

**Tuvaluan People's Explanations of Pacific Underutilisation of Mental Health  
Services in New Zealand.**

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## Abstract

This doctoral study explored Pacific underutilisation of mental health services in New Zealand, in addition to the associated consequences of late presentations in acute care or forensic service provisions. According to available literature, there are visible patterns showing multiple barriers that influence help-seeking behaviours amongst Pacific people for the treatment of mental disorders/illnesses. Current interest in this issue in New Zealand by government, academic, medical and even public discourses has been immense. However, sufficient research has not been forthcoming which may account for the slow progress in improving Pacific use and access of mental health services. The aim of this research was to explore explanations of underutilisation in relation to Tuvaluan mental health needs, the extent and types of assistance received, and whether these were adequately sought and received. The theoretical conceptual framework that guided this doctoral study, *Bronfenbrenner's Ecological Systems Theory* (1992), was combined with a qualitative descriptive research framework that unearthed Tuvaluans explanations of their experiences and attitudes towards mental health services in New Zealand. The research question *What are Tuvaluan's explanations for the underutilisation of mental health services in New Zealand* was answered via qualitative research data collection methods of focus groups and semi-structured interviews. A sample of seventeen Tuvaluan participants were involved, the participants were recruited from four groups of stakeholders; mental health consumers, relatives, mental health professionals and community representatives. The thematic analysis revealed influential factors particularly the unexpected finding of homeland factors that were scarcely located in other studies' findings as a barrier. The findings additionally reiterated the global literature of barrier factors that include: lack of mental health knowledge, apathy and stigma found in the way ethnic minorities explain low use of mental health services, despite differences in race and contextual circumstances. Similarities in the patterns of journeys towards the use of mental health services in line with research based on other ethnic minorities was also identified in this study. These findings contribute to an understanding of the reasons of low use of mental health services and the journeys towards the use of mental health services by Tuvaluans, Pacific and other minority populations living in New Zealand and in other western countries.

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**Attestation of Authorship**

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

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Fakafetai lasi.

## **Chapter 1: INTRODUCTION**

The primary purpose of this thesis is to present qualitative research findings that explored Tuvaluan people's explanations of Pacific underutilisation of mental health services in New Zealand (NZ). There has been considerable interest recently in the concept of service underutilisation experienced by racial and ethnic minorities, and its relevance to understanding treatment gaps. Research evidence confirms that late and acute presentations to mental health providers lead to higher rates of compulsory treatment and forensic admissions. The literature has raised concerns due to varying patterns of service use, access, and outcomes across ethnic populations. There are countless ways to investigate this problem and deliver the evidence required. The Ecological Systems Theory provides a broader foundation to underpin the research. This chapter will explain the rationale to explore the underutilisation of mental health services in NZ by Pacific people. A background of the state of mental health services in NZ is also included to set the context and identify the challenges regarding how this issue has evolved as a problem for Pacific people. The research aims are also included.

### **Rationale and Significance of the Research**

Firstly, I will describe my personal rationale for this study. My involvement in mental health began with my training as a nurse in the 1980s; however, even more, it was witnessing the sufferings of close family members from various mental conditions. I witnessed their journeys of suffering from the illness, treatments, rehabilitations, and relapses that engulfed most of their lives, my life, and the lives of my immediate family members. It is the experience of the many heartbreaks due to ignorance and confusion and our lack of knowledge as to how to assist our family member, or where, how, and when to access mental health services during psychotic outbreaks. This experience cost my parents, siblings, my consumer family member, and myself forty years of our lives due to worry, heartaches, and sadness as we journeyed together in the countless treatments, recoveries, and rehabilitations of his mental condition.

I am also a product of experience as a migrant, and a member of the Tuvaluan community group here in Auckland since my arrival in the 1970s from the Pacific islands. My conceptualisation of this problem and making sense of it was guided by my experiences as a migrant, with a cultural background which also influenced my choice of research methodology to investigate this mental health issue.

Being a mental health worker is poles apart from my experience as a relative of a mental health consumer. It is a world of technicalities, legalities, policies, employment

contracts, codes, standards, and professional practices; where employment responsibilities and specifications are based on principles of treatment, recovery, safety, outcomes, rights and of course, health. The rights of the mental health consumers are the ultimate building blocks of many guiding policies in the mental health sector, and to a lesser degree, the rights of the employee and the relatives are also recognised, defined and prioritised. Endeavours towards cultural competency and human rights endowments of consumers have existed, but the problem is whether these rights are exercised, promoted, and enforced in the services. A top-down hierarchical system and its wider effects dictates the mental health sector, structurally and in operational terms, which results in extensive impacts on the community and its citizens' health behavioural choices. These experiences also persuaded the use of an ecological systems framework to guide this investigation.

Consequently, I have journeyed as a relative of a mental health consumer, a mental health professional, a migrant and a Pacific community member. These positive experiences ignited the passion to explore and engage with Tuvaluan participants to understand their explanations of their attitudes and behaviours in relation to mental health service utilisation in NZ. On a positive note, I wanted to examine other Pacific people with similar journeys to our family's experiences. It must be acknowledged that every journey is different, and these diversities and commonalities need to be explored to gain an understanding of the factors that influence Pacific individuals, families, and even communities about their choices to use or not to use mental health services.

### **Rationale.**

The issue of Pacific underutilisation of mental health services is synonymous with a fundamental human right to health that defines it as a "highest attainable standard of physical and mental health" (World Health Organisation, 1948, as cited in Braverman & Gruskin, 2003, p. 255). The assertion is that the right to mental health is equally as significant as the right to physical health. This human right has been entrenched in international laws and treaties. The right to mental health has multiple components; but, for the purpose of this thesis, one measure involves the right and entitlement to medical care that are readily available, non-discriminatory and of adequate quality standard (World Health Organisation, 2000). As will be argued in the literature review chapter, this has not been the case in many countries, including in NZ.

The right to mental health and other rights (social, economic, and political rights) are holistically inclined, interdependent, and interrelated and therefore,

individually achieved. The mental condition itself is not the only complicated aspect of mental illness: social conditions and barrier risk factors such as financial difficulties and discrimination are added hindrances. The *Convention on the Rights of Persons with Disabilities* (Hendricks, 2007) ensured the protection of human rights of people with disabilities, including those suffering from psychosocial conditions. Consequently, the non-discrimination principle is a significant recognition. This emphasis on our right to mental health in conjunction to other rights, complements the philosophical position of this study and supports the adoption of the ecological systems framework to guide every aspect of its design and research processes.

An important rationale for this study is the contribution it will make to Pacific mental health literature that has been lacking in the past two decades in NZ (Pulotu-Endemann, et al. 2007; Suaalii-Sauni, et al. 2009; Samu, et al, 2011), by providing evidence-based knowledge for mental health professionals working with Pacific people. A gap in qualitative studies of Pacific beliefs was identified, particularly in relation to mental health service utilisation and its implications of compulsory acute hospitalisation, including forensic admissions, suicide, and other adverse outcomes. Thus, this study seeks to address this gap.

### **The Significance of the Research.**

The present study is the first of this type conducted in NZ for Tuvaluans or Pacific people that has included a sample of four diverse groups of stakeholders. These groups have the relevant experience to contribute to the issue of Tuvaluan and Pacific underutilisation of mental health services. A few studies by Pacific researchers have explored Pacific people's access to health services (Tofi, 1996) and mental health services (Fa'alogo-Lilo, 2012; Vaeau, 2013), but these studies have restricted their investigations solely on the perceptions of mental health consumers and mental health professionals. These studies also differed in that they did not examine Pacific people's explanations of high acute admissions and/or high forensic service utilisation by Pacific people as negative consequences of underutilisation of mental health treatment services. Quantitative studies of any Pacific mental health issue, often preferred by the health agencies and policymakers/authorities, are also limited (Haarhoff & Williams, 2017).

The decision to examine the issue of underutilisation of mental health services by Pacific people was initiated through encounters with several NZ commentators and their recommendations for urgent research into the disproportionately high compulsory admissions into acute mental health services and forensic services (Abas, Crampton,

Robinson & Vanderpyl, 2003; Ramage, et al., 2005). The concern raised was why was psychiatric assistance not sought earlier? Ramage et al. (2005) also highlighted the need for research into the perceptions of Pacific mental health consumers and their families in relation to the use of mental health services. These NZ commentators claimed that a focus on primary mental health services could play a key role in addressing the issue of Pacific people's underutilisation of mental health services. According to this reasoning, to understand minority people's underutilisation of mental health provisions, an investigation into the extent of primary mental health services' adverse role in discouraging Pacific people's motivation in seeking its services for the treatment of mental illnesses is essential (Haarhoff & Williams, 2017). Durie (2001) additionally recommended further research to explain why general practitioners' (GP) referrals for Maori and Pacific people are marginal, yet referrals by the courts and the police are comparably high: 66 percent higher than other populations (Allen & Laycock, 1997).

Most importantly, Le Va (2009), the Pacific mental health unit of Te Pou (New Zealand's National Centre of Mental Health Research and Workforce Development) had listed in its research agenda a call for research into Pacific low use of mental health services in NZ and its subsidiary effects of high acute and forensic admissions and longer hospitalisations. Le Va prioritised this issue as an urgent matter for future researches. A review of Le Va's research agenda two years later (2011) showed that this topic was one of a few that was not chosen by researchers thus securing my choice to investigate this vital topic for my doctoral research.

## **Background.**

**Pacific People in NZ.** The Pacific population is the fourth largest ethnic group in NZ according to the 2013 census (Statistics NZ, 2015), the majority (36.8 percent) residing in the Auckland area. The median age range is 33.7 years, 45.7 percent are NZ-born, and the median income is \$22,600. The population is comprised overwhelmingly of the young, with a diversity of ethnicities and language fluency from various island nations and communities (Southwick, Keneally & Ryan, 2012; Statistics NZ, 2014). This complexity of the Pacific population, rich in diversity of cultures, values, customs, languages, and lifestyles, is a warning to researchers and academics to be wary of stereotyping Pacific people as a homogeneous identity, or a standard definition of Pacific people (Suaalii-Sauni, et al., 2009). Rather, these differences are significantly advantageous to guide the investigations, examinations, explorations, and problem solutions of any Pacific issue. Thus, a "one size fits all" approach does not apply to

Pacific people (Southwick, et al. 2012) owing to its disregard of people's diversities. Other differences in terms of migrant status, inter-generational and demographical constituents can produce relevant explanations that are central to the problem of accessibility, and therefore underutilisation of mental health services by Pacific people. Pacific people as a population disproportionately suffer from low socio-economic status due to lower incomes and a high degree of unemployment (Southwick et al. 2012; Statistics NZ & Ministry of Pacific Island Affairs, 2011).

Alternatively, commonalities exist amongst Pacific Island groups through genealogical links, which generated a common heritage, a collective identity as a Pacific Islander with similarities in language, kinship beliefs, histories, cultural components, and indigenous knowledge (The Health Research Council, 2014). Most importantly, Pacific people originated from the Pacific Ocean region (Figure 1). Components of the Pacific homelands persist in NZ via religious congregations, community gatherings, traditional and customary practices, and activities, and are passed on through generations.

**Tuvaluans in NZ.** Tuvalu is an island in the Pacific that is made up of 8 islands (see Figure 2). A background situational analysis of Tuvaluans living in NZ as recent migrants to this country in the 1990s to the present, shows that Tuvaluans are experiencing similar issues around acculturation as other Pacific ethnicities as they adapt to their new country of residence (Simati, 2009). According to the 2013 census (Statistics NZ, 2015), 46.6 percent of Tuvaluans were NZ-born, an increase from the 37 percent in 2006, of which 77.5 percent were below the age of 15 years, while 73.1 percent stated Tuvalu as their birthplace. This explains the high numbers of Tuvaluans who are fluent in the Tuvaluan language (63.2 %) and the high numbers living in a family situation, or extended family system. Income distribution is quite low, with 11 percent having no source of income, 58.4 percent earning approximately \$20,000 per annum, and a mere 2.6 percent had an income over \$70, 000. These demographical details are important for the data analysis and the interpretation of the current data for this thesis.



Figure 1: The islands of the Pacific Ocean: Micronesia, Melanesia and Polynesia



Source: <http://scholarworks.unt.edu/cgi/viewcontent.cgi?article=11691&context=etd>

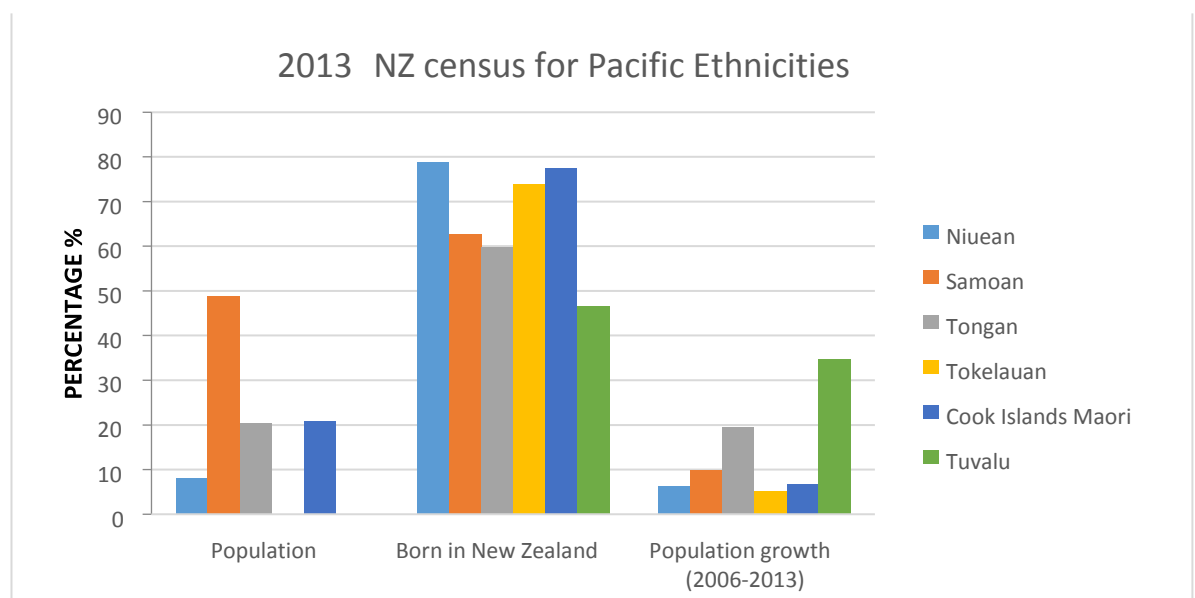
Figure 2. Tuvalu Atoll.



Source: <http://www.beautifulpacific.com/tuvalu/>

**Pacific and Tuvaluan forecasted growth in population numbers (see Figure 3).** The forecasted growth of the Pacific population in NZ suggests escalating health needs; hence the call for an urgent investigation of Pacific mental health issues. Statistical evidence (Statistics NZ, 2015) projects the Pacific population in NZ will increase to 0.44 million in 2025 and to between 0.54 and 0.65 million in 2038 from its 2013 census number of 0.34 million. A significant trend is that Pacific children will increase from 13.4 percent of the total population to 19.6 percent in 2038. Whilst the Tuvaluan population is quite small in numbers, a mere total of 3, 537 people in NZ in 2013 (Statistics NZ, 2015), the census showed that 42 percent of this number was under the age of 15 years, leading to a prediction that the Tuvaluan population in NZ will increase markedly in the future. The Tuvaluan population increased by 34.7 percent between 2006 and 2013, which was much higher than the other Pacific ethnic groups (Statistics NZ, 2015). In addition, the ongoing problem of sea levels rising round the island of Tuvalu potentially endangering the lifestyles of Tuvaluans may mean that more Tuvaluans will migrate to NZ (Gemenne & Shen, 2009; Simati, 2009).

*Figure 3. Pacific Population Growth in NZ.*



Note: The chart above of the 2013 Census does not show the Tuvaluan or Tokelauan population numbers living in NZ because the Tuvaluan ethnic population numbers were 3,537, or less than 1 percent and the Tokelauan ethnic population was 7,176, also less than 1 percent.

### **Tuvaluan Beliefs, Worldviews, Customs and Traditions.**

Sources of literature regarding Tuvalu and its people are a rarity. This is a limitation to this study for literature on Tuvaluan customs and traditions, particularly as belief systems and worldviews are required as elucidatory tools to illuminate the participants' attitudinal statements. Therefore, historical accounts such as the anthropological and ethnographical studies, supplemented with international and regional reports that were mainly based on geographical or economical fields were utilised. This meant that the inclusion of only a small portion were selected from the plethora of customs and traditions, particularly those that apply to health or mental health and the Tuvaluan research framework: *Te Pa*.

An ethnography study of a Tuvaluan atoll *Nanumea* by Chambers (1983) has been applied consistently throughout this paper for its excellent portrayal of Tuvaluan lifestyle and how it is guided by belief systems, traditions and customs. For instance, the custom of *tufa* (sharing) overawed the author, who designated a whole chapter to explicitly illustrating its beneficial components to the survival of the people in a small island with meagre resources. Accordingly, this sharing custom was the guiding foundation that underpinned the establishment of Tuvaluan relationships she encountered in her study. Illustrated examples included such relationships as the rapport between *tino tokotasi* (individuals), *kaiga* (family), *taugasoa* (friends), *te lotu* (church), or *te fenua* (community) dues. She concluded that Westernised interpretations of this sharing concept were extremely difficult and lacking for Western models are inapplicable. These exchanges are not two-way systems of giving and receiving, such as a trade or barter, the latter concept of barter in Tuvaluan is *taui*, a completely different concept. The author concluded that these social structural interactions are "reciprocity exchanges" that Western models fail to rationalise. The Tuvaluans related it to the giving of *mealofa* (gifts) of *alofa* (love), when people have sufficient resources to share, so they were not tallied. The significance of this exchange is measured through the standpoint of the giver, and less on the receiver. It means that the giver has excess resources, therefore the opportunity to share accompanied by elations of compassion, affection, generosity and love for the receiver. Alternatively, the custom of *akai* (request), transpires between strong bonds of relationships between relatives or friends, and as a symbol of the solid connection of the relationship, the receiver makes a request and the giver shares with the pride and honour of being chosen for the request (Chambers, 1983).

Thus, the traditional custom of egalitarianism is vital in the islands, its main function being to maintain a collaborative and balanced system of living in a small geographical area with meagre resources. The risk of one element becoming more dominant will threaten the harmonious life, hence the reason for the non-existence of individualism (Chambers, 1983). This explained the longevity of people in the islands, despite a multitude of risks that undermine their survival. Collaborative social systems of customs are modes of survival, purposely to enable resource distribution and availability for all, such as the concept of *tufa* (sharing, resources, and skills), *feasoasoani* (general assistance), *kaiga* (kinship) and *te fenua* (community membership). These values are ingrained in concepts of *sharing* and *caring* that extends to looking after their vulnerable and *tino fakalofa* (outsiders, strangers) (Resture, 2010).

### **Pacific Mental Health in NZ: A Summary**

A concerning factor relating to Pacific mental health is the disproportionate high incidence of serious acute psychological illnesses with Pacific people seeking treatment only when the symptoms become severe (Ministry of Health, 2008). This pattern of behaviour is detected in the low use of mental health services, as well as in the small numbers of Pacific people seeking needs assessment support. The lack of reliable data about Pacific mental health issues has inhibited a comprehensive focus on Pacific mental health (Lee, Duck & Sibley, 2017). Another reason for this investigation of this issue was influenced by a report by the Ministry of Health, *Health Loss in New Zealand 1990-2013* (Ministry of Health, 2016a), which conveyed that long standing mental health conditions accounted for 88 percent of health loss in NZ and 35 percent of all youth health loss, including 19 percent of the total disability-adjusted life years (DALYs) in 2013.

There is some evidence of recent developments in NZ's mental health services in terms of responsiveness to Pacific mental health needs that were initiated by the establishment of multiple policies and legislation by government authorities in the form of national mental health strategies and policy documents. It is part of a political trend whereby governments are now accepting the status of health disparities and poor health outcomes experienced by Pacific people, thereby initiating priority targets to eliminate these problems (Ministry of Health, 2005; Southwick et al. 2012).

The difficulty of accessing health services as one of the prime causes of health inequalities faced by Pacific people, mirrors what has been established in the literature

(to be discussed in the Literature chapter). Several criticisms cited economic barriers in relation to medical consultation and prescription fees, transportation and other related elements are major influential factors (Lee, et al., 2017). Evidence shows that Pacific people tend to seek General Practitioners' (GP) assistance as their first point of seeking treatment on the onset of a mental health disorder (Ludeke, et al. 2012; Williams, et al. 2017). As the first point of contact of mental health services is primary mental health services (Williams et al, 2017), the primary mental health sector has been a priority target for reforms developed to aid in lowering these consultation and prescription costs, and therefore improve access to mental health services. For instance, the *Primary Mental Health Initiatives (PMHI)* in 2004, enabled the creation of Pacific based health organisations to provide culturally appropriate services for their people. More recently, in July 2015, the Ministry of Health (2017) expanded the *Zero Fees for Under-6s* to include children under 13 years. The key purpose of these reforms is to remove inequity and inequality from the health status of Pacific people and increase access to medical care.

The question is: have these health and mental health policies dealt with issues of health inequality, especially access of, and the low use of mental health services by Pacific people? Were these issues recognised and acknowledged, and to what extent were strategies initiated to solve them, successful and viable? Every elected government had set goals to reduce health disparities faced by Pacific and Maori populations in New Zealand (Creech, 1999). The goals acknowledged that Pacific inequities must be solved through a focus on primary health care for it is more effective than a focus on the general health system. This is observed in primary mental health policies particularly in relation to access issues via strategies such as the increase in Pacific workforce and Pacific service providers (Ludeke, et al. 2012). Another illustration of one of these initiatives include the universal free access to health services that was later altered to neo-liberal strategies of the 1980s. It included targeted schemes and equity funding to Primary Health Organisations (PHOs) and the creation of a network system of partnership between health services and other agencies (Widodo, 2007). With the development of existing reforms in relation to the delivery of health services by the establishment of District Health Boards (DHBs), one of the primary targets was to assist in the planning of mental health services to cater for the mental health needs of its users (Southwick et al. 2012).

An additional strategical plan is the *Pacific Health and Disability Action Plan* (PHDAP) which was followed by a series of papers produced to review it, another

means of establishing strong evidence (MOH, 2008). This long-term plan of direction and actions for the improvement of Pacific health outcomes surmises the importance of Pacific participation in the reduction of health disparities (King, 2002). For this study's focus, the important section of the PHDAP is the Goal 6 which states that 'To deliver disability support and health services that will enable disabled Pacific peoples to participate fully in their communities' (King, 2002, p. 1). Furthermore, in line with the NZDS (New Zealand Disability Strategy) Goal 6 objective, it is acknowledged by PHDAP in 2 of its Goal 6 objectives that the quality of the disability services need to improve and upgraded to improve Pacific access of these services. Another paper: *Pacific Peoples and Mental Health: A paper for the Pacific Health and Disability Action Plan review* (MOH, 2008) also reviews Pacific Health and Disability Action and has been applied in the discussions in this paper.

The consequences of Pacific underutilisation of mental health services is the disproportionately excessive numbers of compulsory admissions by Pacific people equally in community and inpatient mental health facilities, comprising nine percent of the total admissions in 2005, as well as in forensic services (MOH, 2007; Robinson, Robinson & Wheeler, 2005). It must be noted however, as Simpson, et al. (2003) findings of a review of *The National Study on Psychiatric Morbidity in New Zealand Prisons* have conveyed, undiagnosed people with mental illness is a major problem in New Zealand prisons, obscuring true statistics of forensic admissions. It raises issues of the need for urgent provisions for screening, assessment, and treatment provisions in prisons to identify and cater for the mental health needs of these people. Statistics further showed that Pacific use of acute inpatient services is disproportionately higher than the general population (198 vs 170 per 100,000) (Baxter, Kokaua, McGee, Oakley-Browne, & Wells, 2006). Higher costs due to longer hospitalisation were also reported for Pacific clients in contrast to both Maori and the general population (Buckingham, Burgess, Solomon, Pirkis & Eagar, 2006).

**Mental health of Tuvaluans in NZ.** A situational analysis of the Tuvaluan population in NZ is crucial to make sense of their explanations and attitudes of mental health. The Tuvaluan population is quite small, so inclusion in the census or other statistical sources is merely categorised as part of the remaining "Other Pacific" category. Therefore, the teasing out from this category of the exact numbers of Tuvaluans with mental health problems is a complex task. The *Te Orau Ora* document (Ministry of Health, 2005) did state that the 'Other category' of Pacific minority

populations within the Pacific population makes up 18 percent of Pacific client users of mental health services, yet it includes a mere 13 percent of the total Pacific population in NZ.

### **Theoretical Conceptual Framework**

The complex multiple factors that exert an influence on minorities' utilisation of mental health services highlighted the importance of deciding on a suitable conceptual framework to aid the identification, classification and categorisation of the literature. The theoretical conceptual framework was chosen for its capability to adequately accommodate the complex and diverse system of interconnected and inter-dependent factors (Kelly, 2006) involved in the utilisation of mental health services by Tuvaluan and Pacific people.

A conventional model, Bronfenbrenner's *Ecological Systems Theory* (1992) provided a theoretical conceptualisation framework for the issue under study. The use of this model is appropriate because of the holistic inclination of Pacific people's belief systems and worldviews (Health Research Council, 2014). Ng Shiu (2013) argued that Pacific and indigenous health belief systems are not the outcome of mere individualistic factors. Pacific health belief systems are applicable to the ecological systems framework by Bronfenbrenner (1992) because this model addresses the environmental, policy, social, economic and psychological factors that affect people's choices of health behaviours (Sallis, Owen, & Fisher, 2015).

Bronfenbrenner's model of human behaviour is composed of four principles that are multifactorial, multi-levelled, behaviour-specific, interdependent and interrelated influences of behaviours (Sallis, Owen, & Fisher, 2008). It incorporates a system's driven entities with its subsystems: micro system, mesosystem, macro system and the links connecting these systems, the exosystem.

The framework of this study considers the unique characteristics of the mental health consumers, their families, the communities they are embedded in, and the social, political and economic environments they are located in which influences their health choices to use or not to use mental health services. As Bronfenbrenner's model asserts, there are links between all the factors concerned, that, through the process of socialisation, assimilation and acculturation, affect the beliefs and attitudes that collectively impact on the help seeking health behaviours of the individuals, families, community as well as the structure, operation and value systems of mental health services. However, a reversal of the impacts is possible

too, so that the contexts and interests of the individuals, families, communities and mental health services, may in combination or individually influence government policies. For this reason, it is crucial to examine the relevant attributes of these entities to make sense of way their individual and collective factors affect the use of mental health services.

A number of researchers have used Bronfenbrenner's theoretical model on which to base their studies as it assists in examining the interplay of societal and human interactions (Sallis et al. 2008). Furthermore, social problems have varying definitions and solutions for they are complex and are extremely dependent on the perceptions and experiences of diverse stakeholders (Peirson, Boydell, Ferguson, & Ferris, 2011). Each level of influence must be targeted and explored so that behaviour changes are understood. For instance, changes in an individual's and population's environments, policies, social norms and support are likely to encourage positive health behavioural choices (Sallis et al. 2008).

#### **Relevant Concepts.**

*Figure 4. Mapping the Process of the Underutilisation of the Mental Health Services Issue.*

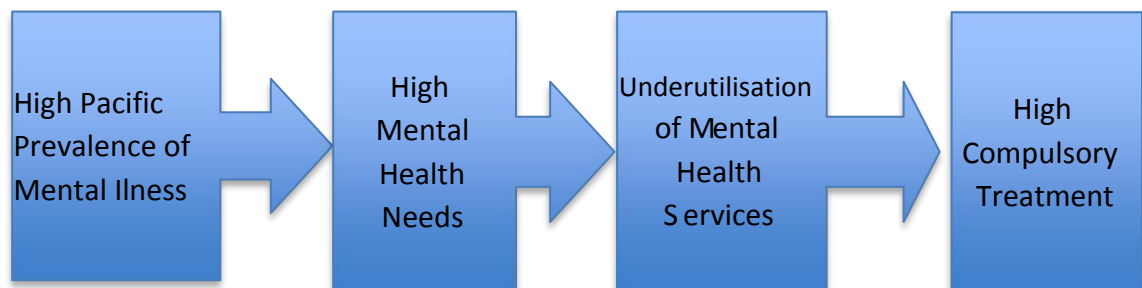


Figure 4 above maps the process or pathway to the utilisation of mental health services. It begins with the statistical evidence of high prevalence of Pacific mental illness in the NZ population (Baxter, et al. 2006) that translates into high mental health needs requiring adequate and efficient treatment (Sartorius, 2015). This is where the simplicity of the issue lies. The problem arises when we continue our analysis to the next stage where utilisation of mental health services occurs, resulting in wellness due to treatment received. At this stage, when it applies to minority populations, including Pacific people, it leads to underutilisation in compulsory treatments (Simpson et al. 2003). A closer inspection of the process illustrated above, shows that it fails to convey the complex system of relationships. The arrows between the boxes or categories



indicate links that connect these elements, which will be thoroughly discussed in the following chapters. This pathway (Figure 4), while unique to minorities in Western societies (Cauce, Domenech-Rodríguez, Paradise, Cochran, Shea, Srebnik, & Baydar, 2002; Rothi & Leavey, 2006) including Pacific people (Simpson et al, 2003; Trauer et al. 2006; Ministry of Health, 2007; Robinson, Robinson, & Wheeler, 2005), is highly interconnected.

The ecological system's approach, detailed in Chapter 2 has been revolutionary as a tool to understand psychological, financial, social, and other determinants of health behaviours. Consequently, an individual has an extended system and subsystems of an interrelated network that needs untangling to understand the connections between them. Relevant concepts are identified and their meanings and usefulness to the discussion of this study require precise definitions. Many of these concepts have been confused and employed interchangeably despite their differences. Berg (2009) insists that the most difficult part of a research design is the operationalization of its concepts because it is the most important. We must also remember that clients and professionals have differing versions of these concepts (Andersen, 1995). A cautious explanation and distinction of each term are clarified next.

Firstly, the proportion of mental illness rates (*prevalence*) of a population is normally indicated as either a percentage, a fraction, or the number of cases at a specified time, or at least experienced once during a lifetime (Sartorius, 2015). This means that many people experience *mental health needs* that need treatment and care; these provisions must be efficient, equitable, sufficient quantity of provisions, and lead to equality of outcomes (Sartorius, 2015). These are the first two stages of the process. Prevalence of mental health needs is not the focus of this study, but its usefulness is to situate the issue of underutilisation in context and as background information to make sense of the phenomenon. However, an onset of a mental disorder does not necessarily represent a mental health need for care and treatment (Andersen, 1995). Decisions regarding the care and treatment of mental health needs are a complicated system of determining its necessity. Some commentators suggested that it should be determined by the impact of clinical treatment of the disorders; therefore, at a population level, need is defined in terms of the entire population's positive gains from treatment and its care (Wang, et al. 2007). This definition is problematic because there is no acceptable and adequate measure of public gain when treatment is received.

The next step in the process is the *utilisation* of treatment provisions to cater for the high rates of mental illness, therefore high needs. A differentiation between the two

concepts of *utilisation* and *accessibility* is vital in order to be precise in terms of statistics, barrier factors and other facts in the ensuing chapters. *Utilisation* means the actual using of the services, while *accessibility* refers to getting to and entering the services (Andersen, 1995). The distinction of the concepts permits a clearer interpretation of statistics so that data on admission rates will refer to utilisation foremost (how many are/were in the services prior to discharge), and indirectly to accessibility (how these admissions gained entry) into the services.

Other relevant concepts identified in the process above that are connected to the topic include specifying the *types of mental health services*. It is crucial to specify the type of mental health service needed, whether it is primary (first point of contact and referral system such as GPs), secondary (follow-up treatments such as psychiatric services), community (community care and treatment such as residential care), in-patient hospitals (acute provisions for severe cases) or forensic (services for mental health consumer offenders). As will be observed in the literature review, the target as the major cause of the problem is primary mental health services because these provisions are the first point of contact of mental health services (Statistics NZ & Ministry of Pacific Island Affairs, 2011); therefore, its influence as a barrier is enormous. Inappropriately, the literature consistently refers to mental health services without specifying which service is being addressed.

Related to the above concepts, is the importance of the exact type and number of *visits* being referred to the service. For instance, if it is a follow up visit, then it is usually for secondary services that the primary mental health services (first visits) have made referrals to. A vital note is that a visit to mental health services may be the result of the “revolving door syndrome” (re-admittance due to relapses after bouts of wellness), and in this case, when involving minority and Pacific pathways, the primary services are usually by-passed. Despite this, primary services are the main type of first visits, and therefore is the first mental health service to be researched and referred to in the literature due to its influence and impact on whether treatment is sought.

The influence of the *type of mental condition diagnosis* is relevant to understand help-seeking behaviours by the mental health consumer and their support systems, especially the relatives. The most often treated mental illnesses are schizophrenia, manic depression (bipolar) illness, personality disorders, depressive disorders, anxiety disorders, addictions, and drug-induced psychoses due to drug addictions. It is important to distinguish the mental illness diagnosis that is discussed, despite the complexity of detailing the many mental conditions.

Lastly, the distinction between the two concepts of *equity* and *equality* is essential to understand the financial barriers to accessing mental health services, particularly primary mental health services, and their effect on minorities and Pacific health disparities. Health *equity* relates to the unfair share of resources and other means that result in the *unequal* health outcomes and status of certain groups of people (Braveman & Gruskin, 2003). Past policies have endeavoured to solve the financial barriers of consultation fees of especially GPs based on principles of universal coverage or targeted vulnerable needs only (Widodo, et al. 2007).

The simple outline of the issue under study depicted in the linear process diagram above fails to portray the connection between the high mental health needs that lead to underutilisation which eventually leads to outcomes of admissions into forced treatment and incarcerations. Detailed discussions of the process are provided in later chapters.

People of colour, according to epidemiological studies, differ from Whites who seem to have a completely different pathway to using mental health services (Cauce, et al. 2002). The people most in need of treatment for mental disorders, the non-white ethnic and racial minorities, including Pacific people, experience higher underutilisation rates of mental health services disproportionately despite the presence of substantial mental health needs. This study attempts to investigate the dynamics that drive Tuvaluan people to detour from the usual process of accessing mental health services.

The high prevalence of mental disorders amongst ethnic and racial minority populations in Western countries has been consistently declared (Broman, 2012; Yeh, Takeuchi & Sue, 1994), regardless of the contextual diversity of the countries. A review of findings from the World Mental Health surveys on the global burden of mental disorders in 28 countries, where information on prevalence rates were included, indicated that widespread rates of mental disorders were identified (Kessler, et al. 2009). The review also states that a small proportion of these people with disorders received treatment (Wang, et al. 2007). Higher levels of poor mental health outcomes were particularly related (Cokley, Hall-Clark, & Hicks, 2011). In the context of NZ Pacific people's prevalence of mental illness, the first epidemiology national survey, *Te Rau Hinengaro: The New Zealand Mental Health Survey 2006* findings conveyed high rates of 12-month prevalence of mental disorders and lower use of mental health services by Pacific people than non-Pacific people (Baxter, et al. 2006; Eagar, Trauer, Mellso &, 2005; Foliaki, Kokaua, Schaaf, & Tukuitonga, 2006; Kokaua, Schaaf, Wells, & Foliaki, 2009; Ministry of Health, 2008; Yorke). This confirms that the

consequence of this high prevalence of mental illness translates into high mental health needs, which leads to an urgent requirement for essential provisions to cater for these needs. As the ensuing chapters will unfold, a growing body of literature will highlight the significance of low usage of mental health services that affects issues of equity and equality in health outcomes for racial and ethnic minorities, including Pacific people in NZ.

A synopsis of the literature sources relating to the issue of low use of mental health services confirmed it as a worldwide problem, experienced mainly by “people of colour” (Broman, 2012; Yeh, et al. 1994). Notably, the field of mental health is most affected by barriers of utilisation than any other health system (Fleury et al. 2012). This contention is not surprising because mental health has psychological, social, economic, political, and other ecological pressures, which interact in a cyclical way (Minas & Lewis, 2017) that makes this area of health enormously complicated.

The international literature identified a thematic list of factors that extensively affect people’s use of mental health services. An exhaustive range of studies has identified multiple influential factors that explain why people do not use mental health services. These factors are ordered into categories of *affordability* (transport, medical charges), *availability* (lack of local services, youth, and minority medical professionals), *accessibility* (how to enter services), *alienation* (cultural incompetency, mismatched beliefs and delivery of mental health services), *psychological factors* (stigma and diagnosis) and *problem definition/evaluation* (self-diagnosis and evaluation). The dynamics of linkages amongst these concepts are particularly noted, therefore, concluding that commonalities are presented more than distinctions. This is unsurprising due to the literature reviewed tending to be sourced from Western countries (Fakhoury & Priebe, 2002). These commentators criticised the unequal balance of available academic literature for being overloaded by North American, European, and Australian/NZ literature and overlooking and undermining literature from non-Western countries. Priebe et al. (2005) justified it as due to the robust ethos of mental health research, which includes the high numbers of immigrant researchers in these countries.

### **Research Aims**

**Overall aim.** To explore Tuvaluan explanations of the underutilisation of mental health services in NZ.

**Specific aims:** were to explore explanations and attitudes to the following mental health issues:

1. Utilisation of mental health services.
2. Access to mental health services.
3. Availability of support services to facilitate utilisation of mental health services.
4. Consequences of underutilisation on compulsory acute treatment and forensic services.

### **Chapter Summaries.**

This thesis has six chapters. Firstly, in Chapter 1 the topic of the research and its rationale was introduced, a brief background of the researched population Tuvaluans as a Pacific group were described and the mental health status of Tuvaluans and Pacific people in NZ was presented. In Chapter Two the issue of underutilisation is theoretically and conceptually justified and described by the literature review. This literature review chapter identifies international and national sources that have addressed issues of underutilisation of mental health services, and critically assesses gaps in this knowledge base. In Chapter 3, a description of the process of decisions about the choice of the qualitative descriptive methodology that is grounded on underpinnings of an interpretive paradigm that confirm the choices of research methods is presented. The *Tuvaluan research framework: Te Pa* is introduced here, detailing how it complements a holistic overview of Tuvaluan values, customs and cultural outlooks that aided the research design, research processes and interpretation of the findings. The findings are located in the next two chapters: Chapter 4, ordered analytically the themes detected from participants' answers to the research questions, which also fulfilled the aims of the study. The chapter additionally outlined the pathway framework and the Bronfenbrenner's ecological system's model that were applied to aid in the interpretation of the findings, alongside the barriers associated with each stage of the pathway process. Alternatively, Chapter 5's added descriptions of the findings that involved the implications of the state of underutilisation of mental health services, and the solutions proposed by the participants are presented. The discussion chapter, Chapter 6, interprets the findings in more detail and raises other pertinent issues. The

chapter finalises the thesis by connecting all the chapters, discussing the strengths and limitations of the study, and offering recommendations for further studies.

## Chapter 2: LITERATURE REVIEW

### Introduction

A literature review reveals the investigations of past studies that explored, analysed and evaluated the topic of interest to the research investigation, and identified relevant knowledge gaps. The core purpose of this chapter is to examine the literature on the utilisation of mental health services by Pacific people in NZ. Hence, this chapter will firstly examine the historical development of the deinstitutionalisation of mental health services in NZ, and the extent of underutilisation of mental health services by minority people in the international arena, followed by literature in the NZ context. A critical analysis of this literature from an ecological systems approach that philosophically underlies the stance of this research will be undertaken. The employment of the pathway towards mental health services framework has additionally assisted the analysis of the literature to show how previous studies are relevant to underutilisation. The literature review outlines the stages of the journey to accessing and, eventually, using mental health services, and how it was applied in studies. The benefit of employing the ecological and pathway frameworks is to filter and select the relevant literature from the myriad sources identified and assist in the conceptualisation of the issue and a smooth logical flow of the chapters. Thus, the literature was described and critically reviewed in relation to the stages of symptom identification of mental illness, help seeking behaviours and the final selection and decision-making behaviours that lead to treatment service utilisation. A critical analysis of the barrier factors and other related obstacles was additionally included.

### Searching the Literature

The literature was searched electronically to identify relevant studies and publications in the following databases: Medline, PsychINFO, Google Scholar and Health & Medical Complete (ProQuest), Pubmed and New Zealand Health Information Service (NZHIS). The key words applied were *Tuvalu, Pacific people in New Zealand, Pacific/Tuvalu mental health, utilisation, use, access, accessibility, barriers, obstacles, mental health services, treatment services, help seeking, forensic, acute, inpatient hospitalisation, psychiatric services, ecological systems approach, migration, migrant health and compulsory treatment*. Electronic searches were filtered to include only materials that were published from 2000, Many relevant articles were also located through the bibliography sections of the

identified sources, of which some of these readings were older than the specified period of publishing. Despite the diversity of disciplines that these sources of literature were located from, the following are the main subject areas these articles were retrieved from: Mental Health; Counselling, Psychiatry and Psychotherapy, Public and Social Welfare (Sociology); Ethnic and Racial Studies, Behavioural Sciences, Health and Social Care and Social Sciences. The total amount of literature that were included in this thesis is 202, which does not account for the many references that were read particularly in the early stage of researching the topic of Pacific underutilisation of mental health services in NZ.

### **A Historical Analysis of the Deinstitutionalisation of Mental Health Services.**

The term “deinstitutionalisation” connotes the meaning of the “closures and downsizing” of former asylums (Fakhoury & Priebe, 2002) and the transfer of mental health treatment provisions from psychiatric hospitals to the community (Lesage, 2000). The old days of asylums adhered to custodial frameworks that had historically undermined and eroded the human rights and freedom of choice of mental health consumers. The goal of deinstitutionalisation was to replace this traditional type of care with inclusive community care (McDaid & Thornicroft, 2005).

However, it has been suggested that the deinstitutionalisation of mental health services from hospital-based treatment to community types of services may have contributed to the low utilisation of mental health services by people of colour minorities including Pacific people in NZ. This transition process led to economic pressures faced by existing community mental health services that resulted in ethical issues of access, and therefore the low use of mental health services by minority people (La Roche & Turner, 2002).

The case of deinstitutionalisation in Europe is an illustration of the negative effects of closures of asylums, criticised as dictated primarily by fiscal motives (La Roche & Turner, 2002). The critics argued that this new system completely changed the types of treatment and recovery systems that included a wide range of services to cater for the mental health needs of the community. Widespread condemnations targeted policymakers’ fiscal motives by neglecting to make available sufficient replacements of the specialists and community resources that were required to source this new system of mental health treatment and care (Jansman-Hart, Seto, Crocker, Nicholls, & Côté, 2011).



This trend led to shortages of community mental health teams, psychiatric nurses, social workers and residential staff required to resource the needs of deinstitutionalisation developments in Europe. A further example is in the United States where the capitation system (fixed amount of funding per patient) and the lack of co-ordination between the funders and the agencies resulted in low quality and ineffective provisions for patients who suffer from severe mental health conditions (Fakhoury & Priebe, 2002).

Prior to the transition to community care, traditionally, the confinement of mental health patients in asylums, secluded and isolated from public view was the norm. This asylum system of care instigated negative images and attitudes towards these people. The transition into community mental health services did not alter the negative feelings towards the mentally ill; rather it persisted. One of the main reasons for this continuation of negative attitudes towards the mentally ill was alleged to be due to media coverage of incidents associated with psychiatric patients in public spaces, which strengthened public criticism and mobilised anger against the presence of "dangerous" mental health consumers in the community (Fakhoury & Priebe, 2002). This intensified phobia towards the mentally ill and incited strong opposition towards inclusive rights. It reinstated attitudes in favour of exclusion, hence, reinforced public calls for confinement as a measure of social control of these people in forensic and prison systems. Issues of stigma and negative consequences of discrimination, namely marginalisation and exclusion (Cleary, Horsfall, & Escott, 2014) became an ongoing issue that increased people's reluctance and inability to seek and use mental health services. Public opinion of mentally ill people evolved around notions of condemnation of their living in their midst (Wilson, 2000), and attracted deliberate misconceptions and opposition of deinstitutionalisation attempts to house and rehabilitate these people in the community. Consequently, the stigma surrounding mental illness and its treatment persisted despite the transformation of the mental health system from asylums into the community setting.

**The NZ experience of deinstitutionalisation.** The NZ experience of deinstitutionalisation from an institutional model of care to a recovery model of care in the community (Ministry of Health, 2016b) that started in the 1980s was gradual and marred with problems (Wilson, 2000). By 2000, the increased number of mental health consumers in the community meant that the inpatient general

hospitals' supply of beds was inadequate to cater for the high demand for its services, coupled with the shortages of psychiatrists and general mental health professionals (Wilson, 2000). Out of the ten major psychiatric hospitals, six have been closed while the remaining four transformed into forensic, acute hospitals or combined with general hospitals.

The types of mental health community provisions that currently exist in NZ were purposefully developed to complement inclusive and citizenship rights of people, comprised of community care teams that provide 24-hour crisis services and general hospital acute wards, residential provisions of rehabilitation, and social support services (Wilson, 2000). Additionally, there are a variety of specialised services, such as the child and youth services, Pacific/Maori/consumer peer provider services, forensic services and acute inpatient hospitalisation. A national study in the same period found that 40% of all admissions to acute services remained in the services yet these services no longer meet the clinical criteria. The lack of services to support people with medium mental health needs when they are discharged, has become a major policy priority (Ministry of Health, 2016b).

The lack of an adequate mental health workforce, especially Pacific and Maori ethnic cultural specialists, is an ongoing problem. This negative statistical evidence has propelled a project undertaken by Pacific scholars (Southwick & Solomona, 2007) to assess the recruitment and retention of the Pacific mental health workforce. The researchers found that, firstly, mental health as a career option requires promotional campaigns to attract a potential Pacific workforce in the mental health sector, but this requires the backup of the education system. Secondly, they found that lack of knowledge of mental health is a major problem in the Pacific community and proposed that the Pacific wider community must be educated via health promotion educational programs to support the recruitment of a Pacific mental health workforce. The researchers stated that an increase in the Pacific workforce and the adoption of cultural competency standards under the terms of the Treaty of Waitangi and Pacific cultural models will assist accommodating the cultural needs of Maori and Pacific clients.

### **The Evidence: Existing Literature**

This literature review is not exhaustive, but inclusion of all materials located were stringently filtered due to space restriction in this chapter. For this reason, only the most relevant literature that includes a focus on ecological studies was included.

Gaps in the literature regarding the research topic were identified. Firstly, there is limited NZ research that investigated the low use of mental health services that this study aimed to investigate, primarily because the main focus was on the high Pacific forensic and acute admissions in NZ. Secondly, there was a lack of research on the pathways to the utilisation of mental health services in accordance with Pacific people's experiences, including an absence of literature on the general population in NZ. An unexpected limitation in the literature regards studies into youth mental health. This is regrettable because this population group is higher in numbers than other age groups in terms of mental health issues. Increased research into this age group would be enormously beneficial for governments to plan and establish mental health provisions for youth.

The literature was organised into key themes extracted from the countless studies and commentaries that explored why minority people, including Pacific people in NZ, are less likely to use mental health services. As consistently stated throughout this thesis, the overlapping matrix of factors is the result of a complex web of inter-dependency relationships (Cauce et al., 2002; Kelly, 2006) within an ecological system. This makes it a daunting task to make sense of individual factors because each is dependent on other factors. An attempt to split the units into independent items within this network of systems is to some extent, an endeavour to untangle a very complex social world of interconnectedness. A further gap in past studies is the lack of connecting the factors under investigation, holistically, in such a way to understand how several factors were associated or influenced other factors or outcomes. Cauce et al. (2002) have asserted that a focus on an individual in relation to disability behaviour or aetiology will be obsolete in the near future. This foresight makes sense since access to mental health services is more problematic than accessing general health services (Snowden, Masland, & Ciemens, 2006).

The disproportionately high numbers of ethnic minorities forecasted to require mental health services (Yeh, et al., 1994) and the soaring numbers of untreated cases worldwide (Wang, et al., 2007) have emerged and represent complex health issues for governments to solve (World Health Organisation, 2001).

The *Pathway to the Utilisation of Mental Health Services* is a concept that was applied as a framework to understand the journey through the different stages to the usage of mental health services. Rogler and Cortes (1993) defined it as the:

"sequence of contacts with individuals and organisations prompted by the distressed person's efforts, and those of his or her significant others, to seek help as well as the help that is supplied in response to such efforts." (p, 55).

The concept of “pathways” can be a useful framework to assist research designs investigating the issue of utilisation of mental health services (Rogler & Cortes, 1993). This study applied the pathway to mental health services to structure the literature review and in the interpretation of findings in a logical and orderly way. It is a process; therefore, its use enabled the separation of the pathway process into appropriate stages. Each stage of the pathway is then examined in detail, particularly any factors that hindered the progression to the next stage. This framework was also applied to assist the interpretation of the findings, and its immense contribution to understanding the findings and previous studies was enormously beneficial.

A discernment of the pathways and process of help-seeking for the treatment of mental dysfunctions (Rothi & Leavey, 2006) is one way to locate the subtleties that deduce the high extreme cases of untreated people. Knowledge gained from research investigations into how ethnic minorities first identify mental problems, and how people sought help that will eventually lead to the selection of a service provider is crucial (Cauce et al., 2002). These authors argued that it is more effective to examine the problem of access, therefore underutilisation of mental health services, than the traditional way of investigating rates of mental health treatment or admission rates.

The stages of the help-seeking process do not follow a linear pattern unless it involves voluntary decisions, but in many other circumstances such as forced treatment or in the case of adolescents and children, it could go forward or backwards, depending on the circumstances of those involved.

In addition, this chapter instead reviews the literature in conjunction with the ecological systems framework and the pathway to the utilisation of mental health services was used to assist the presentation of the literature. The potential to examine the issue of underutilisation from any angle exists, but the ecological and pathway frameworks of analysis of the literature provided an effective way of uncovering the dynamics involved in the process of accessing and using mental health services.

### **Prevalence of Mental Illness amongst Racial and Ethnic Minorities.**

According to the World Health Organisation, neuropsychiatric disorders will increase to 15% by 2020 across the world (Kohn, Saxena, Levav & Saraceno,

2004). The impacts, in terms of disability-adjusted life years (DALYs) or living with the disabling condition is debilitating. A major reason for the global increase is due to people's inadequate treatment of the disorders.

Several criticisms targeted the emphasis on prevalence as a method to understand its link to underutilisation of mental health services. The argument surrounds the fact that it does not take into consideration those people who do not access mental health services (Sartorius, 2015). There is no disagreement about the limitation of using prevalence rates to explain underutilisation rates, however, the inclusion of prevalence rates as contended by this thesis is to firstly, convey the high numbers of people suffering from a mental health condition whose diagnosis have been confirmed. Secondly, prevalence rates assist comparisons of ethnic rates of people with a mental illness, even if this avenue of analysis is inadequate due to ethnic disparities in the use of mental health services have been in studies to be used below. According to Sartorius (2015), historically, mental health needs were neglected because of the lack of sufficient and efficient care and treatment provisions and wrongly assessed against prevalence and incidence rates of mental disorders in specific populations. This avenue of analysis is problematic according to Sartorius for the simple reason that some people choose not to seek, and/or access mental health services. Some epidemiology studies have found that even if all the variables associated with barrier factors are eradicated, some individuals still prefer not to seek assistance for their condition (Fleury et al., 2012). Psychotherapy treatment can only be accessed by those who seek it (Shaffer, Vogel, & Wei, 2006).

The latest NZ statistics on mental health prevalence rates for Pacific conveyed by the NZ Health Survey (2016a), reported that Pacific adults' level of psychological distress is 1.5 comparably higher than other ethnic groups. Additionally, the annual reports by the PRIMHD (Programme for the Integration of Mental Health Data), which is restricted to include only the collection of data provided by public mental health services, also conveyed latest statistics of prevalence rates. This information is available and easily accessed from the Ministry of Health website (Ministry of Health. 2017). The database includes information on the prevalence of major mental illnesses and the mental health services that were accessed to treat these illnesses. The current 2017 statistics of NZ prevalence rates of mental illness is reported as an increase from 6.6 percent in 2007 to the current 7.6 percent of adults, and specialist mental health and addiction services use has also increased from 96,310 in 2005/06 to 171,693 in 2016/17 for adults and young people, a higher increase of 113 percent. The increase for Pacific

people is also high, 156 percent. But as Tapsell, Hallett and Mellsop (2017) argued, the first admissions are the best indicator of the true rates because the reported rates were more likely to be affected by rates of inpatient readmissions, length of stays, primary care and the involvement of community teams. Most importantly, reiterating Sartorius (2015) arguments above, it lacks statistics on people with a mental illness condition who do not attend these mental health services.

Several reasons explain the reluctance to use mental health services: lack of knowledge, ability to cope with the condition, alternative treatment options of spiritual and religious healers, alienating cultural characteristics of mental health services, unaffordable high cost associated with access and ineligibility to access treatment services (Sartorius, 2015).

A related argument stipulated that the literature on the prevalence of mental illness and disorders is inconsistent. Harris, Edlund, and Larson's (2005) found that high rates of mental illness and perceived mental health needs relate only to American Indian and Alaskan natives proportional to Whites. In contrast, African Americans, Asians, Mexicans, South/Central Americans and Hispanic-Latino groups exhibited lower rates of disorders and utilisation of mental health services. However, the authors caution the interpretation of these low prevalence rates of mental illness disorders are to be applied carefully due to the presence of limitations. These restrictions include access issues stemming from ecological factors of unaffordability, unavailability of local mental health services, alienation, and cultural incompetency of mental health services. In addition, racial and ethnic minorities' unique conception of mental illness differs from mainstream medical models and this present a significant barrier.

Some excuses for failing to seek help are due to denial of the problem, treatment efficacy, or the belief that people can solve it themselves (Kohn et al., 2004). The widespread lack of knowledge and literacy about mental conditions (Jorm, 2000) add to stigma issues and financial and availability factors which exacerbate the problem worldwide.

The following sections will outline the literature sources from the perspective of the pathway framework.

### **Stage 1: Problem Identification and Evaluation.**

The help seeking process begins when a person or others recognise a symptom (perceived need) that result in the person becoming clinically diagnosed

(epidemiologically assessed), or in some cases, suffers a coerced referral (compulsory, acute and judicial) (Andersen, 1995). A major psychiatric disorder symptom is psychosis located in such diagnoses of schizophrenia cited frequently throughout this thesis. It is defined as a "person's perceptions, thoughts, mood and behaviour are significantly altered" (National Collaborating Centre for Mental Health, 2014, p. 14). Early signs of schizophrenia psychosis are the 'prodromal' period that involves personal characteristics of functioning decline in communication, attention, memory, social isolation and bizarre behaviours. This period can occur between a couple of months or earlier, and it precedes the onset of the acute stage of psychosis or schizophrenia. The acute phase that follows the prodromal period is characterised by hallucinations, delusions, distress, agitation and other unusual behaviours (National Collaborating Centre for Mental Health, 2014). The stage of symptom identification of these "at risk mental states" of the prodromal period has been a focal point of interest for early detection or even preventing onsets of the disorder due to its negative effects on delaying decisions to seek treatment. Early presentations to mental health services are essential to enable a diagnosis to occur. This way, appropriate referrals to vital treatment services and other means of support is established.

An issue that has been raised is regarding who should be authorised the major role of identifying symptoms as a mental illness (Cauce et al., 2002). It may be an obvious answer to state that the medical professional is the one assigned this task and justifiably has the medical knowledge to undertake this role. Nonetheless, when we deal with minority cultural groups, including vulnerable populations, this is not always the case. In reality, various contestants compete as to who is the best person to identify the problem, and the choice is decided according to many contextual and cultural factors that greatly affect the decision-making process. This shows the dominant effect of ecological determinants involved in the initial identification of mental illnesses.

Mental health problems are defined differently by informal systems (non-professionals), such as by family and friends, and from formal definitions (professionals), such as clinical (psychologist, psychiatrist, counsellor) diagnosis (Haque, 2010; Takayama, 2010). The influence of cultural and contextual factors strongly affects the unique perceptions of ethnic and cultural groups (Cauce et al., 2002) that can be conflicting to clinical assessments (Haque, 2010). Mila-Schaff and Hudson (2009), highlighted these significant differences by stating that:

The night sky may hold the same set of stars, yet different people from different cultures see different constellations and ascribe different meanings to exactly the same night sky. This gives an idea of how mental health practitioners can be looking at the same symptoms but ascribing meanings from different cultural systems. (p. 155)

Accordingly, they proposed the essentiality of the existence of a “negotiating space” whereby all competing models meet to familiarise each other in these unique distinctions and adopt essential elements that are beneficial. The combination of western medical elements and Pacific cultural markers of mental health is possible, rather than a total separation of these two models of beliefs, care and treatment of a mental illness.

Epidemiology diagnosis was based on the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* founded on abnormality theories (Sartorius, 2015). This diagnostic system is validated as a uniform and reliable method of diagnosis assessment of mental disorders that has been employed as a global diagnostic assessment tool despite differences in cultural settings. The treatment options were developed and established agreement on its efficiency in treating the various symptoms of mental illness. However, the objectivist basis of epidemiology diagnosis is vastly conflicting to the subjective nature of problem identification that is based on experience, demonstrating the Western bias towards science (Aklin & Turner, 2006).

The distinctions in how cultural groups define and identify mental health problems to that of the medical field are obvious in explanations of deviant and improper behaviours (Haque, 2010). For instance, minority cultural groups will frequently reject medical definitions of "dysfunctional behaviour" as a symptom of a mental condition, alternatively preferring the spiritual, supernatural and religious explanations and having the tendency to confer other opinions (family, friends, religious leaders) to help define the problem (Yorke, Voisin, Berringer, & Alexander, 2016).

Alternatively, the strain of contextual factors such as socio-economic factors on ethnic minorities can heighten the pressure on parents and individuals to ignore the symptoms. These symptoms will increase in severity and eventually result in forced hospital admissions or forensic incarcerations that are the normal pathway in these cases (Cauce, et al., 2002). A good illustration is the impoverished neighbourhoods where violence is a normal everyday life. In these circumstances,



people tend to normalise many unacceptable behaviours that are commonly diagnosed by the medical field as fitting the criteria of a mental symptom. These "dysfunctional" behaviours are common and a reality in these neighbourhoods and violence is a daily occurrence faced in impoverished communities. Hence, contextual and cultural dynamics do determine how mental health problems are defined, and whether treatment is sought.

Often, the individual or his/her support person (family member) evaluate the nature and the severity of the problem in order to assess whether it warrants treatment (Wahlin & Deane, 2012). It can become an issue because the different assessments can invite conflicting various choices, such as between parents and child/adolescents. Another factor that needs evaluation is whether it is temporary and will disappear on its own. These differences in opinions can create delay or even non-action of help seeking. At this point, it can be extremely difficult to make evaluations because they are based on the personal experiences of the individual or of others. For instance, adolescents often experience extreme developmental changes as they transition into adulthood, hence many of their behaviours can be confused as symptoms of mental illness, or vice versa ignored as normal teenage disruptive behaviour. Consequently, this may lead to a delay in seeking treatment for acute symptoms of a mental disorder, or vice versa as wasted energy, time and money seeking help for a normal disruptive teenage behaviour.

In the case of child and adolescent circumstances, the mother usually picks up this responsibility of decision-making (Thurston, et al. 2018). The implications are that adolescents' voices are ignored as immature and lack self-understanding of their own problems. A thematic analysis of a study by Gulliver, Griffiths, & Christensen (2010) indicated that adolescents perceiving stigma and having poor mental health literacy (lack symptom recognition) and trying to deal with the problem themselves are major barriers to help seeking. Conversely, positive experiences of visits and having a family/social support system can counteract these negative predispositions. For these reasons, the authors recommend that reducing stigma strategies and improving mental health literacy will increase youth independence and self-confidence to accurately recognise the symptoms and seek early aid themselves.

Consequently, it is in the interest of mental health services to formulate strategies to minimise the numbers of untreated mental health cases because unless these mental disorders are treated early, they will result in extreme severity,

frequency, treatment refractory and suicidality (Kohn, et al., 2004). Competency in the identification of mental illness conditions at their onset, therefore potential early treatment, is one strategy proposed to offset underutilisation rates (Wang, et al., 2005). A global mental health survey of untreated rates in 15 countries including NZ reported findings that these untreated cases were more prevalent in developing countries, men and older people (Wang, et al., 2007). These researchers criticised the fact that the onset of the mental illness condition has been neglected in studies, and studies tended to focus on existing stages of illness. The duration of the period of delays is important to address as well, so explanations and factors that contribute to such delays are realised. In a similar vein, Andrews, Issakidis and Carter (2001), studied reasons for the poor mental illness treatment in developed countries and concluded that attitudinal and diagnostic factors were major explanations to account for the variances, rather than funding.

In contrast, Jorm (2000) argued that the level of literacy regarding mental health aspects by the ordinary members of the public is minimal, citing a study in the US findings that conveyed higher numbers of the public were familiar with mood rather than somatic symptoms. The author further contented that one of the implications with problem identification of symptoms of a mental disorder is that if the mental health consumer's support person is incapable of adequately conveying the symptoms to primary mental health services (GP), then this first step of communication will be unsuccessful and will exacerbate the existing persistent problem of GPs' missed diagnoses of mental illnesses.

## **Stage 2: Seeking Help.**

The decision to seek treatment occurs when a mental health disorder has been identified as severe and persistent and warrants a treatment. The equation includes the perceived need of treatment that must lead to an action of help seeking (Cauce et al., 2002). On the contrary, it is not as straightforward as this description prescribes. A question raised is: How are decisions made as to where and when to seek help and what are the obstacles faced along the way?" This section will focus on the logic behind the different choices that individuals make when faced with symptoms of mental illness, and the barriers that may discourage help-seeking behaviours

**Obstacles to help seeking.** This particular stage of the process of entry into mental health services has many barriers that influence the decision to seek treatment. It is the most complex stage in the equation of the pathway to using mental health provisions. Explanatory factors drawn from various studies will be discussed below.

According to the findings by Rothi and Leavey (2006) of a study of adolescents' underutilisation of mental health services, five major categories of barrier factors were identified. Firstly, the mental illness condition needs a clear, accurate identification that it is a mental illness, which is then followed by an evaluation it needs treatment. These processes are dependent on people's ecological environments that determine how help seeking eventuates and is accomplished, if at all. Secondly, psychological factors (stigma, fear, shame, denial and self-efficacy) are also influential but indicated that fear of therapy, the disclosing or denial of the mental illness strongly negate decisions to seek treatment. Rothi and Leavey (2006) advocated promotional education programs to inspire adolescents to feel at ease with their mental illness condition and adopt positive attitudes towards mental health services. Thirdly, demographic factors (gender, race/ethnicity, age, and culture) play influential roles in people's decisions to not seek treatment. For instance, females tended to be more willing to seek assistance than males who are more prone to self-stigma. The fourth category of barrier factors concerns the diverse social factors that are embedded in ecological networks and social support systems which can act as positive or negative influences in adolescents' help seeking decisions. The final group of barriers relates to the mental health provisions' features particularly in terms of availability, accessibility and knowledge of its existence and locations.

**Availability of mental health services.** The lack of local mental health services and related resources in areas populated by minority people has been cited as a major problem. However, according to Griner and Smith (2006), even if there are sufficient local mental health services available, the fact that people lack knowledge of the location of mental health services and how to access them limits the use of the services anyhow. Added factors such as lack of childcare facilities and inflexible opening hours can further frustrate people's willingness to attend clinics. However, the scarcity of specialist mental health professionals for children

and adolescents is a strong prohibitive factor to attending clinical assistance (Jansman-Hart, et al., 2011).

***Help seeking disparities between racial groups: The influence of culture and race.*** Ecological influences on people's help seeking behaviours have recently been acknowledged in research (Constantine, Warren, & Miville, 2005). Still, a scarcity of research has considered the impact of social-ecological influences to understand and identify barrier factors of utilisation (Vogel, Wade, Wester, Larson, & Hackler, 2007).

Culture, race, ethnicity and contextual dynamics are consistently associated with help seeking (Cauce, et al. 2002). Their research revealed ethnic differences in how cultural and ethnic groups conceptualise psychological problems, but more so, in how to deal with the problem. For instance, Asian Americans and African Americans prefer not to deal with it at all, hoping the mental disorder will go away or expect sufferers to deal with it by completely ignoring it (Takayama, 2010). Most of the East Asian cultures are ashamed if someone close to the family has a mental illness, because of "loss of face". and seek external aid (non-medical) is sought (Chu & Sue, 2011).

McCabe and Priebe (2004) compared one White and four non-white groups: Bangladeshis, Africans, Caribbeans and West Africans in the United Kingdom (UK) with schizophrenia diagnoses. The study objective was to ascertain whether these explanatory models of mental illness were biological or supernatural. The findings conveyed that Whites agreed with biological explanatory models whereas the non-whites preferred the supernatural explanations. The findings also showed that biological explanations are associated with positive satisfaction with treatment, and consequently inspire help seeking tendencies. Similarly, Jorm (2000) argued that non-Western cultures such as Pacific cultures are more likely to believe in the supernatural (witchcraft and evil spirit possessions) as causes of mental illness which encouraged seeking assistance from healers, uncommon to western cultures.

Ecological social determinant factors including social (stigma) and economic impacts (financial) that can restrict people's willingness to seek assistance. These factors have enormous effects, creating a widening divide in health disparities between ethnic groups. For instance, a study by Hoberman, (1992, as cited in Cauce et al., 2002) found that 90% of African Americans using mental health services were from impoverished backgrounds. One can interpret the statistics positively, as

evidence of a prolific pattern of help seeking and eventual utilisation of treatment services by African Americans. According to the author, this trend of high use by poor African Americans is due to the extensive support for the disadvantaged by a well-developed health support system situated in a democratic society, such as assistance with referrals. Recent contrasting studies however estimated that African Americans are more likely to not seek mental health assistance, in comparison to Whites (Buser, 2009).

Buser's findings attributed the lower rates of treatment of African Americans to their negative attitudes to mental health services, unique coping mechanisms and care disparities in terms of racially differential treatments. Similarly, a study by Snowden, et al. (2006) found that Latinos and Asian Americans experience similar disparities in accessing mental health services. The study found that increasing ethnic bilingual and bicultural staff would increase access rates for this population group and other minorities.

A conclusion from various studies reviewed (Sue, Zane, Nagayama Hall, & Berger, 2009) found differences in accessibility, availability and the quality of delivery patterns of mental health services regarding White Americans and racial, ethnic minority populations. Cauce et al. (2002), also concluded from a literature review that frequently, the influence of cultural and contextual factors (macro system level) have the most impact on utilisation of services. The authors forewarn that the effects of macro system factors must be cautiously analysed for they are "subtle, elusive, and difficult to capture with the traditional techniques used for studying psychological phenomena" (Cauce et al., 2002, p. 44).

This 'cultural conflict' impacts found in multicultural societies in relation to diverse behaviours, customs and cognition (such as attitudes, schemas, beliefs, ideas) have supported the importance of culture and context as explanatory factors to heed (Cuellar, 2000). Cuellar (2000) argues that culture is influential at all levels of an individual's acculturation changes when faced with alternative cultures. For instance, at the macrosystem level, acculturation processes involves values and language; at the exosystem level, acculturation impacts institutions, at the mesosystem level, the social and group behaviours (customs, rituals, foods), mesosystem level, families and social interactions and lastly, at the microsystem level, influencing cognition, emotions and behaviours and ideologies, beliefs.

Moreover, Takayama's (2010) complex review of literature that was guided

by Bronfenbrenner's Ecological Systems Theory (1992) pertaining to barriers to formal and informal help seeking behaviours amongst Asian immigrants and Asian American-born residents, identified systemic factors: macro system (culture, ethnicity, generational and acculturation), exosystem (stigma and shame), mesosystem (family structure, environment and social support) and micro system (gender and age) influences. The patterns revealed that females who have strong cultural ties and second-generation Koreans have low help seeking tendencies, while Japanese Americans were more likely to partake in either self-referrals or referral of others. This suggests that females tended to favour support systems that consist mostly of friends and concluded that differences in acculturation and immigration status strongly influence the course of patterns of help seeking by Asian Americans.

Other explanations for Asian Americans' delay in help seeking behaviours include willpower coping mechanisms, predispositions towards minimisation of emotional and behavioural problems as typical youth developmental behaviours, and the affinity to believe that to seek external aid is a weak trait (Brown, 1998). The aid of elders such as a shaman, or fortune tellers are also occasionally utilised for these types of assistance that are preferred over medical services. Mental health service assistance is pursued only when these external systems of treatment fail to solve the mental condition. The cultural incompetency of mental health services is another profound element associated with the dislike of accessing mental health services by Asian Americans. A further study by Knipscheer and Kleber (2001) of a Latin migrant population, the Surinamese minorities in the Netherlands, found that they experience disproportionately higher psychiatric hospitalisations because of higher severity of illness due to reluctance to use outpatient mental health services. In contrast, an interesting finding in another study (Sue, Zane, & Young, 1994, as cited in Knipscheer and Kleber (2001) established that African Americans were frequent users of mental health outpatient services. This group is slightly different from other minority vulnerable populations for it does not have migrant status. African Americans are historically, long-term citizens so this population lacks definition as an indigenous or migrant group. However, they possess similar traits as a minority people of colour.

These findings are substantiated by other research findings that argue the state of underutilisation is not caused by lack of need (Kung, 2004). Rather, the principal cause of underutilisation is due to people's reluctance to seek treatment.

According to the researchers, the shame element incited by belonging to a close-knit community and reliance on oneself to deal with the distress can be a destructive effect on self-intrinsic feelings of despair.

**Demographic influence.** This section will begin with studies that pertain to the micro system level of an individual's demographic factors such as gender, age, and psychological factors that affect the way individuals seek mental health services. A gender difference was noted by Vogel, et al. (2007) whereby females were more likely to be advised to seek treatment or act as advisors, and therefore are more likely to use primary mental health services. An explanation given for this pattern is that females tend to voice their concerns and emotions more easily to support systems who will encourage help seeking (Cauce et al., 2002). Yet again, the effects of the social environment of family, friends and even the media which encourage this gender behavioural difference, are overwhelming.

The same rationalisation is applied to the poor, whereby referrals are more likely to be provided by social service agencies that are not linked to mental health services while referrals for those who have higher SES (social economic status) tend to be from family and friends (Cauce et al., 2002). This is understandable as the income and educational statuses of the wealthy mean they have the resources for knowledge acquisition and the means to find information.

Fleury et al. (2012), guided by Andersen's model of using health services (1995), reported that needs-related factors (perceived or diagnosed) have extreme impacts on mental health service utilisation. Equally, predisposing factors such as age, gender, marital status, education, country of birth, race and ethnicity strongly dictate the use or not, of mental health services. The authors' review of the literature concluded that the more frequent users are those between 25 and 64 years old, female, married, educated and white (compared to Blacks and immigrants). Additionally, high use amongst those who perceive their mental health status as poor was detected, while enabling factors such as those who believe that it is too problematic to access services usually will not attempt to seek it. The effect of family support and other support systems have mixed results, negatively or positively encouraging or discouraging utilisation. Finally, regular attendance at a medical practice will also encourage usage. Fleury and co-authors also located gaps in the literature in relation to the effects of religious beliefs, judicial involvement,

impulsivity, ongoing violence and aggressive behaviours and their effects on utilisation.

**Social and family support systems.** The mesosystem includes family dynamics and environmental/ecological factors' (such as friends, and social networks) extensive influence on individuals' help seeking behaviours of mental health services.

Accordingly, mental health professionals and treatments are more likely to be assessed as irrelevant due to the aid of these coping mechanisms of personal and cultural resources (Buser, 2009). These factors are gradually becoming a strong focus in mental health research (Rodgers, 2009). In spite of this, few researchers have utilised an ecological approach in their research methodologies. One example is the link between the deterrence impacts of stigma and culture. For instance, Rodgers (2009) demonstrated that environmental factors influenced Mexican American students' perceptions of lack of social support by family compared to adequate support from other support systems, while feelings of cultural familiarity strongly motivated students' decisions to seek treatment. This focus on ecological determinants in terms of the influence of social networks on people's help seeking decisions was confirmed by a study by Vogel, et al. (2007) whereby peers, friends and family's prior experience and knowledge of mental health utilisation will either encourage or discourage seeking treatment.

**The problem of stigma.** The concept of stigma and the process of help seeking intertwine in significance when we try to understand the reasons why people do not seek assistance for mental health needs (Vogel, Wade, & Haake, 2006). Stigma involves misconception, negative stereotyping and labelling and are common factors that deter individuals from seeking help. Other implications include social discrimination such as mental health consumers' persistent experiences of rejection when applying for housing and employment (Hamer, Finlayson, & Warren, (2014). Two types of stigma experienced consistently by the mentally ill, such as stigma that originates from public attitudes, called *social stigma*. This type of stigma is observed in people's disapproval of the mentally ill and mental illness which differs from *self-stigma*, described as the self-demeaning judgment of being diagnosed with a mental illness (Vogel, et al., 2006). For instance, a study by Rodgers (2009) of university students in the United States, using the ecological



system's theory of social proximity factors (familiarity with mental illness and mental health services) and demographic factors (gender, race/ethnicity) found a correlation between experiences of stigma and help seeking behaviours in a university context.

Similar, and somewhat surprising was a finding by Lauber, Nordt, Braunschweig, and Rössler (2006) who reported that mental health consumers were extremely critical of mental health professionals believing this group as encompassing the most stigmatised attitudes of any group they had ever encountered.

### **Stage 3: Service Selection and Utilisation of Mental Health Services.**

The journey to the utilisation of mental health services begins with problem identification, followed by help seeking and ends with decisions on the selection of the service and eventually its actual usage. However, as Cauce et al. (2002) assert, the first two stages seldom flow smoothly and easily to the utilisation stage. Despite this potential to detour from the normal process, a major advantage of the pathway conceptualisation of the problem of underutilisation is to clarify in some orderly way the often, chaotic process of people's presentations to mental health services.

This stage of the pathway to the utilisation process is unique and complex when involving minority people and it differs vastly from the normal route of mainstream pathways. It is the end stage of the pathway process; therefore, utilisation of mental health services occurs at this point. Rather than the normal track of using mental health services via referrals from primary mental health services into secondary services of psychiatric provisions, utilisation for minority populations typically involves the direct route into forced compulsory admittances (Morgan, et al., 2005). A common referral to compulsory admissions, particularly for minority people of colour, is through the police and the criminal courts (Bhui, et al., 2003). The authors additionally illustrated this by a comparison of African-Caribbean, Black Africans and Whites who were hospitalised with first episodes of psychosis in the United Kingdom (UK) and showed greater levels of compulsory hospitalisation for the minority groups. African Caribbean men had the highest levels of compulsory admissions. Similar studies in the UK with identical findings of comparably high rates of compulsory admissions by African Caribbeans than Whites were also found in the literature (Ivanović, Vuletić, & Bebbington, 1994) and for Black Africans (Davies, Thornicroft, Leese, Higgingbotham, & Phelan,

1996). A literature review by White (2016) suggested that youth minorities who suffer from a mental disorder finally receive treatment when diagnosed in juvenile justice systems.

A few studies have discussed the effects of methodological limitations that may have led to results of high levels of compulsory admissions. Karlsen, Nazroo, McKenzie, Bhui, & Weich (2005) argued that a review of studies to explore this issue revealed its numerous limitations in the research. For instance, inadequate indicators such as crude ethnic categories of White/Black dichotomy and the scarce use of varied sample populations (diagnosis group, or first onset, or chronic level) have been consistently applied in research. Consequently, a generalisation of the findings is very difficult to apply to real life situations. But would the inclusion of a diverse ethnic groupings instead of just the Black/White communities and multitude of conditions, change the findings? Or would this complicate the research design and process and make no meaningful difference to the generalisation of the result?

**Alienation effects of mental health services.** Consequently, the question raised is: “Why does accessing mental health services occur at the acute stage rather than earlier?” A few reasons have been discussed in earlier sections but, the concept of alienation that relates to the culturally alien delivery practices of mental health institutions is deemed a significant factor. According to Griner and Smith (2006), the existing traditional counselling and psychotherapy means of treatment solely caters to the needs of middle-upper class European Americans, without accounting for the needs of the multicultural "others" of society. Correspondingly, study findings by Yeh, McCabe, Hough, Dupuis, & Hazen, (2003) reiterated this pattern of the dominant culture of alienation of mental health services in relation to African Americans, Pacific Islanders and Hispanic ethnicities in the United States. A further barrier identified in this study is the lack of ethnic-specific medical professionals. The shortage of ethnic specific medical staff has been revealed in other studies discussed above, and its impact as a barrier factor is evidenced in the distrust perceptions of ethnic minorities towards mental health services.

The cultural alienation effects associated with mental health services have been demonstrated by other international studies, but mixed results were identified in one study. For example, in the United States, Sue, Fujino, Hu, Takeuchi and Zane, (1991) tested the validity of the cultural responsiveness hypothesis by using a sample of four diverse populations (Asian-Americans, African-Americans,

Mexican-Americans, and Whites) who use outpatient services. The study aimed to explore whether the ethnic matches of professionals-clients led to positive treatment and recovery outcomes and found mixed results. Asian Americans and Mexican Americans decreased their attendance while African Americans increased, but benefited from less positive results. Also, the ethnic match of client/therapist was also related to the length of treatment for all the groups and benefited mostly those people who spoke very little English. The rationale for the researcher's study was to confirm past studies' findings of the shortcomings of mental health service provisions to ethnic minority groups. The following was the evidence they presented: lack of suitable psychological assessments, prejudiced treatment, therapist stereotyping ethnic groups' negative inherent characteristics, underutilisation of services and early cessations, plus the inappropriateness of traditional mental health treatments (Sue, et al., 1991).

Cultural incompetency within mental health services has been described as a forefront influential factor that discourages minority populations from seeking treatment (Sue, et al., 2009). Sue, et al.'s analysis of the concept of cultural competence in relation to mental health services can be summarised as having three levels: the treatment level, institutional operations, and via the system's level at the community level. Its review of cultural competency is at the first level of the service provider/therapist/counsellor treatment. Despite a universal agreement that cultural values and treatment practices are crucial qualities for mental health services to foster and develop to cater to the needs of ethnic minorities, there were differences in how cultural competency was conceptualised and framed in studies. The distinctions include the problems of defining exactly the meanings of essential characteristics and cultural skills, knowledge acquisitions, understanding and respect of multiculturalism and positive outcomes to satisfy the criteria of cultural competency (Sue et al., 2009; Whaley & Davis, 2007). There is some credibility and validity in this assertion that cultural competency is a concept that reflects idealism rather than realism. This particular topic of the inadequacy of the term cultural competency needs further analysis and exploration for it is an extremely significant cultural criterion for all mental health services in multicultural societies to adhere to. The problem is the complexity in choosing a defining agreed universal criterion from the multitude and diverse cultural components available.

### **Child and Adolescent Studies.**

Andersen's model of health service use (1995) related the concept of need either perceived (individual perception) or evaluated (diagnosed), yet, unlike adults, children's need of, and therefore entry to mental health services is dominated by their parents (Wahlin & Deane, 2012), or other support systems or, in some situations, the police (Wu, et al., 1999). It is a totally different pathway of entry and utilisation of mental health services in comparison to that of the adult population.

The majority of mental disorders begin to develop in childhood and about half on these appear by the age of 14 (Kessler, et al. 2005, as cited in Thurston, et al. 2018). Less than 50 percent of the children with a mental illness condition were treated, but this was worse for racial and ethnic minority children (Merikangas et al. 2011, as cited in Thurston et al. 2018). In addition, cited statistics in Ben-David, Cole, Spencer, Jaccard, & Munson, 2017), the US by the Institute of Medicine and National Research Council (2014) reported that a fifth of all young adults had a mental illness at some stage in their lives. Yet, two thirds of this group did not seek help for their condition. Hence, this unmet mental health needs of young people are a major public health issue. The results of the 2000 Youth Health and Wellbeing Survey Series (Clark, et al. 2013), of a longitudinal study of secondary students in NZ is evidence that mental health is one category that had not improved and is negatively comparable to rates of other countries.

Adolescents are marred with numerous obstacles and complexities in their pathways to mental health service use, particularly the criteria for eligibility which varies not only from region to region, but between services (Cauce, et al., 2002). This confusion has resulted in the underutilisation of mental health services by adolescents but over-representing in the use of non-mental health services like school systems and social agencies. For instance, a study by Burns and colleagues (1995, as cited in Cauce, et al., 2002) reported statistics of usage of services to include 70% from the school systems, 11% from primary care, 16% from the child welfare system and 4% from the juvenile justice system.

The high prevalence rate of mental illness among youth in the juvenile justice system, 65 to 75% is concerning (White, 2016). Minorities with mental health issues who were prone to severe treatment and confined in juvenile correctional facilities are markedly more compared to Whites or persons without a mental illness. In spite of the high prevalence of youth mental disorders in the juvenile justice system, mental conditions are not detected and therefore remain

untreated. Research into minority youth in juvenile justice systems is limited according to White (2016), but Whites, females and younger youth were more likely to be referred to mental health systems, while in contrast, minorities were placed in the criminal justice system. Hence, race/ethnicity strongly affects the choice of which system to refer people to for treatment. Furthermore, despite a lower prevalence of mental illness amongst White youth, use of mental health services is higher than minority youths, who paradoxically, have higher prevalence rates of mental disorders.

A further concern that relates to youth is the treatment of mental health problems by non-mental health professionals, made worse by the fact that some of these youths are treated by a variety of multiple treatment settings that render a confused and overburdened youth. The problem is exacerbated in ethnic minorities' situations, which consist of numerous family social network systems comprising diverse informal consultants that include: extended family members, friends, traditional healers, school officials and church and community leaders who act as gatekeepers (Cauce, et al., 2002). When cultural norms spurn psychotherapeutic interventions, help seeking is discouraged in favour of informal advice (Tata & Leong, 1994), especially by ethnic minority parents. In contrast, White individuals will personally contact mental health professionals, but ethnic minorities will consult other agencies first for advice or will seek someone to contact formal services on their behalf (Takayama, 2010). Connolly, O'Reilly and Rosato's (2007) study of the environmental and individual factors that influence young African American's success with mental health services conveyed that race/ethnicity, gender and availability were limiting factors associated with initiating access.

### **Mental Health Literacy.**

A significant factor that appears to inhibit the successful progression of journeys towards utilisation of mental health services is the widespread unawareness of symptom identification, and therefore delaying, or resulting in an absence of, seeking of treatment. Mental health literacy is a concept that was coined by Jorm, et al. (1997, as cited in Jorm, 2000) who defined it as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (p. 397). The definition designates three elements to be emphasised that

include ability to identify the symptoms, manage and prevent the onset of a mental disorder (Jorm, 2000).

### **Compulsory Psychiatric Admissions.**

It has been established in the Introduction chapter that the ultimate utilisation of mental health services by minorities is forced treatment and care in the form of compulsory and forensic admissions. This section will discuss compulsory treatment/care and forensics mental health services.

In terms of acute hospitalisations, the eligible criteria to be admitted as an involuntary patient is firstly, the presence of a mental disorder that is severely a risk of harm to oneself or others (Chun, Mace, Katz, 2016) hence requiring a crisis intervention (Fanneran-Hamilton, Bradley, & McNally, 2017). The increase in admissions to acute inpatient hospitalisation is evident in western countries, such as in the UK, an 8.3% increase was observed for the 2013/2014 period (Health and Social Care Information Centre, 2015, as cited in Fanneran-Hamilton et al., 2017).

The other consequence of underutilisation of mental health services is the disproportional high Pacific admission rates into forensic services (Ministry of Health, 2017). Forensic mental health services are provisions of care and treatment to people who have a diagnosis of a mental health illness, and who have committed an offence with a defence of insanity (Jansman-Hart, et al., 2011). So, to be released, it must be satisfied that the person is no longer a physical or psychological threat to the safety of society.

The advent of deinstitutionalisation into community mental health services and stricter criteria of entry into psychiatric service provisions means that more people are released into the community, resulting in difficulty managing people with severe, aggressive, disorderly and psychotic symptoms. Hence, police are called to deal with the situation, and eventually the courts are involved due to a crime being committed. This is often the pathway of entry into forensic services experienced by minority people as a first point of entry into mental health services. Taira, et al. (2001) described it as a cyclical process of entry into mental health services. In contrast, Jansman-Hart et al., (2011), using the findings of a study in Canada, USA and Europe showed that resource allocation for this area of mental health is considerably provided and funded, but, at the expense of other mental health services that are clearly declining. As more resources are channelled into forensic services, less is provided for non-forensic mental health services. This

section of mental health services requires urgent and complex interventions and associated trained law and clinical staff due to escalated psychotic and dangerous behaviours of offending.

One reason to explain the high demand for forensic services include the rise in transfer of severe cases of mental health patients and inmates into forensic provisions as well as the surge in numbers of co-morbidity (substance and alcohol abuse) that lead to high incidences of violent behaviours (Hodgins, Tjihonen & Ross, 2005, as cited in Jansman-Hart et al., 2011). A more plausible explanation is offered by Crocker, Hartford and Heslop (2009, as cited in Jansman-Hart, et al., 2011) who argued that the lack of training of police officers to deal with the mentally ill, or even to distinguish mental disordered behaviours influences their decisions during arrests to opt for forensic referrals rather than the complex and strict rules of admissions into general mental health services.

It is important that this high demand for forensic provisions is linked to cultural minority populations' low use of mental health services, and to examine whether the unique cultural markers and contextual circumstances have increased ethnic populations' usage of forensic services. However, there is limited acknowledgement of this link in the literature that forensic admissions are due to more people delaying or refusing to seek help for the treatment of their mental conditions. Most of the many explanations provided in the literature tend to focus on attempts to explain the rise of criminal behaviour amongst the mentally ill, or the increasingly strict criteria of general mental health services that dissuade decisions to refer arrests to its services, and political/social intolerance of crime.

### **The Pacific Region**

Mental health in the Pacific regional states has been portrayed as inadequate due to lack of pharmaceuticals and treatment facilities, in addition to limited mental health professionals (Hughes, 2009). The absence of mental health facilities means that primary mental health services are over-burdened, and in most island states, churches and community organisations collaboratively act as replacements for limited mental health provisions (Hughes, 2009; Morris, 2009). The absence of inpatient mental health facilities in some island states has led to the use of jails to house mentally ill people suffering from serious mental illness (Morris, 2009). However, a recent positive development is the establishment of the Pacific Islands Mental Health Network (PIMHN) that unites Pacific regional states to collectively

provide treatment options as well as upgrade mental health provisions (Hughes, 2009).

The Pacific regional states are underdeveloped and economically backward, including its health systems (Deva & D'Souza, 2012). Out of a total of Western Pacific regional states, 14 Pacific Island Countries (PIC) were identified by the World Health Organisation as in the category of low or medium income and labelled as developing countries. PIC states are sparsely populated, comprising small atolls that spread out in the vast Pacific Ocean, therefore, accessibility issues in the form of delivery of mental health treatments is a problem. Transport is expensive and very slow.

These limited mental health facilities in the PIC's means that the pathways framework is irrelevant as an analysis tool. Therefore, the discussion of this region will explore the avenues that people utilise as coping mechanisms in the face of absence or limited mental health facilities.

### **Tuvalu and Other Pacific Regional States Mental Health.**

The Pacific regional states, including Tuvalu, are engulfed with problems due to lack of treatment facilities for mental health needs and even if some provisions are available, its delivery of services is problematic due to high costs and geographical difficulties of access (Deva & D'Souza, 2012). The existence of ecological, social, political and economic influences on the lives of mental health consumers, including the availability of mental health services and how these are accessed has been an ongoing problem (Hughes, 2009). The problem is exacerbated by the lack of priority that governments place on mental health compared to other medical services (Hughes, 2009). Inadequate funding resulting in a small fraction of available facilities, pharmacology, modern equipment and promotional initiatives has been identified as a major factor. The deplorable situation of mental health has additionally led to the emigration of medical professionals to higher paid jobs overseas. The existence of these issues means that primary services are over-utilised for mental health diagnosis/treatment (Hughes, 2009).

Hence, the treatment gap in mental health care in many (PICs) is pronounced and has been a priority for external organisations to solve (Whitley, 2015). The World Health Organisation's statistical data demonstrated that more than 90% of those who suffered mental health disorders in the 12-month period of 2004 did not receive any form of treatment or care (Kohn et al., 2004). Explanatory factors



include limitations of services and mental health professionals which led to the issue of mental health identified as part of a prioritised health issue in the 2011 Pacific regional meeting of Pacific Ministers of Health.

There are many challenges in relation to the issue of mental health in the Pacific region. A report by the World Health Organisation (2005) concluded that because mental health is not prioritised as a major health strategy by Pacific regional governments, coupled with problems of stigmatisation and discriminatory attitudes, and lack of awareness of its significance, the emphasis is on other health needs. Mental health care and treatment are difficult to be implemented into this structural operation that heavily evolves around primary health care. It requires specialised types of care and treatment, which most of the Pacific countries lack in monetary terms and in professional competency to develop an infrastructure for mental health services. Requirements that are non-existent in many countries in the Pacific region are governance, financing, health service delivery and organisation, legislation, policies, strategic plans and programs, workforce, services and facilities, as well as nongovernmental organisations (NGOs) (World Health Organisation, 2005).

If the pathway to mental health service utilisation is applied to Tuvalu mental health, it is non-existent because mental treatment provisions are non-existent. The literature regarding mental health provisions in Tuvalu was very limited. The sparse information retrieved is sourced from the Tuvalu Ministry of Health document, *Strategic Health Plan 2009-2018 Report* (Tuvalu Ministry of Health, 2009) which provided a short report about Tuvalu mental health status. The report acknowledged the limited provisions and meagre resources and shortage of trained mental health staff. There is no mental health policy for Tuvalu which is an indication of the lack of priority of governments, and maybe the public in terms of mental health.

Tuvalu is one of the PIC underdeveloped regional Pacific states discussed above that has very limited resources, particularly fiscal resources to be able to source and sustain the structural demands of health needs of its people. The limited health budget is consumed substantially by non-communicable diseases (NCDs) management which has been an ongoing priority for Tuvalu governments, with the shortage of doctors and nurses (Panapa, 2014). Tuvalu has a Department of Health whose role is to provide health services, the hospital, clinics and public health care. In spite of this, private medical centres, pharmacies or clinics are absent on the

island, but the presence of NGOs has been beneficial. These NGOs such as the Tuvalu Family Health Association (TuFHA) work in collaboration with the Department of Health. In addition, the lack of a mental health policy in Tuvalu does contradict government overall aim to improve people's health and access to healthcare. Tuvalu additionally has a Bill of Rights provision that specifies rights to wellbeing and quality of life (Panapa, 2014) which presumably exclude mental health wellbeing.

However, useful information was provided by a report, *Youth and Mental Health in Tuvalu: A Situational Analysis* (Morris, 2009), detailing a study of the mental health of Tuvaluan youth in the islands. This report revealed that the state of mental health provisions included a mere two beds in the only general hospital located on the capital island of *Funafuti*. Yet at the same time as the report, twenty-nine people were diagnosed with a mental disorder. Persons with violent psychotic symptoms were jailed because of the non-existence of inpatient acute mental health facilities. The only mental health professional on the island was a nurse who has some mental health training, hence people are looked after by their relatives as the only form of care. Pharmacology treatments are unavailable, nor are there medical reports of mental health patients. Traditional support systems provided by social structures of the family, community and church play exceptional roles in the psychological, social, physical and spiritual nourishment not only for the mentally ill, but for all citizens. This is evidenced in the form of NGOs agencies and church activities that provide home visits and assist relatives and persons with a mental disorder cope through counselling and sport activities (Morris, 2009).

According to Resture (2010), the virtually non-existent state of Western mental health treatment in Tuvalu has little impact due to the availability of alternative treatment options of *tufuga* (traditional healers) whose importance is still revered in Tuvaluan societies. Other types of traditional healing practice that were documented by Kogh (1961) is a potion *vailakau* that consists of herbal coconut oil, root oils and leaves that is normally rubbed on the bodies of people suspected to be affected by mental illness.

### **The NZ Mental Health System**

The mental health system in NZ is part of the overall New Zealand health system. There are three subsystems: funding, financing service provisions, and governance (Blank & Burau, 2004; Widodo, 2007). The role of Finance is to enable

affordable and universal access to public health and personal healthcare. Therefore, in NZ, as in other Western countries, the primary aim is to reduce financial barriers to accessing healthcare (Widodo, 2007). This is enabled through resource collection, pooling of resources and by the purchasing of interventions. Consequently, one of the causes of healthcare inequalities is explained by the allocation and organisation of health resources which results in unequal access to healthcare and its related problem of quality of health services (Widodo, 2007).

A complex system of various types of mental health services and its support services that cater to mental health needs in NZ range from government agencies, Ministry of Health, Ministry of Social Development and a host of other social services. These services provide funding, planning, policy advice and employment, housing and financial assistance to mental health consumers (Ministry of Health, 2008). In NZ, to be admitted to disability support services (DSS) that are funded by the Ministry of Health, a disabled person's eligibility criteria are:

“physical, psychiatric, intellectual, sensory, or age-related disability (or a combination of these), which is likely to continue for a minimum of six months and result in the reduction of independent function to the extent that ongoing support is required”, (Ministry of Health, 2008, p.1).

Placements and admissions into suitable treatment and care facilities depend on the existing pathological needs of the individual. Apart from psychiatric provisions, non-psychiatric support systems previously listed are recruited to assist in the rehabilitation and recovery aspects of these individuals (Ministry of Health, 2008).

The framework guiding the Ministry of Health funded disability support services is based on the social model of disability (Ministry of Health, 2008). The model promotes an inclusive approach to the treatment of mental health consumers. Basically, it endorses equal treatment of the disabled and the non-disabled. In other words, it fosters a strong connection towards the importance of an inclusive society of all people regardless of any physical, psychological or sensory impairments.

Whilst, in spite of limited overall research in NZ of mental health issues, significantly more is written about the mental health issues that relate to these vulnerable and marginalised groups of citizens such as Maori, Pacific and Asians. However, there is little literature, apart from official documentation, about the pathway process to mental health service utilisation or how people in New Zealand access mental health services. The following section will present a review of literature of mainstream, and Maori first, followed by an outline of literature specific to the issue.

The few studies that are available on this topic demonstrated an understanding of mainstream factors, such as a study conducted by Abas et al. (2003) into a correlation between socio-economic deprivation and the numbers of bed usage in mental health facilities to determine the extent of the problem of resource allocation. The cohort study of psychiatric inpatients in 1998 to 2000 in Counties Manukau, conveyed similar findings to international evidence that residents of deprived areas use psychiatric services more frequently than those who live in less deprived areas. It supports the argument that underutilisation of mental health services is prevalent amongst people who have low socioeconomic status (Abas, et al., 2003). These explanatory factors of infrequent use found in the study clearly relate to socioeconomic factors of low income, unemployment, lack of vehicle ownership and sole parenting. According to a study by Abas et al. (2003), and similarly argued by Durie (2001), staff selection systems to decide admittances from the high numbers of people competing for limited beds is an important factor to consider, regardless of the fact that the majority of clients tend to live in deprived residential areas. It raises a crucial question (Abas, et al., 2003): “Are such disorders common in poor areas because unwell people select to live there, being unable to afford to live elsewhere, or because conditions in these areas cause the disorders?” (p.439). But then, residents do live in poor areas because they cannot afford to live elsewhere so are susceptible to developing mental illness in addition to being unable to afford access to treatment services. The constant reference to economic depravity as an influential barrier to affording medications, consultancy fees and transport costs tends to operate in unison to discourage motivation to seek psychiatric services.

Recent statistical trends have consistently indicated that Maori involuntary admissions have been increasing to become the highest user, comparable to other ethnic groups (Te Puni Kokiri, 1996). The high rate of admissions was described as the result of limited access to primary mental health services, even though referrals from judicial agencies such as courts were exceptionally high (Tapsell & Mellsop, 2007). An examination of the NZ literature highlighted the extent of this problem for Maori (Robinson, et al., 2005) and attributed this issue to the distinctions in the diagnostic, treatment expenditure and circumstances of access that differ for ethnic groups. Similarly, research of Pacific child and adolescent mental health services is also evidently scarce in NZ, despite the fact that Pacific and Maori youth represent more than half of their respective populations. A study by Ramage et al. (2005) of

referral professionals such as GPs and social workers, reiterated international findings of barrier factors of accessing mental health services by this age group that comprise lack of knowledge of available services, stigma, limited adolescent/youth mental health specialists, strict referral criteria, long waiting queues, high costs and cultural incompetency in the delivery practices of services.

**Government strategies and initiatives.** Evidence of government initiatives to improve mental health services and their delivery systems, and most importantly, government acknowledgement of ecological effects on people's health lifestyles, choices and access to health services exists in important documents.

Plans to resolve Pacific underutilisation was included in the *The Pacific Health and Disability Action Plan* (King, 2002). It referred to two objectives: the development of strategies to find new and better mental health services and improve the practice/knowledge cultural competency of associated workforce. Another document, *Tupu Ola Moui: Pacific Health Chart Book 2004* (Moui, 2004) also referred to the difficulties of Pacific access to mental health services. Other evidence of government commitment is a written statement in *Te Orau Ora: Pacific Mental Health Profile 2* (Ministry of Health, 2005) to upgrade the cultural competencies of the workforce and increase Pacific providers of mental health services. *Te Orau Ora* was developed to provide information on the mental health status of Pacific people in NZ. The information in *Te Orau Ora* attempts to better represent Pacific numbers within the Mental Health Information National Collection (MHINC) data and is intended to assist the planning of service provision. It is this limitation that influenced the government to provide evidence of Pacific patterns of health service utilisation in this country that initiated the successive series of papers to review whether the objectives were achieved, including the objective to increase Pacific mental health providers and workforce.

### **Pacific People's Mental Health in NZ**

The first ever epidemiological study of the prevalence of mental health illness in NZ *Te Rau Hinengaro: The NZ Mental Health Survey* (Baxter et al., 2006) made it possible for Pacific mental health issues to be at the forefront, and conveyed findings of prevalence and access patterns. For the first time in NZ, new information revealed that Pacific people have the highest burden of mental disorders as well as experiencing inequitable underutilisation of mental health services (both

hospital and community settings) (Eagar et al., 2005; Ministry of Health, 2008) and primary health services (Dowell, et al., 2009). The Ministry of Health's *Te Tahuhu Improving Mental Health Plan 2005-2015 Plan* (2005), repeated Pulotu-Endemann, Annandale, and Instone (2004), who found that Pacific people delay using mental health services until symptoms become severe. A recent study conducted by the Ministry of Health (2013) showed the occurrence of psychological distress amongst Pacific adults is 1.8 times more likely than the rest of the population (10% to 6%), yet the difference in the percentage of Pacific diagnosis as opposed to the national rate was 7% to 16% average. The Ministry of Health (2013) concluded that "Pacific adults may differ from the rest of the population in how and when they seek help and or in their access to mental health services" (p.63). A limitation of the national mental health survey is its non-inclusion of schizophrenia or bipolar disorders, diagnoses that are highly linked to mental health compulsory and forensic admissions (Robinson, et al., 2005).

The main barriers to accessing mental health services by Pacific people that are documented in the NZ literature are transport difficulties, inflexible opening hours, costs involved, and alienation features of service provisions (Hiscock, Pearce, Blakely, & Witten, 2008; Southwick et al., 2012) low income, unemployment, lack of vehicle ownership and sole parenting circumstances (Abas, et al., 2003). However, these studies do not specify the exact type of mental health service (primary/secondary/ethnic specific), and/or the type of visitation (first or subsequent visit) in the findings. Although primary mental health services, normally involving first visits to General Practitioners (GPs) have been singled out as the most problematic, there is lack of detailed research into the other services/types of mental health services' barrier factors, such as secondary mental health services, ethnic specific providers or other follow-up services.

Other factors that may hamper people's willingness to seek health services are restrictions on immigrant use of these services, which is an eligibility issue, resulting in unaffordable high costs of assessment/treatment for non-citizens, barring a section of the population from receiving treatment. This issue is paramount to the Tuvaluan situation as recent immigrants to this country, and many are non-residents under temporary work and student permits (Gemmene & Shen, 2009; Simati, 2009).

## **Pathway Process to Using Mental Health Services by Pacific People in NZ.**

**Problem identification.** A gap recognised in the NZ literature involves the absence of studies that relate to the identification of mental conditions by lay people and minorities. The international literature, in contrast, contained substantial references to the pathway process of utilisation of mental services, including detailed information related to symptom issues.

**The help seeking process.** Several materials relating to how people in NZ sought treatment for mental disorders were found in the NZ literature, particularly in relation to Pacific and Maori peoples. In contrast to the normal first pathway process of mainstream people, where primary mental health services are initially the first point of contact for assistance to be referred to psychiatric services and other secondary services, the Pacific route appears to bypass primary mental health services. The following are explanations for this conclusion.

The recent project to increase the knowledge base of strategies to improve Pacific access to primary mental health services (Southwick, et al., 2012) is a welcoming trend in assisting Pacific use of mental health services (Barwick, 2000). When interpreting the findings of such studies of primary services, caution needs to be exercised for this project is about accessing for general illnesses and not specifically for mental illness. This study showed that Pacific participants' explanations of accessing primary health services are overwhelmingly based on economic impacts in terms of costs accrued visiting GPs such as transport costs and consultancy charges, in addition to difficulty organising appointments, communication problems with GPs during consultancies as a result of language complications and absence of interpreting services, limited local services available, and culturally incompetent, racist and unsupportive staff attitudes (Southwick, et al., 2012). Several of these factors are identical to the reasons offered by the health professionals. These health professionals further stated that an advantage of being a Pacific islander, and a fluent speaker in a Pacific language is a valuable resource. For these reasons, they are aware and understand the reasons for the comparably high incidences of Pacific people who do not see the doctor for mental health needs. Other reasons given also included lack of transport, no phone, cost and lack of prioritising health needs over a myriad of other needs.

Southwick et al. (2012) also offered solutions. The goal of capitation funding is to provide equitable benefits for those of high health needs, yet at

practice level a fee is still charged, which is inconsistent with the purpose of the funds. Southwick et al recommended that this fee must be removed. Secondly, ethnicity data is still somewhat problematic because of its inconsistency, for it must contain the ethnic characteristics of not only those persons who accessed mental health services, but the non-attendees too. Thirdly, since transport problems were cited as the chief factor in inhibiting attendance of a GP service, the location of these facilities should be situated on the routes of public transport systems; or as some providers have done, provide shuttle buses for easier transport options. Lastly, appointment systems that are flexible, convenient and immediate, need to be established to counter the problem and make it easier to book appointments that are suitable to people.

### **The Problem of Primary Mental Health Services in NZ.**

Primary health-care services, apart from emergency health services, are one of the first points of entry into health services. Primary health services are community-based, commonly comprised of GPs and Practice Nurses, and its provisions consist of education, prevention and treatment of illnesses that are not life-threatening (Statistics NZ & Ministry of Pacific Island Affairs, 2011). It also acts as a referral source to secondary services when it deems the illnesses are severe. Thus, it is a priority service in all matters of health. It must demonstrate quality, efficiency, equitability and equality principles in its treatment and care of all people, regardless of race, ethnicity, age, gender, religious affiliations and all other principles of diversities of a multicultural and democratic society.

Consequently, its value as a crucial determinant of health outcomes must be recognised. But more so, it needs to provide “timely” access to its services when a health need arises, particularly, a mental health need (Southwick et al., 2012). However, criticisms have emerged regarding the shortcomings of primary mental health services (Hiscock, et al., 2008). Studying geographically and socioeconomically deprived health outcomes, the researchers described primary health services as inhibiting access to further secondary services by acting as gatekeepers for referrals to specialist treatments, tests and other secondary health services.

According to a Statistics NZ and Ministry of Pacific Island Affairs report (2011) into primary health organisations (PHOs), Pacific enrolments are quite high, including mainstream primary health enrolments. But the advent of Pacific health



providers that are comprised of co-ordinated diverse services (health promotion, primary care, secondary care and social services) is an achievement that must be acclaimed. It must be noted that the report is not solely about mental health provisions. It covers all health needs and thus visiting rates may alter if we look solely at mental health needs.

The cost factor associated with access to primary mental health services has been cited as the main deterrence to Pacific use of primary health services (NZ Statistics & Ministry of Pacific Island Affairs, 2011). Yet, subsidies, and other funding have increased (Southwick et al., 2012).

### **Alienation Features of Mental Health Services in NZ towards Pacific People.**

The question arises: “What role do mental health services; particularly primary mental health services play in unintentionally discouraging Pacific users of its services?” The reason for this query is the possibility that even if there are no barriers to overcome, and availability of facilities or services are unproblematic, there will still be evidence that people nonetheless refuse to use mental health services. This problem has been consistently discussed and remedies have been sought by governments (Ministry of Health, 2008). This justifies the concept of *alienation* for suggesting that these services act as a barrier (Ministry of Health, 2005), a form of institutional constraint, and “institutional racism.” For instance, the lack of educational/promotional programs and language difficulties in the communication between staff and mental health consumers/relatives are inhibiting factors for passing on information about mental illness/disorders, types of treatment and care, procedures and other support systems. The medical psychiatry jargon and complicated English routinely used in these settings are incomprehensible to many Pacific people. Accordingly, Pacific people rely on their own interpretation of mental illness and even self-diagnose via spiritual meanings (Ministry of Health, 2005). The mismatch is further divided by Pacific models of mental health and its treatments as based on holistic, cultural and spiritual beliefs (Pulotu-Endemann et al., 2004).

Another limitation of mental health services is the lack of knowledge of Pacific cultural beliefs of mental illness and styles of care. Most importantly, there is no Pacific delivery of mental health service model (Southwick & Solomona, 2007; Suaalii-Sauni, et al., 2009). This is illustrated in a recent study by Ludeke et al. (2012) of Pacific underutilisation of primary health services that found

explanatory factors such as language and communication problems, rushed consultations, appointment unavailability, difficult communication with reception staff and lack of Pacific staff presence. These limitations are a few of the multitude of factors that may impact on the use of mental health services, particularly primary health services to be adequately responsive to Pacific mental health needs.

Notwithstanding, solutions to improve mental health services have been developed and introduced to the health sector. The *Seitapu Framework* was formulated for this precise purpose, that is, as a standard of Pacific cultural competency criteria for all mental health services and workforce to abide by when treating and caring for Pacific clients. It is a scheme to attract Pacific people to use the services (Parsonage, Siō, & Leger, 2009). The framework had promoted and enabled leanings towards an adoption of holistic, cultural, spiritual Pacific values and belief systems to be applied at every procedural stage of the assessment, treatment and care processes when dealing with Pacific clients (Tamasese, Peteru, Waldegrave, & Bush, 2005). In the same way, other initiatives include the establishment of Pacific mental health service providers and increases in the Pacific workforce (Southwick & Solomona, 2007). These interventions are documented in the *Moving Forward: The National Mental Health Plan for More and Better Services* document (Mental Health Commission, 2002).

Moreover, the access rates for the Counties Manukau District Health Board Pacific child and adolescent populations including their families were a low 0.53% per annum for the period of 2005 to 2008 and 0.84% per annum for 2009 to 2012, yet the Ministry of Health's benchmark was 3% annually (Vaeau, 2013). Vaeau's recent study of Counties Manukau's *Whirinaki* (mental health facility) showed that this low rate of access is a problem plus the fact that the referrals tend to be older. He concluded that educational and anti-stigma programs, acculturation and generational understanding have not impacted to alter the strong hold of traditional Pacific beliefs and attitudes regarding mental illness. Additionally, he argued that the way Pacific people identify mental illness/symptoms are further factors to explain these low access rates and older age of referrals. Conversely, in relation to subsequent visits, barriers by adolescent users are comparably less, due to positive factors of more confidence in the service provided, as well as feeling positive about the treatments. Vaeau, (2012) recommended that clinicians must communicate thoroughly all the aspects of the mental illness/disorder, the treatments involved and

that the approach “For Pacific by Pacific” is the best approach for Pacific children and adolescents’ mental health needs.

**Pacific migrants and mental health services in NZ.** The Tuvaluan people’s status as a recent migrant population (Simati, 2009) underlies a focus on migrants and mental health treatment gap disparities. One significant finding highlighted in Te Rau Hinengaro: The New Zealand Mental Health Survey 2006 was that the numbers of Pacific migrants with mental disorders is half (15%) that of the NZ-born Pacific group (31.4%). An interesting related statistic showed that the younger the age of the migrant on arrival to NZ, the more susceptible they were to develop a mental illness.

Several explanations were offered to explain this phenomenon that equipped migrants’ modes of resistance, alleged to be comprised of an extensive support network system of an extended family and church, added with having been socialised in Pacific customs and cultural beliefs. This enables migrants to withstand the impact of acculturation influences, such as lifestyles of alcohol and substance abuse ((Ministry of Health, 2008; Minister of Health & Minister of Pacific Island Affairs, 2010). Yet, a focus on acculturation arguments, particularly in research topics of language and health service use which Sonn and Fisher (2005) described as “the cultural changes of immigrants” failed to formulate an acculturation model to inform and guide these studies as a measurement and analytical tool. Nevertheless, it is suggested that the advantage of traditional societies such as those located in the Pacific islands is the less stressful environment and lifestyle that normally induces the onset of mental illness such as found in more civilised environments. A study by Murphy and Taumoepeau (1980) into Tongan islanders in their homeland tends to confirm this thinking. This argument asserts that typically, a historical remnant ideology of colonialism views inhabitants of developing backward nations as uncivilised so will not be able to deal with the different lifestyles of a modern civilized world (Sartorius, 2015).

In contrast, Stillman, McKenzie, & Gibson (2009) criticised the persistent contentions that migrations from under-developed nations to developed countries are advantageous decisions. They argued that the positive benefits of increased wages, and education do not equal to the negative outcomes of psychological impacts. A recommendation by these authors is for further research to identify the effects of migration and to carry out comparison studies of pre- and post-migration

experiences rather than the traditional existing methods of comparing migrants' experiences to citizens of host countries and mental health effects. Equally, a study by Pernice and Brook (1994) of migrants from Asia, the Pacific and Britain conveyed that experiences of discrimination led to consequences of restricted associations with their own ethnic communities, unemployment and lacking having close friends which increased vulnerability to the development of anxiety and depression symptoms. These adverse experiences affected the Asian and Pacific migrants more than the British migrants. However, there is a lack of information specifically on the subject of Pacific migrant utilisation of mental health services (Barwick, 2000). This is a grave limitation in the literature due to the fact that the Pacific ethnic group is comprised of a substantial number of migrants. This is one major gap in the literature that identifies this doctoral research as significantly contributing to Pacific mental health research and to minority mental health research internationally.

### **The Utilisation of Mental Health Services in NZ by Pacific People.**

The third stage of the pathway process to using mental health services is vastly different for Pacific and Maori people in NZ than for other ethnicities. A host of studies and official statistics have revealed that Pacific and Maori people predominantly utilise compulsory treatment and forensic mental health services rather than the typical secondary services of psychiatric treatments (Oakley-Browne, Wells, & Scott, 2006). This pattern of utilisation of mental health services is similar to other minorities as conveyed by the international literature. Compulsory treatment and care in NZ is instructed by the Mental Health (Compulsory Assessment and Treatment) Act 1992 which defines the circumstances and criteria of eligibility subject to compulsory assessment and treatment. In NZ, offenders diagnosed with a mental disorder are incarcerated in forensic services under the legislation *Criminal Procedure (Mentally Impaired Persons) Act 2003* which is Part 7 of the Criminal Justice Act 1985. The Act outlines procedures of detention, assessment and care of offenders diagnosed with a mental disorder. Studies of forensic admissions in NZ reflected an identical correlation with statistics of international forensic populations.

### **Pacific Models and Beliefs of Health and Mental Health**

Pacific health belief systems and practices determine how trust and confidence in the NZ mental health system is promoted, for it will determine whether it will encourage or discourage people's access and utilisation outcomes (Statistics NZ & Ministry of Pacific Island Affairs, 2011). Substantiated and on-going evidence of the depravity of health outcomes experienced by Pacific people in this country has led to an increase in the production of health models that essentially guide the health system to cater for the health needs of Pacific people. This has been well documented in the literature and acknowledged by successive Ministry of Health agencies. For instance, a similar study (Agnew et al. 2004) as this study into the perceptions of Pacific health professionals, mental health consumers and family members to suggest a Pacific delivery of mental health services model found that the participants were informative of several Pacific health models. For instance, *Te Vaka Atafaga* clinical assessment framework to use in the assessment of Tokelauan clients, the *Fonofale* and *Faafaletui* model, the *Pandanus Mat* Model to name a few

Recent dialogue and strategies to attract attention towards the accumulation of Pacific norms, values, belief systems and worldviews into operational and cultural competency standards for all health systems to abide by, has been slow but progressing. This has been established through the *Seitapu Framework* (Pulotu-Endemann et al., 2007). At present, an evaluation to determine its success has not eventuated. The *Seitapu Framework* was purposely conceived for mental health workers, educators, employers and funders that work with Pacific consumers or associated organisations. The framework established standards of Pacific cultural competency requirements that must be adhered to when working with Pacific people, and it has been applied extensively in NZ. It situates the competent worker as of central importance, consequently, other units (such as consumers and relatives) in the relationships will function well as a team depending on the degree of competency of the worker.

The main Pacific beliefs about mental illness and mental health are grounded in the realms of holistic phenomenon. For instance, the *Fonofale* model of health (Pulotu-Endemann et al. (2007) purports that an individual's total wellbeing is fulfilled when all the components of the physical, spiritual and social wholeness are intact with no malfunction. It is depicted metaphorically as a *fale* (house), and its interrelated components of the rood (culture, beliefs and cultural values), four posts (spiritual, physical and mental units of wellbeing) and the space encircling this

foundation that include the environment, time and context aspects of wellbeing (Manuela & Anae, 2017). Once a discrepancy occurs, then it is expected that an illness or disorder will result. Mental illness and disorders especially are believed to be a broken linkage to the ancestral spirits due to an offence or broken taboo of customary traditions being committed.

A central mode of Pacific culture is the care of relatives who suffer from mental illness in their own homes (Pulotu-Endemann et al., 2007). Pacific families as a support system are central to the recovery of relatives. Families are relevant actors in the identification of the symptoms of mental illness, and appropriately assist in seeking primary mental health services early. Another key aspect of Pacific culture is that the community is critical, hence communal duty of care is a significant element of Pacific culture whereby the responsibility for health and wellbeing via social and psychological support is grounded as the function of the community (Health Research Council, 2014). The concept of *reciprocity* is instilled in Pacific cultures as the exchange of not just goods, but knowledge, loyalty and social goodwill to ensure harmonious relationships are established. The concept of a peaceful existence with others is critical to Pacific culture, hence the concept of *respect* is crucial for the maintenance of this balanced and peaceful co-existence environment. The essentiality of awareness and accepting one's position and status in society, and respecting the hierarchical statuses are promoted (Health Research Council, 2014).

### **Conclusion**

The literature review revealed a substantial amount of information regarding the mental health issue of underutilisation of mental health services experienced by ethnic and racial minorities in the international arena and in NZ. The international sources were so numerous that arranging the literature along the pathway process of utilisation of mental health services framework helped organise it into relevant categories. However, the scarcity of literature from NZ and the Pacific region made it difficult to follow this pathway framework, but it has the advantage of identifying knowledge gaps in this field of research. Most of the literature was reiterated consistently, irrespective of contextual location or ethnic differences, particularly the structural ecological dictates of mental health services' underutilisations, such as financial and socioeconomic factors. However, a significant distinction in aspects of minority mental health include paradoxically high prevalence rates but low usage of

mental health services compared to mainstream statistics, and the delay in accessing treatment services that lead to the disproportional high compulsory admissions into acute and forensic services. Hence, the literature addressed the distinctions in ethnic, racial mental health behaviours as significantly resulting from cultural and contextual factors. This literature has extensively provided background information that will assist clarify the concepts that will be addressed by the research question in the next chapter.

### Chapter 3: METHODOLOGY

#### Introduction

This chapter will describe the way the issue of Pacific underutilisation of mental health services was investigated using a descriptive qualitative research methodology. It is based on the interpretive paradigm that is grounded in the belief that epistemological and ontological reality and truth are located in the participants' perceptual realities and lived experiences of an issue under investigation. The selected research methods successfully provided answers to key research questions and fulfilled the research objectives. In addition, the Tuvaluan research framework, *Te Pa*, that is additionally included in this chapter is a framework designed to correlate and complement the chosen methodology and infuse Tuvaluan cultural and customary values and protocols into the research process.

#### Features of Qualitative Research

Qualitative research comprises two main features, the *primary characteristics* include “people” who compose the nucleus focus as social actors whose actions, works, expressions, interpretations, meanings and productions are meaningful (de Gialdino, 2009). Qualitative research descriptions of social actors' accounts of events and behaviours are measures to understand how participants make sense of these observations and experiences (Cochran, et al., 2008). The *secondary characteristics*, in contrast, establish a higher value on the “context”, which includes situations and circumstances where these social actors were located and the influences on the behaviours/attitudes of people (Cochran et al., 2008). The interactions that occur between these two phenomena of people and their contextual settings result in the creation of ‘meanings.’ The research subjects interpret and create meanings of their ‘realities’ whereupon, researchers in turn, construct interpretations of these meanings.

Despite the diverse methods of qualitative research which can be contestable (Grant & Giddings, 2002), these authors have identified debatable and confusing aspects of research dimensions that must be clarified to make sense of “what, how and why” this study's research design was chosen.

The existence of a dichotomy between quantitative and qualitative research implies that the two are so contrasting in aspects of research methodology, particularly ontological and epistemological claims that dictate differences in data collection and data analysis methods (Al-Busaidi, 2008). Qualitative research



approaches prioritise the diversity of truths, arguing that there is no objective reality. Consequently, it is inductive, a contrast with the quantitative deductive approach of abiding by theories. This underlying principle of subjectivity is the foundation of qualitative research. It permits a diversity of facts, which is dependent on the receiver of this truth whether it is accepted. Therefore, it is not the search for facts that is given precedence because the concept of “facts” is questionable. Rather, it is exploring people’s opinions about an issue under study (O’Leary, 2004).

Some commentators have seen the boundary between qualitative and quantitative research in recent years as blurry, overlapping and complementary to each other (Al-Bussaidi, 2008). This is illustrated in the use of mixed-methods for triangulation where interview methods have been used to substantiate the statistical data.

Paradigms in qualitative methodology vary due to their associated distinct ontological statements. The specified assumptions about *what* ought to be known (ontology) and its justifications determines the methods of *how* it is to be known (epistemology), and its assessment once it is acquired through research processes (Cresswell, 1994; Grant & Giddings, 2002). Paradigms then, are research traditions that are comprised of an “implicit body of intertwined theoretical and methodological belief that permits selection, evaluation, and criticism” (Kuhn, 1970, p.17, as cited in Grant & Giddings, 2002). However, as Babbie (2013) cautions, because paradigmatic assumptions are implicitly included in belief systems and worldviews and become established as societal norms, their subjective nature determines that they are neither true nor false. Anomalies exist, which, in turn replace current assumptions. Therefore, for criteria of rigour to apply, research objectives must be able to link justifiably to the paradigmatic principles applied (de Gialdino, 2009).

As this study’s research topic concerns a Pacific issue, the use of a western research methodology that is guided by non-Pacific model was also applied, but with caution. Discrepancies clearly exists between the western and Pacific modes of epistemologies and ontologies. For instance, Nabobo-Baba (2008: p. 2) referred to the “unchecked and careless use of frames” that undeniably disregard indigenous languages, knowledge, principles and philosophies when researching Pacific indigenous people. From her research experience with her Fijian community in her homeland Fiji, she was confronted with several challenges that resulted from the mismatch expectations by academia and the Fijians. She concluded that the

researched population is central to dictating the research, their epistemologies must be respected and ontological methods of acquiring this knowledge must be a process of self-determination that they are entitled to. Nabobo-Baba maintains that epistemologies are always socially constructed, not permeated by the researcher.

This cultural understanding is imperative in current times of increasing multiculturalism in western countries (Baugh & Guion, 2007). These culturally sensitive research approaches should focus on shared knowledge, language, worldviews, common cultural, historical and political experiences, and behaviours that uniquely identifies groups. For instance, research approaches conducted with African communities are unique, for it includes the total immersion of the researcher in the group activities and lifestyles and affirm constant strong relationships through participation and input throughout the research process. When researching minorities, the researcher is expected to be an 'insider' rather than an 'outsider' in terms of prioritising every aspect of the research from the perspectives of the researched group (Baugh & Guion, 2007).

#### **Advantages of qualitative research methodology in mental health research.**

Whilst quantitative research methods have an important place in health research, when studying interactions between people, qualitative research is more suitable because of its focus on meanings, experiences and viewpoints of the participants (Pope & Mays, 1995). For instance, a quantifiable investigation into admission rates of Pacific mental health consumers for information on utilisation rates will not inform the researchers about the explanations for use or non-use of services. On the other hand, an exploration of intangible phenomena through experiences, ideas and values are more likely to unearth information of the essence of the phenomena under investigation. For instance, understanding the effects of stakeholders (families, social groups, and media) may be enhanced by studying the participants' attitudes towards their encounters (Peters, 2010). This author argue that qualitative research possesses high validity functions due to its inductive value. Consequently, answers to the research questions are derived from the participants rather than predetermined by theories. Additionally, the research is not in linear fashion, but is flexible because the researcher can go backwards in the research process to make alterations, as new information is acquired (Maxwell, 2008; Pope & Mays, 1995). For this reason, reflexivity is constantly occurring during the

research processes Each stage is dependent upon the other, therefore any change in one influences changes in the other.

The scientific, practical and ethical benefits of qualitative methods if applied to mental health research are intensified (Peters, 2010). It is a health field that is highly complex due to the multiple medical conditions, symptoms and pharmacology involved, and the holistic exploration into the extensive impacts of an extended network of families, professionals and society. Researchers are confronted with challenging behaviours, impairments and behavioural difficulties, and sensitive topic issues. Despite these negativities, the acquisition of in-depth information from mental health consumers' voices makes it worthwhile (Peters, 2010). These voices contribute to new theories, interventions and changes in service provisions to be more responsive to mental health consumers' distinct needs.

### **Descriptive Qualitative Methodology.**

According to proponents of descriptive qualitative methodology such as Sandelowski (2000) and Neergard, Olesen, Andersen, and Sondergaard, (2009) research designs that are guided by this methodology are not tainted by theories, literature reviews, or other historical background information. The research designs were drawn from naturalistic principles that purports a natural state of sampling techniques of descriptive methodology which recommend purposive sampling techniques, purposely to select participants who can contribute considerable information for the study. To minimise the manipulation of the "voices" of the participants, semi-structured interviews and focus groups are suggested to acquire "true" reflection of the realities presented. Open-ended questions are preferable to enable the participants to relay their thoughts without researcher influence, control and manipulation of the narrative process. Thematic analysis of the data, commonly applied in descriptive methodologies, is enabled via coding strategies of this data, and presented in a logical manner. The qualitative descriptive research approach can have overtones of other qualitative research approaches, and if this is the case, it is imperative to acknowledge and detail these similarities (Lambert & Lambert. 2012)

One of the major problems I have encountered in my journey as a doctorate student is the time-consuming task of understanding, and eventually choosing, one methodology from the vast array of qualitative research methodologies. The numerous names assigned to each one that have commonalities and differentiations under specific types of research methodology, were confusing. Sandelowski (2000)

described this problem as an ongoing issue that smears the research world she labelled “methodological acrobatics”. The complication of “naming” with a “terminology” that researchers repeatedly mistakenly use to validate their research, yet in practice they often fail to apply it. The argument that these research methodologies are descriptive methodologies, but erroneously or intentionally categorised under the umbrella of other terminologies, and because descriptive research is criticised as “simplistic” and lacking knowledge contribution (Guba & Lincoln, 1994; Lambert & Lambert, 2012). For this reason, Neergaard, et al. (2009) argued that it is infrequently chosen as a valid research approach. Consequently, a profusion of research methodologies is named and classified variously

If the researcher can justify the “label” or “name” of the chosen research methodology as compatible to the research aim, then it should have no boundaries and should not be restricted to conform to what is a multiplicity of interrelated theoretical/philosophical underpinnings of the qualitative research world.

What is important is that the study is based on the researcher’s construction of a theoretical framework that is dictated by ontological assumptions of reality and epistemological ways of achieving the knowledge of the topic at issue. As explicitly identified by Hycner (1999), “the phenomenon dictates the method (*not vice versa*)” (p.156). Thorne (2016) similarly argues that this profusion of theory and conceptualisation in enquiry is an expected development phase as it is the result of years of qualitative research that were originally designed by a traditional qualitative research approach. In its infancy, the qualitative research discipline was developed to counter the positivism and objectivism ideals of quantitative research approaches. Countless usage has led to trends departing from these qualitative traditions because it is continuously being developed. It is the nature of progress.

As a novice researcher, my experience of locating a methodology that accurately satisfied the stipulations of one methodology approach was challenging. After consideration of the qualitative methodology choices, I decided upon the qualitative descriptive research methodology grounded under the realms of an interpretive paradigm. Consequently, the main objective is to describe and explore Pacific underutilisation of mental health services according to Tuvaluan participants. Originally, it was planned that less manipulation of the raw data by the researcher’s theory, conceptualisation or research assumptions’ influence in the interpretation of the data (Sandelowski, 2000) was crucial. Therefore, the findings must be “as close to the data as given, or data near” (Sandelowski, 2000, p.78).

However, in 2010, Sandelowski retracted many of her statements, suggesting that proponents of the descriptive approach erroneously misinterpreted these. She concluded that “No study of any kind could ever be so conceptually naked, even studies which offer no explicitly stated theory” (p. 79). She argued that all studies have some degree of interpretation. Instead, she proposed the interpretive paradigm as vital, and utilised it as the basis of her data collection/analysis methods, which she named “thematic surveys”.

Following this updated and current acceptance of an interpretive stance in relation to descriptive methodology, the topic and the issue of this particular study was influenced by my personal experiences as a mental health worker, being a relative of a mental health consumer and a member of a minority ethnic-specific Pacific population, Tuvaluans. This was depicted as “experiential data” by Strauss and Corbin (1990, as cited in Cochran et al., 2008). The theoretical underpinnings of Bronfenbrenner’s ecological model were chosen for its compatible philosophies to my ontological and epistemological positions that dictated the choice of the final research design. For instance, Sandelowski (2010) reminds that we must distinguish between being open-minded to preconceptions that will determine research and being empty-headed or ignorant. However, as Cochran et al. (2008) cautions, external influences such as literature reviews and your experiences must not overpower, dominate or restrict your research. The research objectives must be adhered to foremost.

Bronfenbrenner’s ecological systems model is argued as suitable for this research for it promotes the notion that actions, and choices are decided in relation to entities belonging in a system. The essence of Bronfenbrenner’s ecological theory that applies to this study is that it affirms that people’s choices to seek the help of mental health services are consequences of not only internal, but also external influences, and are inclusive of time and space.

The ontological and epistemological compatibilities between the ecological system’s theory and descriptive/interpretive philosophy provided the best choices of data collection methods for this study in terms of narrative methods of focus groups and interviews, as well as the data analysis method. The data analysis process allows the researcher to analyse the data in accordance with conceptual identification of thematic issues raised by the participants’ explanations.

Thus, the decision was to formulate a conceptual framework based on the literature findings and my experiences and knowledge as a Tuvaluan Pacific person,

a relative and a mental health worker. This assisted in the data analysis and interpretation which aligns well with the interpretive paradigm. The fact that a literature review was undertaken to identify previous discourses of this phenomenon and a historical contextual analysis of the issue is evidence that this study is leaning more towards interpretive principles. These influences on the researcher's interpretation need to be acknowledged and made transparent, and extreme care must be taken to prioritise the participants' interpretations of their own data (Cochran et al., 2008; Sandelowski, 2010). Allowing the participants, the freedom to check the researchers' data analysis results, particularly the final report, is one ethical way of ensuring its occurrence.

Subsequently, using a qualitative descriptive methodology that is guided by an interpretive paradigm is a way for Tuvaluans as Pacific people to express their feelings and describe their experiences of using, failure or refusal to use, mental health services. It is an avenue for Tuvaluans to contribute to knowledge and policies that will improve their lives.

Currently in NZ, following international trends, there is a growing push to promote and advance mental health consumers' participation in the decision-making, planning, delivering and evaluating mental health institutions (Happell, et al., 2014). As Oliver (1992) asserts, researchers need to be part of the struggle against the disabled's oppression by using their research to empower them over and above their own agenda. An example of such a study was undertaken by Hamer et al. (2014). The study was prompted by mental health patients' criticism of the disabled's persistent exclusion as citizens and their unequal participation as members of NZ society. The findings of this qualitative research of service users' explanations of issues of citizenship rights suggested that the recovery model that underpins the care and treatment philosophy in mental health services has not altered the stigma and discrimination faced by service users because it is based on a biomedical model.

### **Pacific Research Frameworks**

Previously, Pacific research and researchers had restricted and minimal choices but to utilise research models that were clearly unsuitable for their investigation. Still, in the last two decades, Pacific research frameworks have been formulated and have been used appropriately by Pacific researchers in the pursuit of exploring, describing and evaluating Pacific issues.

Common principles and themes that have been depicted in Pacific research and health models have prioritised the holistic contexts of the spiritual and physical wellbeing of persons, as well as the strong emphasis on the relevance of networking, and cooperation with clinical and other support systems. Despite the abundance of health models, common themes have been identified such as the concept of wellness, variously defined metaphorically but with incorporating symbols that are shared and understood well by Pacific people. These metaphors are illustrated through such concepts as the *fale* (meeting house), clinical assessments as *te vaka* (canoe), and research models as the *kakala* (garland making) which are then merged with Western models of care (recovery, wellness, strength) (Suaalii-Sauni, et al., 2009). Tamasese et al. (2005) research into Samoan perceptions of mental health issues identified participants' main emphasis on the Samoan concept of 'self', which the authors argue is the theoretical foundation that allows an expanded understanding of Samoan mental health needs and strategies to improve mental health services to cater for these needs.

The development of Pacific research models to guide the investigations into issues affecting Pacific peoples, taking into consideration Pacific perspectives, ownership and constructions of the processes and protocols of the research process, was a response to the discontented reaction by Pacific people of Western research frameworks (Tamasese et al., 2005).

A significant updated document published by the Health Research Council of New Zealand (2014), is a valuable guideline of ethical and conceptual outlines for researchers and research participants investigating Pacific people and issues. It outlines firstly, the productiveness of a meaningful and reciprocal relationship between the researched participants and researchers, each benefiting from the research process. Secondly, it specifies the relevancy of incessant consultations with the researched community as a vital ethical component of any research procedure relating to Pacific people, for the simple reason that communal and community facets are the cornerstone of Pacific life. Community leaders must be consulted throughout the research process and given the opportunity to participate and check the data analysis/interpretation to see whether it aligns with cultural values of the participants. Thirdly, in accordance with the guidelines, cultural sensitivity and respect must be abided in ways that illustrate Pacific protocols during the research process, and upgrade Pacific health research capacity through fostering Pacific involvement. Lastly, Pacific indigenous knowledge and worldview must be

acknowledged as outstanding in their own right. This special and unique knowledge is to be used as a starting point of any investigation to guide, gather, analyse and interpret data appropriately in tune with Pacific values and culture. The socio-cultural environments of Pacific lives and critical issues can be understood better through this vantage standpoint of Pacific knowledge.

The *Fa'afaletui* research model (Tamasese et al., 2005) deserves inclusion. It was developed to encompass a Samoan framework of gathering knowledge metaphorically from people of societal stratification that include mountain people, people on tree tops and canoe people. This information gathered is then scrutinised by the elders who will disseminate their final reports to the rest of the village. Kupa's (2009) clinical assessment of Tokelauan mental health patients deserves mention too for it guided the formulation of the Tuvaluan research framework, *Te Pa*, by its Tokelauan principles of *inati* (communal sharing), *fatu paepae* (matriarchal leadership) and *vaka* (canoe).

### **Incorporating the Tuvaluan Research Framework: *Te Pa*.**

In 2011, I submitted a master's dissertation, which included a Tuvaluan Research Framework *Te Pa* (Tufala, 2011) that I formulated and proposed may be used as a research framework when researching Tuvaluan participants or Tuvaluan issues. A search of the literature failed to find a Tuvaluan research framework. The supervisor of my master's programme in the field of Health Science at the University of Auckland encouraged the development of this Tuvaluan research framework to guide the research project I was undertaking.

Prior to its formulation, an analysis of Tuvaluan lifestyle, customs, traditions, values and principles (located in the literature review chapter) were informed to provide the researcher with a better grasp of the research model's technicalities and processes. The influence of Tuvaluan protocols are the fundamental guiding principles in its application to be used as a research framework. The following are the stages of *Te Pa* describing the research process. For the simple reason that *Te Pa* is the first and only Tuvaluan research framework, it is detailed thoroughly in this section.



### **The Tuvaluan Research Framework: Te Pa**

The *pa* is a traditional fish trap erected by placing stone weirs strategically to catch seasonal fish that are located on the reefs of lagoons. The fishing concept that was chosen is appropriate because it is a daily necessity for a survival activity for Tuvaluans. Kennedy (1929) described Tuvaluans' fishing activity as an exciting spectacular experience to witness compared to other Tuvaluan activities. Chambers (1983) reports that seafood and fish catch are the staple diet produce that is a source of ninety-five per cent of the peoples' total protein consumption. This traditional fishing method has been overtaken by modern fishing equipment such as fishing nets, outboard motors and metal hooks. It complements the qualitative descriptive methodology for it merely describes the research process in a metaphorical way, accompanied by relevant Tuvaluan principles, customs and traditions identifiable not only to the Tuvaluan participants, but also to assist in the analysis and interpretation of the data.

Currently, there is no detailed recording of the use of this fish trap in Tuvalu, yet, it is well known amongst Pacific nations as a common method of catching fish. The techniques used are practically identical; even other Pacific Polynesians use the wording *pa* to label it. The aims of these fish traps are similar: to trap the fish with the incoming tide by the positioning of stone weirs (modern methods use chicken wire) to encourage the fish to swim into the fish trap and become trapped with the outgoing tide. Ono and Addison (2009) have described detailed accounts of this type of fishing in Tokelau and in Samoa, Lieber (1994) and Armstrong, Herdrich and Levine (2011) descriptions were practically identical to the Tokelauan *pa*. However, the main source of information regarding the Tuvaluan *pa* was derived from conversations with Tuvaluan elders in Auckland, NZ. The table below is a summary of the *Tuvaluan Research Framework: Te Pa* and a detail of how it applies to each stage of the basic research process.

Table 1. *The Stages of the Tuvaluan Research Framework: Te Pa.*

Stages of <i>Te Pa</i>	Research Process
STAGE 1: <i>Maopo'opoga o manatu ite faitega o Te Pa.</i> (Collaborative discussion and decisions about the building of the <i>pa</i> ).	What is the research topic and research question?
STAGE 2: <i>Faitega o Te Pa.</i> (Building/Erecting the <i>pa</i> ).	Research Design: Methodology
STAGE 3: <i>Taega o ika.</i> (Collection of the trapped fish).	Data Collection
STAGE 4: <i>Fakasoasoaga o ika.</i> (Counting, inspection and dividing of the fish).	Data-analysis/Data Interpretation
STAGE 5: <i>Tufaga o ika.</i> (Distributing the fish).	Reporting/Dissemination

### The Research Process.

The research process that was undertaken in this study will be described in an orderly format where each stage is introduced with the Tuvaluan research framework, *Te Pa*, followed by an outline of how it relates to the research process at each stage and ends with a description of the actual stage of the research process.

#### Stage 1: *Maopo'opoga o Manatu ite Faitega o te Pa (Collaborative Discussion).*

The original decision to erect a *pa* can be an individual initiative, an immediate family or a communal decision. The elders are always consulted prior to the erection of the *pa* (Kogh, 1961). The traditional view is that the sea belongs to all (Chambers, 1983; Kogh, 1961), however, in modern times, the permission of the island council *fale kaupule* (elected members, so represent the people) and the bylaw regulations determine its final location, meaning that the state “owns” or more likely “controls” the usage of the sea and shores. This situation implies that tradition has been undermined gradually by modernity in recent times, whereby communal ownership has slowly been overtaken by individualism. Although it is a slow process, it is occurring. The decision to build a *pa* can be an individual or

communal decision, depending on the need. These changes are occurring in other Pacific countries as in the case of Samoa, Lieber (1994) described the transformation of authority over fishing rights whereby the traditional control by colonial masters to individual local persons is occurring. In Tuvalu, consultations with and permission sought from other key bodies in the community are essential before work is commenced.

**Research process: what is the research topic, research question?** The first stage of *Te Pa* is similar to a researcher perusing decisions concerning the research topic, and how to approach it via a research question. It can either be an exploratory investigation of the Tuvaluan population situation in terms of mental health service use, or an evaluative study to locate influential factors of limitations of use and access, or a comparative study of Tuvaluans (NZ-born and migrants); the options are numerous. Goal setting is a further crucial decision to consider. For instance, Maxwell (2008) suggested an important question to assist in determining research goals is to decide whether your issue and study is worth investigating because of its influence on policies or practices. The motives for investigating the issue and your expectations of the results, if any, must be clarified.

Consultations with other parties, such as supervisors, advisors, fellow colleagues, the participating population, communities or a research team is a vital measure usually taken by researchers in the early stages of the research process. The key here is to work collaboratively with the Tuvaluan community as the researched population via consultations as to whether the research topic is applicable to their needs, or the community (The Health Research Council, 2014) may propose an alternative research topic. Just as significant as the erecting of the *pa*, significant stakeholders, and the community (of essential and interested parties) are sought for advice on protocols, and to validate the research proposal. Tuvaluan beliefs about mental illness must be understood and acknowledged first. Usually it is regarded as an illness of shame, a taboo topic (Malua, 2014). Hence, this topic must be dialogued with the Tuvaluan community with caution, cultural sensitivity and humility (The Health Research Council, 2014). Tuvaluan values of respect and community prioritisation and participation are vital (Lauti, 1997). It is imperative that the research design accompanies these values. The researcher must always remember that the community is the heart of Tuvaluan society, therefore empowering means of communication must apply. It must instigate a partnership of

expectations of outcomes that are mutual and aligned well between the researcher and the researched (The Health Research Council, 2014). Thus, consultation with the Tuvaluan community will be a significant requirement throughout the entire research process, but more so at this initial stage of decision-making as to the topic and research design.

**This study's research design: (maopo'opoga o manatu ite faitega o Te Pa).**

The limited research into Pacific mental health issues (The Health Research Council, 2005), and for the purpose of this study, Pacific underutilisation of mental health services (Le Va, 2009, 2011), has propelled an urgent need to find solutions via strategies to improve this dire situation. In accordance with Pacific health beliefs and the ecological systems framework, a holistic and ecological exploration of the problem must be completed first. The study topic is a Pacific issue and involves Pacific (Tuvaluan) participants thus a collective input into any decision about the study is essential, including thorough planning into how it will benefit the people it is intended to assist in improving their lives.

Consequently, advice was sought from my Tuvaluan extended and immediate family members, friends, colleagues and members of the Tuvaluan community individually, as to whether it is a viable research topic to pursue, and of their thoughts into Tuvaluans being used as potential participants for the research. It was decided that community consultations through meetings was not a viable option due to the taboo and stigmatized nature of the topic, and the fear that it may discourage potential participants, in particular the relatives and mental health consumers. However, the Tuvaluan community members spoken to were admirable, and offered support and appreciation that one of their own was researching an issue that included Tuvaluans as a sample population. Despite the countless advice offered, the most vital and common advice noted was the caution of locating Tuvaluan mental health consumers or their relatives as participants. The trepidation was due to stigma issues that surround mental illness and its associated aspects that are rife in Tuvaluan community attitudes. A fellow Tuvaluan researcher (Malua, 2014) experienced the same difficulties of recruiting and locating Tuvaluan participants who had Tuberculosis (TB) for her NZ study. She explained that TB is a taboo illness, and sufferers of this disease endure discrimination and stigma from fellow Tuvaluans. Like mental illness, the topic is rarely discussed in any context.

Several consultations with my supervisors secured decisions on the following aims, research questions and research methodology that were chosen.

**Research Questions.** The main research goal of this study that was introduced in Chapter 1 is to explore Tuvaluan people's explanations of Pacific people's underutilisation of mental health services in NZ. Consequently, as guided by this study's conceptual research framework and the research objectives, the proposed research key question is:

*What are Tuvaluans' explanations for Pacific underutilisation of mental health services in NZ, and the implications of this underutilisation?*

The umbrella research question above is very broad in scope and has been restructured into specific questions to answer the main question and achieve the objectives of this study. The following specific questions were examined and asked at the focus groups and interviews:

*Focus group and individual interview questions.*

- What are Tuvaluans' explanations about Pacific underutilisation of mental health services in NZ?
- How are Pacific and Tuvaluan people using mental health services in NZ?
- Are Tuvaluan mental health consumers, their families and their communities supported with adequate advice/information about mental illness, adequate treatments and service provisions and assisted with how to access mental health services?
- What type of mental health services are utilised by Pacific/Tuvaluan people and how do they differ from those services not utilised?
- What are the implications of not seeking mental health service assistance? For instance:
  - Compulsory treatment (inpatient and community)
  - Forensic incarceration

**Interview questions.** The interviews focused on gaining an insight into the personal experiences of the participants in relation to their involvements with

mental health services. Therefore, the main question below was asked first, then was followed by the other questions as depicted above:

- What are your experiences in dealing with mental health services?
- Prompt questions and statements are:
  - So how did you feel?
  - Why do you think it happened? How often did it happen?
  - Tell me more about it!
  - Why? When? What? How? Where? (These prompt questions were asked to gain further information from the participants).

## **Stage 2: Te Faitega o Te Pa (Building the Pa).**

The *toeaina* (male elders) who are renowned and well respected in Tuvalu for possessing considerable wisdom and knowledge, and the *tautai* (expert fishermen) (Kennedy, 1929) decide the location of the *pa*. They decide which side the *pa* will face. The decision as to where to face it is based on the *alaga ika* (the way the fish are swimming from and to). The Tuvaluans regard this *solo* (swarm) of a variety of fish, usually at spawning stage, as due to fish being “crazy” depending on the moon phases. Such species of fish as *maiava*, *otala*, *ise*, *te vete*, follow the “smell” or “*kola*” of the *kavaliko* (baitfish), and get trapped in the process. *E isi loa ona masina, kae e isi foki matakaiga tau aso e sopo ai a ika*. (It is only a few *matakaiga* (family) who possess the *poto* (knowledge) of the day and month that the different types of fish are scheduled. The current is also a determining factor of its location, so it is built *ki namo* (face the lagoon) where the current is easier to handle. The absence of records of the Tuvaluan *pa* compel an adoption of other Pacific examples of *pa* for these are practically identical, such as the Samoan *pa* that were well recorded in the literature. The Samoan *pa* were described by Armstrong, et al. (2011) as slightly variant: some were built of coral stone or coconut leaves to form weirs and some were V-shaped weirs with wire netting walls. The wire netting ones were the modern types which, even in 1920s, were regarded as a functional permanent replacement to the traditional *pa* that required constant repairs. The majority of the *pa* were located at the mouths of lagoons, and some had two openings, so that fish were trapped on the rising tides as well as the falling tides.

**Research process: Research design (methodology).** This stage is applicable to the research design stage. The methodology is chosen in accordance

with the topic, the research aims, type of research questions and whether qualitative or quantitative based research tools are used. Community consultation is also significant here as well. As the building of *te pa* indicates, there are certain Tuvaluan fishing experts, the *tautai*, who have the knowledge and these experts must be sought respectfully, for their guidance. The research design has to be structured and planned strategically, just as the *pa* is built, in order to choose the best methods to acquire the right data or fish, at the right time (tides) in terms of suitable hours, and environments (currents) in terms of suitable locations, costs, cultural and language barriers. The Tuvaluan people, led by their “experts” and community leaders need to be included in all the consultations for advice and consent. The literature findings exposed wider social, political and economic determinants of low utilisation and barriers of access of mental health services by minority people, therefore the methodology needs to bear this in mind at this stage of the research design process. The methodology chosen needs to comply with ontological, hence paradigmatic guidelines that will determine epistemological choices.

#### **This study’s chosen methodology (*faitega o Te Pa*).**

**Sample.** After lengthy discussions and planning with supervisors, and in accordance to the research design and the aims of this investigation, it was decided that the sample would be Tuvaluans. As Gemenne and Shen (2009) notes, NZ is the main destination of Tuvaluan migrants, so it is the best place to conduct fieldwork regarding Tuvaluan issues overseas. It was originally decided that a representative sample from the main Pacific Island groups in Auckland would be used, but since I am a Tuvaluan, an ethnic specific focus was thought to be more advantageous. For instance, an interpreter would not be required as the researcher is fluent in the Tuvaluan language. Cost and time-consuming issues were averted. Identical to the Malua (2014) study of the experience of Tuvaluans with TB illness in NZ, researching amongst your ethnic people, and especially people that you have close associations with, means boundaries around your role as an insider researcher must be established.

Peters (2010) states that qualitative research does not warrant a representative sample. A purposive sampling technique was utilised to recruit certain individuals whose attributes permit eligibility to participate in the study. The sample was composed of ethnic Tuvaluans residing in Auckland and 18 years old

and over. Other attributes of the participants were to be a mental health consumer (non-diagnosed or clinically diagnosed person with any type of mental illness), family member of a mental health consumer, any Tuvaluan community member and mental health professionals. The mental healthcare workers included anyone who had or currently works in the mental health field. The small Tuvaluan population in NZ entails that the sample include a wide range of participants to represent the perceptions of the four different groups (consumers, relatives, community representatives, mental health professionals). This multi mix of participants generated a diversity of beliefs about mental illness, needs, treatment and utilisation, and therefore provided richer data. Validation of the study also occurred with a diverse group of stakeholders (Groenewald, 2004). A snowballing technique (Babbie, 2013) that involved word of mouth was also decided as the best method, which involved soliciting recommendations from informants and participants for potential participants by passing on the *Information Sheets* or my contact details to interested parties.

Below is a summary of the number of participants in the sample and the demographic details of the sample.



Table 2. *Total Number of Participants.*

Attribute	Category	Number
Age	18-25	3
	26-35	4
	36-45	2
	46-55	6
	56-65	2
Gender	M	6
	F	11
Income	Student	3
	Unemployed	1
	15000-25000	1
	25000-35000	1
	36000-45000	2
	Over \$45,000	4
	Not revealed	4
Migrants	From Tuvalu	13
Educational Qualification	No Qualification	3
	High School/Course qualification	5
	Undergraduate Degree	5
	Postgraduate Degree	3
	Not revealed	1
Marital Status	Married	10
	Widower	2
	Single	4
	Divorced	1

Note: Table 2 shows that most of the participants are over 45 years of age (8), and only 3 were under 25 years of age. A mark difference in gender, 11 females and only 6 males, higher numbers of incomes over \$36,000 than less and more people with undergraduate and postgraduate degrees, and more married or have been married statuses.

### **Stage 3: Taega o Ika. (Collection of the Trapped Fish).**

The fish are collected when the tide is out. Young men open the opening of the pa for the fish to enter, and it is closed when the tide is going out, trapping the fish. Traditionally, as a communal owned activity, the *ulu ote fenua* “*te aliki*” (the head of the village, “the chief”) usually gives the consent to *asi* (check) and *tae* (collect) the fish using *tae* (scoop nets) or *tao* (spears). It is important that the fish are collected frequently otherwise the eels will eat them. A crucial note is that even if it is individually owned as in present times, any person is welcome to help himself or herself, unlike the traditional way of waiting for the consent of the village chief for collection to commence. Similarly, Armstrong et al. (2011) description of the Samoan pa collection of fish is identical to the Tuvaluan methods of using hand nets, when the tides retreat and on the incoming tides.

**Research process: data collection methods.** Similar to the collection of the trapped fish, the data is gathered according to the specified methodology. The fish here represent the data, and the methods of collection can be varied, identical to the diverse methods of catching the fish. Respect for Tuvaluan protocols and customs must be applied in all communications, especially in the sampling process of recruitment and data collection tools of interviews, focus groups or surveys. The Tuvaluan custom of *sharing* including information and knowledge can be recognised in this process, if it is not abused, or misinterpreted. The participants must be consulted about the research process, its purpose and the expected outcomes, as well as the reasons for the gathering-of-information techniques that were applied. Consent must be sought prior to any data collection methods to occur.

### **This study’s data collection methods (taega o ika).**

**Focus groups and semi-structured interviews.** The rationale for diverse data collection methods using focus groups and semi-structured interviews, and the inclusion of a range of stakeholders in the sample is to provide validity (Groenewald, 2004). The composition of focus groups was in separate groups to minimise intimidation or uncomfortable feelings by participants as the composition has strong effects on whether the participants will interact and feel sufficiently confident to contribute to the discussions (Fern, 2001). It is for this reason that the mental health consumer individual was separately interviewed too.

Initially, there were supposed to be three focus groups of 6 participants in each focus group, except for the mental health consumers who were planned to be interviewed individually. This plan was diverted due to problems of recruitment that made it very difficult to find willing participants. The warnings by Tuvaluan people that stigma and feelings of shame is a major problem that might hinder recruitment was underestimated by the researcher. The stronghold of stigma and shame showed in the data responses and the reasons why there were many gatekeepers, particularly the relatives of mental health consumers. This resulted in difficulties in locating participants. It was decided that the total number of 17 participants was adequate rather than the initial planned number of six participants per each group, a total of 24 participants. Neuman (2000, as cited in Groenewald, 2004) cautioned that the power of gatekeepers must be taken seriously, for they are “someone with the formal or informal authority to control access to a site” (p.352). These gatekeepers decided access to potential participants, and so, to some extent the mental health consumer participating numbers was disappointingly less than the other groups.

Another problem encountered was finding a location, date and time that suited all the participants to meet in focus groups, resulting in numerous reschedules, particularly for the mental health professionals. This is understandable as most of these participants work on roster-type shift work schedules, or on-call by bureau agencies. This group was additionally problematic because the numbers of Tuvaluans who work in the mental health field were overestimated. After countless failed attempts at recruitment, it was realised that qualified Tuvaluans with professional qualifications and training in the field of mental health were limited. Many Tuvaluan healthcare workers are not qualified health professionals who work for employment agencies and on-call randomly to any healthcare institution, including mental healthcare providers. After consultation with my supervisors, it was decided that due to these unforeseen setbacks, the mental health professional focus group members would be interviewed individually rather than as a focus group at their chosen locations (see Table 3). However, one of the GPs turned up to the Relatives focus group because she was available at that particular time and date of the meeting.

On the other hand, the group of relatives only had three participants that turned up to the focus group, but one of the relatives was unable to attend at the specified time, and therefore was individually interviewed instead (see Table 4). Fortunately, it was easier to find the six community representatives, and this group

consisted of a variety of ages (see Table 5). The mental health consumer group of six participants was initially planned to be interviewed individually, however, the stigma issues involved were so strong and their impact on relatives that resulted in their acting as gatekeepers was extreme, so the reduction in the number recruited to only one in this group was understandable, but unforeseen. One other mental health consumer was planned to be interviewed but he exhibited symptoms of psychosis, so the interview was cancelled. Another problem with this group was the fact that the information of potential mental health participants was derived from the snowballing tool of recruitment. It became apparent that the information was not always accurate because it was based on assessment and erroneous diagnosis by laypeople.

All the relevant paperwork was signed at the focus group meetings or at the interviews. Formal information sheets were provided and included a consent agreement to be signed by the researcher and the participants. The Ethics Committee's approval (see Appendix A) was granted on the basis that separate documentation (information sheets, consent forms) needed to be provided for the mental health professionals and for nonhealthcare workers and written in the Tuvaluan language. The information letters (see Appendix B) included the researcher's name and affiliations, the purpose of the research and the positive benefits/advantages it would yield for the participants. The consent form (see Appendix C) stated details of the research, the conditions that must be adhered to by the researchers, and details of tasks/activities that the participants would undertake, such as to be interviewed, and the interview tape-recorded, analysed and interpreted. Confidentiality was a priority, so participants were informed that their names or other personal details would not be identified. For privacy issues, the data would be locked in a safe place for at least six years and participants were additionally informed that they could withdraw from participation during any stage of the research process.

All interviews and focus group discussions were audiotaped for accuracy, with permission that was included in the consent form. The consent form was signed during their attendances, while the information sheet was emailed or given to them prior to the meetings or interviews as requested but signed at the focus meetings or interviews. In addition, a demographic sheet (see Appendix D) was issued to each participant to fill in during the meetings or at the interviews, which conveyed the demographic and migrant status details of each participant that would

be useful to assist in the interpretation and data analysis process. A *koha* in the form of a blanket was presented to each participant to show appreciation of their participation and contribution to the research. This is evidence of the reciprocal relationship valued in Pacific culture (Chambers, 1983; The Health Research Council, 2014).

To assist with the thematic analysis of the data into findings and its interpretations, a further itemisation of each group's participants' relevant attributes is crucial. The following tables have been formulated for this purpose:

Table 3. *The Mental Healthcare Workers Group of Participants.*

Profession	Gender	Age Group	Migrant Status
GP (Interviewed)	Male	45-54 age	Migrant from Tuvalu.
GP (attended the Community Members' focus group)	Female	25-34 age	Migrant from Tuvalu.
Youth/School Counsellor (interviewed)	Female	35-44 age	1 <sup>st</sup> Generation NZ-Born
Forensic worker (interviewed)	Female	45-54 age	1 <sup>st</sup> Generation NZ-Born
Mental Health Nurse (interviewed)	Female	45-54 age	Migrant from Samoa.
Community Support Worker (interviewed)	Male	45-54 age	Migrant from Tuvalu.

Note: Table 3 shows details of the 6 mental healthcare workers: gender (more females, 6 and 2 males); the majority were between the ages of 35-54 years (5), and only 2 aged between 25-34 years. The participants worked in different health fields, however, they all had experience working with mental health consumers. There were more migrants from Tuvalu (4) while only 2 were NZ-born, All the participants in this group were individually interviewed except for female GP who attended the community representatives focus group for reasons of convenience to her schedule.

Table 4. *The Relatives Group of Participants.*

Relation Status	Age Group	Migrant Status
Mother	45-54 age	Migrant from Tuvalu.
Uncle	55-64 age	Migrant from Tuvalu.
Niece	35-44 age	Migrant from Tuvalu.
Daughter (interviewed)	25-35 age	NZ-Born

**Note:** Table 4 shows details of the four members of the Relatives group, three were over the age of 35 years, and are all migrants from Tuvalu, and only one was younger, but older than 24 years of ages and a NZ-born. Three out of 4 were females.

Table 5. *The Community Members Group of Participants.*

Participant	Gender	Age Group		Migrant Status
Pastor	Male	45-55		Migrant from Tuvalu.
Community Elder	Male	55-66		Migrant from Tuvalu.
Tertiary Student	Female	18-24		NZ-Born
Student	Female	18-24		Migrant from Tuvalu.
Student	Female	18-24		Migrant from Tuvalu.
Retired Social Worker (interviewed)	Female	55-64		Migrant from Tuvalu.

**Note:** Table 5 shows the details of the six community representatives group, whereby five were females, three older than 45 years of age, and three youths (all students), and all except one are migrants from Tuvalu. The focus group for this group consisted of 5 participants, and 1 participant was interviewed. Out of the six participants in this group, 4 are migrants and the two NZ-born are all younger than 25 years of age.

Table 6. *The Mental Health Consumer's Attributes.*

Mental Health Consumer (interviewed)	Male	55-64 age	Migrant from Tuvalu.
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#### **Stage 4: Fakasoasoaga o Ika (Counting, Inspection and Dividing of the Fish)**

The caught fish in Tuvaluan societies (Chambers, 1983) are always brought to the *malae* (community space/grounds) where they are counted, inspected and divided amongst *mataniu* (families). The bigger and most sought-after fish are usually allocated to the most respected and high-status figures of Tuvaluan society (Chambers, 1983; Kennedy, 1929): the *faifeau* (pastor), the *ulu aliki* (chief), *tao aliki* (second in line to the chief), *fale kaupule* (elders). The rest is divided amongst the remaining families. It is important to note that people who are more in need of the fish, usually the families who have no sons or whose men are absent, are prioritised. The role of division of any commodity in Tuvalu is bestowed upon only certain families. This role is known as *te kau ote nifo* (dividers) (Chambers, 1983; Isako, 1983).

**Research process: data analysis.** Like the counting, inspection and dividing of the fish, the same process applied to the data analysis, usually with the use of computerised programs. It is recommended that persistent consultations with the researched group to assist in the analysis of the data, for instance, in the translations of the non-English data, or at times, to double check that the researcher's interpretation of the data was consistent with that of the Tuvaluan participants. This is important, as research is not neutral; it comprises the researcher's bias, beliefs, values and worldviews, so a balance of interpretations must be ensured (Whittemore, Chase, & Mandle, 2001). As explained above, there are certain roles responsible to this operation, *te kau ote nifo*, the same role being assigned to individuals or groups of Tuvaluans that the researcher must attempt to seek advice and assistance from for the data analysis and interpretation.

**This study's data analysis (Fakasoasoaga o ika).** The focus groups and interviews' audiotaped data, following the guidelines of a thematic analysis method by Joffe (2012) were transcribed verbatim, and after close familiarisation with the data, codes or themes were assigned to relevant categories that were identified in the data. Peters (2010) affirmed these successive stages, and that it is common for researchers in qualitative research to go back and forth during the familiarisation and thematic analysis of their data. The transcriptions were conducted by myself and two other persons who were paid on an hourly basis to assist. All who assisted, or had some access to the data, signed a confidentiality form (see Appendix E).

The data analysis was based on a thematic analysis method, which is compatible to the topic issue of mental health utilisation (Joffe, 2012). Similar texts were manually retrieved under the same category of themes. These themes can either be implicit or explicit, deductive or inductive; thus, a systematic method of identification is needed (Joffe, 2012). It involves the identification of patterns of common concepts that are prevalent in groups. These are located in the participants' thoughts and feelings and how they conceptualise their place in their social environment. The aim is to acquire people's representations, with less emphasis on accuracy (Joffe, 2012). Alterations were made to the list of categories as new ideas were detected. The constant checking and re-checking established validity confirmation (Whittemore, et al., 2001). Therefore, a coding system (Joffe, 2012) was used based on a conceptual map that could guide the examination of the data, in the form of a coding book. This code manual contains a full set of codes derived from the raw data itself or were theoretically influenced by previous studies. The codes were analysed contextually and less on frequency, as advised by Joffe (2012).

However, it is still an ethical concern when the researcher is the decision-maker, as to what constitutes the themes or categories, and the hierarchical placements of these categories. Nonetheless, the supervisors' constant checks, and the hierarchical placements of the categories, were modes to ensure reflexivity in the process. It is important that the researcher acknowledge and substantiate the choices as well, for transparency to occur and this has been frequently applied throughout this thesis. Moreover, saturation occurs when the same themes are detected consistently, and no new information is found (Pulotu-Endemann et al., 2007). The verbatim data and the quotes included in the thesis itself will substantiate the accuracy of the data and its interpretations, additionally allowing the transparency aspect of the analysis (Pulotu Endemann et al., 2007).

### **Stage 5: Tufaga o Ika (The Distribution of the Fish).**

The Tuvaluan custom of sharing has been widely discussed above, but, regarding communal activities such as communal fishing, the allocated portions are delivered to the people. This role of distribution to the community is also bestowed on certain families who are called *te kau ote tufa* (Chambers, 1983; Isako, 1983).

**Research process: Reporting/dissemination.** The final reports will be presented to all stakeholders involved. As previously explained, Tuvaluans



prioritise the community as the ultimate nucleus of Tuvaluan society, so the dissemination of the finished report will be reported to the Tuvaluan community for feedback and information. This sharing of the finished product (or fish) must emphasise *mealofa* (gifts) of *alofa* (love); therefore, it needs to fulfil the expectations of the receiver (researched population) and the giver (researcher). As stated in previous chapters, this “reciprocity exchange” is a vital aspect of Tuvaluan custom to convey appreciation from both parties, the giver and the receiver (Chambers, 1983).

**This study’s reporting/dissemination process.** A huge appreciation of the participants’ contribution to fill the gap of evidence-based knowledge that is crucially needed in NZ is strongly emphasised. Without their participation in this research, the issue of Pacific underutilisation will continue to undermine the wellbeing of Pacific people in this country. The participants were given a choice as to whether they wanted to receive a copy of the final report of the research. All the participants requested a copy of the report. At this stage of writing, the reports have not been disseminated until it is finalised into a thesis as many had requested it in a thesis format. Reports will be sent via post, email, or personally handed to them. The participants were encouraged to give feedback as a group (Tuvaluan Community Trust Board, Ministry of Health, various Tuvaluan churches and any other interested parties that request it). Several conferences have been attended to disseminate the findings of this study as well, while others are in the planning stage. Lastly, papers are planned to be published as journal articles, both in NZ and internationally.

### **Ethical Considerations**

The Auckland University of Technology (AUT) has its own ethics body (AUTECH) that administers policies to regulate ethical requirements for research that involves human participants. These regulations gear around the basics of privacy and confidentiality issues, accountability and safety components for the participants and to a lesser degree the researcher/s during the research process. A major consideration of this study is the safety of the vulnerability of the mentally health consumers being interviewed in case the research has dire consequences on their mental and psychological states of mind. No major issues or incidents were raised during the interviews. A potential issue was prevented when attending a planned

interview with a mental health consumer, the researcher noted that the potential participant was exhibiting acute psychosis and immediately cancelled the interview.

Apart from AUT's ethical requirements, there is legislation that covers research on human participants and the mental health services where the mental health consumers are patients or residents. In addition, mental health professionals as employees have their own specific ethical requirements that the researcher must identify, address and fulfil. The nature of the research is not medically, diagnostically or in any form related to the pathological aspects of individual mental health consumers. Rather it is a population approach study about the practice of using or not using mental health services, so consents were not required from these external mental health services or professional bodies.

A major requirement is that the researcher must ensure that the research will not disadvantage the participants in any way (The Health Research Council, 2014) but will directly benefit and improve health outcomes and health equity for the most vulnerable, and the researched population. One of the objectives of any research that involves human participants is that the research outcomes must benefit the participants and the populations/groups/organisations that are being investigated. As a fellow Tuvaluan and a Pacific Islander residing in NZ, my goal was to improve the lives of Tuvaluan and Pacific peoples and researching a dire mental health issue is one way of achieving that aim.

In summary, the Health Research Council's *Guidelines on Pacific Health Research* (2014) is a tool to assist Pacific research to follow protocols and crucial requirements when conducting research on Pacific populations in NZ. This study had attempted to abide by these guidelines. Evidence of this is indicated in the following practices: respect of relationships and full engagement according to cultural protocols; study outcomes benefitting both the researcher and the Pacific/Tuvaluan communities in NZ; full protection of participants via privacy and confidentiality procedures and constant consultation with Tuvaluan people of research processes; and the dissemination of reports given to participants and the Tuvaluan community.

Hence, upon careful adherence to the criteria and key principles outlined by AUTEK, the letter of approval was received on the 18 February 2015 (*Appendix A*).

### **Conclusion**

This chapter has described the sequence of stages of the research design process and its justifications. The qualitative descriptive methodology was the most appropriate to explore the research question. It was a particularly effective approach to acquire Tuvaluan people's explanations and attitudes of the issue. The Tuvaluan Research Framework: *Te Pa* was used as a tool to translate the research process into a more friendly and complementary process for Tuvaluan people and to be implemented alongside normal research processes. The granting of ethical approval is evidence that regulations to protect the participants during the research process have been thoroughly checked and permitted by the university's ethics body and a conclusion that this study followed the criteria of a valid and credible research.

## **Chapter 4: FINDINGS. The Pathways to the Utilisation of Mental Health Services by Pacific People.**

### **Introduction**

The reporting of the qualitative research findings is the most challenging stage in the research process. It involves the presentation of a summarised rich voluminous data in a logical fashion enabled by the process of coding and thematic analysis. These findings were extracted from the “voices” of the Tuvaluan participants that explain the underutilisation of mental health services by Pacific people in NZ. The findings are conveyed in two chapters. Chapter 4 depicts the themes via the pathway journey to the utilisation of mental health services, and the associated barriers involved in each stage. The outcomes and implications of this Pacific pathway process that end in the underutilisation of mental health services, and proposed solutions are reported in Chapter 5. Several themes were novel, and some themes were revealed in other studies. In analysing the raw data, Bronfenbrenner’s ecological systems model was employed as a useful tool to make sense of the various determinants and influences that impeded or promoted Pacific people’s journeys towards the treatment of mental illness.

### **Linking Bronfenbrenner’s Ecological Systems Model to the Findings**

Consistent with the ecological systems model, Pacific people’s prioritisation of the *family*, both the immediate and extended family units, is consistent with principles of the ecological systems model units (Manuela & Anae, 2017; Mulder, et al. 2016). Initially, Bronfenbrenner’s ecological model focused on the microsystem level effects of intra-familial influences, but later, encompassed the extra-familial elements based on the belief that these external domains affect family processes (Bronfenbrenner, 1986). Hence, the micro-, meso-, exo-, and macro- systems were used to guide the analysis and interpretation of the research findings. The proposition is that the focus cannot solely be on the mental health consumers, families and mental health services due to the multiple factors that interact and co-exist between the entities to allow or disallow access to mental health services. Essential elements that must also be included are the wider impacts of institutions of social, educational, cultural and legal controls, not to mention the political and economic influences that have a significant effect on the development of the individual, family and community beliefs, and eventually, on health behaviours. Despite the distinctions in the entities involved, there exists commonalities, and

overlaps in the relationships. Each network in the system has a reciprocal role, a top-down and bottom-up triggering process of effects. This is natural as humans live in a life of social complexities. It is this dynamic of links and influences that this analysis of the qualitative data attempted to extract, despite its complexities.

The environmental effects are crucial in understanding the health choices and behaviours of the family and its individual members in relation to mental health service use. These effects are visible in the findings. A review of past studies of external influences on family development by Bronfenbrenner and his colleague (Bronfenbrenner and Crouter, 1983), revealed two main paradigms: 1) external influences on the intra-familial development) and, 2) structural extra-familial influences on the development of families. These externalities were divided into 3 types: mesosystem (intra-familial), exosystem (extra-familial), and chronosystem (changes over time). The ecological paradigm is based on multiple of influences and is an extremely useful tool in linking environmental effects, with behaviours and health outcomes (Stokols, 1996). Reiterating Sallis, et al's, (2015) argument, the ecological model positively contrasts from behavioural models due to its inclusion of an expanded outlook which includes the community, organisational and political impacts and not solely the personal attributes of the individuals and its immediate social linkages.

Such clarification indicates that the systems are not *nested* as many commentators have described, rather, they are *networks* (Neal & Neal, 2013). So rather than disregarding the influential links between the units, or the proposition that each unit is cocooned in hierarchical levels, the units are inter-related in bilateral and multiple systems of interconnecting and reciprocal relationships at the same and distinct levels.

### **Applying the Pathway Construct to the Findings.**

The participants described a sequence of stages of entry into mental health services in search of treatment for a mental health condition, in addition to associated barriers faced in the process. This chapter details Tuvaluans' explanation of Pacific people's underutilisation of mental health services as descriptively simple, involving stages of behaviours embedded in contextual, structural, social, and cultural influences, and how the decisions and choices were determined. The incorporation of the pathway framework has been a valuable tool to understand the behaviours of a minority population in its attempts, or lack of, solving a mental health issue. On closer scrutiny,

the data concerns health behaviours that are the results of choices and decisions. The findings conclude that Tuvaluans, as a Pacific ethnic group in NZ, are less inclined to seek treatment for mental illnesses due to various demographic and ecological factors that dominate attitudinal facets, belief systems, and worldviews. In other words, it comes down to lack of choices due to the dominant paths that may instil feelings of helplessness and hopelessness in people and communities. If belief systems and worldviews influence mindsets to view mental illness in a certain way, added with structural inadequacies such as, lack of facilities or an alienating culture, then pathways are structured to proceed in a certain way.

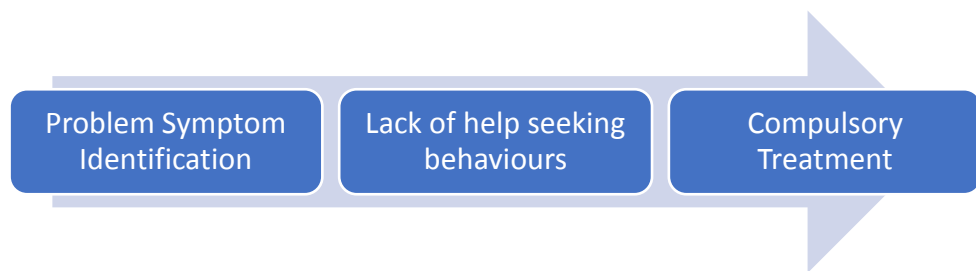
Each stage of the pathway presents obstacles that either halt or detour the pathway to alternative routes that lead to other options of diagnosis and treatment, such as supernatural explanations and healers. The findings explain that Tuvaluans' health behaviours are less decided by intrapersonal (biological, psychological) factors, but more so by interpersonal (social, cultural) determinants and circumstances of their families (microsystem), the community and government policies (macrosystem) and the varied interplays between microsystem entities (mesosystem), and institutional school of thought (exosystem) (Sallis, et al. 2015). These multiple and multilevel influential factors that affect the decisions to use or not mental health services are core principles of Bronfenbrenner's ecological model. Each pathway has its unique history, structure, direction, and barrier factors at each stage, including the duration in-between each stage (Rogler & Cortes, 1993).

According to the findings of this research, Tuvaluan people's pathway is influenced by people's lack of knowledge of the symptoms of a mental illness. Lack of knowledge of the symptoms associated with a mental illness lead to problems with symptom identification of an onset of a mental illness (stage 1), therefore, delaying seeking treatment (stage 2) which will eventually lead to service utilisation (stage 3) via compulsory admissions into acute hospitalisations or forensic services if a crime is committed.

The findings, analogically, are likened to a set of dominoes, whereby if the first domino falls, it will set in motion events that affect the course of actions of the next stages. In this case, if the commencement of the first stage in the process is blocked due to problems with symptom identification, no chain reaction will occur due to the consequence of inaction. However, the participants offered explanations of this blockage (barriers) and how it influenced the choice of "inaction" and delayed behaviours.

There were two types of pathways identified in the findings. The first pathway is through the identification of the symptoms of a mental illness, followed by help seeking from primary mental health services (GP), who refers the patient to secondary mental health services if the assessment diagnosis is a mental illness. As explained below and in the literature, the pathway process rarely occurs when it concerns Tuvaluans, Pacific people, or ethnic minorities for it is not as straightforward as portrayed above. Rather, the second pathway to the utilisation of mental health services introduced in Chapter One is more fittingly realistic as an outline of Pacific pathway to mental health treatments, in accordance to the Tuvaluan respondents. The findings collaborate the literature in Chapter Two, which showed that minorities in western countries tend to bypass primary mental health services and are often forcefully admitted directly into compulsory mental health services (Abas, et al., 2003; Ramage, et al. 2005; Simpson, et al., 2003).

*Figure 5. Tuvaluan Pathway to Mental Health Services*



### **Stage 1. The problem of symptom identification (The First Stage).**

“... we often say, “oh but we don’t know the warning signs” well it’s pretty clear, for me the early warning signs are pretty clear. If someone is spending all their time in the bedroom, sleeping like all day sleeping, if someone is locking themselves away they can’t handle being around people, that’s not normal. Not eating, not sleeping – not sleeping is a big give away, not eating not drinking is another give away..... It’s pretty obvious, if you know someone is doing those things in excess or is not being normal or doing their usual behaviour, that’s how you know something’s not right. So, I think we need to emphasise on that.”

“...people need to know. Not just sit back and go “oh I thought about it, I’m thinking about it,” while this other person is going through hell. So, we need to just stop thinking and just act. Like we really need to act.”

Mental Health Nurse

The symptoms or “warning signs” as defined by the medical field, dominated the discussions. A major explanation for the inaction or delay in help seeking is linked to a failure in identifying the first onset of a mental illness.

The mental health nurse's statement above described Tuvaluan people's inability to react to these warning signs, illustrated by her emphasis on the responsibility of the family and other support systems' lack of recognising symptoms of a mental illness. This negative inference is a common attitudinal pattern by the healthcare participants. As health professionals, they have expertise and vast clinical competency and familiarity of having witnessed the symptoms in their workplaces, yet they fail to view the problem from the perspective of ordinary, inexperienced lay people. The approach of this nurse's condemnation is not on the individual, but on its immediate support systems. In contrast to the other groups of participants (mental health consumers, relatives, and community representatives), the mental health professionals were more concerned and focused on the concepts of apathy, lack of urgency to act, and procrastination as significant reasons for Tuvaluan and Pacific peoples' "incompetency" to identify symptoms of a mental disorder, understand and solve mental health predicaments.

**Emphasis on the Family and the Community.** The findings conveyed the strong role of the families and the Tuvaluan communities in influencing the pathway journeys to treatment mental health services. In contrast, there was less emphasis on the role of the individual suggesting that Tuvaluan individuals possess minimal control over their destinies. It contrasts with western ideology on individualistic responsibilities to steer personal destinies. Earlier chapters have consistently delved into this cultural belief systems of Pacific and Tuvaluan people and the findings of this study strongly supported these contentions (Pulotu-Endemann et al., 2007). For this reason, the family, the Tuvaluan community, mental health services and political systems were viewed negatively for failing to successfully navigate the Pacific pathways to mental health services.

The findings additionally conveyed a reluctance by migrant Tuvaluan living in NZ to adjust to the lifestyle of their host nation was evident. This was illustrated by this older participant who explained that mental illness conditions that are prevalent in NZ are non-existent in Tuvalu. This explanation was often used to justify Tuvaluan's belittling the importance of symptom identification of a mental illness or its treatment. But as the discussions ensued, an understanding emerged of the link between awareness of symptoms and accessing preliminary treatment as told by this migrant participant.



“It is a new topic for us Tuvaluans. We need to be educated how to identify this problem. Cause we always say, “he is funny” and need to identify mental illness, and aware it is a problem, just as bad as the others that’s it, it will get better, and we have to be educated to identify these small changes.”

(In Tuvaluan) “..... tino Tuvalu e seai i latou te mea tenei te mental .... i latou e normal.... e fakapikopiko fua. Maybe tomorrow ko lei.”

(In English): “...for Tuvaluan people mental illness doesn’t exist...to them, it’s just normal...that they are just sulking. Maybe tomorrow it will be okay.”

Elder Male Community Member

These findings are significant because they conveyed that the pathway process was halted even before it began through inaction that occurs at the commencement of the pathway process to the utilisation of mental health services. This is shown by an expressed logic that if symptom identification of a mental illness is not addressed due to failure to recognise it, then feelings of indifference, and therefore, failure to act is the ultimate consequence. Inaction or alternative routes (external aid from the norm) of aid will occur. Consequently, in all cases of this delay or absence of treatment, the severity of the symptoms will undoubtedly intensify. Interventions at this stage of the process are important to enable a change of action to motivate people to act. The findings conclude that a focus on problem symptom identification is crucial even before we inform the public on service provisions and how to access these services. Educational programs must include information on this pathway process, particularly to identify symptoms of psychoses and where to seek help.

Several sources in the international literature are consistent with this study’s findings of problems with symptom identification by minority populations as experienced by Tuvaluans in NZ. For instance, Brown (1998) argued that Asian Americans experience difficulties associating unusual behaviours as symptoms of mental illness. Asians describe these symptoms as exactly showed, such as in situations when someone who is having a violent fit is viewed as exactly that – someone is jumping up and down having a fit, not necessarily a mental illness symptom. Perceived stress and distress are strongly dependent on the values and beliefs of minority populations, which decide incentives to access or not, mental health services. Brown (1998) also claimed that indigenous beliefs are ignored in studies that relate to the symptomology and treatment aspects of mental illness. Ethnic minorities tend to express somatic presentations rather than psychological symptoms (Knipscheer & Kleber, 2001; Yorke, et al., 2016) to describe mental distress misrepresented by naïve Western clinicians as more severe than its actual state of distress. Moreover, Teagle, (2002, cited in Wahlin & Deane, 2012) conveyed

discrepancies in the way parents and their teenage children's interpretations of the symptoms of a mental illness. Teagle's study reported that parents fail to recognise internal mental health symptoms (e.g. anxieties) but are easily able to identify external symptoms. In contrast, teenagers failed to identify somatic symptoms but were able to identify internal problems. The teenagers and their parents also differed in perceptions of the severity of the condition, but more problematic is the teenagers' difficulties in expressing their internal psychological symptoms. Consequently, it is a barrier to help seeking and accessing mental health services as both are dependent on parents' decisions which is based on the ability to accurately identify the symptom.

These findings showed that Tuvaluan people also tend to seek clinical aid for physical illness symptoms such as headaches and lack of sleep, where after further interrogation and assessment the diagnoses eventually indicated a mental illness condition. The male GP participant evidenced this in a statement that described his Pacific patients as very defensive of a mental illness diagnosis. He was certain that it is a strategy to minimise the shame and stigmatization of a mental illness diagnosis, but it disadvantageously hindered its detection. Therefore, it is unsurprising that in the thirty years of his employment as a general practitioner, a mere two Pacific patients sought his assistance for mental illness, and they were both Tuvaluans

## **Stage 2. The Help Seeking Stage.**

"Sometimes, us Pacific Islanders, we sometimes are not aware of the providers and maybe we are less informed by the public .umm, we are not aware that they are there. We just don't know. So, when it's happened like, if one of our families suffer from mental sickness, we tend to look for help but then there's hardly any help."

Male Elder Relative

If symptoms of a mental illness are successfully identified, the process will continue to the next stage of the pathway which is help seeking. However, the findings conveyed that this stage also consist of obstacles that hinder the successful progression of this stage.

The effect of the inter-relationship in the microsystem and mesosystem of support by parents, relatives, friends, and schools in recommending, promoting, and finding assistance for people with mental illness has been evidenced in the findings and the literature. For instance, Ben-David (2017) has argued that the trend towards seeking advice and support during first incidences of mental illness episodes from informal sources rather than from mental health services has increased in America. These informal sources of support by parents, relatives, friends, the school system,

and general practitioners play a key role in obtaining formal help for adolescents with psychological problems (Thurston, et al, 2017). A study by Barrera, et al., (2016) of young Latino adolescents reported similar findings whereby advice for help seeking is sought within the microsystem sources of stakeholders.

The literature tends to focus on barriers to the utilisation of mental health services, particularly in the help seeking phase and less on positive elements that facilitate utilisation. For instance, many of the complexities and difficulties faced during all stages of the pathway process involve the first episodic experience, yet one positive aspect of subsequent episodic experiences of relapses is the knowledge acquisition and familiarity with the pathway process and the structure and operation of the mental health system. The relative's statement below is suggestive of his realisation that the normal route for assistance is through a GP after experiences of subsequent episodes of psychosis by his relative. However, during the first episode of the psychotic incident, his family had presumed the violent and unusual behaviours were criminally related and sought help from the police instead.

“.....that time we didn't even know who to approach, like what... or should we ring the police? To come and ....and they gave us all the information.”  
 “...we normally take them to the GP. And from there, they just advised us where to go.”

Male, Elder Relative

According to the male GP, there are diverse reasons to explain Pacific people's lack of help seeking behaviours from clinicians. He stated that Tuvaluans traditionally maintain supernatural explanations of the causes of mental illness, therefore embracing healers.

“From experience, even same with the Pacific people, they don't like or know how to seek and come for mental advice. ....  
 “.....the Tuvaluans, I can't even ...I mean they don't seek help. And the same as all the Pacific people. Like you know, from mental health, our people they don't seek help, sometimes they seek it from outside .....or directly go to the Crisis, or the police, mmm.”

Male GP

### **Stage 3. Utilisation of Mental Health Services.**

The normal route to the utilisation of mental health services begins with the identification of a mental health concern, followed by accessing primary mental health services such as GPs, who perform clinical assessments and referrals to psychiatric mental health services. However, the Tuvaluan and Pacific pathways is distinctive because it often bypasses primary mental health services and proceeds directly to compulsory acute and forensic interventions. Problems with symptom

identification and other barrier factors delayed treatment, as discussed above, leading to the escalation of severity of psychotic symptoms, and the ultimate forced acute and inpatient hospitalisations, incarcerations at forensic services and other negative consequences of this delayed help seeking behaviour. The third stage of the pathway process is outlined in Chapter 5, which details the compulsory mental health services and other negative consequences that participants depicted are implications of the failure to, or delayed use of mental health services.

### **Barriers**

Descriptions of treatment barriers can vary depending on the stakeholder involved. A noteworthy aspect of the findings is that the major themes were drawn from the participants' accounts of barriers that hindered Tuvaluan and Pacific peoples from accessing mental health services which drove people to seek other options of assistance. These barriers are: the umbrella theme of *apathy*, as the consequence of the themes of *lack of knowledge* and *homeland influences*.

#### **Theme: Apathy**

The theme of Tuvaluan people's apathy in connection to all areas of mental health is consistently visible in the data and is therefore prioritised as the major umbrella theme. The impact of apathy as a barrier is extensive, and quite unexpected, but understandable once the sub-themes are linked to this theme. It is an overarching explanation for help seeking pattern of behaviours.

The theme of apathy has not been reported in other studies or in any NZ research, or minority studies in relation to people's use of mental health services. This study distinctively showed that lack of knowledge was a dominant factor in forming patterns of disinterest amongst Tuvaluans. Nonetheless, as indicated in the findings, this pattern of beliefs is subconscious and unintentional, for these are likely to be the results of contextual socialisation and educational effects that became part of norms of everyday life. This finding of apathy reflects Tuvaluan people's attitudes, beliefs, and lack of knowledge about mental health issues.

#### **Theme: Lack of Knowledge.**

The findings of this study unearthed the fact that people were unaware of symptoms of a mental illness in addition to where to seek treatment for it and how or if they qualify to access it. The lack of knowledge, and hence apathy about the

pathological aspect of mental illness or its symptoms, was highlighted strongly and consistently in the data. However, this study's aim excluded a focus on the pathology aspect of mental illness. The aim was to uncover the participants' explanations of observations, experiences, or lack of, at the onset of an episode of a mental illness and what determined whether help seeking was acted upon in this situation.

Moreover, there is widespread naivety of psychotic behaviours, its treatment, the available mental health services, and access of these services when the need arises. The gap in those who "do not know," (laypeople) who are the majority, those who "know it all" (mental health professionals) and the in-between knowers (consumers and relatives), is an extensive divide. Alternatively, it is also deemed as the gulf between those who have experience in the phenomenon and those who have not have this experience.

"Sometimes we just sit at home and we don't even know what to do, you know. And the problem gets worse and worse and the family can be threatened....you know, your life as well."

Elder male relative

The migrant participants were certain that this lack of knowledge situation was a consequence of homeland beliefs and practices concerning mental illness that will be discussed next.

### **Theme: Homeland Influences.**

Adoption of homeland beliefs and practices in relation to mental illness is a key theme of this research. Homeland influence as a barrier is widespread for it encompasses the broad cultural, social, and even political influences of the pathway process towards the usage of mental health services. Consistently, the findings referred to experiences in the homeland that dominate the health behaviours of Tuvaluans in NZ. It reflects migrants' attitudes regarding mental illness and its treatments, viewed as the main barrier to using mental health services.

Constant references to the homeland was not expected for it did not align with past studies' findings, particularly in NZ. It is the first study that informed a particular minority population has linked their population's underutilisation of mental health services to the belief systems regarding mental illness and its treatment practices, and the structural inefficiencies of the mental health system in their homeland. It is an addition to recent positive moves by Pacific people to profess their realities (ontology) to define, explain and solve the problems faced by Pacific people (Nabobo-Baba, 2008). It means that because this theoretical and

conceptual route has not been previously unearthed by academia, the voices of the researched population must be upheld. The Tuvaluan participants have described this explanatory factor as a significant influence in relation to the utilisation of mental health services, hence this reasoning should be respected, and its integrity acknowledged (Harding, 2004, cited in Nabobo-Baba, 2008). Knowledge claims are always socially and culturally contextual and not universal. Accordingly, knowledge claims about homeland influences reflect the realities of life of Tuvaluans in Tuvalu regarding mental illness and its treatment that continued to NZ.

The lack of mental health literacy about the pathology of mental illness that is coupled with an absence of mental health facilities in the islands were described as major influential factors that contribute to Tuvaluan unfamiliarity with treatment services in NZ. The following is a list of sub-themes of homeland persuasive attitudes and health behaviours adopted in NZ in relation to its effects in delaying the commencement of the pathway process towards treatment. The macrosystem influences in relation to cultural and the social exosystem rooted in historical, traditional and lifestyles of Tuvaluans in their homeland, added with structural circumstances of the health system was consistently highlighted in the findings. These influences of health behaviours and attitudes towards mental illness and its treatment interact to form dominant barriers in the help seeking choices of Tuvaluans in their host country of NZ.

**Lack of mental health facilities in Tuvalu.** The constant inferences to the homeland Tuvalu to explain the way Tuvaluans in NZ think, behave and justify their preferences and expectations of mental illness and treatments were detected. A former social worker and older female migrant, in the same tune with the other migrant participants, situated a link between treatment practices of the homeland to explain the low use of mental health services in NZ. She emphasised that Tuvaluans have the notion that mental illness cannot be “cured.” But upon clarification, the absence of a cure perspective merely refers to the absence of mental health services in Tuvalu.

“....to my understanding, those people (the mentally ill), we don’t....we don’t have a cure for it. There is no cure for...like how I see it in NZ, like you go to the mental health (services), and you know, like having been diagnosed and you were given medication and all that. But in Tuvalu there is no mental health (treatment)....ah...specialists or no mental health services like what we have in NZ.”

“Like for example if you are pregnant, you go to the hospital. There is a service there for women, you know, a nurse there to check you through your pregnancy, you know, until you give birth. And so are other services in the hospital, like if you are sick you go there, get a Panadol then you go home. But nothing there to say “You go to the mental health room” because it’s so fakama (shameful) if you are mental.”

Retired Female Social Worker

But a female relative was critical of the absence of a mental health national policy, evidence that it is not a priority at government level either.

“Te Red Cross tena e help neia kae seai se mental health policy a tatou. (The Red Cross is there to help but we (Tuvalu) have no mental health policy.”

Female Relative

**Mental illness is not a serious illness.** The participants’ constant referral to the homeland “back home” strongly implies that the behaviours of Pacific people in relation to health is a continuation of life and attitudes from the islands. For instance, one participant spoke of the familiar beliefs by Tuvaluans in the homeland that mental illness is not a serious illness which led to coping strategies of waiting for the problem to pass. The mental health nurse described Tuvaluan belief systems about mental illness that resulted in common practices of leaving the problem to go away on its own, and that families can cope and manage mental illnesses. This theme was frequently raised.

“Often our Pacific Island people left it, left things too long and believe “no, we can manage things ourselves” well no you can’t.”

Mental Health Nurse

Likewise, the retired social worker explained why Tuvaluan people do not regard mental illness as a serious condition because it resembles the nature of an easy simple life in Tuvalu that is uncomplicated.

“I think the life in there when I was growing up, it’s just like the birds. They don’t worry about what they’re eating like what the bible says.”

“There is no worry at all. And life is not difficult at all. And that’s why we treat everything, is not serious. Cause if you are hungry you just go down to the beach, and get something to eat.”

“Oh, .....what a paradise. No stress, no mental health.”

Retired Female Social Worker

This view was also commented by another community member who is an elder male participant who believes stress exist only in NZ and is non-existent in the islands.

(In Tuvaluan): “Se lei te stress ne? I Tuvalu e seai. Ko Niusila fua e isi iei. Ako i Tuvalu e seai se stress. Ka stress koe ko fano koe o kake iluga ote niu. Ne? E lei ko fiafia koe.

Fano faika, fano ki tai, ...e tuku fua i Niusila nei. Seiloa neau ki tokolua (indicating the other 2 migrants), ako au i toku olaga i Tuvalu, seai. There's no such thing as stress."

(In English) Stress is not good hey? In Tuvalu, there's nothing. It only exists in NZ. If you get stressed, you just climb the coconut tree, hey? Then you will be happy. Go fishing, go to the sea.....its (meaning stress) found only in NZ. I don't know about those two (referring to the other migrants), but that's my life in Tuvalu, nothing. There's no such thing as stress."

Elder Male Community Member

**Cope on one's own.** According to the findings, the non-existence of mental health facilities, specialists, or even psychiatric nurses in the homeland of Tuvalu has affected people's attitudes towards mental illness, and its treatment. According to the migrant participants, the non-existence of mental health facilities, initiated feelings of apathy towards mental illness as an insignificant, simple illness that leaves people no choice but to persevere and cope with the illness on their own in their homes.

This practice is similarly occurring in NZ according to the participants. The male GP emphasised that this may suffice for a mental illness diagnosis like depression, but it is difficult to deal with a complex diagnosis like psychosis in the home setting. Therefore, strong social supports within other structures at the microsystem level are described as a barrier for prolonging the symptoms without seeking the medical support it gravely needs.

"The Tuvaluan perceptions is just like ...um like going back home, they don't have specialists treatment you know. They don't have specialists like psychiatrists or even psychiatric nurses like they have at that level. From experience they don't have it back home...and most ahh, like the Tuvalu like any other Pacific people.....they can manage at home, .....especially depression.... commonest mental illness and like any other Pacific.... patient.... they don't turn up...because us Pacific and the Tuvaluans, what we call social support at home, it's always with them.... but its other things like psychotic..... difficult to manage, they get referred ...."

Male GP

Another GP participant, who is younger and a female, reflected that this explains why Tuvaluans in the islands rarely consult a doctor. The aid of a doctor occurs only when people are in the brink of dying, a contrast to life in NZ. This may explain why Tuvaluans in NZ have a slow reaction to the severity of symptoms of mental illnesses for they are unseen and invisible, and therefore, unpredictable. These symptoms are difficult to describe to others as well, but the stigmatisation and shame associated with mental illness is an added discouraging factor to its identification. The female GP participant's attitudes towards patients' visits to her



surgery in NZ are interestingly noted as influenced by her experience growing up in the islands.

“Sometimes, some patients come in and I’m like: “Really, is that what you coming in for?” You know, because when I was growing up in the islands, if I was to see a GP, if I were....you know, tou tino ka mai ko tai mate (our people visit the doctor when they are dying). That’s what they go to doctors. So mental health is seen as (pulls her face to show it’s no big deal) ...you know.”

Female GP

**Family support system.** The support systems back home in the islands by families makes coping with mental illness tolerable and manageable for people with a mental health condition that migrant participants have frequently discussed above. The female migrant GP states that it is the reason why the condition is believed as insignificant, and very common, because the family’s support is always present to help cope with the illness.

“I think te kau Tuvalu (Tuvaluans)..... a tino se mafaufau fua pela me seai se masaki, me se masaki fua e cope fua tino ne latou (people believe it’s not an illness, because one can cope with it as) it’s common. ....don’t see that as an illness because we have families to cope with it.”

Female GP

**Discrimination.** Despite the strong family support systems to assist the mentally ill people to cope with the condition, a few participants commented that attitudes and treatments of the mentally ill in the islands were described as discriminatory and excluded from normal activities of society:

“Pela me se joke, ne? It’s like a joke, hey?.....they stay out in the umu (outside cooking facility) while everyone else....”

“E tuku loa ke nofo i latou i koga lailai ... (they are left on their own, in dirty places)” ...

Female Community Member

**Religious beliefs.** Understandably, if mental health facilities are lacking in Tuvalu and are not prioritised at government level, then people will endeavour to seek any form of explanations to understand presentations of the mental illness. At the same time, there will be speculative attempts to locate some sort of treatment or cure for it. Tuvaluans found both explanations in religious beliefs as reasoned by the excerpt below. The indirect impact of the macrosystem according to the ecological system’s theory is conveyed via the traditional customs and way of life in Tuvalu that were adopted from the teachings of missionaries who introduced Christianity’s values, principles, norms, and rules of how people should live peacefully with one

another. Several participants contended that the influence of religious beliefs is a significant factor on life in Tuvalu and are certain this belief system resumes in NZ.

“.....understanding drives our people’s lives, is the Christian’s understanding. Because that’s the only first book that we read. ....And that’s the knowledge of what they read, from the bible, that’s the only knowledge they translate into how they live. So, the beliefs is also, you know, impact with any of the educations,...that’s the only resource they have. The bible and what’s in the bible is what they believe.”

Retired Female Social Worker

**External Help from Healers and Spiritual Leaders.** The male GP stressed the fact that from his experience as a GP, Pacific people do not know about medical treatment or the fact that they can consult GPs about mental disorders. He suggested that this may be explained by Pacific beliefs in supernatural explanations that portrays people with psychosis as possessed by ghosts. For this reason, they seek external help from religious leaders and spiritual healers. This attitude is consistent with studies of Latin Americans’ causal attributions of religious and supernatural factors to explain mental illnesses, therefore, are more likely to seek aid from religious leaders and healers (Kuo, et al. 2015).

“One thing um.....our people believe.....in the supernatural like for example if you see someone like ...with those elements of psychosis, and they think, .....like as a ghost or something like that...”

Male GP

Similarly, the retired social worker was adamant that the lack of mental health medical treatment facilities in Tuvalu is the major reason for people to seek alternative traditional and religious sources of treatment. But she acknowledged that this attitude may be generational, implying that the younger people may not share the same beliefs.

“.....Tuvalu, they don’t have doctors, they don’t have ... Well, with us, so much in the safe hands of God.....here, its professional healing, it comes and cure people. But the natural, that’s what I’m saying, the only healing, the only cure we have because we have no doctors, is our beliefs. ....You don’t go to the professionals, we rely on our beliefs. Which is the bible. The only thing that travels to each in Tuvalu, and that’s my generation (beliefs).”

Retired Female Social Worker

The older community participants echoed identical reasonings that belief systems about mental illness influenced by homeland beliefs may dissuade Tuvaluans from seeking aid because they do not expect treatment services to exist in NZ. Thus, alternatives, such as pastors and healers are sought in NZ just as they are in the homeland. For instance, an older male participant said that:

“Back in Tuvalu, when somebody is acting strangely, or acting foolishly, they usually take them to the...uh,...uh...magic people, milimili (massage) and all that stuff.....it doesn't do any good at all but that's how the other people feel.....but it's related to agaga (ghosts) and all that stuff. But that's what happens ... they never take them to hospital....they rather do it with black magic.”

(In Tuvaluan) “Au faipati atu loa faka tino Tuvalu. Toku talitonuga kafai e masaki au i toku mafaufau io me ko toku agaga, au se fano kite medical doctor. Au ko fano kite spiritual doctor. I toku talitonuga kaati e mafai neia o cure ne?”

(In English) “My belief, as a Tuvaluan, is that if I have problems with my thinking or my soul, I would not go to seek the medical doctor. I will go to see the spiritual doctor. Because I believe he/she can cure me, hey?”

Elder Male Community Member

**Shame, stigma, and taboo problems.** One indirect effect of lack of mental health literacy problems are feelings of shame and stigma which deter discussions of mental illness in any context as taboo. The migrant participants referred to it often, and always linked it to macrosystem effects of traditional beliefs involving mental illness and its treatment that are adopted from the homeland.

It is one of the most influential barriers to using mental health services (Becher, Pieper, Ueffing, & Zschorlich, 2013). Stigma is a negative effect of stereotyping, prejudice, and discrimination (Corrigan, 2005, cited in Buechter, Pieper, Ueffing, & Zschorlich, 2013) that targets certain groups of people, such as people with mental illness.

People's lack of knowledge of mental illness often results in misleading diagnosis as intellectually handicapped, a common stereotype by laypeople. Likewise, these discriminatory labels and the effects of stigma and shame additionally target family members. The implication of these negative intrinsic attitudes of shame and stigma is that mental health consumers are being excluded as not part of society (Rescheme, 2008, cited in Buechter et al., 2013), as depicted by one of the participants. Because of widespread experience in dealing with mental health consumers and their families, the mental health nurse contended that the biggest determinant to delaying help seeking is shame which pressures families to “cover up” their relatives' mental illness conditions.

“And I think often, there's a big shame on some families and that is something we struggle half the time is that we have to re-educate the family and that's a big part usually because they have their own perception, their own beliefs, and yet they stop the person that needed help from accessing those processes ....”

Mental Health Nurse

The pastor (community group member) was adamant that this traditional attitude that people with a mental illness brings to the family and shunned by the

community, existed historically in Tuvalu. He described how it was dealt with in pre-colonisation times.

“I think the mentality that our people have, I know that back in history, um, I think it’s similar with all the other Pacific island people, when they have disabled people. They sort of bring shame on the family. Just like Nukulaelae (an atoll in Tuvalu), until now, they still have that stone where they sacrificed babies and all of these disabled. By doing this, they take away the shame away from the family. So I think there is still some continuity up to now. This sort of mentality.”

Pastor-Community Member

He believed that these feelings of shame are stronger in the young due to communication shortcomings with parents:

“It’s quite common in our Pacific communities especially at this age. Especially the problem of being “maa” (shame). E maa kafai e fai o lotou problems ki lotou matua (They are ashamed to tell their parents their problems). So akoakoga taua (So important lessons) we need to open more, pela (for instance)....as you said: you have to tell someone you are comfortable with their problems, rather than you gonna find your own way.”

Pastor-Community Member

The majority of the relatives also spoke about the “shame” aspect of mental illness that families feel, and the effects of shame of having a relative with the condition. The fear is that they may be shunned and ostracized by the community.

“They don’t want others to know that their family have a problem of mental sickness in the family itself. It’s like a shame or something. Some people just keep it to themselves.”

Elder Male Relative

These traditional attitudes about mental illness has continued to plague Tuvaluans in NZ. For instance, the male GP reported that Pacific people are very defensive if a diagnosis is for a mental illness, and his Pacific patients dislike being labelled as mentally ill, which he feels is the reason for not seeing the doctor about it.

“..... that is why they don’t want to come, and they are very defensive, and just like anyone else, they don’t want to be called mentally unwell.”

Male GP

In the same manner, this community support worker stressed the *fakama* (shame) notion to explain people’s ignoring the signs of mental illness:

“Actually, it takes a while. .... because of that fakama feelings, so it takes a while for them..... (long pause) And they..... (long pause) it’s sad....it’s sad they don’t notice this. And they..... (long pause) ...Ahhhh some of them, they just ignore it. They bury it, or are very in doubt .....and some of the’ experience, they try to seek mental services.

“Yep, that is a part of the fakama, that’s part of the reason our people they get cover for that reason.”

### **Stigmatization of the Mentally Ill as Intellectually Handicapped. A**

significant and unexpected finding voiced especially by the migrant participants deals with the lack of knowledge of mental illness that can lead to people's mistaken diagnoses of the person as intellectually handicapped. This association and confusion between the two medical conditions may be a consequence of the fact that Tuvaluans lack linguistic descriptions of both medical conditions. The participants stated that Tuvaluans do not have specific words for labelling mental illnesses. The closest words typically used are similarly applied to intellectually handicapped people such as "*valea*" (stupid/crazy). This derogatory term was used frequently by the participants in this study, however, the terms used by a participant below "masaki ote mafaufau" is evolving as an official label to define and identify a mental illness. For instance, for my Master dissertation study undertaken in 2010, several elders were asked for a term that would best label a mental illness and the term "masaki ote mafaufau" was offered by most of them. The word *masaki* in Tuvaluan means an illness, while *mafaufau* translates to the mind, or thoughts, therefore, the total meaning of the words "masaki ote mafaufau" translates to *an illness of the mind*. This limitation in language "resource" when attempting to translate cultural sources alien to another or vice versa, requires urgent attention. The Tuvaluan government has an obligation to provide an official term for the mental illness condition to stop usages of derogatory terms like *valea* (stupid/crazy).

Discrimination towards these people, plus stigmatized stereotyping and the taboo nature of mental illness are normal occurrences, not only in Tuvalu, it seems that it continued to be practised here in NZ as well. The mental health consumer noted that the constant ridicule of the mentally ill as intellectually handicapped is another implication of these misconceptions, and this is occasionally noted in the discussions.

(In Tuvaluan) "... e fakalofa foki a tino kola e fai me e valea, tela la a tino kola e masaki kite mafaufau. Kae e olo fakalili, e olo o tutala ki latou. Se amanaia ne tatou, tena la a tino pela, e fakalofa kii loa me ia latou e olo o fai sale pela me e valea fua."

(In English) "...it's sad for those people who are regarded as crazy/stupid (intellectually handicapped) because these people have mental illness instead. We ignore/disrespect them. It is sad how people treat them as crazy/stupid."

(In Tuvaluan) "Ke malamalama a tino, me i tino e fai pela me e valea, kae fakalofa la te tino me e masaki ite mafaufau.....Se valea la kote mea loa e masaki. Ako tino e look down ne latou,..."

(In English) "For people to be knowledgeable because people describe them/us

(Mentally ill) as intellectually handicapped, but it's sad because they have mental illness. They are not crazy (intellectually intelligent). But people look down on them."

Male Mental Health Consumer

The mental health consumer participant stressed the importance of Pacific people being knowledgeable about mental illness, mostly to distinguish between the intellectually handicapped and the mentally ill. An example of the mental health consumer's criticism above is explicitly illustrated by this quote from the retired social worker, who has her own view of a mental illness and what caused it.

"....for myself, personally, when I hear the words mental health, it's sort of something that I don't want to be recognised ...as mental health (consumer). Because I see it as the crazy people, you know, and that's why I don't want really to be labelled as a mental health (consumer), you know....that I got mental health (illness).....Yeah, well, coming to NZ, it's like, back in the islands if you have mental health (illness), like.... There's a word in Tuvalu called fakavalevale (act stupidly) in Tuvaluan ....."

"..... what I've seen, the mental health people there like "tino fakavalevale" (people who act stupid), it comes, it's normally when they are born. They were born like that. Intellectual something. E fanau loa mai ko masei o lotou ulu (they were born with damaged brains), maybe kote taimi ne nofo i loto te tinae ote matua (maybe, it's during the developmental stage in their mothers' wombs), or something really wrong with te matua (the mother) and that's why they born like that."

Retired Female Social Worker

### **Characteristics of Mental Health Services in NZ as Barriers.**

Several participants were concerned of the failure of mental health services to respond to Pacific mental health needs, had prior dealings with mental illness as a mental health consumer, relative or who had worked in the field. These experiences provided these people with extensive knowledge of the operations of the mental health system. The mental health professionals voiced the most opinions on this topic.

A few references to barriers of mental health services in the utilisation process were noted in the findings. A key finding consists of criticisms of logistical problems in relation to the slow interventions by acute services when contacted for help. Further complaints targeted issues of cultural incompetency of staff, lack of training of GPs in mental health, unaffordability, immigration and the futile visits to primary mental health services to be prescribed simple medications like paracetamols. The literature referred to many other structural barriers that were not indicated by the participants, such as lack of transport (Lee, et al., 2017). The following section will illustrate participants' criticisms of mental health services'

role as barriers depicted as explanations of Pacific low use of mental health services.

**Primary mental health services.** Primary mental health services' role as the first point of contact of mental health services have been investigated by numerous researchers. For instance, Jorm (2000) argued that it dictated the pathway to utilisation and often acted as a gatekeeping mechanism for entry to secondary mental health services. The participants who are non-mental health professionals were unaware of the importance of primary mental health services in this respect. Those who did initially seek help for mental illness from GPs remarked that family support system advised and channelled them to consult a GP, consistent with the literature presented above. However, they had not made the connection between mental illness symptoms and health. They had assumed it was either criminal, spiritual, adolescent developmental behaviours or environmental effects on people that caused the unusual behaviours. The mental health consumer and relatives recalled their first experiences of the first onset of psychotic episodes and spoke about the years of subsequent relapses and readmissions. These experiences resulted in knowledge acquisition of the process of accessing mental health services. A mental health consumer, whose current knowledge is extensive due to a twenty-year period of relapses and readmissions, was cautious of GPs as lacking clinical training to treat mental illness symptoms:

(In Tuvaluan) "I tokita kona me e akoga foki kite mafaufau me e akoga fua kite foitino?"

(In English) "These doctors (GPs), do they have training only of the body, or the psychology of people too?"

Male Mental Health Consumer

The participant doctors agreed and stated that a major concern relates to the consultation practices in doctors' surgeries that disallows sufficient time to assess and ascertain a diagnosis and/or treatment for mental health patients. Consequently, Dowell, et al., (2009) argued that primary mental health services prefer a mental health clinician in their midst to deal with intensive mental health needs that would minimise the negative factors of time-consuming consultations and GPs' lack of training in mental health. Simon et al. (2009) contended that GPs are not needed to undertake postgraduate mental health training and revealed that GPs preferred collaboration with specialist services rather than acquire further training in mental health. The male GP participant similarly asserted that what is urgently required is a

separate clinic staffed by psychiatrists and other psychotherapist clinicians that would support GP referred customers. This view supports the study finding by Simon, et al., (2009) that the demand for psychiatric care is extensive and GPs are not adequately trained to deal with mental health patients.

“Screening for mental illness, i.e. KPI or key performance indicator for payment allocation..... GP normally has 15 mins, and very difficult for GPs assessment of mentally ill consumers in that brief time. We do not screen them, unless they have an obvious mental condition, so the 15 minutes time is inadequate.”

“For example, like diabetes it will take me like 15 minutes when they come in, you just ask them questions about their medications but if you pick up someone that is depressed or something like that, it takes me an hour. Because you must sit down and ask all these questions and make sure they are safe and if they are not safe, you just refer them, you know. You just have to refer or call the Crisis Team.”

Male GP

The female GP participant additionally voiced similar concerns related to short allocated consultancy sessions and GP's lack of training in mental health.

“.....minutes too short a time to talk much and we are always pressured by time. Like, we need to finish in 15 minutes, and then see another person so if we use just a half an hour talking, which we really want to do, you'll be getting stressed because you have 2 other patients waiting.....the GP should know that they have services that they can refer them to, who can actually spend like an hour,. Free. And who are professionals like mental health people to talk about....so that's what palagis (white people) know, we are not professionally mental health trainees. We know things like “oh, yeah, I've got the cold, or sinus you know.....But mental health, it's always kind of “Ohhhh, what to do, what do I do?” You know...should I give injections or this?”

Female GP

The male GP also stated that the financial barriers incurred by GP consultation costs is one of the greatest barrier to accessing mental health services since primary mental health services is the entry point of contact for people with symptoms of a mental illness condition. Hence, financial barriers pose a major structural barrier to the utilisation of mental health services by Pacific people. Even if people can identify symptoms of a mental illness, they are faced with another financial barrier of consultation charges. The GPs' statements are referring to issues of inequity, inequality and disparity barriers to health services as discussed in earlier chapters. This participant linked government measures via legislations and policies and its consequences on Pacific mental health behaviours.

“..... the greatest barrier for Pacific people is the affordability as it is the first entry, first point of entry, mainly the GP.”

“I think it's the awareness and probably the affordability as well. For example, with the Pacific providers now, it's ....you know....just must thank Labour (political party) for bringing down the costs of GP charges cause I remember when I was here, the student cost \$30 for a doctor (visit) and that was in the late 80s and 90s, and paying your medicine is more like a hundred per trip. That's when I was a



student and I found that very very expensive, and when you are sick, you don't go see the doctor until you are very very sick."

Male GP

However, according to the female GP participant, some GP mental health consultations are free, and she worries that Pacific people are ill-informed of this fact. It is another illustration of government strategies to increase the utilisation of mental health services by vulnerable populations. This information shocked the other participants for they had no idea it was a free service, but as she explains, it is only for mental health consultations.

"If you go for a mental health consultation with a GP it should be free."  
 "...yeah, if you are having problems like you are stressed, or not sleep well, not eating well, and you are stressed, you go to the GP and talk to them why .....counselling services. They are really focusing on Pacific because we are the ones that don't go. Yeah like "okay there are free services, come and get it". But doesn't really matter out there. I tino se olo cause ite togi mafa (because people don't go because it's too expensive) you know."

Female GP

**Pacific mental health service providers.** According to the forensic worker, Pacific mental health service providers have considerable problems due to the large number of clients that come through their services. For this reason, the assessment process is not always thorough which can be regarded as a barrier to help seeking. If the clientele of these Pacific mental health service providers is too numerous, how can quality and efficient services be provided if, as this participant asserts, the assessments, care and treatment are not thorough.

"one of cultural workers was working at Lotofale (Pacific mental health service provider) and he said he had over 100 caseloads. So, something must be happening, I don't know."

"..... for Lotofale, I think it's like a real rush sort of, you know..."

".....that's what I find is the general mental health it's ...um.... yeah.... they come and adjusting their [treatment] then "out". Even if they end up on the street and that's the problem."

Female Forensic Worker

In contrast, other participants praised the existence of Pacific mental health service providers, such as the male GP who associated these providers with providing affordable services to Pacific people. He praised Pacific service providers for employing staff competent in Pacific cultures and fluent speakers in Pacific languages.

"Pacific mental health providers are good, was no mental health services specifically for Pacific. Good to have staff of own ethnicity, speak same lingo, and same colour when treating clients."

Male GP

A young female participant also promoted the value of culturally competent Pacific ethnic staff. She mentioned that after a few unsuccessful attempts to give her mother medication by the psychiatrist, it was the presence and advice by the Pacific mental health worker that encouraged her mother to finally consent to taking her medication.

“I think the Isa Lei (Pacific mental health provider) people, the Pacific Islander, she (her mom) felt comfortable with her.”

“When she talked to my mom that she had to take pills then she (her mom) agreed to take it.”

“...she felt safe and more comfortable with her. Or with any Pacific people that is around her.”

Young Female Relative

**Mainstream mental health services.** Some mental health professional participants were adamant that cultural competency was a required resource that all mental health staff must have to efficiently work with Pacific clients. This requirement was commented on by the forensic worker who was critical of certain staff she works with, usually originated from overseas, who ignored Pacific cultural protocols. She regarded this as a serious barrier to using mental health services as it portrays mental health services as an unresponsive and uncomfortable mental health system for Pacific people to seek help from. Even though her assertions are based on her experience working in forensics, it is likely that this criticism can be applied to all mental health staff incompetency when dealing with Pacific clients, particularly employees of mainstream services.

“I think a lot of them seem..... is arrogance. Yeah you know they think they know better.....they really need to work in partnership with the Pacific people because some of them, they don't understand the um you know how we/the perception..... How the protocols of what the way we do things for example .....this particular UK staff, out of NZ, .....And um he writes a lot, he sends out letters to the Pacific island people. ....and I said to him, that's not how you deal with our people. I said, you seem to like to write. You don't do that...that's not how you...cultural thing and also it's very, that's really disrespectful - you need to um...I mean I showed him how to do it one way. I contacted the family, I had a meeting with you know, and with him involved and face to face you know, in a very respectful manner with talking to the family. You know, I said this is how you do it. And then he found that they were a bit more receptive. So it's not just yeah....A lot of it is they don't know how to deal with our people.”

Female Forensic Worker

The forensic worker strongly recommended staff training in cultural protocols for working with Pacific people and valued the contribution of cultural workers.

“I always encourage my team to don't forget the cultural workers. Once they start to tap in like one of our nurse, a lot of them come from the UK and their mentality is totally different and because I've been there long enough to know, I know my job so and then they start to, I started tapping them to be cultural..... Then they can see that it's making a big difference.”  
 “..... I think it's not just about educating the clients but it's also educating the team you're working with.”

Female Forensic Worker

However, this participant complained that the cultural workers comprise of Samoan and Tongan ethnic origins therefore she recommended more cultural workers of other ethnicities, or a team that could work with all Pacific ethnicities. Currently, the other Pacific island communities are sought when required for advice and support when dealing with their people.

“.....when we dealing with the Pacific Island people we have a cultural team - our Pacific island culture team .....consists of um a Samoan cultural worker and a Tongan cultural worker..... So we need a Pacific .....within our culture team that is able to work with all ethnicities in the Pacific island group....If we dealing with any other ethnicity group um outside those.....groups.....we have to rely on the... like for example, Niuean or Cook Island, we have to rely on their communities.”

Female Forensic Worker

### **Support Systems.**

One of the aims of this study was to explore participants' views about whether there was adequate social support in relation to mental health advice, information and care given to Pacific people. The participants frequently referred to the strong family support systems that encouraged self-reliance as a coping mechanism which was often adopted from the homeland and has been discussed above. At the same time, it was seen as a disincentive to help seeking, consistent with some studies findings (Kuo, et al., 2015; Milville & Constantine, 2006). Although these studies were based on Latino participants, similar findings were repeated in studies of other minorities which described strong family support systems that served psychological needs negating help seeking from other sources.

Barrio and colleagues (2008) studied the mental health needs of older Latinos from the perspective of three stakeholder groups of mental health consumers, primary care physicians, and health caregivers. Although they found an overlap in the barriers reported across the groups, they also found discrepancies between patients and physicians' explanations of barriers, suggesting that physicians consistently overlook the realities and needs of their Latino clients (Barrio et al., 2008). This is important because if physicians do not accurately identify their

patients' needs and barriers to mental health care, they will be limited in helping and may even undermine their attempts to treat the mental conditions (Barrera, et al., 2016; Valdez et al., 2011).

The mental health professionals stated that there are adequate social supports in the public arena which Pacific people choose not to utilise. In contrast, a relative participant was critical of the fact that people are unaware of the existence of these support services which is a significant problem that needs fixing. It is apparent that the mental health professionals know the existence of these support systems due to the nature of their employment as mental health professionals, but the ordinary Pacific person is unaware of these provisions. The question raised is: "Whose role is it to inform the public of the existence of these mental health services?" In contrast to the other mental health professionals, the forensic worker was critical that support for Pacific people in terms of mental health literacy programs and general information provisions, care and treatment are limited.

"I don't think it's enough. I think it could be more.....I think the Pacific Island people need bit more support."

Female Forensic Worker

In contrast, the male GP reasoned that, compared to life in NZ where Tuvaluans become isolated from family support systems, people have support resources of families in the homeland, especially by parents. He said that Pacific people need to cease reliance on family support but utilise medical facilities for mental disorders because pharmacology and technological advancements mean mental illness can be treated.

"People will need to change their mental thinking ...and change it like...Nowadays the medical world is pretty advanced , it's so advanced and even medication,.....And just to be aware of this coping, I mean like a home life, if you are hungry you may go next door or see someone to help but now we are so busy .....now people live on their own and you don't have that social support or someone like your parents or you can bounce some ideas how to...just like any mother having their first child and they don't have experience looking after."

Male GP

In contrast, the mental health nurse highlighted Pacific people's strong family support system as an advantage in facilitating support for Pacific people experiencing mental disorders.

"I think that's one good thing about um the Pacific island people is that they do reach out and they often reach out to their families and they are very supportive."

Mental Health Nurse

According to Barrera, et al., (2016), it is essential that mental health services acquire knowledge of their client's support systems to be able to plan applicable interventions appropriately. This will assist monitor the pathways of individual users of services and how these support systems aided in the help seeking or hinder the pathway towards mental health treatment services.

### **Other Barrier Factors.**

The participants rarely spoke about other barriers that have been described in other studies. However, the effects of the macrosystem's policies of immigration and financial factors were often cited as major problems in impeding help seeking tendencies.

**Immigration.** The GP participant talked about the many years working as a GP, and how Pacific people rarely came to him for mental health advice as they were unaware the symptoms exhibited were mental illnesses. However, he recalled two Tuvaluans who were the only patients that came to seek mental health treatment. The two patients had histories of mental illness in the islands, and he referred one patient to secondary services. The trigger was the stress dealing with immigration applications, and this resulted in symptoms of not sleeping and being delusional. According to the GP, immigration problems are one barrier to accessing mental health services in NZ because non-residency or citizenship disallows eligibility for treatment. The issue of immigration as a barrier was stated repeatedly by the participants which is illustrated by the GP participant:

“... ..one person at the top of my head that I treated and I referred her for secondary services.....What I heard is that she has a history of mental illness, you know. Back at home as well. She was stable and then I think she was going through immigration applications which is very stressful as well. And you try to sort out as it takes a lot to organise, your medical, and your work, and all of those things ...so much going on and you know, it shows, the stress and the depression, from there and she becomes psychotic as well cause of that.”

Male GP

The GP explained that having non-citizenship or non-permanent residency status means that these people must bear expensive treatment costs. Although they still receive treatment if its dangerously severe therefore categorised as an emergency, the lack of eligibility means that they are faced with an astronomical bill after treatment. This is another reason that discourages non-permanent residents from seeking mental health services.

“...they still have to pay. It is a bit different from other disease, for example Tuberculosis (TB) or anything like that. I mean it’s a risk to NZ. I mean for example TB, are infectious and I treat TB, less stressful for the patient. It is free treatment...it is the law of the country. But for mental illness, you have to pay.”  
 “...chest infection, if it is acute like asthma or heart attack you will be treated. But you have to pay for that.”

Male GP

### **Differing Explanations**

This section will present differences in explanations and attitudes that were observed in the findings between various groups of participants. The distinctions in perspectives between the migrants from Tuvalu and their NZ-born counterparts were identifiable, as well as between the younger and older participants. These examples assert that the umbrella label “Tuvaluans” describes an ethnic group which is misleading because it ignores the fact that its members are not homogenous in many ways. The same problematic label of Pacific to categorise diverse ethnic groups under the umbrella term “Pacific people” disregards its heterogeneity, a criticism that has been widely recognised in the literature, particularly by Pacific scholars (Manuela & Anae, 2017). More interestingly in relation to this study, the Tuvaluan population is evolving as a microcosm of its parent Pacific population with units of diversely contrasting sections of views about mental health. The assertion is that a person’s standpoint on the matter depends on one’s knowledge of mental health, whether it is traditional or grounded in the medical model, or migrant status from Tuvalu, generational or age,

### **Migrant Versus NZ-born Views.**

Major distinctions were revealed in the findings, particularly involving differences in the NZ-born versus migrants’ attitudes and choices of actions in relation to help seeking. A number of participants described contrasting contextual factors of acculturation in either the homeland or in NZ to explain the differences in attitudes and health behaviours towards symptom identification of mental illness, help seeking and utilisation of mental health services. For example, one of the NZ-born participants from the relatives group remarked that she started the help seeking process by consulting her extended family members. She was recommended to contact the right services (GP), and to research for herself information on the internet about mental health services and how to access them. Her decision to act, and the way she did it contrasted with the migrants and older participants. Her first point of call was to seek advice from her close support system of family, and

secondly, she has the capacity as a NZ-born educated in NZ that enabled usage of technological resources.

“I think the way she’s (the mother) thinking, the way she was talking got worse and worse and I started to look for help. Like, looking on the internet, researching, for mental health services.”

“I think .....I tried to take her to the GP (according to the family member)...and she refused to go to the GP. And then I called the mental health services (Crisis).”

Young Female Relative

Her response when asked how she got the contact details of the services, is typical of young, NZ-born people, well acquainted with technology, she replied:

“I googled it.”

Young Female Relative

The forensic worker further stated that the youth culture clash is indicated in the different values and worldviews of the NZ-born and the expectations by parents. This illustrates migrants’ difficulties in acculturation and adapting to the NZ way of life. This adversity, combined with dysfunctional family factors, contributes to the high Pacific suicide levels in NZ (Tiatia-Seath, Lay-Yee, & Von Randow, 2017).

“Yeah and also the culture clash, I think they can't even ....., you know, the odd one coming straight from the island or even the one that was born here. You know they all are really lost. A lot of them come from broken families you know.”

“They (NZ-born) have different values and different how they look at things.”

“...I'm not saying that's the case but many cases, is what I come across with these island people I deal with, because they have that gap that they don't understand how to deal because this is a new issue to them.”

Female Forensic Worker

The contrast between the participants who were born in NZ and migrants is evident in all aspects of participants’ explanations of the topic being investigated. Also, a clear conflict between the two “worlds” of the NZ-born participants and migrant participants in terms of misunderstandings and misinterpretations of each other are clearly observed in an older male’s comment.

(In Tuvaluan) “E penei la mo islands ne? Penei mo ia tenei (referring to a young NZ-born participant) te koga tela e maua neia tena comfort zone, ko tena room. I Tuvalu, seai se room. Se open house loa. There’s nowhere to hide. Ne? Niusila nei it’s like that. Kafai tamaliki e lock herself in the room, “E vau ki tua, vau ki tua. E iloa ne au ia koe e muni ke seai ne au galue ke fai. Vau, vau ke fai sau galue ke fai.” Te la te kilo faka Tuvalu .....kafai e entertain neau ana manakoga e fano faeloa o fai pela ka spoil neau aia. E iloga sose mea e manao iei, ko fai pela ..... in a way e se .... Kaati e sili ke vau kite mea tenei ....pela .....come out of the room....ne? Kafai la e fai pela “ok, a koe, e iloa neau ia koe ko stress nei, koe ko fano kite McDonalds. Tomorrow, ko fai mai foki, “e stressed, ave la au kite McDonald. Tena sua fakalavelave, ite child ne? E lua feitu kola e tau onoono tatou kiei. E take advantage o matua kae teia la ate tamaliki, tena la, ko manako faeloa ke

fakafiafia ia ne? Io ke seai ne ana galuega ke fai, ke nofo fua aia ite potu ne? Me lei kia ia. Ikai.”

(In English): “Like in the islands hey? I’m referring to what she said (referring to a young NZ-born participant) that her comfort zone is her bedroom. In Tuvalu, there are no rooms. Only open houses. There’s nowhere to hide, hey? It’s like that here in NZ. If a child locks herself/himself in her/his room, “Come out, come out. I know you are hiding from doing chores. Come, come out and do some work.” That is the Tuvaluan perspective.....if I entertain the child’s wish, he will continue doing it so to be spoiled. So everything he/she wants something, this is what he/she will do.....in a way, it’s wrong.....Maybe it’s better this way....to come out of the room, hey? But if its “ok, I know you are stressed now, so I will take you to McDonalds.” Tomorrow, the same thing will happen, he/she gets stressed, take to McDonalds. That is another problem, for the child hey? We need to look at the problem in two ways. If parents are taken advantage of, the child will always want to be made happy, or to avoid doing chores, so will want to stay in the room all the time hey? It’s not good for the child.”

Older Male Community Member

Consequently, the constructs of ethnic identity, acculturation and cultural orientation as portrayed in the findings are manifestations of the inter- and intra-group distinctions (Manuela & Anae, 2017). The findings echoed these authors’ contentions that the heterogeneity that exists in the Pacific ethnic population in NZ are presented in the Tuvaluan ethnic group too which is explained by cultural factors and not solely via demographic or contextual differences. Competency in the Tuvaluan culture (language, attitudes, genealogy affiliation knowledge) as evidenced in the migrants from Tuvalu, differentiates them from the NZ-born worldview. The migrants are equipped with the knowledge and experiences of life in the island of Tuvalu so their understanding of the cultural norms, customs, traditions, lifestyles, and the absence of mental health system in Tuvalu, enabled their expanded interpretation of the topic and explanations of underutilisation of mental health services in NZ. These migrants have the experiences of both worlds of the homeland and NZ, so their contribution to Tuvalu, Pacific and global knowledge has been underestimated.

These conflicting ways of thinking of the NZ-born Tuvaluans and migrants from Tuvalu is an expression of the contrasting contexts of upbringing: the cultural, social, and environmental settings that influenced their belief systems and worldviews (Manuela & Anae, 2017). According to these authors, the key is to explore each cohort’s ontologies and epistemologies, including an analysis of the broader ecosystems that are embedded in the macrosystem levels will improve our understanding of the impacts to induce these differences. Moreover, an inclusion of the acculturation process that Tuvaluans face in intercultural contact contexts in NZ with the host significant culture will eventually result in conflict as both parties attempt to adapt and negotiate to the cultural needs of the other as argued by Berry (2005). As the



findings imply, it is the Tuvaluan migrants that need to adapt, adjust, and assimilate to life in NZ, hence acculturation, is crucial. If marginalisation, separatism, and a non-participation lifestyle occurs instead, continuity of lifestyle practices from the homeland will remain and maintained in NZ. Tuvaluan migrant's lack of knowledge of mental health issues in NZ will continue and efforts to improve it will be needed.

### **Young versus Older Participants' Explanations, Attitudes, and Experiences.**

This study revealed a second conflict between young participants who are all NZ-born and their older counterparts. The young participants were unaware of the issue of underutilisation of mental health services that may be the result of lack of experience due to their young age, and/or the fact that it is not taught in the NZ high school curriculum. This is problematic because it may create an illusion that mental health is an adult's concern, which is a dangerous misconception as statistics show that suicidal victims are mostly young people (Tiatia-Seath, et al., 2017). For instance, this young female participant acknowledged her lack of knowledge of mental health services and how to deal with mental illness:

“Yeah...what are mental health services?”

“I wouldn't know what to do.”

Young Female Community Member

The young participants' demeanour also illustrates the differences in the age groups. They were visibly uncomfortable and had to be coaxed to speak, and when they did they were timid, anxious, lacking in confidence and were quite emotional. It was quite a task to encourage them to speak about the topic, not just for me, the researcher, but for their older counterparts as well. The following factors are subset themes uncovered in the findings.

**Lack of communication.** A young NZ-born female cried a couple of times during her talk and was emotional about having to speak her mind for the first time about her family in a Tuvaluan meeting in front of her elders. Out of the three young participants in the community group, she was the only brave one that spoke often about the topic of discussion. She complained about the constant presumptions, misunderstandings, and misinterpretations by her parents about her and her siblings' behaviours. She wants Pacific parents to listen to their children because communication between parents and their children is lacking. She attempted to link mental health to Pacific parents' traditional ways and experiences

in the islands that influenced how parents perceive their NZ-born children's behaviours, such as parents' consistent presumptions that something is wrong with their children, even psychologically wrong. She believed that parents' different upbringing in different environments (socialised in the islands and later migrated to their host countries) is the cause of many problems in the family due to lack of insight of each other's "worlds."

"And they needed to just listen more and ....literally listen, not always have an input and come back with an input.....they think we are more palagi (Europeanised) and you know, not our culture. But we are living in NZ and so they can't or need to understand that or it's gonna drive us mad."

"When I'm at home, my foundation is my room.....it's my comfort zone where I feel and they think, my parents think there is something wrong with me because I always lock my room."

"Parents .....need to stop referring us straight away....I mean...they think we are sick. If anything happens, straightaway they think we are sick. They need to like also talk to us. And understand where we are coming from. But also see our perspective how we were brought up in NZ. Yeah, just like, understand where we are coming from."

Young Female Community Member

The young female participant gave reasons why she disliked seeing the doctor and described barriers such as, being administered simple medications like paracetamol, waiting time in the doctor's surgery, and financial factors:

"..... if I'm sick my mom would book an appointment straightaway but I will only go because stuff like that, the cost, and the waiting period and because they give us the same stuff like paracetamol which is already stored at home on the fridge. (laughs) It is reasons like that that you think you can wait it out till it's over."

Young Female Community Member

Nevertheless, she did feel that young people need a support system of people to listen to their concerns for they dislike asking for help, and reiterated the cost, and the waiting.

".....although there is lack of knowledge and we don't ask for help, we don't ask for help cause we think no one is willing to give us any. It is just a matter of who will listen. And who will listen to how we feel and give us a supporting answer. Not just keeping throwing at us to go to the doctor, go counselling, cause those stuff you've got to wait for it and it costs like all that stuff. Yeah that's what makes us not want to go to services."

Young Female Community Member

The female GP participant, a migrant, spoke about the attitudinal differences between migrants versus NZ-born, churchgoers and non-churchgoers, imperative when developing educational programs. She maintained that church and religious leaders are significant sources of aid and encouraged people to freely talk about their mental problems to "anyone" that they can form a special bond with.

“..... the older generation, like us too always believe that somehow, God will somehow always help us. You know, so it’s really important for religion to be there, either going to church or something. But tenei au e fai (what I am saying) it’s really important to get pastors involved...”

“.... because you don’t need a counsellor like mental health professionals to just talk to someone. She (points to the males) a counsellor, you can be, it’s when you lose that person to talk to that’s when the problem becomes really really big. We see people trying to commit suicide because they don’t have a friend, they’ve broken up with a boyfriend or partner ....so um, they can’t talk to their parents. And they don’t go to church.”

Female GP

### **Example of a youth intervention programme.**

The inclusion of this youth intervention programme in this discussion is important to convey the behaviours and decisions by young Pacific people, and their parents’ reactions to the programme. One of the participants was a former practitioner (counsellor/youth worker) who worked with low decile schools in the treatment, prevention and intervention alcohol/drug programs for Maori and Pacific students. She talked about adolescent and youth services. According to her, these students came from low socio-economic family situations and were referred by social workers/schools/boards of trustees, or self-referral for drug/alcohol and behavioural issues like self-harm, depression and anxiety lows, sexual abuse, and other disorders. Her role was to provide counselling services, but if the conditions were extreme, urgent referrals to advanced specialist health services was the normal procedure.

Her information made a considerable contribution to knowledge of adolescents and young people’s referrals and general pathways to mental health services. According to Farmers et al., (2003), increasing calls for more provisions for mental health needs of adolescents and children are currently proposed, but the problem is, little is known about the existing mental health services established solely for these age groups. Thus, existing developments in this area have concentrated on inpatient and outpatient provisions and have ignored the existence of other services. Some services are external to the mental health sector but need examining too. The findings complement Farmers et al. (2003) assertions that the education sector is a major facilitator and entry provider of mental health provisions, as illustrated by this participant’s contentions.

“So, we were based within the community and families and low decile schools around Auckland. And it was around engaging ...schools to identify if they have behavioural issues that affect some kind of mental health, then will pick up those young people.”

“.....we currently have Maori and Pacific students .....um and because we were based in these lower decile schools ...you know the families in those areas are of low socio as well as of Pacific or Maori. ..”

She commented that due to the conflicting principles of young peoples' right to confidentiality and the parents' duty of care, families were sometimes unaware that their children were enrolled in the programs because the adolescents seldom confide in their families. In this case, which right should be prioritised, the parents right to be informed or the confidentiality rights of the child? This issue and other presenting questions are discussed in Chapter 6. The participant above contended that young peoples' attitude about confidentiality is caused by feelings of disappointment, high mental health issues and the fact that youth lack knowledge of their own symptoms. Furthermore, families find it problematic to pick up these disorder indicators because of the complexity of adolescent developmental behaviours that can confuse the identification of mental illness symptoms. The findings also conveyed that adolescents were more likely to seek informal advice and assistance prior to visiting a GP, counsellor or teacher and are very cautious of confidentiality and stigma issues. A similar finding was identified in an Australian study (Wahlin & Deane, 2012) relating to families' motivation to seek and access treatment. Hence, it is a major concern for people with a mental disorder and their families is the issue of confidentiality in relation to the sharing of information due to the delicate nature of mental illness. Yet, the sharing of information is a major tool of cooperation between health professionals and families (Kuipers, Yesufu-Udechuku, Taylor, & Kendall, 2014). However, in summary, the issue of confidentiality contributes to families' lack of knowledge of mental health issues.

“But in regards to the young person we are working with..... In most cases they did not want to be ..... A lot of worry about..... what would their family think because most of the time when they came to us their family wouldn't know that they were part of our program.”

“They could be aware of what they feel. But some young people don't even know and aren't aware that what they feel or think is different than you would have.”

Counsellor Youth Worker

She talked about her experience dealing with the families and about Pacific peoples' reluctance to seek assistance for mental illness conditions. Her explanation of this common behavioural pattern includes: coping with the illness on your own, strong family support system, stigma and strong feelings of shame which were also commented by the other participants. She repeats the other health professional's statements of the current adequacy of mental health services, but its usage is dependent on the choice of Pacific and Tuvaluan people who tend to not utilise it.

“.....I think there a lot of mental health services around. ....But I don’t think it’s something that we ....you know seek out and go get. And when it does comes to mental health issues ...You sort it out on your own, like yourself as an Islander.....There’s stigma around um, judgments from other people if they knew .....you are a parent of a child with mental health issues whose got the blame .....like they haven’t done something right.....”

Counsellor Youth Worker

### **Traditional and Western Knowledge about Mental Health.**

Without a doubt the findings revealed that the traditional knowledge of mental health was persistently conveyed in the explanations. In contrast, there was almost an absence of reference to the western model of mental illness, except by the health professionals. This group of health professional participants were knowledgeable about the support systems provided in the public system, how to recognise the warning signs of a symptoms of a mental illness, and the differences in the diverse roles of mental health services. Interestingly, this group was also well versed with Tuvaluan and Pacific models of mental health, which may be explained by a strict requirement of Pacific cultural competency standards (Seitapu Cultural Competency) for all mental health workers in NZ to be adept with. In contrast, the young and NZ-born participants had no knowledge of any element of mental health, except for the young female relative who experienced her mother’s first episodic incidence of a mental disorder.

The participants depicted the current situation of mental health in the homeland, which needs careful research attention to understand its negative effects on how Tuvaluans view mental health in NZ. The “warnings” by the participants is that Tuvaluan health behaviours here in NZ is a recurrence of health behaviours in the islands, yet contextually, the two environments are extremely contrasting. For instance, familiarity with Tuvaluan beliefs of mental illness and its treatment were prevalent, such as the religious and supernatural elements of explanatory factors of a mental illness symptom, and the significance of healers and religious leaders in its treatment. In order to change health behaviours, such as to increase Pacific mental health utilisation is to educate people so that they understand that the way of life and belief systems common in the islands is not suitable to life here in NZ.

### **Conclusion**

This first part of the findings detailed information on the health behaviours of Tuvaluan people that led to underutilisation of mental health services conceptualised via theoretical models of Bronfenbrenner’s ecological system and the pathway sequence of stages that led to compulsory treatment. The ecological principles

applied conveyed that the Pacific pathways to the utilisation of mental health services has multiple levels of influences embedded in the micro-, meso-, macro-, exo-systems, that include intrapersonal, interpersonal, organisational, community and public policy.

The findings suggest that mental health service utilisation is the consequence of a system of related and interconnected psychological and cultural components that apply to different stages of the pathway process of utilisation of mental health services. The findings additionally conveyed that the Pacific pathway towards mental health treatment is unique, and detours from the normal processes that include symptom recognition and evaluation, help seeking, accessing and eventually the utilisation of treatment services. It is consistent with the literature into minority health behaviours which are dictated by the macrosystem factors of the political, economic, institutional and social systems of socialisation that formed Tuvaluan lifestyle, attitudes, belief systems and worldviews. However, on closer examination, the Pacific pathway process to the use of mental health services is not as unique as it appears. Similar patterns are experienced by other minority populations in NZ such as Maori and migrants, where identical delays in help seeking have led to the escalation of severity of symptoms and compulsory interventions (Abas, et al., 2003; Ramage et al., 2005).

## **Chapter 5: FINDINGS: Tuvaluan Explanations of Pacific Underutilisation of Mental Health Services, Implications, and Potential Solutions**

### **Introduction**

The purpose of this chapter is to inform the findings in relation to the implications of Pacific underutilisation of mental health services in NZ and the solutions proposed by the participants. The ecological system's approach enabled a sophisticated analysis of the findings to make sense of the pathways to the usage of mental health services by Pacific people in NZ. The findings assert that interventions and educational measures are crucial to change behaviours, enable symptom identification, and enhance help-seeking knowledge, in order to improve access to mental health services. Earlier chapters identified barriers that prevented a smooth pathway to the utilisation of mental health services. This chapter presents the implications of Pacific underutilisation of mental health services because of these barriers. The solutions suggested in the findings overwhelmingly recommended the establishment of mental health literacy programmes for Tuvaluan people. Upgrading Pacific people's knowledge of mental health aspects is essential to make relevant health behaviour choices and decisions. The mechanisms to achieve this must incorporate all levels of the ecological systems to minimise the negative barriers at the micro-, meso-, macro-, exo-systems levels of individuals, families, communities, mental health systems, mental health policies, environmental and economic factors.

### **Implications of Underutilisation of Mental Health Services by Pacific and Tuvaluan people.**

Another aim of this research study is to explore Pacific peoples' explanations and attitudes of the implications of underutilisation of mental health services in NZ. As told above, the findings shown the lack of understanding on this issue, and the extent of apathy, depending on the type of participant group membership. to mental health issues. The implications of underutilisation of mental health services was unknown to the participants apart from the mental health and other healthcare professionals. This is not surprising because this group had dealt with the adverse consequences of delayed aid and treatments so made comments about the negative outcomes of underutilisation such as: suicide, self-harm, acute and forensic admissions. The mental health consumer and relative groups however, had experienced and witnessed hospitalisations, attempted suicides, self-harm and

forensic incarcerations, but they did not link these adversities as the consequences of delaying help-seeking behaviours. This was an unexpected finding.

Furthermore, the majority of the participants did not link low use of mental health services to high compulsory acute and forensic admissions, suicide, longer hospitalisations and costly treatments. In other words, unawareness of the negative consequences of underutilisation of mental health services was widespread amongst Tuvaluans. Lack of knowledge relating to the existence of forensic services by most participants was also an unexpected finding.

### **Implications of Problem Symptom Identification.**

According to the participants, if symptoms of a mental condition are not detected, laypeople adopt speculations such as intellectually handicapped diagnosis, developmental disruptive behaviour, violent criminal behaviour or behaviour caused by spirits and curses. In the case of the migrant participants, homeland traditional attitudinal and belief systems regarding mental illness were normally adopted in response to identifying a mental distress. The problem arises when these homeland practices are applied to the very different NZ context and thus adversities result as a consequence of this way of dealing with an episode of a severe psychotic episode, particularly first episodes.

**Police intervention.** The implications of the failure to recognise the symptoms of a mental illness disorder were understood well by the health professionals, relatives, and mental health consumer groups of participants. The mental health consumer strongly felt that officials and health professionals who deal with mental health consumers urgently require training in mental health. Essential educational programmes must target these professional who deal with the mentally ill, such as the police. The nature of the police role is often the first point of contact to manage mental health consumers during episodes of extreme psychosis. For this reason, it is imperative for the police to be trained to identify and distinguish mental illness symptoms from criminal behaviour and thus prevent the mistreatment of the mentally ill. The mental health consumer participant stated that his experiences with the police indicated that police normally resort to violent handling of the mentally ill due to lack of knowledge and understanding of mental illness. Consequently, this participant described appalling experiences during episodes of un-wellness of having to be dealt with by the police who were often quite “violent” due to this



misunderstanding of the mentally ill. He recommended that early intervention by psychiatrists and counsellors is a priority for they are able to distinguish mental illness symptoms from criminal behaviours. He stressed the importance of early intervention during these crisis situations, and urged people need to know how and where to contact the Crisis team because this team is better trained to deal with the mentally ill.

(In Tuvaluan) “.....taa aka ne pulisimani kae faatoa iloa fakamuli aka me se tino e masaki ite mafaufau. Sea la te aoga me ko logo fio te tino ne taaga ne pulisimani. Pulisimani e olo kite lotou galuega. Ako tino te Crisis pela mote psychologist, e tau iloa ne latou me kaia ate tino e amioga ei pela. Pela e fano o fai amioga pela. E tau iloa ne latou. Te faiga loa, ko latou muamua e tau olo o,... ka tuku pela sena mea ne fakamasei, e tau ona olo kiei, ke iloa ne latou me masaki kite mafaufau me ikai. Io me se vaega tino loa pena.”

(In English) “.... beaten by police, but later they realise that the person suffers from mental illness. What is the use then because the person is badly beaten. Police people are just following their duties. But the Crisis people and the psychologist, they would know why the person is behaving this way. They should know. The best way, is for them to first assess people whether they are mentally ill or not. Or that he is just that type of person (bad)”

Mental Health Consumer

Another participant (niece of a mental health consumer) recalled her first experience with mental health services and agreed that for family relatives' safety, police are sometimes the first and best option in an emergency. Reference to practices in the homelands is also voiced and illustrates the strong effect of homeland on migrants' attitudes in how to deal with mental illness.

“From my case, I think the fact that they don't do anything about it back home. So, in my case its straightaway to the police. And um...cos we can't control our family, he ended up causing, um you know, accidents and that is why it ended in police case and they will refer us to the best people.”

Female Family Relative

**Traditional healers & religious leaders.** Some participants felt that the failure to identify the symptoms as a medical problem lead to Tuvaluan and Pacific people seeking aid from religious leaders, therefore they too should be educated to recognise mental illness to enable urgent help-seeking for their “flock.”

(In Tuvaluan) Ako te mea taua, a faifeau kona loa o lotou galuega, te tino ko la ana mamoe kola e lavea neia e amioga pela, e tau o latou o talo kiei, kae ave ne latou ki koga kona, ki tino kola eiloa ne latou o fai a mea kona.

(In English) It is very important to recognise the importance of church pastors because it is one of his lambs and when faced by this type of behaviour, the pastors can pray for them and take them to these mental health services for they will know what to do.

Mental Health Consumer

**The family levels.** It was noted by some participants that families fail to differentiate mental illness behaviours from ordinary developmental disruptive behaviours, which often results in beatings of mentally ill children. This is an important finding because if families fail to pick up a mental illness condition early, the delay in treatment will undoubtedly worsen the condition to dangerous situations, apart from the physical injuries due to the beatings.

(In Tuvaluan) E fakafaigofie te avega ... I lo te taa soko te tamaliki ne te matua kae tela la te tamaliki e masaki ite mafaufau.

(In English) It is easier to carry the burden (ie for parents to be knowledgeable) ...rather than constant beatings by the parents yet the child has mental illness.

Mental Health Consumer

Most of the mental health consumers and relatives' experiences involved constant relapses and re-hospitalisations referred to as the "revolving door" syndrome where readmissions occur after periods of wellness. This cycle of constant deterioration and un-wellness results in relatives becoming familiar with recognising the symptoms, and the need to contact mental health services urgently during these psychotic episodes. The first onset of a mental illness was depicted as extremely difficult and dangerous for the relatives particularly, but when later relapses occur, they were more aware of the symptoms and what to do to seek help.

".....we are already aware of the services and the providers so as soon as there is a problem with the mental sickness we take her straight to the proper place where she gets treatment."

Male Family Relative

Some of the participants recognised that the behaviours exhibited were abnormal but failed to act due to lack of comprehension as to what measures to take which resulted in the hope that the problems would eventually go away. All the migrant participants agreed that this practice of "not doing anything about it" is common in the islands as discussed in Chapter 4. However, a young NZ-born daughter of a recently diagnosed mental health consumer reflected on her experience of the first time her mother showed symptoms. She stated that it was extremely difficult to recognise signs of a mental condition because her mother acted so normal:

"She looks serious, like the way she talks, she thinks it's real. Yeah, but it's not."  
 "Even if you tell her it's not real "Yes it's real." But sometimes you think it's true, and then...yeah, but it's not. Because the way she tells her stories, it sounds it's true, but it's not."

Female Family Relative

**The community levels.** An example of this failure to recognise symptoms of mental illness was also described as occurring at the community level and the importance of educational programmes to curb the discrimination and ill treatment of mental health consumers. Community knowledge acquisition would prevent “incidents” by mentally ill people. The mental health consumer participant steadfastly concentrated on the need for all people to be educated about symptom identification of a mental illness. His constant referral to the importance of symptom identification to avoid beatings of mental health consumers at the family and community levels is an expression of his traumatic experiences of physical violence during his episodes of un-wellness by the police. He did not blame the police for they were unaware of mental illness symptoms. Failure to identify psychoses behaviour as a mental illness condition also results in the long arduous process of sufferers being passed to and from within services.

(In Tuvaluan) “.... pela mote example tenei ne matea neau a (named 2 men) ne taa ne laua a (named a mental health consumer) ite tuisi. Ne taa aka ne laua me se fakalogo. Ne? Kae iloa aka fakamuli a (mental health consumer named) e masaki kite mafaukau kae fakalofa la me se iloa ne laua me masaki ki te mafaukau...”

(In English) “..like this example I witnessed (named 2 men) who beat (named the mental health consumer) at a social. They gave him a beating because this consumer would not listen to them. But sadly, later they found out that he has a mental illness.”

Mental Health Consumer

**Self-harm and Suicide.** A relative participant commented on her friend’s suicide that she believed was caused by the constant bullying during their schooling. The friend was diagnosed for depression in her early teens, which was much later than when her initial symptoms had occurred. She had also suffered stigma, shame, and embarrassment since her diagnosis that eventually resulted in suicide. According to this participant, if her friend’s symptoms of depression had been picked up earlier she may have had counselling and psychiatric interventions that may have prevented her suicide. An Australian study by Bugeia et al., (2015) found that nearly half of all suicides in the state of Victoria were carried out by people who were undiagnosed with a mental illness. This suggested that these people had not sought clinical assistance for their condition, so it was recommended that improving the mental health literacy at the population level will certainly reduce the number of suicides. On the other hand, the findings of Bugeia, et al.’s (2015) study also showed that there were several suicides by people had earlier been diagnosed with mental illness. This means that services need to be more equipped to pick up the suicidal risk factors.

“...my friend (named, also a Pacific Islander) .... committed suicide. She had a mental illness too. She had depression. Diagnosed with depression. And I think it became worse and then she had to start seeing doctors and that’s when she became really sad and .... She committed suicide.”

(And her reason for her friend’s suicide is): “I think it’s the shame and being embarrassed.... I think she was sad because she can’t be normal again.”

Female Family Relative

There was just one relative who conveyed her understanding of the implications of delaying help seeking:

(A relative uttered): “They harm themselves.”

Female Family Relative

The mental health nurse’s professional knowledge of mental illness was portrayed in her statement about the adverse consequence of suicide that occur when people do not take the psychotic symptoms seriously:

“But ultimately when it is acute over time that it can lead to suicide. And yes, it can lead to them acting out and kill themselves because they’re hearing voices, saying, “look, go and stab yourself, go and jump off the bridge.” And often we assume “oh, that’s just someone being silly,” you know, doing this sort of stuff. But no, the experience is real for the people that experience mental illness.”

Mental Health Nurse

**Crisis & Inpatient Hospitals.** The mental health nurse’s description of the inpatient mental health service she works in and the range of mental health conditions treated there (bipolar disorder, schizophrenia, borderline personalities, anxiety, and people with self-harm tendencies) and the criteria of entry to this service is that the condition must be severe. Other relevant services (community mental health services, police, social welfare, CYFS, family services and chaplain services) also work closely with these inpatient mental health hospitals. Reference to the multiple supports that surround the mental health system’s treatment and recovery of mental health consumers is consistently discussed in the literature review chapter. Some sources in the literature claimed the phenomenon as the nature of deinstitutionalisation which involves an inclusive model of living in the community, therefore requires support from a variety of agencies.

The mental health nurse’s extensive work experience in acute inpatient hospitals indicated in her description of this service as the “last stop of the journey” However, the treatment and the care process are ongoing, even though it is the end of the road for the particular psychotic episode. The delay in help seeking meant

people had exhausted their resources and patience, personally as a mental health consumer or relative in support of someone with a mental illness:

“Umm . often the service that we, you know, that I’m involved in it’s umm inpatient, which is usually the public services and it’s usually the hospital services. Umm .... it is often gone through the process through either your GP or either through community um and then it .... its, our part, is the last part. It’s mainly to do with the real acute um part of someone’s experience you know with mental illness.”  
 “Normally.... it’s usually the end stop so it’s not until people have really reached the end of all their resources and everything’s exhausted that by the time they get to us normally people are at their ends wits....”

Mental Health Nurse

As for referrals to inpatient hospitalisation, the courts, police, and families are major sources, but in relation to young people, they are usually referred by the above in addition to Child, Youth, Family Services (CYFS) and schools.

“.....from my experience, often the young people are brought in because family realised or you know um something’s not right.um and .....through the police or just through themselves.....we rarely have self-referrals which is you know them bringing in themselves presenting themselves in hospital but often it’s through the other services like there’s the police and there’s the court and um CYFS and then often their school as well that’s got concerns. ...and so often the young people are experiencing a range of services and it’s not until.... its decided to a whole sort of a multi-disciplinary sort of services that they you know realise oh okay what do we need to do?”

Mental Health Nurse

A relative female participant described her first communication with Crisis or Acute services as quite a daunting and complex experience. This can act as a barrier if you are new to the mental health system. However, her description of her experience with the Crisis team has been valuable because she learned about this service’s operation, practice, and the criteria for eligibility to be accepted into their service. Her assessment of the Crisis team’s dealings with her attempts at help-seeking was quite critical and she stated that eligibility to be accepted to be treated depends on the criteria of “potential harm.” She warned that even if a person overcomes the problem of symptom identification, and is aware of how to contact the Crisis team for aid, the complicated procedures still present a significant hurdle that the relatives need to face to successfully obtain help:

“They just ...the first time I rang, they just asked what’s been happening and what type of things that she’s speaking about, her stories and they asked questions if she’s showering? Sleeping well? And I said “yes” but they said they can’t really do anything because it’s not really .... what’s that word again, (researcher utters not bad enough) ...yeah.....to do something.”  
 “But they just said, “If anything happens, just ring back. Like physically, or ..... like hitting somebody, or endanger anybody or harming themselves. Something like that.”

Female Family Relative

It was clear that the participant did not understand that the Crisis team and admission into hospital are decided by potential safety concerns in relation to the criteria of harm to oneself or others.

“And then I think, maybe a few weeks later and then she hit my dad with a hot water bottle. (laughs) When he was sleeping. Because she told him to lock the door, but my dad didn’t lock it because she was worried about people coming into the house and stuff. And that’s when I called the Crisis. And then they decided to come.”

Female Family Relative

The Crisis team’s assessment in this case was by phone whereby the Crisis mental health nurse accepted the participant’s mother’s refusal to take her medication as reasonable over the relative’s concerns.

“Cause she was better.... they actually talked to mom and assessed her on the phone and when they gave the phone back to me, they said, “your mom is alright.” (laughs). And I said “okay?”.

“...what’s going on...they don’t know what’s been going on.”

“They should have continued (her medications), instead of that 4 months waiting, they should’ve forced her to take it her medications. Then I rang about 3 times....and they said.....3 times during that period to come and give some more medications but they said because she refused it they can’t force her. And she hasn’t done anything bad..... Because it gone worse. Yeah, cause when she was taking the medications when they came to give her just one pill each night, she was back to normal.”

“But now she’s gone really worse. But she’s taking 2 pills and she’s still...no change as much as before.”

“Maybe if the Pacific Island people came over instead of the fella (psychiatrist)...to give her medications (the second time around), she might have....”

Female Family Relative

The above excerpt suggests that despite the lack of knowledge of the mental health system, family members or carers often have extensive experience and knowledge of the respective mental health consumer because they had cared for their family member in many situations, without external health professional aid. They preferred to contribute to the treatment and care plans, so health professionals must acknowledge the roles family support systems have played in managing the symptoms prior to service use. Yet, these relatives felt ignored and undervalued by health professionals as illustrated by this participant. The statements of frustration, and anger by the family member above is evidence of family members’ negative experiences of mental health systems that may increase distrust and lack of co-operation between the relatives and the mental health services.

**Forensic Services.** The forensic mental health worker participant was impressive in her thorough description of the role of forensic mental health. She also concluded that Pacific people tend to enter forensics in extreme states of un-wellness due to ignoring symptoms until it has escalated to crisis situations, not choosing to access mental health services and being too embarrassed to ask for help:

“Um so I work in the Mason Clinic.... and my experience with people, with um the Pacific people in my area um..... Pacific people and um I have to say not Tuvaluan people because I haven't had any Tuvaluan people come through our service but, um, so I have to generally speak on Pacific people, and um, the highest ethnicity that comes to our services is Samoan, Tongan, Niuean, Cook Island, and the odd Tokelau people. And the entry into the forensic mental health service is that they have to be, have to have a mental illness and that they have to also commit a crime and that is the criteria into coming into my service. Um and my experience with people using the mental health services is that, um, a lot of the Pacific island people that comes into Mason Clinic they become really unwell. They get to the point where, um, they become in a crisis situation and from my experience, um, working with the PI people, they don't really access help, they don't ask for help because, so I think, one is, because they are... embarrassed,”

Female Forensic Worker

This participant further said that earlier interventions by primary mental health services would have prevented the likelihood of a crime committed, ending in forensic admissions, and added a surprising observation about Pacific forensic clients. According to the participant, mentally ill people tend to commit crimes, mostly to their families. This is not surprising because Pacific families tend to be the support systems and since help was not sought earlier, psychosis can escalate to dangerous levels. The other participants also commented on this pattern of dangerous behaviours.

“So, if there was earlier intervention from the services, yeah I think that could help. But the problem with our Pacific people is that a lot of them, they shy away from those services and then by the time they get into the mental health service, it's too late because they have reached their crisis. That's the problem.”

“.....the Europeans and other ethnicities .....most of them use the primary (services) before they get into our service. And that's how by the time they get into our services, it's not too bad.”

“.....a lot of the crime, um, is aimed within their own family structure.”

Female Forensic Worker

She also spoke about increases in the Pacific youth population and the substance-abuse triggers of mental illness in forensic admissions.

“..... some other trigger is psychosis from drug induce..... What I notice is, the age group, when I first started it was more like, not many young people, but there was more like 30 plus you know that age group. Yeah I don't know if there is something happening you know generally with our PI people.”

Female Forensic Worker

She claimed that forensic services encourage Pacific-specific resources like traditional healers and spiritual religious leaders but in conjunction with forensic models.

“.....our service we actually encourage that um but it has to be in alliance with .....normally the consultant psychiatrist so um and that's the good thing about working in the service that I work because we work alongside with the cultural methods and principles. So we have encouraged the use of their own, you know for example, fofo (massage) and herbal medicine.....”

“.....a lot of the island people ..... also rely on their minister of their church to come and work together with the family. Also, the, you know the hierarchy like um, for example in the Tongan community, a lot of them use their matriarch, you know, they bring in their grandmother or their senior aunty or whatever....”

Female Forensic Worker

### **Potential Solutions**

Analysis of the qualitative raw data showed that the main explanations of Pacific underutilisation of mental health services specify Tuvaluan people's apathy that resulted from lack of knowledge in relation to the pathology (symptoms), treatment of mental illness and the locations of these services.

The strategies that the participants offered as solutions were focused on improvement in the mental health literacy of Tuvaluans and Pacific people. The ideal solution is to engage more Tuvaluans into treatment services and overcome the stigma attached to mental health services. Accurate information about the aetiology of psychiatric conditions, symptom identification, and treatment options delivered via educational programs, advertisements, verbal informational consultations, media, and social media exposures were measures suggested to educate Pacific people. The participants argue that the contents of these educational programs must target the symptoms of a mental illness, its treatment and what to do if an onset of mental illness is experienced or observed. Knowledge of mental health services is also vital, as well as their respective functions and how to access these services in times of need. It is important that the content is not too overwhelming with too much information that may hamper Pacific people's motivation to learn. Particularly useful to be included, as the pastor reminded, was that Tuvaluans should identify ways of how best to educate Tuvaluan people because many of the normal ways have not worked.

“....what is needed, and what some people need to.....be aware of, that I think they need to be educated. So, looking at what are ways they need to be educated. How they are going to receive that message? Do we run workshops or like that? It is all about community pulling together and raising awareness as to how important it is and with that mental health issue.”

Pastor Community Member



Participants further highlighted the need for educational programs specifically for personnel who deal with the mentally ill, and for ordinary Pacific persons. So, the Pacific community population must be targeted as well as those who work with Pacific people.

### **Content.**

There were various suggestions offered by the participants as to the content of the educational programs should include. The suggestions further pinpointed that the differences between the way the young and NZ-born styles of locating information and learning styles need to be considered and included when developing educational programs.

**Symptom identification.** A few participants believed that the responsibility to be educated about the symptoms of a mental illness lies with the family and not the individual (potential mental health consumer).

(In Tuvaluan) Kaati e faigata ite individual ke iloa neia ia ia ko masaki. Kaati kona te family e tau o pick up ne latou ako te tino tela ko pokotia ia ia e normal loa. Ako i tatou konei, ko isi se kese. Ako mafai ne tatou take it from there.

(In English) Maybe it's difficult for the individual to know he is sick. Maybe it's the family who should be able to pick up the person is suffering from it, because the person thinks he is normal. But for us, we can tell the difference. And we can take it from there."

Elder Male Community Member

**The location and contact details of mental health providers.** Most of the participants highlighted the need for educational initiatives that include information on what to do when in need of mental health services via various mediums as suggested by this relative. He felt that it is the role of the government to provide people with the details of service provisions.

".... let people know the providers are there. Especially the government to let us know that the people that these are the providers who you need to come to them if we need help."

Elder Male Relative

The young female relative's advice on helping youth to access mental health services was also based on experience and provided very useful advice that needs to be included in the content of the educational programme. The emphasis on the children and adolescents is essential because there is a lack of information in the public arena that caters specifically to this sector of the population. This is good

advice for it is in line with evidence from study findings such as Wahlin and Deane's (2012) Australian study which found that family members were usually the first to mobilise adolescents to access mental health treatment services. The same study revealed that the statistics around the time of investigation showed that many adolescents with a mental illness did not seek treatment aid, but those with severe symptoms are more likely to seek the help of medical professionals than those with moderate symptoms. However, attitudinal, and practical barriers tend to be a stronger factor in the decision to seek assistance.

“...to get them to see the doctor.”

“Maybe let someone, like an adult, let them know.....like a family member.”

Young Female Community Member

### **Homeland and traditional beliefs about mental illness and its treatment.**

A notable theme that emerged throughout the data was the constant reference to the homeland's beliefs about mental illness and how it affected symptom identification and treatment practices in Tuvaluan NZ residents' health behaviours. Most of these participants also contended that these beliefs, practices and behaviours must be identified, and their impacts acknowledged and either eradicated or adjusted to the NZ context. A good example of this contention is stigma, which was frequently described by the participants.

**How to combat stigma.** Stigma, discrimination, and taboo attitudes about mental illness must be acknowledged to end their dire effects and improve the use of mental health services. All the groups understood the effects of stigma on Tuvaluan people, and some viewed that its inclusion in the contents of the educational programs is vital. The idea is to proliferate discussions of mental health issues given that mental illness is rarely discussed in any context by Tuvaluans because it is regarded as a taboo topic. The mental health professionals suggested that people need to be taught its resemblance to common ailments such as Tuberculosis (TB), diabetes, and cardiovascular diseases to minimise its influence that generate negative attitudes of mental illness. The recommendation is that people need to be made aware that mental illness can be cured.

“.... awareness program intervention relayed people's fears that it's similar to any other illness, need to be treated but a bit longer. Education is the key. Especially not to put people down who are mentally ill. For example, obesity not easy to fix as it involves background knowledge to its cause, and even medical sector struggling to deal with it. Pacific people and Tuvaluans are similar in their stereotyping of these illnesses.”

Male GP

This proposal aligns well with Buechter, et al. (2013) who recommends strategies to combat stigma related to mental illness in society. The authors recommend educational programs, contact, and protest strategies. The function of educational interventions is to eradicate myths associated with mental illness and replace these with facts. Alternatively, contact measures that emphasize the importance of forming mental health consumers' discussions groups to support each other and devolve experiences in public arenas, or even through videos was suggested. Protests, on the other hand, involve campaigns targeting mistaken representations of mental illness, especially by the media through writing complaints, phone calls, and public denunciations in the form of press releases, marches, sit-ins, and boycotts. The aim is not only to educate people to recognise mental illness and where to go to seek help, but to reduce other barriers of help seeking behaviours such as stigma and discrimination and other negative implications of mental illness. However, these suggestions must be in tune with Pacific cultural styles of learning, and appropriately delivered in ways that affiliate with Pacific cultural modes of protocols.

“.....I think our people shouldn't be ashamed of mental illness. It's like having somebody with asthma. It's like having somebody who's got diabetes. The only difference is it's to do with the mind and you know, the sad thing is, it's because someone with mental illness experiences something way different to someone who has diabetes and who has asthma. Those you can predict but mental illness you can't and so the problem is we need to react rather than be inactive when we see these things and we need to be able to reach out to our ones that are affected and say “look this is what's happening this is what we can do”, rather than “this is what's happening, we going to keep it indoors and not spread the word”.

Mental Health Nurse

In a similar vein of comparing mental illness to common ailments, and the importance of differentiating mental illness from intellectual disability, a mental health support worker declared that:

“With mental health problems, I don't know whether our people have mental health awareness to make them realise that mental health .....is just the same as diabetes, high blood pressure and so on. That it's part of a physical body and it's just that he's mentally ill. So mental illness is different from intellectual disability.”

Male Mental Health Support Worker

**Understanding cultural influences.** A few participants focused on cultural influences that must take second place to the importance of adjusting and adapting to the modern Western lifestyles in NZ. The pastor strongly promoted a change in Pacific attitudes to follow the lifestyle in the context of living in NZ and

recommended Tuvaluans and Pacific people start using their own measures and frameworks to tackle issues confronting them. It is a significant issue that needs detailed discussion of how people acculturate and become assimilated to their host countries in many aspects of life. The influence of homeland beliefs about mental illness and how it is dealt with in the Pacific homelands seemed to continue to be adopted by Tuvaluans in NZ. As already discussed in Chapter 4, the findings conveyed that some migrants have accepted assimilation while others have steadfastly kept their traditional ways of beliefs about mental illness and how it should be treated.

“.....there’s a lot of influence from our cultural side of things. There’s one thing...even though we value our traditions and our history, on the other hand we need to realise that we are in the 21st century. And we need to move on, you know, we are in this new era, and new generation so we need to come up with .... we need to create something, a model or framework that work for us here in NZ. Cause it’s all about the monoculture, you know, the palagi methods and ways of dealing with those problems. Or ethics ways of dealing with those problems. I think it’s about time we bring our own ways you know. Just to see whether it works or not. “

Pastor-Community Member

### **Delivering Health Promotional Educational Programs.**

**Discussion groups.** A popular mode of delivery of these programs that several participants proposed was to cater to the learning styles of Pacific people are through discussions at meetings. The constant reference to the importance of the community in Tuvaluan society in solving issues that are significant to people is evident in many of the participants’ statements. For instance, this male elderly relative proposed that support groups provided by the Tuvaluan community are vital for sharing experiences and ideas.

“In the island community groups, family groups, all these kinds of groups.”  
 “Let’s share ideas and information. Probably I don’t know more about what you gone through with your family with mental sickness and you don’t know what happen to myself. If we share ideas ...we try to learn from ...I will learn from all. And well share the ideas together. Maybe we will come together for a better solution our solutions for to help our people with those kinds of things.”

Elder Male Family Relative

However, he also suggested that these groups must try to include the mentally ill in the discussion groups to help and support them.:

“Maybe we can uh, we can help with their thinking. We can identify them, try to identify these kinds of people. And then we approach them: “Are they all right? Is there any problem? Especially with the um...mental violence. They or we would approach the community and the community would let them know who are these people.”

Elder Male Family Relative

However, many of the participants were cautious about how these discussion groups would eventuate due to the taboo topic of mental illness at Tuvaluan gatherings. They argued that the topic of mental illness is an extremely sensitive matter that is rarely discussed, especially at the community and other social gatherings. The participants referred to its potential effect in inhibiting people's willingness to attend programs, including workshops and other health promotional initiatives. The male GP suggested that educational programs should follow in the lines of the TB awareness initiatives which successfully eradicated the stigma that was commonly linked to that illness. For instance, the forensic worker agreed that mental illness is a *tapu* (taboo) topic of discussion and suggested that the first strategy is to educate the elders of a Pacific community.

"....it's just, I think it's a lot of education on um you know and just teaching from probably like even within the seniors of that Pacific you know grouping. You say, "hey it's ok, do you have a problem?" But that's the other problem, a lot of them don't acknowledge they have the mental health, they think it's something that's spiritual or something like a 'tapu' or something. You know? What's the word, I don't know the Tuvaluan word but you know what I mean. And that's the problem, they don't look at it, view it as mental health."

"They see it as a curse or something."

Female Forensic Worker

Even the mental health professional participants felt that the topic of mental illness should be openly discussed at the community level. Yet again, it was emphasised that the community leaders need to take the reins of leadership and initiate strategies.

"And we can see that they are not taking it seriously with you know shame, and the way, the other way, they should talk to them. Ne? Ki tino ote (to people of the) community."

"Cause it happens a lot in families."

"Ko tou tino ko la matua (It's our elders) ....it's up to us to do something about it. Ke na gata (It has to stop)."

Female GP

**Tuvaluan learning styles.** The former social worker stressed the importance of health promotional programs facilitators to avoid randomly turning up and organising workshops. Rather, the people must be familiar with these facilitators to gain their trust that it is worthwhile to attend such workshops. Tuvaluan customary styles of learning are usually in groups, not individually. However, she contended that the migrant and NZ-born Tuvaluans are so distinctive in many ways, especially their learning styles, English fluency and technological competency when developing these educational programmes.

“I think um, people, as I said, when I say people, it’s not the generation that is born here, it’s the Tuvaluans that are not born here. They.... they are not comfortable with education. Education to them is.....” Oh, um,” you know. There’s no education. But they can, because they like going .... together. Because that is our lifestyle, they always get together. So that’s where the education can reach them by using our people, people that they know they trust. As I said you won’t, if .... if you ask one person to go, it’s hard. If you ask like a group, or connect with someone in there, using their own people ...”

“..... our people say “oh, we are coming to the workshops.” And they say, “who’s that person?” ..... So how we help them, is like, go there. If we go to church, the people there that they really trust, give the message to those people to help you, but don’t just appear yourself.”

Former Female Social Worker

### **Distinctions between the young and older adults’ learning styles. A**

distinction between the young and NZ-born participants with the older and more traditional participants’ views about how best to deliver the information to Pacific people was observed throughout the group discussions. For instance, one proposal dealt with the young Tuvaluans’ frequent use of the internet and suggested that this technology is a better possibility for them to access and learn the information:

“.... they are into Facebook and all these kinds of.... random advertisements to be in Facebook.”

Elder Male Relative

***Face-to-face communication.*** A young female community participant was also adamant that educational programs for the young are crucial, however, they must be delivered in ways that the young will be interested in such as face-to-face methods. Her message is congruent with Barrera’s (2016) findings into Latino’s help seeking patterns engaging religious and traditional healers who are more likely to listen intently to their problems. It was recommended that service providers, families and other support systems are taught listening techniques so that they can motivate an initial interest and subsequently, attract help seeking behaviours.

“Pamphlets....no it’s not a problem but it’s like they don’t want to deal with you? It’s like they just give it to you, like I don’t want to discuss ..... with you. So, does it help the more you talk?”

“Because, physically..... speaking touches you inside and those people will spread the word. But if it doesn’t touch you, “oh yeah” they are not even gonna talk about it. But if someone you know who can help you and can touch base with everyone, you will spread the word to people that really need the help.”

Young Female Community Member

***How to empower youth’s needs over elders’ traditional ways.*** A major observation deals with the manner of participation in the discussions. It was clear that the youth’s voices were very minimal during the focus group discussions. It seems this behaviour is typical of youth during gathering with elders. The elders in

the groups were unaware of this problem and were quite amazed when they saw that their presence affected the youth's reluctance to speak their minds. It was agreed that this issue needs to be resolved and Pacific protocols changed to acknowledge, accept and respect youth's ideas and thinking, or have separate group discussions. The youth's failure to speak in the midst of their elders was noted in all the group discussions, and one reason for this was commented on by the mental health nurse as due to elders' fixed traditional views.

"Yeah, yeah, and often they struggle to communicate with the elders because they (elders) are very fixed in their beliefs and how things should be done and how things should be dealt with."

Mental Health Nurse

**Advertisements.** Several participants referred to the importance of the written information that should be in the form of leaflets and pamphlets and placed where Pacific people congregate such as in churches, community halls and medical centres and broadcasted through the Pacific and Tuvaluan radio station.

"I think they should have mass awareness advertisements, regarding this from government respect for the mental. Maybe in churches....or community halls, they should have all that kinds of information so people will read and people will know "oh yeah, I saw it somewhere," medical centers...everywhere can access notices, maybe tv as well. Where people can ...radios. Those are kinds of information which need to be ...you know disseminated to the public, especially to us Pacific islanders."

Elder Male Family Relative

### **Educational/information programs through Pacific island radio station**

**531 PI.** Most of the participants advocated the Pacific island radio station *531 PI*, as the quickest way of increasing the awareness by Tuvaluans. The radio station distributes a weekly slot for each Pacific community group in Auckland. The Tuvaluan regular slot is every Friday evenings for two hours. The island radio broadcasts only in the Tuvaluan language so it needs to accommodate NZ-born listeners by the addition of the English language too. A further suggestion was via social media such as *Facebook* to target the young and NZ-born generation.

"The quickest way of increasing the awareness is the media, like the Tuvaluan program that is on every Fridays ... we just need to be banging this every week. And make these people aware if you are sick or you know. And sometimes it's to explain more the symptoms of mental illness like if you are not sleeping well or you are not coping with managing daily things or you are angry all the time because there are things behind it cause you are aware of it. So, you can go and seek and call advice and ask ...yeah."

"I think too there's services that are available because every community there is a mental health service community available in different areas.... They do geographically situated but I thought people like, I'm talking about the media like our radio stations, give out the number like there is a common number its

0800800700 that's a common one that people don't often ring. They have 24hr service and you can also go online you know, the ones that you can ring online. All these services work together so they would say oh ring this number cause they would talk about specific mental health issues."

Mental Health Nurse

The community support worker agreed that radio programs are the medium of communication to educate the Tuvaluan and Pacific people for he was once interviewed on the Tuvaluan radio.

"They interviewed me once, and they asked me what my views were on the radio.... but they only interviewed once. I hope it's a regular program for our community because, you know, I believe that everybody here is talking about obesity as the problem, but the unseen problem is mental illness...you know, it's the unseen problem. And the issue is right here. I can speak about the signs ...how to control it and help our Tuvaluans to realise that it is very essential for us, you know, to have the knowledge, the information, so they can.... services you know they can access help."

Male Community Support Worker

**Follow examples of other successful health programs.** The GP was particularly critical of the limitation of mental health promotional programs in relation to mental health literacy needs of the Pacific community. He insisted that these can become successful like the diabetes and cardiovascular health promotional programs that visited Pacific churches and communities to educate people on healthy lifestyles and nutrition. The outcomes of these workshops have been tremendous as information on how to access medical providers or services has been beneficial. Hence, the GP stated that mental health needs similar programs. He complained that as far as he knows, no mental health programs have conducted church or community consultations, yet many other illness programs have run ongoing workshops for rheumatic fever, immunisation, diabetes and cardiovascular disease. The latter two were initiated, coordinated and organised by himself for the Tuvaluan population. He places the blame for the inadequate mental health programs on government funding, because mental health is not a priority like other illnesses, it therefore lacks funding allocation.

In contrast, the forensic worker reminded that the problem of "choice" still needs to be resolved. Her argument is that there may be adequate provisions established to cater to the mental health needs of Pacific people, but if they choose not to use these facilities, then we need to investigate why this is happening. The earlier chapter has already delved into the Tuvaluan explanations why Pacific and



Tuvaluans at times, choose not to complete the pathway course to mental health services.

“I mean we can get the funding, we can get all these.... but are they going to use it (the services), that is the problem, that's the big question aye?”

Female Forensic Worker

This assertion propels a quest for further research, such as this current study, to examine the reasons why Pacific people choose to not utilise convenient, affordable, and local mental health services when they become available.

### **Conclusion**

The thematic analysis of the raw data revealed considerable insight into Tuvaluan people's thoughts in relation to the issue of Pacific underutilisation of mental health services in NZ. After scrutiny of the themes, it was evident that the participants were discussing journeys to the eventual use of mental health services. Hence, the best mode of organising these themes was undoubtedly via the pathway framework. The findings conveyed that Tuvaluans believe that most Pacific people, including Tuvaluans lack mental health literacy.

The aim of this study was to investigate Tuvaluan people's explanations of the issue of underutilisation of mental health services, and whether support provisions were provided to Pacific and Tuvaluan communities, families, and mental health consumers. A further aim was to identify Tuvaluan attitudes about compulsory treatment in acute and forensic admissions. Pacific people's apathy about mental health was a significant theme that the participants conceptualised as the key explanatory factor describing Pacific unawareness of symptoms of a mental illness, and the delay in help seeking.

Based on this lack of knowledge of aspects of mental health, proposed solutions targeted the education of Pacific people and Tuvaluans to enable knowledge and skills to identify symptoms at the onset of a psychotic episode, and how to access mental health treatment promptly. Pacific utilisation of mental health services has not improved according to statistical evidence and it is suspected that recent provision of mental health information may not have been effective in reaching its target population or, more likely was seen as unimportant by its audience.

## **Chapter 6: DISCUSSION**

### **Introduction**

This chapter will expand on the previous two chapters that described the findings of this study. It will endeavour to extend the discussion on the bilateral and multilateral factors associated with the individual and family units of a microsystem and how it relates to the communities and its institutions, and to elements of the cultural, belief systems of the macrosystem and its political systems. Several issues were raised about Pacific pathways to the utilisation of mental health services. Firstly, the discussion will acknowledge the significance of the theoretical models of the ecological system theory and the pathway framework that guided this research process and the interpretation of its findings. Secondly, the acculturation process also applied meaning to the participants' explanations as a migrant population, particularly of homeland influences and their place in their new residence of NZ. Thirdly, the heterogeneity aspect of the Tuvaluan population as a people, along with internal factions will be discussed. A detailed discussion of the effects of barrier factors on health behaviours and its influence on the by-passing of primary mental health services as an important first point of contact with mental health services will also be discussed, and a reflection on the dire effects on the equity, equality and consequent disparities faced by Tuvaluans and Pacific people. Lastly limitations of this study are detailed, and recommendations, in particular, future research options are proposed.

The inter-connectedness of the themes complicated the analysis of the data. However, the researcher's role is to endeavour to untangle the "voices" of the participants and its meanings and not ignore or exclude them. The ideas were meaningful to the participants and were employed to rationalise perceptions of events, behaviours and attitudes of their own, or of others in different contexts, so every effort must be applied to make sense of the philosophical thinking behind their usages. The issues were identified by the participants as crucial as either impacts, effects or outcomes of attitudes, behaviours, events, and environment.

Several ambiguities were observed in the findings that need to be acknowledged prior to further discussions to clarify the standpoint of this thesis and avoid confusion about the topic under investigation. The topic of discussion concerns Pacific underutilisation of mental health services, and it seems that all the participants understood this aim. However, because the viewpoints were derived from a sample of Tuvaluans, their explanations were twofold: firstly, the responses made references to knowledge of general Pacific people's experiences and secondly, it was unmistakably

evident that the participants were also speaking ethnic-specifically of their own experiences as Tuvaluans, or of other Tuvaluan experiences. What needs to be clarified then is that the participants were viewing the topic as a Pacific issue, but using Tuvaluan experiences, beliefs, attitudes and culture as explanations. After all, it is a Pacific issue, not solely a Tuvaluan issue for it lacks statistical evidence to warrant this contention.

The findings of this study suggest low use of mental health services by Pacific people is a result of rigid authoritarian and traditional cultural worldviews that have not successfully merged with the complicated structural and medical model of the NZ mental health system. The findings illustrated that the dominant persuasive factor is the culture component of a belief system instilled in people's mind-set. The proposed solution identified by the participants is not based solely on changing the "physical" behaviours, but the historical, psychological, political, sociological and cultural inheritances of Tuvaluan people's belief systems regarding mental illness and its treatment approaches. Alternatively, it can be argued that the NZ health system has a duty to be more responsive towards Pacific mental health needs (Ministry of Health, 2008). Both measures demanding solutions. The participants in this study were adamant that a change in attitudes and beliefs about mental illness would be the most productive solution, in other words, the acculturation of Tuvaluan people is essential for any progress to occur in the use of mental health services.

But as Vaeau (2013), a Pacific clinician, stated, it is not an easy solution as proclaimed, and most interventions have not been effective. He concluded that despite the impact of education, anti-stigma campaigns, increasing generations and acculturation, Pacific beliefs and attitudes in relation to mental health remain largely unchanged. Further detailed discussions on the acculturation process below will unravel the findings of this current study and justify why Pacific attitudes about mental health appear to remain unaltered. The acculturation process will be discussed below which will rationalise the contention that the outcomes of acculturation will take years, generations or even centuries to manifest into results (Berry, 2005). The usefulness of the pathway and ecological frameworks will be examined in the next section.

### **The Appropriateness of the Pathway Framework for this Study.**

This study offered a clearer picture of the underlying dynamics involved in the pathway to the utilisation of mental health services by Tuvaluans as Pacific people. These subtleties are diverse, and dependent on a multitude of situations, contexts, demographics and group factors. This study indicated that the common pathway to using mental health services for Tuvaluan people is guided by specific cultural attitudes held by migrants that are adopted from their homelands. These attitudes continue to influence the behavioural and attitudinal health facets of Pacific people in NZ. The question raised then, is: what about the NZ-born Pacific people?

At first encounter with the findings it appeared to present Pacific pathways to the utilisation of mental health services as unique. But as argued by Agnew, et al. (2004) close examination of the literature uncovered identical experiences by ethnic minorities in other western countries. Although this study is ground breaking in alerting the issue of Pacific underutilisation of mental health services to be studied by this pathway framework, this avenue of research has been widely conducted by international researchers. However, a search of the NZ literature, did not find any source of a Pacific pathway, particularly in the area of mental health service use, and by a minority population like Tuvaluan people.

The pathway framework enabled the identification of many explanations of why Pacific people underutilised mental health services in this country. The pathway framework is a process, a system, therefore, by examining each stage of the process, the participants' explanations were able to be analytically scrutinised to detect significant themes and the inter-level interactions between the multi-level ecological systems of impacts. In doing so, barriers that hindered the progression to the next stages of the pathway process were able to be identified, analysed, assessed and interpreted.

The pathway framework additionally facilitated the detection of gaps in the literature, in particular, the literature on Pacific regional states' under-developed mental health systems. All the migrant participants spoke about the lack of mental health facilities in the homeland, and the pathway approach was able to link homeland contextual elements to the underutilisation of mental health services in NZ. Multi-level analysis made it possible to see a clearer picture of homeland influences on Tuvaluans' health behaviours in NZ. This is particularly relevant in relation to NZ as it revealed a lack of epidemiological studies and the inadequacy of formal statistics required to

answer the questions raised and make sense of the explanations provided by the participants in this study.

An erroneous method of calculating Pacific prevalence of mental health disorders mistakenly concluded statistics as showing low prevalence compared to other ethnicities. It means that the utilisation statistics of mental health services were additionally recorded as low (Bridgeman, 1996; Ministry of Health, 2005). The inappropriate recording of Pacific utilisation rates has resulted in the development of inadequate mental health policies for Pacific people. A related issue of criticism is that community care in NZ is based on international evidence and developments and adopted regardless of the incompatibility with demographical populations that are inapplicable to the NZ setting. Limited research of this issue in the NZ context meant that the challenges faced were largely unforeseen.

Updated statistics of prevalent rates and utilisation in NZ are urgently required, not merely reflecting restrictively (District Health Boards) DHB's, or PHOs, or even NGOs statistics but a combination of information from all sources of these providers. This poses an additional problem when mental health and other disability data are combined as disability statistics. Nevertheless, a caution in using these statistics of prevalence and admission rates must be exercised for they are not accurate statistics of the total numbers of people with mental illness. These statistics exclude persons who do not access mental health services (Sartorius, 2015). The negative consequence of this gap of updated official statistics is observed by commentators' such as Gluckman's (2017) application of outdated important survey statistics from the national mental health survey conducted in 2002-2004 *Te Rau Hinengaro: The NZ Mental Health Survey*. These outdated mental health survey statistics continue to be used as evidence of official statistics on the prevalence rates of mental illness in NZ.

### **Effectiveness of the Ecological Systems Model**

The appropriateness of Bronfenbrenner's ecological system's model to assist in the interpretation of the findings of this study has been very positive. Interestingly, it enabled the discovery of the role of the individual as minimal, but appropriately and fittingly complements Pacific belief systems and worldviews for the individual's position hierarchically in Pacific culture is practically non-existent. The nucleus arrangement of Pacific "being" is holistically inclined therefore people belong to a group, a family, a community, an organisation, an entity with 'others'.

As a Pacific issue under study, explanations are diverse, reflecting the perspectives of the entity the individual belongs to, which in this case as Tuvaluans, rather than dependent on the perspectives of an individual's choices of behaviour. The impact of influences is multilevel whereby Sallis, et al. (2015) has even gone so far to describe the arrangement as "robbing the individual of dignity" (p 479) because of the influence of diverse, multiple factors that impact and shape individual behaviour choices.

The findings of this study complemented the literature that described minorities as tending to rely on their informal support systems of immediate families. This cultural emphasis on the family and other microsystemic external support systems emphasizes families' responsibilities and obligations to undertake the symptom identification task, assist in the help seeking endeavours and the accessing of mental health services rather than being reliant on the individuals.

The dominant view from these findings is that external informal support systems of the family is essential for the successful completion of the pathway journeys to utilisation of treatment services. The assumed contention informs a view that it is a "duty of care" cultural requirement to care for relatives in need. Throughout the findings, and extensively collaborated by the literature, close relatives adopt this ethics of care concept as a duty, and the role of the medical professionals are restricted to apply pharmacological and therapeutic treatments. The duty of care ethic applies particularly to all areas of mental health care of adolescents and children, so the total responsibility and obligation for this age groups in relation to mental health services utilisation solely lie on their parents or other guardians and carers. On the other hand, some participants have repeated the warnings located in the literature (Kuo, et al. 2015) that suggests that strong familial support can be problematic as it can delay the help seeking process, which the GP participant warns as inadequate for severe cases that need extensive pharmacological and psychotherapy treatments.

Some aspects of the individuals were however had an important effect on the outcomes. For instance, demographical details contributed to influencing the underutilisation of mental health provisions. Age differences and migrant status were an important factor as to whether traditional beliefs were held. Findings showed that the older and Tuvaluan born participants had more knowledge and experience of both "worlds" of NZ and the homeland and provided a considerable contribution to the study. Higher educational status, income status and gender were less influential in accessing mental health services, but experience and knowledge about the condition

itself (symptom identification) and the location of mental health provisions were significant influential factors.

Sallis et al. (2015) warns that an ecological research framework can be very demanding and complex, particularly when it involves several of the multi-levels of the ecological system framework. However, multi-level investigations are beneficial to unearth an in-depth comprehension of social and cultural issues. It is only through these types of research that multi-level interventions can be formulated. Nevertheless, the complexity and time-consuming factors that are involved in the setting up and organising the various resources required, and the length of time it takes to witness any political, economic and social successful outcomes of these interventions must not be underestimated. This study attempted to explore the issue via a multi-level investigation, inevitably, many inter-related factors were identified that made the data analysis an extremely productive task.

Since the 1980s, health promotion approaches have experienced a paradigm shift from an emphasis on individual behaviour change to a focus on environmental factors conducive to collective benefits (Stokols, 1996). As Pacific people, the participants' solutions to the problem of underutilisation of mental health services fostered community-based participation in the designing and delivery of educational programmes. Alternatively, a focus on an upgrading the knowledge of all people through environmental strategies of health promotion rather than concentrate on one individual was viewed to benefit more people.

### **The Acculturation Effects on Tuvaluan Health Behaviours.**

The chronosystem level embedded in the ecological system can be identified in the findings in terms of a significant change in the cultural, psychological and social aspects of Tuvaluans due to migration from the homeland Tuvalu to the host country of NZ. The findings specifically depicted the acculturation changes as the distinct cultures merged and how this affected the way both sets of people adjusted to harmoniously co-exist. The Tuvaluan population group level of changes are culture, customs, language, behaviours, values and attitudes. Of major significance when applying the acculturation perspective to the findings, homeland influences dominated the explanatory factors raised by the participants of Pacific underutilisation of mental health services in NZ.

Consequently, this study accentuated the contextual effects of the homeland and host country of NZ in determining whether mental health provisions are utilised by Pacific people. The findings in relation to homeland influences showed that participants

persistently referred to, are collapsed into Bhugra's (2004, cited in Prabhugate, 2010) three phases of analysis: pre-migration, migration and post-migration contexts of analysis. The idea is that the context of the homeland must be investigated to comprehend the migrants' social, economic, political, cultural settings and belief systems of Tuvaluans prior to migration. Tuvaluans' influx of migration to NZ must be understood as the result of fear of global warming sea level rising rather than forced migration. This is an important consideration for it will determine how they were received, accepted and treated socially and politically in NZ. The findings also showed that elements of this homeland were viewed to have continued to be practised in NZ. Similarly, the host country needs examining for it is the only way to understand how the merging of the cultures have occurred and the outcomes of this co-existence in a multicultural setting.

Homeland influences were consistently referred by the migrant participants throughout the focus group and interview discussions. The pre-migration features were meaningful to the participants as explanations for Tuvaluan health behaviours in NZ, that included the non-existence of a mental health system in Tuvalu. The rationalisation is that this absence of a mental health system prompted people to seek treatments from traditional healers and to rely on cultural and customary practices such as coping strategies of leaving it to pass, and strong family support systems as the only options. One participant spoke about the hopelessness and helplessness situation faced by the mentally ill and their families regarding the treatment of mental illnesses. Consequently, knowledge of mental disorders and its treatment has not changed from the traditional beliefs that evolved around supernatural and religious beliefs, despite modern technological advancements. The state of Tuvalu economy is still weak, evidence in its political status as one of the underdeveloped countries in the Pacific region, which, even now, still lacks a mental health policy according to the participants. This describes the current contextual state and practices of mental health in Tuvalu. According to the participants, this explains the limited knowledge, beliefs and attitudes regarding mental illness and its treatments that the Tuvaluan migrants brought with them to their newly adopted country of NZ.

Despite the diverse theories of this acculturation process, this discussion delves only into what was in the findings and apply it to existing theories. For instance, it is likely that apathy arose out of lack of knowledge which shows that whatever knowledge the migrant group brought with them from the homeland was not applicable and certainly is distinct to the NZ context regarding mental health. Another noted



misconception is the view that mental illness and intellectual handicap conditions are identical, and this stigmatized attitude resulted in the common derogatory labels such as *valea* (stupid) commonly used to label both conditions.

There were different levels of knowledge acquisition amongst the participants regarding the research topic and these seemed to correspond to mean different acculturation levels. However, it must be noted that this is a small qualitative study, findings and a larger scale study's finding may be different. Despite this, Tuvaluans could be described as falling into one of the categories of acculturation of Berry's theory. Some have become assimilated (adoption of host culture), integrated or bicultural (adoption of host culture but maintain homeland culture); or separatism (rejection of host culture). This can lead to conflicts in the way participants explain the problem of underutilisation of mental health services.

In multicultural societies integration approaches are encouraged through policies and legislations (Sam, & Berry, 2010) which have been detailed in Chapter 2. The findings conveyed this difference in levels of acculturation, and that most Tuvaluans still held traditional beliefs and therefore either refused to accept the medical model explanations or they are still in the process of assimilation, adjustment and integration. After all, it does take time for the acculturation effects to evolve. For instance, the NZ-born participants were aware of their parents' beliefs and practices which they argued is the result of the distinct contexts of socialisation and upbringings in Tuvalu. Another group of participants were able to distinguish and compare the two vastly contrasting contexts of their homeland and the NZ medical world of mental health, while others were reluctant to accept NZ's culture and norms. This post-migration phase reveals vulnerability factors generated by these conflicting states of acculturation which can result in culture shock and culture conflict. This is off-set by resiliency factors of positive cultural identity, social support and social-economic advantage (Sam & Berry, 2010).

Hence, major cultural indicators have been revealed in the findings of this study: illustrated by the distinct coping styles of Tuvaluans to deal with mental illness, the strong familial support and the help-seeking channels used by participants. The difference between the individualistic host environment and the migrant collectivist homeland society are vast resulting in migrants experiencing a host of distress and stress, and having to accommodate and adjust to the beliefs, values, culture and aspirations of the host nation (Prabhugate, 2010).

Subsequently, the study of immigrants' use of mental health services can be framed from the perspectives of the social, cultural and environmental factors analysed via the ecological model to explore the relationship between the individual and the environments of pre-migration, post migration and current host environment. For instance, the microsystemic levels of factors can include: family, friends, work and church, the mesosystemic level: wider networking families and other elements in the microsystem; the exosystemic level includes: public and government policies and activities; and the macrosystem consists of the beliefs and attitudes of the citizens in host countries towards the immigrants (Prabhughate, 2010). Lastly, the chronosystemic level is crucial in this study for it dominated the findings of this study via homeland beliefs of the migrant participants. The influence of homeland beliefs on the attitudes, beliefs and behavioural practices towards mental illness and the treatment approaches were extensively presented in the findings. The robust findings of homeland effects on participants' explanations of Pacific underutilisation of mental health services are attempts to make visible their experiences as Tuvaluan migrants living in a new environment in NZ. Chronosystem factors visible in the explanations include problems with English language fluency, cultural identity, isolation from family and friends, along with other features in the host nations. Tuvaluans are still in the process of acculturation, adaptation, adjusting and assimilation to life in NZ.

The fact that there are variations in stages of ethnic, cultural and social identities amongst the participants is evidence of this acculturation process (Ward, 2001, cited in Prabhughate, 2010). For instance, all the migrants in the study referred to the homeland influences as crucial, the variations in their belief systems and knowledge regarding mental illness and its treatment additionally are distinctive, dependent mostly on the age of the participant. The older migrant participants were more traditional and knowledgeable about the homeland situations while the younger participants were more apathetic about their homeland. Consequently, the individual's cultural identity can either be positioned within native roots, or has adopted and assimilated to the host culture, or becomes bi-cultural. The classification of the levels of acculturation into high, medium or low is determined by generational, birth place, length of time since migration, English fluency, and resident location in their own ethnic area (Baugh & Guion, 2006). One migrant participant who is an elder insisted that "If you are in Rome, do as the Romans do", but at the same time, argued for the importance of establishing Pacific models to use solely for Pacific peoples. Berry (2005) states that there are variations of acculturations through culture

shedding and culture learning, for it takes time, and the fact that the findings conveyed a lack of knowledge of mental health services and its treatments is evidence that Tuvaluans are still partaking the acculturation process. Even at the family level, variations of acculturation by its members occur in terms of differences in acculturation strategies or its progress.

Lastly, it has previously been viewed that a uni-dimensional phenomenon will result whereby the dominant group overpowers the other through assimilation leading to the formation of one culture. Rather, as Berry (2005) has argued assimilation has not always occurred due to universal resistance to it, and secondly, cultural groups still exists in host countries contradicting this theory. Another controversy exists to question whether traditional societies like Tuvalu require western type of mental illness treatment in terms of the medical model. The Samoan case reported by Mulder, et al. (2016) also question the argument that developing traditional countries like Samoa must upgrade its mental health system to accommodate the unmet mental health needs of its people. The authors argued that they have not witnessed any evidence that shows that substantial unmet mental health needs exist in Samoa. They reasoned, as already discussed above, that Samoa has strong family ties in a collectivist society, so people tend to accept, support each other during crisis times. This is demonstrated by the small numbers of people who experience severe psychotic conditions, compared to the high Pacific rates of mental illness in NZ. It certainly implies that NZ mental health system may learn and adopt from these cultural coping styles to minimise reliance on clinical treatments.

### **The Bypassing of Primary Mental Health Services in the Pacific Pathway to Mental Health Services Utilisation.**

A significant finding that needs addressing is the bypassing of primary mental health services by Tuvaluan and Pacific peoples. Several explanations were offered such as: problem symptom identification, failure to differentiate mental conditions and criminal behaviour, lack of knowledge of mental health services, family support care in the home and traditional coping strategies. Interestingly, the mental health worker group predominantly referred to the alienation and financial barriers of mental health services compared to the other groups, targeting mostly primary mental health services. More importantly, both GPs identified the lack of psychiatric training by GPs that results in the time-consuming assessment procedures and they highly recommended psychiatric services to be established in GP practices because normal

surgery consultation sessions are a mere 15 minutes, too short a time for a mental illness assessment consultation.

**Primary mental health services as the culprit.** An alternative school of thought using evidence-based research has maintained that even if people were competent in identifying symptoms, acting on this identification was discouraged if people lack knowledge as to where and how to seek treatment. The literature tended to place the blame onto primary mental health services, especially GPs for not effectively fulfilling their role as first points of contact. These findings, corroborated by the literature, found that its deterring gatekeeping functions were an inhibiting factor in disallowing the transition to further secondary services. Additionally, the cultural incompetency of its staff, service structure and practices are additional restrictive factors to motivating people to access mental health services. The high numbers of trained mental health clinicians who are non-ethnic minorities and often lack bilingual fluency, therefore possess cultural insensitivity to ethnic minority cultures (Atkinson, Jennings, & Liongson, 1990) and this is a common limitation. The two GP participants of this study further suggested reasons to explain the inefficiency of primary mental health services to cater to ethnic minority mental health needs as more likely due to lack of funding, and the cultural incompetency of consultation assessment procedures. This study also found other barrier factors specified in the literature such as the unaffordability of prescription and consultation charges, language difficulties, and insufficient consultation time allocated for the assessment of mental health disorders.

Other research has found comparable experiences to Pacific people who typically bypass primary mental health services, consequently partaking a direct route to compulsory hospitalisation or forensic admissions. For instance, a study comparing African-Caribbeans in the United Kingdom to their White British counterparts (Bhui, et al., 2003), found that the main mode of referral for African-Caribbean's who were experiencing acute stages of psychoses were through the police and criminal justice system. The same case is observed in Asian American populations (Leong & Lau, 2001) and American Puerto Ricans (Rogler & Cortes, 1993). Like Pacific people in NZ, there is evidence of repeated occurrences of a disproportional prevalence of mental illness amongst these ethnicities, who, at the same time, are prone to underutilise mental health facilities.

### **The Issue of Eligibility into Psychiatric Mental Health Services and the Concept of Harm.**

A controversial issue raised by the study participants from the relatives group to explain the delay in help seeking, was the unrelenting refusals by their mentally ill family members to see a doctor or any of the other primary mental health services for a referral. This is a typical scenario and solved only when the behaviours escalate into severity. The violence caused by the severe symptoms elicit safety concerns, and the police or Crisis teams are called to intervene. It is only at this stage that a person is referred to or more precisely forced into psychiatric care. Treatment is still delayed due to time-consuming assessment procedures, coupled with the controversial issue of the mental health consumers' rights always overriding the relatives'. For this reason, the mental health consumers' denial of a mental condition is believed over the relatives' concerns. The relatives' criticisms of mental health system's primary priority were focused on the mental health consumers' rights and preferences. This is a common occurrence and is discussed by Prins (2010) as being the result of a patient-centred mental health care system that has evolved since the 1980s. Seemingly, the system developed in response to frustrations with the old biomedical model, whereby the mental health patients are treated as passive recipients of treatment and care, and their rights forfeited.

Subsequently, the patient's perspectives and preferences are incorporated into decisions over health care needs and treatment. This principle of mutual decision making is reflected in the Crisis team's exchange of information with the potential mental health consumer, resulting in the eventual agreed options and course of treatment chosen. These procedures are instructed under legislation, such as the Mental Health Act in NZ, which is an official and legal measure of permitting patient's active participation in their own treatment planning and delivery options. The mental health services therefore, will only intervene if there is strong evidence of harm and safety elements. However, the relatives' arguments make sense for their concerns is to avoid delays, for the time-consuming assessment procedures not only endanger their lives due to the danger aspects of their family member's severe mental states, but also delays the treatment aspects. Secondly, when the Crisis teams are called for help, they need to attend these calls immediately, because this delay is the reason why the police are frequently called to deal with the situation.

### **Shame, stigma, discrimination.**

The considerable misconception of mental illness in the islands, which produced mystic beliefs of its origin also denotes feelings of shame and stigmatization to be associated with mental illness. References to historical customs of shame and rejection by families and communities that, sacrifices were customary practices to relieve families of this shame. The exclusion of the mentally ill in the islands was also apparent in the way they were left on their own, ostracised from community happenings, as long as they were “fed and clothed well”. These people were often jailed due to the lack of mental health facilities to house the severe cases incurred additional shame on families. The stigma associated with misconceptions regarding mental illness, led to beliefs that the mentally ill lack intelligence, and that they are “born” intellectually handicapped.

The findings also showed that Tuvaluans perceive no distinction between intellectually handicapped conditions and mental illness. To non-clinical participants, the two conditions are identical and even applied the same definitions to describe both diagnoses with labels such as *valea* (stupid), *fakavalevale* (act stupidly). These derogatory labels illicit discriminatory and exclusionary treatment of the mentally ill in the islands. Regrettably, this is an ongoing problem faced in NZ too as conveyed by the participants. Additionally, it has been cited in the literature that these damaging misconceptions about mental illness is the most influential factor that impedes the use of mental health services by ethnic minorities. For instance, Asian Americans see the use of treatment services for mental illness as a sign of weakness (Root, 1998), whereas Latinos’ negative beliefs of mental health services result in customs to keep it in the family but if necessary, seek assistance only from religious and community leaders as opposed to disclosing private matters to outsiders (Altarriba & Bauer, 1998). On a more distinctive note, Snittker and colleagues (2000, as cited in Buser, 2009) contended that African Americans who ascribed mental illness as genetic or caused by family upbringing were inclined towards help seeking tendencies in contrast to people who attributed the condition to God's will. However, African Americans were more likely than Whites to believe in God's will as a more significant cause of mental illness, therefore, explaining the reason for this group's tendency to be unwilling to seek help.

### **The Gap Between Tuvaluan NZ-born and Migrants**

Widespread assumption of the existence of homogeneity in terms of values, attitudes and beliefs in the Pacific population disregard the ethnic specific diversities

of its composition. As Yorke et al. (2016) argued in relation to African-American ancestry, this migrant population's demographics will eventually evolve to diversify and ultimately, comprise of multiple factions. Stakeholders such as clinicians, researchers, policymakers and educators must equip themselves with this knowledge of diversity and its effects on help-seeking attitudes to be able to develop culturally appropriate mental health services for these people.

This study identified a huge gap between the NZ born and the older migrant participants in relation to attitudes, English/native language competency, worldviews and identity acceptance differences (The Health Research Council, 2014). It was apparent that the younger generation and the NZ-born remain isolated from any Pacific island settings or discourses. The tactics they suggested as solutions to this issue of underutilisation differ from each other.

Moreover, according to Fa'alogo-Lilo (2012), the domination of Pacific traditional values and beliefs are placed in significantly higher esteem than those of the NZ-born, more so in the contexts of acceptance by Pacific service providers or by mainstream service providers who are unaware of this difference. This suggests that if you do not possess Pacific language fluency and cultural competency, and abide by Pacific cultural principles, then you are not regarded as Pacific, despite the fact that your ethnicity is Pacific. Consequentially, it is essential that this internal-group diversity is understood for its effect on patterns of help-seeking are enormous (Abe-Kim et al., 2007). This means that migrants receive better care from mental health services and lesser rates of mental illnesses. These authors also found that second-generation Asian Americans tend more to follow in the footsteps of migrants than first-generation persons in patterns of utilisation and perceptions of satisfaction of service treatment efficiency. This raises the question as to where do NZ-born and young Pacific people fit, in terms of culture? How do we close the gaps in Pacific health disparities if we have internal disparities within Pacific communities? A simple response would be to avoid existing attempts towards "uniformity" thereby ignoring differences such as generational, place of birth, ethnic specificities, gender and other differences which will undermine the emphasis on more important identity indicators that categorise Pacific people. Grouping Pacific people together as one people who behave in the same way can perpetuate the problem further.

The NZ-born Pacific participants' lack of knowledge of Pacific cultural beliefs of mental illness and its treatment must be heeded. This group clearly disclosed a conflict of worlds with that of their migrant parents and elders in their

attitudes about the topic of underutilisation. They maintained that the NZ lifestyle and its health system's resources were vastly different from the homeland, hence, a host of different experiences of socialisation, upbringing, education and other opportunities exist in the two countries. For this reason, they question why mental health services should adopt, develop and implement treatments and their delivery in accordance with the culturally competent Pacific migrant people's philosophies and expectations (Southwick et al., 2012; Statistics NZ, 2014). The argument asserts that the expectations of the Pacific way are unrealistic and unsuitable to the NZ way of life, in particular, the health system. These findings suggest that it is these influential elements are situated in or belong to the homeland only and thus should not apply to developed host countries like NZ. The non-existence of mental health facilities in Tuvalu means that people have no treatment options but to succumb to the traditional methods used such as healers and witchcraft. Despite the consistent arguments that favour these supposedly traditional cultural features of Pacific people that must be complied with when dealing with Pacific people for it to be judged culturally competent, its relevancy to the NZ context must be explored. If it does not fit within the current context then omit it or at least minimise its use.

A contrasting perspective illustrated in findings of several studies (Samu, et al., 2011; Southwick, et al., 2012; Suaalii-Sauni, et al., 2009) argues that cultural advisors and staff are crucial to Pacific mental health. Pacific mental health consumers and their relatives' preferences for Pacific staff in the field of mental health indicated by this study cannot be ignored. However, an alternative view is that these preferences by mental health consumers and their relatives may be due to being "comfortable" rather than to needs. Hidden dynamics exist, and research into the reasons why minority people request to be dealt with by their own people is an important topic for future research.

### **Underutilisation of mental Health services is a Health Inequality and Inequity Dilemma.**

The underutilisation of mental health services or any health service must be interpreted as a health inequality and inequity issue for Pacific people. The goal by most countries including NZ is to attain vertical equity, which simply implies that those with the greatest health needs receive the most health care (Sheridan et al., 2011). Despite government goals towards this principle, it certainly is not happening in NZ.



Any preventable access to vital health services means that unfair distribution of resources is occurring and maintained. However, the findings of this study minimised the role of government as responsible for the socioeconomic circumstances that disadvantage Pacific people's access to health provisions. The reason for poor access to health provisions could be explained by the lack of mental health literacy amongst the non-professionals. The only participants that cited this were the two GPs, and a young participant, who linked the financial burdens experienced by Pacific people as the major cause of mental illnesses and the lack of funding for mental health promotion education programs. Instead, the findings prioritised the cultural traditional belief system and influences adopted from the islands that dominate all other barrier indicators. An added question raised is: "Why is it that previous restructuring of strategic health systems aimed at equitable health distribution for all has not worked to increase Pacific people's use and access of mental health services?" The GP spoke about the Labour government's initiative of capitation fees to enable affordability to GP visits, and the development of Pacific mental health service providers. So why have these not worked? This reasoning may be clarified by the concept of complex problems termed "wicked problems", for they are:

"difficult to clearly define; have many interdependencies and are often multi-causal; are often not stable; usually have no clear solution; are socially complex; hardly ever sit within the responsibility of one organisation; involve changing behaviour; are often characterized by chronic policy failure; and attempts to address them often lead to unforeseen consequences." (Sheridan et al., 2011, p. 1).

The strategies aimed at these wicked problems of health inequity need to be accompanied by a government approach to mobilise a collaborative system amongst interested parties. NZ has already developed health equity national policies, but they need regular monitoring and refinements, both self-monitoring and by other entities such as the Ministry of Health monitoring DHBs who in turn monitor PHOs that have their own self-monitoring systems (Sheridan, et al., 2011). Equally, primary mental health services and the development of social policies and population health approaches were cited as crucial in the attainment of health equity. However, as these authors argue, opposition by a small number of health workers who are reluctant to follow strategies towards equality of access has undermined these endeavours. Consequently, the status quo is maintained whereby advantaged groups are well resourced and well supported. Levelling up programs and educational programs

should aim not only for lay people and common public citizens but for all healthcare workers purposely to alter attitudinal and workplace practices.

### **Limitations of this Study**

This present study contained several limitations that need to be acknowledged for transparency reasons. Firstly, this study used a qualitative research approach, which is subjective in nature and due to the researcher being the central mode of interpreting the data, it can also raise reliability and validity uncertainties due to the possibility of researcher bias (Whittemore, et al., 2001). However, the researcher utilised different measures to minimise these problems, such as bracketing, access to the data by participants and using a variety of data collection methods of semi-structured interviews and focus groups.

Qualitative researchers use various methods to maintain validity, rigour and reliability in their studies, (Berg, 2009) via the following methods: *triangulation* (different data collection sources, trained researchers, theories); *respondent validation* (participants to double check the accuracy of interpretation of data); *reflexivity* (self-awareness of biases, prejudices, values, decisions during the entire research process); *negative cases* (the checking for any inconsistency in the data and disproving the hypotheses or theories); *differing perspectives* (different angles of experiences therefore types of participants). Moreover, when dealing with the idea of rigour, to be able to be described as good research, involves integrity in the collection of data and transparency/accuracy/honesty throughout the research process for credibility to be ensured. The study's research methodology has adhered to all these requirements.

Furthermore, the generalisation of the data is extremely difficult because the sample is small in numbers; and hence not representative, but contextual. The implication is that it is difficult to apply to clinical settings. The emphasis on participants' descriptions of the phenomena mean that those who are not competent communicators (timid), may not have contributed as well as others, or worse, the mental health consumers may not be in the right state of mind to make logical and meaningful viewpoints (Berg, 2009). These concerns are typical of criticisms aimed at qualitative studies and have been noticed during the interview and focus group meetings. The small numbers of mental health consumers, and youth, and NZ-born participants comparably was unfortunate, and it reflected in the overpowering voices of the more dominant groups of migrants, mental health professional

participants and the older participants who were over 45 years of ages. The focus groups that combined placement of the youth and older participants exacerbated the situation further, whereby, the youth were restricted by customary dynamics of “not speaking in the presence of your elders in meetings.” The emotional state of the young woman who cried during the community member’s focus group was a situation that must be avoided in future research, therefore, a suggestion is to have separate focus groups for Pacific youth and their elders. Additionally, all the participants spoke adequate fluent English which was not a criterion of eligibility to participate in the study. However, the absence of non-English speakers meant that Tuvaluans who were not fluent in the English language may have issues and concerns that would have contributed to their difficulties in fully participating in the study to inform experiences and attitudes of the topic issue.

**Methodology Issues encountered during the research process,** One major challenge faced during this research was the small population of Tuvaluans in Auckland and in the wider NZ region. This limitation has wide implications in terms of recruiting eligible participants, which are compounded by problems of stigma and discrimination of those who have mental illness. Consequently, relatives literally refused to divulge information about mental health consumers due to this custom surrounding mental illness which created gate-keeping practices. In addition, participants informed me that certain people in the community have a mental illness, and their diagnoses were based on the “odd ideas they provide during meetings”, or due to unusual behaviours. It can be quite embarrassing on the researcher’s part to decide whether to approach this person as a potential mental health consumer participant. To minimise the uncertainty and confusing situation encountered, it was decided that the person must be clinically diagnosed, which limited further the number of potential participants with a mental illness condition.

**Mental health workers.** This group of participants have extensive professional experience working in the field of mental health that comprise a range of specialities and roles (GP, Acute/Crisis, forensic, residential and support workers, counsellor, and social worker). Whilst diversity was an advantage for validity justification of the information across participants, on the other hand, the knowledge of each specialty groupings was confined to their specific service setting and job specification. An interesting observation was the lack of knowledge that participants

had of each other's professional roles. This was illustrated by the forensic worker who was wondering why there is lack of quality assessment of clients when they reach forensic services by primary mental health services or other referral systems (courts/police) before entry to forensic services. It is clear from the literature review and the findings of this study that the primary mental health services (particularly GP services) and the justice services do not deal with or have minimal assessments of the mentally ill. Their roles are to refer clients to secondary mental health services, only if they suspect a presence of a mental illness symptom. Apart from lack of training in mental health, GPs in this study contend that the people with severe mental illness require a holistic type of treatment that is totally beyond them. Their role is restricted to monitor and treat physical illness, so they are reluctant to assess mental health needs. The police/courts additionally have no clinical psychiatric training to perform clinical psychiatric assessments for they only refer affected people to appropriate services.

Recruitment was a very time-consuming process and was the most difficult stage in the entire research process. The snowballing technique helped tremendously whereby information about potential participants was gathered. However, due to ethical restrictions, the information sheets were distributed to third parties, and the lack of replies was discouraging. All who assisted in this research signed a Confidentiality Agreement (see Appendix E) that consisted of a clause to not divulge any information sighted or heard of at any stage of this process.

### **Conclusion and Recommendations**

The issue of underutilisation of mental health services is a global problem, generally faced by minority people of colour in Western multicultural countries (Yorke, et al., 2016). Mental illness is the greatest contributor to the global disease burden placing pressures on carers and substantial demands on health systems. To reduce the rates of these untreated cases is to understand the complexities involved in the way these minorities' make decisions about accessing mental health services. This study has fulfilled the research objectives and answered the research question: *what are Tuvaluan people's perceptions about underutilisation of mental health services by Pacific people in NZ?* Most of the findings reiterated the literature review and a few were unforeseen.

## Solutions.

In the course of the discussions and interviews, the participants felt the need to express ideas of strategies to improve the situation of Pacific underutilisation. A consensus was established that health promotion education programs will productively improve the rates of use of mental health services. However, it was unanimously agreed that the contents of the teachings should be based on the pathway process and related barrier factors. They felt that the inclusion of the situation of mental health in the islands, including the belief systems relating to mental illness and its treatments would generate background information about the influence of cultural attitudes and behaviours when deciding mental health choices. This will promote the way of thinking that NZ is vastly different than the Islands because of the existence of available treatment facilities. A need to combine the different learning needs of migrants and the NZ-born was identified and addressed particularly in terms of teaching methods. The older and migrant participants prefer a health promotion style of teaching to incorporate community involvement and follow the successful previous Tuvaluan health promotional educational programs of workshops (cardiovascular diseases, rheumatism, diabetes and TB workshops). Other forms of educating the community that were suggested were via advertisements in the Tuvaluan/Pacific radio stations, leaflets and the internet such as *Facebook*.

The objective of this study was to describe Tuvaluan people's explanations of their own experiences of mental illness and accessing mental health services. This permits a closer insight into how Tuvaluans and Pacific peoples make sense of the issue as individuals, family members and community members and for those having worked in the field of mental health as clinicians or other health professionals. This data was gathered using a descriptive research methodology that is grounded in philosophical principles of a naturalistic paradigm. The aim was to get as close as possible to the participants' "facts", obtained from their experiences or non-experiences (as in the case of the community representatives) of the phenomenon under investigation. As a Pacific island ethnic group, the Tuvaluan participants living in NZ represented the voice of Pacific islanders for this study. For this reason, to gain as close as possible to accurate information, a *Tuvaluan research framework: Te Pa* accompanied the descriptive methodology to instil Tuvaluan values, cultural norms and protocols in the research process. Despite a

few controversies and problems encountered, the research methodology achieved its purpose and successfully produced answers to the research questions.

This research will contribute to the wellbeing of Pacific people in NZ and ethnic minorities in the global arena for it will initiate dialogue into homeland influences and promote further research around this phenomenon. The use of the pathway framework in this study was exceptionally advantageous for reasons identified throughout this thesis, however, more importantly, gaps in the literature, particularly in New Zealand regarding Pacific mental health.

### **Recommendations for Further Research**

This study has contributed to the evidence on which to base strategies to improve Pacific usage of mental health services in NZ. However, there are many questions that remain unanswered. This section includes recommendations for further research that are drawn from the findings of this study:

- First and foremost, the usefulness of the pathway framework in guiding this study is important, for as a tool, it discovered gaps in the literature. For instance, symptom identification, help-seeking and accessing mental health services were identified as problems faced by Pacific and other minorities whatever the contextual circumstances. Yet, few studies have applied this framework in research designs, which is unfortunate for its application would have exposed major hidden elements that this research was able to locate through this framework. An excellent illustration is the state of mental health systems in the Pacific, and other migrant homelands in the international arena depicted in the literature review. The pathway framework as a research tool would have located the absence, inefficiency and high numbers of untreated cases. Hence, this study has extracted the crucial need for research into the state of these homelands that are deprived of efficient mental health systems to replicate this study to confirm this study's finding that homeland influences are an important factor that contributes to underutilisation rates in host countries. This study may be the first that has used the pathway framework in the NZ context, and its value is substantial as addressed in the findings. However, it is a small-scale study, therefore more research is required for Maori and other Pacific ethnicities, as well as the growing Asian population in NZ.
- Studying the pathways to the use of mental health services for youth, with a focus on ways of symptom identification and help seeking behaviours, would be

beneficial. The lack of studies of mental health of young people in NZ is a major concern, particularly for Pacific youth.

- Additionally, the study findings recommended health promotion education programs and measures as a solution to increase the mental health literacy of Pacific people, and reduce the stigma associated with lack of knowledge. An evaluative study of these educational interventions pre- and post- intervention would be beneficial to assess the efficiency of these interventions. The suggestion is to examine, not merely the level of literacy achieved, but whether these initiatives translate in improvements of utilisation rates of mental health services by Pacific people.
- Pacific mental health providers were developed for the sole purpose of attracting Pacific people to access and use treatment services. However, it seems that these providers have not been evaluated to establish whether outcomes were achieved. The findings also revealed that heavy caseloads for these providers result in the rushed discharge process of patients to the “streets” due to lack of space which is a critical concern that needs investigation. Evaluative research should also target mainstream mental health service providers in relation to the Pacific pathway to using their services, and their processes of interactions with Pacific families and the problems encountered dealing with Pacific clients.
- Another key finding is the contrasting beliefs/attitudes/worldviews of the Pacific NZ-born and migrant participants. This calls for an investigation into the effects of Pacific cultural markers that have been defined as Pacific cultural competent standards to abide when working with Pacific clients. But do these standards apply to Pacific NZ-born people who have lived most of their lives in NZ and have never been to the Pacific islands? Further research regarding this issue is highly recommended.
- A further recommendation is the inclusion of the topic of mental health within the secondary school education health curriculum to increase awareness and improve knowledge of mental illness and its treatments by youth

### **Lessons from Methodological Issues.**

When investigating sensitive issues such as mental health, TB and sexual topics that are taboo topics of discussion in Pacific island communities, it is a daunting task to gather support and interest from Pacific communities. In this study it was difficult to recruit participants such as those directly involved as mental

health consumers and, their relatives. The relatives acted as gatekeepers to undermine access to mental health consumers despite assurances of confidentiality. A recommendation for future research is to seek participants from health services to gain direct access to mental health consumers rather than via snow-balling techniques. Other types of participants such as mental health professionals and relatives would be easier to recruit this way as well. Gaining consent and ethics approval from the health boards and specific mental health services is worthwhile and easier than applying the time-consuming recruitment methods such as snowballing techniques.

### **Concluding Thoughts**

This study has made a robust contribution to Tuvaluan, Pacific, NZ and global knowledge about the low use of mental health services by Tuvaluans, Pacific and minority peoples in NZ and other western multicultural societies. By far, the most significant finding was the importance of homeland influences as significant explanatory factors of Tuvaluans, Pacific and minority people's underutilisation of mental health services, which was sparsely depicted in the literature. This could explain why this Pacific mental health issue remains an ongoing problem. The concept of apathy was noted as overwhelmingly influenced by lack of knowledge of mental health aspects, in addition to the adverse outcomes of involuntary hospitalisation and forensic incarcerations. The degree of lack of mental health literacy was unexpectedly high and predominantly widespread amongst Tuvaluans. For instance, the participants presumed that it was unnecessary to have the capacity and/or even the right to know facets of mental illness, its treatment, where the services are located and its entry process. The expressed assumption is that this knowledge is reserved for the experts only. However, it must be acknowledged that a multitude of factors that are interrelated are all important influences on the course of actions that either initiate or deter minority people from accessing mental health services. Hence, proposed solutions targeted this knowledge gap and the overall perception is that the health promotional education initiative is the answer to the problem.

This investigation into a Pacific mental health issue has been a positive journey for the author. It must be noted that even though ethnic Tuvaluans were the researched participants, their perceptions can be viewed as representing the voices of Pacific people in NZ. The research process required many alterations as new



ideas and thinking evolved during the study. The choice of this topic of underutilisation of mental health services by Pacific people in NZ was a difficult decision that was selected from countless other Pacific mental health issues to research.

The value of this study was summarised by one of the participant's evaluation of this issue, that even if effective treatment provisions are freely and numerous available, these could be useless if people choose not to or are unable to receive treatment. This philosophy clearly summaries the usefulness of this study, for this Pacific mental health problem is and was not just about the existence of political, social, and economic influences or other structural dynamics. It encompasses people's choices, and this study helped to gain a closer understanding of the ecological determining factors, many hidden and subtle, that led to Tuvaluans' people's mental health behavioural decisions around the utilisation of mental health services.

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## Appendices

### *Appendix A: Ethical Approval*



### AUTEC SECRETARIAT

18 February 2015

Janice Paterson

Faculty of Health and Environmental Sciences

Dear Janice

**Re Ethics Application: 14/395 Tuvaluan/Pacific perceptions of utilisation of mental health services in 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 17 February 2018. As part of the ethics approval process, you are required to submit the following to

AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 17 February 2018;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 17 February 2018 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research

undertaken under this approval occurs within the parameters outlined in the approved application.

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

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

All the very best with your research,



Kate O'Connor

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Sarai Tufala [sartuf@xtra.co.nz](mailto:sartuf@xtra.co.nz)

Auckland University of Technology Ethics Committee

WA505F Level 5 WA Building City Campus Private Bag 92006 Auckland 1142 Ph:  
+64-9-921-9999 ext 8316 email [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz)

*Appendix B: Participant Information Sheet*

6 September 2014

Project Title: Tuvaluan/Pacific views about the use of mental health services in New Zealand.

Researcher: Sarai Tufala

Supervisors: Professor Janis Paterson, Dr. El Shadan Tautolo.

Talofa

My name is Sarai Tufala. I am a student at Auckland University of Technology (AUT). I am looked after by Professor Janis Paterson and Dr. El Shadan Tautolo. I am a Tuvaluan, from the island of Nukufetau (my dad is Elisaia Teafiula) and Funafuti (my mother is Suria Elisaia). If I complete this study, it will mean I will be able to pass the qualification, Doctor of Philosophy (Ph.D.). You are invited to take part in this study.

*What is the reason for this research?*

This research will try and find out information about the low use of mental health services in New Zealand by Pacific people. Tuvaluan people's ideas will be used to get this information.

*How did you pick me and why am I being invited to be part of this research?*

Someone that you know has passed this Information Sheet to you. If you would like more information, or would like to be part of the study, please get in touch with me.

*What will happen in this research?*

There will be 3 different meetings:

- For only 6 family members of people who suffer from mental illness.
- Another group of 6 Tuvaluan elders.
- Another group of 6 people who have or had mental health jobs.
- The last group will be of 6 people who suffer from mental illness who will be interviewed on their own.

Also, 2 family members, 2 Tuvaluan community members, and 2 people who are mental health workers will also be interviewed individually. So, there will be 3 meetings and 12 people will be interviewed. The group meetings will be in a church hall and all the interviews will be in a *Café*. Each focus group will last at least an hour while each interview will be about 45 minutes to an hour long. I will do all the group discussions and the interviews, as well as work with the information that you provide. All the meetings and interviews will be taped, but only if you all agree to this.

*What are the problems that might happen?*

I know that mental illness is a hard topic that Tuvaluans do not like to talk about, especially in a group. Another problem is that mental health workers may be too scared to speak about what is happening to at their work or relatives and people who have mental illness may be too scared too to speak about their community support workers, or of the residence or hospital they are in, or of their relatives. The same with the relatives may be scared to speak too bad about their relative, or the way these relatives are cared or receive treatment.

*How will these discomforts and risks be alleviated?*

It is important to know that your name will not be known, because a number will be used instead of your name. Also, the information you give will not show that it is from you. Everyone must try and speak in the meetings without feeling embarrassed, and it is good that the groups are divided into different types of people, 1 group for relatives only, 1 group for only community leaders and one group for only mental health workers. The interviews will be just one person and the researcher, so no one else will know what you say. All the information will be locked in a cupboard for 6 years and destroyed too after this time.

*Why is this research good?*

This study will bring a lot of good things for Pacific people and Tuvaluans too because it will help us understand the problem of why Pacific people and Tuvaluans do not go for help to fix their mental illness, or for their family members. It will also help us understand mental illness better. It will also mean I can finish my doctorate study and get my qualification.

*How is my name and information protected from being known?*

No names will be used. The data will be seen only by me. I am also the only person that will work with the data, but if I need someone to help me, or if my supervisors want to check the information, they will have to sign a form too, to make sure they would not tell anyone about who you are, or any of the other people who take part in the study. You can leave the study and remove the information you give at any time without giving an explanation, even up to the time it is completed. The information will be stored with the Consent Forms. The tapes will be locked in a different place from the information, to make it harder for people to know it is you and your information. The information and the tapes will be destroyed at the end of 6 years. But because of the small Tuvaluan population in Auckland, we can be totally certain that you and the information you provide will not be known by others.

*What are the costs of being in this research?*

The costs to be part of this research will be your time, and transport to and from the focus group meeting or interview.

*When do you want me to decide whether to be part of this research?*

An estimated time to think carefully about being part of this study is at least 1 to 2 weeks, and ring or email me of your decision. My phone numbers and email address are shown below.

*How do I agree to participate in this research?*

The Consent Form is signed as evidence that you have agree to take part in this research.

*Will you give me the results of this research?*

The research report will be given to each person who took part in the research.

*What do I do if I have a problem about this research?*

If you want to know more about what this project is about, or you have a problem with it, then please email or ring the researcher Sarai Tufala, [sartuf@xtra.co.nz](mailto:sartuf@xtra.co.nz), 011 64 0272383839, and/or the Primary Supervisor: Professor Janis Paterson, [janis.paterson@aut.ac.nz](mailto:janis.paterson@aut.ac.nz).

But if you want to know more about the way the research will be done, or have a problem with how it will be done, then ring or email the Executive Secretary of AUTECH, Kate O'Connor, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz), 921 9999 ext. 6038.

*Whom do I contact for further information about this research?*

If you want more information regarding this research, feel free to contact us on the following contact details: Researcher: Sarai Tufala, [sartuf@xtra.co.nz](mailto:sartuf@xtra.co.nz), or the Primary Supervisor: **Janis Paterson**, [janis.paterson@aut.ac.nz](mailto:janis.paterson@aut.ac.nz).

Approved by the Auckland University of Technology Ethics Committee on 18/02/15  
AUTECH Reference number 14/395

*Appendix C: Consent Form*



28 September 2014

*Project title:* Pacific perceptions of underutilisation, late presentation, and longer hospital stay in New Zealand mental health services: The Tuvaluan people's perceptions and experiences of mental health services in New Zealand.

*Project Supervisor:* Professor Janis Paterson ([janis.paterson@aut.ac.nz](mailto:janis.paterson@aut.ac.nz))

*Researcher:* Sarai Tufala (011 64 0272383839, [sartuf@xtra.co.nz](mailto:sartuf@xtra.co.nz))

- I have read and understood the information provided about this research project in the Information Sheet.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I have been assured that anonymity of my identity and confidentiality of my data is secured.
- I agree to take part in this research by participating in the focus groups and/or to be interviewed.
- I understand and agree that I will not talk about what is said in the focus group or divulge the identity of fellow participants.



- I wish to receive a copy of the report from the research (please tick one):

Yes ☐No ☐

Participant's Signature:

Date :

Participant's Name Printed:

Participant's Contact Details (if appropriate):

**Approved by the Auckland University of Technology Ethics Committee on  
18/02/15 AUTEK Reference number 14/395**

Note: The Participant should retain a copy of this form

*Appendix D: Participant Demographic & Characteristics Sheet*Participant Demographic & Characteristics Sheet**Demographic Details**

NAME: \_\_\_\_\_ Female:    or    Male:    (Please tick)

Age: \_\_\_\_\_

Suburb/City you live in \_\_\_\_\_

Employment: \_\_\_\_\_ Income: \_\_\_\_\_

Married? Yes:                      No:                      (Please tick)

Highest Qualification? \_\_\_\_\_

**Other Details:**

Are you a:

CONSUMER?\_\_\_ Diagnosis? \_\_\_\_\_ When?

\_\_\_\_\_

Are you with a mental health service? \_\_\_\_\_ (Name if yes)

RELATIVE? \_\_\_\_\_

Is it your child?    Brother?    Sister?    Parent?    Other? (please tick)

If other, please specify.....

TUVALUAN COMMUNITY MEMBER? \_\_\_\_\_

MENTAL HEALTH WORKER? \_\_\_\_\_

Job status \_\_\_\_\_

What organisation do you work for? \_\_\_\_\_

ARE YOU NZ-BORN? \_\_\_\_ Or A MIGRANT ..... FROM TUVALU? \_\_\_\_

How long have you lived in NZ? \_\_\_\_\_ (Years)

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*Appendix E: Confidentiality Agreement Form*



**Research Title:** Tuvaluan/Pacific views about the use of mental health services in New Zealand.

**Researcher:** Sarai Tufala

**Confidentiality Agreement**

I, ..... Will keep the confidentiality of the research data and other materials that I will encounter during the transcription process, or any of my dealings with the researcher, and research process.

Signature: ----- Date: -----

