal and professional growth. My mom is my example of focus and determination. My father, a tireless motivator, has consistently believed in my potential and has been instrumental in helping me pursue my goals.

I am also thankful to my daughter, Sophia, who has been a true source of inspiration for me. Her encouragement and support have always been there when I needed them the most. Sophia has a remarkable ability to find the right words to uplift and motivate me. I am grateful for your presence in my life, Sophia.

Lastly, I would like to thank my husband, Nicholas. I appreciate our friendship and your endless dedication to me. Thank you for all those words you used to inspire me to keep going and remind me of my potential. They resonated in me. Even in the face of challenges, you have consistently helped me see the silver lining and pushed me to strive for constant improvement. Thank you for being my rock and always bringing out the best in me.

List of Tables

List of Appendices

Attestation of Authorship

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

Date: 11 July 2023.

Chapter 1: Introduction

This chapter introduces the study and provides background information on the topic. It outlines the background, my interest in the topic and the purpose of the study. Finally, a summary of the thesis structure is provided as a conclusion to the chapter.

What barriers and facilitators do Latin American women migrants face when accessing and utilising primary health services for mental health care needs in New Zealand (NZ), and how do these experiences affect their perception of mental health care in the country?

In the past decade, New Zealand has experienced a substantial rise in the inflow of migrants (NZ Productivity Commission, 2021). The migration process is recognised as a significant source of stress, and various factors associated with the migrant status contribute to an increased risk of mental health issues (Ho, 2004; Kirchner & Patino, 2021; Kirmayer et al., 2011; Llacer et al., 2007; Lopez et al., 2004). Women migrants are at an increased risk of developing mental health issues and substance misuse (Kirmayer et al., 2011; Salas-Wright et al., 2018; Todd, 2011). The COVID-19 pandemic has added additional stressors to their lives and contributed to mental distress vulnerabilities (Benjamen et al., 2021; Lunnay et al., 2021; Sullivan et al., 2020; WOMHEn, 2021).

Primary health care services in New Zealand are the entry to the population's access to mental health support, offering a crucial opportunity to identify the population in need and offer appropriate care (Ministry of Health, 2001). However, as many studies have shown, migrants can face diverse barriers to accessing timely and adequate health care (Andrulis & Brach, 2007; Gideon, 2011, Kanengoni et al., 2018; Pinedo et al., 2018). There are barriers associated with both migrant and healthcare services impeding efficient care delivery to migrants.

As little has been researched and understood regarding this reality within the Latin American women migrants and their mental health situations in New Zealand, this study sought to gain insights into their experiences of accessing and utilising primary health services for mental health care needs in New Zealand to understand the barriers and facilitators they encountered as well as how the events shaped their perception of primary healthcare services. In order to gain inside knowledge and clearly understand the phenomena, a qualitative descriptive approach was used, underpinned by a transnational feminist theoretical framework. A transnational feminist perspective sustained the development of the research inquiry and was applied to the entire study process. It served as a foundation to guide a deeper understanding of this particular group's perspectives, acknowledging their vulnerability without dismissing their positions and social connections in their country of origin.

Through semi-structured in-depth interviews, eight Latin American women currently living in New Zealand shared their experiences and perceptions of care about the mental health assistance received in these settings. A thematic analysis of the data was conducted, and the findings were organised into three themes: "Accessing Primary Health Services for Mental Health Needs", "Engaging with Primary Health Services for Mental Health Needs", and "Connecting with Primary Health Services for Mental Health Needs".

1.1 My background

My professional journey began in 2013 when I graduated from medical school in Brazil and started working in an emergency department in Rio de Janeiro. That year was crucial for my decision-making process regarding the specific medical specialisation I should pursue within the field. While dealing with a high volume of patients and demands, I had a major shift in how I viewed care. In the midst of rushing from one patient to another, I ensured I found time to ask about the patient's psychosocial background. I felt an instinctive urge to look at them beyond their complaints rather than just focusing on their immediate issues. Despite the chaotic environment, from that small effort, I remember seeing how it positively impacted their response to the care received and how I felt more fulfilled by providing better attention to them. That was when I realised that the most suitable speciality pathway for me to pursue as a doctor should be psychiatry. In the following three years, I was trained in the School of Mental Health of Rio de Janeiro, Instituto Philippe Pinel, to become a psychiatrist and had the opportunity to immerse myself in the dynamic mental health field. Working with mental health in such a diverse setting as Rio de Janeiro, which holds so many levels of attention, enriched and evolved my professional experience but also affected all aspects of my life.

Getting so close to so-called "madness" and frequently relying on my intuition to offer emotional support to others as a last and, in some cases, best possible resort demanded from me an intensive process of self-learning. This learning about myself also pushed me to understand and challenge my position in the world. I felt encouraged to pursue new opportunities and roles along the way. So, I have found new roles. Now, I am a Brazilian migrant woman who has lived in New Zealand for five years. That also blends with other roles of mother, wife, daughter, sister, friend, student and citizen of both homes – New Zealand and Brazil – which I have continued to stay connected to and relied upon along my way.

1.2 Why this topic?

While in New Zealand, I have been experiencing my own process as a migrant. I have been going through assimilation and adaptation to the culture and norms to develop an understanding of my social and professional position in this new society. In 2020, during the pandemic, like the entire world, I experienced unique feelings and had to adapt to that emerging situation in order to find ways to cope with the new reality. In one of my attempts to adapt to the emerging reality, my husband and I supported our neighbours and purchased duck eggs for morning meals. It was not until a week later, while feeling severely unwell, that I looked for a GP to understand the violent episodes of vomiting, diarrhoea and persistent nausea I was going through.

Through a quick assessment and, at that point, my first contact with someone outside the *bubble* created in my household for the previous months, the GP requested a blood and stool test to investigate my symptoms. Even though I do not usually overshare, when he asked me how I was coping with the isolation, I remember feeling the words slip from my mouth, and I cordially responded that I was not doing well. The GP ignored that. A week later, he contacted me to communicate that my tests were unchanged. I thanked him for the attention and, over the phone, said in a relieved way that I came to the realisation why I was experiencing those symptoms – it was the duck eggs. There was still no interest in my mental health during that conversation.

That experience has made me reflect on the health system I was inserted into. Since I was not in practice in New Zealand, I have tried to understand how things work from the *outside*. Now, I am not a health provider but only a health system user. So, I spent some time thinking about the occasion as a precious opportunity to have received mental health support. Indeed, at that point, I needed that attention. It was not why I looked for a GP in the first place, but it was an opportunity to be supported.

Naturally, I made connections with my previous experiences in primary health care as a mental health professional in Brazil, when I rotated in the psychiatry residency program as a liaison providing GPs directions to manage their mental health cases. I acknowledge how challenging it was for them to deliver adequate mental health care through general practices. Then, I considered other *Latinas* who, like me, were struggling with psychological distress, feeling powerless and without emotional support to deal with all of this. The rollercoaster of emotions intrinsic to the migration process should have been already a concern for those with few emotional resources. Are these women feeling supported? Are they receiving the attention they think they deserve? Do they think that New Zealand's primary healthcare services are able to look at them to identify and deliver their best potential support? What are Latin American women migrants' experiences?

1.3 What is the purpose of this study?

This study's purpose is to explore the experiences of Latin American women migrants when accessing primary health services for their mental health care needs in New Zealand in order to understand the barriers and facilitators they encountered while seeking appropriate attention. It also examines how these experiences influenced their perceptions of mental health care in New Zealand. Ultimately, the study aims to provide recommendations to enhance mental health care practices for Latin American women migrants in Aotearoa New Zealand.

What are the experiences and perceptions of Latin American women migrants while accessing and utilising primary health services for mental health care in Aotearoa New Zealand? The study's aim and objectives are:

- To understand barriers and facilitators of access and utilisation in primary health services for mental health care and the effect of these experiences on perceptions of mental care for Latin American women migrants in Aotearoa, New Zealand as their first opportunity to receive mental health support.
- To make recommendations that can be applied to guide improvement in mental health care practices to Latin American women migrants in Aotearoa, New Zealand.

1.4 Significance of this study

This study aims to generate knowledge to support health promotion focused on a minority ethnic group in Aotearoa New Zealand. Due to the lack of mental health and migrant research on Latin American women migrants in New Zealand, little is known about this group's experiences while accessing and utilising primary health mental services for mental health care. International literature has shown that Latin American migrants face multiple barriers worldwide to accessing and utilising health services. Some studies also suggest that women migrants are at a higher risk of developing mental health distress. However, an examination of New Zealand's realities regarding this group's experiences is necessary. If the outcomes confirm international trends, this study has the potential to provide a theory that could guide improvements in New Zealand's health policies for minority populations.

This study is limited to producing objective and descriptive knowledge of the potential issues through these women's experiences to make such recommendations. However, it is believed that the research process of recruitment, interviews and results are opportunities to raise awareness of the subject among the Latin American women's community in New Zealand itself. The study may elicit their active participation to claim their rights and citizenship through disseminating information, reciprocity and self-reflection on parallel realities.

Finally, the study's outcomes have the significance of encouraging further research approaches and methodologies that explore these women's mental health status and need to comprehend what is necessary to change and improve their well-being. As a researcher, this study has enabled me to develop my expertise in the research field and gain a deeper understanding of New Zealand's primary health care services for mental health care to the needs of ethnic populations.

1.5 Key Concepts

Latin American population and languages

New Zealand's Latin American population consists of 11 ethnic groups from the following countries: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Mexico, Peru, Puerto Rico, Uruguay and Venezuela (Census, 2019). According to Nava et al. (2022), Latin American languages include Spanish, Brazilian Portuguese, and 560 indigenous languages. Spanish is the dominant language spoken among the Latin American population, as it is the primary language in all South American countries except Brazil, and a few other countries and islands, such as Cuba, Suriname and French Guyana. Portuguese, though, is widely spoken across South America. However, it is only the official language of Brazil. Brazil is the most populous and largest country in South America, so even though Portuguese is not the dominant language for most nations, almost half the population of South America speaks it.

Migrants

In this study, the term “migrant” refers to individuals who have changed their country of usual residence, irrespective of the reasons for the move, legal status, or length of stay. It is important to note that refugees, who are individuals forced to leave their country due to well-founded fear of persecution, conflict, or violence, are not included in this study (IOM, 2019). Refugees have unique circumstances that fall under a distinct scope and are not the focus of this particular research topic.

Primary Health Care

Even though primary health care may hold a broader definition, in this study, primary health care is limited to general practices and the consultation with general practitioners (GP).

Psychological or Mental Distress

Mental distress is used throughout this thesis instead of mental illness. Mental distress is a term that involves a broader perspective of individuals’ mental suffering. It supports the vision that individuals may face challenges that impact their lives due to social, psychological, spiritual or health disruption determinants. Recovery is only possible if individuals are considered as a whole (Patterson et al., 2018).

Mental Health Needs

For the purpose of this study, “mental health needs” refer to the requirements of individuals seeking professional help to address their mental distress and, ultimately, improve their overall well-being.

1.6 Structure of my thesis

Chapter One: Introduction. The chapter provides background information on the research topic, methodology and methods. It also presents my background, interest in the topic, purpose and significance of the study, and key concepts used in the thesis.

Chapter Two: Literature review. The literature review gathered information regarding migrants' mental health and access to primary healthcare services in New Zealand and worldwide. It presents the demographics of migration in New Zealand, focusing on the Latin American population, followed by an overview of migrants' mental health, with a particular focus on women migrants experiencing mental health and primary health care services as the entry point for them to seek mental health help. It concludes with a review of studies about migrants' experiences and a highlighting of the gap in the literature on Latin American women's access and utilisation of health services.

Chapter Three: Methodology and methods. This chapter describes the methodology and theoretical framework used in the study. It is followed by thoroughly describing each method applied to recruit and select participants, collect and analyse data, and the ethical considerations and rigour.

Chapter Four: Findings. The chapter introduces the participants and follows with subchapters containing the themes of the study's findings. The three subchapters are “Accessing Primary Health Services for Mental Health Needs”, “Engaging with Primary Health Services for Mental Health Needs”, and “Connecting with General Practices for Mental Health Needs”.

Chapter Five: Discussion. This chapter summarises the study's key findings, correlating with existing literature and analyses further implications of the topic. The chapter also presents recommendations based on the study's findings and the strengths and limitations of it.

Chapter 2: Literature Review

This chapter introduces the literature relevant to migrants' mental health, focusing on the Latin American population and women migrants and their experiences accessing and utilising primary healthcare services for mental health needs in New Zealand and worldwide. Current gaps in the literature are present in the chapter. First, the search strategy is presented with the search terms, dates and databases used.

Five themes were found in the literature review to describe and illustrate the various experiences of migrants accessing and utilising primary health care services for mental health needs in their host countries: "Demographics, New Zealand Migration and Latin American Migration", "Migrant Mental Health and Women's Particularities", "Ethnic Women Experiencing Mental Distress, Providing Mental Health Support for Ethnic Migrant Women in New Zealand" and "Ethnic Minority Population Accessing and Utilising Health Care Services in New Zealand".

2.1 Search Strategy

The main databases employed to search were PsycINFO, SAGE, PubMed, MEDLINE EBSCOhost and Ovid. Other databases were also used, including Scopus and Emerald Insight. Mixed methods and quantitative studies were included when their sections had relevance to the research topic. Reference lists of articles pertinent to the study were also useful for sourcing additional publications. The initial search terms included variations of "Latin American migrant", "migrant mental health", "migrant New Zealand", "mental health primary healthcare", "mental health New Zealand", "migrant women", and "mental health migrant women". Alternative terms were also included, such as "GP mental health", and "mental health access", as well as potential alternative names for mental health, such as "mental distress", "mental illness", "psychiatric disorders", and primary healthcare, such as "general practices" and "family practices".

The literature aimed to search studies from 2015 to the present to ensure the relevance of the articles. However, due to the limited studies conducted on the Latin American population, women migrants and women's mental health, for example, the search time frame needed to be expanded to studies from 2005. Special attention was given to limit the search to as current as possible studies related to New Zealand's health care services and policies. In this case, research published exceeding the 5-year time frame was only included if the findings were significant to the research topic. The exclusion criteria were articles involving children, mental health assistance related to different settings other than primary healthcare and studies not presented in English.

2.2 Literature Review

2.2.1 Demographic, Migration and Latin American

In the past decade, New Zealand has experienced a substantial rise in the inflow of migrants, accompanied by significant demographic transformations in the last 30 years (New Zealand Productivity Commission, 2021). Migrants arrive in New Zealand from a diverse range of countries and are motivated by multiple reasons, such as economic opportunities, quality of life, political stability and safety, education and research opportunities, family reunification and migration policies designed to attract skilled workers and entrepreneurs (New Zealand Productivity Commission, 2021).

Over the years, New Zealand has seen an accelerated influx of the Latin American population (Stats NZ, 2019). According to the Census 2018, the Latin American community represents 0.5% (25,731) of the total New Zealand population. Although a relatively small number, especially compared to the enormous influx of other ethnic groups in the country, the Latin American population has shown steady growth and nearly doubled every five years since the 2006 Census. The Latin American subgroup has outpaced both the Middle Eastern and African subgroups within the last decade and has more than tripled from 2006 to 2018. There is an evident lack of specific information from this group due to the non-categorisation of their separate migrant members of the Latin American ethnicity, gender, age and sometimes differentiation between members who were born in New Zealand or the Middle Eastern and African subgroups. Overall, there is a shortage of demographic knowledge about this population in New Zealand.

Limited knowledge exists regarding the contextual aspects of the Latin American population in New Zealand, particularly studies that recognise the heterogeneity within this population and identify its specific characteristics (Durr, 2011; Hoffman & Papoutsaki, 2019). Dewey (2022) presents in a recent literature review of Latin American migration to Australia that although Latin American migration research has made progress in addressing gender inequality and exploring gender constructions in the migration experience in the past decade, labelling Latin American migrants as a single category overlooks the diversity among this group, as the idea of this population often functions as a national identity in the diaspora. The effect of migration on people's lives depends on numerous factors, including the individual's circumstances, goals, psychosocial context and economic conditions prevailing in the countries of origin and host countries. Individuals can experience both positive and negative impacts from resettlement in a new society, making migration a personal and unique account for each one. For this reason, it is essential to consider an entire migratory trajectory when examining health determinants in this population (Llacer et al., 2007).

2.2.3 Migrant Mental Health and Women's Particularities

Migration itself has been generally associated with various forms of stress that may contribute to deterioration in mental health (Ho, 2004; Kirmayer et al., 2011; Llacer et al., 2007; Lopez et al., 2004). Migration is a significant source of stress for most people because it involves risk, loss, new demands, and new experiences (Kirchner & Patino, 2011). There are many factors commonly associated with the migrant status that are thought to contribute to an increased vulnerability for mental distress, such as a change in socioeconomic status, inability to speak the host country's language, loss of professional qualifications, separation from family and people of a similar cultural background, discrimination and prejudice within the host country, traumatic experience prior to migration, and the assimilation process (Carlisle, 2006; Kanengoni et al., 2018; Lopez et al., 2004; McDonald et al., 1996).

The stress in female migrants tends to be much higher when compared to males in the same situation (Kirchner & Patino, 2011). International research has shown that although Latin American women are less likely to leave their countries of origin with psychological distress, their vulnerability can increase under the experience of cultural stress (Kirmayer et al., 2011; Salas-Wright et al., 2018). In the US, for example, Latin American women migrants are more likely to have an earlier and more persistent course of depression and alcohol consumption than non-Latinas (Valdez et al., 2018). Although New Zealand lacks research on the group, it is known that migrant women suffering acculturation stress or lacking cultural identity are at increased risk of developing mental health issues and substance use (Policy Briefing Paper, 2013; Todd, 2011). Overall, acculturation stress and lack of cultural identity correlate closely to mental health distress and substance misuse (Todd, 2011).

More recently, the COVID-19 pandemic has added a stressor to migrant women's lives and has made them more vulnerable to experiencing mental health issues (Benjamen et al., 2021; Sullivan et al., 2020; WOMHEn, 2021). Although the impact of the pandemic on migrants' mental health in New Zealand is not yet clear, it is known that it dramatically affected Latin American countries, adding a psychological stressor to these women living abroad (Ashktorab et al., 2021; Connor et al., 2020). New Zealand's border controls and regulations have made travelling back to their home countries very expensive and time-consuming, limiting their movements out of and into the country (Guadagno, 2020, Palmer et al., 2020). Migrant women experienced distress related to media messaging, resource insecurity, distrust of the healthcare system, trauma from the illness or death of others, isolation, the burden of caregiving, and fear of infection (Connor et al., 2020). Women's alcohol consumption has increased in frequency during COVID-19 as a coping mechanism to deal with stress and the required social distancing (Lunnay et al., 2021).

Women migrants' identity is based on many other factors beyond their gender as they face fierce competition for survival in the face of ethnic and gender discrimination (Carlisle, 2006). While in New Zealand, not only do women migrants encounter challenges within the migration process, but also the social disadvantages still culturally prevalent in the country (Human Rights in New Zealand, 2010). Women are either forced into traditional gender roles or experience persistent inequalities in the workforce, besides facing high rates of sexual violence and lower representation in public decision-making (Ministry for Women, 2019; Policy Briefing Paper, 2013). The NZ Mental Health Survey data show that under normal circumstances, New Zealand women are already more likely to experience psychological distress than men (Every-Palmer et al., 2020).

Gender disparities exist in all cultures, but their intensity varies depending on the specific time and place. It is crucial to examine how migration can impact patriarchal connections and determine whether it reinforces or disrupts them to a better comprehension of the mental health risks involved with migrant women. In order to understand how migrant women's mental health is affected in the host country, it is necessary to identify gender-specific stressors, resources and vulnerability of the specific population (Llacer et al., 2007).

2.2.4 Ethnic Women Experiencing Mental Distress

Marginalisation describes the position of individuals, groups or populations outside of “mainstream society” living at the margins of those in the centre of power, cultural dominance and economic and social welfare (Schiffer & Schatz, 2008). Migrants, women and people experiencing mental health issues are characterised as an overlapping group for marginalisation in society; they are usually underrepresented in the social-political convention and often have difficulty achieving community inclusion (MacIntyre et al., 2019; Roguski & McBride-Henry, 2020; Simon-Kumar, 2018).

The majority of the population group tends to be employed in low-skilled and low-paid jobs regardless of educational attainment and previous experience; even though this can be a reality for men as well, women may be disproportionately affected as they are more susceptible to experiencing a loss of status, have lower proficiency in English and lack a voice in public discourse (Gideon, 2011; Llacer et al., 2007). This reality traps them in the stereotype of migrants being less educated or professionally qualified, further limiting opportunities for advancement and contributing to social isolation (Carlisle, 2006). A study conducted in a Latin American community settled in Auckland explored their ideas about belonging in New Zealand society and found that some individuals, although feeling New Zealand is their home, did not consider themselves part of New Zealand society (Durr, 2011). Migrants struggle over recognition, rights, and entitlements of their citizenship (Umut & Reynolds, 2018).

Marginalised individuals have been shown to have a higher prevalence of mental distress than the age-matched general population (Priebe et al., 2012). Correspondingly, individuals experiencing mental distress or substance misuse are usually excluded from accessing the full range of opportunities typically available to the population in general (Ponce & Rowe, 2018). Mental health users can face significant administrative and financial obstacles in accessing health services, have lower participation and be neglected in the distribution of health resources (Priebe et al., 2012).

2.2.5 Providing Mental Health Support for Ethnic Migrant Women in New Zealand

The Primary Health Care Strategy (Ministry of Health, 2001) sustains that a strong primary healthcare system is central to delivering and improving health, particularly tackling health inequalities. Primary health care services, thus, serve as the initial point of entry in New Zealand for this population to seek help for any health issue, including mental distress. General practices provide support within their own settings or facilitate appropriate referrals to other relevant resources when required. General practitioners are the health professionals who assist individuals with their mental health needs. Their core role is to provide appropriate advice, interventions, and support for patients' mental health needs. The New Zealand Mental Health Service and Addiction Service Monitoring Report, Te Huringa (2022), showed data relevant to the sector performance, improvements and goals. It illustrates that a survey executed by the Royal New Zealand College of General Practitioners estimates that, between 2020 and 2022, 30% of general practitioner appointments had a mental health component, and the New Zealand Health Survey indicates that 9.6% of adults experienced high or very high levels of psychological distress. Moreover, between 2020 and 2021, an estimated 152,993 people (around 3% of the population) accessed primary mental health services, which are services available through general practices, such as extended consultations and talk therapy.

In New Zealand, similar concerns were identified when GPs shared their experience while dealing with mental health in primary care; time constraints, lack of psychiatric skills, medico-legal factors related to life insurance, and stigma are some of them (Dew et al., 2005). Chung et al. (2022) investigated the experiences of mental health services providers for the ethnic Chinese population in New Zealand and concluded that the current mental health support strategy provision is inadequate to support these populations, causing them delays in accessing help.

In the UK, a recent study by Parker et al. (2022) explored barriers and facilitators to the communication between GPs and patients about emotional concerns in primary care. They found that both GPs and patients face difficulties exploring emotional concerns during the consultation. The shame of emotions, guilt for using the GP's time and fear of not being understood are common concerns among patients. The challenges faced by GPs in providing effective mental health support include limited time to address emotional concerns, especially listening to the patients, also an inability to accurately diagnose and prescribe treatment for mental health disorders, dealing with patient resistance to mental health diagnosis due to societal stigma, and insufficient support from available referral services. The study emphasises the healing and therapeutic nature of an empathic and warm approach from the GP with patients when their relationship is a facilitator in providing adequate mental health help as it reduces symptoms and encourages emotional disclosure, identification, and adherence to treatments.

2.2.6 Ethnic Minority Population Accessing and Utilising Health Care Services in New Zealand

Latin American migrants are less likely to seek help when struggling with their mental health and substance misuse issues and in need of support (Pinedo et al., 2018). Many barriers are known to hinder the migrants from seeking, accessing and utilising mental health services. These barriers include fear of the stigma of mental health, logistical barriers, affordability, lack of credibility of health practitioners and their practices due to not understanding patients' social context, lack of social support, and language barriers that make understanding health information and navigation of the health care system difficult (Andrulis & Brach, 2007; Gideon, 2011, Kanengoni et al., 2018; Pinedo et al., 2018). Lindenmeye et al. (2016) stress that, after all, migrants may not seek help to avoid being perceived as a burden to the system. In the last instance, it is also worth drawing attention to migrant women who often face challenges in accessing mental health services due to the multiple roles and responsibilities they assume within the household and workplace (Kirmayer et al., 2011).

Many studies have explored the migrant barriers while accessing and utilising health services worldwide. However, little is known about Latin American migrants' experience while accessing New Zealand's health care services. Chiang et al. (2021) have reviewed findings from select health-related studies among other minority ethnic groups in New Zealand, highlighting the barriers these populations experience to accessing healthcare services. Ethnicity differentiation was notable in the access and use of any health services, as well as low rates of mental health service utilisation and delayed seeking of psychiatry services. The impact of dominantly Western values in existing conceptualisations and measurements of illness and intervention practices, cultural perceptions and stigma are some concerns regarding healthcare practices for ethnic populations. Chiang et al. (2021) also mentioned studies that found that discriminatory healthcare practice influences and reduces help-seeking behaviours, lack of awareness, use of services and reliance on experts to make medical decisions.

Patterson et al. (2018) collected mental health experiences and knowledge from various sources in New Zealand, including the population, services, and providers. The report highlights the need for improvements in primary care services to ensure that New Zealand’s primary healthcare can effectively meet the needs of at-risk groups, including migrant populations. Given that, current research in New Zealand must prioritise efforts to understand the challenges migrant populations face to address their needs.

2.2.7 Conclusion

The Latin American population in New Zealand is on the rise. There is knowledge associating migration with a higher risk for mental distress, particularly among women migrants. Studies have also suggested many challenges these populations may encounter to access healthcare services effectively in the host countries. In New Zealand, qualitative research on the Latin American migrant population is scarce, specifically on women’s experiences accessing healthcare for mental health needs. Little is known regarding their mental health status, barriers and facilitators to access health services to mental health needs in New Zealand either. Efforts to understand their experiences and demands are critical to guarantee accessible and efficient mental health access to them.

Chapter 3: Methodology and Methods

3.1 Introduction

This chapter presents the methodology and methods employed in the study. A qualitative descriptive approach was used to gain inside knowledge and clearly understand the experiences of Latin American women when accessing and utilising primary health care services for mental health needs as well as their impressions of care obtained from these experiences. A transnational feminist theoretical framework sustained the research's development and was involved in each step of the study process. The methods used to recruit participants, the sampling approach , collection and analysis of data, as well as the considerations taken to ethics, confidentiality and rigour of the study, will be described in the sequence.

3.2 Philosophical underpinnings

Women have increasingly become a large proportion of migrants in and across international borders, but even so, they still maintain subordinated and disadvantageous positions in society (Montenegro et al., 2011; Zhao et al., 2023). There has been a dominant form of knowledge produced by Western researchers that perpetuates the effects of colonialism and imperialism in studies directed at these populations; these approaches are critiqued for assuming that women worldwide share the same patriarchal oppression as others (Parisis & Thornton, 2013). However, the reality is that globally women differ in their political, economic and social backgrounds of shared oppression, and any attempt to comprehend them as a homogenous group fails to acknowledge the asymmetry in power that women from the "first world" and those in the "third world" experience (Mendonza, 2002).

Transnationalism *per se* involves the study of new flows of culture resulting from the versatility of people and ideas across national boundaries (Mendonza, 2002). Migration research and policies have lacked a holistic outlook of these populations and have not considered how transnational life affects and shapes these women's psychological and social well-being (Zerbe Enns et al., 2021). Transnationalist research, thus, acknowledges that studying women migrants' lives requires considering their connections with the host and origin countries because migrants maintain ties to their origins even while incorporated into the host country (Upegui-Hernańdez, 2011). Therefore, to understand women's migrant current experiences in their new environment, consideration of their past realities must be taken to see their lives as a whole (Upegui-Hernańdez, 2011).

Transnational feminism in the Latin American context has provided a fertile ground for decolonising knowledge, and the research process itself is essential to empowering Latin American, indigenous, Afro-descendant women and oppressed groups (Upegui-Hernández, 2011). Transnational feminism theory, therefore, aims to support that the perspectives of marginalised voices are centralised (Zerbe Enns et al., 2021). This study utilises a transnational feminist lens to shape the research questions and processes and eventually contribute to the topic rationale. Additionally, the research topic *per se* helps raise awareness of the Latin American migrant women's community thus disseminating a sense of reciprocity between them and encouraging further participation in community initiatives, support groups, or advocacy efforts that aim to address their unique challenges and promote their well-being.

It is important to acknowledge that this study does not intend to generate feminist theoretical insights but rather to offer a lens form which to review descriptive findings regarding the experiences and perceptions of mental health care among these women in New Zealand. Nevertheless, it is crucial to recognise that the mental health care of Latin American migrant women in New Zealand is a complex and evolving topic that requires a deeper understanding of their contextual realities and specific needs. This study is an initial effort to explore and describe potential issues related to their experiences and perceptions to produce knowledge that can be applied to improve mental health care practices.

3.3 Methodology

A qualitative descriptive (QD) approach is relevant for this study because of its potential to focus on poorly understood areas in a healthcare context and potential amenability to intervention (Neergaard et al., 2009). The approach offers an opportunity to gain inside knowledge and learn about the event under investigation by focusing on the participants' worldview and unique experiences (Bradshaw et al., 2017). A clear, rich and straightforward description of phenomena emerges from the participants' voices and reflects their environmental and cultural context with little influence of the researcher (Sullivan-Bolyai et al., 2005). The result is a comprehensive summary of phenomena in colloquial terms that can suggest directions to change behaviours, improve outcomes, or ameliorate negative health consequences (Sandelowski, 2000; Sullivan-Bolyai et al., 2005).

QD findings may be particularly relevant to promoting access to and use of health services for minority populations (Sullivan-Bolyai et al., 2005). Using a theoretical orientation to develop QD research allows QD findings to reach larger contexts and build scientific knowledge on the topic; QD can accommodate diverse paradigms, including feminist theories (Sandelowski, 2000). The utilisation of this design is also shown to be particularly relevant to healthcare professionals undertaking primary research, as it allows flexibility as research questions and study findings change during an investigation (Doyle et al., 2019; Kim et al., 2016). Novice researchers can effectively use this method to address relevant issues in their practice setting, offering valuable contributions to the knowledge of existent significance to them and their practice setting (Doyle et al., 2019). Considering this, the methodology emerged as being particularly suitable for this study's purpose as it facilitated a clear and comprehensive understanding of the experiences and perceptions of such a small and under-recognised group as Latin American migrant women in New Zealand. Moreover, given my source of interest in the topic being my previous professional background and personal experiences as a migrant woman in New Zealand and me a novice researcher myself, this methodology enabled the reduction of personal bias with little interference from my perspective in the results.

3.4 Methods

The following section will present the research ethics, methods, and rigour employed in the study, which enabled the exploration and description of the participants' experiences and perceptions when seeking mental health support in primary healthcare services in New Zealand. A rationale for each method applied throughout the research process will also be provided.

3.4.1 Ethical Considerations

The Auckland University of Technology Ethics Committee (AUTEC) granted this study's ethical approval on 28 September 2022, with the number 22/188 (Appendix A). The process of applying for ethical approval helped me consider aspects related to participants' confidentiality and safety, especially to take further consideration of their potential vulnerability while speaking about mental health. The initial approval was granted with a request to recruit and interview women in the Marlborough region. However, as the research recruitment process started, women from different locations in New Zealand showed interest in participating. Interviewing women from various locations in New Zealand was thought to enrich sampling variation and, consequently, the study's discussion by bringing a wider range of women's perspectives across other areas of New Zealand. Therefore, an amendments request was submitted, and the approval was given by AUTEC on 4 November 2022 with the number 22/188 (Appendix B), enabling the expansion of the participant recruitment inclusion criteria nationwide. All documents described in the research process were also granted in the same ethics application and are illustrated in the Appendices section of this study.

3.4.2 Sampling and Recruitment

The resource used to recruit participants was a virtual flyer. The flyer was advertised in three Latin American women's private virtual communities on Facebook: *"Mujeres Latinas en Nueva Zealand", "Mulheres na Nova Zelandia", and "Familias Brasileiras de Blenheim"* on three different dates, September 30, 2022; October 4, 2022; November 21, 2022. Participants interested in participating expressed interest through private messages on Facebook or via email, and the Participant Information Sheet was emailed to them.

Initially, the study was designed to recruit Latin American migrant women living in the Marlborough region to share their experiences accessing and utilising primary health care services for mental health needs in New Zealand. However, once the research was advertised on social media groups, women from other regions demonstrated interest in participating. A purposive sampling strategy with maximum variation was used to achieve a sample that includes a wide variety of representatives from the target population (Sullivan-Bolyai et al., 2021). A researcher's ultimate goal in any qualitative study is to defend their sampling strategies as reasonable for their purposes (Sandelowski, 2000). Therefore, in an attempt to follow the sampling strategy, expand the sample variation, and achieve a more comprehensive variety of voices, the criteria for participation were modified to include Latin American migrant women nationwide.

The inclusion criteria contained Latin American women migrants who currently live in New Zealand, are over 18 years old, and with the experience of having accessed and utilised New Zealand's primary care services in the last five years seeking mental health care. The advertisement of the criteria change brought more potential participants interested in the research. However, it was only throughout the interviews, listening to women who live in different social contexts in New Zealand, that I could realise how advantageous it was to explore different settings. Diverse narratives were raised from that, enrichening the discussion with nuances of the shared phenomenon of interest until data saturation was reached.

The potential participants self-identified and selected themselves as a woman and within the study's criteria. Except for gender self-identification, the criteria fulfilment was confirmed before participation. It is worth noting that primary health care in the recruitment flyer was not specified as general practice. However, when potential participants showed interest in the research and contacted me, it was clarified through messages that the selection was aimed at participants with experiences in general practice settings. The Participant Information Sheet also reinforced and specified the purpose of primary care services as general practices for the study.

Overall, 18 Latin American women contacted me interested in participating in the research. A Colombian woman contacted me via email, and while we were arranging the time for the interview, she stopped replying to my messages. A Chilean woman also contacted me through my email, but using the Spanish language. She also stopped responding while arranging the time for the interview. I replied to both potential participants in English, shared the Participant Information Sheet in Spanish, and offered a Spanish mediator during the interview. Two Brazilian women from the Auckland region and two others with unspecified locations contacted me via Facebook private message. However, after multiple attempts, they could not find time for the interview. Two other Brazilian women contacted me via Facebook private message to ask if mental health support provided by their midwives would be part of the inclusion criteria. As this study focuses on the experience of women seeking mental health care with general practitioners, these women did not fulfil the research criteria. Finally, two health professionals contacted me offering to refer Columbian refugee clients assisted in the Marlborough region to participate in the study. As this study focuses on the voluntary migratory process, these women's perspectives would not fit the study parameters. Refugee situations are a different subject that is not addressed in this study.

The study originally intended to use a sample size of 10 participants, prioritising an ideal sample size that described the phenomenon of interest while providing maximum variation to achieve data saturation. Eight Brazilian women participated in the research. Even though each participant shared unique background stories, similar perspectives started to emerge when exploring their experiences and perceptions of mental health care in New Zealand. In this sense, as it reached data saturation, the eighth participant was the last. After all, the sampling saturation strategy was conducted in accordance to answer the research questions (Saunders et al., 2017).

3.4.3 Informed Consent

The participants were free to choose to participate in the research. Upon initial contact, the potential participants received a copy of the Participant Information Sheet in English and their native language, Portuguese or Spanish. The document outlined the study's purpose and potential discomforts, risks, and benefits related to their participation. The Participant Information Sheet also provided mental health services options in case they needed to be assisted after the interview. When the volunteer opted to participate, the Participant Consent Form was sent via email, with copies in English and their native language, Portuguese or Spanish (Appendix E). All participants returned the acknowledged and signed English document to my email address prior to the interview. The documents have been stored on a private backup hard drive.

3.4.4 Privacy and Confidentiality

In accordance with the participant's consent, all the interviews were recorded and stored on a private backup hard drive. Only my supervisors and I have access to it. The data collected was only used for what was required. As the interviews involved disclosing participants' personal and sensitive information, the confidentiality and privacy of the data were ensured. No identifiable information was transcribed. Concerning the participants' rights, maximum attention is given to maintaining their privacy and confidentiality.

3.4.5 Data Collection

Due to the COVID-19 pandemic circumstances, the interviews were conducted over virtual technology. The data collection occurred during an individual interview of approximately 60 minutes through Zoom software. After the participants returned the consent form via email, a Zoom meeting link was sent to the participant. The Participant Information Sheet offered participants to be interviewed in their native language or English. For Latin American women who have Spanish as their first language, a mediator was offered. For Brazilians, as

Portuguese is my first language, I undertook the interview myself. All study participants were Brazilians and opted to speak Portuguese during the interviews. The interviews were then undertaken in Portuguese, digitally recorded, transcribed and translated into English. The interview audio was recorded by Zoom software and transcribed via HappyScribe software.

Semi-structured in-depth interviews using an interview guide developed from the literature were conducted to explore the experiences of Latin American migrants accessing and utilising health services for mental care needs in New Zealand. The main advantages of the semi-structured interview method are related to the flexibility and versatility of enabling reciprocity between the interviewer and participants, allowing the interviewer to improvise follow-up questions based on participants' responses and allowing space for individual verbal expressions (Kallio et al., 2016). Open-ended questions and probes were used to encourage participants to express themselves freely, as well as techniques such as paraphrasing or requesting the participant to repeat their answers to help promote clarity and accuracy of the data, ensuring that my interpretations accurately reflected their true experiences and narratives (Bradshaw et al., 2017).

Interviews are "conversations with a purpose" where the researcher encourages participants to relate experiences and attitudes relevant to the research topic (Undurraga, 2012). A semi-structured interview schedule is the list of questions that guides the interviewer to ask the participant (Bearman, 2019). The quality of the interview schedule affects the implementation of the interview and the analysis of the collected data (Kallio et al., 2016). Sullivan-Boylan et al. (2021) recommend using a framework to guide and focus interview questions. In this study, a transnational feminist perspective, together with the scope of the research problem, sustained and shaped the development of the interview plan.

Additionally, a framework suggested by Kallio et al. (2016) with five phases of semi-structured interview development was implemented. The preliminary step was an appropriate selection of existing data for the literature review, followed by comprehension of the subject. Later, background knowledge and research questions developed the interview schedule (Appendix H). Lastly, the first interview was used as a pilot test of the interview schedule. Once it was tested and modified to reflect the pilot findings, the interview schedule formulation was concluded. The rigorous development of a qualitative semi-structured interview guide contributes to the objectivity and trustworthiness of the study and makes the results more plausible (Kallio et al., 2016).

In this study, the interviews aimed to produce knowledge from Latin American women migrants’ experiences and perspectives while accessing and utilising health services for mental care needs in New Zealand. The transnational feminism theoretical framework supported the shape and flow of the interview. It was crucial to encourage topics that allowed these women to express their social backgrounds, connections with and influences of their country of origin to better comprehend their experiences and reasoning (Upegui-Hernańdez, 2011). Participants shared their personal stories and often drew comparisons of the health system in their countries of origin. From another point of view, as Bearman (2019) emphasised, as the data produced in semi-structured in-depth interviews are based on the participant’s experiences, it is intrinsic that all data contained reconstructed facts and descriptions of the participant’s social meanings and backgrounds. Therefore, the transnational framework was indeed double-embedded into all data collected.

An effective semi-structured interview contains meaningful prompts that generate complex, nuanced thoughts and descriptions of the phenomenon of interest relevant to the participants (Bearman, 2019). Demonstrating a non-judgmental and respectful interest in the participants’ perspectives is very powerful and necessary for achieving rich descriptive responses (Sullivan-Bolyai et al., 2021). Strategies to access participants, overcome different backgrounds, and reduce the potential emotive distance between the participant and the researcher are feminist practices and were used in this study (Undurraga, 2012). Strategies to improve rapport and the method’s quality were used before, during and after the interviews, such as practising and becoming familiarised with the interview process before the interview, permitting appointments convenient for the participants’ schedules, ensuring and communicating before starting recording the interviews through the software and guaranteeing the participants’ consent and confidentiality throughout the interviews (Bradshaw et al., 2017; Sullivan-Bolyai et al., 2021; Undurraga, 2012).

3.4.6 Transcription and Translation

The transcription process is a valuable tool for early career scholars to actively engage in reflexivity and challenge their biases and assumptions during the qualitative research process (Shelton & Flint,2019). Each approximately 60-

minute interview session of this study was transcribed verbatim to generate the English content for data analysis. All information was audio recorded using Zoom software and transcribed via HappyScribe software, which has both the Spanish and Portuguese languages available. The Portuguese audios were transcribed into Portuguese texts and later translated by me into English. Both transcription and translation passed through a continuous verification process of the original audio to avoid misinterpretation. The interviews were subjected to multiple revisions during the data analysis process until the themes were defined, ensuring that both the explicit and implicit meanings embedded in the language were captured. After the translation was concluded, the material was stored on a private backup hard drive.

3.4.7 Data Analysis

This study employed Braun and Clarke’s thematic analysis framework to analyse the data collected. Thematic analysis is an approach that involves identifying, analysing, and documenting patterns or themes within a dataset, offering a comprehensive and detailed understanding of the data (Braun & Clarke, 2006). This method highlights the active role of researchers in producing knowledge, with themes emerging through their reflexive engagement with theoretical knowledge, analytic resources, interpretation, and data. The data collection and analysis co-occurred, enabling mutual adjustment and minimising the risk of errors and omissions that could arise if identified later in the process (Sandelowski, 2000; Turale, 2020).

Braun and Clarke’s (2006) thematic analysis method involves six stages. The first stage is designed to familiarise the researcher with the data. A strategy to become immersed in the data is an active repeated reading of the transcriptions with the participants’ audio recordings. I started the data analysis, therefore, within this stage of transcribing and translating the interviews, followed by multiple readings of both forms of content to ensure the precision of the participants’ narratives. The process of transcribing and translating the interviews, listening to the participants’ voices and reading the texts repeatedly helps the data analysis process in exploring themes and subthemes (Bradshaw et al., 2017). This recurrent verification of both texts helped me to identify key features emerging from the data.

The second stage of the data analysis started there, when these key features emerged and became initial codes. An initial list of ideas about what was relevant in the data was organised using NVivo software. At this stage, I used participants' quotes to help to merge these codes. Later, with a list of coding, I moved forward to the third data analysis stage, which involved a deeper analysis of these codes to form potential themes. The participants' relevant quotations were used as a collage within the identified themes. An initial thematic map was designed to have a visual representation of the different codes into potential themes.

Stage four involved a revision of these potential themes. I reorganised the themes multiple times to ensure enough cohesive data supported them. Braun and Clarke's (2006) guide suggests that themes must be meaningfully combined while there are still clear and identifiable distinctions between them. Mind maps helped me with the continuous formation of themes and evolved to the data analysis of stage five when an adequate thematic map was obtained. In stage five, the themes were organised to be identified through the "story" they told in relation to the study's purpose. Subthemes were then assessed to help with the expansion of the data details.

Stage six marks the final analysis of the data and involves producing a report that provides a concise, coherent, logical, non-repetitive, and interesting account of the story the data tell within and across themes (Braun & Clarke, 2006). In this stage, the research questions were tested within the themes and subthemes.

3.5 Rigour

Qualitative studies require coherence and logic, evidence of systematic work, ethical integrity and relevance to guarantee trustworthiness and rigour (Finlay, 2006). In order to ensure the rigour of the research, a framework developed by Lincoln and Guba (1985) supported my decisions. This framework relies on principles to demonstrate the quality of the qualitative analysis. These principles are credibility, confirmability, dependability and transferability. Each of them addresses different aspects of the research process. In this sense, strategies to achieve each of the four principles and enrich the research to its full potential of quality were considered throughout the entire research process and are described as follows.

Credibility

Credibility is a principle that demonstrates confidence that the results are accurate, credible and believable, especially from the participant's perspectives (Forero et al., 2018).

Engagement

Several factors played a role in facilitating engagement with the participants and a thorough exploration of the information shared during the interviews. My common background as a Brazilian migrant in New Zealand was instrumental in applying a transnational framework, as it led to a deeper understanding of the participants' references and experiences. This mutual understanding enhanced the quality of the conversations. Additionally, being a migrant Brazilian in New Zealand allowed for a mutual interest in the study's potential outcomes, benefiting the participants' belief in my purposes. The fact that we spoke the same native language, Portuguese, created a sense of fluidity in our conversations, enabling open and natural expression of thoughts and emotions related to the topic. Lastly, my professional background as a Brazilian psychiatrist instilled confidence in the participants, assuring them of the sensitivity and confidentiality with which their experiences would be treated. This created a dedicated space for them to share their experiences, knowing their stories would be respected and conducted appropriately.

Interview Process and Techniques

The rigorous development of a qualitative semi-structured interview guide contributes to the objectivity and trustworthiness of the study and makes the results more plausible (Kallio et al., 2016). The interview schedule was used in an initial Zoom meeting as a pilot to test the objectiveness of the questions to answer the research questions and confirm that satisfactory timing was given to perform a quality interaction between the participant and me. The pilot test also helped me to familiarise myself with the interview method and equipment.

Peer Debriefing

Throughout the procedure, I counted on the input of my supervisors to navigate me through the processes and provide feedback towards my interpretations and further analysis. The directions were discussed in fortnightly meetings organised during most of the study's year. Correspondence via email was also a form to exchange feedback.

Dependability

Dependability is a principle that ensures the findings of a qualitative study are repeatable if the investigation occurred within the same cohort of participants, coders and context (Forero et al., 2018).

Thick Description

A clear description of the research context, participants' characteristics, methodology and methods enable the assessment, relevance and applicability of the findings of the study to other contexts. Therefore, a full description of this study's approach was offered earlier, with directions on the chosen methodology, ethical requirements, data collection and analysis and the nuances planned and occurring between each step. Rich and detailed accounts of participants' experiences are also illustrated through quotes and background information to enhance understanding of their specific contexts and promote dependability. The quotes are presented in English, utilising colloquial terms and expressions as closely as possible to the original speech.

Audit Trail

Dependability involves establishing consistency in the research process by adopting measures such as documenting each decision made throughout the study (Bradshaw et al., 2017). An audit trail was a strategy used to support my decisions along the research process, especially when collecting and analysing the data. It helped with the overall organisation of thoughts and information during the interviews, the timeline of procedures and reflections that later helped with data coding.

Confirmability

Confirmability addresses the objectivity and neutrality of the research findings. This serves to extend the confidence that other researchers would confirm or corroborate the results (Forero et al., 2018).

Reflexivity

Qualitative research findings must be shaped by the data collected from participants, without reflections from the researcher's bias, motivation and interests (Finlay, 2006). The researcher is central in shaping the overview through the study's theoretical, ontological, personal and cultural frameworks (DeSouza, 2004). Therefore, the researcher must exercise reflexivity throughout the study process to ensure rigour and transparency (Undurraga, 2012). This requires the researcher to critically examine how social background, assumptions, positioning, and behaviour affect the research process (Finlay, 2006).

Throughout the research decisions and strategy, and considering similarities to my own background, thorough consideration was taken regarding reflexivity. In order to minimise my influence on data interpretation, multiple measures were applied, beginning with the chosen methodology of the study. I have understood and acknowledged my interest and similar background to the research topic and participants. A written field diary with inner reflections was used after each interview and helped shape my understanding of each interaction to promote more mindful decisions. Additionally, a deep and honest consideration of my positionality was provided earlier to justify the study's topic. Discussions with my research supervisors also played a crucial role in adding depth to my reflexivity.

Shelton et al. (2019) defend the value of transcription in encouraging researcher reflexivity. They emphasise that transcription presents significant prospects for reflexivity as the interaction between the researcher and participant provides a valuable opportunity for researchers to introspectively analyse themselves, the participants, and their mutual influence and impact on each other. Although the transcription and translation process demanded a considerable amount of time, it made me get closer to the data and assume familiarity and embeddedness of its content.

Triangulation

Triangulation means using multiple sources of data, methodologies and theoretical methods to enhance the quality and validation of the results (Forero et al., 2018). The use of transnational feminism as a theoretical framework orientation enriched the development of the qualitative descriptive methodology. It boosted the scope and referential data, helping to explore the topic further. The strategy also expanded the study's discussion, enabling the findings to be potentially applied in further research with a more robust variety within the subject as it looked at the minority ethnic population's mental health with a specific perspective and lens.

Transferability

Transferability extends the degree to which the results can be generalised or transferred to other contexts or settings (Forero et al., 2018).

Purposive Sampling

A purposive sampling strategy with maximum variation was used to achieve a sample that includes a wide variety of representatives from the target population (Sullivan-Bolyai et al., 2021). An adjustment was made earlier at the recruitment stage to expand the sample variation and achieve a more comprehensive variety of participants. Initially, the criteria included Latin American migrant women who had the experience of accessing and utilising primary health care services for mental health needs in New Zealand and lived in the Marlborough region. Later the criteria were modified to include Latin American women migrants who currently live in New Zealand, over 18 years old with the experience of having accessed and utilised New Zealand's primary care services in the last five years seeking mental health care.

Asserting the purposive sampling strategy, these women self-selected themselves for the study, and the criteria fulfilment was secured before participation. The participants' self-interest and active and voluntary willingness to participate increased the transferability of the study as the specific nature of the inclusion and exclusion criteria was applied (Campbell et al., 2020). The purposive sampling strategy enhanced this study's transferability because the specific and detailed inclusion criteria convey a clear picture of the participants involved (Campbell et al., 2020).

Chapter 4: Findings

This chapter commences with a description of the participants' background information to improve an understanding of their specific contexts and motivations to access mental health support in New Zealand. Therefore, information acquired from their interviews is provided with referential quotations. A summary of information collected from the Participant Socio-demographic Sheet (Appendix F) is presented in Table 1.

The chapter proceeds and concludes by offering the study's findings. Three main themes emerged in the thematic analysis of the data collected from the participants' interviews, capturing the essence of their experiences and perceptions of care while accessing and utilising general practice services for mental health needs. The overarching themes are *"Accessing Primary Health Services For Mental Health Needs", "Engaging with Primary Health Services For Mental Health Needs",* and *"Connecting with Primary Health Services For Mental Health Needs".* Each theme is further divided into three subthemes, as shown in Table 2.

4.1 Participants

The study used a purposive sampling strategy with maximum variation to achieve a sample that includes a wide variety of representatives of the target group. The inclusion criteria encompassed Latin American women migrants who currently live in New Zealand, over 18 years old, with the experience of having accessed and utilised New Zealand's primary care services (general practices) in the last five years seeking mental health care. Eight Brazilian women participated in the research. The topic of interest brought and revealed similar standpoints among the participants' experiences. However, each of these participants highlighted their unique background stories and distinctive experiences .

The study's focus is on these women's experiences while accessing and utilising primary health care services for mental health needs and their perception of care in New Zealand, aiming to provide descriptive and straightforward results related to the topic. However, this study's methodological framework foundation intrinsically acknowledges that these women's backgrounds may impact their experiences and impressions. Therefore, this chapter offers a brief description of some background information that the participants shared during the interviews. The intention is to contextualise the participants' perspectives as migrant women seeking mental health help and improve the reader's understanding of the population under study. Additionally, it is also worth noting and emphasising that in order to align with the study's methodological framework, the participants' information is provided particularly with lens on and attention to their status as migrant women seeking mental health help in New Zealand.

In the context of this study, *roles* mean the variety of positions and obligations that women assume in their lives. It involves how women see themselves as responsible for their households and their own well-being. The weight that participants put on this sense of responsibility as part of their roles and how it could have potentially impacted them to seek a mental health professional is particularly highlighted as follows. Motherhood, marriage, abusive relationships, domestic violence, social isolation related to the migration process as well as to the recent COVID-19 pandemic, and professional adaptations in the host country were some of the issues these women attached to their experiences throughout the interviews.

It is also important to explain that even though not all participants intentionally aligned their roles to being part of their mental health care needs, in most cases, women presented with stories of a gender-related concern or with a migrant context that subsequently led them to talk about symptoms of feeling emotionally overwhelmed, depressed, or anxious. This suggested a potential association between these factors impacting their mental health. Some participants connected their routine life obligations and relationships with their mental health status, while others attributed these experiences as the direct cause of their symptoms and, therefore, the need for mental health assistance. Some participants even indicated that their symptoms were relieved by resolving the role-related issues.

The information related to participants' backgrounds is presented as a summary of the narratives using pseudonyms, and describes situations prior to their experience with primary health care in New Zealand. As consistent with the methodology of the study as well, each participant has their information illustrated with minimal interference from my interpretations. The subsequent stories have the potential to resonate with readers who may recognize elements of their own experiences. Hence, it is vital to reinforce that all participants' identities have been preserved using pseudonyms. Table 1 provides information collected from the Participant Demographic Sheet and helps to summarise their backgrounds.

Table 1. Demographic Information of Participants

Pseudonym	Time in NZ	Employment Status	Children	Language Ability	Current in MH Treatment
Alessandra	5 years	Employed Full-time	One	Good	No
Juliana	15 years	Employed Full-time	Two	Excellent	No
Roberta	20 years	Employed Full-time	One	Excellent	No
Camila	11 years	Employed Full-time	Four	Excellent	No
Sabrina	14 years	-	Two	Excellent	No
Carolina	7 years	Employed Full-time	Two	Excellent	No
Livia	5 years	Employed Full-time	No	Excellent	Yes
Simone	15 years	Employed Part-time	Three	Fair	No

Simone

Simone has lived in New Zealand for 15 years. In 2007, she left Brazil with her husband and three children. *"I left behind everything that was mine, but it was unconscious; it was for love. I would do it all over again."* She explained how she saw that her relationship impacted her first years living in New Zealand. *"Marriage is like a company, right? So, it was a partnership, and it worked. Wow, we moved to another country and had to take care of the children, take care of a house, maintain a house, and survive."*

Simone said that the couple was progressing well toward their goal of obtaining a visa to live permanently in New Zealand. Time passed quickly when they finally reached their purpose, and that is when her first anxiety symptoms emerged.

So that worked really well. We lived to work, to take care of it, take care of the children. We were moving forwards to get NZ residency, you know? That was our focus. You see, we got NZ residency in 2012/2013. I felt like it just happened. Suddenly we got residency. But, then, not long after, I fell. I think I was pursuing that so intensively that when we got it, this anxiety problem came, revealing that the relationship no longer existed. We took a long time to understand this.

She believes that this former life being dedicated full time to her marriage and children is why she fell sick.

I had no idea what was going on. Today looking back, joining the dots, you know, I think it has to do with my whole life in general, but mainly because unconsciously, I put my marriage, my family, in a level far above my own place. I lost my identity, and I lost my place. I lost my place because I had to have a family and a marriage. It was not the fact that I came to New Zealand... because actually, I came to New Zealand for that. I came to be with my family. For me, family was the priority. So, you can have an idea, on Christmas or my birthday, my children did not know what to give me as a gift. I had no identity.

Simone said that even though many times she felt desperate to go back home, her family needs always came first. *"I do not want to stay here anymore, but I like it here, here I can keep my family, here I can raise my children, here I can be independent."* She realised that the fact of not understanding herself and, therefore, not being able to reveal her own needs contributed to generating her symptoms.

I was always behind my husband because the husband is who... I gave my voice to him to make that family work. I did not have to, he did not ask me, and I did not have to do it that way, right? But for some reason, I think I repeated things, you know? Because he did not come to me and say, "You cancel yourself", but I thought I should. I was not aware at the time. So, I think I had anxiety because of these situations that I have been living in my life, and that this anxiety... I think that when you have anxiety or depression, you need to look at something you cannot see.

Simone went to see her GP for the first time and engaged in a year of treatment with medication. She has never been offered psychological therapy in New Zealand and affirms that through her own online research, she found a way to eventually understand and cope with her symptoms.

So today, I am aware that this movement that led me to anxiety was all the things I was experiencing in my life and the experience I was having, and it was not just... I experienced earthquakes here; it all destabilised me, you know? Many things made me question staying here, making me want to run away and go home.

Alessandra

Alessandra, who has lived in New Zealand for 5 years, also came to accompany her husband, who had a job opportunity. She does not evaluate her process of migrating as similar to most other migrants, as she arrived in New Zealand with a residency visa. *"I came with my husband, and we already came with a residency visa, so I think we had a very comfortable situation. Of course, everyone gets here, and, in the beginning, they have to work with any job, struggle, you know."* However, she pondered all the situations that involved resettling in a different country and how it affected her feelings.

We used to live in Nelson, and then we moved to Blenheim because my husband got a new job in Blenheim. He spent 6 months doing a course in the North Island, so I ended up staying alone in Blenheim. It was hard for me to find a job, but then I got one, which was a really bad one, you know, that whole process, right? So, I think all of this made me feel that way, but it certainly was not the main reason because I think I came to New Zealand in a comfortable condition. What was most difficult and what I think helped a little to make me feel depressed is that, in the beginning, it was difficult to find work.

Alessandra explained that she felt things got even harder when she had her first baby.

I already had many of these symptoms when my son was born. I did not have anyone, I did not have any family here, you know, there are few friends, and no one else. So I ended up isolating [myself] a lot. It [was] just me and my husband. So, in the beginning, it was very difficult for me not to have any support apart from my husband, who, in fact, had to work and *everything. So it was complicated. I was feeling really overwhelmed. But, for me, it was normal. As a new mother, you have to be overloaded.*

When the first COVID-19 lockdown happened, Alessandra found out about her pregnancy. The circumstances affected her plans of bringing her family to New Zealand and helping her postpartum.

So that's when I got pregnant. We didn't know what was going to happen, right? We first thought that the lockdown would pass soon. I had the expectation that when my son was born, someone from the family would be able to be here. To this day, they still don't know my son. He's turning two today, by the way. And nobody knows him. We felt a lot for not having anyone. We don't know anyone. There's nobody, no friend who can help, no family to help. It's really hard."

Alessandra had postpartum depression and joined a mental health group for mothers, recommended by a Plunket nurse. Without resolution of her symptoms, she later went to see her GP to try to understand her feelings.

Juliana

Juliana has been in New Zealand for 15 years. She came with her family when she was 15 years old. She is the mother of two children. Juliana shared traumatic situations involving her relationship with the father of her children and a difficult period of postnatal depression in which she engaged in a 9-month-long treatment with medication after having her first baby.

I did not think it was postnatal depression. Actually, I had not even imagined it in my head, but later I talked to the midwife about how I felt about my child. Many times, I looked at him and cried. I thought, 'I am not good, right?' That is when there was a correlation with postnatal depression. I went to the GP and took medicine for nine months.

Juliana took the medication prescribed by her GP, and, with her friend's help, she sought a private counsellor.

I took medicine for 9 months, and I started to feel happier. I thought, "Oh, okay, the problems I had were related to postnatal depression." So I got back with his dad. And actually, I was really... I thought I was really happy. I thought I was doing really well in every aspect of my life, I thought *everything was headed in the right direction. We were looking for a house to buy, we were happy, I was feeling good. I was feeling good as a mother. There was a moment when I thought I was doing great until... No. I started to see that I was starting to self-isolate, and then I saw that his father was disappearing a lot, you know? "Where are you?"*

Juliana said that on one occasion, she took all the medication the GP provided at once in a suicide attempt. She received immediate support from the emergency department.

Sabrina

Sabrina has lived in New Zealand for 14 years. She talked about anxiety-related issues during her first pregnancy when she sought help from her GP.

I spent many years without having anything [anxiety symptoms]. I was normal. During my pregnancy, everything came back, and then I felt sick all the time. I went to the hospital several times, but when I got there, the arrhythmia went away. My heart reached 130 bpm, you know, with me standing still, sitting, watching television, and suddenly, out of nowhere, that palpitation started again.

Sabrina received attention from her GP at that time. However, a few years later, the anxiety symptoms returned.

And then, this year, when it came, it came much stronger – and funny because at the end of last year, it was really hard for me, I had a lot of family problems, and I went through hell, and back. It was the worst end of the year of my life. I have never had anything like it, you know? I even thought about disappearing from the map. Very dark thoughts and I felt nothing. After this tsunami passed, when I finally found myself again at my peace, it started to come. And it came much stronger.

As the interview was going on, Sabrina could reflect on how she felt overwhelmed during this second period of crisis and what helped her relieve the symptoms.

That was the way I found it, trying to find myself. I started trying to change my routine, exercise more, and focus on myself a little because as the kids are in home-school, I ended up closing myself off, and everything is about them. I kind of went to the sidelines. From what I read, I thought, "I think it will help me if I do something for myself, to start exercising."

Sabrina has dedicated full attention to her two children in the past years. Both are in home-schooling, and she pointed out how the lack of time for herself impacted her mental health.

She also expressed her uncertainties regarding staying in New Zealand for the following years.

Everything was wonderful, but then, after I had a child, there was more of a feeling like, "What am I doing with them?" They need grandparents, you know? My best childhood memories come from my family, and now, they don't have it, they don't have it. No cousins, no grandparents. I find this very sad.

Camila

Camila moved to New Zealand 11 years ago. *"I have three teenagers here, I'm a single mother, so they take up most of my time."* She also raised concerns regarding cultural aspects involving the upbringing of Latin American youths from other generations in New Zealand. She argues that the lack of help from culturally competent professionals to guide Latin American families through difficult times has significantly impacted her family.

My kids won't leave the house just because they want to leave the house. They're going to leave home to study or work in another city. It's my culture. I'm too old for these things. Or they will leave when they get married. But there is a shock, right? The shock is because they have New Zealander friends, and they grow up here; their teachers are from here, and everything else. They are from here. So that generates a lot of crises, a lot of anxiety in my family.

Camilla said that two of her children had also seen mental health professionals in New Zealand.

She spent part of her interview telling stories about her family and the various situations involving their mental health, safety, and adaptations to New Zealand's culture. There were many occasions when she visited her GP for mental health assistance. She remembered her first visit.

When I arrived in New Zealand, I had this experience. I came alone with three children. I was here as a single mother, and then I started a relationship that didn't work out. I was a victim of domestic violence, so I *went looking for help. I was lost. I was losing my visa, I had three very young children, I had no home, I didn't know anyone, anyway... I was out of my country, I couldn't travel to Brazil because who can afford a ticket that quickly? So I was in a very stressful situation, a lot of stress.*

Carolina

Carolina is also a solo mother in New Zealand. She has been here for seven years. Two years ago, she looked for a GP to help her with what she believed to be an episode of depression. She shared how difficult it is to deal with all the pressure and nuances of migrating without support.

I find it frustrating. I don't have any support, you know. The doctor didn't refer me to a psychotherapist. I couldn't make friends with locals... I think it accentuates more about what I was feeling. And, then, it was always when it came to mind, "Oh, I'm going to drop everything. I'm going back home because what am I doing here?" You start having second guesses – "Is this really what I want? Is this really where I want to stay?" I don't have anyone, I can't even go to therapy, I don't even have a friend to talk to, to vent, what's going on?" Then, you're like, "Ah, I want to leave, I want to leave, I want to leave." But I'm here not only for myself but for my daughter, you know? That's when I stop, take a deep breath, analyse it and say, "But will going back really be the best? Will I be able to pay for my daughter's school, the rent, have a car, have this, have that", you know? Am I going to be able to give that safety to my daughter? Then I say, "I'm not going back." So, come on, one more time, take a deep breath, lift your head, and let's try it alone again," you know? And, then, one more day you get up and one more day you try, but it's quite frustrating. It's quite frustrating not having anyone to count on. You look to one side, you look to the other, you're here in despair, in anguish, in solitude. And then what do we do? I don't know, I don't know what to do. It's very frustrating, it's very frustrating. It has made me rethink more than once if New Zealand is where I want to stay. You cry inside the house when you can't take it anymore. My daughter asks, "Why are you crying?" and I say... It's hard.

Roberta

Roberta has resided in New Zealand for two decades. She is married, has one daughter and works in full-time employment. She has visited GPs to address her mental health needs on different occasions. She navigated through postnatal depression as well as familial challenges. More recently, Roberta has faced a difficult illness that has left her emotionally vulnerable and needing mental health support. She describes the ups and downs of the assistance received in primary health services for mental health care in New Zealand and states that her support network in the country has been essential for her mental well-being throughout the years.

I go to the church every Sunday. We end up creating a family bond with the people you've known for so long, so it becomes family. So I had a lot of support now when I got sick. Both in the practical part, people bringing me food for three weeks, and in the emotional part too. People with more experience who have already gone through similar situations made all the difference in this emotional process. I was reaching a stage... I won't say it passed, but I avoided people. I started not wanting to see the people I have frequent contact with, close friends. But at the end of the day, I have a very good support network, and even when I distanced myself from this support network, I realised that even from a distance, people were interested in knowing how I was doing. They were always there for me.

Livia

Livia has lived in New Zealand for five years. She has a partner, no children and works in multiple jobs and sectors. She explained she went through psychiatric treatment for anxiety in Brazil, but when she moved to New Zealand, she had completed the treatment and was feeling well. However, after three years of living here, her anxiety symptoms restarted.

In the last 2 years, I started to notice that I wasn't well anymore. And last year, I thought I was really not well. I had ups and downs and had days when I cried. I'm not a person who cries a lot. I'm a person with a mood, let's say, stable. I'm not a person who is very happy, very sad, very excited, very nothing. I'm always there, maybe, "blasé," let's say. I never, never have much or little, you know? It's a more controlled thing. And there were days when I was not in my normal. I started to have a lot of nightmares. I still have a lot of nightmares, so I decided to look for [a] GP.

Livia emphasises how her personality and habits have changed since she arrived in New Zealand.

When I was younger, I was super extroverted. I had a lot of friends and stuff, but as time went by, I reduced it, and I got more into myself and stuff, but when I got here in NZ, I stayed maybe like this in a cocoon practically, you know? I have lived in my bubble. The problem I notice is when I have social interactions with people, I feel it drains me of energy, like, literally. So much that if I spend a few hours talking to people or having interactions with people, I get drained physically, emotionally, everything like that, and I have to sleep. I sleep for hours in the middle of the afternoon if I have interactions, let's say, in the morning.

She explains the impact of these changes in her life until she gets to the point of seeking mental health attention.

Before, I even engaged in this small talk, but now I'm more like this, difficult. I closed myself off. I went to the GP, and I said that, but very briefly, right? Because the consultation is very short. She heard that and told me that "life is hard."

Livia felt overlooked by her GP and said:

Sorry, but waking up at 7 am wanting to drink wine because I'm already stressed at 7 am. I barely woke up, and I already had my cortisol through the roof. It's not normal. I don't want to go out to see people on the weekends. I just want to stay at home, and sleeping 12 hours a night is not normal. Then I got upset with the GP's response. I accepted what she told me, right? I'm not going to argue with her, obviously. But I changed GPs.

4.2 Themes

This section presents the themes found during the data analysis that intend to answer the research questions. They captured what was meaningful about the data and described patterned responses and meanings. See Table 2.

Table 2. Themes, Subthemes and Associated Findings

Accessing Primary Health Services	Obtaining mental health information as a migrant	• Lack of mental health information • General practices as a barrier to accessing psychotherapy services
	Seeing the GP as a	

For Mental Health Needs	condition to accessing psychological therapy services	• Uncertainty about how to access ongoing mental health support
	Accessing ongoing mental health support	
Engaging with Primary Health Services For Mental Health Needs	Mental health assessment in general practices	• Non-comprehensive assessment • Positive relationships as a facilitator to quality care • Mismanagement of mental health distress
	The importance of developing rapport when offering mental health support	
	Support and management of mental distress	
Connecting with Primary Health Services For Mental Health Needs	Impressions of mental health care in general practice	• Negative perceptions of care • Continuous help-seeking behaviour after receiving mental health support • Mistrust in general practice settings as timely and efficient mental health assistance
	Effects of the mental assistance received in the recovery process	
	The prospect of receiving mental health attention at general practices	

4.2.1 Theme: Accessing Primary Health Services for Mental Health Needs

The participants’ experiences in navigating and accessing mental health assistance in New Zealand’s primary health care are gathered under the theme *“Accessing Primary Health Services For Mental Health Needs”.* Within this theme, three subthemes were identified to provide a descriptive and comprehensive understanding of their experiences and perceptions of care while accessing general practice services for mental health needs. The subthemes were organised as *Obtaining mental health information as a migrant, Seeing the GP as a condition for accessing psychotherapy services* and *Accessing ongoing mental health support.*

Subtheme: *Obtaining mental health information as a migrant*

Six of the eight Latin American migrant women who participated in this research revealed that they did not know where to go when they realised their need for a mental health professional. *"We arrive here, and we have no idea how different the health system is."*

Camila moved to New Zealand 11 years ago. She is a solo mother of three teenagers and has been to the GP on many different occasions throughout the years to seek mental health assistance for herself and her children. She remembered the first time she was told to visit a GP to deal with a traumatic experience of domestic violence in her family. *"I was a recent immigrant. I had been in New Zealand for a year. It was all very new. You don't know the system, do you? In fact, I had never even been to the doctor here before."*

Camila compared the pathway Brazilians usually follow to receive mental health attention with the New Zealand one.
Culturally, if we compare the GP in New Zealand with the GP in Brazil... in Brazil, it would be our last option. The emergency room is the option when you don't have a doctor. Even if you have health insurance or are using public health, we Brazilians have the habit of going to the specialist. Nobody makes an appointment with a GP in Brazil.

Alessandra has lived in New Zealand for five years. Two years ago, she went through a period she evaluated as postnatal depression, hence the need for a mental health professional.
I didn't know I had to see a GP. I would never think about it if it was not for the group of mothers. We always think about GP when you have a physical problem, when you're sick, or something like that, right?

Roberta moved to New Zealand 20 years ago. She also talked about her first experience.

Someone working at a migrant support organisation in Blenheim suggested it. He said, "Look, I think it would be good to go to the GP. I'll go with you. You need mental health support; you're not right."

Carolina, one of the participants who sought mental health help from a GP, received information through her partner when he noticed her mood had changed. During the interview, she seemed to still not fully comprehend the mental health services available in the country.

It would be interesting if there was more information available. On my social media, I see many advertisements for online therapy. I don't think they are even New Zealand based. I don't know if New Zealand has this service. I think we really need to stop talking so much and not acting, you know? We must stop talking about "mental health awareness" and do it.

In contrast, Livia spoke about a different experience of obtaining information about where to access mental health care in New Zealand. During her five years living in New Zealand, she learned she should see a GP for any medical requirement. For her, healthcare understanding came through the absorption of this new society's aspects she was inserted into.

I knew I had to see a GP from the years I've lived here, but when I thought I needed help, I thought of a psychiatrist first, going to a psychiatrist. Then I thought, "No, I have to go to a GP, you know, to get a referral so that I can go to a psychiatrist."

Simone and Juliana found information when family or work colleagues explained that they should see a GP to receive mental health assistance. Sabrina did not specify the source of information. She only stated that she learned from an early visit to her GP, not long after arriving in New Zealand, when she needed a doctor to repeat her prescriptions.

Overall, for six of the eight participants, the instructions to see a GP to receive mental health attention in New Zealand was only made apparent when they were already facing a challenging situation that demanded urgent mental health support or when they were going through critical mental distress. Two participants already knew they needed to see a GP when they perceived their need to seek mental health help.

The participants did not receive formal instruction or common-knowledge advice on accessing and obtaining mental health assistance in New Zealand. For each participant, mental health assistance information was delivered by different sources, and for the majority, when they were already in need of help.

Subtheme: ***Seeing the GP as a condition for accessing psychological therapy services***

Five of eight participants affirmed visiting a GP exclusively to obtain a referral to a psychiatrist or a mental health professional who would provide psychological therapy, such as counsellors and psychologists.

Sabrina has experienced a long-term struggle with episodes characterised as anxiety. She believed that in the past, while in Brazil, she received misinformation regarding the actual cause of her condition and spent an extended period taking anxiolytics to treat a heart condition. Since she moved to New Zealand, she has been trying to understand why she has recurrent periods with symptoms such as tachycardia, sweating, angst and insomnia. In her first pregnancy, excluding heart-related diseases, her GP diagnosed her with anxiety disorder. Last year, struggling with a new episode of the condition, she went to see her GP to request a referral to psychological therapy. Sabrina said she wanted to understand the root of her psychological distress.

I was feeling awful, and as we can’t go directly to a psychologist in New Zealand, so I went to see my GP. I explained to him what was happening. I told him I was feeling very unwell and would like to be referred to a psychologist and undergo therapy.

Obtaining a psychological therapy referral was also Alessandra’s main expectation while seeing a GP. *“I needed a professional to do some therapy. I needed therapy to work on my problems and help how I was feeling, you know?”* Alessandra refused to take antidepressants to treat a condition she self-evaluated as depression. She understood her symptoms as the consequence of various emotional concerns she experienced before, during, and exacerbated after her pregnancy. She acknowledged some of her feelings and thoughts as “long-term issues”, which only a psychologist could help her delve into.

Carolina, who had previously undergone treatment for depression with psychiatrists and psychologists in Brazil, went to her GP to receive a referral. She said, *“Maybe, the day I went to the GP, if I had talked to this counsellor instead of the GP, maybe I would have gotten what I was looking for.”*

Camila and Livia approached the GP with the purpose of obtaining a referral to a psychiatrist, recognising it as the sole pathway available to access the service.

However, these participants found it implausible to require a GP’s evaluation to obtain a referral to a mental health specialist, especially to a psychological therapy service. In their views, the need to discuss and work on their emotional issues would be clearly assisted by such a professional, and that should not be a provision for the general practitioner to estimate. As Camila conveyed:

So, my question is, if I have a mental health problem, why can’t I be referred to a psychiatrist? Because I can have an attention deficit, I can have autism, I can have so many things that only the psychiatrists have the resources to screen. The GP is not prepared.

From their perspective, being dependent on another professional’s assessment to determine their eligibility for the specific form of mental health support only hindered their access to these services. *“I wonder why we have to wait until we have access. There is a huge difference between the GP and the specialist, even in the form of care,”* concluded Camila.

Furthermore, six participants described feeling uncomfortable sharing emotional issues with their GP. Disclosing their feelings to a professional who would only refer them instead of directly providing the therapeutic service they desired was perceived as an invasive experience. Moreover, three of them described the uncomfortable feeling of disclosing emotional issues to various GPs, who were not mental health specialists, to eventually receive the expected referral to a psychological therapy service. One of the participants, Carolina, who was grappling with recurring episodes of depression, recounted the uncomfortable experience of seeking mental health support from her GP to obtain a referral to psychological therapy.

I think issues related to mental health are a subject that are difficult to deal with. When I was in Brazil and went to therapy, I went through many psychologists until I found one whom I identified with and wanted to talk *with and continued doing my therapy, you know? It is already difficult for you to open up to a professional who specialises in this area, let alone with a general practitioner. You have to be telling your GP your feelings in the hope that they will understand that you need to be referred to a mental health professional. Then what does it mean? If you manage to be referred to someone else, you'll have to tell everything you already told that doctor back there again, you know? I don't like this approach.*

Roberta shared that her long-term GP has always shown difficulty detecting her need for mental health assistance and offering her a referral. She has resided in New Zealand for two decades and has visited GPs to address mental health needs on different occasions. She navigated through postnatal depression as well as familial challenges. More recently, Roberta has faced a difficult illness that has left her emotionally vulnerable and needing mental health support. Drawing from her personal experiences, she shared her perspective on primary health care services.

In New Zealand, it is very difficult for the GP to understand you and refer you to a specialist, whether in mental health or any other area. As Brazilians, we are used to seeing specialists. We have this habit, and we want to see a specialist. But, here, the GP tries to solve everything while many times they know they won't be able to solve everything. Especially because their [workload] with patients is very high, they don't have time to investigate or read your records.

For Roberta, GPs are a barrier to delivering early mental health assistance.

Three participants found themselves referred to professionals different from the ones they believed would manage their mental health needs. There were cases in which the GP attempted to address the participants' needs by referring them to alternative professionals other than those they requested. Sabrina, for example, requested from her GP a referral for a psychologist, a mental health professional who she believed had the skills to attentively address and guide her in managing her anxiety symptoms. However, the GP hesitated and chose to initially refer her to an occupational therapist.

I opened up to him about everything I was feeling and going through, but he refused to send me to the psychologist directly. I asked him, "Is there *any way you could refer me to a psychologist?" He said, "Well, yes, I can and all, but first, let us start with an occupational therapist."*

Although she attended one session with the occupational therapist, Sabrina did not continue with the treatment. She perceived the care received as incompatible with her needs and did not revisit the GP to seek further help.

If I knew the root of the problem, then she could have helped me, you know? But I did not know. I didn't know what was causing all this. Where is this anxiety coming from? So how am I going to go there for her and tell her what's wrong when I don't know what's wrong.

Six participants showed frustration due to the inability to directly schedule an appointment with a mental health specialist when they were aware of their need for such specific support. For Camila, the requirement of seeing a GP to obtain a specialist referral is the most challenging aspect of her experience while accessing mental health attention in primary health care.

The GP doesn't always welcome you in the sense of knowing what you need – "Ah, you really need a specialist." They try to solve the problem. So this part, I think, is the most difficult when accessing mental health support in New Zealand.

Subtheme: ***Accessing ongoing mental health support***

Five participants referred to counselling sessions by their GPs felt that the number of sessions allocated to them was insufficient for the complexity of the problems they were experiencing. Furthermore, while in these services, they faced a lack of guidance on how to access additional sessions. The information they received regarding the number of sessions initially allocated to them seemed definitive, leaving them with a sense of being unassisted and uncertain about how to proceed.

Alessandra, who went through six counselling sessions, still believes that a psychologist is a professional that could deal with her mental distress. However, while she cannot access a psychologist, she believes she would benefit from additional counselling sessions. *"I think having access to six counsellor sessions is too little for someone dealing with tough situations. I still consider the fact that it would be nice to have a counsellor again."* When her counselling sessions finished, she felt she still needed further attention, as her symptoms were still present. However, she did not receive guidance on how or where to continue the assistance. She understood that to extend the number of counselling sessions, she had to see her GP again, share her symptoms, and request another referral. At the same time, based on her previous experience, Alessandra assumed that the GP would not refer her to the psychologist, so her feeling is that she is lost in the healthcare system. *"To this day, I would love to have access to a psychologist, but that's the thing – How am I going to? I have no idea how!"*

Similarly, some of these participants who were referred to professionals other than those they specifically requested, such as counsellors or occupational therapists, expressed their dissatisfaction with the level of complexity of the mental health attention provided by these professionals. They believed that their techniques did not adequately address their mental health needs, and they continue to await access to a psychologist's service. *"So I'm still thinking about finding a way to have access to a psychologist, but I don't know how yet. I've thought about trying to go back to the GP and talk again, but I don't know."*

Five of the eight women interviewed were still awaiting support from a psychologist. Some participants explained their preference to a psychologist based on their previous experiences. In Brazil, they received psychologists' technical expertise and obtained positive results. In their views, psychologists hold a more comprehensive range of resources to treat complex mental health needs. Camila, who had several negative experiences with counsellors, said:

Another barrier in New Zealand healthcare is that when you have a mental health problem and the GP makes a referral, you will hardly see a psychologist. You will see a counsellor, a social worker, or a nurse who was trained in the mental health area. Most mental illnesses require a theory, right? If you are going to practice with a patient, you have to have a theory behind that. Psychologists have different theories, and the patient chooses the professional based on that. But, here, in New Zealand we don't have this option. I feel like they put a band-aid on your pain until it bursts, and that's why we have one of the highest suicide rates in the world, the band-aid won't last a lifetime.

As a last instance, Carolina shared a different experience in which she initially received mental health support from her GP, who assured her of a referral to some form of talk therapy, and she had not been able to access these services yet as no contact was ever made. She said she had been waiting for a phone call to schedule the mental health professional for two years. Her feeling is of being neglected and unsure how to access such services. *"I intend to one day really find out how I can access mental health care here in New Zealand. I have this right."*

Altogether, participants who sought mental health support from their GP with the expectation of receiving a referral for psychological therapy felt that the assistance provided was either insufficient or unfulfilled. Some participants are still awaiting additional counselling sessions or psychologist services, while others have not accessed any form of talk therapy at all.

In conclusion, this theme presented Latin American migrant women's experiences navigating the healthcare system to access general practices and receive mental health assistance in New Zealand. The three subthemes developed were *"Obtaining mental health information as a migrant", "Seeing the GP as a condition for accessing psychological therapy services", and "Accessing ongoing mental health support". The data contained descriptive information regarding these women's perspectives on accessing mental health support. It included illustrative quotes that showcased their experiences and perceptions of care.*

4.2.2 Theme: Engaging with Primary Health Services for Mental Health Needs

The theme "Engaging with Primary Health Services For Mental Health Needs" highlights the participants' experiences while utilising primary health care for mental health needs. It focuses on the participants' perceptions of care in relation to their interactions with the GPs while receiving attention. Therefore, the data are categorised into the following three subthemes: Mental health assessment in general practices; **The importance of developing rapport when offering mental health support;** and **Managing mental distress in general practice settings.**

Subtheme: Mental Health Assessment in General Practices

Five out of eight participants disclosed that their mental health assessment process involved the use of a self-administered questionnaire. They explained that when they presented their emotional complaint to the GP, they were given a questionnaire and instructed to complete it with information on their current mental health state. Subsequently, the completed questionnaires were evaluated by the GP, who diagnosed some participants with a certain level of depression or, in other cases, anxiety. The GPs then determined the intervention strategies based on this assessment.

Four years ago, Simone went to a GP for the first time while living in New Zealand. She recalled having complaints that she associated with irritable bowel syndrome, but during the consultation, the GP gave her a mental health questionnaire that she was required to fill out. The GP diagnosed Simone with anxiety on that occasion, and she returned home with antidepressants. Simone expressed feelings of *"inadequacy and invasion"* when the GP immediately handed her a questionnaire without engaging in a conversation. *"I felt like just another number, a checkbox on their list. It was so impersonal, and I didn't feel heard or understood at all."* From this experience and the lack of trust in the GP it instilled, Simone self-managed her treatment for a year and went to the general practice clinic only to collect the prescriptions.

Juliana reached out to the GP for mental health assistance during an episode of postnatal depression. She was enduring an abusive relationship at the time and had no insight into the situation. Upon undergoing the evaluation process using a self-administered questionnaire, she pondered not realising the influence of that assessment on the following events of her life. During our interview, she expressed dissatisfaction with this assessment tool, perceiving it as flawed due to its reliance on the patient's mental state to provide a self-evaluation. Juliana elaborated that the time constraints during the consultation may have influenced her responses to the questionnaire, leading to either an overestimation or underestimation of her experiences.

The problem is that I think there are certain things that I rushed to mark because there was no dialogue about it, you know? And I think there is a lot of interpretation. When you do this type of questionnaire from one to 10, you will always have one. I think that if there had been a conversation, maybe it would have modified certain parts, and maybe it would have made me understand more how I was feeling to help me too.

Juliana believed that engaging in a meaningful conversation with her GP could have clarified her own feelings and, therefore, her interpretations of them. This way, she would have been able to give more accurate answers and potentially alter the subsequent course of events. Juliana explained that she received no formal diagnosis but was prescribed antidepressants. *"There wasn't much talk about my own psychological state, you know? The GP simply said, 'You're going through a difficult time. Take your medicine here.'"*

Juliana left the assessment with a prescription for a month-long treatment. However, she took all the medication at once in a suicide attempt. Subsequently, she was rushed to the emergency department, where she received immediate support. Reflecting on her experience, Juliana believes that if her GP had thoroughly assessed her mental state, he could have identified her potential risk and taken steps to guide her towards the appropriate care she deserved.

I think if the GP had spent five minutes talking to me, nowadays I know, after I ended up in the hospital. Oh, okay, there was a mental problem, but it wasn't only that. If someone had talked to me, I would have heard that it wasn't just a chemical issue. It was an abuse issue, you know? It was a matter of the fact that I was going through a lot of things.

On the other hand, Roberta shared a positive experience with a locum GP she consulted. She contrasted her experience of being assessed through a self-administered questionnaire in the past with her most recent consultation. She found her GP interaction from last year to be distinct and expressed astonishment at the considerable level of care and attention she received from her. Roberta acknowledged the limitations of primary healthcare consultations, such as time restrictions and an overloaded case load of patients they deal with, but recognised the effort of the healthcare professional in providing excellent attention.

This second time there was no questionnaire. It was a conversation, a long consultation. She spent a longer time than a standard consultation. If you go to the GP, you know you have 15 minutes, no more than 15 minutes. I know you can call and make a double appointment if needed. I didn't ask for one this time, and I wasn't charged either, but she took the time to talk to me. She didn't have this questionnaire. She took the time, talked to me, and asked me to come back.

Roberta characterised her appointment as a “lucky coincidence”, as her initial encounter with the GP and the attentive care she received positively impacted her treatment. The GP made changes to her medications and provided ongoing monitoring of her condition. However, as Roberta was not registered with this locum GP and her original GP returned to the clinic a few weeks later, she could not reschedule further consultations with the locum GP and eventually self-discontinued her treatment.

The beauty of it all was this doctor, who called me a couple of times to check how I was doing. She said to me in that first conversation, “I’ll keep an eye on you.” And, really, she called me twice, meaning she really said it and did it. She kept an eye on me. Something that had never happened because you know how busy they are, right.

Another common experience that participants described when utilising general practices for mental health support was the distant attitude that GPs assumed while assessing their needs. The impression is that the GP treated them as “just another patient in the line”. Examples include that GPs conducted their assessment not only with questionnaires but also by offering medication as the first approach for their complaints, giving automatic responses, or lacking interest in what they had to say. Participants felt discouraged when they perceived the assessment as following a routine procedure. *“It lacks an individual approach. They should evaluate each situation. There is no use in following a protocol,”* Alessandra said.

For them, when the doctor appeared to be unavailable to provide active listening during the assessment, they were also unable to fully grasp the true importance of the assistance they were seeking. In other words, when the mental health assessment did not provide an opportunity for open conversation, the participants had the impression that the doctor did not understand their needs. The experience seemed to inhibit the participants’ connection with their GP and left them with the impression that there was a lack of care from the GPs towards them. *“It was a checklist. There was no personal care. In fact, it felt like an obligation, a formal thing. No, it’s like that, they already have a protocol,”* Simone said.

Additionally, participants who received a superficial mental health assessment linked it to the lack of knowledge the GP had about them to establish further directions related to their assistance plan. They believed that GPs who relied on questionnaires or did not take the time to engage in meaningful conversations lacked a comprehensive understanding of their individuality and needs, directly impacting the quality of the interventions the GP provided. In these cases, the intervention plan suggested by the GP was generally medications as an immediate approach to their complaints.

The GP's response seems to be a routine standard of procedures. So it was the procedure. How does a GP treat a person with anxiety who comes to their office? It is treated like that, giving medication. They follow a protocol. They don't listen to you. They don't understand that you are different from me and that what works for you may not work for me.

Subtheme: The Importance of Developing Rapport When Offering Mental Health Support

Regardless of the subsequent outcomes of their mental health assistance experience, four participants described having situations in which they felt comfortable sharing their emotional issues with their GP. They attributed that to the fact of having a good relationship with their doctors. Two of these participants had been with the assigned GP for years and had already undergone health support for other medical issues. The other two built a relationship from the first mental health appointment.

Alessandra had built a relationship with her GP throughout her five years living in New Zealand. She described her GP as "flexible" and explained that she had always felt comfortable requesting tests and medicine for herself and her son. Alessandra appreciated that her doctor used to comprehend her way of *"seeing things"* and did not resort to antidepressants to solve her emotional struggle. Even though her GP did not refer her to a psychologist, the professional she believed herself to need, she valued the open space to talk to her GP and the GP's attempt to help her when the GP referred her to the counsellor, evaluating their relationship as a facilitator when accessing mental health care in primary health care.

I liked this GP a lot. She actually just left my health care centre but was a professional that I really liked. She was very flexible. When she offered me to take meds, I mean, she didn't offer [medication to] me, she asked, "Have *you thought about taking an antidepressant?" I said, "No", and that was that.*

After a few counselling sessions, Alessandra still felt the need to see the psychologist. However, she explained that as her GP has left the general practice clinic she is enrolled in, she felt discouraged to expose her emotional issues and request a further referral to a health professional with whom she still has not created a bond. She believed, though, that if her past GP were available for her to reschedule a consultation, her need would be fulfilled.

I haven't even tried it yet because she, the other GP, at least, I knew that I could come and say, "Look, you referred me to that primary mental health. I did the sessions, and it was good, but it didn't solve my problem. Is there any way I can see a psychologist?" I think she would help me.

Livia, Roberta and Sabrina also spoke about the experience of having a good relationship with their GPs. They felt satisfied with their GPs' level of attention during the consultation, their sensitivity, attentiveness, and genuine interest in understanding their situation. They appreciated being listened to and felt comfortable sharing their struggles.

Livia went through a negative experience with her past GP, whom she believed dismissed her feelings. She changed GPs by way of a recommendation of a person who worked in a pharmacy she usually goes. According to her, the GP this person recommended was known for having an understanding of mental health.

I had a consultation with him, and he was completely opposite to my past GP. He even researched a Brazilian psychiatrist to recommend to me. He was very sensitive. So much so that I recommended him to other people because I thought the attention he gave to me I haven't had from a doctor since I've ever been in NZ. He showed an interest. Sometimes the doctor is like, just on the computer, you're talking, and they are there writing, don't look at you. But with this new GP, I felt more like I was talking to a person. Like, I was talking to a friend, really.

On the other hand, Roberta, Juliana and Camila found their long-standing relationship with their GP to be *"difficult and lacking in dialogue during consultations".* Camila, who has switched GPs multiple times, highlighted the absence of trust and connection with her current GP. She compared the Brazilian doctors' approach to building a connection with their patients and her relationships with GPs in New Zealand, noting that doctors here tend to adopt a more distant approach to patients.

It's a matter of trust. In Brazil, we build a connection with the doctor, even in the public health system. Here, I think it's like a "production line", you know? In the health system in NZ, the doctors are more distant – it may be from their culture. They set a dividing line.

The frequent rotation of doctors within the clinics emerged as a significant underlying factor that acted as a barrier for the participants to foster stronger relationships with their healthcare providers. Roberta, who has been with this current GP for many years, feels uncomfortable sharing her emotions with her and believes they never built rapport. Before this current GP, though, the general practice she is enrolled in changed her GP multiple times. She believed that this frequent change negatively impacts the quality of care. *"There is no continuity of care when you change GPs. You go there just to solve the immediate problem, and you don't have an evaluation of what has happened before."*

During a period in which her allocated GP temporarily left the general practice clinic for a licence, Roberta had the opportunity of seeing a locum GP and experienced an extremely positive experience with her. After a month, with the return of her original GP, she could not reschedule with the locum GP as the general practice clinic did not permit the change. She believed that receiving continuous support from that same GP with whom she created a bond and thoroughly managed her mental health treatment would have transformed the mental health attention she needed into a positive outcome.

It would have been much easier if I had been following up with that same doctor since January. So I would have that openness to talk about things other than the physical part, to talk about my mental health. When you meet a new GP, you have to start all over again, and then you have to build a relationship with another doctor to finally create an opening to feel comfortable to talk.

Carolina and Simone explained that they had never interacted with those GPs before that first appointment for mental health needs. As a result, they believed that it influenced their uncomfortable feeling of sharing emotional issues with someone they did not build a previous relationship with and created the impression that building one from that point onward was unattainable.

All participants emphasised the relationship they built with their doctors as fundamental to making them feel comfortable when asking for mental health help and exposing emotional issues. A good relationship between patient and GP, based on trust and communication, was closely associated with positive experiences and outcomes, such as adherence to treatment and patient retention with the GP. Conversely, a strained long-term relationship or a lack of rapport during the first appointment seemed to impede the delivery of appropriate mental health care contributing to patient dissatisfaction.

Subtheme: Managing Mental Distress in General Practice Settings

Six participants shared experiences where the GPs failed to acknowledge their emotional struggles and recognise their need for mental health support. Instead, dismissive responses were received from them, showing a minimal level of attention and interest in their mental distress.

Livia, who was enrolled with this GP, made an appointment concerning her mental health situation for the first time. She had treated anxiety disorder in Brazil with a psychiatrist and psychologists before migrating. Even though she did not experience a recurrence of those symptoms in the first three years of living in New Zealand, she reached a gradual point in which her social isolation, depressed mood, unwillingness to leave the house, oversleeping and coping drinking mechanism to manage the symptoms were consciously impacting her life. When she revealed her symptoms and asked for mental health support from her GP, he discredited the importance of the facts. Livia explained, *“So he said, ‘You have to understand that life is difficult for everyone. You’re saying your life is more difficult, that it’s complicated for you in New Zealand, but life is tough.’”*

Carolina, who had previously been treated for an episode of depression in Brazil, reported the recurrence of similar symptoms following her five-year residency in New Zealand. She sought mental health support through a GP and openly communicated her emotions and the need for mental health care. Contrary to her expectations of receiving empathetic understanding and a caring attitude, the doctor’s interest remained solely on Carolina’s present living situation in the country, disregarding a mental health evaluation and her claims for mental health help. *“The doctor looked at my face and said that if I had a job, if I was with my daughter in the country and if I had a partner who was Kiwi, I had nothing to be sad about. Like, I had no right to be sad because I had everything in life.”*

Roberta expressed frustration while sharing the experiences of consistent dismissive attitudes from her GP over time. The negative experiences consolidated a deep mistrust of the GP’s ability to provide adequate mental health assistance to her. As she confronted the overwhelming challenges of a serious illness, Roberta gradually withdrew from sharing her emotional struggles with the GP, hesitant to open up and risk being overlooked again.

I felt like I didn’t open up to him anymore because it wasn’t worth it, I knew I wasn’t going to get anywhere. He was going to say, “Oh, it’s nothing.” It’s hard to talk about your emotions to someone you know is going to say, “Oh, it’s nothing.”

Six participants had similar experiences with GPs. For them, to have their emotional struggles ignored by a healthcare professional designated to offer initial mental health support exacerbated their mental distress. Disregarding their emotional struggles in the setting where they should ask for and receive mental health attention created a sense of lacking reliable resources they could count on within New Zealand’s healthcare system. Livia said:

When the doctor comes to you and says, “You have no reason to be sad”, you feel angst, anxiety. Someone who should be esteemed – it was the doctor saying, “No, you are wrong to be sad”! You leave the clinic worse than you entered."

Livia, Camila, Roberta, Juliana, Carolina and Livia suggested that GPs lacked the competence to manage their mental health issues. Carolina compared the assistance she had previously received in Brazil with the support she obtained on her first mental health assessment in New Zealand. She firmly considered that her GP dismissing her mental distress indicated his lack of skills to deal with mental health issues.

I don’t think the GP had any training in mental health. I think mental health is a particular area. Mental health demands specific training. I don’t think everyone knows how to deal with this sort of situation, but I believe that if the country asks you to see a general practitioner first, they must offer *adequate attention. My GP had no understanding of mental health. As a person who has already used mental health care in Brazil, I think this is not the "approach". You can't lessen anyone's pain, you know? So, I think that if he underestimated my pain, my feelings, my anguish, for me, he had no idea how to deal with mental health.*

4.2.3 Theme: Connecting with General Practices for Mental Health Needs

The theme "*Connecting with General Practices for Mental Health Needs"* highlights participants' prevailing impressions of care after the experiences of accessing and utilising primary health care services for mental health needs. This theme explores the participants' perspectives concerning their feelings after obtaining assistance, how they perceive the effect of the assistance in their recovery process, and how these experiences impacted their adherence and reliance on general practices as competent settings to manage their current and future mental health needs. The subthemes developed are *Impressions of mental health care in general practices; Effects of the mental assistance received in the recovery process; and The prospect of receiving mental health attention at general practices.*

Subtheme: Impressions of Mental Health Care in General Practices

Five participants held negative perceptions of the mental health assistance they received. These negative perceptions stemmed from various factors in their multiple experiences, including the GPs being inept in managing their mental health needs, slow or no access to psychological therapy services through general practices, limited psychotherapeutic support sessions or narrow professional skills from these psychotherapeutic services to manage their mental distress effectively.

Camilla examined a series of experiences she had with her GPs in the past to receive mental health support and perceived the environment as usually confrontational to her. She explained that when she saw her GP for mental health needs, she was always in a position where she had to convince him of the legitimacy of her needs, which generated stress and frustration. She said:

It's very bad. That's why I don't like going to the doctor here in NZ because I'm always on the defensive. To fight? No, not to fight, but it's not always an easy experience where I can say, "Wow, this doctor knows everything."

Three participants strictly evaluated leaving the setting where they received assistance feeling worse than when they arrived. Simone, diagnosed with anxiety and prescribed antidepressants in the first consultation with the GP, said, *"I had my problems, problems with myself, with my marriage, and other things. So, I was in a tangle. After that consultation, I was even more in darkness. I didn't understand anything, and in fact, I got worse."*

Carolina, who sought mental health help from a GP for the first time and felt he dismissed the seriousness of her symptoms, said, *"I went to that consultation feeling really sad, and I think I must have left the clinic worse than I entered it. Because at the end of the day, you start to question yourself, your own feelings."*

Conversely, three participants, who shared positive and negative aspects of their experiences throughout the interviews, perceived the overall assistance received was positive as they felt welcomed and supported by their GPs. Regardless of previous negative experiences or undesirable outcomes related to referrals, when the GP demonstrated attentiveness and a genuine interest in understanding their circumstances to find solutions, they evaluated the overall experience with a good sentiment.

Alessandra felt conflicted about her overall impression of the mental health assistance provided in the general practice as she could not access the psychological therapy support she believed to need. However, she held a positive impression towards the quality of her GP's assistance. She appreciated her GP's attentiveness during the consultation and how respectful she was of her preference not to take medication. The trust and solid relationship with her GP supported the impression that the GP did her best to provide care. *"Yes, I felt the GP welcomed me, yes. Maybe my frustration has to do with the referral. I really hoped that I could have the session with the psychologist."*

Subtheme: Effects of the Mental Assistance Received in the Recovery Process

All participants who received mental health attention from their GPs pursued additional mental health services in New Zealand, engaged with self-oriented methods and substances or sought a mental health professional in Brazil to ease their mental distress. These behaviours were justified by insufficient explanations about the proposed treatment plan or the mental health situations, proposed strategies incompatible with their realities and possibilities of execution or, in some cases, a total lack of an intervention plan presented by the GP.

Simone was diagnosed with anxiety in her first consultation with the GP. She was prescribed antidepressants and received no elucidation of the cause of her diagnosis, referral to a psychological therapy service or even a clear understanding of the GP's management of their case. Simone explained that she did not have sufficient proficiency in English to understand the GP, so she was accompanied by her daughter, who translated the consultation for her. She believes, though, that her English skill was not the reason for the GP's lack of guidance.

I don't think the language influenced the situation; my daughter was there. And I think that if the GP realised that I was not understanding, he should have looked for an alternative. He should have checked for a mutual understanding. When I interview my clients, English speakers, Kiwis or Indians, I ensure that the communication happens.

For Simone, the problem seemed to be a failure to communicate the management plan and discuss what she was presenting. *"He did not explain how that anxiolytic would make me feel the next day. So I came home and used what? Google, because I needed answers. I started reading a lot about anxiety to try to help myself with the tools I had."* Simone explained she felt *"lost"* when first diagnosed with an anxiety disorder and prescribed medications. She left the consultation and explored online resources to overcome her emotional struggles and find answers to her questions.

I did my own research to understand how an anxiety medication worked. Then I researched how long I would have to take that medication until I got rid of it. If it caused dependence or not – I was looking for the answers.

Simone self-managed her treatment and did not return to the GP for mental health needs. She believed her recovery had come through her own efforts to understand herself and find compatible solutions to her beliefs.

My luck is that I walked a long path of self-knowledge through astrology. I've always been interested in psychology because, you know, Jung used it a lot. He influenced astrologists because he spoke a lot of archetypes.

So, as I am an astrologist, I have had self-knowledge stored away. I rescued that to be in peace with myself.

Camila believes she still has not received an efficient approach from her GP and explains that she also has to find knowledge as a coping mechanism to manage her mental distress.

I don't think about my problem. I just like to study. I study, I have several degrees in New Zealand. I'm doing one more, and I'm arming myself with knowledge. I don't do yoga as the GP recommended, but I go for walks, I exercise. My solution is to try not to focus too much on my tension.

While seeking mental health help from her GP, Alessandra initially intended to receive a referral to a psychologist. She refused medications and underwent six counselling sessions. Her GP left the practice she is enrolled in, and she did not feel confident to open up again about her emotional issues to a different GP with whom she has not built a bond yet and ask for further help. At the moment of the interview, 6 months after the first appointment with the past GP, she still experienced the same symptoms.

Except for the counselling sessions, none of the GPs' strategies proposed for Alessandra could have been completed. As an alternative to psychological therapy and medications, Alessandra's past GP suggested she initiate physical activities to dedicate time for herself and improve her well-being. Alessandra acknowledged her need to have personal time to help improve general aspects of her mental health; however, she felt frustrated with the GP's recommendation as it, in practice, was incompatible with her reality.

They suggested doing physical activity, right? Then I said it was something I would really like to do. I looked for some things I could do on my Friday off and there is nothing on Fridays. Nothing. Almost all activities, mothers' therapies in groups, things like that, are usually available at times and days of the week for those who don't work, you know? It's complicated. How am I going to do it?

Alessandra could not implement the GP's recommendation as she divided her time between work, house maintenance and caring for her two-year-old son. How the case was managed has prompted Alessandra to view the health professional as not being in touch with her reality and suggesting solutions unattainable for her to proceed. She believed that little consideration of what was possible for her was considered when suggesting it as part of the recovery plan.

Six participants felt that the lack of cultural knowledge regarding the Latin American population impacted the care received from their GPs. Camilla explains that GPs have made generic suggestions of joining the church or another group of Brazilians to improve their well-being in the country. However, little investigation of her individuality was considered when making these suggestions.

NZ is a multicultural country, so really, before the patient enters the room, you have to read their file. Of course, there won't be enough time for the GP to Google about Brazilian culture. But perhaps ask where the person came from, having the interest to ask culturally, "What would it be like in your country?" to have this close approach.

From a different perspective, Sabrina, who refused medication and did not see the benefit of the occupational therapist sessions, researched ways to relieve her anxiety.

Nothing came from the experience in the general practice. So that was how I found healing, trying to find myself. And then, I started trying to change my routine, exercise more, and focus on myself a little. One of the things I did was read about mushrooms at the micro-dosage [level]. And then I found it here in NZ, and I did. That was what helped me. That is what pulled me out of rock bottom. Never again I felt anything.

Roberta found solace in the community and spiritual connections.

Over time, I've been coping better. I know several people, and I have deep friendships with people from here, and there's the church I belong to, and I think having that spiritual side counts a lot. It helps you with the emotional part too, right?

Juliana, who received no emotional support or referrals from her GP, managed to receive counselling sessions through a friend who recommended and paid a professional that worked in the church.

So this is the only way I have to get help. Either I do it this way and take medicine, or how will I seek help? You see? Later, talking to a friend, she *said, “No, I know a counsellor who works privately at Nativity Church.” So she paid for me, and I went. Privately.*

Three participants, as a last resort, sought help from professionals in Brazil. Carolina had online consultations with a Brazilian psychologist. Livia went to Brazil to consult with a psychiatrist. She returned to New Zealand with a prescription that her current GP is in charge of renewing. She also has online consultations with a Brazilian psychologist. Camilla also consults online Brazilian doctors, believing they are more reliable in offering effective measures.

Subtheme: The Prospect of Receiving Mental Health Attention at General Practices

Five participants described an apprehension of immediately needing mental health support again and having no option but relying on general practices to receive assistance. Various reasons contributed to this feeling, but there was a prevailing sentiment of scepticism towards the effectiveness and speed that the attention could be delivered.

Carolina, who relied on a Brazilian psychologist to alleviate her symptoms of depression, said:

If I come to a time when I feel really bad, like, I’m really depressed, I don’t even want to get out of bed, I don’t have any expectations that I’m going to get help in the area of mental health in New Zealand as fast as my body and mind need it. I don’t have that expectation. I don’t think it’d be fast, I don’t think it would happen.

Carolina has been waiting for psychological therapy for three years. She does not believe that general practices could provide instant mental health support to her.

If I needed to go back to the same service now, I would sit down and cry. I would call my mother, and at most, I would go to the same therapist who helped me the other time in Brazil.

Livia expressed feeling terrified by the idea of relying on mental health services in New Zealand, stating, *“One of the things that I’m most afraid of is that I need care because I know I won’t have it. I’m afraid. I’m afraid of needing it, for sure.”* She also expressed concerns about the cost of such care:

I'm also afraid of needing care, receiving it, and later being charged an amount that I cannot afford. And I will have to pay with perhaps something like an instalment plan, so I will have a debt, you know? I don't like the idea of having debts, so I'm afraid of that too.

When Simone was asked about her inclination to return to the GP for mental health support if she faced mental distress and difficulties again, she refused to return to a general practice service as she questioned its ability to provide efficient support. *"I would seek help in an online service in Brazil because I would know I would get a follow-up. My fear is not having proper treatment here in New Zealand."*

Similarly, they also felt hesitant to return to general practice services for mental health care because they anticipated the exhaustion of starting over again and disclosing their emotional information to different professionals until they finally achieved mental health assistance.

Sabrina did not plan to return to the GP to insist on a referral to a psychologist. She explained:

I thought to myself, "Ah, okay, I'll go back there, and he'll finally refer me to a psychologist. How long will it take before I see a psychologist?" I kind of gave up. I don't want to go through all that. It's already a pain to be touching the wound, you know? If you have something that hurts, you don't want to be touching it all the time.

She believes a psychologist could help her understand the root of her anxiety symptoms, but after self-care measures and the use of micro-dosing mushrooms, she found herself in a balanced psychological state. However, although she feels hesitant to return to the GP, she accepts that if the symptoms reappear severely, she would have no option but return to the GP.

I feel totally unmotivated to return because it was already very difficult for me to go to the doctor, to open up, to tell him everything, you know? And then I have to do it all over again, with someone else, and then do it all over again. It's exhausting. But let's assume that it was coming back really strong again. Then I could go on the GP.

Camilla said that because of all her experiences with general practices, returning to the clinic to seek mental health support would be her last resort.

Really, if I get depressed, like those who neglect self-care, who stop eating or start overeating. Or if I stay in bed, and don't go to work, then I think I would have to look for a GP. In New Zealand, you cannot skip steps.

She also disliked the idea of starting over again, disclosing her feelings to the GP and anticipated that it would not have a resolution. *"I get very irritated with the healthcare system in New Zealand. Really, if there's one thing that depresses me, it's having to face it, having to talk to the doctor, starting all over again."*

Alessandra, Roberta and Juliana also worried about returning to general practices for mental health support as they mistrust the capacity of these services to deliver efficient and prompt mental health attention. However, as they recognised that it would be their only option to access mental health in New Zealand, they felt they had to deal with this reality. Juliana, for example, considered returning to her GP for mental health needs but now with a practical understanding of her limitations in support. She learned from her previous experiences that she cannot rely on the GP to provide efficient mental health assistance, so she plans to guide her GP to what she believes she will need.

If I go back to my GP, it would be knowing what I want. "I need help with some medicine, I need this to help me or refer me to counselling." But I wouldn't go there believing she could tell me what my problem is, you know? I think I'd go there just to... It became, like, just the person who signs, sends the note, basically that. I don't feel like I could go there and say, "Oh, this is my problem. Help me find a solution." I don't feel it.

Conclusion

The three themes developed in this study explored and described the complex experiences of Latin American migrant women in New Zealand while accessing and utilising primary health care services for mental needs and the effects of these experiences on their perceptions of care. Through a descriptive and detailed presentation of the findings, barriers and facilitators that these women faced during their experiences were presented. The following chapter will provide a discussion of the key findings.

5. Discussion

5.1 Introduction

This research focuses on exploring Latin American women migrants' experiences of accessing and utilising primary health services for mental care needs in New Zealand in order to understand the barriers, facilitators and strategies they encountered to access and utilise these services effectively. It also focuses on examining the effect of these experiences on their perceptions of mental health care in Aotearoa, New Zealand. Eight Latin American women migrants in New Zealand participated in semi-structured interviews to share their experiences and perceptions while accessing and utilising primary care services for mental health needs. The participants' interviews produced rich data that reflected their experiences and perceptions with personal depth. The research questions guided the thematic analysis process of this data to organise themes of the shared areas of interest. Subthemes were then utilised to further explore and delve into specific elements related to those areas. Three main themes emerged from the thematic analysis*:* Accessing Primary Health Services For Mental Health Care Needs; Engaging with Primary Health Services For Mental Health Care Needs; and Connecting with Primary Health Services For Mental Health Care Needs. All subthemes are previously illustrated in the findings chapter.

There is little research on migrants' mental health care in New Zealand, especially within this study's population. These findings are expected to offer particular significance concerning the mental health needs of this group investigated. Providing a deeper understanding of Latin American women's experiences while accessing and utilising mental health care services also contributes to better comprehend their needs within mental health services. This chapter summarises the key findings of this research and discusses their implications with existing research and theories related to migrants' mental health in New Zealand and worldwide. It then follows by presenting the study's strengths and limitations, recommendations for practice and education, and finishes with the conclusion.

5.2 Summary of Findings

This study aims to produce knowledge to support mental health promotion focused on a minority ethnic group in Aotearoa, New Zealand. The lack of research and understanding of Latin American women migrants' mental health status and needs in New Zealand has piqued the researcher's interest. Exploring this population's experiences while accessing and utilising mental health support in New Zealand as well as the effect of these experiences on their perceptions of care, is believed to be essential to contribute to developing such knowledge. The research questions, therefore, were formulated to gain a broad comprehension of this minority ethnic group concerning barriers and facilitators they faced within their experiences. In order to answer the research questions, the data were divided into three themes and later categorised into subthemes. The data specified in each subtheme was presented earlier, and the key findings suggested by them are disclosed as follows, along with their interpretation and significance in relation to the research questions.

5.2.1 "Accessing Primary Health Services For Mental Health Care Needs"

The theme "Accessing Primary Health Services For Mental Health Care Needs" allowed the identification of patterns related to the participants' experiences of accessing general practice services to receive mental health support. It was possible to observe that participants did not know where to access mental health support in the country before the urgent need to receive help. They had no health understanding of how or where to access the available services before their need became pressing. Additionally, further data analysis within the theme has brought to attention the fact that most of the participants' motivation for accessing primary health care services for mental health needs was to obtain a referral to psychological therapy services within the public system. The data suggest that the condition of accessing general practice services to request a referral to psychological therapy services ultimately was seen as a barrier for them in accessing adequate mental health support.

Lack of Mental Health Information

The data showed a significant pattern in the participants' responses about becoming aware, from a migrant point of view, of where to access mental health assistance in New Zealand. It was observed that the participants only gained knowledge of how to proceed within New Zealand's healthcare system to access mental health help when they faced urgent mental health needs or distressing situations. Before experiencing a specific health requirement, they had no understanding of navigating the healthcare system. Even at the time of the interviews, after receiving attention from primary healthcare services, some participants still felt lost and unsure of where to seek additional mental health assistance. This finding suggests that this population received and still obtains limited information about accessing mental health help within New Zealand's healthcare system. The disparity in health information backgrounds between the country of origin and settlement appeared to influence the confusion among the participants as they often drew comparisons with their Brazilian experiences when describing their experiences of accessing mental health services in New Zealand. However, further examination of barriers that hinder their access to mental health information is needed to comprehend associated factors.

The finding is consistent with previous studies that suggested that migrants worldwide face barriers to accessing health information (Baumeister et al., 2021; Czapka et al., 2016). In New Zealand, researchers have explored health literacy among ethnic minority populations, and the results are also consistent with international literature (Akhtar et al., 2022; Sa'u Lilo et al., 2020; Xiang et al., 2023). Xiang et al. (2023) recently conducted a study involving an analysis of New Zealand's general practices' websites and interviews with Asian migrants to understand the barriers and experiences of their navigation in New Zealand's primary health care. The research findings highlighted the lack of information and resources for navigating the New Zealand health system, particularly for Asian migrants. Existing resources on these websites assume prior knowledge that most migrants do not possess. Studies have also explored common factors related to migrants' limited health information. Aspects associated with the migration process impact the access to health system information, such as lack of information about New Zealand's legislation, acculturative stress, language barriers, racism, discrimination, lack of cultural identity, and lack of culturally competent health professionals (Babar et al., 2012; Baumeister et al., 2021; Kanengoni et al., 2018; Todd, 2011).

Previous research has not investigated the health literacy status and barriers to accessing health information among the Latin American population, particularly migrant women, in New Zealand. While the main focus of this study was not specifically on the health literacy of this population, the experiences shared by the participants provided valuable insights that suggest challenges in accessing timely and comprehensive mental health information. These alarming finding adds to the existing knowledge of health literacy of the migrant population in New Zealand by contributing to an emerging understanding of the potential issue among this populational group, emphasising the importance of further research.

The importance of Latin American women migrants having mental health literacy is closely related to this population's high risk of developing mental distress

(Kirchner & Patino, 2011; Kirmayer et al., 2011; Salas-Wright et al., 2018; Smith & Ireland, 2020). Their need to understand at an earlier stage of arrival in New Zealand how and where to access mental health support is crucial for them to navigate the system and make effective decisions. People with low health literacy are more likely to have poorer health outcomes (Ministry of Health, 2010).

New Zealand's Ministry of Health (2001) has determined that general practices are the main path through which the population accesses assistance for mental health needs in New Zealand. When individuals need a mental health service, the pathway is to schedule an appointment with their regular GP or choose a general practice that accepts new patients to enrol. They can be assisted in the setting or receive a referral for further assistance within the public health system. This type of health information is obtained through what is known as health literacy.

Health literacy is the essential skill through which the population acquires health knowledge, motivation, and capacity to access, understand, appraise and make effective healthcare decisions (Smith & Ireland, 2020). It has become a key contributor to effective disease management, improved health outcomes and the overall efficiency of health care (Baumeister et al., 2019). Therefore, it is crucial to ensure that Latin American women migrants, a group that accumulates multiple vulnerabilities to mental distress, have sufficient levels of health literacy to navigate New Zealand's health system to make conscious and timely decisions regarding their mental health.

The causes of limited health literacy are not limited to individuals' skills; they are also associated with the situational and political conditions of the environment that includes the infrastructure, policies, processes, resources, people and relationships that make up the health system (Baumeister et al., 2021; Smith & Ireland, 2020). Reducing access barriers will require healthcare organisations to create or expand their involvement with and connections to the community in need (Andrulis & Brach, 2007). Some of the changes to increase health literacy in the health sector suggested by the Ministry of Health (2012) would highly benefit ethnic groups, such as making health services more accessible to navigate, redesigning health care services resources to meet the minority groups' particularities, including language and perspectives, improving the availability of interpreters and training health professionals to be culturally competent communicators.

General practice posing a barrier to accessing psychological therapy services

The data have shown that most participants accessed general practices to obtain a referral to psychological therapy services or psychiatrists. However, the requirement of going through the GP's evaluation to obtain a referral was seen as a barrier to effectively accessing the mental health care they believed they needed. From their perspectives, the need to work on their mental distress with psychological therapy sessions was uncontested, and that should not be a condition for the general practitioner assessment . They also described feeling uncomfortable when disclosing their feelings to a professional who would only refer them instead of directly providing the therapeutic skills they desired. It felt particularly invasive to those who had to share information with various GPs in order to eventually access such services.

The finding suggests that this population has seen general practices as a barrier to accessing counselling, psychologists and psychiatrist services. The majority of the participants opposed engaging in pharmacological treatment to manage their mental distress and believed that the immediate mental health support necessary to relieve their symptoms would be obtained through such professionals. Rather than facilitators in providing mental health care, the GPs were believed to hinder the pathway to access appropriate support, as they do not hold such skills and function as only intermediate professionals that allow the referral to be completed.

This finding has a novel outcome that highlights the disparity between participants' experiences and the intended role of general practices in coordinating access to psychological therapy services in New Zealand. The Primary Health Care Strategy, established in 2001, designates general practices as the primary pathway for mental health support. Patterson et al. (2018) further emphasises the pivotal role of GPs in providing comprehensive mental health assistance, including appropriate advice, interventions, support, and referrals to specialists. However, this study's findings reveal a conflicting reality wherein general practices may not efficiently facilitate referrals to psychological therapy services for this population.

As previously mentioned, the current instruction is for individuals to seek help for any mental health-related needs through general practices, including when the need is exclusively for referrals for psychological therapy. However, the latest Mental Health Service and Addiction Service Monitoring Report (2022) acknowledges that longer waiting periods for accessing mental health and addiction services remain challenging in New Zealand. Efforts are being made to address these issues and improve the demands for referrals in primary healthcare services. The aim is to create a more inclusive and responsive mental health and addiction system that caters to the needs of all individuals. The report emphasises the importance of advocating for an improved system that addresses inequitable access and underserved communities, with a particular focus on Māori and marginalised communities, including the Pacific population, former refugees, and migrants.

Although the issue of referrals to mental health services in New Zealand revolves around the availability of referral services, the fulfilment of inappropriate or incomplete referrals, professional training, funding allocation, and the provision of alternative approaches, such as e-therapies, rather than questioning the role of GPs in coordinating referrals, this study's finding provides a significant contribution to the ongoing discourse on mental health access for minority populations within the healthcare sector (Allwood et al., 2019; Patterson et al., 2018; Mulder et al., 2022). Notably, the finding aligns with the current emphasis on the urgent need for improved access to mental health services and the provision of a broader range of service options to cater to specific population needs. However, it suggests that minority ethnic populations should be able to access psychological therapy services within the public system directly and without requiring a GP assessment for referrals. Considering the multiple barriers to health access inherent to the migration status mentioned earlier, this measure could improve this population's access, mental health awareness, well-being and satisfaction with the healthcare system in New Zealand.

5.3.2 "Engaging with Primary Health Services For Mental Health Needs"

The theme "Engaging with Primary Health Services For Mental Health Care Needs" produced subthemes that examined the participants' experiences of utilising general practice services. The subtheme *"Mental health assessment in general practices"* reveals the negative impact of non-comprehensive medical assessments on the participants' perceptions of mental health care. The subtheme "Managing mental distress in general practice settings" has revealed data supporting that GPs lacked the mental health skills to welcome and manage these women's mental distress. The findings are discussed as follows.

Non-Comprehensive Assessment

The use of self-administered questionnaires as an assessment tool was a significant concern for many participants. They felt that this strategy lacked nuance and failed to capture the complexity of their feelings when responding, representing a barrier for the GP to understand their actual mental health status effectively. Likewise, participants highlighted the negative impact of a non-comprehensive approach as a form of mental health evaluation on the mental health support outcome and, ultimately, their perception of care. According to them, the inability to carefully assess each individual with their particular needs prevented the GP from understanding their actual needs and, therefore, hindered the exploration of underlying issues from applying appropriate intervention plans.

In contrast, three women who received an attentive approach during their assessment from their GP explained the powerful effect of this interaction on their feelings of being cared for and the overall treatment outcomes. Descriptions of the GP being careful to take the time to listen to the psychosocial aspects of their complaints and the patient feeling comfortable speaking during the interaction by noticing the GP was not speeding through the consultation were seen as facilitators to these positive experiences.

The finding suggests that using self-administered questionnaires as an assessment tool or a non-comprehensive approach during the assessment was perceived as a barrier to the participants' perception of appropriate care, as they believed the GPs failed to capture the complexity of their feelings hindering the understanding of their mental health status. Conversely, an attentive approach during the assessment, where the GP took the time to listen to the psychosocial aspects of their complaints, was seen as a facilitator to enhance their perception of mental health care and foster their trust in the GP's intervention plans.

This finding is compatible with research conducted in New Zealand that found that when GPs establish effective communication with patients, they gain their trust to talk about personal feelings and are more likely to effectively diagnose and treat psychological problems (Dew et al., 2005; Hartdegen et al., 2017; Thomas et al., 2010). Recent international literature has also emphasised the therapeutic value of a positive relationship between GP and patient, where the GP explores and shapes a deep understanding of the patient's emotional concern during the assessment to support the management (Parker et al., 2020).

Little research has been undertaken regarding established questionnaires to screen for psychological problems in primary care, though, especially within New Zealand's realities. A study from 2005 explored the efficacy of screening and case-finding for psychological disorders in routine general practices in New Zealand and suggested that screening a patient in their first assessment through questionnaires may produce better results in identifying cases of psychological problems compared to evaluating long-term or frequent patients already familiar to the GP (MaGPIe Research Group, 2005). Another study from 2006 showed that treatment levels with psychotropic medication were lower when GPs used externally assessed measures of a disorder rather than when they used their diagnosis skill (MaGPIe Research Group, 2006). These results challenge the experiences and perceptions of effective care among this study's participants. Conceivably, the migrant women's realities may differ and demand further consideration than the general population.

Machado et al. (2022) found that women's migration experiences significantly influenced their healthcare needs, preferences and expectations when accessing healthcare services in Canada. However, they emphasised that health professionals continuously overlook this population and do not approach them with the understanding and cultural humility they need. They believe the dismissiveness of their contextual migration experiences and status while providing health care reflects long-term discrimination and the country's lack of more specificity migration policies. One direction recommended to improve the quality of care provided for them was to implement post-arrival health assessments for this population, which comprehend their migration journeys, including prior experiences related to healthcare, gender-based violence, and family separation. Similarly, Chung et al. (2022) found that GPs in New Zealand lack awareness of the Chinese community's needs and particularities. The GPs justified that the inadequacy of primary care for this population is indeed due to the misunderstanding of their needs, but mostly because there is an absence of policies and funding to support language and culturally appropriate services.

On the other hand, Patterson et al. (2018) acknowledged that the extent GPs can accomplish during 15 minutes of consultation is restricted and compromises the assessment's quality. It was also recognised that limited knowledge and training in mental health are often a barrier to providing appropriate mental care, including a comprehensive assessment. Nonetheless, GPs were still expected to be part of a core role of general practices and offer early diagnosis and interventions to the population.

This study's findings follow the limitations confronting a proper assessment of ethnic populations with mental distress. In addition, it reinforces the urgent need for improved mental health assessments for this population, in which health professionals look at them, acknowledging their particularities and vulnerabilities, such as difficult health access, communication and cultural barriers and at-risk mental distress. It also emphasises how crucial the assessment step is in shaping the quality of mental health care provided as the starting-point interaction between GP and patient and a foundation for both of them to perceive each other, and the care received and provided, respectively. In order to improve the quality of care for at-risk populations, special consideration must be given to them.

Mismanagement of Mental Health Distress at General Practices

Another significant pattern in the participants' experiences while using the general practice settings was the feeling that their psychological distress and the need for mental health support were not acknowledged during consultations with GPs. This lack of recognition and understanding associated with dismissive responses from healthcare professionals designated to provide mental support was seen as exacerbating their despair, creating a sense of mistrust toward general practices as a safe setting to seek mental help. Due to insensitive responses, some participants perceive the GP as a professional unprepared to offer mental health support.

While this was not the experience of all participants, the finding suggests that for the majority of them, GPs inadequately addressed the mental distress of some individuals by failing to acknowledge their needs and circumstances. They lacked the welcome and support a health professional should provide while offering mental health care to a vulnerable population such as migrants. The dismissive response to explicit requests for help transcends the absence of a competent assessment that enables the diagnosis of specific disorders; it reveals a marked lack of empathy and unwillingness to assist individuals seeking assistance.

This study's finding aligns with the finding obtained by Whitley et al. (2006), in which migrants in Canada perceived a lack of time and a dismissive attitude from their doctors during interactions, creating the perception of an uncaring and hostile attitude towards them. Their study also found that these experiences acted as a barrier for migrants seeking further mental health support and contributed to this population's underuse of these healthcare settings. From a different perspective of dismissive behaviour from health professionals in general practice settings, Hamilton et al. (2016), also in Canada, found in their qualitative analysis of mental health service users' experiences of discrimination that dismissive behaviour from health professionals emerged as a notable form of discrimination within the context of mental health services, and further intensified the individuals' mental distress.

On the other hand, Peñuela-O'Brien et al. (2023) found that delivering care in the context of cultural differences is challenging as health professionals and migrants may share a "lack of" or a "different" understanding of mental health problems concepts. This can occur mostly because health professionals lack knowledge of migrants' cultural background, which leads to misunderstanding what is considered a socially acceptable response or what indicates psychopathology. Besides that, the language barrier between them can add a stressor to the situation. They suggested numerous strategies to overcome this problem within the migrant population, such as flexibility to offer them longer consultations, effective collaboration with voluntary organisations to support their additional needs, specialist supervision for health professionals, partnerships with migrant communities, and adopting a person-centred approach.

This present study's findings add to the knowledge of migrant and mental health experiences within the New Zealand primary care context. Further research is needed to explore the contextual factors to identify the issues of dismissive behaviour from health professionals to the Latin American women's population seeking mental health support in general practice settings. However, it is crucial to recognise the significant concern of missed opportunities in supporting this population at a higher risk of mental health access and distress, either by unskilled health professionals, the lack of health professionals with cultural competency or due to discrimination.

5.2.2 "Connecting with Primary Health Services For Mental Health Needs"

Lastly, the theme "Connecting with General Practices for Mental Health Needs" combines participants' perceptions of care generated from their experiences of accessing and utilising primary health care services for mental health needs. The subtheme "Effects of the Mental Assistance Received in the Recovery Process" explores the participants' experiences receiving support in the general practice setting and their perception of care regarding the direction given and their recovery. The data shows that Latin American women migrants in New Zealand perceived the mental health support delivered in the general practice services in New Zealand as insufficient to reach their recovery, leading them to find alternative methods of relieving their mental distress.

Continuous Help-Seeking Behaviour After Mental Health Support

All participants who received mental health attention from their GPs pursued help-seeking strategies from additional mental health services in New Zealand, engaged with self-oriented methods and substance use or sought a mental health professional in Brazil to ease their mental distress. They justified these behaviours due to insufficient explanations about the proposed treatment plan or the mental health diagnosis, proposed strategies incompatible with their realities and possibilities of execution or, in some cases, a total lack of an intervention plan presented by the GP to alleviate their symptoms.

This finding aligns with previous research that suggests that migrants have a negative attitude toward psychotropics, preferring that health professionals adopt a more holistic approach in the clinical encounter, addressing not only health issues but also social problems to draw the treatment plan (Whitley et al., 2006). The behaviours of overprescribing medication and lack of tailored assistance tend to make the migrant population perceive the treatment they received from their doctors as ineffective. Furthermore, the dissatisfaction with treatment strategies can also be influenced by the barriers that migrant populations face in primary care settings, such as language barriers, cultural differences, and discrimination, which usually result in a higher incidence of misdiagnosis, underdiagnosis, and referral to inappropriate services (Dow, 2011; Teunissen et al., 2014). Migrants, after all, have reported that health professionals and services usually do not understand their needs (Chiang et al., 2021; Roth et al., 2021).

The utilisation of health care settings for mental health support is influenced by migrants' help-seeking patterns and the legal framework of the host country (Lindert et al., 2020). Little is known regarding the Latin American population's mental help-seeking behaviour in New Zealand. In the UK, Gideon (2011) explored the health-seeking strategies of Latin American migrants in London and observed multiple barriers to this specific population's access to the NHS and a range of alternative approaches they found to solve their health problems. He found, for example, that a considerable number of Latin Americans, rather than use the NHS, telephone a doctor “back home” to consult with them and receive a more personal approach. This strategy was considered safer to resolve their problems, as they better trusted doctors in their country of origin. Gideon also found that Latin American migrants in London mistrust the NHS quality of treatments and commonly self-diagnose and self-medicate themselves.

In Finland, Roth et al. (2021) found that non-European migrants prefer to use unprofessional help strategies to deal with their mental distress, such as self-care, support from family members, or religious assistance. The migrant population in their study suggested that recruiting staff members from immigrant backgrounds, providing services in their native language, and offering information on topics like mental health and religion, women’s rights, and providing them with the ability to make their own choices could improve their access and adherence to treatments.

Still, regarding migrants’ help-seeking behaviour, it is important to highlight that migration is associated with an increased pattern of alcohol abuse (Gutmann, 1999; Lopez et al., 2004). In New Zealand, there are ethnic disparities in alcohol consumption and substance misuse among women. These disparities are closely linked to acculturation stress, a sense of cultural disconnection and mental health distress (Patterson et al., 2018; Policy Briefing Paper, 2013; Todd, 2011). In the US, Latin American women migrants are more prone to experiencing depression and alcohol consumption at an earlier stage and longer than the non-Latina population (Valdez et al., 2018). Recent studies in the US also suggested that Latin migrants may be at a heightened risk of developing prescription drug misuses, such as opioids, benzodiazepines, and cannabis (Peteet, 2019; Westrick et al., 2022). The tendency to alcohol and drug misuse as a coping strategy to deal with mental distress among this population should be further explored in New Zealand.

Ultimately, this study’s findings are congruent with the empirical literature that negative experiences with doctors in general practice settings may influence migrants’ future attitudes toward mental health professionals and treatments (Whitley et al., 2006). Conversely, positive help-seeking past experiences with mental health services can help mitigate negative beliefs and stigma surrounding help-seeking, making it crucial in promoting future help-seeking behaviour for mental health issues (Roth et al., 2021).

5.3 Recommendations

The study's findings enabled a critical discussion about the effect of low health literacy on the access to mental health services among Latin American women migrants in New Zealand. Recognising the importance of having a high level of understanding regarding the available mental health services to seek help is essential to guarantee that this community feels adequately supported in New Zealand. Improving communication and raising mental health awareness promotes an enhanced decision-making process through timely access and early support.

In this sense, early post-arrival and continuous mental health education resources focused on Latin American women migrants in New Zealand present an essential mental health promotion measure. Facilitating mental health information to enhance mental health awareness and access among this population will likely require healthcare organisations to create or strengthen their engagement and connections to the specific community. Mental health information resources for this minority ethnic group should include culturally appropriate messages to resonate with the community's context, ensuring they are responsive and meaningful to the intended audience. Language barriers must also be considered to guarantee effective health communication.

The findings also shed light on the general practice setting as a barrier that Latin American migrant women perceived to accessing psychological therapy services to deal with mental distress. Enabling direct access to psychological therapy services has the potential to enhance mental healthcare for this population. Direct access would provide a sense of security and trust, allowing them to disclose their emotional issues to a dedicated and competent professional. This approach would also help dispel the notion that GPs are insufficiently equipped to meet their mental health needs, thereby fostering greater reliance on GPs for other medical concerns while promoting specialised psychological therapy services as a distinct and essential aspect of mental healthcare.

Psychological therapy services should be equipped with professionals who are skilled and hold tools to refer these women to general practices or directly to psychiatric services in case they receive patients that seek psychological therapy exclusively but present with a need for medical mental health support, a referral should occur. Patients with mild mental health needs should be then referred to general practices, and patients with moderate to severe mental health needs to psychiatrists, ensuring a continuum of care from less to complex mental health care. Psychological therapy services, then, should help in a coordinated role and address complicated mental health issues.

Collaborative networks between psychological therapy services, general practices and psychiatrists should be encouraged to ensure a comprehensive approach to this community's mental healthcare. A multidisciplinary approach within services where healthcare professionals exchange skills and knowledge regarding individuals' determined psychological and social aspects is likely to enhance the effectiveness and quality of mental healthcare offered to this minority ethnic population.

The findings also showed that the relationship between members of this community and the GP is powerful in offering quality care. The GP's interest, availability and efforts to understand the individual in front of them laid the foundation for building positive relationships in these settings and promoted the participants' confidence in their assistance. Therefore, practical recommendations to enable and strengthen this relationship involve an extended duration of consultations where GPs encourage open and non-judgmental communication during the assessment process, creating a safe space for individuals to express their concerns and experiences. These women must also be enabled to actively participate in their care planning and decision-making processes, sharing their ideas about what methods and approaches are effective for their recovery..

Developing training programs and resources for healthcare professionals to enhance their cultural competency and sensitivity to these women's specific needs presents valuable for improving the quality of care provided to this population. Health professionals must acknowledge and have special consideration for this population's vulnerabilities to better perceive and address potential challenges and risks there might be. This attentiveness will lead to more tailored and effective care. Another valuable measure to be considered in the sense of skilled health professionals is recruiting more professionals with a migrant background to exchange knowledge and sensitivity with other professionals and embrace migrant communities.

Lastly, there is a latent need for migrant research to focus on Latin American migrant women's mental health in New Zealand. Women's mental health and all aspects connected with their well-being are ever-evolving subjects that demand meticulous and sensitive examination. Participatory action research could encourage and help these women to raise their voices and enhance their citizenship rights in New Zealand, contributing to a better understanding of their needs and an improved sense of belonging and well-being in the country.

5.4 Strengths and Limitations

Exploring the Latin American population in New Zealand was both a strength and a limitation during the recruitment process. As discussed earlier, the Latin American community in New Zealand consists of 11 different countries. They present as a heterogenous group with some similarities but many specificities. Recruiting women from this enormous group was challenging. At the same time that I, the researcher, a Latin American woman migrant, may have transmitted reciprocity in the advertisement and attracted many potential participants, as Spanish is not a language I have fluency in, I could not offer the same exchange for the interviews. A Spanish mediator was offered to them when they contacted me, and I believe that the language barrier played a role in them not proceeding. The result was the formation of a homogenous group of Latin American woman Brazilians who speak Portuguese.

At the same time, having a homogeneous group of Brazilian participants has shown strength in the study findings because it explored in depth the whole context and background of experiences and perceptions attached to such a specific population among Latin American women migrants in New Zealand. The transnational feminist theoretical framework that underpins the study gained power due to the participants' shared country of origin and overview of the concepts of health systems, gender roles and mental health. Healthcare systems in Latin America vary significantly among countries and are characterised by pronounced socioeconomic disparities. The accessibility and quality of healthcare services also differ among them, thereby influencing individuals' health-seeking behaviours. Moreover, there are distinct differences between the roles and responsibilities of health professionals in Latin America, impacting people's expectations regarding healthcare delivery (Nava et al., 2022).

Mental health *per se* is a sensitive subject, so the fact that the participants' recruitment was through online resources became challenging. There was no face-to-face interaction during the recruitment process, which may have been seen as a factor in the volunteers trusting and engaging with the research. Stigma and confidentiality might have interfered with their willingness to participate as well.

The sample size of eight women also presented a strength and a limitation. It was a strength because data saturation occurred during the interviews, with the participants sharing similar experiences meaning a collective understanding. However, even though the sample strategy change favoured the recruitment of women in more places in New Zealand, the sample size could have reached other areas in the communities, adding to a more comprehensive overview of experiences across New Zealand.

In addition, although the study was planned to involve participants in the data analysis phase by sharing the transcription and translation of their interviews with them to verify the interpretation of the data and, therefore, enhance its accuracy, in practice, it became a challenging strategy. In most cases, participants either faced difficulties in finding the time or found challenges with the translation. However, to ameliorate the setback and ensure a strategy to enhance the accuracy of my interpretations was being applied, I used techniques through the interviews, such as paraphrasing the participants' responses, summarising the order of events of the information they shared, and requesting clarification of the facts when I was uncertain of them. Additionally, at the end of each interview, I asked the participants permission to contact them if I found it difficult to hear their exact words during the transcription process or if I needed to confirm further information. As a last strategy, the findings are presented with illustrative quotes from the participants' voices This ensures that their perspectives are effectively conveyed and represented in the study.

Lastly, this study demonstrates its strength in giving voice to a minority ethnic population in New Zealand that faces multiple risk factors for marginalisation within society and appears little recognised in New Zealand's migrant policies.

5.5 Conclusion

This research aimed to explore the barriers and facilitators faced by Latin American women migrants when accessing and utilising primary health services for mental health care in New Zealand and how these experiences shape their perception of mental health care in the country. The literature reports an increased risk of mental distress associated with migrant women and limited healthcare access and use associated with gender and migrant status. Migrants, women and people experiencing mental health issues can be an overlapping group that experiences marginalisation in a society as they tend to experience lower levels of privilege and attention in the distribution of resources than the general population. Efforts to ensure that efficient mental healthcare is provided for them are essential to promote health and guarantee high levels of well-being among this population. General practice services, as the main setting where this population access and receive mental health support, must secure accessible, skilled and sensitive assistance.

The findings of this study based in New Zealand align with existing research, suggesting that globally Latin American women migrants have low mental health literacy regarding available support services to receive and continue to receive mental health assistance. The study revealed that the requirement to see the GP to obtain a referral for psychological therapy services in the public system was seen as a barrier to accessing timely and efficient mental health care, besides being invasive. Other findings were related to the perception that non-comprehensive medical assessments are inadequate for mental health support and that dismissive responses to mental distress complaints are due to a lack of empathy and mental health skills among general practitioners. Primary healthcare services were perceived as unreliable in addressing their mental health needs.

The significance of this research lies in its contribution to understanding the unique challenges faced by Latin American women migrants in accessing mental health care in New Zealand. Overall, the study suggests that barriers exist in regard to this population's access to timely and appropriate mental health support. Additionally, there are barriers to engaging Latin American women seeking mental health help in general practice services. After all, the study identified numerous missed opportunities for general practice services to respond to Latin American women migrants' requests for help.

When migrant women voluntarily seek mental health help, there is a valuable opportunity to offer immediate and quality care to relieve their distress, improve their quality of life and shape their reliance on these settings for future needs. Therefore, there is a pressing need for improvements in mental health care delivery to Latin American women migrants in New Zealand. This study makes recommendations that can be applied to guide these improvements, such as promoting mental health information, facilitating direct access to psychological therapy services, fostering collaborative participation of mental health care professionals to discuss individual subjectivities and intervention plans, a better quality of mental health assessments in general practice settings with extended duration consultations and professionals that show sufficient cultural sensitivity, recognition of the populations’ vulnerabilities, and who encourage their active participation in care planning.

In the last instance, it is essential to bridge the gaps between migrants’ needs and the healthcare system to provide appropriate support and address their mental health concerns to ensure equitable and effective mental health care. Future migrant research should focus on a deeper and longitudinal understanding of Latin American women migrants’ mental health status and needs in New Zealand, as well as encourage their co-participation in creating a more inclusive and supportive mental health care environment.

References

Akhtar, S. S., Heydon, S., & Norris, P. (2021). Access to the healthcare system: Experiences and perspectives of Pakistani immigrant mothers in New Zealand. *Journal of Migration and Health, 5*, 100077. https://doi.org/10.1016/j.jmh.2021.100077

Allwood C., O'Brien A., & Glue, P. (2019). Referrals from primary care to community mental health teams: What's missing? *Journal of Primary Health Care,* ***11*****(4)**, 334–341. https://doi.org/10.1071/HC19053

Andrulis, D. P., & Brach, C. (2007). Integrating literacy, culture, and language to improve health care quality for diverse populations. *American Journal of Health Behavior, 31*(Suppl. 1), S122–S133. https://doi.org/10.5555/ajhb.2007.31.supp.S122

Ashktorab, H., Pizuomo, A., González, N., Villagrana, E., Herrera-Solís, M. E., Cardenas, G., Zavala-Alvarez, D., Oskrochi, G., Awoyemi, E., Adeleye, F., Dalivand, M. M., Laiyemo, A. O., Lee, E. E., Aduli, F., Sherif, Z. A., & Brim, H. (2021). A comprehensive analysis of COVID-19 impact in Latin America. *Research Square,* rs.3.rs-141245. https://doi.org/10.21203/rs.3.rs-141245/v1

Babar, Z., Pengelly, K., Scahill, S. L., Garg, S., Shaw, J. (2013). Migrant health in New Zealand: Exploring issues concerning medicines access and use. *Journal of Pharmaceutical Health Services Research, 4*(1), 41–49. https://doi.org/10.1111/j.1759-8893.2012.00105.x

Baumeister, A., Chakraverty, D., Aldin, A., Seven, Ü. S., Skoetz, N., Kalbe, E., & Woopen, C. (2021). "The system has to be health literate, too" – Perspectives among healthcare professionals on health literacy in transcultural treatment settings. *BMC Health Services Research, 21*(1), 716. https://doi.org/10.1186/s12913-021-06614-x

Bearman, M. (2019). Focus on methodology: Eliciting rich data: A practical approach to writing semi-structured interview schedules. *Focus on Health Professional Education, 20*(3). https://doi.org/10.11157/fohpe.v20i3.387

Benjamen, J., Girard, V., Jamani, S., Magwood, O., Holland, T., Sharfuddin, N., Pottie, K. (2021). Access to refugee and migrant mental health care services during the first six months of the COVID-19 pandemic: A Canadian refugee clinician survey. *International Journal of Environmental Research and Public Health,* 18(10), 5266. https://doi.org/10.3390/ijerph18105266

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research, 4*, 2333393617742282. https://doi.org/10.1177/2333393617742282

Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101, DOI:10.1191/1478088706qp063oa

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Bywaters, D., & Walker, K. (2020). Purposive sampling: Complex or simple? Research case examples. *Journal of Research in Nursing, 25(*8), 652–661. https://doi.org/10.1177/1744987120927206

Carlisle, F. (2006) Marginalisation and ideas of community among Latin American migrants to the UK. *Gender & Development, 14*(2), 235–245. https://doi:10.1080/13552070600747230

Chiang, A., Simon-Kumar, R., & Peiris-John, R. (2021). A decade of Asian and ethnic minority health research in New Zealand: Findings from a scoping review. *The New Zealand Medical Journal, 134*(1542), 67–83.

Chung, D. W. K., Hall, K. H., Nie, J. B., & Jaye, C. (2022). “There is a huge need, and it’s growing endlessly”: Perspectives of mental health service providers to ethnic Chinese in Aotearoa New Zealand. *The New Zealand Medical Journal, 135*(1556), 62–72.

Connor, J., Madhavan, S., Mokashi, M., Amanuel, H., Johnson, N. R., Pace, L. E., & Bartz, D. (2020). Health risks and outcomes that disproportionately affect women during the Covid-19 pandemic: A review. *Social Science & Medicine*, (266), 113364. https://doi.org/10.1016/j.socscimed.2020.113364

Czapka, E. A., & Sagbakken, M. (2016). “Where to find those doctors?” A qualitative study on barriers and facilitators in access to and utilization of health care services by Polish migrants in Norway. *BMC Health Services Research, 16*(1), 460. https://doi.org/10.1186/s12913-016-1715-9

DeSouza, R. (2004). Motherhood, migration and methodology: Giving voice to the other. *The Qualitative Report, 9*(3), 463-482. https://doi.org/10.46743/2160-3715/2004.1919

Dew, K., Dowell, A., McLeod, D., Collings, S., & Bushnell, J. (2005). “This glorious twilight zone of uncertainty”: Mental health consultations in general practice in New Zealand. *Social Science & Medicine, 61*(6), 1189–1200. https://doi.org/10.1016/j.socscimed.2005.01.025

Dewey, T. B. (2022). Migration flows, communities, cultural practices and gender: A literature review of Latin American migration to

Australia. Journal of Iberian and Latin American Research, *28*(2), 202–220. https://doi.org/10.1080/13260219.2022.2132271

Dow, H. D. (2011). Migrants' mental health perceptions and barriers to receiving mental health services. *Home Health Care Management & Practice, 23*(3), 176–185. doi:10.1177/1084822310390876

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing, 25*(5), 443–455. https://doi.org/10.1177/1744987119880234

Dürr, E. (2011). To belong in Aotearoa New Zealand: Latin American migrant experiences in multicultural Auckland. *Journal of Ethnic and Migration Studies, 37*(3), 503–519.

Every-Palmer, S., Jenkins, M., Gendall, P., Hoek, J., Beaglehole, B., Bell, C., Williman, J., Rapsey, C., & Stanley, J. (2020). Psychological distress, anxiety, family violence, suicidality, and wellbeing in New Zealand during the COVID-19 lockdown: A cross-sectional study. *PLOS ONE, 15*(11), e0241658. https://doi.org/10.1371/journal.pone.0241658

Finlay, L. (2006). 'Rigour', 'ethical integrity' or 'artistry'? Reflexively reviewing criteria for evaluating qualitative research. *British Journal of Occupational Therapy, 69*(7), 319–326. https://doi.org/10.1177/030802260606900704

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., McCarthy, S., & Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC Health Services*

Research, 18(1), 120. https://doi.org/10.1186/s12913-018-2915-2

Gideon, J. (2011) Exploring migrants' health seeking strategies: The case of Latin American migrants in London. *International Journal of Migration, Health and Social Care, 7* (4), 197–208. https://doi.org/10.1108/17479891111206328

Guadagno, L. (2020). Migrants and the COVID-19 pandemic: An initial analysis. *Migration Research Series N° 60.* International Organization for Migration.

Gutmann M. C. (1999). Ethnicity, alcohol, and acculturation. *Social Science & Medicine, 48*(2), 173–184. https://doi.org/10.1016/s0277-9536(98)00325-6

Hamilton, S., Pinfold, V., Cotney, J., Couperthwaite, L., Matthews, J., Barret, K., Warren, S., Corker, E., Rose, D., Thornicroft, G., Henderson, C. (2016). Qualitative analysis of mental health service users' reported experiences of discrimination. *Acta psychiatrica Scandinavica*, *134 Suppl 446* (Suppl Suppl 446), 14–22. https://doi.org/10.1111/acps.12611

Hartdegen, M., Gibson, K., Cartwright, C., & Read, J. (2017). Stressful events and circumstances reported by patients prior to being prescribed antidepressants. *The New Zealand Medical Journal*, *130*(1448), 45–53.

Ho, E. S. (2004). Mental health of Asian immigrants in New Zealand: A review of key issues. *Asian and Pacific Migration Journal, 13*(1), 39–60.

Hoffman, L. N., & Papoutsaki, E. (2019). Mapping the communicative ecology of Latin American migrant women in New Zealand. *Pacific Journalism Review,* 25(1/2), 225–241.

https://search.informit.org/doi/10.3316/informit.526256712061929

Human Rights in New Zealand. (2010). Ngā Tika Tangata O Aotearoa. Human Rights Commission.

International Organization for Migration. (2019). Anuall Report 2019. https://www.iom.int/resources/annual-report-2019

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing, 72*(12), 2954–2965. https://doi.org/10.1111/jan.13031

Kanengoni, B., Andajani-Sutjahjo, S., & Holroyd, E. (2018). Setting the stage: Reviewing current knowledge on the health of New Zealand immigrants: An integrative review. *PeerJ, 6*, e5184. https://doi.org/10.7717/peerj.5184

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of qualitative descriptive studies: A systematic review. *Research in Nursing & Health, 40*(1), 23–42. https://doi.org/10.1002/nur.21768

Kirchner, T., & Patiño, C. (2011). Latin-American immigrant women and mental health: Differences according to their rural or urban origin. *The Spanish Journal of Psychology, 14*(2), 843–850. https://doi.org/10.5209/rev_sjop.2011.v14.n2.31

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., Pottie, K., & Canadian Collaboration for Immigrant and Refugee Health. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ: Canadian Medical*

Association Journal, 183(12), E959–E967. https://doi.org/10.1503/cmaj.090292

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications.

Lindenmeyer A, Redwood S, Griffith L, Teladia, Z. & Philimore, J. (2016). Experiences of primary care professionals providing healthcare to recently arrived migrants: A qualitative study. *BMJ Open*. https://doi: 10.1136/bmjopen-2016-012561

Lindert, J., Schouler-Ocak, M., Heinz, A., & Priebe, S. (2008). Mental health, health care utilisation of migrants in Europe. *European Psychiatry, 23*(S1), S114-S20. doi:10.1016/S0924-9338(08)70057-9

Llácer, A., Zunzunegui, M. V., del Amo, J., Mazarrasa, L., & Bolumar, F. (2007). The contribution of a gender perspective to the understanding of migrants' health. *Journal of Epidemiology and Community Health, 61*(Suppl. 2), ii4–ii10. https://doi.org/10.1136/jech.2007.061770

Lopez, O., Haigh, C., & Burney, S. (2004). Relationship between hardiness and perceived stress in two generations of Latin American migrants. *Australian Psychologist,* 39(3), 238–243. https://doi.org/10.1080/00050060412331295054.

Lunnay, B., Foley, K., Meyer, S. B., Warin, M., Wilson, C., Olver, I., Miller, E. R., Thomas, J., Ward, P. R. (2021). Alcohol consumption and perceptions of health risks during COVID-19: A qualitative study of middle-aged women in South Australia. *Frontiers in Public Health, 9*, 401. https://doi:10.3389/fpubh.2021.616870

Machado, S., Tayyar, E., Berry, N. S., Lavergne, R., Wiedmeyer, M. L., Krüsi, A., & Goldenberg, S. (2022). "It's not just about being here, but what brought you here”: A qualitative study of the role of migration experiences in shaping im/migrant women’s access to healthcare. *Health & Place, 77*, 102888. https://doi.org/10.1016/j.healthplace.2022.102888

MacIntyre, G., Cogan, N.A., Stewart, A.E., Quinn, N., Rowe, M. & O’Connell, M. (2019). What’s citizenship got to do with mental health? Rationale for inclusion of citizenship as part of a mental health strategy. *Journal of Public Mental Health, 18* (3), 157–161. https://doi.org/10.1108/JPMH-04-2019-0040

MaGPIe Research Group (2005). The effectiveness of case-finding for mental health problems in primary care. *The British Journal of General Practice*, *55*(518), 665–669.

MaGPIe Research Group. (2006). The treatment of common mental health problems in general practice. *Family Practice, 23*(1), 53–59. https://doi.org/10.1093/fampra/cmi097

McDonald, R., Vechi, C., Bowman, J., & Sanson-Fisher, R. (1996). Mental health status of a Latin American community in New South Wales. *The Australian and New Zealand Journal of Psychiatry,* *30*(4), 457–462. https://doi.org/10.3109/00048679609065017.

Mendoza, B. (2002). Transnational feminisms in question. *Feminist Theory,* *3*(3), 295–314. https://doi.org/10.1177/146470002762492015

Ministry for Women. (2019). Gender inequality and unpaid work: A review of recent literature. Author.

Ministry of Health (2001). *The Primary Health Care Strategy*. http//www.moh.govt.nz

Ministry of Health. (2010). Kōrero Mārama: Health literacy and Māori results from the 2006 Adult Literacy and Life Skills Survey.

Author. https://www.health.govt.nz/publication/korero-marama-health-literacy-and-maori-results-2006-adult-literacy-and-life-skills-survey

Ministry of Health. (2012). Rauemi Atawhai: A guide to developing health education resources in New Zealand. Author. https://www.health.govt.nz/publication/rauemi-atawhai-guide-developing-health-education-resources-new-zealand

Montenegro, M., Capdevila, R. & Sarriera, F. H. (2011). Towards a transnational feminism: Dialogues on feminisms and psychologies in a Latin American context. *Feminism & Psychology, 22*(2) 220–227.

Mulder, R. T., Bastiampillai, T., Jorm, A., & Allison, S. (2022). New Zealand's mental health crisis, He Ara Oranga and the future. *The New Zealand Medical Journal*, *135*(1548), 89–95.

Nava, A., Estrada, L., Gerchow, L., Scott, J., Thompson, R., & Squires, A. (2022). Grouping people by language exacerbates health inequities – The case of Latinx/Hispanic populations in the US. *Research in Nursing & Health*, *45*(2), 142–147. https://doi.org/10.1002/nur.22221

Neergaard, M. A., Olesen, F., Andersen, R. S., Andersen, S., R., & Sondergaard, J. (2009). Qualitative description – The poor cousin of health research? *BMC Medical Research Methodology, 9*, 52. https://doi.org/10.1186/1471-2288-9-52

New Zealand Productivity Commission. (2021). *International migration to New Zealand: Future opportunities and challenges* (NZPC Working Paper No. 2021/09). www.productivity.govt.nz/intl-migration

New Zealand Mental Health and Wellbeing Commission (2022). Te Huringa: Change and Transformation. Mental Health Service and Addiction Service Monitoring Report 2022. Wellington: New Zealand. https://www.mhwc.govt.nz/assets/Te-Huringa/FINAL-MHWC-Te-Huringa-Service-Monitoring-Report.pdf

Patterson et al., 2018. *Report of the Government Inquiry into Mental Health and Addiction*. https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/

Parisi, L., & Thornton, L. (2012). Connecting the local with the global: Transnational feminism and civic engagement. *Feminist Teacher, 22*(3), 214–232. https://doi.org/10.5406/femteacher.22.3.0214

Parker, D., Byng, R., Dickens, C., Kinsey, D., & McCabe, R. (2020). Barriers and facilitators to GP–patient communication about emotional concerns in UK primary care: A systematic review. *Family Practice, 37*(4), 434–444. https://doi.org/10.1093/fampra/cmaa002

Peñuela-O'Brien, E., Wan, M. W., Edge, D., & Berry, K. (2023). Health professionals' experiences of and attitudes towards mental healthcare for migrants and refugees in Europe: A qualitative systematic review. *Transcultural Psychiatry, 60*(1), 176–198. https://doi.org/10.1177/13634615211067360

Peteet B. J. (2019). Psychosocial risks of prescription drug misuse among U.S. racial/ethnic minorities: A systematic review. *Journal of Ethnicity in Substance Abuse, 18*(3), 476–508. https://doi.org/10.1080/15332640.2017.1381662

Pinedo, M., Zemore, S., & Rogers, S. (2018). Understanding barriers to specialty substance abuse treatment among Latinos. *Journal* *of Substance Abuse Treatment, 94*, 1–8. https://doi.org/10.1016/j.jsat.2018.08.004

Policy Briefing Paper. (2013). Women and alcohol in Aotearoa/New Zealand – Te waipiro me ngā wāhine i Aotearoa. Alcohol Healthwatch and Women's Health Action.

Ponce, A. N., & Rowe, M. (2018). Citizenship and community mental health care. *American Journal of Community Psychology, 61*(1–2), 22–31. https://doi.org/10.1002/ajcp.12218

Priebe, S., Matanov, A., Schor, R., Straßmayr2, C., Barros, H., Barry, M. M., Díaz-Olalla, J. M., Gabor, E., Greacen, T., Holcnerová, P., Kluge, U., Lorant, V., Moskalewicz, J., Aart H Schene, A. H., Macassa, G., & Gaddini, A. Good practice in mental health care for socially marginalised groups in Europe: A qualitative study of expert views in 14 countries. *BMC Public Health, 12*, 248. https://doi.org/10.1186/1471-2458-12-248

Roguski, M., & McBride-Henry, K. (2020). The failure of health promotion for marginalised populations. *Australian and New Zealand Journal of Public Health, 44*(6), 446–448. https://doi.org/10.1111/1753-6405.13048

Roth, M., Lahti, M., Gustafsson, N., Berg, J., Kaitala, E., & Kuosmanen, L. Non-European immigrants' self-described strategies for mental health promotion and perceptions of Finnish mental health services: A qualitative descriptive analysis. *Perspectives in Psychiatric Care, 58*(4), 3016–3023. https://doi.org/10.1111/ppc.13096

Salas-Wright, C. P., Vaughn, M. G., Goings, T. C., Miller, D. P., Chang, J., & Schwartz, S. J. (2018). Alcohol-related problem behaviors among Latin American immigrants in the US. *Addictive*

Behaviors, 87, 206–213. https://doi.org/10.1016/j.addbeh.2018.06.031

Sandelowski M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*(4), 334–340. https://doi.org/10.1002/1098-240x

Sa'u Lilo, L., Tautolo, E.-S., & Smith, M. (2020). Health literacy, culture and Pacific peoples in Aotearoa, New Zealand: A review. *Pacific Health, 3*. https://doi.org/10.24135/pacifichealth.v3i0.4

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, *52*(4), 1893–1907. https://doi.org/10.1007/s11135-017-0574-8

Schiffer, K. & Schatz, E. (2008) Marginalisation, social inclusion, and health: Experiences based on the work of correlation. *European Network Social Inclusion & Health.* https://www.drugsandalcohol.ie/11927/1/Correlation_marginalisation_web.pdf

Shelton, S. A., & Flint, M. A., (2019). The value of transcription in encouraging researcher reflexivity. https://doi.org/10.4135/9781526477705

Simon-Kumar, R. (2018). Inclusionary policy and marginalised groups in Aotearoa/New Zealand process, impacts and politics. *Kōtuitui: New Zealand Journal of Social Sciences Online, 13*(2), 246–260. https://doi:10.1080/1177083X.2018.1488750

Smith, J. A., & Ireland, S. (2020). Towards equity and health literacy. *Health Promotion Journal of Australia, 31*(1), 3–4. https://doi:http://dx.doi.org/10.1002/hpja.317

Stats NZ (2019). 2018. Census data user guide. www.stats.govt.nz

Sullivan, C., Vaughan, C. & Wright, J. (2020). Migrant and refugee women's mental health in Australia: A literature review. School of Population and Global Health. https://www.mcwh.com.au/wp-content/uploads/Lit-review_mental-health.pdf

Sullivan-Bolyai, S., Bova, C., & Harper, D. (2005). Developing and refining interventions in persons with health disparities: The use of qualitative description. *Nursing Outlook, 53*(3), 127–133. https://doi.org/10.1016/j.outlook.2005.03.005

Sullivan-Bolyai S. L. & Bova, C. A. (2021). *Qualitative description: A "how-to" guide*. University of Massachusetts Medical School Publications. https://doi.org/10.13028/8vwe-xc61

Teunissen, E., Sherally, J., van den Muijsenbergh, M., Dowrick, C., van Weel-Baumgarten, E., & van Weel, C. (2014). Mental health problems of undocumented migrants (UMs) in the Netherlands: A qualitative exploration of help-seeking behaviour and experiences with primary care. *BMJ Open, 4*(11), e005738. https://doi.org/10.1136/bmjopen-2014-005738

Thomas, D. R., Arlidge, B., Arroll, B., & Elder, H. (2010). General practitioners' views about diagnosing and treating depression in Maori and non-Maori patients. *Journal of Primary Health Care, 2*(3), 208–216.

Todd, F.C. (2010). *Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems*. Ministry of Health.

Turale, S. (2020). A brief introduction to qualitative description: A research design worth using. *Pacific Rim International Journal* *of Nursing Research, 24*(3), 289–291. https://he02.tci-thaijo.org/index.php/PRIJNR/article/view/243180

Umut, E. & Reynolds, T. (2018) Introduction: Migrant mothers challenging racialised citizenship. *Ethnic and Racial Studies, 41*(1), 1–16. https://doi: 10.1080/01419870.2017.1334939

Undurraga, R. (2012). Interviewing women in Latin America: Some reflections on feminist research practice. *Equality, Diversity and Inclusion: An International Journa*l*, 31*(5), 418–434. http://dx.doi.org/10.1108/02610151211235442

Upegui-Hernández, D. (2012). What is missing in the transnational migration literature? A Latin American feminist psychological perspective. *Feminism & Psychology, 22*(2), 228–239. https://doi.org/10.1177/0959353511415831

Valdez, L. A., Garcia, D. O., Ruiz, J., Oren, E., & Carvajal, S. (2018). Exploring structural, sociocultural, and individual barriers to alcohol abuse treatment among Hispanic men. *American Journal of Men's Health,* 1948–1957. https://doi.org/10.1177/1557988318790882

Westrick, A. C., Vazquez, V., De La Rosa, M., Romano, E., Rojas, P., & Sanchez, M. (2022). Prescription drug and cannabis use among recent Latinx immigrants pre- and post-immigration to the US. *Substance Use & Misuse, 57*(2), 175–184. https://doi.org/10.1080/10826084.2021.1990342

Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: A qualitative study from Montreal. *The Canadian Journal of Psychiatry, 51*(4), 205–209. https://doi.org/10.1177/070674370605100401

WOMHEn. (2021). Left behind: Migrant and refugee women's experience of COVID-19. Author. https://www.genvic.org.au/wp-content/uploads/2021/10/LeftBehindWOMHEnReport61021FINAL.pdf

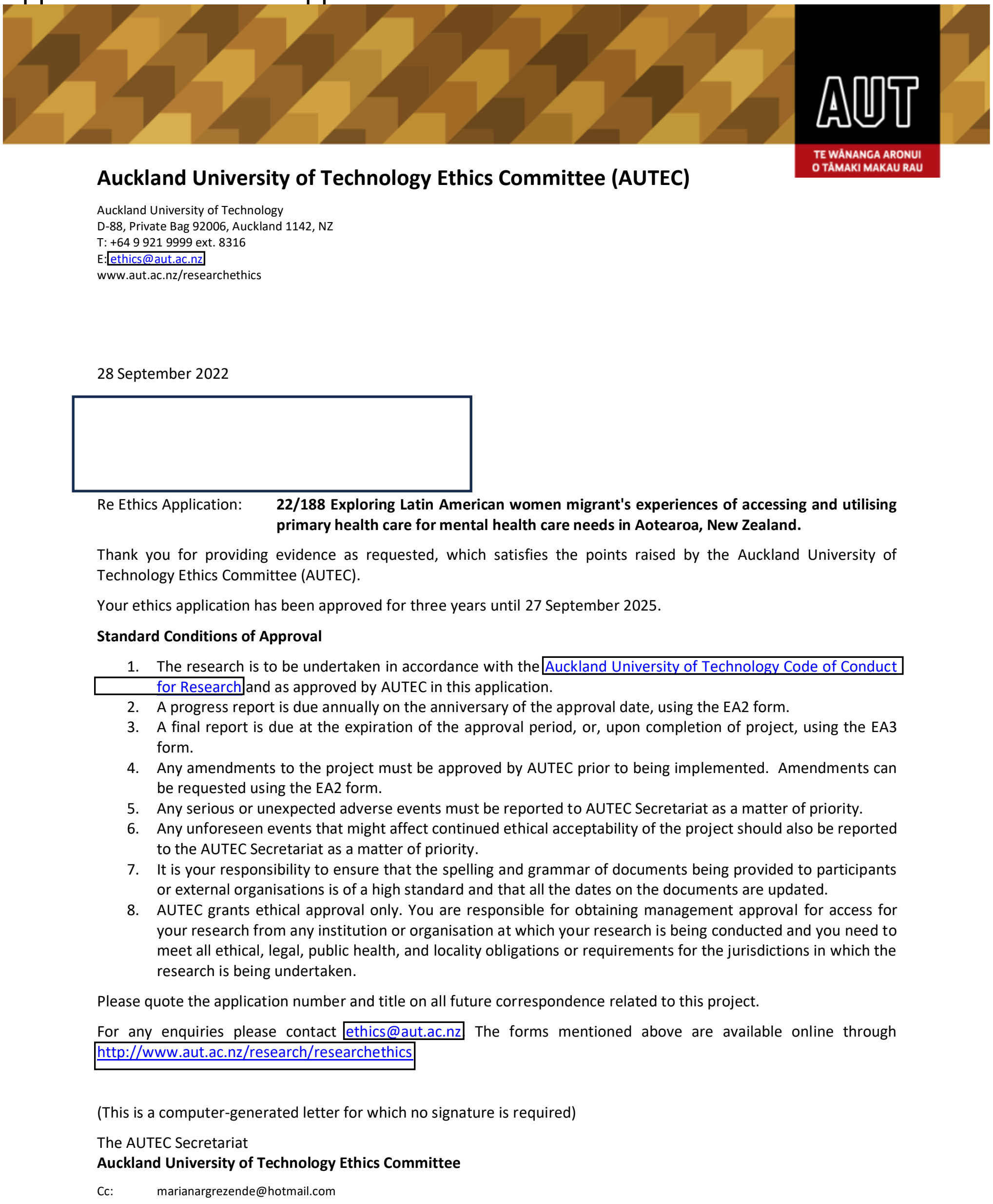
Xiang, V., Parackal, S., Gurung, G., & Subramaniam, R. M. (2023). Asian migrants navigating New Zealand primary care: A qualitative study. *Journal of Primary Health Care, 15*(1), 30–37. https://doi.org/10.1071/HC22132

Zhao, X., Akbaritabar, A., Kashyap, R., & Zagheni, E. (2023). A gender perspective on the global migration of scholars. *Proceedings of the National Academy of Sciences of the United States of America*, *120*(10), e2214664120. https://doi.org/10.1073/pnas.2214664120

Zerbe Enns, C., Díaz, C., L. & Bryant-Davis, T. (2021) Transnational feminist theory and practice: An introduction. *Women & Therapy,* *44*(1–2), 11–26. https://doi.org/10.1080/02703149.2020.1774997

Appendices

Appendix A – AUTEC Approval



Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

28 September 2022

[redacted]

Re Ethics Application: **22/188 Exploring Latin American women migrant's experiences of accessing and utilising primary health care for mental health care needs in Aotearoa, New Zealand.**

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 27 September 2025.

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.
8. 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: marianargrezende@hotmail.com

Appendix B – AUTEC Approval of Amendments

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

4 November 2022

[redacted]

Re: Ethics Application: **22/188 Exploring Latin American women migrant's experiences of accessing and utilising primary health care for mental health care needs in Aotearoa, New Zealand.**

Thank you for your request for approval of amendments to your ethics application.

The minor amendment to the inclusion criteria (New Zealand) is approved.

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.
8. 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. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

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: marianargrezende@hotmail.com

Appendix C – Participant Information Sheet in English

Appendix B: Participant Information Sheet

Date Information Sheet Produced:__________

Project Title

Exploring Latin American women migrant's experiences of accessing and utilising primary health care for mental health care needs in Aotearoa, New Zealand.

An Invitation

My name is Mariana Ribeiro Garcia de Rezende. I am a student completing my master's degree of Health Practice at Auckland University of Technology. I am interested in learning more about the experiences and perceptions of Latin American women migrants who seek mental health care at primary health services (General Practitioner, GP) in New Zealand.

I invite you to consider volunteering for an interview for this research. I am the researcher, and I will also be the interviewer. Your participation in this research is voluntary, and you can withdraw at any time for any reason. You will not be disadvantaged in any way if you do not choose to participate in this research.

This study is being conducted as part of my practice project to conclude my Master program. The brief version of the study will be submitted for publication to appropriate academic health journals. The findings of the study may also be introduced to the Latin American community at community group meetings and submitted for publication in organizations' newsletters.

Taking part in this study is voluntary (your own choice). You can choose to be interviewed in your native language, English, Portuguese, or Spanish. If Spanish is your preferred language, a translator will be present. Please take the time to read this Participant Information Sheet and the Informed Consent Form and decide whether to participate in this study. Please feel free to discuss any of your concerns about the project with the researcher.

What is the purpose of this research?

The purpose of the study is:

1. To understand barriers to access and utilise primary health services for mental health care in Aotearoa, New Zealand.
2. To understand facilitators to access and utilise primary health services for mental health care in Aotearoa, New Zealand.
3. To explore the effect of these experiences on their perceptions of mental care services in Aotearoa, New Zealand
4. To pose recommendations for guiding improvement in mental health care practices for Latin American women migrants in Aotearoa, New Zealand.

The findings of this research may be used for academic publications and presentations.

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:

- ☐ Latin American women
- ☐ Migrants who currently live in the Marlborough region
- ☐ Over 18 years old
- ☐ With the experience of having accessed New Zealand's primary care services in the Marlborough region in the last five years seeking mental health care

How do I agree to participate in this research?

My contact details are provided below. Contact me, Mariana, if you are interested in participating in this study. I will invite you to sign the consent form before the interview begins.

Your participation in this research is voluntary (it is your choice) and whether you choose to participate will neither advantage nor disadvantage you. 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 will happen in this research?

The data collecting will occur during an individual interview of approximately 60 minutes. Prior to the interview, I will contact you to set a time if you agree to participate in the study. Due to the COVID-19 circumstances, the interview will be conducted over online technology, such as Zoom. I will support and guide you with organising Zoom connections and setting up prior to the interview.

Our discussion will be recorded, and some notes will also be taken to accurately document your story. I have prepared some questions that can guide and prompt our discussion and you are welcome to have a copy of this prior to the interview, alternatively I will provide a copy for you during the interview. Please note that these prepared questions are only a means of prompting our interview.

At the end of the interview, there will be a Socio-Demographic Characteristic Form to be completed.

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 research supervisor 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 discomfort and risk caused to you will be minimal since the interview will be a form that is like a daily conversation.

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.

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.

Throughout or after any period of the interview, in case of any psychological disturbance or discomfort, including suicidal ideations or behaviour, you have ensured psychological support through free services, such as:

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

☐ Health Point 08005676666

☐ Lifeline Aotearoa 0800 543 354 (suicidal thoughts or behaviour)

☐ Marlborough Community Assessment Team Contact details 0800 948 497 (24 hours a day, 7 days a week).

☐ AUT Student Counselling and Mental Health can provide up to three free sessions of counselling for research participants. If the participant wish to use the counselling sessions provided by AUT, they will need to identify the researcher and the research project they have been involved in when they make their appointment. The counselling provided for the Marlborough region will be online via a video call. Phone +64 9 921 9292 or email counselling@aut.ac.nz

What are the benefits?

You may benefit from thinking and talking about your experiences of accessing health and support services. The information you obtained from this study might help you experience fewer barriers to accessing health services in the future. In addition, your contribution may impact other Latin American women migrants in the future. The wider community may benefit as the researcher aims to improve the utilization of health services in New Zealand.

As a researcher, I can also benefit from this research project. I can have a deeper understanding of the field, improve my expertise during the research, and complete my qualification.

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 other participants. If the information is stored electronically this will be password protected. Only the research supervisor 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.

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 interview.

What opportunity do I have to consider this invitation?

Time will ge given prior to data collection for you to read the information sheet and consent form. If you have further questions there will be an opportunity for you to discuss and clarify this information. There is no obligation for you to participate in the study. You have up to two weeks to consider this information once you have received this information sheet. However, if you decide 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?

Yes, you will receive a copy of the summary of this study (1-2 pages), if you are interested.

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

Any concerns regarding this project or researcher should notify in the first instance to the Project Supervisors:

Professor Eleanor Holroyd:
[redacted]

Appendix D – Participant Information Sheet in Portuguese

Apêndice B: Folha de Informações do Participante

Ficha de Informação de Data Produzida: 09/2022

Título do Projeto

Investigando as experiências de mulheres migrantes latino-americanas de acesso e utilização de cuidados primários de saúde para necessidades de saúde mental em Aotearoa, Nova Zelândia.

Um convite

Meu nome é Mariana Ribeiro Garcia de Rezende. Eu estou concluindo meu mestrado em Ciências da Saúde na Universidade de Tecnologia de Auckland. Estou interessada em aprender mais sobre as experiências e percepções de mulheres migrantes latino-americanas que procuram cuidados de saúde mental nos serviços de saúde primários (Clínico Geral, GP), em Marlborough, Nova Zelândia.

Convido você a considerar se voluntariar para uma entrevista para esta pesquisa. Eu sou o pesquisadora e também serei o entrevistadora. Sua participação nesta pesquisa é voluntária e você pode desistir a qualquer momento por qualquer motivo. Você não será prejudicado de forma alguma se optar por não participar desta pesquisa.

Este estudo está sendo realizado como parte do meu projeto de prática para concluir meu programa de mestrado. A versão resumida do estudo será submetida para publicação em periódicos acadêmicos de saúde apropriados. Os resultados do estudo também podem ser apresentados à comunidade latino-americana em reuniões de grupos comunitários e enviados para publicação nos boletins das organizações.

A participação neste estudo é voluntária (sua escolha). Você pode optar por ser entrevistado em seu idioma nativo, inglês, português ou espanhol. Se o espanhol for seu idioma preferido, um tradutor estará presente. Por favor, leia esta Folha de Informações do Participante e o Termo de Consentimento Livre e Esclarecido antes de decidir se deseja participar deste estudo. Sinta-se à vontade para discutir qualquer uma de suas preocupações sobre o projeto comigo, caso tenha interesse.

Qual é o objetivo desta pesquisa?

1. Compreender as barreiras ao acesso e utilização dos serviços de saúde primários para cuidados de saúde mental em Aotearoa, Nova Zelândia.

2. Compreender os facilitadores para acessar e utilizar os serviços primários de saúde para cuidados de saúde mental em Aotearoa, Nova Zelândia.

3. Explorar o efeito dessas experiências em suas percepções de serviços de cuidados mentais em Aotearoa, Nova Zelândia

4. Propor recomendações para orientar a melhoria das práticas de atenção à saúde mental para mulheres migrantes latino-americanas em Aotearoa, Nova Zelândia.

Os resultados desta pesquisa podem ser usados para publicações e apresentações acadêmicas.

Por que estou sendo convidado a participar desta pesquisa?

Você está convidado a participar desta pesquisa se:

- mulheres latino-americanas
- Migrantes que atualmente vivem na região de Marlborough
- Maiores de 18 anos
- Com a experiência de ter acessado os serviços de atenção primária da Nova Zelândia na região de Marlborough nos últimos cinco anos em busca de cuidados de saúde mental

Se voce tem interesse em participar:

Meus dados de contato são fornecidos abaixo. Se deseja participar, por favor, contacte-me.

Convido você a assinar o formulário de consentimento antes do início da entrevista.

Sua participação nesta pesquisa é voluntária, e se você optar por nao participar, nao havera qualquer consequência a você. Você pode desistir do estudo a qualquer momento. Se você optar por se retirar do estudo, você terá a opção de remover quaisquer dados identificáveis como pertencentes a você ou permitir que eles continuem a ser usados. No entanto, uma vez que as descobertas tenham sido produzidas, a remoção de seus dados pode não ser possível.

O que vai acontecer nesta pesquisa?

A coleta de dados ocorrerá durante uma entrevista individual de aproximadamente 60 minutos. Se você concordar em participar do estudo, entrarei em contato para marcar o horário da entrevista. Devido às circunstâncias do COVID-19, a entrevista será realizada por meio de tecnologia online, como o Zoom. Vou apoiá-lo e orientá-lo na organização das conexões do Zoom e na configuração antes da entrevista.

Nossa discussão será gravada e algumas anotações também serão feitas para documentar com precisão sua história. Eu preparei algumas perguntas que podem orientar e estimular nossa discussão e você pode ter uma cópia disso antes da entrevista, ou durante a entrevista. Observe que essas perguntas preparadas são apenas um meio de solicitar nossa entrevista.

Ao final da entrevista, haverá uma Ficha de Caracterização Sociodemográfica a ser preenchida.

Após nossa entrevista, terei as gravações de áudio transcritas. Sua identidade não fará parte de nossa entrevista gravada, e eu me comprometo a manter sua privacidade e confidencialidade ao longo desta pesquisa. Comprometo-me a usar as informações apenas para os fins indicados no seu formulário de consentimento. Meu supervisor de pesquisa e eu seremos as únicas pessoas que terão acesso aos seus dados e nenhum terceiro terá acesso às informações que você forneceu como parte deste projeto de pesquisa.

Quais são os desconfortos e riscos?

Falar sobre sua experiência pode desencadear alguns problemas emocionais para você e isso pode causar desconforto. Espero que o desconforto e risco causados a você sejam mínimos, pois a entrevista será como uma conversa diária.

Como esses desconfortos e riscos serão aliviados?

Vou aconselhá-lo e lembrá-lo no início de nossa entrevista que, se preferer, você nao precisará responder a todas as perguntas, e isso de forma alguma afetará sua participação contínua no projeto de pesquisa.

Você pode desistir do estudo a qualquer momento. Se você optar por se retirar do estudo, você terá a opção de remover quaisquer dados identificáveis como pertencentes a você ou permitir que eles continuem a ser usados. No entanto, uma vez que as descobertas tenham sido produzidas, a remoção de seus dados pode não ser possível.

Ao longo ou após qualquer período da entrevista, em caso de qualquer perturbação ou desconforto psicológico, incluindo ideação ou comportamento suicida, voce tem assegurado apoio psicológico através de serviços gratuitos, tais como:

Linha de saúde 0800 611 116, www.healthpoint.co.nz

Ponto de Saúde 08005676666

Lifeline Aotearoa 0800 543 354 (pensamentos ou comportamento suicida).

Equipe de Avaliação da Comunidade de Marlborough Detalhes de contato 0800 948 497 (24 horas por dia, 7 dias por semana).

A AUT Aconselhamento Estudantil e Saúde Mental pode oferecer até três sessões gratuitas de aconselhamento para os participantes da pesquisa. Caso o participante deseje utilizar as sessões de aconselhamento oferecidas pela AUT, ele deverá identificar o pesquisador e o projeto de pesquisa em que esteve envolvido no momento do agendamento. O aconselhamento fornecido para a região de Marlborough será online por meio de uma videochamada.

Quais são os benefícios?

Você pode se beneficiar pensando e falando sobre suas experiências de acesso a serviços de saúde e apoio. As informações que iremos obter deste estudo podem ajudá-lo a enfrentar menos barreiras para acessar os serviços de saúde no futuro. Além disso, sua contribuição pode impactar outras mulheres migrantes latino-americanas no futuro. A comunidade em geral pode se beneficiar, pois essa pesquisa visa melhorar a utilização dos serviços de saúde na Nova Zelândia.

Como pesquisador, também posso me beneficiar deste projeto de pesquisa. Posso ter uma compreensão mais profunda da área, aprimorar meus conhecimentos durante a pesquisa e concluir minha qualificação.

Como minha privacidade será protegida?

Sua privacidade e confidencialidade de suas informações também serão protegidas, seus dados de entrevista armazenados, formulários de consentimento assinados e seus detalhes de contato serão armazenados e mantidos separadamente de outros participantes. Se as informações forem armazenadas eletronicamente, elas serão protegidas por senha. Apenas eu e meu orientador de pesquisa teremos acesso às suas informações, e estas serão acessadas apenas para os fins desta pesquisa. Conforme mencionado, nenhum terceiro terá acesso às suas informações.

Quais são os custos de participação nesta pesquisa?

Não há nenhum custo financeiro para você além do tempo necessário para nossa entrevista.

Que oportunidade tenho para considerar este convite?

Será dado tempo antes da coleta de dados para você ler a folha de informações e o formulário de consentimento. Se você tiver mais dúvidas, haverá oportunidade para você discutir e esclarecer essas informações. Não há nenhuma obrigação de você participar do estudo. Você tem até duas semanas para considerar essas informações depois de receber esta folha de informações. No entanto, se decidir antes, pode sempre contactar-me. Mais uma vez, por favor, esteja ciente de que sua não participação ou envolvimento não irá desfavorecê-lo de forma alguma.

Receberei feedback sobre os resultados desta pesquisa?

Sim, você receberá uma cópia do resumo deste estudo (1-2 páginas), se estiver interessado.

O que devo fazer se tiver dúvidas sobre esta pesquisa?

Quaisquer dúvidas sobre a natureza deste projeto devem notificar em primeira instância aos Supervisores do Projeto:

Preocupações com a condução da pesquisa devem ser comunicadas à Secretaria Executiva da AUTEC, ethics@aut.ac.nz, (+649) 921 9999 ramal 6038.

Com quem devo entrar em contato para obter mais informações sobre esta pesquisa?

Por favor, guarde esta Folha de Informações e uma cópia do Formulário de Consentimento para futura referência. Você também pode entrar em contato com a equipe de pesquisa da seguinte forma:

Dados de contato do pesquisador:

Appendix E – Informed Consent Form

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Appendix : Informed Consent Form

Project title: Exploring Latin American women migrant's experiences of accessing and utilising primary health care for mental health care needs in Aotearoa, New Zealand.

Project Supervisor: Professor Eleanor Holroyd

Researcher: Mariana Ribeiro Garcia de Rezende

○ I have read and understood the information provided about this research project in the Information Sheet dated _______________. The possible problems and solutions during the research process have been explained to me, and I can ask my own questions.

○ I understand that notes will be taken during my interview and that it will also be recorded 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, I will be offered the choice between having any data that is identifiable as belonging to me removed or allow 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:

……………………………………………………………………………………..

……………………………………………………………………………………..

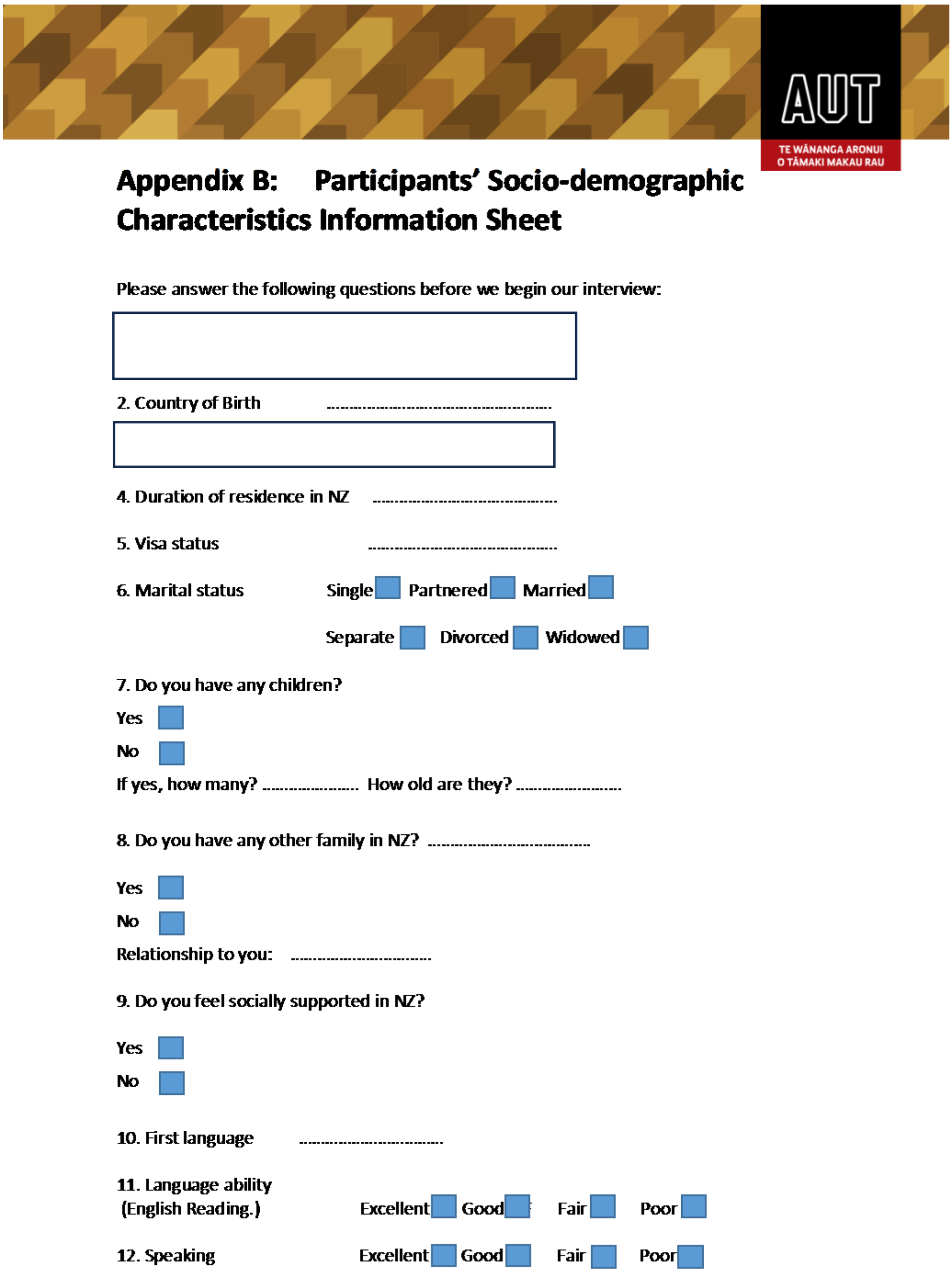
……………………………………………………………………………………..

……………………………………………………………………………………..

Date :

Approved by the Auckland University of Technology Ethics Committee on 09/2022 AUTEC Reference number 22/188.

Appendix F – Participants' Socio-Demographic Characteristics



Appendix B: Participants' Socio-demographic Characteristics Information Sheet

Please answer the following questions before we begin our interview:

[redacted]

2. Country of Birth ………………………………………………

[redacted]

4. Duration of residence in NZ ……………………………………

5. Visa status ………………………………………

6. Marital status Single ☐ Partnered ☐ Married ☐

Separate ☐ Divorced ☐ Widowed ☐

7. Do you have any children?

Yes ☐

No ☐

If yes, how many? …………………… How old are they? ……………………

8. Do you have any other family in NZ? ………………………………

Yes ☐

No ☐

Relationship to you: ……………………………

9. Do you feel socially supported in NZ?

Yes ☐

No ☐

10. First language ……………………………

11. Language ability (English Reading.) Excellent ☐ Good ☐ Fair ☐ Poor ☐

12. Speaking Excellent ☐ Good ☐ Fair ☐ Poor ☐

13. Employment status Full-time ☐ Part-time ☐ Retired ☐

Unemployed ☐ Other ………………………………………

14. Health insurance Comprehensive ☐ Specific illness cover ☐ Other ☐

None ☐

15. Highest Completed Qualification No formal education ☐ Primary school ☐

College ☐ Tertiary level ☐ Please specify:

16. Are you currently under any mental health treatment?

Yes ☐

No ☐

17. If yes, is this treatment based in NZ?

Yes ☐

No ☐

18. Have you previously followed a mental health treatment ?

Yes ☐

No ☐

19. If yes, was this treatment based in NZ?

Yes ☐

No ☐

Approved by the Auckland University of Technology Ethics Committee on 09/2022 AUTEC Reference number 22/188

Appendix G – Advertisement

Hey, Latinas!

IF YOU ARE A LATIN AMERICAN WOMAN

MIGRANT IN NEW ZEALAND

OVER 18 YEARS OLD

WHO HAS ACCESSED A PRIMARY CARE SERVICE FOR

MENTAL HEALTH SUPPORT

IN THE LAST FIVE YEARS

Would you like to share your experience for a research paper on mental health care?

Contact me through private message or at

marianargrezende@hotmail.com for more information.

Your participation will be confidential and will help us understand better our community needs.

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Approved by the Auckland University of Technology Ethics Committee on 09/2022 AUTEC Reference number 22/188.

Appendix H – Recruitment and Interview Schedule

AUCKLAND UNIVERSITY OF TECHNOLOGY ETHICS COMMITTEE (AUTEC)

Recruitment and Interview

Recruitment

The resource used to recruit participants will be a flyer. The flyer will be advertised on Latin American women's private virtual communities on Facebook, such as Mujeres Latinas en Nueva Zealand, Mulheres na Nova Zelandia and Familias Brasileiras de Blenheim.

Participants interested in participating will express interest with the researcher through private message or via e-mail.

Hey, Latinas!

IF YOU ARE A LATIN AMERICAN WOMAN

MIGRANT IN NEW ZEALAND

OVER 18 YEARS OLD

WHO HAS ACCESSED A PRIMARY CARE SERVICE FOR

MENTAL HEALTH SUPPORT

IN MARLBOROUGH

IN THE LAST FIVE YEARS

Would you like to share your experience for a research paper on mental health care?

Contact me through private message or at marianargrezende@hotmail.com for more information.

Your participation will be confidential and will help us understand better our community needs.

Approved by the Auckland University of Technology Ethics Committee on ___ AUTEC Reference number __.

Interview

- Written consent will be obtained from each participant prior to each interview.

- Each interview will last approximately 60 minutes. The information will be recorded and transcribed through transcription software.

- The interviews will be conducted in English, unless the participant opts to speak in their native language, Portuguese or Spanish. The researcher will conduct Portuguese interviews and use a translation service to transcribe it afterwards. For Spanish interviews, a translator mediator will be used during and afterwards.

- The interview will be recorded through the Zoom dispositive application, upon written consent obtained. I will take brief field notes during the conversation to help me guide the interview. Data will be documented using Microsoft word and Microsoft excel, and recorded information from the interviews will be transcribed using a transcription software called Otter.ai.

- To collect the participants' contextual information, I will provide a Sociodemographic Characteristics Information Form on completion of each interview.

Introduction

In each interview session I will start by welcoming the participant. I will introduce myself (researcher) and permit the participant to introduce themselves.

I will provide a brief description of the research objectives and briefly why I am conducting the research. Appreciation for the participation will be highlighted.

Semi-structured in-depth interview

Based on a transnational perspective, the interview will be undertaken considering the participant's experience with mental health as a whole, not only in the host country. Therefore, semi-structured in-depth interview questions will be adjusted according to each participant's individuality, acquiring a deep understanding of their perspectives as human beings and not only their lives as migrants. The focus remains on producing content for the research question; their experiences while accessing and utilising primary health services for mental health care needs in Marlborough, New Zealand**.**

1) Have you experienced any psychological distress?
2) Have you ever sought mental health help?
3) Have you ever undertaken any mental health treatment?
4) While in New Zealand, have you ever sought mental health care help?
5) What was your first strategy to alleviate psychological distress?

6) Where was the first place that came to your mind when in need to seek mental help?
7) Have you ever sought primary health services in New Zealand for mental health needs?
8) How did you find out about primary health services as a place to seek for mental health support?
9) How was the experience of booking an appointment?
10) What were your expectations of your consultation in the primary care service while seeking for mental health care?
11) How was the experience of the consultation?
12) What worked well during your first consultation?
13) What did not work well during your first consultation?
14) What could have gone better?
15) Did you return for the follow-up?
16) How do you feel regarding the primary health service experience while seeking for mental health care in New Zealand?
17) If in need, would you return?
18) Would you recommend primary care services to a relative or friend experiencing psychological distress?
19) Would you like to add something else?