Ruby Tuesday

SOSO'O LE FAU I LE FAU: AN APPRECIATIVE INQUIRY INTO PACIFIC MENTAL HEALTH PRACTICE AND ITS POTENTIAL CONTRIBUTIONS TO MAINSTREAM, PUBLIC MENTAL HEALTH POLICY IN AOTEAROA

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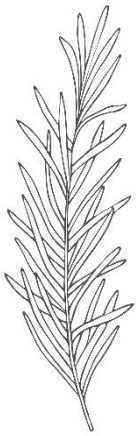
Faculty of Health and Environmental Sciences, School of Public Health and Interdisciplinary Studies

A thesis submitted to Auckland University of Technology in fulfilment of the requirements for the degree of Doctor of Philosophy

This thesis is dedicated to the memory of my beloved Nana, Jean Cora Mulholland (née Malcolm).

1928 – 2013



Abstract

This thesis – *Soso'o le fau i le fau: An Appreciative Inquiry into Pacific Mental Health Practice and its Potential Contributions to Mainstream, Public Mental Health Policy in Aotearoa* – explores the topic of strength and success in Pacific mental health (MH) practice in Aotearoa/New Zealand, particularly in terms of how this strength and success might inform and improve mainstream (non-ethnic-specific), public MH policy. It aims to support the development of mainstream, public MH policy that values, affirms, and acknowledges the strength and success of Pacific MH practice, and that recognises and acts on the potential of Pacific approaches to MH to support the wellbeing of diverse New Zealand communities. This aim is pursued in response to ongoing discrimination against Pacific peoples and their values, understandings, and approaches (both generally and in health policy spaces), and to a "national MH crisis" in Aotearoa that is disproportionately impacting Pacific peoples. Talanoa – guided by the values associated with the Kakala Framework and the positive principles of Appreciative Inquiry - were undertaken with 33 Pacific MH practitioners (PMHP), service managers/leaders (PMHSM), Tāngata Whai Ora (TWO, MH service users) and family of TWO. During these talanoa the successes of PMHP and PMHSM were explored, alongside the strengths that informed and supported these. Participants shared that PMHSM and PMHP have been successful in a wide variety of ways, providing care that focusses on healing and on addressing the root causes of distress; that strengthens families and communities; that integrates different approaches to care in innovative and responsive ways; that meets wider health, relational, spiritual, and socioeconomic needs; that is culturally affirming; and that ensures TWO feel seen, valued, and genuinely loved. They also reflected that PMHP and PMHSM were particularly successful in creating work environments where staff felt safe, supported, and cared for. Underpinning and shaping these successes was the concept of Vā, and the spiritually resonant, relational onto-, axio-, and epistemological position that it expresses. The talanoa then explored participant views on what mainstream, public MH policy would

look like if it valued, affirmed, and acknowledged both these successes, and the Vā as the strength behind them. Participant responses from this part of the talanoa were woven together into a collective vision for an inspiring and accessible policy, grounded in and nourished by the values, understandings and approaches indigenous to Aotearoa and the wider South Pacific. This vision includes a range of strategies and actions that participants recommended and that would help overcome entrenched workforce development and contracting issues; support a more transparent and accountable MH system; nurture cultural, community, and service user leadership; and contribute to the development of cost effective and innovative approaches to providing mental health care that actively empower TWO, families, and communities. Through this vision, the enormous potential of policy that values, affirms, and acknowledges the strength and success of Pacific mental health practice becomes clear, enabling this thesis to highlight the innumerable benefits that might be enjoyed by all New Zealand communities should such a policy be realised.

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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 used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), 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.

Ruby Tuesday

25/08/2023

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Let us come into his presence with thanksgiving; let us make a joyful noise to him with songs of praise! – Psalm 95:2

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Ethics Approval

Ethics Approval for this research was granted by the Auckland University of Technology Ethics Committee (AUTEC) on 21/08/2019, application number 19/240. Further detail will be provided in Section 3.3.1 of the thesis.

1.0 Introduction

1.1 Research Topic, Questions, and Aim

This thesis – *Soso'o le fau i le fau: An Appreciative Inquiry into Pacific Mental Health Practice and its Potential Contributions to Mainstream, Public Mental Health Policy in Aotearoa* – explores the topic of strength and success in Pacific mental health (MH) practice in Aotearoa/New Zealand, particularly in terms of how this strength and success might inform and improve mainstream (non-ethnic-specific), public MH policy. It aims to support the development of mainstream, public MH policy that values, affirms, and acknowledges the strength and success of Pacific MH practice, and that recognises and acts on the potential of Pacific approaches to MH to support the wellbeing of diverse New Zealand communities.

This aim was pursued through the blending of the Appreciative Inquiry (AI) process (1-3) and the Kakala Research Framework (4) (see Section 2.2.2). Two sets of strengths-focused research questions were asked, each aligned with the Discover and Dream stages of the AI 4-D cycle (1-3):

> ***Discover:*** *What has been successful in Pacific MH practice in Aotearoa/New Zealand? What are the unique strengths of Pacific MH practice that have empowered this success?*
>
> ***Dream:*** *What might mainstream, public MH policy in Aotearoa/New Zealand look like if these strengths and successes were valued, acknowledged, and affirmed? What potential does such policy show to support the MH of all New Zealand communities? What results might such policy achieve and what differences might we see?*

These questions sought to first determine what strong, successful Pacific MH practice looks like, before moving on to consider what opportunities for positive change exist through the recognition of said strength and success in mainstream, public, MH policy.

1.2 Context and Rationale

Pacific peoples have always been a vital part of Aotearoa. Migration from throughout the Pacific Islands (Samoa, Tonga, the Cook Islands, Fiji, Niue, Tuvalu, Tokelau, Kiribati, Hawai'i, Rotuma and a range of other islands/island groups) to Aotearoa has been taking place for the past 800-1000 years (5-7), with a dramatic increase occurring in the 1950s, 1960s, and 1970s (6, 8-10). The increase in the Pacific population of Aotearoa at this time supported the growth of the nation's manufacturing and agricultural sectors, as well as making significant contributions to forestry, healthcare, and domestic sectors (6, 10). Many of the migrants from this period settled permanently in New Zealand, and many more have joined in subsequent years, so Pacific peoples now constitute a significant percentage (8.1%) of the New Zealand population (11). This 8.1% percent of the population is culturally, ethnically, linguistically - and in many other ways – diverse, young, and plays a significant role in all aspects of New Zealand life, making enormous contributions to politics, economics, academia, sport, and the arts and culture scene (7-9, 12-20). Beyond all of this, Pacific peoples contribute enormously to the social world of Aotearoa, as citizens, family members, friends, and colleagues; Pacific peoples are an integral part of the fabric of everyday life in Aotearoa.

Despite their significant and ongoing contributions to Aotearoa, Pacific peoples experience significant discrimination at both a personal and a systemic level. New Zealanders show strong biases against Pacific peoples, with one 2013 report highlighting only 11% of New Zealanders believe Pacific

peoples are good for the economy, 50% that there are "too many" Pacific migrants in New Zealand, and 62% that Pacific migrants increase crime rates (higher than any other group by well over 30%) (21). These attitudes are not new. Historically, Pacific peoples have been subjected to discriminatory migration laws, racial profiling, violent police tactics, harassment/abuse in the street, derogatory advertisements and political campaigns, and language suppression, as well as facing discrimination when attempting to access housing, participate in education, and engage in employment (22-25). This discrimination has been driven, in many cases, by a long-held, underlying Western colonial belief in the inferiority of Pacific peoples and societies, and by the ensuing construction of Pacific societies as "behind" and of Pacific peoples as ignorant, stupid, uncivilised, and innately incapable of intellectual activity (26). These pernicious constructions have persisted through the attitudes and institutions of Western colonial governments and societies, and, in following, Pacific peoples continue to face overt personal and systemic discrimination in public, at school and work, and when accessing health and social services (18, 20, 27-33).

This persistent discrimination contributes to range of negative outcomes for Pacific peoples. For example, Pacific ethnicity is persistently associated with poor health, social, and economic outcomes; even when accounting for other variables, Pacific peoples are paid significantly less than Pākehā, have lower rates of home ownership and are more likely to live in inadequate housing, experience higher rates of disability, higher rates of preventable illness and co/multi-morbidity of conditions, have a lower-life expectancy, and experience lower levels of educational attainment (8, 32, 34-42). Strong links have been made between these inequitable outcomes and aspects of discrimination such as: negative biases amongst service staff, employers, and landlords; the lack of cultural understanding and competency demonstrated in health, education, and social service environments; and the failure of mainstream health, education, and social services to operate in a way that acknowledges and accommodates Pacific lifestyles and lifestyle pressures (6, 20, 23, 27, 30-

33, 37, 43-50). Exacerbating these negative impacts is the fact that, when Pacific peoples do seek to affect change in and through the mechanisms considered appropriate by Western colonial institutions (e.g. through participation in democratic systems, in governance or in policy development, or through the production of critical academic research), biases against them and their ways of knowing and doing often result in the marginalisation of their contributions/efforts, with said contributions being dismissed as unscientific/lacking rigour, too complex or time consuming, or relevant only to a small fraction of the population (4, 44, 51-59).

Interwoven with this history of inequity and marginalisation is what has widely and repeatedly been referred to as a national MH crisis; the 2006 MH Survey - *Te Rau Hinengaro* (60) - indicated a full 20% of New Zealanders will experience mental illness in a given 12-month period. This proportion does not appear to have improved over time, with recent research indicating the figure is now closer to 28% (61). The impacts of widespread mental illness and distress in Aotearoa are significant. Not only does serious mental illness cost the state 12 billion dollars (5% of GDP) per year, but it costs each of those experiencing it an average 25 years of life (62). In light of what has already been shared, it is unsurprising that Pacific peoples are experiencing significantly worse MH outcomes (19, 63-68). *Te Rau Hinengaro* (60, 63-65) indicated both that 25% of Pacific peoples will experience mental illness in a given 12-month period, and that the figure increases to 33% amongst young Pacific peoples. As with the rest of Aotearoa, this situation appears to have worsened. The 2015 New Zealand MH Monitor Survey found Pacific adults were experiencing at least medium psychological distress at a rate of 28.4% (compared to 17.7% overall) (69) and a 2022 study undertaken by Le Va found that "*Mental health is the biggest area of concern for Pasifika people*" in terms of their overall health and wellbeing (70). Furthermore, Pacific youth reported experiencing depression (25%), anxiety (50%), low mood (41%), and thoughts of suicide (26%) at significantly higher rates than their European peers (20%, 38%, 36%, 18% respectively), and making suicide attempts at nearly four times the rate (11.7% v 3.2%) (71).

Pacific peoples also face significant barriers to accessing MH services and receive support at a much lower rate than they experience poor MH (33, 45, 63-65, 68, 72-74).

My particular line of Inquiry was inspired by the recognition of the context and issues detailed above, and by the awarding of the National Suicide Prevention contract to Le Va in 2017[1]. At this time, Le Va had been delivering a suicide prevention programme designed for Pacific peoples for two years (75). This programme – *FLO Talanoa* – was co-created alongside Pacific communities, and is grounded in Pacific values, understandings, and approaches to MH. It had been highly successful, and Le Va proposed and were offered a contract to deliver a *national* mainstream suicide prevention training programme both rooted in Pacific values, knowledge, and approaches to MH *and* able to meet the needs of New Zealand's diverse populations. The programme is now successfully being delivered under the name *LifeKeepers* (76). The awarding of the National Suicide Prevention contract to Le Va constitutes a rare example of a government ministry openly acknowledging that a Pacific-led programme might not only be relevant to and successful amongst Pacific peoples, but also amongst diverse New Zealand communities. This ignited a spark, a hope the time might be right to highlight the immense potential of a wider array of Pacific values, understandings, and approaches to MH, and so, in 2017 I began preparing for this project.

In 2018, the flames of this hope were fanned. Aotearoa was criticised by the United Nations for its "insufficiently responsive" MH services (77), and - in response to both this and a growing awareness of the aforementioned state of crisis - a nationwide Inquiry into MH and Addiction was launched (78). This Inquiry was completed later that year *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction* (62) (henceforth HAO) was published. Broadly speaking, *HAO*

[1] Le Va are the national Pacific mental health workforce development organisation and a community education NGO for whom I worked between 2017 and 2021.

(62) reported that national MH policy – and the MH system it coordinates – have not been working well for anyone, including Pacific peoples. It described how…

> *"New Zealanders of diverse backgrounds asked for a more values-based and holistic approach to promoting the wellbeing of individuals, families, and communities" (62)*

and expressed that…

> *"..many dimensions of the aspirations of Māori and Pacific peoples, especially the call for a holistic approach, point the way for all New Zealanders." (62)*

These findings reinforced the significance of my chosen topic and its timeliness. *HAO* (62) affirmed that systemic discrimination and the exclusion of Pacific values, understandings and approaches to MH were having a negative impact on outcomes for Pacific peoples and gestured towards an emerging recognition of the value of Pacific understandings and approaches to MH, of a growing openness to their potential benefits for diverse New Zealand communities. Furthermore, *HAO* (62) made forty recommendations (of which 38 were accepted in principle (79)), and - alongside *New Visions: Collective Solutions* (72) (the Pacific report on the MH Inquiry) and the subsequently released *He Ara Oranga Wellbeing Outcomes Framework* (80) – set out new aspirations for MH care in Aotearoa, painting a clear picture of what a strong, successful MH system in New Zealand could and should look like.

According to these documents (62, 72, 80), a strong, successful MH system is one that will support New Zealanders to "thrive together" by ensuring they are safe and nurtured; have what is needed; have their rights and dignity fully realised; experience healing, growth, and resilience; feel connected and valued; and have hope and purpose. The realisation of such a system would necessarily be supported by MH practice that:

- focuses on wholeness, healing, and holistic wellbeing.
- supports connectedness, spiritual wellbeing, physical wellbeing, and healthy relationships.
- is present to and empowers families and communities to care for each other.
- enables participation in and contribution to family and community.
- recognises and addresses the impact of cultural alienation and generational deprivation.
- affirms cultural identity and indigenous rights.
- embraces Māori and Pacific worldviews and modalities.
- is delivered with love, compassion, empathy, and relational mindfulness.
- meets people where they are.
- addresses the social and economic determinants of health.
- involves and nurtures ties to whānau/family.
- includes addiction, suicide prevention, disability, and other overlapping areas of health practice.
- addresses the root causes of distress, disorder, and anguish.

This is the definition of success used – in tandem with elements identified by participants –to guide my appreciation of "What has been successful in Pacific MH practice in Aotearoa/New Zealand?" throughout this thesis.

There is a clear need for action-oriented research to help overcome both the inequitable MH outcomes experienced by Pacific peoples and the discrimination against Pacific peoples and their values, understandings, and approaches, their ways of knowing and doing, both in general and at the level of governance and policy development. There is also a need for research that will support the realisation of the aspirations for the national MH system expressed through *HAO* (62), *New Visions: Collective Solutions* (72), and the *HAO Wellbeing Outcomes Framework* (80). Such research is needed *now* in order to nurture the growing recognition that working towards the former will support in

achieving the latter. The research for this thesis has been undertaken to order to help meet these needs.

1.3 Researcher Position

My name is Ruby Tuesday (née Ruth Mulholland). I undertake this research as a third generation Pākehā (of and strongly connected to her Gaelic heritage); a queer person in their mid-thirties; a dissenting-but-practising adult convert to Catholicism; an ethical socialist and believer in the return of lands and administrative control to indigenous populations; tangata whai ora (TWO)/a consumer of MH services (GAD, CPTSD); and a disabled person (ASD-1). I come from an academic background in religious and cultural studies – particularly exploring the intersection of Pākehā identity, modernity, and the role of religious imagery in New Zealand popular culture (81, 82) – and a professional background that includes research, alternative education, and community MH education. As such, I undertake this research wearing kaleidoscopic glasses, bringing many overlapping and intersecting lenses to bear on my thought.

This research has, on one level, been undertaken from an etic perspective; I am not of Pacific descent and have no *formal* ties (e.g., through marriage) to the Pacific community in Aotearoa. However, there is also an emic *element* to my work, and it has been undertaken in the context of close personal and professional relationships with Pacific people and communities; I genuinely love and am deeply grateful to the Pacific people and communities I am connected with and am committed to them in a way I take incredibly seriously. I recognise and acknowledge my own in-between-ness. I am not an insider, and I experience a wide range of privileges that come with being a member of the hegemonic ethno-cultural group, including the privileges that accompany whiteness and the choice to

"opt-out" of Pacific spaces should participation become too confronting or uncomfortable for me. However, I am also not a complete outsider. Pacific people – and their values, languages, issues, and achievements – constitute my everyday milieu, and I have strong relationships with and meaningful responsibilities to the Pacific people and communities in my life which both preclude my opting out and keep me accountable.

The in-between-ness mentioned above has influenced this research in a variety of ways. For example, I bring a strong pro-Pacific bias to my work and undertook the thesis fully expecting – based on my observations while working in the sector – to find Pacific MH practitioners (PMHP) and Pacific MH Service Managers and Leaders (PMHSM) were working in a variety of successful ways, and their practice would show strong potential to support the MH of diverse New Zealand communities. While such biases may be seen as a shortcoming, they supported me to avoid working in a way that perpetuates discrimination against Pacific peoples and their values, understandings, and approaches to MH, whilst also creating space for me to focus on the "why" and "how". Despite my strong positive regard for Pacific people, however, I am still Pākehā, and Pākehā norms and institutions constitute my cultural mother tongue. My research has also been impacted by all the complexities of translation; a thick Pākehā accent rests on my attempts to communicate about Pacific things and/or in Pacific ways, and my representations of Pacific values, understandings, and approaches have all been (re)shaped by an ingrained Pākehā syntax and lexicon.

My background as a MH consumer must also be considered as this has contributed significantly to both my choice of research topic and my interpretation of the data collected. My interactions with the MH system in Aotearoa/New Zealand echo a lot of what was shared in *HAO* (62); I have found - and continue to find - the system cold, dismissive, slow to respond, dehumanising, and ill equipped to address family harm, trauma, and complex needs. It is perhaps unsurprising that – while

working for Le Va - I found the warm, responsive, humanising, holistic, and family-focused practice of my Pacific colleagues to be both inspiring and intriguing. Seeing how they worked, I couldn't help but consider how much better things might have been for me (and others like me) if I had been treated the way they treated TWO. This thesis is personal and reflects both my negative experiences with New Zealand's MH system and my admiration for my colleagues.

The other lenses noted in the introduction to this section – such as my age, gender, sexuality, spiritual, and political views - are doubtlessly influential too. While there is not space within this statement to explore them all in depth, I hope my disclosure of the others supports the reader to better understand me and my voice within this work.

1.4 Exclusions

There are a number of relevant topics and/or perspectives that will not be included in this thesis. These exclusions have been driven by a number of factors including the limitations of the thesis format - particularly in terms of word count and sample size – and the limitations of the researcher, as a Pākehā and an individual with no clinical background. The time *period* in which data was collected (late 2019 – mid-late 2020, covering the *onset* of the COVID-19 pandemic and occurring prior the publication of the report on and response to the Health and Disability System Review (83-85)) has also played a role, primarily impacting the final two exclusions listed below. This thesis will not include:

- ethnic- and/or gender-specific insights.
- discussion of addiction and suicide prevention services as distinct areas of MH (with these instead being included through both the sample and the natural overlap between these domains and "mental health").

- clinical evaluation of my participants' contributions; I am not a clinician (as noted above), and furthermore – as will become evident throughout the thesis – evaluating Pacific approaches to MH through a strictly clinical lens (e.g., one grounded in a bio-medically led understanding of psychiatric medicine and/or clinical psychology) has often led to their devaluation and diminishment.
- discussion of the potential risks and shortcomings of Pacific approaches to mental health.
- consideration of policy and practice in the Pacific islands, or into the relationships between policy and practice in New Zealand and in the Pacific islands.
- discussion of COVID-19 and its impacts on both mental wellbeing and the delivery of MH care.
- discussion of MH services in terms of their coordination and form under the *new* health system entities - Te Whatu Ora / Health New Zealand and Te Aka Whai Ora / The Māori Health Authority – announced in response to the Health and Disability system review (83-85) (instead focussing on the District Health Board-based system current from 2000 – 2022 (86-88)).

1.5 Overview and Structure of the thesis

The thesis will begin with a literature review, exploring four key topics as follows:

- Vā and the ethical frameworks, values, and understandings that underpin the Pacific worldview,
- Pacific (mental) health concepts and aetiologies,
- Pacific approaches to and aspirations for MH care, and
- Pacific exclusion from public MH policy.

The first two sections of the literature review provide the reader with a basic understanding of the Pacific worldview, as grounded in the concept of Vā, and of Pacific understandings of (mental) health and illness. This will support readers to contextualise the findings and a more informed and positive engagement therewith. The second two sections focus on cementing the rationale for this thesis. They position the findings of this thesis in terms of their relationship to existing literature regarding Pacific approaches to MH care and in terms of the public policy environment (pre- and post-*HAO* (62)). This is followed by a description of the underlying methodologies (Appreciative Inquiry (1-3) and the Kakala Research Framework (4)) and methods (Talanoa (89-95) and Appreciative Interviewing (1-3)) used in this thesis, and a reflection on their application and impacts on how the research was carried out.

The findings and discussion are then presented. Participant responses to the "Discover" question are explored first and five key areas of strength and success are discussed:

- Vā and Values Based Practice;
- Resistance and Persistence;
- Family Focus;
- Putting Tāngata Whai Ora First; and
- Leadership.

These findings highlight the positive impacts of the Pacific worldview and Pacific understandings of MH on Pacific MH practice and demonstrate how these find lived expression in approaches to caring for TWO.

From there the findings and discussion shift to focus on the "Dream" questions and present a vision for a mainstream public MH policy that values, acknowledges, and affirms the Pacific strengths

and successes presented in the “Discover” section. This includes suggestions for change at the level of the policy document itself, as well as recommended actions and strategies regarding:

- the development of Pacific leadership and services;
- changes to funding, contracting and evaluation;
- approaches to growing and supporting the workforce; and
- the implementation of more holistic, family-oriented Service Delivery Models (SDMs).

As this vision is woven together, numerous pathways to positive change are made visible and the positive potential of valuing, affirming, and acknowledging Pacific strength and success become more tangible and practically present. This vision is accompanied by a section reflecting on the efficacy of Pacific approaches to MH care amongst non-Pacific TWO and a section anticipating the positive changes that might be achieved through such a policy. These final two findings/discussion sections serve to highlight how such a policy would create benefits for all New Zealand over and above the many benefits to Pacific peoples.

The thesis then concludes with a reflection on its significance, of the contribution made to understandings of Pacific approaches to MH care and to contemporary and future discussions of public mainstream MH policy. Considerations of the thesis’ strengths and limitations as well as directions for future research and next steps are also presented at this point.

2.0 Literature Review

2.1 Vā and the Ethical Frameworks, Values, and Understandings that Underpin the Pacific Worldview

To appreciate Pacific success in MH - and the unique strengths that empower that success - it is necessary to develop an understanding of Vā. At its simplest, "Vā" simply means space. However, the Vā is not an empty space - an expanse or open area as is typical of Western conceptions of space - but rather, a space between people, places, things, and spiritual entities, connecting and holding these in relationship (96, 97). It is a space that is felt rather than seen, and is "imbued with energy, memory, history, essence, and interactions…a repository of what has been, what is, and what can be" (98). Vā also expresses a particular ontological, axiological, and epistemological position shared throughout the Pacific and central to the Pacific worldview. These positions are explored below.

2.1.1 Vā as Ontological Position

While I focus primarily on Samoan and Tongan representations of Vā (as these are the most available in English language literature), it should be noted this concept is present throughout the Pacific. Dr. Karlo Mila determined that Vā, as a concept, is present in more than 22 Austronesian languages (99)[2]. This recognition of co-understanding is echoed by others, such as Ka'ili (96), Airini et al. (57), and by Va'ai, who describes a range of culturally specific expressions of this shared emphasis on relationality and interconnection:

[2] Note that in this thesis I will be using the Samoan and Tongan spelling - Vā – as Samoan and Tongan sources have provided the bulk of my theoretical grounding.

> *"Cook Islands Maori speak of an embracing relational energy called piri'anga, referring to relevance, relationship, and connection. In Tokelau, relationality is va fealoaki and fakaaloalo, referring to sacred relationship, honour, and respect. In Fiji it is veiwekani, meaning relationship, community, respect, and harmony. In Niue it is vaha loto mahani mitaki, referring to maintaining good relationship and honouring the other in the community. In Samoa it is va and faaaloalo, referring to face-to-face reciprocity and respect of relational spaces. In Tuvalu it is va fakaaloalo and olaga fakatau fesoasoani, referring to respectful relationships and reciprocity. In Tonga it is faka'apa'apa and tauhi vä, referring to acknowledging and returning respect as well as keeping sacred relationships in harmony." (100)*

This fundamental emphasis on relationship has divine origins. In the indigenous Samoan worldview, this comes from an acknowledgement of the atua (god) Tagaloaalagi as the progenitor and common ancestor of all things on earth (101), that "*the environment, humans, the animate and inanimate – all natural life – [has] its source in the same divine origin, imbued with life force, interrelated, and genealogically connected"* (102). The Tongan indigenous reference also expresses a belief in common ancestors and divine co-heritance; *"In the tala tukufakaholo e fonua (oral tradition of the land), Tongans are descendants of Limu (seaweed) and Kele (mud clay), two natural elements of the homeland of Tonga…Within this tradition, all Tongans are connected genealogically to Tonga (their fonua) and to one another"* (96). Lived Tongan social structures echo this understanding, with vaha'a (a system of genealogically related titles and attendant hierarchy) being organised in terms of their connections back to the divine rulers of different Tongan dynasties (103). In 2023, Christianity dominates the spiritual landscape of the Pacific, however, these traditional cosmologies (with their emphasis on sacred co-heritance and interrelationship) still play an important role (100, 103, 104). There is a sympathetic and mutually reinforcing relationship between these traditional cosmologies and key aspects of the gospel message, which Va'ai (100) locates and expresses well:

> *"Because God is relational (or Trinitarian), relational life is another name for a Godly life. Where there is harmony of relationship, God is present… spirituality is not about living only 'for' God, as if God is found elsewhere. Rather, it is about living*

> *in mutual relationship with God through living in harmony with other humans, land, oceans, creatures, and ancestors." (100)*

Regardless of whether the relationships between people, their God(s), and their environment are understood as deriving from the indigenous Gods of the Pacific or from the Christian God, these connections highlight that all are family/kin, and that – by virtue of shared divine descent and co-heritance – that these family/kin relationships are inherently sacred. Vā, the spatial conception of these relationships, is also understood as an *innately sacred space*.

This innate, pervasive sacrality is expressed, in Samoan, through the concepts of Vā fealoaloa'i and Vā tapuia. Literally translating to "respectful space" and "sacred/tapu space", these terms respectively make a *"distinction between the social spaces that arise from the social organisation, and those spaces that stress the spiritual justifications for that social organisation"* (105).

> *"Within va fealoaloa'i (the relationships of mutual respect in socio-political and spiritual arrangements), there exists tapu and sa which define by way of linguistic, ritualised protocols and etiquette, how one ought to relate to the other. There exists such relationships (for example) between matai (titular heads of families and villages), between brothers and sisters. These relationships are va tapuia (relational arrangements which are especially sacred). " (106)*

Thus, while all relationships are sacred and require an attitude of respect, there are also, amongst these, some – such as *"relationships between parents and their children; ali'i (titular heads of families and villages), and tulafale (titular orators); matai (generic term for ali'i and tulafale) and families; matai and village; brothers and sisters; taulasea (traditional healers) and those under their care; people and their God/s"* (106) - which require the acknowledgement of/behavioural response to specific tapu[3] that uniquely express and honour this sacredness.

[3] "*Tapu* in its fundamental sense means, that which is forbidden to the ordinary. *Sa* has its nearest English equivalent in the word, sacred. It can also mean forbidden to something that is sacred. *Tapu* within relationships between people ensures that the human condition remains in a state of wellbeing." (106)

The quote above highlights the significance of the Vā tapuia between brothers and sisters, and between Matai, their villages, and the families in their care. The particularly tapu nature of these relationships gestures toward the centrality of family and home(land) - and of the relationships associated with these - in terms of locating and interpreting the Pacific ontological position. This centrality manifests through a pervasive emphasis on kāinga (Tonga), ʻāina (Hawai'i), kāinga (Māori) and aiga (Samoa). While often glossed as "family" or "land", they have a particular meaning in terms of the *relationship between family and land*:

> *"Kainga… is one of those concepts that changes in meaning as it moves across the Pacific. It can mean family, extended family group, and a family clan that is associated with a particular piece of land or dwelling…towards the Eastern islands, it means home itself…Kainga is about who and where we are intrinsically connected to, that place and those people we associate with ourselves…our families and where we belong…the places and people who nourish and feed us." (99)*

Thus, conceptually, kāinga draws attention to the spatial-locational aspects of family, and to the relational-genealogical aspects of place, referring to the lived/terrestrial embodiments of sacred genealogical connections between the two and the literal and metaphorical ground upon which Pacific understandings of "being-ness" and of "being-in-the-world" are built.

Meeting other people in Pacific contexts is thus ideally accompanied by an act of reciprocally sharing who one is related to and where one comes from. This process has been formalised in practices such as whakawhanaungatanga (Māori), fa'afeiloaiga and fa'atulima (Samoan), as well as fakafe'iloaki (Tongan), all of which are – as reflected by their linguistic components – practices whereby genealogical and geographical infromation is exchanged in order to identify connections and facilitate acknowledgment of ecah other *as family* (107-113). Establishing such connections serves to inform

others about one's identity and role, both generally, and *in the particular context in which the exchange takes place*. They help to map and delineate the sacred space between oneself and the others present, giving structure to the relationships, elucidating and strengthening connections in time and space, and bringing to the fore any of the more tapu/sa areas of the Vā that need to be considered.

The temporal aspect of connection to and through kāinga also requires further attention. Philosopher and former Samoan head of state, Tui Atua Tupua Tamasese Ta'isi Efi famously wrote:

> *"I am not an individual; I am an integral part of the cosmos. I share divinity with my ancestors, the land, the seas and the skies. I am not an individual, because I share a "tofi" (an inheritance) with my family, my village and my nation. I belong to my family and my family belongs to me. I belong to my village and my village belongs to me. I belong to my nation and my nation belongs to me. This is the essence of my sense of belonging."(114)*

Here he both reaffirms the divine origins of all life and highlights that, through this genealogy, one holds and shares an "inheritance", "birthright", or "(official) office" (tofi), with their family, village, and nation. This co-heritance binds all together in the present *and* in the past and future. When identity is understood genealogically – through kāinga, one's ancestors and home(land) - the past is lifted into the present, in and through one's being. Similarly, the future is drawn down through the understanding one will be part of the next generation's story. In the Samoan context this trans-temporal-collective-being-in-the-world can be expressed through the concept of tuātagata:

> *"When one uses the term tuātagata, the image of a face and ideas of fa'aaloalo emerge. Tuātagata, as an abbreviation for the phrase "o tua atu ole tagata" (tua meaning behind, thus behind a person) assumes that behind a person there are always the faces of his or her father, mother, extended family, village, land, sea, ancestral spirits and so forth." (115)*

When people share who they are related to and where they come from, they carry those people and places with them into the relational space. Any tapu or respect that those people command - and the relational spaces that their existence and histories inform - are also co-present. Relationships and actions in the present have effects that reflect and impact on the past and future. Even actions undertaken or experienced alone/by oneself are undertaken or experienced in relationship with the people, places, things, and spiritual entities of the past and future; when inhabiting the ontological position expressed as Vā, one is never *one*, but always one-in-relationship (116).

Vā then is *"a spatial way of conceiving the secular and spiritual dimensions of relationships and relational order, that facilitates both personal and collective well-being"* (Anae, 2007 cited in 57). It is "*the intricate and sacred ties between person and person, people and their environment, people and the cosmos, people and animal and plant life and people and their gods"* (102). It is *"…relationship, connection, space, distance, responsibility, obligation, state of being, position, standing, and so much more"* (Fanaafi Aiono Le Tagaloa cited in 99). It is a flexible and contextually specific space of relational connection. It is a repository of memory, of the people and places that have come before and that we carry with us. Vā is a uniquely Pacific ontological position, a way of understanding, expressing, and living out one's being-in-the-world *in and through one's being-with-others*.

2.1.2 Vā as Axiological Position

Vā, as an ontological position, also expresses a clear axiological and ethical position. Ontologically, Vā communicates an understanding of individual and collective life as innately sacred and as both being-in-relationship-with and relating-in-the-context-of. Axiologically/ethically, it expresses a demand to recognise the sacred in others and respond accordingly, to purposefully and

carefully maintain the relational space through appropriate language and behaviour, guided by relevant values (106, 117). Vā can – and should – be understood as an Ethics-with-a-capital-E. It is a distinct ethical framework, a system of values that can be used to reason which behaviours or courses of action will lead to the most moral outcome (as well as delineating what constitutes a moral outcome). In Samoan this axiological position, and the ethical framework it informs, is expressed through the imperative to teu and tausi le Vā. Teu le Vā means "'to *keep (for example, in the heart or in the mind) the space', to put away (in a safe place) the space, 'to look after the space', or to 'tidy up the space'"* (57), particularly after some kind of breach. Tausi le Vā refers more to the everyday maintenance/preservation of the space (but also connotes care, tending, and nurturance) (105, 118). The Tongan equivalent of these terms is tauhi Vā, which is understood in terms of *"…a commitment to sustain harmonious social relations with kin and kin-like members" with tauhi meaning "to take care, to tend, or to nurture" (96).* One can also soli le Vā (Samoan) - "trample" the relational space - damaging it by behaving disrespectfully/carelessly, without due awareness of and deference to the sacred nature of those present (118).

This need for respect and care brings us back to the notion of Vā fealoaloa'i -"respectful space". This term shares the same root as fa'aaloalo, "being respectful"; a core value in Samoan culture, and throughout the Pacific, appearing as faka'apa'apa (Tongan), fakalilifu (Niue), and fakaaloalo (Tokelau) as well. Fa'aaloalo - here used to represent these broader Pacific conceptions of respect - is reciprocal, evoking both communion between people and a mutual flow of care, goodwill, and positive regard:

> *"…the term fa'aaloalo (commonly translated to refer to the ideas of reciprocity, respect or communion) stems from the root word alo, meaning face…fa'aaloalo refers to two faces - two individuals, families, or communities - facing or meeting each other in the spirit of respect...A relationship of fa'aaloalo invites that one's way of acknowledging another life is by showing deference to that living being and to reciprocate what is good…wherever possible when meeting one another,*

> *individuals take responsibility for showing deference…The principle of fa'aaloalo invites one always to be mindful that when interacting with others, one must be concerned for the wellbeing of the other." (115)*

When being respectful in accordance with fa'aaloalo, the other person's dignity and wellbeing takes precedence over one's own. This is regardless of one's formal role or social status. In Pacific cultures, significant respect is shown to leaders/authority figures and there is a strong "upward" flow of respect. However, as highlighted, fa'aaloalo relationships are reciprocal, implying an expectation that the person in a higher structural position will also demonstrate respect for the those "under" them, placing their dignity and wellbeing at the centre of decision making and behaviour, so respect flows both up *and* down. Enacting fa'aaloalo in relationships thus requires loto maualalo (Samoa) or humility – loto fakatokilalo (Tonga), loto holoilalo (Niue), tā'aka'aka (Cook Islands) - all of which reflect "lowering" oneself, or having a "lowered" heart – another key value, separate from but integral to respect, and expressing the moral imperative to position oneself "below" others in relationship.

Together, fa'aaloalo and loto maualalo combine to engender a strong ethos of service in Pacific cultures.

> *"One of the most important values of the Fa'a Samoa, or the Samoan culture, is that of tautua or service (Apulu, 2010; Huffer & So'o, 2005; Tui Atua, 2007); tautua to your matai, tautua to your 'āiga, tautua to your nu'u, tautua to your atunu'u, and tautua to your lotu." (Seulupe Dr Falaniko Tominiko cited in 107)*

It is of particular note that tautua is understood as being both the pathway to a matai title in Samoan culture – *O le ala i le pule o le tautua* (the path to leadership is service) – *and* that the role of the matai is one of service, of guardianship and care for the families, villages, and land over which they govern (107), affirming the humility and reciprocal expectations of fa'aaloalo. In the traditional Samoan social context tautua is constituted by being responsive to the needs of one's matai and one's family, behaving in a way that preserves the family name, and practising traditional arts such as oratory (107).

This service ethos is naturally extended outwards – in recognition of the interconnectedness of all life – and is articulated outside of the traditional familial context as, for example, an imperative to serve the Pacific community as a whole, to provide warm hospitality to office guests, and/or to share resources and support with schoolmates, friends, or members of one's congregation (96). Such acts of service are a vital form of tausi le Vā, strengthening the connections between people and encouraging return gestures of kindness and solidarity.

Alongside and interconnected with the values of respect, humility, and service, is love; *Angai i te maruu i to'ou ngaakau, eka na roto mai te aro'a i ta'au ka rave* (Feed humility and love into your heart and it will emerge in your kindness). Love – Aro'a (Cook Island Māori), Aroha (Māori) Aloha (Hawai'i), Alofa (Samoa), 'Ofa (Tonga) – represents something slightly different in Pacific cultures and needs to be differentiated from "love" as it is generally used in English:

> *"[These words] translate not only as love, but as compassion, sympathy, and mercy…not only desire and affection, but also…sadness felt in pity and compassionate empathy…relating in ways that manifest love, grace, and altruistic kindness. Two proverbs from the Maori and Cook Islands…"Aroha mai, aroha atu" and "Aro'a atu, aro'a mai"…speak to the flow of love as being a mutually sustaining loop…love flowing out from us and love returning to us." (99)*

To illustrate this difference, it is perfectly acceptable to say to a Tongan acquaintance "'ofa atu" (love/kindness/warmth to you) when parting or even to end a professional email, whereas it would be unthinkable to say "I love you" to a Pākehā under the same circumstances. 'Ofa/alofa can also be understood as more of a familial love – brotherly or maternal/paternal – reflecting the warmth experienced and the kindness required by the recognition of genealogical interconnectedness, the acknowledgment of others as tuātagata, and by the way in which we *"see ourselves mirrored in the other"* (56).

The reciprocal understanding of respect and of alofa/'ofa provided above also highlight the importance of reciprocity, harmony, and balance to the Pacific axiological position. Mila defines the two root concepts which underpin Pacific conceptions of reciprocity – atu and mai (Tonga, Samoa, Tokelau, Māori, Cook Island) – as well as their subsequent combination, atamai (Tonga, Samoa, Tokelau, Māori, Tuvalu):

> *"Atu can be translated as what comes from you, flows from you, what goes from you into the va…[Mai is] What flows from others towards us? What are we on the receiving end of? What are they sending towards us into the va and why?...Atamai is the double-spiral, the cognitive/spiritual/emotional flow of what comes in towards you, how you process, interpret and give meaning to that internally, and how that informs and influences what comes from you into the va." (99)*

Atu, Mai, and Atamai express a need for constant mindfulness regarding what is flowing into and out of the Vā and how this flow affects the heart, mind, and spirit of those sharing in it. It also expresses a sense of balance and harmony; Mila (99) refers to a "double spiral" and elsewhere notes "*Vā is closely associated with balance and harmony in relationships and the natural order and aesthetic of human interconnections and relationships"* (Mila-Schaaf, 2006 cited in 57), a point echoed by other Pacific philosophers (114, 119). The apparent simplicity of atu, mai, and atamai belie a profound ethical imperative. Balance and harmony, as expressed through reciprocal flow, do not necessarily connote sameness and commensurability, nor do they necessitate contemporaneity of exchange (96). Atu, mai, and atamai are not "reciprocity" or "give-and-take" in the way Western thought might assume – they are not transactional nor prone to quantifiable measures of "equal exchange" – but rather, have connotations of giving the best one can as an expression of gratitude for the best one has been given.

The axiological position expressed by Vā – underpinned by the understanding of life as innately sacred and experienced both in-relationship-with and in-the-context-of – thus requires one

to demonstrate respect, to humble oneself and serve the needs of others, and to ensure everything which flows from oneself into the Vā, flows with love, respect, and deference to the needs of others, so it will uphold their dignity and wellbeing. This is what it means to teu ma tausi le Vā, this is the ethical demand embedded in the Vā as an ontological position. This is the Ethics of the Vā.

2.1.3 Vā as Epistemological Position

Building on the understanding of Vā as an ontological and axiological position, recent theory has also moved to explore Vā as an epistemological position, a way of explaining how knowledge is constructed and experienced by Pacific peoples. Much of this discussion has focused on differentiating the epistemological position expressed by Vā from those dominant in the Western academic institution, particularly those associated with the Western scientific tradition (such as bio-medicine). Western science makes claims to universality – ratified by repeatability, reproducibility, and replicability – and, in following, to singularity (26, 54, 100, 120). If, to be true, something must be universally and singularly true, then knowledge embedded in/dependant on specific contexts or other cultural paradigms cannot be "true" in the same way. Rather, such knowledge is viewed as contingent, and therefore invalid, irrelevant, or otherwise lesser. Scientific knowledge and its proponents also have a tendency toward right-wrong/either-or thinking and toward the prioritisation of "universal truths" over contextual "cultural" knowledges, and thus toward positioning the perceived categories of scientific and cultural knowledge as contradictory, oppositional, and mutually exclusive (26, 100, 120). Pacific knowledge and ways of knowing have often been belittled as a result of these claims and tendencies, particularly in medicalised fields such as health where "the privileging of biomedical Western evidence over Indigenous knowledge" (52) has repeatedly resulted in the marginalisation and exclusion of "unscientific" Pacific understandings and approaches (20, 26, 31, 52, 53).

A Vā-led approach to constructing knowledge is constructivist, dialogic, and contextual. It brings together the ontological and axiological position of the Vā to put forward a way of constructing knowledge that "move[s] away from the 'must be hermeneutics' shaped by a 'one truth ideology'" and gives "freedom and courage to the Pacific people not only to control their own lives but to…offer healthy and holistic alternatives"(100). Mila and Hudson (120) describe how Vā – drawing on the ontological and axiological position it expresses – can be understood as a space which exists and facilitates respectful and mutually deferential relationships between ideas and paradigms (echoing its representations of the relational space between people, places, and entities). This approach to knowledge and knowledge construction supports all to come together in goodwill to seek similarities, identify differences, generate creative energy, and participate in *"synthesising, balancing, and integrating"* (120) new understandings. It also requires *the context* of knowledge constructions to be taken into account, considering when, where, how, why, and by/for whom knowledge is being constructed in order to inform the evaluation and appreciation of that knowledge (120, 121). This is a radically different lens. Vā – through its prioritisation of relationship and context – supports the idea that truth is plural and that the validity of knowledge is negotiable, determined by its relevance to the space and time in which it is shared, the purpose for which ideas are brought together in relationship with each other, and the relationships between both these ideas and the parties that generated them (120, 121).

Additionally, as with all Vā relationships, respect and reciprocity are key; there must be a recognition of and respect for the power held by all parties/ideas, a willingness to connect, to give and take, to listen and speak, and a preparedness to move and be moved. There is a desire to be conciliatory and (re)conciliatory, to find a place of agreed meaning and understanding that acts over and above any desire to be right or to determine a universal or singular truth (120). The Vā as an

epistemological lens thus avoids the binary, either-or tendencies of Western scientific thought and resists the urge to position one idea or party as innately better or more valid than another and allowing for difference and multiplicity to exist and persist. Vā represents an inclusive epistemological position, neither eschewing the scientific nor diminishing the "cultural", instead operating to "mediate the polarity" (45) between Western scientific, bio-medical thought and Pacific knowledge traditions with respect for both.

2.2 Pacific (Mental) Health Concepts and Aetiology

Pacific understandings of (mental) health, (mental) illness and the factors contributing to these differ significantly from those that dominate contemporary mainstream MH settings (20, 31, 33, 62, 72-74, 122-125). The understandings most routinely deployed in such spaces tend to be grounded in bio-medical thought, positioning illness as a primarily physical issue that affects physical bodies, and health as the absence of such issues (74, 126). In New Zealand, mainstream MH settings tend to deal with the brain as a largely isolated organ, locating mental illness within the brain of an individual, and focussing almost exclusively on dysfunction of the brain and resulting issues (20, 31, 62, 72, 73, 106, 120, 122, 127-131). Within this understanding, MH is implicitly defined as the absence of such dysfunction/issues. The bio-medical approach to MH – or, more accurately, mental illness – is epitomised by the definition provided in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-V) (131):

> *"a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning." (131)*

The application of the bio-medical model to MH has been challenged on many fronts, and Western understandings of MH *are* slowly shifting towards a more bio-psycho-social model. For example, in 2023 the World Health Organisation (WHO) defined MH as:

> *"a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community." (132)*

Despite this shift, the bio-medical approach persists, supported by its relevance to and efficacy in physical health and by the ingrained systemic emphasis on the DSM as a guide for most processes regarding the assessment and diagnosis of mental illness (for example, the DSM is used by the Ministry of Health to code and collate information about mental illness (133) and underpins the clinical guidelines shared by the Royal Australian and New Zealand College of Psychiatrists (134)).

Echoing the relational, interconnected perspective expressed through the concept of Vā, Pacific understandings of health focus on the relationships between different domains of human experience and how these affect each other, the whole person, and the person-in-relationship. Numerous Pacific models of health belief exist – such as Dr. Pulotu-Endemann's Fonofale model (135), Kupa's Vaka Atafaga (136), and Tu'itahi's Fonua (137) – all reflecting a non-reductionist, unified view of health, wherein a complex nexus of related and interdependent parts all need to be both functioning well, and functioning well *together* in order for wellbeing to be maintained. The Fonofale model (135) is the best known of these:

Figure 1 - Fuimaono Dr. Karl Pulotu-Endemann's Fonofale Model

The Fonofale model (Figure 1) uses a fale (house) to represent the various components of wellbeing. While the model is derived from a Samoan context, the fale is a symbol easily recognisable to peoples from across the Pacific. The model was developed and is used to represent a shared, pan-Pacific understanding of health (135, 138). The pou (posts) of the fale are grounded in and stabilised by *family*. This evokes both the foundational role of the family in Pacific cultures, and the connection between family and (home)land (kāinga). The pou are supported by this foundation, extending upward to connect with *culture* (represented here by the roof). Much like the roof of a fale, culture is complex and *"dynamic… [including] the culture of New Zealand reared Pacific peoples as well as those Pacific people born and reared in their island homes" (138)*. When the various strands of culture are woven together tightly, into a strong, coherent sense of identity, they provide shelter and protection for the pou and the foundation. Each pou represents different aspects of health; spiritual, physical, mental, and other (e.g., gender and sexual health, socio-economic health, health as it relates to age/life-stage etc.). All of the elements of the fale are encompassed within a circle wherein the words "time", "environment", and "context" are inscribed, emphasising the impacts of the past, present, and future;

of the physical environment (natural as in kāinga/family and (home)land or otherwise); and of personal, social, political, economic, and legal contexts on health and wellbeing.

The Fonofale model brings to the fore three key components of Pacific health belief; these being *balance* and *relationship*. In order for the fale to stand, all elements must be in a state of balance; the floor must be level, the pou must be of similar strength and size, and the roof must be lashed squarely and evenly to them. They must also, however, be operating *in relationship*, all components must be positioned appropriately with regards to each other in physical relational space and must be providing reciprocal support, bearing weight, holding firm, or keeping the others dry in a way that reinforces/complements the other parts of the fale. All elements are necessary to the fale, they only make sense in the context of the fale, they impact and are impacted by each other, and they must function together in a balanced, reciprocal relationship to ensure the fale remains strong over time, able to withstand any changes in the environment. When considering Pacific health beliefs, one must thus think of mental health as (mental) health, necessary to and structurally integrated with health in general; just as the Pacific self is always one-in-relationship-with-others, the pou is always pou-in-relationship-with-other-components-of-the-fale, and MH is always mental-health-in-relationship-with-familial-cultural-physical-spiritual-socioeconomic-and-sexual-health.

The spiritual aspect of Vā is also of profound importance in Pacific health beliefs. As discussed, teu ma tausi le Vā is not only *important* in Pacific cultures but is a sacred acknowledgement of and response to a divinely inherited cosmological order. This cosmological order includes not only traditional atua, the Christian god, and ancestors as noted above, but also spirits linked to the environment, to specific families or villages, and to specific tapu, as well as the existence of spiritual other-worlds (102, 103, 106, 130, 136, 139-143). This spiritually resonant worldview informs aetiological beliefs that continue to shape Pacific peoples' understandings of how and why illness

occurs. For many Pacific peoples, a breakdown in health – particularly in the health of the mind, heart, and/or spirit – can be understood as having been caused by a breakdown or imbalance in the respectful and reciprocal relationships that nurture and maintain spiritual order. Depending on beliefs, cultural background, and upbringing, such breakdowns/imbalances may be understood as having been caused by disrespecting the Vā tapuia; through disrespecting a tapu specific to a place or entity; by failing to enact the duties and responsibilities which support the maintenance of balanced and reciprocal relationships; or through the loss or alteration of a fundamentally important relationship (73, 103, 106, 125, 128, 130, 136, 140-145). Even where the impacts of Christianity and contact with Western science and bio-medicine have had a significant impact, the breaking of tapu, failing to enact duties and responsibilities, and otherwise losing important relationships all still hold significant sway in terms of Pacific understandings of health, and of MH in particular. The importance of balance and relationship – along with the spiritual significance of these to (mental) health – is succinctly summarised by David Lui's Soifua Maloloina model (140) (Figure 2), which represent people, kāinga/family and (home)land, and god(s) in a perfectly balanced, connected, and flowing relational loop:

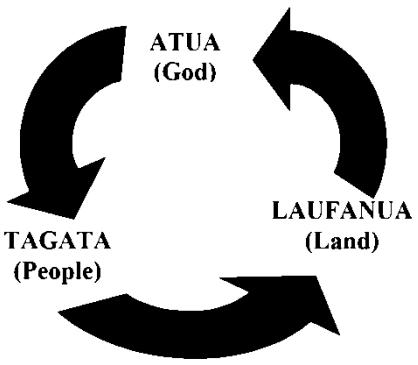


Figure 2 - David Lui's Soifua Maloloina Model

(Mental) health for Pacific peoples can thus be understood less as freedom from significant disturbances in cognition, emotional regulation, or behaviour, and more as a state of overall wellbeing wherein psycho-emotional and psycho-spiritual equilibrium can be maintained and enacted and

embodied in healthy, respectful, and reciprocal relationships with others, the environment, and the divine.

Before concluding this section, it should be noted Pacific models and bio-medical/bio-psycho-social models can – and do – coexist in the understandings of TWO, of MH practitioners, in some models of delivery, and in the work of some practitioners (72, 73, 106, 120, 128-130, 144, 146-155) (see Section 2.3.4). However, this coexistence is often uneasy and is biased against, disadvantages, or otherwise minimises/sidelines Pacific understandings. Professional ethics, organisational structures, models of delivery, approaches to measurement and evaluation, understandings of best practice etc. informed by bio-medical and bio-psycho-social models do not readily accommodate the Vā and Vā-informed models of health belief, nor their expressions (20, 31, 62, 72, 73, 106, 120, 122, 127-130). The persistent privileging of bio-medical models of MH has thus contributed to the development and perpetuation of a MH system that fails to engage with human beings as whole and relational beings, dissects human experience and excludes significant components of wellbeing and has consistently failed to meet the needs of Pacific peoples (as evidenced in Section 1.2).

2.3 Pacific Approaches to and Aspirations for Mental Health Care in Aotearoa

There exists a significant body of literature that describes Pacific values, understandings, and approaches to (mental) health in the New Zealand context. It has largely focused on answering two key questions:

- "What are Pacific understandings of and approaches to MH?", and
- "What would we need to see for services to be more appropriate for and responsive to Pacific peoples?"

This reflects an emphasis on explaining and justifying the contextual application of the Pacific onto-, axio-, and epistemological position in MH to a non-Pacific audience, necessary in response to both the discrimination against Pacific peoples (and their values, understandings, and approaches) *and* the inequitable MH outcomes experienced by Pacific peoples in New Zealand. This section of the literature review will thematically summarise this body of literature, outlining what is already known about Pacific approaches to MH care in the New Zealand context and the aspiration for culturally appropriate/responsive mental health care implicit in these. Note this section will not include policy documents that reflect aspirations for Pacific MH, as these will be discussed in Section 2.4.

2.3.1 Building and Maintaining Relationships

The Pacific approaches to MH care used and aspired toward in Aotearoa strongly emphasise the building of safe, trusting, respectful, and meaningful relationships with TWO (and, as discussed in Section 2.3.2, their families) (73, 74, 103, 106, 125, 129, 136, 139, 144, 146, 150, 151, 153, 154, 156-160). The literature discusses a number of factors necessary to/supportive of building and maintaining such relationships. The attitude of the MH practitioner is highlighted as particularly important, and it is noted that the MH worker needs to approach TWO with warmth, unconditional positive regard, as equals, and *"in the spirit of service, with humility…being non-judgmental, respectful, displaying compassion and flexibility…"* as *"these are attitudes that convey genuine interest and respect, thereby contributing to a meaningful relationship"* (158). Pacific approaches/approaches desired by Pacific peoples also ensure relationships are built in a gradual, round-about way, through plenty of informal conversation, the sharing of genealogical information and personal/family stories, and/or through socially-oriented home visits prior to formal appointments (74, 139, 158). This is necessary as it is inappropriate/rude in Pacific cultures to begin addressing sensitive issues before connections and a sense of trust have been established (57, 103, 144). The literature also reflects the importance of these

relationships being grounded in authentic and heartfelt care for TWO (72, 124, 144, 147, 154, 158, 159, 161), with one PMHP (Seiuli Dr. Byron Seiuli) discussing counselling as a mea'alofa - a gift or love offering (159, 160) and another (Karen Lupe) describing the importance of making connections through the heart/feeling centre (rather than through the brain/thinking centre) (154). The use of Pacific languages and ethnic-specific relational protocols; culturally appropriate communication styles; health literacy-led strategies for communication; explicit discussions of confidentiality and the provision of support beyond the parameters of one's role are also noted as strategies for building and maintaining safe, trusting, meaningful relationships in the delivery of MH care by/for Pacific peoples (68, 72-74, 103, 106, 128, 129, 147, 156, 158, 162-164).

2.3.2 Including and working with family

Recognising family as the foundation of wellbeing (135, 138), Pacific approaches aim to facilitate the direct involvement of family (immediate and extended) as a means of ensuring the consumer is surrounded by an informed and understanding support network, relevant relational issues (recognised as a key source of mental distress) can be identified and addressed, and communication between all involved parties can be effectively kept open (33, 73, 74, 106, 124, 125, 129, 136, 146, 150, 155, 165). The literature acknowledges there are times when TWO do not *want* family involvement/when family involvement is inappropriate (and emphasises this should be respected) (73, 128). Nevertheless, such involvement is still positioned as ideal, and, even when a direct relationship with the family is not possible, attention to familial relationships is still considered vital (73, 125, 128), supporting effective care through the mechanisms listed above. In addition to using the relationship building strategies identified above, Pacific approaches to MH - and the approaches Pacific peoples hope to see more of - also facilitate family involvement by:

- assessing the impact of TWO and their mental illness on the family, recognising when they may be overwhelmed, and providing information, support, and respite as necessary;
- appropriately enacting knowledge of relational tapu and/or seeking support from matua to navigate these;
- involving the family in treatment plans and maintaining open communication; and
- tailoring the approach, informed by an understanding that levels of connectedness, engagement with extended family, access to familial support, and attention to tapu and protocols will vary significantly across families (33, 72-74, 103, 125, 128, 129, 136, 146, 150, 166).

2.3.3 Overcoming stigma and discrimination

Pacific peoples experiencing mental illness often face "double discrimination" (167), dealing with both negative social attitudes towards mental illness *and* towards Pacific peoples. Further to this, many face stigma and discrimination from *within* their own communities due to the traditional association of mental illness with the breaking of tapu, and – in the case of younger and New Zealand born Pacific peoples – judgements related to linguistic and cultural shifts through migration (19, 74, 103, 123, 124, 147, 155, 156, 158, 161, 167-177). Pacific approaches to MH – as well as those that would more effectively meet the needs of Pacific peoples – acknowledge these experiences of stigma and discrimination, and in following, focus on nurturing the Vā, on reconnecting TWO with their families, communities, and wider society by creating inclusive environments, nurturing acceptance, and supporting social participation (notably supported by concurrent developments in the Pacific disability and youth health spaces) (72, 73, 125, 147, 155, 161, 171, 176, 178-187). In terms of the discrimination targeted towards those experiencing mental illness, the literature identifies a variety

of ways in which Pacific approaches to MH encourage communities to accept TWO, and TWO to accept themselves. For example:

- employing, empowering, and developing TWO in leadership roles;
- offering peer-support alongside clinician-led care;
- acknowledging TWO understandings of their mental illness and working with these;
- supporting TWO to take part in everyday tasks, community events, and family activities;
- empowering TWO to tell and share their stories in creative ways;
- providing welcoming, family-like environments;
- offering community education programmes and/or supporting families to better understand mental illness;
- developing and using positive, Pacific-language-based terminology; and, echoing Section 2.31
- offering love to and engaging in genuine, meaningful relationships with TWO (72, 73, 139, 146, 147, 155, 158, 161, 188-191).

These approaches have all been noted as strengthening feelings of acceptance and inspiring a sense of hope in TWO, connecting them to their communities, affirming their dignity and potential, and helping them to build a future filled with strong relationships and positive social contributions (72, 146, 147, 161, 188).

Pacific MH services – and the MH services desired by Pacific peoples – also work to nurture strong, positive, cultural identities, thus addressing the impacts of the internal and external discrimination noted above. The effective involvement of family, and the adoption of loving attitudes support this; family provides links to culture through genealogy and the sharing of cultural knowledge and practices, while demonstrations of love – from family and from others in the community – help

to mitigate experiences of tension and exclusion (114, 123, 125, 147, 155, 171). BP4P and ethnic-specific services have also been identified as important for nurturing cultural identity; for older and island-born Pacific peoples, such services acknowledge and affirm the values, beliefs, and understandings of MH they bring with them, while for younger and New Zealand born Pacific peoples these can – where offered flexibly and with awareness of complex/multiple cultural identities – provide opportunities to learn about and connect with such values, beliefs and understandings (72, 73, 125, 128, 130, 136, 146, 147, 150). Further to this demonstrating ethnic-specific and intercultural competency; supporting connections to church communities; facilitating participation in cultural activities; providing cultural mentoring; involving elders and community leaders in care; discussing and applying Pacific concepts in therapy; exploring and affirming genealogical ties; naming and exploring experiences of cultural in-betweenness; and destigmatising New Zealand born status and multi-ethnic identities by framing these as strengths have all been noted as means through which MH services and practitioners can contribute to positive MH outcomes by countering discrimination, and demonstrating acceptance (72, 120, 123, 125, 128, 139, 147, 155, 162, 171, 187, 192, 193).

2.3.4 Integrating the best of multiple worlds

Relevant to the idea of embracing cultural inbetweenness and of destigmatising complex ethno-cultural identities is the idea of integrating the best of multiple worlds. Section 2.1.3 described how the concept of Vā can act as an epistemological position that allows for the validity of knowledge to be determined by its relevance to context, purpose, and relationship (120, 121). The literature has identified this epistemological position as a key feature of Pacific approaches to MH and as a perspective that must be more widely adopted should non-Pacific services and practitioners wish to better meet Pacific peoples' MH needs (45, 72, 120, 146, 148, 151, 155, 158, 192). It highlights how Pacific MH services and practitioners often work in ways that aim to *integrate* the potential benefits

and advances offered by bio-medical, bio-psycho-social, and other approaches to MH with those informed by Pacific health beliefs and traditional practices. The focus on contextual relevance and on integration avoids replicating the exclusivist, "one truth ideology"(100) of Western science, with PMHP and TWO alike openly acknowledging:

- medication can be beneficial in the treatment of mental illness;
- psychiatry, psychology, mindfulness practices (grounded in Buddhist belief and practice), and numerous Western approaches to talking therapy show promise;
- MH beliefs can exist on and move along a spectrum, changing depending on context, life stage, and issue; and
- a complementary blend of cultural and clinical expertise is both possible and necessary (45, 73, 103, 106, 118, 120, 125, 128-130, 139, 144, 146-148, 150, 153, 154, 158-160, 192-196).

2.3.5 Understanding and applying holism

The literature repeatedly identifies holism as a key feature of Pacific approaches to (mental) health. Not only are holistic models of health belief (see Section 2.2) presented as important, used to inform non-Pacific health providers and express a vision of what effective (mental) healthcare for Pacific peoples should look like, but they are also *applied in practice*, used to guide and shape therapeutic processes and SDMs more appropriate and effective for Pacific peoples (45, 72-74, 98, 103, 118, 120, 128, 130, 136, 139, 146, 150, 158, 159, 162, 192, 197-199). The literature describes a number of assessment tools and therapeutic approaches – including the Popao model (146), the Mea'alofa model (144, 159, 160), Mana Moana (98, 198, 200, 201), the Matalafi Matrix (197), and Galuola (139) – which support the practitioner to consider and address not only the mental wellbeing of TWO, but their physical health, family relationships, socioeconomic state, migration status, cultural connectedness and identity, environment, and spiritual wellbeing. Reflecting what was shared in

Section 2.2, spiritual wellbeing is of particular importance in Pacific holism; this can involve drawing on both indigenous spiritualities and Christianity (separately or concurrently), and manifests in a variety of ways (e.g., prayer, contemplation, engagement with relics, the use of traditional healers, traditional ceremonies and rituals, visiting or caring for one's (home)land, addressing relational conflict, and a range of other practices). These practices are usually conducted in tandem with/alongside mainstream approaches to MH, and are facilitated by PMHP through collaborative relationships with elders, church leaders, and traditional healers (73, 103, 106, 120, 128-130, 136, 139, 140, 146, 148, 150, 158, 165, 192, 202, 203). While spirituality is strongly emphasised, and most other aspects of Pacific holism are well covered in the literature, the impact of environmental wellbeing is *not* widely addressed; a surprising fact given the centrality of kāinga/family and (home)land. As the impact of climate change intensifies, however, environmental wellbeing *is* emerging as a more significant aspect of Pacific holism and the need for more attention to it moving forward has been expressed (199).

Flexibility and responsiveness have also been highlighted as key features of Pacific holism. Time, location, and role parameters all tend to be fluid in order to ensure the relationship with TWO is nurtured and the full spectrum of their identified needs are being met (33, 45, 72, 73, 103, 128, 130, 147, 150, 156, 162). Mainstream SDMs are not usually conducive to such flexibility, responsiveness, and prioritisation of relationship (20, 31, 33, 62, 72-74, 122-124), however the SDMs emerging from Pacific models of health, practically illustrate operational approaches that better support the provision of holistic care appropriate for Pacific peoples. Assoc. Prof. Sione Vaka's Ūloa Model (130, 150) is a particularly strong example, drawing on traditional Tongan fishing practice to outline an approach to MH SDM focused on keeping TWO in the centre, while all parties collaborate around them to provide balance and support (150).

2.3.6 Working with stories and symbols

Though discussed less frequently/in less depth than most of the themes presented above, the literature also reflected that Pacific approaches to MH often make use of stories/storytelling and symbols as therapeutic tools. As noted in Section 2.3.1, Pacific approaches to providing MH care often include personal disclosure, the sharing of genealogical details and family/personal stories as a means of establishing a trusting relational space between PMHMP and TWO, wherein tapu or otherwise difficult topics can be safely and appropriately discussed (139, 158). The importance of sharing stories goes beyond the rapport building process, however, with one PMHP (Dr. Siautu Alefaio) sharing how giving TWO the space to tell their stories, to talanoa/"just talk," uninterruptedly and without the structure of a formal assessment helps to ensure TWO feel heard, supports TWO to process their feelings and experiences, and provides the practitioner with the opportunity to gain a deeper and more nuanced understanding of the TWO, their feelings, thought processes, and background (139). Various forms of narrative therapy – particularly where culturally embedded myths and metaphors can be used to represent difficult experiences or emotions – are also discussed (153, 158, 204). Such approaches have been noted as supporting TWO to frame and express emotional experiences they may not otherwise have language for, as alleviating the awkwardness of directly expressing feelings, and as sparing TWO the shame of openly discussing tapu concepts (153, 158). Group therapy is also discussed in the literature, with TWO describing how opportunities to share their stories with others experiencing similar issues has reduced their sense of shame, helped them feel accepted, lifted their spirits, connected them to their peers and aided them in building support networks (72, 73, 147, 188).

The body of literature reviewed above provides significant insight into how the onto-, axio-, and epistemological position expressed by Vā is applied in and through Pacific approaches to MH care. It also indicates numerous pathways toward increasing the appropriateness and responsiveness of

MH services for Pacific peoples in Aotearoa. What the literature *doesn't* do is discuss what is *being done well* in Pacific MH/by Pacific MH practitioners. Furthermore – by virtue of the necessary emphasis on advocating for change to meet the needs of Pacific communities – it doesn't explore the relevance of these values, understandings, approaches and aspirations *beyond the Pacific community* (though it must be acknowledged that Dr. Karlo Mila (72), Professor Roger Mulder, Leota Dr. Lisi Petaia, Fuimaono Dr. Karl Pulotu-Endemann et al.(205), and the late, honoured Prof. Sitaleki Finau (206) have all indicated Pacific approaches to (mental) healthcare *should* be recognised as valuable options for all New Zealanders, but have not explored this idea in depth). It is hoped this thesis will speak into this particular gap.

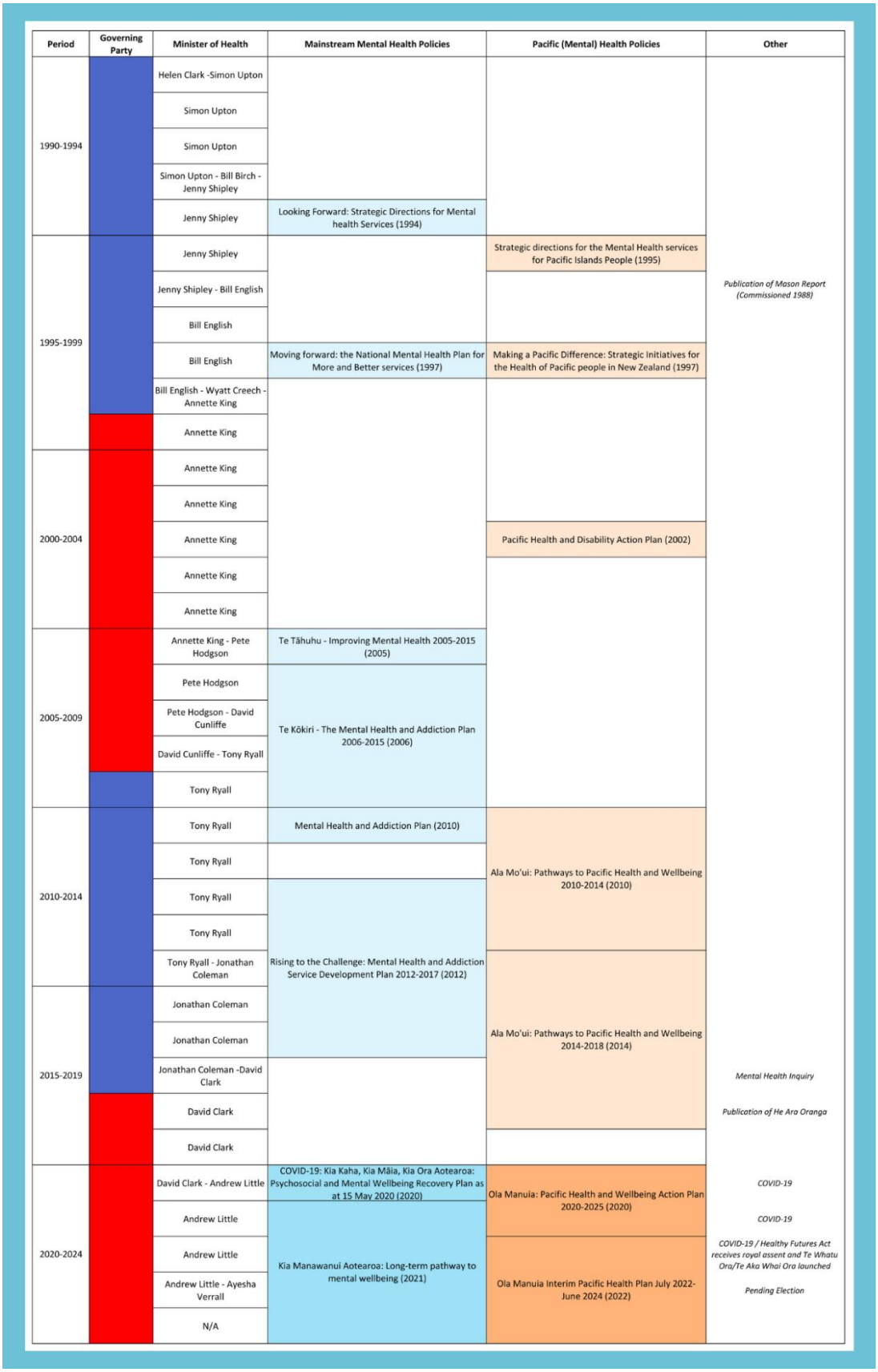
2.4 Pacific Mental Health in Public Health Policy

This section of the literature review evaluates the inclusion of Pacific MH in public, mainstream MH policy, in public Pacific health policy, in the Briefings to Incoming Minsters (BIMs) and in governmental budget speeches and estimates of appropriation. The first section – 2.4.1 – will cover the period from the earliest digitised policy records (1984) through until the launch of *HAO* (62) in 2018. The second section – 2.4.2 – will summarise what has occurred in these policy areas since, describing and reflecting on any shifts between the release of *HAO* (62) and June 2023. These discussions will be actively critical, seeking to identify gaps in the inclusion and representation of Pacific peoples. While gaps are highlighted, this is not meant to belittle the efforts made by Pacific policy actors as they seek to ensure Pacific voices are heard. Evidence has shown that such spaces are hostile to Pacific policy actors (52, 53), and there is an underlying assumption that the highlighted gaps are the result of such hostility and of systems and processes that persistently impede the clear, contextualised, and operational expression of Pacific values, understandings, and approaches.

2.4.1 Pacific Mental Health in Public Health Policy Pre-He Ara Oranga

A comprehensive review of public, mainstream MH and Pacific health policy documents (i.e. strategies, action plans, white papers, evidence reviews, workforce development plans, progress reports etc.) published between 1984 and 2018 (45, 60, 63, 64, 66, 135, 167-170, 207-247) has been undertaken, alongside a review of all Briefings to the Incoming Minister of Health (BIMs) from this period (225, 244, 248-272), and of the budget speeches and estimates of appropriation (Health and Pacific Island Affairs/Pacific Peoples) for the second year of each new government between 1998 (earliest digitised record for this document type) and 2018 (273-280). These have been reviewed to facilitate an evaluation of the inclusion, prioritisation, and representation of Pacific MH in public health policy prior to the MH Inquiry. While the importance of the wider range of documents is recognised, this review will focus on discussing and summarising findings related to the strategies and action plans reviewed, the BIMs, and budgets documents (135, 207-216, 225, 244, 248-280).

MH and Pacific health both emerged as distinct policy areas in the mid-late 1990s (see Figure 3). The first official public MH strategy – *Looking Forward: Strategic directions for the Mental Health Services* (207) – was published in 1994. *Looking Forward* (207) laid out the government's priorities for MH service development, particularly emphasising the development of community MH services in response to the Oakley, Donaldson, and Mason reports (207, 265, 281). *Looking Forward* also prioritised several population groups, these being "Māori, young people, and people with severe psychiatric disabilities" (207). Pacific peoples are mentioned a total of two times in this first mainstream, public MH policy document, both under "Other Priority Groups" (207) as part of a list alongside refugees, older adults, and people who use primary MH services. Lack of evidence regarding the specific MH needs and aspirations of Pacific peoples *is* noted (207), however, there are no action points requiring research into these (207).



Period	Governing Party	Minister of Health	Mainstream Mental Health Policies	Pacific (Mental) Health Policies	Other
1990-1994		Helen Clark -Simon Upton			
		Simon Upton			
		Simon Upton			
		Simon Upton - Bill Birch - Jenny Shipley			
		Jenny Shipley	Looking Forward: Strategic Directions for Mental health Services (1994)		
1995-1999		Jenny Shipley		Strategic directions for the Mental Health services for Pacific Islands People (1995)	
		Jenny Shipley - Bill English			*Publication of Mason Report (Commissioned 1988)*
		Bill English			
		Bill English	Moving forward: the National Mental Health Plan for More and Better services (1997)	Making a Pacific Difference: Strategic Initiatives for the Health of Pacific people in New Zealand (1997)	
		Bill English - Wyatt Creech - Annette King			
		Annette King			
2000-2004		Annette King			
		Annette King			
		Annette King		Pacific Health and Disability Action Plan (2002)	
		Annette King			
		Annette King			
2005-2009		Annette King - Pete Hodgson	Te Tāhuhu - Improving Mental Health 2005-2015 (2005)		
		Pete Hodgson	Te Kōkiri - The Mental Health and Addiction Plan 2006-2015 (2006)		
		Pete Hodgson - David Cunliffe			
		David Cunliffe - Tony Ryall			
		Tony Ryall			
2010-2014		Tony Ryall	Mental Health and Addiction Plan (2010)	Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010-2014 (2010)	
		Tony Ryall			
		Tony Ryall	Rising to the Challenge: Mental Health and Addiction Service Development Plan 2012-2017 (2012)		
		Tony Ryall			
		Tony Ryall - Jonathan Coleman		Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018 (2014)	
2015-2019		Jonathan Coleman			
		Jonathan Coleman			
		Jonathan Coleman -David Clark			*Mental Health Inquiry*
		David Clark			*Publication of He Ara Oranga*
		David Clark			
2020-2024		David Clark - Andrew Little	COVID-19: Kia Kaha, Kia Māia, Kia Ora Aotearoa: Psychosocial and Mental Wellbeing Recovery Plan as at 15 May 2020 (2020)	Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025 (2020)	*COVID-19*
		Andrew Little	Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing (2021)		*COVID-19*
		Andrew Little		Ola Manuia Interim Pacific Health Plan July 2022-June 2024 (2022)	*COVID-19 / Healthy Futures Act receives royal assent and Te Whatu Ora/Te Aka Whai Ora launched*
		Andrew Little - Ayesha Verrall			*Pending Election*
		N/A			

Figure 3 - Timeline of Mainstream Public Mental Health Policy and Pacific Health Policy by Political Party and Minister of Health

After the launch of *Looking Forward* (207) – recognised as not addressing "the special needs of Pacific Island consumers" (207) – Crawley, Pulotu-Endemann and Stanley-Findlay were Commissioned to gather Pacific communities' perspectives on how MH services in Aotearoa might best meet Pacific peoples' MH needs and aspirations. Their community consultations led to the publication of the first dedicated Pacific health policy, and the *only* dedicated Pacific MH policy: *Strategic Directions for the Mental Health Services for Pacific Islands People* (135). This document, prepared by Pacific authors in direct consultation with Pacific communities, not only provides rich, culturally embedded insights into the values, understandings, and (MH) experiences of Aotearoa's Pacific communities, but also represents the most comprehensive expression of Pacific MH needs and aspirations in the history of New Zealand health policy. The document makes a number of clear and achievable recommendations for action, including the:

- establishment of a National Advisory Council for Pacific Islands MH within the Ministry of health;
- urgent collection of Pacific islands MH data;
- development of early-intervention approaches to reduce self-harm and suicide;
- provision of education and support for Pacific families to assist them in caring for TWO within their families;
- provision of MH care in primary and community health settings;
- development of a cultural advocacy service;
- training and recruitment of Pacific MH professionals; and
- improvement of cultural safety in mainstream MH services, with a long view to developing "by Pacific for Pacific" (BP4P) services (135)

Just over half of these recommendations were incorporated into 1997's *Moving Forward: The National Mental Health Plan for More and Better Services* (208) (the action plan attached to *Looking*

Forward (208)). *Moving Forward* (208) included actions focused on the improvement of cultural safety in mainstream services, the development of the Pacific MH workforce, the development of BP4P services, and the collection of Pacific Islands MH data. These recommendations were those most aligned with wider priorities and with existing organisational structures, SDMs, and practices. While there are clear gains to be made by adopting recommendations that can be implemented quickly and with minimal systemic disruption, the decision not to establish a national Pacific MH council, develop a cultural advocacy service, or provide education for family members caring for TWO at home is problematic; these rejected actions are those most aligned with Pacific values and health beliefs and most supportive of Pacific peoples gaining meaningful political influence. Furthermore, while *Moving Forward (208)* highlights the need to consider intra-Pacific diversity and that Pacific MH beliefs differ from Western MH beliefs, no explanation – let alone exploration – of this is provided. Despite these shortcomings, *Moving Forward* (208) is the public mainstream MH policy (prior to the MH enquiry) most engaged with and emphatic about supporting the MH needs of Pacific peoples. It mentions Pacific peoples more frequently than any mainstream public MH policy since; provides clear and specific action points related to Pacific MH needs; and takes *some* direction from evidence generated directly by Pacific communities and health advocates. It also, crucially, lead to the establishment of the Pacific Provider Development Scheme in 1998, supporting the development of – and the precedent of dedicated funding for – BP4P services (10, 241).

The ambivalence towards Pacific peoples and their MH needs and aspirations evident in these first two mainstream MH policy documents has been remarkably persistent. There has been some positive progress in terms of representing Pacific peoples' MH needs in national mainstream MH policy; for example, cultural safety, responsiveness, and competency – along with the development of the Pacific workforce (and, to a lesser degree, of Pacific services) – have been fairly consistently articulated as necessary since the late 1990s (208-210, 212) and, Pacific peoples have been explicitly mentioned –

and thus, technically, included – in all but one of the mainstream MH policies published between 1994 and 2017 (Pacific peoples are excluded from the *Mental Health and Addiction Plan 2010* (211)). Unfortunately, however, these mentions of Pacific peoples have been lacking in detail and problematically framed. For example, during the 1984-2018 period, Pacific peoples are *not once* afforded a dedicated section in national mainstream MH policy, nor are their needs consistently and/or systematically addressed under other relevant headings (207-212, 228). When they are mentioned, the specific MH needs and aspirations of Pacific peoples have often been obscured, either by conflation with the needs and aspirations of tāngata whenua or through the positioning of Pacific peoples alongside a diverse array of other population groups with very different needs (207-210, 212). This lack of visibility has been exacerbated by the ongoing lack of consistently collected, up-to-date data regarding the MH of Pacific peoples (66, 167-169, 207-211, 242); the failure to make use of and reference the work of Pacific health researchers and advocates in the construction of MH policy documents (207-212); and a lack of consistent consultation and engagement directly with Pacific peoples and communities (209-212).

The inclusion of Pacific peoples in national mainstream MH policy has also been characterised by a lack of meaningful, detailed, or affirmative engagement with Pacific values, knowledge, and approaches to MH (207-212). The fact Pacific peoples' values, understandings of, and approaches to MH differ from the dominant clinical/bio-medical model is only explicitly noted in *Moving Forward* (208), with subsequent documents vaguely gesturing towards the "unique needs" of Pacific peoples or to (unspecified and unexplained) Pacific models of health (209, 210). No public mainstream MH policy provides any detail around what these unique needs or models of health might be, nor how they might interact with dominant models of health, SDMs, or practices (let alone giving any consideration to how they might be instructive, inspiring, or supportive of better outcomes) (207-210, 212). Pacific peoples' values, understandings of, and approaches to MH are addressed – in some detail

and with some reflection on their operationalisation – in the *Blueprint* documents prepared by the MH Commission (66, 167, 168, 217). However even here in these adjunct documents, differences are only ever positioned neutrally – as something for services and practitioners to be aware of, acknowledge and navigate in order to improve health equity for Pacific peoples – and never as a potential source of innovation or positive change within the wider (mental) health system.

Where *Looking* and *Moving Forward* (207, 208) – in tandem with *Strategic Directions for the Mental Health Services for Pacific Islands People* (135) – represented a high point in terms of the inclusion of Pacific peoples (and their MH needs) in public health policy, the last policy published prior to 2018 – *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017* (212) – represents a low point, exemplifying the issues detailed above. This document contains no evidence of community consultation or engagement with Pacific research, no recognition of differing values, understandings, and approaches, and only addresses Pacific peoples' MH needs and aspirations under an overarching section called *"Cementing and building on gains in resilience and recovery for Māori and for Pacific peoples, refugees, people with disabilities and other groups"* (212). Within this section there is a brief paragraph explaining Pacific peoples "have higher rates of MH issues than the general population and have lower rates of MH visits" (212), however there is not a single action mentioning Pacific peoples, and that observation constitutes the full extent of the document's engagement with Pacific MH.

In addition to the publication of *Moving Forward (208),* 1997 also saw the creation of Aotearoa's first public *Pacific* health policy: *Making a Pacific Difference: Strategic Initiatives for the Health of Pacific People in New Zealand* (16, 215, 241). *Making a Pacific Difference* (215) was published after significant public consultation (215, 282), and covers all aspects of health, from asthma to cancer (215). It spends some time discussing exactly how a range of socioeconomic factors impact on Pacific

health and service access, as well as unpacking Pacific health beliefs and their relationship with Western health beliefs. In this piece of policy, *"a mutually beneficial coexistence"* is posited, with Pacific and Western health belief systems being positioned as *"distinct, but not mutually exclusive"*, echoing the epistemological position inhabited by Pacific peoples. Unfortunately, there is scant information relating to MH in *Making a Pacific Difference* (215). There is a section heading for this health domain, however it is only afforded one page in the entire 56-page document (despite having been published after *Strategic Directions for the Mental Health Services for Pacific Islands People* (135)). There is also no meaningful discussion/development of Pacific health beliefs *as they pertain to MH*. In addition to the lack of information about Pacific MH beliefs, much of what is presented does not align with the MH priorities identified by Crawley et al. in *Strategic Directions for the Mental Health Services for Pacific Islands People* (135), nor those identified by the consultation groups whose input ostensibly shaped the policy (219, 282).

The next Pacific health policy – *The Pacific Health and Disability Action Plan* (216) – took a big step backward in terms of acknowledging and affirming Pacific values, understandings, and approaches to MH. While the document mentions family is important to Pacific peoples and indicates a need to *"develop an increased awareness of the practice of Pacific traditional healing as alternative and complementary healing"* (216), that is the full extent of the policy's engagement. *The Pacific Health and Disability Action Plan* (216) also dedicates even less space to MH than *Making a Pacific Difference* (215); it is not identified as a priority health area, and of the 31 action points listed in the plan, only two focus on this aspect of wellbeing (216). The policy does have some strengths: wide-ranging community consultation was undertaken, in addition to the involvement of both the Pacific Health Sector Reference Group and a number of other Pacific health leaders, and there is some acknowledgment of the importance of self-determination for Pacific peoples (216).

Another Pacific health policy is not seen until 2010, with the publication of *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010-2014* (214). Between *The Pacific Health and Disability Action Plan* (216) and *'Ala Mo'ui 2010-2014* (214), two significant reports exploring Pacific (mental) health were produced: *Tupu Ola Moui: Pacific Health Chart Book 2004* (242) and *Te Rau Hinengaro - The New Zealand Mental Health Survey* (60, 63, 64). Unfortunately, neither of these studies are referenced in *'Ala Mo'ui 2010-2014* (214), despite the oft-articulated need for quality Pacific health data. It is likely *Te Rau Hinengaro* (60, 63, 64) is not referenced as MH is only mentioned five times in this policy, and only once in a strategic action (214). There is also a shift *away* from community engagement and toward the use of expert advisory groups and peer-reviewed research in this document, representing a growing distance between Pacific health policy and Pacific communities (214). *'Ala Mo'ui 2010-2014* (214) does go slightly further than its predecessor in terms of providing a meaningful explanation of Pacific health beliefs and their role in supporting improved outcomes, emphasising holism, and including spirituality, family, and environmental factors in its definition of holistic health care.

'Ala Mo'ui 2010-2014 (214) is followed, four years later, by *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018* (213). This second *'Ala Mo'ui* (213) has some significant strengths. It references a number of Pacific authors external to the Ministry of Health, acknowledges Pacific diversity both conceptually and through the use of multiple languages, and expands on the importance of family, providing family-specific actions, indicators, and targets. Furthermore, it focuses on wellness over illness and identifies cultural protective factors such as social connectedness and religious participation (213). This policy also consults more widely than *'Ala Mo'ui 2010-2014* (214), though it does still restrict itself to sector leaders, service managers and other "experts" (213). Unfortunately, the second *'Ala Mo'ui* (213), much like the first, barely touches on MH; the only action provided is that "DHBs will implement the Pacific specific actions in the *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017*" (213). This is a serious issue given that, as mentioned

earlier, there are no Pacific specific actions in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017* (212). In 2018, at the time the MH Inquiry was publicly announced, *there had not been a policy action point committed to Pacific MH for a full five years (2014-2018)*.

The examination of mainstream public MH policy from the 1984-2018 period reveals Pacific peoples have been largely invisible in this shared policy space. The examination of Pacific health policy reveals MH has generally been overlooked as an area of specific concern for Pacific peoples. This lack of Pacific presence in mainstream MH policy, coupled with the lack of presence of MH in Pacific health policy, shows that the MH needs and aspirations of Pacific peoples were not being prioritised in public health policy prior to 2018, despite the evidence of higher need and lower access to support (33, 45, 60, 63-65, 68-74). It also means that the potential and relevance of Pacific values, understandings, and approaches to MH were not being acknowledged, explored, or drawn on at a policy level; they were barely being engaged with at all.

Further evidence of exclusion and deprioritisation is found through the review of BIMs, budget speeches and estimates of appropriation for 1984-2018 period. The review of the BIMs (225, 244, 248-272) found that – despite MH having been a distinct area of public policy since 1994 (207) – MH had not been consistently put forward as a priority for action in the briefings to incoming Ministers of Health, thus reducing the likelihood of MH being prioritised by said Ministers (let alone their prioritising specific aspects of MH/its relevance to specific population groups). It also found that – - despite there being qualitative insights into the MH needs of Pacific peoples since 1995 and clear epidemiological evidence of higher rates of mental illness since 2006 (60, 63, 64) – *Pacific MH had only been put forward as a ministerial priority twice* (225, 249, 269, 270), *with each instance being more than a decade apart*.

In terms of the budget speeches, MH is mentioned in 1998 and 2001, (278, 279), but disappears from the agenda in 2010 (280). Pacific peoples are not mentioned in 1998 (278), are mentioned several times in 2001 (279), and then are only mentioned in 2010 with regards to the Pacific Rim and the Trans-Pacific Partnership Agreement (and not in terms of Pacific communities in Aotearoa at all) (280). *We do not see any intersection of Pacific peoples and MH in any of these speeches* (278-280). In terms of the allocation of funding to Pacific MH through the estimates of appropriation, MH spending and spending on Pacific peoples and Pacific health does *appear* to increase over time (this is difficult to meaningfully assess due to changing budget formats, health system structures, terminology, and inflation) (273-277, 283), however, *not a single appropriation is dedicated to Pacific peoples' MH in any of the reviewed Vote Health or Vote Pacific Island Affairs/Pacific Peoples estimates* (273-277, 283).

2.4.2 Pacific Mental Health in Public Health Policy Post-He Ara Oranga

This section of the review will focus on the policy environment in the post-*HAO* (62) period (2018 - June 2023) (67, 284-302). During this period, the MH Commission was reestablished (as Te Hiringa Mahara / the Mental Health and Wellbeing Commission – a now "permanent" supervisory and advocacy body with a 13-strong board and leadership team, of whom only one is Pacific) (301), and numerous other relevant, policy-adjacent documents have been published and reviewed (85, 88, 161, 303, 304), however, as above, the focus will be exclusively on strategies, action plans, BIMs, and budget documents.

After the expiry of *Rising to the Challenge* (212) in 2017, three years elapsed before another health policy of any kind was published. In 2020 *COVID-19: Kia Kaha, Kia Māia, Kia Ora Aotearoa: Psychosocial and Mental Wellbeing Recovery Plan as at 15 May 2020* (291) – an interim policy document detailing how the government intended to support the MH of New Zealanders during the pandemic – was released. Despite a strong discursive focus on equity, acknowledgment of the negative impacts of *"pre-existing, historic, and generational inequities"* (291), a description of holism including spiritual, cultural, and environmental wellbeing, repeated references to Pacific peoples, and an explicit recognition of the increased risk they faced as a result of COVID-19, there are *no actions* focused on meeting the MH needs or supporting the wellbeing approaches of Pacific peoples in this document (291). Not only did Aotearoa go three years without a MH policy in place, but when one *did* finally emerge, Pacific MH need and approaches were still not a meaningful part of it (despite the findings and recommendations of *HAO* (62) and *New Visions: Collective Solutions* (72)).

2021 saw the launch of a fully-fledged public, mainstream MH policy: *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* (67). This strategy represents a sudden and significant improvement in many regards and meaningfully responds to the recommendations published in both *HAO* (62) and *New Visions: Collective Solutions* (72). Rather than using a western framework as it's starting point, it draws on "Pae Ora" ("healthy futures", a concept/model expressing the government's vision for Māori health) and *Whakamaua: Māori Health Action Plan 2020–2025* (67, 305). Through this, a more holistic, spiritually resonant, and collectively oriented foundation is laid, making this policy innately better suited to supporting Pacific approaches to MH/approaches to MH appropriate for Pacific peoples. This policy explicitly acknowledges the MH needs of Pacific peoples and provides the most nuanced, meaningful description of Pacific health beliefs in a mainstream MH policy to date:

> *"For Pacific peoples, wellbeing encompasses mental, physical, spiritual, family, environmental, cultural and ancestral components, and includes cultural values*

> *that strengthen family and individual wellbeing, such as respect, reciprocity, collectivism and a focus on relationships." (67)*

It has a strong focus on improving social determinants as necessary to improving MH; increasing and strengthening cultural and TWO voices in leadership in terms of both presence and development; investing more in community health promotion, education, and prevention; expanding MH options in primary health; developing new commissioning models; improving data collection and feedback/accountability loops; and collaborating with the Ministry of Education to develop primary and secondary school curricula more supportive of a holistic, wellbeing oriented education (67). While Pacific peoples are not mentioned as often as in *Moving Forward* (208), the adoption of a collective, holistic worldview and the presence of actions points that better reflect the MH needs and aspirations of Pacific peoples mean this policy comes across as the most meaningfully inclusive and affirmative yet. It also explicitly acknowledges that…

> *"Māori and Pacific perspectives on health, wellness and wellbeing are influencing a wider appreciation that people's needs are holistic across physical, spiritual, mental and relational dimensions…" (67)*

…and recognises the need to honour and protect cultural knowledge, indicating an attitudinal turn that will create more space for Pacific values, understandings, and approaches to MH to be safely shared and supported to grow.

Kia Manawanui (67) is not without its faults, however. No Pacific research is referenced and there is no evidence of consultation with Pacific communities or health advocates (though it has been mapped against the recommendations from *HAO* (62), for which there was significant Pacific consultation (62, 67, 292)). Key aspects of a holistic understanding of (mental) health – particularly spiritual and environmental – remain underdeveloped and, while family and community are cited as important through the Pae Tata model, the focus on the individual persists and more collective

elements are not as strongly incorporated as might be hoped. The policy, while aspirational, is also very vague, with the listed actions reading more like a protracted vision statement, describing what the Ministry of Health would like to achieve, rather than how they intend to achieve it. This vagueness is exacerbated by the exclusive use of descriptive outcome statements as progress indicators.

Two public Pacific health strategy documents were also released between 2018 and June 2023; *'Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025* (289) and *'Ola Manuia: Interim Pacific Health Plan July 2022 - June 2024* (290). The first of these (289) – echoing the transformation seen with *Kia Manawanui* (67) – represents the best public Pacific health policy seen to date. There is clear evidence of consultation with Pacific communities and health advocates; Pacific diversity is acknowledged and meaningfully enacted throughout the policy; Pacific concepts – such as "Vā fealo'ai" – are presented as underlying principles; the relationship between culture and care is positioned as "fundamental" (289); addressing the socioeconomic determinants of health is prioritised (particularly financial stability and food security); and a holistic, family centred approach to wellbeing is present throughout (289). Best of all, MH gets its own section (and is in fact the only area of health identified as a priority, with other sections focussing on system levers, life stages etc.). Despite these strengths, there are still gaps in this policy too. For example, the action points and progress indicators often fail to align with the identified priorities (e.g. actions and indicators related to socioeconomic determinants cover life expectancy and housing, without addressing highlighted issues such as financial stability and food security); the spiritual aspect of health and wellbeing is generally ignored; and – sitting at the other end of the spectrum to *Kia Manawanui* (67) – there is an almost exclusive reliance on quantitative measures. Unfortunately, the interim plan (290) – developed in response to the transition from DHBs to Te Whatu Ora and Te Aka Whai Ora (287) – fails to maintain the positive changes seen in *'Ola Manuia 2020-2025* (289), instead replicating its flaws. While MH *is* still listed as a priority in the interim plan (290), and a page of Pacific MH statistics is provided in the appendices

(highlighting persistent access issues and the unique MH needs of Pacific youth), the actions listed for MH are limited to maternal MH and research into the use of Pacific models, with no mention of access or youth at all (290).

In terms of the BIMs, those prepared in 2020 (306-308) barely mention MH; the focus is on COVID-19 and particularly on physical wellbeing and public health responses. Mentions of Pacific peoples in these BIMS reflect this, and Pacific MH is not expressed as a priority. In 2023 Te Hiringa Mahara get their own BIM, meaning MH is put forward as a distinct priority. Their BIM notes MH care is not provided holistically under the current system, seclusion is overused for Pacific peoples, and regular meetings are held with the minister holding the Pacific health portfolio (309). Nothing is said, however, regarding higher rates of psychological distress and mental illness amongst Pacific peoples and there are *no actions or priorities listed in this BIM specific to improving Pacific MH or growing pacific approaches to MH care* (309). MH is also listed as a priority in the Manatū Hauora / Ministry of Health and Te Whatu Ora BIMs (309, 310). Here the discussion focusses primarily on the replacement of the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (311) and the publication of "the Oranga Hinengaro System and Service Framework, which sets expectations for MH and addiction service configuration over a 10-year horizon" (310, 312). A commitment to Pacific equity *is* noted alongside a number of actions relevant to achieving Pacific health aspirations (notably including the establishment of both a Pacific Commissioning agency and a "Pacific health senate"), but again, *there are none specific to Pacific MH* (310, 312).

As for the budget speeches and estimates of appropriation, rhetorical attention to MH is strong in 2019 (285), declines throughout the pandemic (284, 286, 287), and has been picked back up in 2023 with regards to youth MH and recovery from the trauma associated with severe flooding throughout the mid-upper North Island earlier in the year (288). *Pacific MH is not a feature at any*

point (284-288). Spending on MH and Pacific health appears to have either increased or been maintained in the early part of the post-*HAO* (62) period, however, with the transition to Te Whatu Ora and Te Aka Whai Ora (287) and subsequent changes to the structure of the estimates, it becomes impossible to gauge this for the latter part (295-298). 2021 saw *an appropriation* committed to achieving the priorities identified in *'Ola Manuia 2020-2025* (289). As priority six in *'Ola Manuia 2020-2025* (289) is MH, and as there are MH specific actions detailed under that priority, *this constitutes the first – and only – time a reviewed budget has provided a clear line of sight between a government budget and action to specifically support Pacific MH*. In the 2023 health estimates the *"Number of people who have access to Kaupapa Māori, Pacific and Youth Primary Mental Health and Addiction Services through the Access and Choice programme"* (297) is noted as a measure/progress indicator, however, reflecting the absence of appropriations noted above, there are no *appropriations* that can be directly linked to Pacific MH (297, 298).

The review of public mainstream MH and Pacific health policy, BIMs, and budgets from 2018-June 2023 provides evidence of positive change in the five years since the publication of *HAO* (62). This is especially true in the case of policy, wherein there is a more consistent emphasis on Pacific peoples and MH, as well as more nuance and detail in that emphasis. Needs and aspirations that had been overlooked or obscured before are (re)surfacing (for example, the establishment of a Pacific health senate is a step toward answering the call for a National Advisory Council for Pacific Islands MH made in 1995's *Strategic Directions for the Mental Health Services for Pacific Islands People* (135)) and, in *Kia Manawanui* (67), we see glimmers of how a policy might look if it were to value, affirm, and acknowledge Pacific understandings of and approaches to MH and their potential to support the wellbeing of diverse New Zealand communities. These positive shifts are still new and somewhat underdeveloped, however. The changes between *'Ola Manuia 2020-2025* (289) and *'Ola Manuia July 2022 - June 2024* (290) – coupled with the continued lack of prioritisation at the level of both BIMs

and budgets – reflect the risk of current progress being lost as attention turns to health system changes, emergencies, and other issues, thus highlighting the need to keep pushing for policy that better serves the MH needs and aspirations of Pacific peoples and that values, affirms, and acknowledges the potential of Pacific approaches to MH.

3.0 Methodology and Methods

3.1 Methodology

The methodology selected for this research project needed to reflect and enact an appreciation of Pacific peoples, their values, their ways of knowing and doing. It also needed to actively mitigate the risk of perpetuating or reproducing deficit-oriented depictions of Pacific peoples, focussing instead on the affirmation of participants and their viewpoints. This research has thus been undertaken using a complementary synthesis of both the Kakala Research Framework (4) and Appreciative Inquiry (1-3). A description of both approaches will be provided below, alongside reflection on how this methodological synthesis meets the needs outlined above.

3.1.1 The Kakala Framework

The Kakala research framework draws on the Tongan practice of preparing Kakala – *"fragrant flowers and leaves woven together in special ways according to the need of the occasion they are woven for"* (94) – and constitutes the axiological and epistemological underpinning of this project. The framework was first developed by Prof. Konai Helu Thaman as a research process model with four key stages, however it is most commonly used in the six-stage form developed by Dr. Seu'ula Johansson-Fua and her colleagues (4). An explanation of each of the six stages is presented in Figure 4 (the original four stages have been indicated with an asterisk*). Though considered suitable for pan-Pacific use, the Kakala framework is embedded in specifically Tongan ethics, privileging values such as *"faka'apa'apa (respect), loto fakatokilalo (humility), fe'ofa'aki (love, compassion) and feveitokai (caring, generosity)"* (4). Furthermore, it presupposes the importance of tauhi Vā as these values can

Stage	Explanation
Teu*	This is the planning stage, wherein one conceptualises what the garland will look like and decides which flowers will be most appropriate for the intended recipients. This might involve consultation with elders and other knowledge holders who can help ensure the appropriateness of the design and the flower choices. Notably, the kakala is always woven for someone else. In terms of the research process, this is the stage at which one would develop research questions, evaluate the availability of resources, and connect with leaders who can help to ensure that research will be relevant to and meaningful for those it is intended for, that it will make a positive contribution to the wider community.
Toli*	Toli is the stage at which the chosen flowers are sought out and picked, carefully, so that the beauty of the flower is not compromised. This represents the data collection stage of the research process, wherein one seeks out appropriate participants and information to answer the research questions. As with picking flowers, this must be done carefully to ensure that the integrity of the data is maintained.
Tui*	Tui means "to weave". During this stage, the flowers are carefully woven together according to the intended design and in such a way that the beauty and meaning of the flowers is effectively highlighted. This is the point in the process at which data analysis and the writing up or (re)presentation of information takes place. During the Tui stage, the researcher finds themselves weaving together the information that has been gathered, reflecting on the insights that have been made available, and exploring what they mean.
Luva*	The final of the original four stages, Luva refers to the gifting of the garland to the intended recipient. With regards to research, this is the point at which the findings are made available to those for whom the research was undertaken. The inclusion of luva as a vital part of the research process serves to reiterate the need for research to be focused on the needs of the community, relevant to and meaningful for them.
Mālie	Mālie is an expression of reciprocated appreciation, wherein the receiver of the Kakala exclaims at its beauty and at the skills of the maker. This represents the stage of the research process wherein the researcher and the intended audience collectively consider what has been found out, sharing in the appreciation of this, and considering how the findings might best be applied. The inclusion of mālie as a part of the research process represents the importance of what happens after the research has been completed and the need for not only dissemination, but advocacy and action as well.
Māfana	Māfana refers to the feeling of warmth that pervades the relationships between those gifting and those receiving the kakala, the emotional response to the goodwill, recognition, care, and affirmation embodied by the Kakala. As an aspect of research, māfana prioritises the emotional experience of everyone involved in the research and describes a sense of interpersonal warmth and energy. This refers to both to the warmth and energy that has been generated to support advocacy and action, but also to a feeling that the researcher should nurture throughout the research process, in and through respectful, genuine engagement with leaders, participants, and the data itself. While positioned at the end of the process, it is hoped that all aspects of the work be undertaken with and nurture a sense of māfana.

Figure 4 - The Kakala Framework

only be exercised in and through relationships. The Kakala framework prioritises the cultural safety of participants, the active affirmation of their cultural worldviews and values, and the upholding and

honouring of their experiences through active demonstrations of culturally appropriate respect, humility, love, and generosity towards all those involved (4, 54, 94). It assumes the validity of Pacific ways of knowing and doing and of participant contributions and recognises these are most accurately and respectfully understood when interpreted in and through the worldviews of those sharing them (4, 54).

As it was developed primarily for use by researchers of Pacific descent, careful consideration was given to whether or not I should use this framework. I recognised my knowledge of the processes and principles behind it was operating at a lexical/semantic rather than experiential level, however I hoped I would:

a) develop my experiential understanding through the application of said processes and principles, and
b) be supported by this framework to keep these processes and principles front and centre in the way I worked.

Other options – such as phenomenology (313, 314) – were considered. These might have enabled me to honour and uphold the values and understandings of my participants, but none would have empowered me to affirm these in the same way, nor, to keep Pacific processes and principles in the foreground of my research approach. Thus, despite the cross-cultural challenges, the Kakala framework was chosen. I believe this choice has been effective, supporting me to undertake my work as appropriately, affirmatively, and effectively as I can; to bring love, compassion, care, and generosity to my work; to consistently demonstrate respect for my participants, their communities, and their ways of knowing and doing; and to ensure my focus has remained on creating something worthy of gifting back to all involved.

3.1.2 Appreciative Inquiry

My use of the Kakala framework has been supplemented by the use of elements from an approach to organisational, social, and systems change known as Appreciative Inquiry (AI) (1-3). AI is grounded in social constructivism, positive psychology, and image theory and is *"based on the assumption that questions and dialogue about strengths, successes, values, hopes, and dreams are themselves transformational"*(3). It is a flexible and cooperative approach which centres on the AI "4-D Cycle", comprising the "Discover", "Dream", "Design", and "Destiny" stages. This cycle requires those involved to come together – in relationship and in conversation – to work through these stages (Figure 5).

Stage	Explanation
Discover	Participants seek to discover the best of what exists in their field. This stage of the 4-D cycle involves undertaking "appreciative interviews" focused on an affirmative topic (3), with participants sharing about moments where they have experienced success in their organisation or field and exploring the strengths that have contributed to this.
Dream	Participants collectively dream about how their organisation/field could look and what opportunities exists for change. This stage of the AI 4-D cycle "Lifts up the best of what has been and invited people to imagine even better"(3), to create a powerful shared vision for what the future could look like if opportunities to grow strengths - and the successes they nurture – were created and/or taken up.
Design	Participants review the information gathered so far and use this to help them design what their organisation/field should look like. This stage of the AI 4-D cycle involves making choices, selecting from what has been and what could be to determine what should be, what changes will be created. In addition to identifying what changes will be created, it also involves exploring who needs to be involved in creating change, at what levels change will need to be made, and – through a description of the ideal organisation/field – what successful change will look like.
Destiny	Participants identify the actions that must be taken to realise their design and achieve their Destiny. This is the stage of the AI 4-D cycle in which concrete action is undertaken. Wins that have already been made through identifying strengths and successes should be celebrated, and connections between those involved maintained through collaborative action and frequent celebrations of progress.

Figure 5 - The AI 4-D Cycle

The use of the AI 4-D Cycle adds value to this project by lending additional structure to the "Toli" and "Tui" stages of the Kakala framework, and by supporting an approach to data collection, data analysis,

and the final presentation of findings that is not only respectful, but actively affirmative. I sought to use an actively affirmative focus in recognition of the harm caused by negative social attitudes toward Pacific peoples and the ongoing dismissal and diminution of Pacific knowledge. While the Kakala framework allows for constructive criticism – where appropriate and supportive of positive change for participants and their communities – I felt any criticism of Pacific values, understandings, and approaches to MH care would, as a Pākehā researcher, be inappropriate, and would risk contributing to/perpetuating deficit-oriented representations of Pacific peoples and their ways of knowing and doing. AI provided both a theoretical perspective and practical tools that supported me to mitigate this risk. Furthermore, AI has been used effectively by Dr. Cherie Chu as a personal and leadership development approach with Pacific university students in Aotearoa (46, 315). Its compatibility with Pacific values, understandings, and approaches and its suitability for use in Pacific contexts has been noted through her work, and it is hoped this project will highlight other ways in which AI might prove useful to Pacific communities.

3.2 Methods

To carry out the research, I elected to use a combination of two qualitative methods: Talanoa and Appreciative Interviewing. Talanoa aligns strongly with the Kakala Framework and has been explicitly identified as an appropriate method for use alongside it (4, 94). Similarly, Appreciative Interviewing aligns with AI, having been derived from/designed for use as a part of the "Discover" stage of the AI 4-D cycle (3). These choices of method reflect the blended methodological approach described above, as well as the cultural needs of the participants and the exploratory scope of the research questions.

3.2.1 Talanoa

Talanoa is a means of co-constructing knowledge through open, largely unstructured, face-to-face conversations (59, 89, 91, 92, 94, 95). It is distinct from semi- and un-structured interviews, narrative and feminist approaches, and other indigenous research methods in its emphasis on empathic and spiritual connection, relationship, reciprocity, and – crucially – Pacific cultural values and protocols (89, 91, 94, 95, 316). In everyday Tongan "talanoa" simply means to converse or to tell a story, reflecting the often wide-ranging and narrative-led nature of talanoa as a research method. However, when deconstructed, the word reveals some additional nuances. "Tala" means to talk. "Noa" means both common or informal as well as something akin to nothing, blank, void, zero/balance point, everything/anything/nothing (94, 95, 119, 130). Thus, while talanoa can mean to talk informally (e.g., have an everyday conversation) or to talk about nothing (e.g., have a conversation about everyday topics), it can *also* mean to talk until a state of equilibrium is reached, until the conversational participants find themselves at a zero/balance point. These meanings highlight how talanoa as a research method aims to create a space where conversation feels comfortable, safe, and easy, as though it is part of an everyday conversation *and* to encourage those engaged to find/create balance. This does not *require* agreement or compromise regarding the topic(s) of discussion (though this can be the aim). Rather, it requires the open, in-depth exploration of ideas with the aim of achieving a mutual and harmonious understanding of the topic(s) at hand.

When conducted well, talanoa uplifts the spirits of both researcher and participant, generating a sense of māfana/warmth through the demonstration of respect for each other and for each other's knowledge; the willingness to give, receive, and combine knowledge; and the empathic intermingling of both knowledge and emotions (91, 94). To achieve this requires the researcher to demonstrate a high level of cultural competence, to "*recognise participant actions and nonactions,*

what is said and unsaid in combination with how they are or are not said, and then [to] affirm and interpret those through the cultural ways, fonua, of the participant" (95), thus creating a space where Vā-led relationships and trust can be built and/or deepen, collaboration can occur, and Pacific values and cultural norms can be practiced and validated (89, 91, 94, 95, 316). As with the Kakala framework, I hoped the use of Talanoa would help maintain a focus on empathic and spiritual connection, relationship, reciprocity, and those cultural values, protocol, norms, and conversational practices of which I was aware, thus creating as safe and productive a conversational space for my participants as possible.

3.2.2 Appreciative Interviewing

Appreciative Interviewing constitutes one of the "non-negotiable" aspects of the "Discover" stage of the AI 4-D cycle (3). Reflecting the wider ethos of AI, Appreciative Interviews are focused on affirming strengths and uncovering successful areas of an organisation or field through participant stories. They are open, conversational, and only semi-structured. Appreciative Interviewing requires the interviewer to "lead in" to the interview by providing information about the topic and the intentions of the project in a way that *"plants that half-full assumption in the mind of interviewees*"(3), appeals to their humanity, and seeks to "*build bridges between the needs of the organisation/field and "people's emotional needs for…a sense of pride, ownership, belonging, connection, and personal growth*"(3). This "lead in" is then followed by questions that look backward (appreciating what has been, the successes achieved), inward (seeking the strengths that are the source of these successes), and forward (exploring hopes and dreams for the future and informing the next stage of the cycle). Good Appreciative Interview questions draw on people's life and work experiences to guide them through an uplifting positive journey (3). Beyond this they seek to forge genuine, meaningful personal connections between the interviewer and participant, are personally and emotionally affective, can

be ambiguous to allow participant-led exploration, and invite stories rather than abstract opinions or theories (3).

Appreciative Interviewing – through a number of the features identified above – shows a high level of compatibility with talanoa. As with talanoa, it focuses on building genuine, meaningful connections between researcher and participant, of engaging with and sharing in the emotional aspects of participant experiences, and on the open and narrative-led exploration of the same. Appreciative interviewing also helps to operationalise the positive/affirmative focus of AI in and through talanoa, whilst also providing practical guidance for novice researchers – such as myself – that support the implementation of the relational, reciprocal, and emotional-spiritual aspects of talanoa.

3.3 The Research Process in Practice

3.3.1 Teu

A comprehensive literature review was undertaken, and four sets of research questions were drafted: one for each stage of the AI 4-D cycle. It was intended, initially, that this research would include all four stages of the AI 4-D Cycle and that data collection would take place in two parts. The first part would involve one on one and small group talanoa with PHMP and PMHSM to gain insights into their successes and strengths ("Discover") and into their vision for mainstream MH policy in Aotearoa ("Dream"). The second would then take what had been found during these conversations, presenting it back to both the original participants and a range of Pacific policy actors. The aim of this

second stage was to facilitate discussions and collaborative planning around which aspects of the Dream should be prioritised for action ("Design") and around how they might be actioned ("Destiny").

Preliminary meetings were held with 17 leaders in the Pacific MH and Pacific health policy spaces both to seek feedback on the research design, to discuss whether this research was needed, and whether it would be appropriate for me – as a Pākehā – to undertake it. The feedback received from these leaders was positive and, once a few minor tweaks to the research design had been made (e.g., widening the sample from exclusively PMHP and PMHSM to include the perspectives of TWO and their whānau), the provisional year documentation was prepared, and relevant processes undertaken.

Once the topic and design had been approved by Auckland University of Technology, participant information sheets, consent forms, and an appreciative interview schedule/talanoa guide focused the "Discover" and "Dream" research questions[4] was developed and piloted amongst my colleagues. The piloting was both reassuring – colleagues indicated I was carrying out talanoa in a competent, responsive, and affirming way – and instructive, leading to the removal and combination of certain questions, and the addition of new ones, particularly around the impacts of Pacific approaches on practitioner/staff wellbeing (in addition to TWO wellbeing). Once finalised, these materials were submitted as a part of the ethics application for this research, with ethics approval being granted by the Auckland University of Technology Ethics Committee (AUTEC) on 21/08/2019, application number 19/240 (see Appendices Two, Three, Four, and Five)[5].

[4] The specific activities, topics, questions etc. to be used for "Design" and "Destiny" were not developed at this stage as it was recognised these would need to be infromed by the findings of the first stage.

[5] Please note, only documentation relevant to stage one of the research design has been included as, in the end, this was only documentation used.

3.3.2 Toli

The proposed sample make up for part one of my proposed research design is shown in Figure 6, and participants needed to:

- be 18 or over; and
- be/have been a PMHSM, PMHP, or Pacific TWO/TWO's Whānau member in Aotearoa/New Zealand in the past 10 years.

There was an explicit intention to recruit as diverse a sample as possible regarding ethnic, migration, gender, service type or professional roles. Recruitment was undertaken using a combination of purposive and snowball sampling. Through my professional context, I was already aware of a number of potential participants. To avoid any undue pressure, the initial approach to these participants was made by either a colleague or one of my research supervisors. Many of these participants subsequently referred me to others, and in these cases, they lead the introductory process.

My final sample involved 33 participants. These participants were spread across New Zealand's major cities and were diverse in terms of age, ethnicity, and migration background. They had experience working in mainstream and BP4P services (in several cases having worked in both), and frequently identified as a combination of PMHP, PMHSM, TWO, and whānau of TWO. A visual representation of the diversity of my final sample is provided in Figure 7. Furthermore, while the vast majority of the participant group identified with at least one Pacific culture, two participants identified exclusively as Pākehā, and one as Māori. The two Pākehā participants were involved in a group talanoa and were brought by their Pacific colleagues. They participated primarily as listeners and material from their reflections has not been included (not due to a decision to exclude their voices, but because

Cohort	Target # of Participants/Talanoa Sessions	Notes
Pacific MH Service Managers and Leaders	10	Emphasis here will be on on-on-one sessions
Pacific MH Practitioners	10	Emphasis here will be shared across on-on-one and small group sessions
Pacific MH Consumers and their Whānau	5	Emphasis here will be on small group sessions

Figure 7 - Target Sample

Figure 6 - Demographic Features of Participant Group

the points contributed were covered by Pacific participants, and this thesis seeks to prioritise Pacific voices). The Māori participant was invited by his Samoan colleague who wished to uphold the importance of working in a Te Tiriti o Waitangi led way, recognise the significant contribution his Māori colleague makes to the wellbeing of Pacific youth in his care, and acknowledge the personal connections of his Māori colleague to Pacific communities by marriage. On a deeper level, this invitation was also about honouring the Vā between Māori and Pacific people, recognising that the voice of his Māori colleague *"weaves ideals of ancient wisdom and ancestral intelligence that transcend ethnic classification [and] situate his voice within the fabric of Pasifika conversations, expressing tangibly the especial relationship between Tāngata Whenua and Pasifika peoples"*(317). This Māori participant has thus been included as a part of the Pacific cohort, both by invitation and in recognition that Māori – as peoples of Te Moana-nui-a-Kiwa – are also a Pacific peoples (318-320).

Participants were interviewed across 2 small-group and 19 one-on-one talanoa. Where undertaken in person, talanoa most often took place in either the participant's workplace or in a local café, as chosen by the participant. Video conferencing software was used both during the COVID-19 pandemic and outside of pandemic constraints when participants requested this as a more convenient option. This approach reflects both adherence to public health advice but also the growing adaptation of Pacific research methods – such as talanoa – to emerging technologies (90). Hospitality was demonstrated through the provision of food and drink wherever possible, and a small koha/mea'alofa/mea'ofa – usually in the form of grocery vouchers – was also given at the conclusion of each conversation. Talanoa usually took between 1.5-2 hours. Field notes were taken, and – in the case of all but one conversation – audio recordings were made and then transcribed by a professional service. Copies of these transcripts were provided to all participants for validation.

Given that 33 participants were interviewed (as opposed to 25), and that one-on-one talanoa were more practicable than group talanoa in most cases, this first part of the research resulted in an extraordinarily large amount of rich, textured data being collected (upwards of 65 hours). As a result, the decision was made to reduce the scope of the PhD, and to focus only on the research questions relevant to the "Discover" and "Dream" stages, deferring the "Design" and "Destiny" stages until post-thesis. This decision was made to ensure the data already gifted by participants could be honoured and meaningfully explored through the thesis. This decision was communicated to the initial consultation group and to participants, alongside an expression of my ongoing commitment to using the findings to inform action pertaining to the "Design" and "Destiny" stages, post-thesis. The response received was, without exception, understanding and supportive.

3.3.3 Tui

Data was analysed thematically using the six steps outlined by Braun and Clarke (321). Data familiarisation stage was facilitated by listening to the talanoa, reviewing fieldnotes, and manually verifying the transcripts produced against the audio data. Initial codes were then generated. A sample of six transcripts were carefully read – through the lens of AI and through the values of associated with the Kakala framework – to generate a list of representative codes. By virtue of reading through these lenses, the coding was both inductive and deductive. Codes were drawn from participant contributions (thus inductive) but were limited to those which would respectfully highlight the successes, strengths, and dreams for the future shared by my participants (thus deductive). The application of AI as a lens also led to the codes being organised into two distinct groups – "Discover" and "Dream" – to capture the information that would best help to answer the questions related to each of these (Figure 8). The codes were then loaded into NVivo (version 11, and then 12), and all transcripts (and the field notes from the one interview not recorded) were coded.

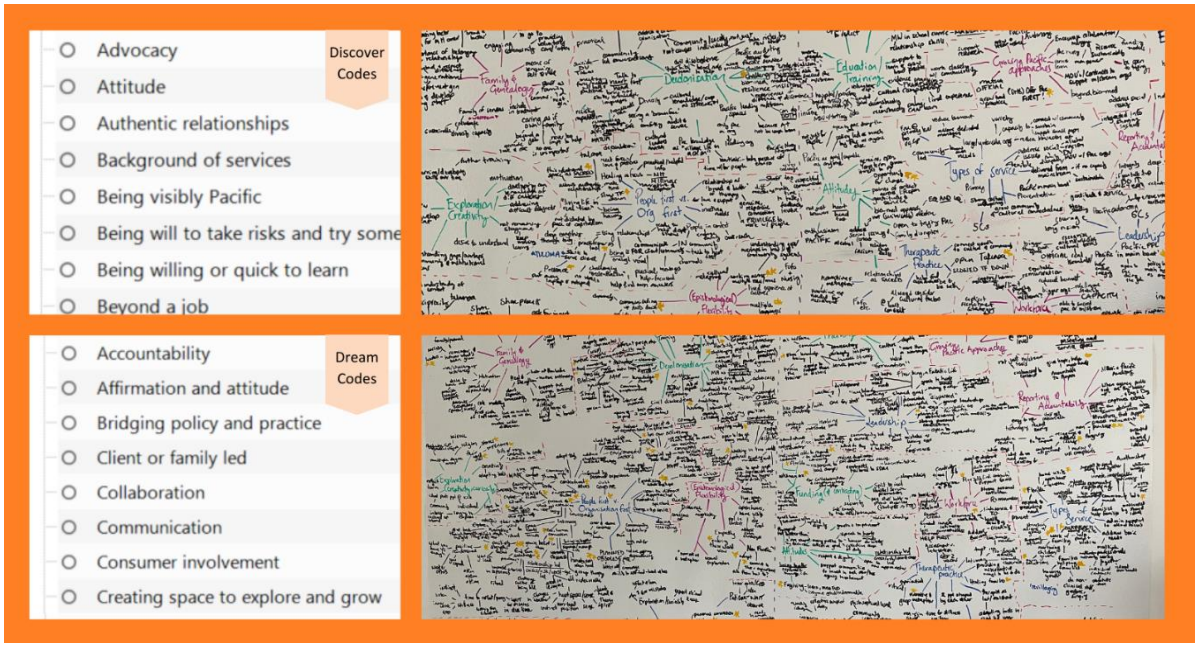


Figure 8 - Sample of NVivo codes and visual mapping

A few additional codes emerged through this process; however, none were combined/condensed. A second round of coding was then undertaken, with a focus on synthesising codes into themes (as per stage three of the Braun and Clarke (321) process). This involved the use of both NVivo, and a visual mapping process undertaken using a whiteboard; codes and ideas were mapped around tentative themes on the whiteboard (Figure 8), and, once the white board was full, this would be photographed, wiped, and the process would start again with the next set of transcripts.

Next, these themes were reviewed. This was achieved by bringing the photographed whiteboard mapping for each tentative theme together and creating an "uber-map", where all ideas relevant to that theme were visible at once. This process also facilitated stage five - –wherein the *significance* of themes must be determined – by helping to reiterate the presence of common themes by highlighting areas of complementarity, interconnection, and flow. The uber-map for the Dream themes is shown in Figure 9 as an example.

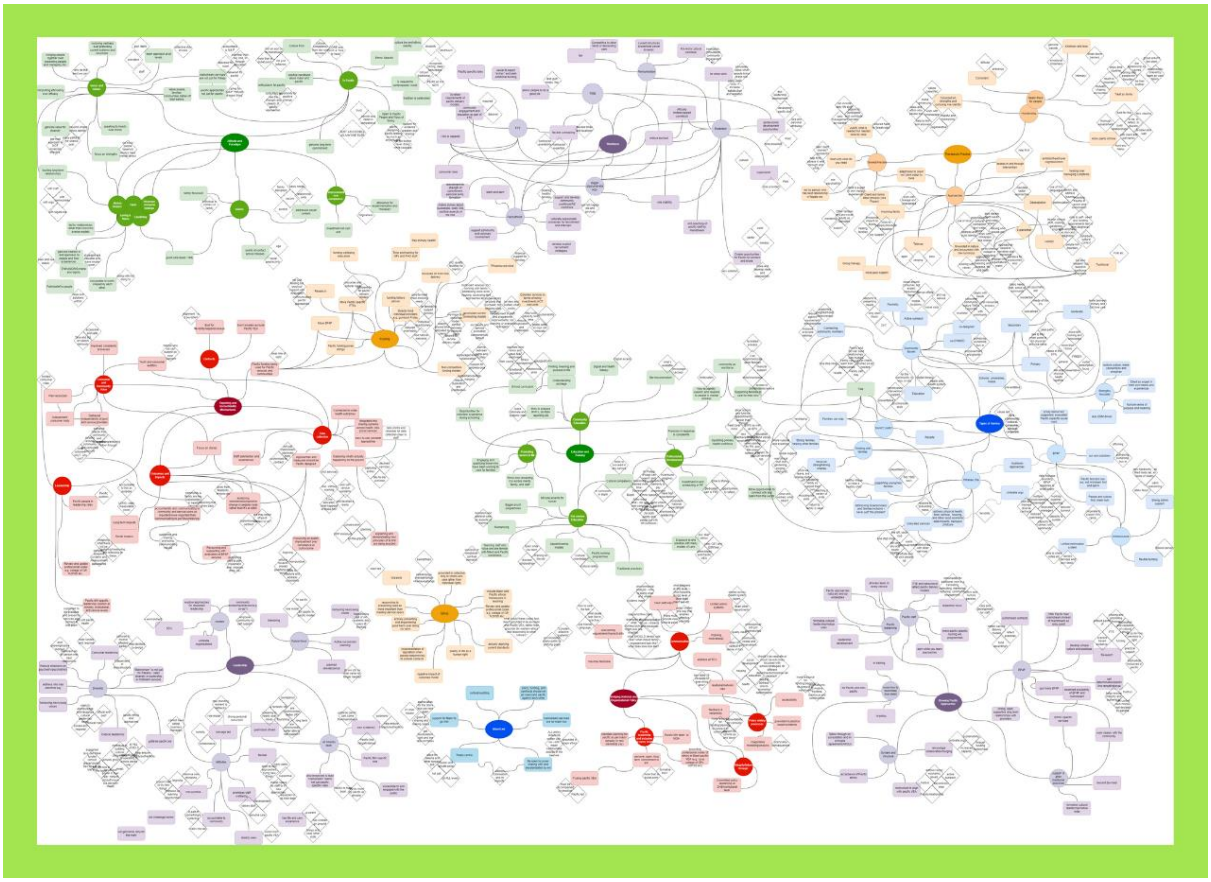


Figure 9 - Uber-map of themes

Once this was completed, the final stage of thematic analysis – drafting the findings and discussion – commenced. The decision was made to present the findings and discussion alongside each other to ensure a clear line of sight from my participant contributions to my interpretation thereof. The initial draft reached almost 200,000 words. Extensive editing was undertaken, guided, as above, by AI and the values of associated with the Kakala framework. This resulted in the narrowing of my discussion and a more streamlined presentation of ideas; however, it also meant many strengths, successes, benefits, and positive impacts – alongside many wonderful policy ideas – were regretfully set aside.

The draft findings and discussion were then prepared for validation. Each participant was sent the pages where their contributions had been used, with other participants' contributions redacted.

This was undertaken as an additional accountability measure in response to concerns expressed by some participants regarding Pākehā interpretation and representation of Pacific knowledge in the past, and to ensure that consent to participate and decisions around the use of names/pseudonyms were genuinely and fully informed. Only minor changes were requested, and almost 1/3rd of participants elected to use their real names (n=11).

3.3.4 Luva, Mālie, and Māfana

The "Luva", "Mālie" and "Māfana" stages cannot properly be undertaken until after the thesis has been assessed. That being said, the "Luva" and "Mālie" stages have already begun through the validation of findings; a number of participants have reached out regarding the strong alignment between the findings and other projects they are working on. These conversations have also given me the opportunity to reiterate my gratitude and my commitment and openness to supporting with next steps. Naturally, these conversations have been māfana, and have signalled the beginning of the "Māfana" stage, a period of shared joy, celebration, and warmth as the completion of the PhD process approaches. Recognising the end of the PhD is not the end of the work, nor the end of the Kakala process. The "Luva", "Mālie" and "Māfana" stages will be discussed in more detail in Section 5.3.

4.0 Findings and Discussion

4.1 "Discover" – exploring the "very best" of Pacific mental health practice

As noted in Section 3.1.2, the "Discover" stage is focused on identifying the best that exists in an organisation or field (1-3); in this case, Pacific MH practice. The research question associated with this stage of the 4-D cycle is:

> ***Discover:*** *What has been successful in Pacific MH practice here in Aotearoa/New Zealand, and what unique strengths of Pacific MH practice have empowered this success?*

The sub-chapters below will describe and discuss the "positive core" of strong, successful Pacific MH practice – here embodied in the concept of "Vā and values-based practice" – before going on to explore how this positive core manifests in three key areas of strength amongst PMHP and their contributions to "successful"[6] MH practice. These three areas are "resistance and persistence", "family focus", and "putting tāngata whai ora first". Despite talanoa focussing on what PMHP are doing well, participants also highlighted a number of ways in which Pacific leadership is crucial to supporting strong practice, and so a fourth area of strength – "leadership" – will also be explored.

4.1.1 Vā and Values Based Practice – the "Positive Core" of Pacific mental health practice

Appreciative Inquiry posits each organisation or field has a "positive core", some essence or deep internal metaphor which acts as the source and foundation for the strength of that organisation

[6] As per the introduction to this thesis "Successful" mental health practice will be defined according to the aspirations expressed through *HAO* (62), *New Visions: Collective Solutions* (72) and the subsequently released *HAO Wellbeing Outcomes Framework* (80).

or field (3). In light of what was shared in Section 2.1, it is unsurprising that participant contributions pointed toward "Vā" as the "positive core" of strong, successful Pacific MH practice. As the "positive core" Vā – and the onto-, axio- and epistemological position it expresses – was also recognised as a defining feature, one that set Pacific approaches to MH practice apart. This section will briefly explore a number of participant contributions that highlight the Vā – and particularly values that accompany it - as a defining feature and core strength of Pacific MH practice. This will set the scene for the following chapters, which will explore how this "positive core" manifests in the strengths of Pacific MH practitioners.

Samoa/NZF31-40 was acutely aware her team operated together in a strongly values-led way - *"I think what our team created was that we did work we did have really strong values, we worked from a place of values"* (Samoa/NZF31-40) – and that this was important for them, binding them together with a sense of shared purpose and guiding their daily work:

> *"I don't want to be too judging of non-Pasifika teams but, these values that we have, they are shared, and our purpose is shared, there is a collective sense… anyone that does come into these caring profession roles does have those values of wanting to care, but maybe also their understandings of what that looks like, their limitations and their boundaries of what that looks like is quite different to Pasifika." – Samoa/NZF31-40*

It is evident, particularly in this second excerpt, that the specific expression of these values is a distinguishing feature of her team and their work. Samoa/NZF31-40 reflects – gesturing toward the ineffability and nuance of the axiological differences – how values such as love, respect, humility, service, and reciprocity are enacted differently amongst Pacific peoples working in MH than they are amongst non-Pacific MH workers. She recognises some similar values are operating, motivating non-Pacific people to work in caring professions and to do their best by TWO, but also that the understandings, emotions, sense of being etc. which informs these values – their ontological

foundation – is fundamentally different. Dwaine Faletanoa'i gestures towards something similar when he says:

> *"I wonder how we replicate that. I don't know if we can. Those values of reciprocity, humility, servitude." – Dwaine Faletanoa'i*

While the ability to translate these values – reciprocity, humility, servitude – into English indicates there is something shared being expressed, his reflection on their non-replicability reinforces their non-equivalence, uniqueness, and rootedness in different ontological ground. Samoa/NZF41-50 too expressed some overlap between her Pacific values and those of *certain* mainstream MH services. She identifies that Child and Adolescent MH Services (CAMHS), with their greater emphasis on family and relationship, were more aligned with her values and her approach to MH care than mainstream adult or forensic MH services. This reflection was shared alongside a story of educational and training spaces where her Samoan identity and culture were suppressed, highlighting how CAMHS was an *exception to the norm*, and thus reaffirming the uniqueness of the Pacific ontological and axiological position and its expression in practice:

> *"I struggled a little bit at uni because I don't think that gave any room for culture, for your identity…I do feel like I had to decolonize myself after uni… that's why working in a child and adolescent service really helped because it was much more aligned to my values, that actually helped me to develop being okay with all the uni stuff, taking the good out of it." – Samoa/NZF41-50*

Samoa/NZM41-50C contributes further to the discussion, echoing both the profound importance of Pacific values to his practice, as well as their difference from those espoused and enacted in mainstream MH settings:

> *"And then my other comment [regarding my strengths] was that Pasifika values made a difference, which was a positive, but also it could be challenging. Having Pasifika values…in a mainstream setting - it's part of my hardest ones, as well." - Samoa/NZM41-50C*

He states his values – embedded in and expressed through his Pacific culture and identity – are a strength of his, one that informs his leadership style and has made a positive difference to his clinical and managerial practice. However, he also points toward these values being different from those of his peers when he highlights the difficulties faced; *"it's part of my hardest ones, as well"*. The acknowledgement of these difficulties, and his persistence in acting according to these values regardless, also emphasises how deeply these values are held and how conscious he is of maintaining his orientation toward them in practice.

These examples demonstrate the centrality of the Vā to the work of PMHP. They confirm Vā as the "positive core" of Pacific MH practice, the strength that defines and sits at the heart of Pacific approaches to MH. They also articulate the uniqueness of this position and gesture toward the ways in which Vā and the values it encapsulates inform and support the positive contributions made by PMHP. The following sections of this thesis will explore these positive contributions in more depth, probing what it means to provide MH services in a way that acknowledges the Vā, inquiring into how this "positive core" manifests in the strengths and successes apparent in the daily work of my participants.

E sui faiga, ae tumau le fa’avae

The ways of doing may change, but the foundations remain the same.

“Our Pasifika values don’t change, our approaches do.”
(Papali'i Seiuli Johnny Siaosi cited in 161)

4.1.2 Resistance and Persistence

Persistence and resistance in the face of pressure to assimilate and conform was one of the key strengths that emerged from the talanoa. Participants shared that their experiences of difference – and of refusing to diminish or devalue that difference – played a vital role in enabling them to provide responsive, holistic, humanising, and family-centred MH care, delivered with love, compassion, empathy, relational mindfulness, and a deep awareness of the impact of cultural alienation, racism, and generational deprivation.

The next three sections will explore how PMHP have demonstrated strength by:

- resisting dominant epistemological perspectives to operate flexibly across a multiplicity of paradigms;
- defying category-based thinking and structures to embrace both themselves and TWO as whole people;
- deploying their knowledge of other life-worlds to challenge the status quo and make space for new, more ethical, and more effective ways of working.

It will also explore how these acts of resistance and persistence relate to and enact both the Ethics of the Vā and a deep, Vā-led awareness of relationality and contextuality.

4.1.2.1 Walking in multiple worlds

This section will build on the ideas discussed in Section 2.1.3 and 2.3.4, exploring how the Vā as an epistemological position constitutes a strength that manifests in Pacific MH practice and that supports the successful navigation and reconciliation of the multiple worlds Pacific peoples inhabit. It

will describe some of the ways in which PMHMP move between and across multiple worlds, accessing and making using of diverse knowledges to provide care that is more holistic, embraces and affirms Pacific worldviews and identities, addresses the root causes of distress to facilitate healing, and ensures TWO feel seen and respected.

Participants shared how – when one is able to perceive different and multiple truths and ways of knowing as being in respectful relationship with each other – one is immediately better supported to operate in multiple worlds, to draw on and make use of the knowledge, traditions, and approaches these multiple worlds contain. The participants in this study recognised this was a particular strength of theirs, and made clear links between their ability to draw on knowledge and approaches from across a range of paradigms to provide more effective care for the people in their communities:

> *"Of all the things I've learned in the Western world, it gives me tools and knowledge. But I'm in a space now that I can utilize that to negotiate what is the best practice. What can it be that will benefit more of our Pacific people?" – Manu Fotu*

Here best practice isn't positioned as a singular, fixed mode of operating, defined by Western scientific and bio-medical evidence. Instead, it is open for negotiation, defined by the context and purpose of the information, by what will be of most benefit *in the situation at hand*; this is the operationalisation of the Vā as a negotiated/negotiating theoretical space (120). The knowledge and approaches Fotu draws on might be cultural, might be clinical, or might be some combination of the two; neither are prioritised or excluded by default. Instead, he is empowered by his epistemological position to draw on either or both, to determine what is best by virtue of what will most benefit the Pacific community he serves.

Participants acknowledged numerous benefits to this approach. For example, they recognised that being willing to respect and engage different types of knowledge helped to ensure they were

open to different types of knowledge, making space for such knowledge to be used in clinical practice. The use of spiritual knowledge and insight was given as an example of this, with its inclusion supporting holistic care and access to levels of healing typically excluded or overlooked by Western science and bio-medicine:

> *"In the mainstream its very head centred, theory centred, and science centred, which has a place. In the Polynesian framework we are very heart centred, spirit centred and what scientists today would call, in quantum theory, the non-local position…you might call it faith, or spirituality, but I think mainstream is slowly beginning to realize that for Pasifika and Māori, the wairua, the Mauri ora, the faith, for want of a better word, believing in things that can't be seen, that is, and needs to be, on the same level of health and healing as science, psychology, and medicine. It must be because it works for us." - Cabrini 'Ofa Makasiale*

Makasiale can not only see a relationship between theoretical physics (as a domain of Western scientific knowledge) and the heart-and-spirit-led knowledges of Pacific societies, noting their overlap, but also that spiritual knowledge needs to be *as respected* as Western knowledge given its contextual and personal efficacy in facilitating healing. The profound importance of this respect for different types of knowledge, particularly for spiritual knowledge, is illustrated below:

> *"There's a [matua I know], and he's talking to me about his daughter… she heard voices. She had been diagnosed with schizophrenia, and her father could identify all the voices. They were all people that had passed within her family and yet, she still just got all the drugs and no real cultural treatment…I interviewed Pacific consumers who were completely traumatized by their experiences. Knew that it was something else… For most of them their dignity had been completely squashed. They hoped there was another way of understanding their experiences that gave them some dignity, but it was beyond their reach." – Dr. Karlo Mila*

By being open to multiple ways of knowing, – including not only the clinical and the cultural, but also the spiritual and ancestral – and by respecting the value and position of all, PMHP are able to affirm TWO and afford them greater dignity, finding ways forward that resonate with their worldviews and accommodate how they experience and understand their own illness:

> *"There's such a focus on medication compliance and psychosis. But, from my experience, people have to often live with their voices and their experiences all the time. And the medication often doesn't work, or it works to a degree. It turns things down, but people still have to learn how to live with it. And then how they make meaning out of that is really important and is your way in. But if you don't value a world view or how somebody sees and understands their experiences, then you're just never going to get anywhere." – Cook Island/NZF31-40*

These excerpts *also* highlight how the Vā – as an epistemological position – supports successful MH practice by encouraging Pacific practitioners to focus on how knowledge makes people *feel*. Focussing on relationships – including the relationships between ideas, between the people sharing ideas, and between ideas and people – requires consideration of how different ideas or approaches impact people emotionally:

> *"It's important that we start to really get into that topic around how people are treated. Because at the end of the day it doesn't matter what modalities, what knowledge you've got, if you've got your own biases and racism happening, you're never going to get good engagement." – MāoriM41-50*

A Vā-led approach to knowing and doing supports PMHP to remember – for those in distress – that being kind is always going to be as important to the success of a treatment approach as being "right".

Being able to walk in multiple worlds means PMHP are not only more open to and respectful of multiple ways of knowing and doing, but also that they have access to and lived experience of the same. PMHP in Aotearoa have significant experience of Western-scientific, bio-medical, and clinical ways of knowing and doing. While it may be stating the obvious, they also have lived experience of Pacific cultures and communities:

> *"Another strength of the way you practice is you have strong lived experience of the communities you serve?// Yeah. I'm still part of the community. I come from that community." – Sipaia Kupa*

The practical impact of this is that PMHP bring to their practice both significant clinical knowledge and an in-depth, connection-based understanding of their communities:

> *"I can do the Pacific stuff and I can do the mainstream stuff. You can't do the Pacific stuff. I can play in that field, and I can play in your rugby field as well." – TongaM41-50A*

> *"I have a strong clinical background in assessment, diagnosis, and management of patients…But also I do have a strong cultural background as well." – Sipaia Kupa*

Kupa – and PMHP like her – have strong clinical knowledge and skills and are able to deliver MH care in a way aligned with their Western training and with Western-institutional norms. As an active part of their communities, they also have experience of their strengths, their struggles, and their history in a way not easily gained when approaching said communities from the outside. This cultural- and community-specific knowledge actively enables them to provide care embracing Pacific worldviews, affirming cultural identity, and addressing cultural alienation as well:

> *"Every single Pacific worker knows it matters they're Pacific…. they bring with them a whole bundle of shared experience and zero racism and an understanding of lived experience, not as someone that's sick, but as Pacific people, that immediately sets people at ease." – Dr. Karlo Mila*

> *"The additional cultural competencies I bring to my work, my worldview… that's really important when I'm seeing Pacific clients because they don't have to explain their worldview to me. The way I think about these situations and have an understanding of it, which is not just strictly Palagi." – Samoa/NZF41-50*

Lived experience of and participation in Pacific communities supports practitioners to provide a space for Pacific TWO where they feel welcomed, understood, and do not need to explain their cultural worldview or justify themselves and their values/beliefs. Mila also identifies the lack of racism Pacific

practitioners bring with them; having been othered, made to feel different and as though their cultural paradigms and ways of being and doing are "not as good", these practitioners are able to operate in ways deeply sensitive to similar experiences in others. Importantly, this sensitivity is extended to other non-Pacific ethnicities, and supports accepting, non-racist, culturally affirming practice across the board:

> *"I talked to him about the cultural differences [between the predominantly European staff and many of the clients], and said…Because I understand, I come from a different culture. And in this [Western institutional] environment, I see the need…" – Manu Fotu*

Lived experience of both Western clinical and Pacific cultural ways of knowing and doing also means PMHP can embrace, access and competently and authentically make use of a wider range of processes, concepts, and strategies to support their practice. This is not only affirming of Pacific worldviews but opens up different perspectives on the causes of mental distress and different potential pathways to addressing it. For example, TongaM51-60 B shares about the Tongan concept of Puke:

> *"The Tongan word for illness is puke. Puke means hold…in our life we're always moving, when we're sick, someone [or something] is holding us. And we're not able to fulfil, because our movement is around social obligations, spiritual obligations. That's being healthy. And our Tongan word for healing is faito'o… To'o means removing. It's removing what holds them down…That's why when we're sick, we don't really treat the individual. We're finding that flow, what to remove so they're able to move." – TongaM41-50B*

By analysing mental illness through this lens, TongaM41-50B is able to reflect on the experiences of TWO in a radically different manner; rather than asking "what can we do to minimise symptoms/manage this illness?", he asks "what is holding them down/stopping them from moving?". Reflecting what was discussed in Section 2.2, traditional Tongan medicine posits the

someone/something stopping movement is likely to be spiritual in nature, and brought about by an interruption to respectful, and reciprocal Vā relationships (130, 148, 196). Regardless of one's culture or one's spiritual beliefs, however, the central metaphor (and the logic which underpins it) adds significant value to the diagnostic discussion (and also, importantly helps to facilitate more holistic care through its incorporation of the social and the spiritual). The notion of Puke moves us immediately to a place where disruptions to respectful relationships can be given priority and the root causes of distress can be addressed:

> *"If you disrupt the social relationship, it contributes to illness. Same as disrupting the spiritual relationship. It's about going and asking for forgiveness, and when those relationships are mended, then the flow of life continues…it's about removing what stopped that flow rather than trying to control it." – TongaM41-50B*

Access to different perspectives on distress and pathways forward from distress was also discussed with regard to the use of culturally embedded narratives, rituals, and symbol and of therapeutic approaches that operationalise these. These approaches will be discussed in more detail in Section 4.1.4.2, however they too are evidence of how walking in multiple worlds can help to inform practice that is more holistic, culturally affirmative, and effective at addressing the root causes of mental distress.

Being able to access experiential knowledge of Pacific communities and their traditions as well as evidence from bio-medicine and the Western scientific institution also enables PMHP to operate with immense flexibility and responsiveness, adapting ideas and approaches to best meet the needs of the current context. Participants spoke to instances where they had modified Western models, so they made more sense from a Pacific perspective:

> *"Everything that happens, models that come out that we need to adapt to, we put our own Pacific version there, so it benefits our clients, so they can understand it*

and take it from the perspective they're used to, the Pacific perspective." – DHB Pacific MHA Team Member 1

"Play Therapy is very North American-European…And certainly with our clients...it didn't feel real. It was almost too artificial, too different to their lives, the way of play. Had to be culturally relevant for the kids we were dealing with…not a play therapy as you'd kind of traditionally see in terms of therapeutic approaches" – Cook Island/NZF31-40

Modification in the other direction – Pacific to Western – was also described, with Pacific approaches being adapted to accommodate non-Pacific TWO:

"We did a lot of schools and alternative ed where there's not strictly Pacific youth there.//Did you work in the same way with them?//Absolutely.//Was it as effective?//All in all, I think there's a lot of elements they enjoyed. They enjoyed the humour and the creativity; we had drama going and sports. But then, there are other things, such as specific language we might have used…That's where the strength of adaptability [comes in], isn't it? We develop and adapt our programs to make sure they hit the mark with non-Pacific youth as well…Not forcing any one particular view over the other. Respecting both. Like we did in all Pacific teams. " – Dwaine Faletanoa'i

"I remember running a group for guys in prison and we were using Mana Moana…And within this there were some Pākehā boys. And a couple of them had white supremacist perspectives on stuff. And it was interesting, in the first session there was real reticence from them...The first session they were openly like "What has this got to do with us?" But by second, third sessions, they'd bought into the whole lot. I didn't go in there with that approach of "you have to", and I took the time to shape it for them, without being offended by what they were saying." – Cook Island/NZF31-40

These excerpts show how epistemological openness translates into practical flexibility and responsiveness. Through access to a wider range of processes, concepts, and strategies PMHP can choose between these or weave them together as has already been shown, but – more than this – they can also compare and contrast, find equivalencies, make substitutions, reject broken elements, create hybrids, and generate entirely new ways forward to meet the diverse and changing needs of the TWO in their care.

Participants expressed a high level of confidence in their ability work in this way, and identified this as a specific strength of Pacific MH practice:

> *"I can quite readily move between worlds…non-Pacific, Pacific, male, female, all the different types, different cultures, I've always felt like a part of my responsibility is able to respond to my clients in the way that best fits how they're presenting." – Samoa/NZF31-40*

> *"It's not just the cultural stuff, but it's the intergenerational stuff, because you have the New Zealand born and the traditional people from Tonga, like me. We have the ability to move around those dimensions...If you're a young person, we adjust a model of care for you to fit your world. If you're a traditional person who grew up in Tonga and came here, you would still have those traditional ideas and stuff, but we can adjust the model for that. Pacific organizations can adjust to whoever you are. And I think one of the problems for mainstream is they apply the same blanket approach to everybody." – TongaM41-50A*

Many of those interviewed for this study were extremely open to sharing their knowledge, and upheld the idea non-Pacific people could, with immersive engagement and sustained commitment, gain a deep understanding of and some fluency in Pacific cultures and epistemologies (just as they, through years of exposure, have been able to gain fluency in Western culture and Western ways of knowing and doing).

> *"I now have an ability to work across different paradigms //Right. [Having left Tokelau and] learning how to work in New Zealand society, with those other paradigms, those are things that can be learned?//Absolutely they can be learnt.//So it's perhaps a matter of taking time for a lot of our non-Pacific peers?//Yep the only way they can learn it is to be exposed to it and to have some lived experiences of it as well." – Sipaia Kupa*

TokelauF51-60 shares how welcome it is when non-Pacific want to learn to walk in multiple worlds as well, stating it is "awesome" to have passionate non-Pacific people working in Pacific services:

> *"I believe there is value in embracing non-Pacific people who have an interest and passion to work in Pacific services…I see this as an opportunity to share our stories as Pacific peoples, our experiences and our values to provide insight and awareness as to who we are and our ways of knowing, our epistemologies." – TokelauF51-60*

Another practitioner – SamoaF41-50 – shared how she enjoyed mentoring non-Pacific colleagues, and allowing them to observe her work, as she could see they were curious and this was an opportunity for them to learn more, and for her to demonstrate the effectiveness of her approach. While Pacific peoples have understandings and experiences of their indigenous cultures and diasporic communities that will always be inalienably their own, this does not mean cultural knowledge and strengths related to intellectual humility and inter-cultural understanding cannot be developed amongst non-Pacific practitioners. Rather, such strengths must be developed and Pacific peoples – as a group with a strong epistemological framework for navigating multiple worlds of meaning – should be recognised as being well equipped to lead this development.

It has been identified "*the most effective worker for Pacific people is someone who has sound knowledge of…Pacific cultures and processes and has the ability to integrate both Palangi (European) and Pacific knowledge to help their client*" (158). This is something PMHP achieve par excellence. By resisting the "one truth ideology" (100) of Western science and persisting with the contextual, multiplicitous epistemology of Vā, PMHP are uniquely empowered to create spaces where TWO from all backgrounds feel safe and affirmed; where their holistic wellbeing and the root cause(s) of their distress can be addressed; and where the approaches used have been carefully tailored using concepts, processes, and strategies drawn from a more inclusive and wider ranging pool of knowledge.

4.1.2.2 Defying categories to be and work holistically

Persisting with multiplicity and resisting singularity also means refusing to buy into the distinct and separate categories evident in the structure and operation of the Western colonial state and its institutions. This section will explore how PMHP defy the entrenched categories that separate different aspects of healthcare and that separate healthcare from other social services to operationalise a holistic understanding of health and wellbeing, engaging with and caring for TWO as whole, complex human beings. Many practical aspects of delivering holistic care are noted below; these will be explored in greater depth later in the thesis, while the focus here will be on highlighting a range of the factors considered by PMHP to inform their understanding of TWO as whole people, and on reflecting how this understanding can inform a holistic approach to care. It will also explore how PMHP apply the notion of holism to themselves, and how this empowers them to be, value, and make use of their whole selves in and through their work.

Participants in this study recognised the systemic tendency towards focusing on specific health problems and/or only addressing limited aspects of a person's experience as a major factor contributing to the current inadequacy of (mental) healthcare in Aotearoa:

> *"How much of the Inquiry was about saying it's a broken system?...It's knowledge is insufficient to meet the need, it's solution to the pain and mental anguish isn't sufficient because it cuts off its picture of personhood." – Phil Siataga*
>
> *"So, you know in DHB land, MH was always kind of on the side… there was always an issue around TWO coming in there - not for MH issues - they came in there for diabetes, and you need to deal with MH too." – Samoa/NZM41-50A*
>
> *"You can't treat people like problems or treat just the disorder. You have to work with the whole person." – Cook Island/NZF31-40*

While focused on different aspects of this issue, these participants express that a reductionist approach – wherein the focus remains fixedly on a single or narrow range of presenting issues – is ineffective, as the full spectrum of people's needs are not being recognised and met and important

parts of who they are and what they experience are being "cut off". PMHP, on the other hand, place significant emphasis on the importance of engaging with TWO as whole people.

When discussing their understanding of TWO as whole people, PMHP went well beyond ensuring both mental and physical health were considered, placing a strong emphasis on understanding the experiences of TWO and the challenges they had faced in a range of "non-health" contexts. Participants were almost unanimous in their reference to the importance of one context in particular, this being socioeconomic wellbeing. Participants reflected on the immense challenges faced by many TWO and their families as they sought to meet their basic needs (e.g., for safety, shelter, food, and medical care) while struggling with mental illness:

> *"You're supporting young people and families that have really severe MH issues and severe socioeconomic issues as well." – Samoa/NZF31-40*

> *"Someone might be having a MH crisis and it's partly because their fridge is broken down and their car's not working, and because 40% of us are fundamentally in poverty, that's such a big driver..." – Dr. Karlo Mila*

As reflected by Mila, there was also a strong awareness of how these socioeconomic challenges and MH struggles acted in mutually exacerbating ways, with socioeconomic distress contributing to mental distress, in turn making it harder to address socioeconomic distress. PMHP described working to ensure they understood the socioeconomic context and needs of the TWO in their care, making plans and taking action to ensure these needs were met. This helped to interrupt the cycle of negative reinforcement so TWO had the mental and emotional energy needed to participate in more directly therapeutic activities:

> *"You'll do the safety and following the needs putting those things in place first before you can start doing some counselling." – MāoriM41-50*

PMHP also engage with TWO as whole people by developing their understanding of the societal and historical contexts that have impacted them and their families:

> *"We covered things like colonisation and the impact of that on our migrants, on our community. We covered areas like displacement, identity and then narrowed it down to specifics." – Sipaia Kupa*

The importance of societal and historical context was primarily discussed with regards to Pacific TWO, though mention was made of other communities – such as Māori – who have experienced traumatic societal and historical events. Through addressing such events as a part of their approach to providing care, PMHP enact a recognition that TWO exist in an ongoing relationship with the people and events of the past, and that through this relationship the past can be present in the here-and-now. They acknowledge these past collective experiences of trauma can and do impact the present wellbeing of individual TWO in and through their ongoing impact on families and communities. They appreciate exploring these can provide information about underlying factors that may be affecting the present experiences of TWO and contributing to their distress. By acknowledging this they are able to respond to it, moving beyond a model of diagnosing and treating individual symptoms towards one where deep, collective healing can be facilitated and root causes of distress can be addressed.

The environmental context – both in terms of community/family/home environment *and* natural environment/land – was also noted as important. Acknowledging and engaging with the community/family/home environment was seen to enable the recognition of a range of underlying factors that could contribute to distress *and* that could support with healing (this theme will be explored in more detail in Section 4.1.3.2). Participants were clear in their understanding that this context constitutes a significant part of people's experience, one present to them and affecting them almost constantly:

> *"It's the environment…we forget about the conditions, the role of the environment in it all. And actually, what triggers it, it's not just the [dependency on the] drug alone, it's actually the environment that's triggering it or causing people to do behaviour." – Cook Island/NZF31-40*
>
> *"We know we might see them for one hour a week…but they're in families and we need to make sure those families are supported…because it's those families that are going to have the biggest impact on that young person's life…."– Samoa/NZF31-40*
>
> *"We actually survey each household, to get a sense of what they need ... in time we'd know every household, what they need, and a way to respond, and hopefully replicate that in the other areas... And the stuff we're doing here, means we're connecting neighbours, and then supporting their strengths." – Samoa/NZM41-50A*

Engaging with the home/family/community context was seen as vital to ensuring that positive changes last long-term, that the unique circumstances and daily lives of TWO and their families are factored into care, and that communities are strengthened and empowered to care for their members.

The importance of the natural environment/land was discussed somewhat differently but was equally important to how PMHP developed a holistic understanding of TWO. My discussion of Vā notes the profound connection between family and (home)land, the spiritual interconnectedness of people and place expressed as kāinga. This was reflected when practitioners discussed the need to include the natural environment/land in their provision of MH care:

> *"It is [also] the land, the connection to the water, and if the land is not good… That's why we're part of the [local river] restoration… For Māori it's natural, and for Pasifika it's actually returning to that..." – Samoa/NZM41-50A*

It is highlighted here that – by virtue of the spiritual connection to land – harm to/dysfunction within the natural environment/land can also have a negative impact on the wellbeing of TWO. Conversely, working to restore the natural environment/land and actively connecting with it to grow and produce

things can be psycho-spiritually beneficial. PMHP, through their understanding of holism, allow for the psycho-spiritual impacts of environmental harm and disconnection to be acknowledged – impacts of ever-increasing relevance and concern – and are thus empowered to facilitate therapeutic activities that support the restoration and healing of both TWO and of the land in and through their relationship with each other.

Another core way in which PMHP work to understand TWO as whole people is through the inclusion of spirituality as an integral aspect of wellbeing. The practitioners interviewed recognised resisting the exclusion of the supernatural and making space for spiritual perspectives and practices as essential to holding space for the whole person:

> *"We know how to work with that supernatural realm, where the biomedical just cuts it off. It doesn't just cut it off, it actually interprets any supernatural experience or experience it can't explain within the confines of naturalism, as dangerous, harmful, and wrong. We're not allowed to experience that whole self, and that's when people come to me, and say, 'How do I make sense of what's happening?'" – Phil Siataga*

Siataga echoes the participants cited in Section 4.1.2.1 who reflected on the importance of including spiritual knowledge, of recognising the presence of ancestral voices, of wairua, and of the "non-local" to both avoid the pathologisation of spiritual experiences and to ensure the entire experience of TWO can be respectfully acknowledged and meaningfully addressed. The willingness to include spiritual perspectives and practices also supports people to feel safe to be their whole selves, thus supporting them to participate more fully in their care:

> *"You want to look at the holistic person, their spirituality, the other parts that make that person. And I think you can get that real good engagement really quickly by doing that." – MāoriM41-50*

"When we say prayer before beginning a meeting with our patient there's almost an audible sigh of relief as if to say 'Oh, I feel safe. I'm okay here. I feel safe enough to share my story.'…That's a success in itself." – DHB Pacific MHA Team Member 5

PMHP also expressed a clear recognition of the whole person as a cultural person, a person embedded in the values, beliefs, and practices shared amongst their ethnic, disability, rainbow, religious or other communities[7]. Participants described how familiarising themselves with the values, beliefs, and practices of the TWO in their care and supporting them to experience strong, positive cultural identit(ies) was a vital part of engaging with and supporting them as whole people. It was recognised, in many instances, that developing positive cultural connections had been difficult for TWO, with discrimination, ableism, racism, migration history and a range of other factors impacting negatively on their ability to see themselves and their culture(s) as valuable, and, in turn, negatively impacting their wellbeing:

"What's really important is that practitioners plant these seeds. A lot of people I see [for supervision] say 'But people come to me, and they say, 'I don't want none of that [cultural] shit.'' I say 'Well, do you keep planting those seeds?'" because where does the conversation end? Straight away? If I say [to TWO] 'That's okay, let's move on' what have I just done? We have a responsibility to keep planting those seeds." – MāoriM41-50

"Part of it is getting people to feel okay with their cultural identity no matter where they are, but also building their cultural identity 'cause we know that leads to wellbeing." – Samoa/NZF31-40

Providing cultural care – exploring, affirming, nurturing connection to, and providing information about, culture – was seen as an integral part of supporting TWO, helping them to make sense of the past and of themselves, to connect with their community, and to participate confidently in their families.

[7] In the context of this study, the emphasis was very much on ethno-cultural identity.

This strength – being willing and able to engage with TWO as whole people through engagement with their societal, historical, and environmental context as well as their spiritual and cultural selves – supports PMHP to successfully deliver care in a variety of ways. The discussion above shows how viewing people holistically supports deeper, collective healing; nurtures sacred connections; enables the identification of triggers and supports in the world around TWO; and contributes to creating therapeutic environments where TWO feel safe to be themselves. Summarily, it facilitates more in-depth and accurate formulation/diagnosis (and, in following, more detailed and effective treatment planning) and supports meaningful engagement and a strong therapeutic relationship by ensuring TWO feel seen as human beings rather than a set of problems to be solved:

> *"It's being able to provide treatment from a clinical perspective, but ensuring, too, we are… able to look into the person as a whole, not just the MH stuff… it's quite easy to formulate to help towards a diagnosis when you see the person as a whole." – DHB Pacific MHA Team Member 1*

> *"All they want to know is, how much are you using, how often, rather than getting to know the holistic person, because the use is only part of who they are. It's the rest of them that really matters, and once you talk about the rest of them, then they'll probably just start reducing their use anyway, because they know someone's invested and interested in them." – MāoriM41-50*

PMHP also embrace the whole self and strive towards a sense of holism through their understandings of their personal and professional selves. Categorisation and labelling of the self – wherever it limited the scope of selfhood or detracted from a sense of wholeness and complexity – was eschewed by participants and the PMHP in this study who consistently refused to be limited or defined by any one marker. The defiance of limiting categories and persistence with a complex, multi-faceted selfhood was expressed particularly strongly by some of those who identified or who could be identified as Pacific MH consumers. There was a strong sense of resistance when it came to this

identification, not out of shame or discomfort (both participants quoted below are open about their experiences of mental illness) but due to the reduction of one's understanding and expertise to that particular role:

> *"The interview questions, either focus on people's experiences in MH practice or as MH consumers…where you would want to position yourself?// I don't really like that binary. I'm just going to be really straight to the point." – Dr. Karlo Mila*
>
> *"I never took on that label as being this peer support because I thought it was restrictive and I think being able to identify with somebody's journey, that made my work effective." – Tony Fuemana*

These two participants are – in addition to being TWO – MH practitioners, researchers, students, creatives, parents, and worlds more besides. For them, the "consumer" label (used in my interview guide) and the term "peer support" (used with regards to the MH workforce) were felt to be restrictive, perpetuating unhelpful, hierarchical understandings of MH practitioners and TWO. As with others in the study, these participants resisted the idea their perspectives might – or even *could* – be reduced to one aspect of their engagement with MH services, and in doing so encouraged a more holistic consideration of themselves, and in following, of others in a similar position. This consideration is of particular importance when reflecting on the perspectives and experiences of TWO. TWO are often stigmatised and excluded, discursively and socially positioned as less than those who live without mental illness. Resisting these categories and their accompanying labels – whilst still explicitly and unabashedly acknowledging one's "lived experience" – calls attention to their limiting nature, and highlights the expertise, skill, creativity, and complex, irreducible human-beingness labels such as "consumer" often mask. Where the limitations associated with categories such as "consumer" *have* been internalized, this resistance is also inspirational. The presence of those who openly acknowledge their struggles with poor MH whilst also producing excellent research and creative works, raising beautiful families, and delivering effective and responsive MH care themselves, supports other TWO

to embrace a more holistic and complex sense of their own personhood and to see hope and potential in their own lives:

> *"I think it's great in our consumer representation to have somebody like him that's gone through the system, the services and is now a strong cultural leader. It must really provide hope." – Dwaine Faletanoa'i*

Even where lived experience of mental illness was not acknowledged as a part of a participant's background, multiplicity and complexity certainly was. This was evident when PMHP described being asked to distinguish between their cultural and professional selves. Their refusal to align with one over the other echoes the sentiments expressed above; the self cannot be fragmented, and people are capable of being many things at once.

> *"When I was in Tonga… one of the questions that got on my nerves was when a senior doctor says to me, 'How can we differentiate culture and intellect?' I said…'To say they are different is assuming culture is unintellectual.' Culture is intellect. They are one thing." – TongaM41-50B*
>
> *"I can't go into a situation and go, 'Okay, I'm going to be a mainstream person in this role and I'm going to be a cultural person in this role.'…At one of the places I worked, we did have cultural workers, and they're like, 'Oh yeah, I'll accompany you,' and I go, 'Oh, I think I'll be good.' 'Oh no, but you're a psychologist.'…I was like, 'Which part of me do you want to divide out?'; I've got all the psychology competencies, but over and above that [there is who I am as a person and my cultural experiences/self]." – Samoa/NZF41-50*
>
> *"As a part of our cultural processes I was acknowledged as a Matua and then I've coined it as 'consumer matua' but it's not an official job title within the system…This is how my service and my communities recognize me. I'm not allowed to call myself that, because it doesn't fit here. But I am trying to elevate it and keep the connection to community." - Samoa/NZM61-70*

All three of the examples presented here highlight the constructed nature of the categories being resisted and express a recognition that the whole self is present at all times; any limitations placed on that whole self are artificial and imposed. This, of course, does not mean PMHP do not understand

that different parts of themselves – different areas of their knowledge and experience – are more or less relevant in certain contexts. As has been noted, appraising knowledge by its contextual relevance is a strength innate to the Pacific epistemological position. Rather, this recognition and embracing of the whole self as always present empowers these practitioners to acknowledge and draw on all aspects of themselves in their work as *potentially* relevant to the context. It enriches their practice as they start from a place of inclusivity, rather than from within the confines of a given role or field. This both supports the integration of clinical and cultural aspects of care, as well as the modelling of acceptance of the holistic self; PMHP can be more authentically present to and with TWO, simultaneously encouraging TWO to be more authentically present themselves.

The PMHP quoted in this section show strength through their willingness to defy categories that would limit their engagement with and appreciation of human complexity, both in their relationships with TWO and within themselves. They demonstrate how moving beyond a narrow focus on presenting concerns or specific areas of health to recognise and engage with TWO as whole people supports them to develop a deeper and more complete understanding of their needs and to facilitate care in a way more likely to be effective. It was also recognised that embracing oneself as a whole, complex being empowers PMHP both to challenge stigma and defy limiting perspectives, and to approach their work in a more inclusive and encouraging manner.

4.1.2.3 Challenging to create change

Throughout the talanoa, PMHP demonstrated an extraordinary willingness to challenge the status quo, critiquing and actively fighting against ways of thinking and modes of practice that are not meeting the needs of TWO, often at significant risk or cost to themselves. These acts of resistance

made space for or enacted new, more humanising approaches to care, and, in many cases, they also laid the foundations that would support the ongoing implementation and growth of these approaches. The manner in which such challenges are made also emerge as a strength. Through the stories they shared, participants highlighted a range of Vā-led, respectful, persistent, and self-sacrificing approaches to creating change. To reconcile these different-but-related strengths, this section will be structured according to the ways in which challenges have been made, with examples of relevant challenges and the new approaches they have made space for embedded into these examples.

PMHP discussed challenging the status quo through reframing existing structures and processes so they had a stronger focus on creating positive outcomes for TWO and their families. For example, Samoa/NZM41-50C described supporting his team through a service review and restructure process:

> *"A big thing is we started asking "is this actually adding value to the people in our communities?" And that's what's changed and what made us pivot. Before it was around cutting costs, making sure its financially optimal, which is still valid, but…is this actually adding value to the consumers, or family members at the end of service?" - Samoa/NZM41-50C*

Samoa/NZM41-50C shared that a persistent focus on using reviews and restructures as mechanisms for the reduction of costs had contributed to the perpetuation of ineffective approaches to care and stingy, constrained attitudes to decision making. However, by challenging discourse around the *purpose* of these processes and shifting the emphasis away from simply cutting costs, he was able to reframe them, so the focus moved to only spending on services effectively adding value for TWO and their families (thus achieving a reduction in costs *through* a focus on improvements in care). This approach to challenging the status quo does not change how things are done directly, but rather achieves change through shifting attitudes and perspectives. It also operationalises the epistemological position of the Vā; existing structures and processes are not abandoned because of

their flaws. Instead, the motivations for and understandings which underpin said structures and processes are respectfully upheld and brought into critical, transformative dialogue with other priorities and perspectives of greater relevance to the context.

In addition to reframing existing structures and processes, a number of other participants described *using* these structures and processes as pathways to advocate for change, using the status quo to challenge the status quo, as it were:

> *"I knew… that model of care wouldn't have worked for [this TWO] because you spend a certain amount of time per person [and he needed flexible daily care]. What I did was approached my manager at that time and asked whether I could change it… I explained it to the manager, this is what I want to do." – Tony Fuemana*
>
> *"We've also got the trust. We've got our own unique procedures, which have all been through DHB and...our superiors.//You guys have documented procedures, but those procedures are different from what may be happening in other parts of the DHB?//They're certainly different. Yeah…but they are transparent. And they're all being validated." – Dwaine Faletanoa'i*
>
> *"Because our Pacific people were coming through CADS but not fully understanding the intervention, or necessarily making any change…we thought 'we need to do something here'. And that was the response, to try and push a business case through to the management team [to develop a more meaningful and culturally appropriate programme]. And it so happens [a Pacific psychiatrist] was part of that management team. He [and others enabled] seven FTEs from all over the place, and we're doubling our whai ora or clients." – Samoa/NZM41-50A*

These examples highlight the use of existing mechanisms – such as business cases, manger one-on-ones, and internal policy development processes – to both highlight the need for new ways of doing things whilst simultaneously bringing them into being. This approach to challenging the status quo and creating change requires in-depth knowledge of existing structures and processes as well as of alternative approaches to care and is a manifestation the ability to walk in multiple worlds described in Section 4.1.2.1. As with the example from Samoa/NZ41-50C, it also enacts the epistemological

position of the Vā, respectfully upholding existing structures and processes, while bringing them into critical, transformative dialogue. Beyond this, however, these participants describe actively building bridges between Western clinical and management norms and Pacific approaches to care, using the forms of one to re-present, share, and promote uptake of the other.

Another way in which PMHP challenge the status quo and create space for new or different approaches is by engaging with knowledge creation processes recognised and preferred by current institutions (e.g., formal academic and clinical research). This is often done to (re)present Pacific cultural knowledge and approaches the practitioners already know are effective, but in a way that will be taken seriously by the institutions in which they work. For example, TongaM41-50B describes how – on top of his clinical and teaching work – has undertaken a comprehensive and rigorous research project which evaluates a new model of wraparound, family-inclusive care:

> *"That project has four phases…Now's the last phase. I'm talking to psychiatrists and traditional healers and service users... and other agencies in [this DHB area] to try it out…and then, I'll come back [later] and say to them, 'How did it go?' Just to look at the effectiveness of all that." – TongaM41-50B*

TongaM41-50B thus uses formal academic and clinical research as a means of challenging the status quo, challenging current approaches by presenting an alternative not only ratified by generation upon generation of Tongan wisdom and experience, but also "proven" in ways recognised by the current system, again bridging Western ways of knowing and doing with those of the Pacific.

There are also instances where challenges are laid, and new approaches effected through generally complying with current processes but going above and beyond what these require. Such actions challenge the status quo by gesturing towards the ways in which it falls short, highlighting gaps in the way care is undertaken, whilst also taking immediate action to fill some of those gaps and ensure

the needs of TWO are being met more effectively. One example of this approach is shared by the DHB Pacific MHA team below:

> *"The policies in some mainstream services, you see the person three times, they don't engage, you discharge them. A Pacific Island service like ours we can have people from mainstream going 'That's just not on, it's so time consuming' but, we can see people up to 12 times or more… that consistency and caring helps a person trust we really are out there to help." – DHB Pacific MHA Team Member 5*
>
> *"Another success of ours is that we remain at the top of the KPI." – DHB Pacific MHA Team Member 5*

By persisting with what they know will work and reaching out to TWO beyond the required three sessions this team have challenged the status quo, and, by improving engagement and delivering "*at the top of the KPI*" (Key Performance Indicators), they have also demonstrated a three-session policy is inadequate and a more open-ended approach is far more effective. While this approach is less aligned to the Vā epistemologically, it still very much responds to it axiologically; deference is shown to the organisation by adhering to current requirements (as a minimum), and deference is also shown to TWO by ensuring their wellbeing takes precedence over these.

This attitude of fa'aaloalo when challenging the status quo, this willingness to be conciliatory, and to put others needs and preferences before one's own gestures towards something hidden in but central to all of the examples shared so far; the need for self-sacrifice and the willingness to hold personal risk. At a minimum, the participants quoted above are required to sacrifice significant mental, emotional, and social energy to withstand a status quo that tends to exclude and diminish them whilst also critically engaging with that status quo, reflecting on it, and persuading others to do the same. In other situations, this sacrifice is required and more besides. To prepare a business case or approach one's manager with an alternative care plan requires significant research and the preparation of paperwork, usually undertaken in one's personal time and on top of one's care duties. A

clinical/academic research project requires more still, taking time away from family, leisure, and community in an ongoing manner as well as incurring significant financial costs. Then, when it comes to going "above and beyond", risk to one's professional standing is also introduced; while requirements have been met, additional care may be perceived negatively – e.g. *"That extra mile, we were looked at that we are promoting dependency…" (DHB Pacific MHA Team Member 1)* – and one may still face resentment, be subjected to criticism, or undergo performance management as a result of resisting the status quo and persisting beyond it.

Both self-sacrifice and the risk to one's professional standing are intensified when challenges are laid through direct confrontation or through "civil disobedience" (referring here to the active, principled, and peaceable refusal to comply with documented processes, accompanied by action which directly contravenes said processes). Adding to the subtler forms of challenge discussed so far, participants also described numerous situations in which they challenged the status quo through direct advocacy and explicit criticism:

> *"You were always being given this message you were overreacting because you were advocating for [change to benefit] clients…their answer was always 'Well you can't do that for everybody'. And it's like, 'Why not? You make up that you can't have people going out doing all these home visits.'" – Cook Island/NZF31-40*
>
> *"I talked to [the manager of that service] about the cultural differences and said 'If we look for a month how many people kicked off in our ward, and why they kick off, you'd find our staff really started all that…These guys, they are transported away from their families, they don't get any visitors, they don't get their needs met on their terms. No wonder. It's not good for their MH, and we're making it worse by our behaviour.'" – Manu Fotu*
>
> *"Way back in the day, I was working in a [community residential MH facility], and there was a wānanga…I can remember asking two questions, 'Where's Pasifika?' and 'How effective do you think, just generally, globally, has psychiatry been in healing people.'" – Phil Siataga*

Such confrontation and direct challenges require immense courage, as acknowledged by TokelauF51-60 – *"…in terms of having the courage to take my chair and sit myself in a meeting (I was not invited to) however believe my voice must represent Pacific peoples…"* – and is an approach very selectively deployed:

> *"I - at times - don't say something…so I can create space for others…[but] not when I was with people that were above me - That didn't apply 'cause I felt like often I was advocating [for TWO and for Pacific communities] and I needed to say stuff." – Samoa/NZF31-40*

While such an approach to challenging the status quo may seem at odds with the respectful deference required to teu le Vā, the use of direct confrontation was justified by the need to represent the interests of both TWO and Pacific communities. These practitioners – perceiving harm (or the risk of harm) to TWO/the community (or the relationship therewith) – risk their own professional standing and relationships to challenge and potentially soli le Vā between themselves and those in positions of power. In doing so they prioritise the needs of TWO/the community, recognising harming the relationship between themselves and someone in power may serve to protect and meet the needs of many. They strategically soli le Vā to teu le Vā.

> *"When I come here to [the academic institution or my place of work], outside of my community, I bring the needs of my community and I make sure I do the talking on that level." – TongaM41-50B*

Civil disobedience is an approach to challenging the status quo echoing elements of "going above and beyond" and of direct advocacy/explicit criticism. As with these other approaches, the wellbeing of TWO is consistently deferred to, prioritised over other considerations such as current processes, personal cost, and risk to one's professional standing. However, it goes beyond them to take action which immediately broadens the scope of care in ways not possible when adhering to

current processes. Before exploring participant contributions regarding this topic it is important to recall the MH system in Aotearoa/New Zealand is not meeting the needs of the people – Pacific and non-Pacific alike – and is widely regarded as cold, dehumanising, and otherwise "broken" (62, 72, 78).

> *"We talk about innovation and all that, but they also have to toe the system line. How come when we know the current system is broken, we still have to align with the same broken system?" - Samoa/NZM61-70*

With that in mind, those quoted below cannot in good conscience be criticised for "breaking the rules", when they are, in fact, consciously acting in accordance with the Ethics of the Vā and doing what is right/best for TWO in the face of dysfunctional policies and practices.

Participants described numerous situations where they disobeyed organisational policies and procedures to ensure the needs of TWO were addressed:

> *"We've gone and picked up cars from [another city], brought them up here…paid for their repairs, driven them back…the person had no way of getting around and picking up her kids." – Phil Siataga*
>
> *"We weren't allowed to manage their money. But I knew when you're mentally unwell, you have no control…Each week, this guy would come and give me $50…I got into trouble with a few managers, but I really didn't care. From that $50, I was able to buy him enough food for seven days. I would take him with me to the supermarket and we'd walk around and do it together." – Tony Fuemana*
>
> *"Counsellors have boundaries around when [they're available], but especially when you're dealing with young people, you need to be available. It's not very often [a suicide-related call] happens, but when it does, I'd rather pick up and break my sleep because I've had kids that have rung different services and haven't got help. In a great world, if we look at a code of ethics, you're supposed to give kids numbers to ring, but if they're not going to engage with them then something bad could happen. At least if you've got that engagement, you can ring the police and psych emergency, if you need to, you can do all that work. But I don't know it's looked upon as a good practice, in the Western world." – MāoriM41-50*
>
> *They tried to get [a client they had been holding on the ward all weekend] to go to a halfway house…He refused to go. He said, 'I'm happy to just go back on the street,' but you can't just discharge anybody without an address, so I said, 'Look,*

> *you can't go anywhere until you sign this paper. Which means, once you walk out that door, it's up to you. I'll drive you down the street, you can go wherever you want to go, but you need to sign the paper first.' …you could actually lose your job over discharging him knowing that was his intention…All he wanted to do was leave the ward and he wasn't actually that unwell he was going to [hurt himself or anybody else]... But that's about understanding people, doing different things, and applying different things at different times to do what's required, that's important." – FijiM51-60*

These stories represent acts of courageous and considered resistance within a flawed system, a refusal to perpetuate harm, exclusion, suffering, and the dehumanising denial of self-determination, even if said resistance might cost these practitioners their jobs. They challenge the status quo by quietly and persistently demonstrating what effective MH care delivery *should* look like. As these actions tend to be hidden from the organisations in which they take place, this approach to challenging the status quo tends to have less of an impact in terms of *organisational* change, however, it is perhaps the *most* impactful in terms of creating positive change in the lives of TWO, as, through these acts of "civil disobedience", TWO immediately have their needs met, are supported to participate in daily life, are respected and empowered to make choices reflecting their preferences and are engaged in trusting relationships where care is always available. This approach to challenging the status quo achieves the goals current processes aim for but miss and yields benefits where it matters most; in strong relationships with and positive outcomes for TWO.

> *"It gives you so much mileage when you go the extra distance for people… [you] gain this trust and bond with them, straight away// If you were to ask them, that's my reputation.// And you notice a difference in the attitudes towards you…// And people know you're really standing with them, you're really beside them. And that's not a cognitive thing. It's just caring. They know you care." – Phil Siataga and MāoriM41-50*

It is clear these participants know they are working outside of organisational policy and processes, and while the willingness to do this – to sacrifice one's own money, time, leisure, and professional standing to meet the needs of TWO is deeply admirable – it shouldn't be necessary.

PMHP should not need to sacrifice themselves to provide quality care. There is a real need for PMHP to be supported to both provide effective holistic (MH) care in a manner that is fairly remunerated and doesn't unduly impact on the wellbeing of themselves and their families and to share their good work without fear of negative consequences.

PMHP also discussed working outside of the system, persisting to ensure the delivery of effective (MH) care through connecting with and relying on community networks.

> *"That's the part [Pacific providers] do best…they're more connected to our communities. They know where they are. They know the existing network that's already there. If you run a project by a Pacific organization, they know exactly where to go to get this project done." – TongaM41-50A*

This was particularly helpful when official systems were slow, unresponsive, or resistant to implementing the types of change Pacific practitioners knew would be most beneficial:

> *"If no one's doing by Pacific, for Pacific, we just create it, and that's what I've been doing, so I'm active around putting those pieces of work together, and I'm blessed to have [good people and] other providers around." - Samoa/NZM61-70*

> *"We do work by ourselves. We don't lie down and cry. We just get up and keep going." – DHB Pacific MHA Team Member 1*

For these practitioners, once of the best ways to challenge the status quo, is to bypass it as much as possible, simply getting things done by leveraging the power of the collective to achieve what is necessary. This approach to challenging the status quo leans into the Vā relationships extant in Pacific communities, enabling PMHP – as a part of these communities – to draw on the knowledge, expertise, good will, time, and material resources shared to support projects that will nurture the community. As noted above, it shouldn't be incumbent on Pacific practitioners and their communities to make

such sacrifices to develop the (MH) services they need, however, this is another way in which PMHP effectively challenge the status quo to create positive change.

The PMHP who participated in this study all recognised the status quo is not meeting the needs of TWO. This chapter shares how these practitioners have acted on that knowledge, using reframing, bridge-building strategies, a willingness to go above and beyond, direct advocacy, civil disobedience, and collective community action to both challenge the status quo and to share insights into, provide pathways toward, or actively implement new ways of doing things. In many cases this has been done at significant cost to the PMHP involved, many of whom have undertaken costly research, prepared time-consuming business cases, and risked disapproval and even disciplinary action to bring about the changes they knew were necessary to improve care for TWO. The challenges they have respectfully and carefully laid have been successful in their attempts to support a more holistic and humanising MH system, by introducing new services, improving programme uptake, reducing ineffective spending, evidencing models of collective service delivery and, at the bottom line, directly providing care to TWO that addresses not only their MH challenges but their wider contextual needs.

Ala ‘i Sia, ala ‘i Kolonga

Skilful at Sia, skilful at Kolonga.

4.1.3 Family Focus

PMHP have demonstrated particular strength in their orientation towards and focus on family as a core aspect of MH care. The aspirations expressed in both the mainstream and Pacific reports on the 2018 MH Inquiry (62, 72) reflect a need for a MH system that involves and nurtures ties to family. This is an aspiration that PMHP – through their strong focus on family – are already successfully achieving in their work, while demonstrating further success by showing how said focus can also serve to affirm cultural identity, address the root causes of distress and disorder, and better empower families and communities to care for each other.

I will begin this section by exploring how PMHP draw on the understanding of shared, divine descent and Vā relationships to connect with and support TWO as if they were members of their own family. I will then move on to look at how said practitioners understand and respond to TWO as part of a family unit, both factoring in the role family can play in contributing to/perpetuating distress, as well as working to ensure family are supported and successfully involved in the care of their loved ones. The final sub-chapter will take a step sideways, turning to look at how PMHP build family-like relationships in and between workplaces and the various positive impacts of this.

4.1.3.1 Engaging with tāngata whai ora as a part of our families.

For many participants – across age ranges, ethnicities, and professional roles – TWO were seen and engaged with, not as "clients" or "consumers", but rather as a part of the practitioner's family. This perspective was understood as a definite strength and one that contributed significantly to successful MH practice. By seeing and engaging with TWO as family, the PMHP who participated in

this study created therapeutic relationships in which TWO felt safe and were nurtured, where they could experience healing, were supported to grow, and felt genuinely loved, cared for, and connected to those providing their care.

The ability of PMHP to engage with TWO as family begins with recognising TWO *are* family:

> *"When I first started working for corrections and went into the prison and saw these men, I had this overwhelming [sense of], 'Oh my gosh, you could be my brother, my uncle, my cousin' …that's very different with Pacific…the sense of, it's not quite ownership, but it is like there's less distance." – Samoa/NZF41-50*
>
> *"One of the strengths of Pacific practice is…there wasn't that really patronizing divide between 'I'm the expert that's going to help you and you're the sick person'…it was more like, 'I can see my family in you and so, you're my family, and I'm going to help you the best I can'." – Dr. Karlo Mila*

The above quotes highlight how, for PMHP, TWO are not seen merely as people receiving services, as clients or consumers. Rather, they are human beings whose presence echoes and evokes the presence of family, of people these practitioners care deeply about and feel a deep sense of responsibility toward. However, as per Section 2.1.1, within the indigenous Pacific reference – all TWO, in fact all tāngata – do not simply echo and evoke family but *are* family. This has a profound impact on the shape of the relationship. For PMHP, relationships with TWO are less governed by the expectations of a provider-client or doctor-patient relationship, as per current, dominant models of MH care. Rather, relationships with TWO are *"governed by the imperatives of being kin"* (101). They are relationships where professional distance is less valued than genuine connection, where responsibility towards the other party is keenly felt, and where the "patronizing divide" that often exists between the "expert" and the "sick person" can be overcome by respect, 'ofa/alofa and deference to the sacred being-ness and wellbeing of the other party.

The MH practitioners interviewed shared countless examples of how they and their Pacific colleagues enacted this recognition, exploring how this perspective impacted engagement on both an emotional level and a practical level. In terms of engaging with TWO on an emotional level, the primary feeling participants had for TWO was love or 'ofa/alofa; to engage with TWO as family was to love TWO as family. Love was understood – particularly by those who had struggled with their own MH – as being absolutely foundational to the provision of effective care, necessary to meeting basic human needs and creating a space where trust could be built and healing take place:

> *"Yeah, anybody who's had MH problems knows the thing we hate most is being left all alone, and not being cared for or wanted…We want people to love us and care for us…don't give up on me, because I've actually given up on myself." – Tony Fuemana*

PMHP reflected that, while expressing love for TWO was a normal part of *their* practice, something common in their work, it was also something problematised by their colleagues and by the systems in which their work took place:

> *"It's not unusual in a Pasifika context for you to express love for your community, your client, and their families. It does become unusual within a Western context when you talk about countertransference and other inappropriate relationships and boundaries." – Samoa/NZF31-40*
>
> *"One of the real risks is inappropriateness. If we're not careful, vulnerable people can be taken advantage of. I absolutely understand…how important it is to keep an emotional distance. To ensure we do something very cognitive in terms of helping people to problem solve and sort things out. I have no problems with that…But often what really makes people able to change is the notion another person believes in them, that they're capable of change. And to do that, you have to form a [loving, intimate] relationship." – TongaM51-60A*
>
> *"That's a big value we have. Yes, it may seem unethical, but we wrap everything we bring ... we have that love. And it's also quoted in the Bible, 'Of all these things, love is the most important.'" - Su'a Le Mamea Tavaga Afelē Seuala*

Western approaches to MH that rely heavily on the biomedical and the cognitive (such as psychiatry and psychology) have a tendency to shy away from love and intimacy/emotional proximity as unethical, understanding the presence of the practitioners' own familial relationships and emotions in the therapeutic space as dangerous. This is something the Pacific practitioners quoted above acknowledge, understand, and are mindful of.

As discussed in Section 2.1.2, alofa/'ofa represents something a little different to "love" as it is often used in English, more aptly reflecting a familial love, fraternal or maternal/paternal, the warmth and kindness required by recognising interconnectedness, by acknowledging others as tuātagata, and by the way in which we *"see ourselves…"* and, in this case, our families *"…mirrored in the other"* (56). Furthermore, being experienced in and through the Vā and Vā relationships, 'ofa/alofa is also constrained by the Ethics of the Vā; by tapu, rules, social codes, and boundaries designed to protect against soli le Vā and to uphold the sacredness of the relational space. PMHP are thus not carelessly sharing feelings and creating emotional bonds without consideration for how intimacy/emotional proximity, expressions of love, and the shadows of their own previous experiences of family relationships might – positively *and* negatively – impact on TWO. The opposite is true. PMHP recognise relationships – including the therapeutic relationship – as *sacred*. Recognising relationships are sacred means not taking what happens in the relational space lightly. Rather, it means being profoundly attentive to that space, enacting constant self-reflexivity, and expending significant time and energy to ensure the Vā is nurtured, relationships are healthy, and the words, actions, and behaviours one puts into the relational space are only going to be of benefit to the other party.

Remembering this makes it easier to understand how emotional proximity/intimacy and any transference/countertransference borne of seeing and loving TWO as family might be valuable (rather

than problematic). The understanding of TWO as family creates the opportunity for one's *positive* connections to and love for one's family to be mirrored in the therapeutic relationship – in a careful and considered manner – so strong, genuine relationships can be nurtured:

> *"When you meet somebody in MH, you've got to imagine it's your sibling or somebody you love or care about and transfer the way you would deal with them to that person, even though they're a stranger." – Tony Fuemana*

Through this the practitioner is supported to invest meaningfully in and commit themselves to providing effective care for TWO. TWO, on the other hand, are supported to experience secure relationships where genuine and heartfelt love and care are present. This approach – where love and emotional connections are not side-lined as a means of mitigating risk, but instead are centred to allow for careful consideration and mindful expression – has clear benefits when one desires a MH system where tāngata ora feel safe, nurtured, connected, and valued and get to experience genuine healing.

> *"It's about communicating to another person that I feel… I want them to know I'm enjoying their company//They really matter." – Phil Siataga and MāoriM41-50*

Samoa/NZM41-40C describes the importance of love in the practical delivery of MH services. He emphasises the importance of love not just as a feeling, but as an action:

> *"Not many people write it down, but love is a big one. You really need to **do** that love... I don't want people to feel like they're coming here to just do their job and leave…make sure you look after that love ... for yourself, for the job you're doing, for your colleagues, as well. And the biggest one is having that love for the people you serve..." - Samoa/NZM41-50C*

Participants gave a range of examples of what "doing" 'ofa/alofa for TWO looks like, of the practical implications of engaging with TWO as family and loving them. One of the most frequently noted and fundamental of these was – quite simply – taking the time and making the space needed to get to know them, building the connections that establish them as family and highlighting where and how those connections manifest:

> *"Taking time to get to know the person who's in front of you. Whanaungatanga. Take the time." – MāoriM41-50*
>
> *"Even the introductions and how we connect, about where we're from… You just make those connections... When I first went to Pacific Services, and I'd been in mainstream for a while, the first client I see is this woman my mother's age and the first thing she says to me is, in Samoan, 'Where is your family from?' … I was kind of taken aback and [then] thought, 'Duh, this is how we does it.'…" – Samoa/NZF41-50*

Given the onto- and axiological-level importance of whakawhanaungatanga/fa'afeiloaiga/fakafe'iloaki raised in Section 2.1.1, it is unsurprising these processes were considered fundamental. Participants understood them as an important means of demonstrating love for TWO as family, or, perhaps more accurately, of demonstrating the *willingness to love* TWO as family. Not only do whakawhanaungatanga/fa'afeiloaiga/fakafe'iloaki assume connections *can* be made – that TWO *are family* – but undertaking these processes also expresses the *desire* to recognise and honour that, the desire to be meaningfully connected to TWO, affirming they are welcome and valued. The importance and wider impacts of taking time to make, build, and nurture connections with tāngata will be discussed further in Section 4.1.4.1. Here however, it is enough to highlight these processes are one way in which PMHP enact engagement with TWO as family.

Another way in which PMHP described engaging with and loving TWO as family was through assuming familial roles in the professional context; not only recognising and feeling familial connectedness, but *acting* as a brother, sister, mother, or father to those in their care as well.

> *"These guys have that motherly love. The way they talk to them, it's like coming to a comedy, a comedy from the morning until after work because they tell them off." – Fereni Masoe-Afamasaga*

For Masoe-Afamasaga, taking on a parental role is a way of signalling to TWO they are loved and included as family. In this instance, this manifests both as humour, an expression of warmth and ease, and as "tell[ing] them off", setting boundaries in a friendly, loving way. Fuemana also reflects on assuming a parental role and on telling TWO off as a means of demonstrating care:

> *"I've never had to restrain anyone. I've walked away from them; I've kicked them out of cars when they've been really abusive; 'You're walking home'. And then I'll drive down and stop [and wait for them]. They remind me so much of kids if I treat them with kindness and a bit of love. I say, 'Have you finished now? Are you going to get in the car?'….When they're angry in the car and you go, 'Wait here. I'm going to get us an ice cream', you come back, and they've got a smile on their face." – Tony Fuemana*

In the idealised relational space of parent and child, respect and politeness are expected from the "child" and unconditional 'ofa/alofa is demonstrated by the "parent". While some may recoil from the manifestation of this relational framework in a therapeutic setting (see the comments regarding transference/countertransference above), this approach can be seen to both soften the normative power dynamic – parent/child feels innately more supportive and nurturing than doctor/patient, or provider/client – and to create a safe, caring space where problematic attitudes and behaviours can be addressed in a way oriented towards growth and reconciliation rather than management and control. Fuemana highlights how he uses the norms of the parent-child relationship to draw attention to the ways in which the relational space is trampled by aggressive and abusive behaviour, whilst simultaneously supporting TWO to regulate (e.g., by providing them an opportunity to walk it off) and to practice restoring the relationship (e.g., by apologising and getting in the car). He also, through this framework, is able to offer kindness and gestures of goodwill to demonstrate forgiveness and persistent alofa/'ofa (e.g., an ice cream or a joke to indicate the offense is not too serious), thus

helping TWO to feel secure in the relationship, in the knowledge someone cares for and is looking out for them even if/when they behave in challenging ways.

Fuemana also notes "I've never had to restrain anyone", pointing toward the positive role parental love and care can play in de-escalation and in reducing the use of seclusion and (chemical or mechanical) restraint. This was echoed by numerous other participants in this study, two of whom are quoted below:

> *"We had this older gentleman, when I was working in mainstream…He was put into seclusion…I went there and [he's] sitting on the mattress on the floor and there were about five guys and two females standing there ready with the injection…He kept saying 'Go away!' and swearing and carrying on. I said, 'What's happening?'. 'We're ready to give him an injection.' …I walked in … I sat down - and there was an incident form made about me afterward because I wasn't observing the safety protocols - touched his hand and I said '[Name], what is going on?'. As soon as he heard me speak - because I said it in my own language - he changed and said, 'I'm so sorry.' Then he explained, 'Look at them. How dare they? Seven of them standing there and I'm sitting down on the floor.' " – DHB Pacific MHA Team Member 1*

> *"We have this one guy who was a big boxer, and I went to visit. I called a Tongan lady [colleague] to come with me. When we went to [the facility], they brought all the male staff and I said, 'No. Please don't'. We just let [my female colleague] go in. They said, 'He's been pacing around, very aggressive. We're putting her at risk.'. But as soon as [my female colleague] walked in, she called his name, …and then, [he] looked at her and gave her a big cuddle. Those little things... another time we got a call from WINZ. One of our clients was very aggressive, thrashing down WINZ in [the local area]. I was a Duly Authorized Officer, so they told me go and see her, and arrange with the police and they arranged the inpatient unit for admission; the same procedure they usually do. I went to WINZ, and said to her… 'Why are you shouting like that?'. It worked out she hadn't been eating and they haven't really given her the stuff she needs. I took her in the car. Went to get Burger King. Dropped her off home. Then, I got a call from the team. 'We're waiting for you for her to be admitted.' I said, 'No. She's at home.' Anyway, I had a bit of a telling off that we don't buy people food. But, for me, inside, those little things really [make a difference]..." – TongaM41-50B*

By approaching distressed TWO with care and warmth (as a parent ideally would a child), asking about what's wrong, and being prepared to offer comfort – a kind word, a hug, or food – these situations were defused without the use of physical restraints, sedatives, or seclusion. While it must be

acknowledged that cultural knowledge and language skills also played a role here and were clearly helpful, it is evident – even without said knowledge/skills – the kind, warm, motherly/fatherly, ‘ofa/alofa-led approach demonstrated is both more effective and more humane/humanising than the intimidating, fearful, and controlling approach manifest in the approaches to seclusion and restraint that have previously dominated.

These insights into the role of an idealised parental approach to de-escalation are of particular importance as New Zealand works toward “Zero Seclusion” (322). The use of seclusion and restraint – wherein TWO are offered neither goodwill nor the opportunity to repair relationships, but instead are separated from others or subdued when exhibiting problematic or aggressive behaviour – has been identified as a significant problem in the New Zealand MH System and is disproportionately used against Pacific TWO (309, 323, 324). Improvements have been made in recent years (325) and The Health and Quality Safety Commission have begun to advocate for supporting people in distress by *“bringing them into a quiet space, actively listening to their concerns and needs…what happened to them… their triggers and what calms them, offering them food or a drink and involving their whānau”* (322). The stories above highlight how experienced many PMHP already are in using the approaches now being promoted as best practice and how the Pacific understandings of “family” and the mindful use of family dynamics in care have a particular role to play in its achievement.

In addition to assuming a *parental* role, engaging with TWO as family can also take a more fraternal tone:

> *“I figured, if this was my brother, I would want somebody to care for him this sort of way. I decided that way back then…I could only help this guy if I walked alongside him…that actually works for people if you spend time just loving them, even though you're not really a relative, but you can care for them…. It's an easy thing to do…just be their brother” – Tony Fuemana*

> *"In MH, we get so confused by the approach we should take…but we've got to remember we're just human. A lot of people would rather have somebody come and put their arm around them… would rather go, 'Why don't you just come in, be with me at home for a week and just help me clean the dishes, clean my house, wash my clothes and be my friend for a week?'" – Tony Fuemana*

Fuemana describes engaging with and caring for TWO by *being* their brother. For him, this manifests as "walking alongside" them, acting as more of a companion and confidante than when he inhabits a parental role, but nevertheless replicating the intimacy, security, love, and warmth of ideal family relationships and daily family life. Through this, he also gestures towards another core way PMHP demonstrate they see and love tāngata whai or as family. In discussing the need to assist with everyday chores such as doing dishes and cleaning the house, he draws attention to the importance of ensuring the basic needs of TWO are being met and their quality of life doesn't fall by the wayside as a result of their illness or distress:

> *"When people who are mentally unwell, a lot of the time, they forget the most basic things. They forget how to look after themselves daily… you increase their quality of life. Also, not accepting, not allowing them to accept a standard of care that's not good for them." – Tony Fuemana*

Fuemana recognises the burden of mental illness is such that self-care and managing everyday tasks are often neglected in the effort to attend to the internal struggle. His response to this is to move beyond the responsibilities normally ascribed to care workers (whose role is usually to direct and encourage – "*You support them to do the stuff, if you're a MH support worker, you're not actually supposed to do the work for them…but… a lot of the people who experience MH, the last thing their brain can cope with is learning how to look after themselves."*). Instead, he demonstrates his alofa/'ofa through acts of service, supporting TWO by providing practical support, mucking in, getting jobs done, and refusing to accept a less-than-rewarding life for them. He cares for them, thus, not as a MH support worker, but as per the *"imperatives of being kin"* (101), as he would care for his own brother.

Providing care at a level commensurate to what they would provide for a family member – above what one would usually offer to a client and beyond the parameters of most MH roles – was commonplace amongst the PMHP in this study:

> *"I started shopping for him and I made sure he had food in his stomach each day. I made breakfast for him and before I left work there was a meal ready to be cooked in the evening. I did that for two and a half years from Monday to Friday and then got the other staff to do it in the weekends, which was a lot of push back, because a lot of people didn't want to do it..." – Tony Fuemana*
>
> *"I've often seen [my colleague] take people, and these are adults, for bus rides to show them where to get off the bus, where to go, where to catch the train and things like that. That's what it is about with our clients…maybe this is their first chance of getting to know certain things." – DHB Pacific MHA Team Member 1*
>
> *"It wasn't uncommon for team members to use their own money to take their clients out for lunch; we had a matua in our team that used to buy groceries off his own money and give them to families that were struggling...Being able to do that meant a lot for our families..."– Samoa/NZF31-40*
>
> *"When my son got king hit, I wasn't sure whether he was going to live or die, and his mum was living [overseas]. What [that practitioner] did, I said to him, 'Once she gets into the country, can you please make sure there's no barriers [at the hospital], no security and all that kind of stuff,' and he personally waited at the entrance for her to arrive from the airport, and got her straight up into Critical…he just brought her straight up to me and my boy, and I thought, 'Wow, look at that. Tell me any other [practitioner] who would do that?'"- Samoa/NZM61-70*

These expressions of love and care also included ensuring personal milestones and family events – often neglected in inpatient and residential situations – were remembered and celebrated:

> *"I used to take a couple of the guys down to Miranda Hot Pools for their birthday... And we'd go down, have a swim, and then have fish and chips…I did that for like four years." – Tony Fuemana*

None of the examples above represent actions expected or usual from MH practitioners in their professional roles. However, for many Pacific people working in this field, MH support demands this high level of personal care; how can you – according to the ethics of the Vā (and the "imperatives of

being kin") – say you have behaved ethically if you have not shown love to TWO? If you have not ensured they have a clean home and food to eat, can get where they need to go, can participate in their community, can experience belonging, and feel supported?

Echoing what was shared in Section 4.1.2.3 the acts of love and care that constitute engaging with TWO as family are often undertaken at the personal expense of the practitioner, and, as in that section, there are many cases whereby action is needed to officially accommodate these approaches, to reduce the career risk these practitioners face, and to ensure practitioners are fairly compensated for their time, effort, and use of personal financial resources. It should also be explicitly noted these approaches ***are*** more resource intensive; they ask for more effort, emotional presence, self-awareness, contextual responsiveness, and more investment than approaches which rely on the expediency of standardisation and detachment. However, as evidenced, these high-investment approaches are also high-reward; where action is taken to officially accommodate and support these approaches, significant service improvements and better treatment outcomes and quality of life for TWO *will* be seen.

In addition to the positive impacts noted throughout the paragraphs above, one other key benefit of engaging with and loving TWO as family was mentioned. A number of participants noted treating TWO with alofa/'ofa can help to reduce barriers to access (such as the fear of judgement, discrimination, or discomfort) and reduce issues such as appointment non-attendance and disengagement. It has been noted on more than one occasion that TWO often find services cold, hostile, stigmatising, awkward, or otherwise unwelcoming (33, 62, 72). Demonstrating alofa/'ofa helps to overcome this issue by ensuring people experience healthcare environments as warm, welcoming spaces where they feel safe, comfortable, and relaxed enough to build meaningful connections and share about themselves and their experiences.

"…primary health is key. Because this is where our kids go earlier on and if they don't get a good experience, then it puts them off seeing us for counselling. GPs, they've got a big role to play. And the administration staff, the reception area. When you go in, the environment, how warm does it make you feel being Pacific or Māori? Everybody talks about money being a factor in terms of why people don't go to the doctors. But I actually think it's about the lack of engagement and being judged and feeling judged." – MāoriM41-50

"When people come in its feeling that warmth, that inviting feeling within our service. They've made comment because they come into our fono room and that Pacific setting, that makes you feel welcome. Once we engage with them, they can easily engage back with us, with what flows." – DHB Pacific MHA Team Member 6

The anecdotes and excerpts provided above describe numerous benefits of caring about and engaging with TWO as family, a wide range of ways in which this perspective and its emotional and practical manifestations constitute a strength. Throughout the talanoa, participants in this study shared the positive impacts of this strength, reflecting on how engaging with and loving TWO as if they were members of their own family supported them to deliver MH care in a way that nurtured connectedness and the development of consistent, secure relationships; ensured TWO felt welcomed, valued, and genuinely cared about; addressed social and economic determinants of health (such as access to food and transport); minimised the need for harmful seclusion and restraint practices; and contributed to reductions in appointment non-attendance and disengagement. Importantly, this approach was also shown to enact respect for TWO as human beings, as people who are deserving of genuine care and support and of a better quality of life than they are often afforded.

4.1.3.2 Working with tāngata whai ora as part of a family.

Another key strength of PMHP lies in their recognition of the foundational importance of family to wellbeing and in their subsequent action to include, support, and nurture the families of the

TWO in their care. By recognising the impact families have on TWO (and vice versa), they are empowered to take an approach that includes the family in planning and care; addresses family harm; incorporates psychoeducation and relational skills development; provides support and therapeutic care for the family where necessary; and nurtures a sense of connection and 'ofa/alofa. These approaches, in turn, mean PMHP in this study are able to successfully deliver MH care more focused on healing, addressing root causes of distress, disorder, and anguish, and involving and nurturing ties to whānau/family.

Through the explanation of kāinga in Section 2.1.1 and Pulotu-Endemann's Fonofale model (31, 39) in Section 2.2, it becomes clear that family is absolutely foundational to wellbeing in Pacific cultures; it is literally and metaphorically the ground upon which one's home and sense of identity is built. More than just one aspect of individual wellbeing, a strong and stable family – like a strong and stable foundation – can hold the pou of mental, physical, and spiritual health steady.

"Children were always at the centre of the work we did, but they were [also] at the centre of a family. We might see them for one hour a week, maybe two hours, but they're in families and we need to make sure those families are supported…because it's those families that are going to have the biggest impact on that young person's life." – Samoa/NZF31-40

"Families are crucial in making and breaking the recovery pathway of their loved one." – Samoa/NZM41-50A

"We are collective as Pacific; we have a ready framework for how important family is. Of course, in the mainstream setting, young people have their rights. While I agree with that, they also have those rights in the context of a family because, at the end of the day, they might see us as a professional one hour a week. They have to go home to their families. How can you ensure all of that is going to be safe? While families are supporting the young people who might be struggling or who might be angry, how can you do that in a way that preserves the integrity of everyone in the family?" – Samoa/NZF41-50

"The way the MH system works means my efforts are going to fall well short, if all I've got is a prescription to some medication, six sessions of CBT, maybe a referral

> *to a psychologist. All of those things matter, but unless you get a collective response to help that individual..." – TongaM51-60A*

Echoing elements of the discussion around the community/family/home environment in Section 4.1.2.2, these practitioners recognised TWO exist and function day-to-day in the context of a family – and that without healthy, supportive families there to hold TWO steady over time – all efforts within the clinical context would "fall well short". This understanding encourages a view of working with families wherein such work is not an optional or additional aspect of care but is rather a key component of ensuring the needs of TWO can be meaningfully and consistently met.

The understandings above also communicate three key issues relating to the importance of the family context and to working with TWO as part of a family. First, families play a crucial role in "making" their loved one's recovery, for example by providing support and monitoring recovery during the 166-167 hours per week said loved one is not engaged in treatment:

> *"We might see them for one hour a week, maybe two hours, but …it's those families that are going to have the biggest impact on that young person's life." (Samoa/NZF31-40)*
>
> *"They have to go home to their families…families are supporting the young people who might be struggling or who might be angry…" (Samoa/NZF41-50)*

"Making" their recovery can also look like supporting with treatment planning. Participants acknowledged families are able to assist with understanding what is going on for TWO by providing information about their norms and their behaviour gathered in context and over time. It was also noted that welcoming families into the therapeutic space can help to reduce the use of seclusion and restraint; can provide support for overstretched staff; can help ensure TWO feel safe, relaxed, and more confident to participate in their care; and it can reaffirm for TWO they are loved by their family and that their engagement with MH services is not only accepted, but encouraged and supported:

"What's very Tongan was when I worked [in the hospital], we didn't allow extra people to sleep in the unit with the TWO, due to staff numbers and client numbers and things. And then we had a couple of Pacific people who came there. I put my name on the line and said, 'I'm willing to leave one family member here, because if we leave one family member here, we'll avoid taking this person to seclusion and avoid increasing the medication and things as well.'." – TongaM41-50B

"I can think of many examples where I have had the privilege to sit with families for an assessment of a young person. I offer the family the opportunity to open it in a way that's meaningful for them then we begin with each person's story about the presenting distress that's impacting all. I would usually guide the conversation and very often the young person and their family begin to navigate the conversation and when I notice the young person struggling to use words to describe, I would offer whiteboard pen to the young person and ask them to draw, write or express (on the whiteboard) what it is they wish to convey while the parents are asked to sit back. This interactive process of talanoa is negotiated between parents and child, and it's a beautiful thing to observe...the satisfaction I get as a clinician is when Pacific families tell me this model of care works for them. It empowers them to be the experts and navigators of their journey, and as the clinician, I am the tuluma toolkit resource for them…"– TokelauF51-60

The second issue that emerges relates to the role family can play in "breaking" (rather than "making") their loved one's recovery. The participants cited above note a need to ensure the family context is safe and supportive. This implies family environments are – in some cases – *un*safe and *un*supportive, and gestures toward the role dysfunctional family environments play in both shaping and perpetuating mental illness. In terms of *shaping* mental illness, participants echoed the relationally embedded aetiology discussed in Section 2.2, whereby disruption to the Vā and to sacred relationships is often understood as the primary cause of/a major contributor to mental illness and emotional distress. They shared how everything from feelings of disrespect amongst family members to experiences of family violence could contribute to poor mental wellbeing:

"We have one participant [in a study about Pacific elders]…he said sometimes when his kids go to work...after doing the dishes, he stands at the window and stares at his grandchildren with tears in his eyes. He didn't know after all his working time, that all people can think of him is a babysitter and doing the dishes, not acknowledging his other skills." – TongaM41-50B

> *"We did consider a lot the sociological stuff going on…because some of our Pasifika parents were hitting their children - and some it was actual abuse…but then there was also really poor education, understanding of the use of physical force as a disciplinary technique, and the impacts that can actually have on a young person…" – Samoa/NZF31-40*

In terms of *perpetuating* mental illness, it was recognised unsafe and unsupportive family contexts could lead to TWO being (re)exposed to the harmful relationship dynamics they are working through in the therapeutic context, and that this could undermine the progress being made. Fuemana uses the metaphor of religious conversion to highlight how difficult it can be to heal when attempting to function in an environment that is still causing harm:

> *"A lot of people who have experienced MH issues don't come from a healthy background… It's sort of like when you have the Christians going to a non-Christian area and they might convert a person that's come out of a gang home and convert that one person, but that person still has to go back to that gang home, the environment hasn't changed." – Tony Fuemana*

This leads into the third issue, whereby families may themselves need support with their own wellbeing, both to provide a more supportive environment for TWO *and* to help them manage the impacts of their loved one's distress. In the quote shared above, Samoa/NZF31-40 notes "…*there was also really poor education, understanding of the use of physical force as a disciplinary technique, and the impacts that can actually have…"(Samoa/NZF31-40).* This highlights how families are often struggling with a range of beliefs, understandings, and psycho-emotional challenges that contribute to them causing relational harm. As a result of this reflection, she is able to approach family violence (and other forms of relational harm contributing to the distress of those in her care) not with judgement, but with a desire to offer support:

> *"We really respected families and parents and came from the perspective they just needed support, they needed more psychoeducation and help." – Samoa/NZF31-40*

This desire to support the wider family was seen as a key part of facilitating healing for TWO:

> *"A 16-year-old who has just assaulted their partner and is not allowed to see their child. That 'separate them' approach, the male's bad. Let's get this young woman into the women's welfare process…systems that marginalize the male and paradigms that see things as good and bad when really, these are complex issues. The 16-year-old male that's done the assault needs a whole lot of help…when you see a 16-year-old who has assaulted a 16-year-old partner, you'll find a fragmented family…"– TongaM51-60A*

> *"It's about accountability, not about punitive things, but about recognizing and addressing issues - we are too quick to lay blame and punish - not only the victim needs help but the perpetrator [also]…" – TongaM51-60A*

The PMHP who participated in this study understood those who are causing harm within the family – who are disrespectful, violent, or otherwise disruptive – are also in need of support; healing for individual TWO requires healing their families, providing support for, and addressing the source of harm.

It was recognised engaging with families needed to be done carefully, gradually, and in consultation with TWO themselves. For example, SamoaF41-50 shared that in some cases TWO and their family needed to be provided with support separately before they could be supported to heal together. SamoaF41-50 – and Samoa/NZF31-40 – also reflected involving social services was, at times, necessary. However, even where this was the case, practitioners operated with an understanding that connection with and support for the family was an ongoing priority and a key part of ensuring positive long-term outcomes:

> *"When there was risk and other things going on that became a separate matter, but…before we would ever make referrals to Oranga Tamariki, we would always try to talk to the family about it unless it was gonna put that young person at immediate risk, because we have to continue to work with that family...we need to maintain a relationship with the family and we need to ensure we can continue to work with them cause ultimately that's gonna have an impact." – Samoa/NZF31-40*

PMHP also recognise, while the family has a significant impact on TWO, TWO also have a significant impact on the family, acknowledging the stress mental illness places on relationships may compromise the wellbeing of the family:

> *"…my [younger sibling]…[they] suffered with undiagnosed MH issues, but I could see [they were] struggling….[and] I knew because of my upbringing, I had developed some MH problems myself and when my [siblings] passed away, it flicked a switch in me and then I became mentally unwell…my family suffered, my [spouse] and kids. They saw me going through something I didn't understand, and I became lost to them, and to myself..." – Tony Fuemana*

This profoundly personal reflection shows how distress and loss within the family contributed to mental illness, in turn causing suffering and creating distress and risk amongst the next generation. This story highlights the importance of providing support to those around TWO, and of working to "*preserve the integrity of everyone in the family*" (Samoa/NZF41-50), both to assist in the present and as a form of preventative care.

While many of the examples above reflect experiences of working with Pacific families, this does not reflect a belief amongst PMHP that Pacific families are less safe and supportive than non-Pacific families. PMHP were aware of both family dysfunction as a significant contributor to mental distress and of the need to address family dysfunction and provide support to families as a core part of practice *regardless* of ethnicity or culture. Rather, the discussion above demonstrates how the Pacific appreciation for/understanding of family and its foundational importance is a significant

strength supporting the delivery of improved care to TWO from diverse backgrounds. Considering and welcoming the family allows for better contextual understanding of TWO and their issues, facilitates the engagement of supports, increases comfort and confidence, and addresses root issues to strengthen not only individuals but *whole families*, thus supporting long term success and helping to prevent future harm.

Strength was also apparent in *how* this recognition of importance was operationalised, in the approaches used to engage with TWO as part of a family, and to include and involve family in MH practice. The PMHP in this study were almost unanimous in their positive attitude towards working with family. As noted earlier, family work was understood by PMHP as a key component of MH care rather than as an add-on. It was also understood as a privilege, and as a particularly gratifying aspect of their work:

> *"I find it very rewarding to see someone who is very disorganized and unwell and work with them. And after a few weeks, they are totally a different person….You also get to know the family quite well. I enjoy that part of nursing." – TongaM41-50B*
>
> *"When I run courses in stopping family violence, I'm able to just go with the group, where they're at. I'm confident enough, and they can tune in. And they excite me, because they come alive…like little shoots, and they're blooming in front of you. I delight in it." - Cabrini 'Ofa Makasiale*
>
> *"…having the privilege to sit with the families and having them be the tautai, the leader of their own journey…" – TokelauF51-60*

There is a Tongan proverb – *Fofola e fala kae talanoa e kāinga* (roll out the mat that the family might talk) – useful here to explore the importance of such attitudes when engaging with TWO and their families:

> *"The fala, or mat, symbolises the kainga, safety and equal ground…Fofola e fala creates the space and empowers every member of the kainga to talanoa openly and honestly about their personal struggles…" (326)*

It is not possible to fofola e fala and to create a safe, welcoming space where families can be vulnerable and heal if one has an attitude of unwillingness, dismissiveness, annoyance, or resentment, if one believes the work is not part of one's role or is undertaken begrudgingly. PMHP are especially effective in engaging with TWO as part of (and alongside) families through their very attitudes to family work; they approached this more intensive and extensive type of care with humility, warmth, delight, and enthusiasm and – in doing so – created environments where TWO and their families felt respected, welcomed, and valued, safe to share and grow together.

The evocation of kāinga as *"safety and equal ground"* (56) gestures towards another strategy used by PMHP as they work to engage with TWO as part of a family. It was recognised home visits and the delivery of MH care in-home not only supported practitioners to identify and address contextual supports and barriers to recovery (as noted in Section 4.1.2.2), but also created a greater sense of comfort and safety:

> *"People didn't come to us…mostly we went out to where they were. And then we'd go from one person's house, the next person's house…That's a really different way of practicing. It's not clinic-bound...I found [TWO] much more open and engaging when I go and sit and have a cup of tea with them in the kitchen…And then we could start working on stuff…coming up to the hospital or office might've worked for us, but for them it just created huge hassles and they just weren't comfortable there…Our job is to come into their world and then help people through their worlds. But the way the MH model typically works, is people come into the professional MH world. And then they get what they get from that, and then they go back to their own worlds and use that. And that's just not how people work. People work within whatever environment they're in, and it's our job to go into that environment and help them change things about that, to change outcomes and flow from there..." – Cook Island/NZF31-40*

For Cook Island/NZF31-40 the willingness to make oneself available to TWO and their families in-home is a key strength of a Pacific and/or indigenous models of practice, supporting effective MH care. Rather than asking TWO to step out of their daily lives and enter into institutional spaces foreign to them (and that position them not as experts in their own lives but as medical subjects), the in-home approach increases comfort and safety through familiarity and helps to ensure practitioner and TWO can enjoy a more equal relationship. This make it easier to build meaningful relationships wherein TWO are able to open-up and it helps to ensure the insights shared, and interventions undertaken, accurately reflect and are applicable to the lifeworld of TWO.

Participants also shared about using deep reflections on kāinga as a way of working with TWO as part of a family. It was recognised not all TWO knew their families or would be able to enjoy positive connections to family. Kāinga provided a pathway toward this:

> *"…when I was talking about connection to the land. But also, connection to your ancestors… My world view was [informed by significant personal trauma] so I was looking for another narrative, 'Where do I fit? Who do I take after?' I always thought there was an ancestor - someone special - generations ago that I don't know about, who was looking out for me. I talk about the lighthouse…'Who's a lighthouse, who's looking out for you?'. It might not be an immediate family member…//I've often found we have a hunger to know there are people in our lives we can look up to.//And follow in their footsteps." – Phil Siataga and MāoriM41-50*

> *"Being Māori, your culture is around your Whakapapa. It's the most important thing. What happens if you've got a Māori kid has been fostered to eight different homes and doesn't know their parent's name? I had a kid like that. For him to engage with his Whakapapa was a universal one around Papatuanuku and Ranginui and helping him to make sense of what that connection for him was. And then you just see the difference and the change in him. Regardless, wherever he is, he's always connected to Whakapapa. It's huge."- MāoriM41-50*

These quotes reflect a view of TWO as tuātagata, embedded not only in an immediate, physically present and contemporaneous family, but also representing *"the faces of… extended family, village, land, sea, ancestral spirits and so forth.*" (115); the familial foundation supporting and steadying the

pou in the Fonofale is not constituted by the immediate family alone, but by the earth below it, and the ancestors buried therein. Where connection with an immediate, physically present, and contemporaneous family is not possible, this deeper foundation provides a means of connecting TWO to positive understandings of themselves, their family, and their heritage, allowing them to stand tall and build positive familial relationships.

> *"…Then that mana comes up again as beautiful…When people are healing and their story's changing and their foundations are getting more solid…'I'm from somewhere valuable and important. Now I can go with that.' // 'I'm not a piece of shit.'" – Phil Siataga and MāoriM41-50*

It was also shared that these deep reflections on kāinga are valuable in and of themselves, even where positive immediate family connections *are* present, enriching the spirits of TWO and their connections to immediate family, through deeper, stronger connections to culture and identity:

> *"The poverty is not just physical, but poverty of mind and spirit. That's real ... and some of that's connecting to the whenua, connecting to the stories. Connecting to their lineage, not just for Pacific but also for our local Māori." – Samoa/NZM41-50A*

Another strategy for engaging the family of TWO shared was the appropriate and considered involvement of cultural leaders such as *matua* (elders), matai, and *faife'au* (church leaders). Such figures hold knowledge and skills that enable them to ensure tapu are upheld and the Vā tapuia is not trampled. Their presence reflects the matter at hand is being taken seriously/treated with due care and helps ensure TWO and their families can express themselves in and through their own cultural worldviews without being misunderstood. These factors support safety, comfort, the development of mutually respectful relationships, and an accurate, culturally embedded understanding of what TWO and their families are experiencing. Samoa/NZF31-40 shared the following story, highlighting how

involving a colleague who was also a leader in his cultural community supported her to work more effectively with TWO as part of a family:

> *"I was working with a young Tongan female and there was some traction, but the mother - quite traditional Tongan mother, traditional Tongan values - was initially reluctant to engage with me, and it wasn't until I got our Tongan psychiatrist - who was of a certain status in their culture and also had the understanding of their cultural worldview - that she fully engaged and it became an amazing piece of work where he would work with the mother, and because he was able to do that she became much more trusting, we developed a really strong relationship and were able to work together." – Samoa/NZF31-40*

This example also highlights how effective engagement with family necessitates an openness to involving others in the process and the humility to ask for help, to recognise when one's own skills/knowledge are not enough. This same participant shared another example of how a cultural leader supported practitioners in her place of work to engage with TWO and their families by helping to facilitate the initial connection and by carrying out follow up visits:

> *"We have our Matua and he…would come to every initial meeting we had and then any time we were about to discharge he would go back to the family and say, 'How well did we do?'. That was fricking awesome and no one else did that…it was almost like another quality measure…it was good for us too, because you don't get much feedback…and it makes you more accountable." – Samoa/NZF31-40*

By involving a matua thus, the practitioners in her team were supported to build trust with families, whilst also establishing a respected touchpoint outside of the therapeutic relationship who could support with communication between parties and the evaluation of practice. This not only gave TWO and their families a stronger voice in the planning and delivery of treatment but also provided the practitioners with deeply appreciated feedback, supporting them to become ever more effective in their practice.

The importance of effective communication with TWO and their families was also raised in terms of needing to centre TWO and their families, their understandings, and feelings about what is happening:

> *"Language plays a very important part in the session. Some of our clients…we need to use simple language rather than just giving them certain names the clinicians use when they do things." – DHB Pacific MHA Team Member 3*

> *"Especially when you're dealing with families that are quite stressed and they don't want anything to happen to their loved one…Explain the doctors just want to make some checks, do some observation, and at least say, 'He'll be in a nice place and have heaps of food and access to TV and you'll be able to visit him, but we just need to make sure he's in a safe space, so he doesn't cause harm to himself or anybody else and no one will cause harm to him.'…instead of, 'Because he's now under the act and we need to transport him to the hospital.'" - Asiata Malagaoma Lealofi Sio*

For both DHB Pacific MHA Team Member 3 and Sio there is a recognition, when working with TWO and their families, that one must be mindful of the need to present information in a way that makes sense to them, not that is expedient for the practitioner. In addition to ensuring communications are accessible to and for the family, Sio highlights the need for communication to be reassuring, sufficiently detailed, and mindful of the family's anxieties and concerns about their loved one.

PMHP also noted that engaging TWO as part of a family could be supported by communicating in an empowering way, geared toward building strength and nurturing positive relationships, rather than purely informative/utilitarian:

> *"[TWO and their families] love it because we don't often get praised in the PI parenting style. They love it when I say 'Wow, Sione, did you know how you handled that? It was just A, B and C.'…You're doing reparenting, healing, and dreaming, and you're doing exploring, all in one little session, it's all together. You don't have to do 15 years of psychoanalysis and pay me $250 an hour." - Cabrini 'Ofa Makasiale*

Providing positive reinforcement when communicating – highlighting the strengths of how someone has approached an issue or handled something – not only increases confidence, but also helps to encourage the adoption of more positive communication amongst the family with which the practitioner is involved; the opportunity to communicate positively and supportively with TWO and their families is an opportunity to role-model and teach through practice. Makasiale points out how straightforward a thing this is to do, noting it doesn't take specific training, lengthy experience, or financial investment to communicate in an encouraging and affirming way. Samoa/NZF41-50 describes how these positive, affirmative conversations can also serve as a form of reciprocity, supporting effective family work through demonstrating a willingness to give back, to share, and to nurture the balanced flow (atu, mai, atamai (99)) necessary to maintain the relational space:

> *"We're asking people to give of themselves all the time…I always think 'What is it I'm giving them?'. An example…when I'm doing parenting assessments or court reports for parents, I practice quite differently from what usually happens. What usually happens is you are making observations about interactions between parents and young people, and then you write a report, and then usually that report can be accessed by parents via lawyers if they want to read it, and that's it. I always give feedback…For instance, the other day, I was watching some parents and grandparents interact with their kids…I asked them to reflect on that afterwards and then I gave them some really positive reinforcement for those behaviours because I just saw some lovely interactions and the fact these grandparents could think about it and could talk about it...that's how I'm giving back to them. It might not be 'I'm giving you $100,' but what other ways are we giving back to people, rather than, 'Okay, thank you, you let me into your home, now I'm going to go.'" – Samoa/NZF41-50*

This emphasis on positive communication as a form of reciprocity, an act designed to nourish and uplift, helps to ensure the family do not feel as though they have been evaluated, judged, and then side-lined by the MH practitioners with which they have engaged. Instead, they feel seen, validated, valued, and empowered by the interaction. By being mindful of how families experience interactions and communication with mental health services, these PMHP reduce future barriers to access related to confusion, disrespect, apprehension, and fear of judgement.

Opportunities for nurturing the Vā between practitioners, TWO, and families have also been created through the involvement of family representatives in governance. One practitioner shared how involving family in a steering group helped to ensure more effective engagement with TWO and their families overall:

> *"Back in the day when we had a steering group [it was important] to also have, a family advocate, family member, client advocates as well, being part of that and keeping an eye on everything, are we doing the right thing? It was so important for us…"– DHB Pacific MHA Team Member 8*

Involving a family advocate in the steering group supported the team to better understand and respond to needs of families and informed their approach to engagement.

As evidenced by the quotes and reflections shared above, recognising family and family engagement as foundational, and practicing accordingly, is a significant strength of PMHP, supporting them to improve outcomes for both TWO and their loved ones. Of course, engaging with the family of TWO does require some extra effort, but, where undertaken with good will, enthusiasm, and careful consideration it also enables the practitioner to address the root causes of harm are prevent future harm; TWO are surrounded by family who understand what is going on and who have been equipped to provide more effective support and PMHP have a clear, accurate understanding of what is going on for the TWO in their care. Furthermore, TWO find themselves with deeper, healthier connections to family and culture, a stronger awareness of the support around them, and access to spaces where they and their loved ones feel safe to be vulnerable with each other and heal.

4.1.3.3 The "work family"

The importance of family also manifests as a strength of PMHP in the context of the "work family". The PMHP in this study shared many stories of coming together as a well-connected team whose bonds extended beyond those of colleagues to something deeper, more emotional, and personal than one might expect in a professional context. This deep connection to one's colleagues was understood by participants as a fundamental strength of their practice, enabling them to nurture each other's holistic wellbeing, build a sense of connection and belonging, and support one another in times of stress and crisis so that TWO received consistent, connected care. This section will explore the various ways in which such bonds are nurtured in the workplace, as well as exploring the positive impacts thereof.

The connection between colleagues as "work family" is explicitly recognised as an extension of engaging with TWO as family:

> *"I always felt a belief everyone had to be treated with a similar approach. We wouldn't treat TWO [one way], and then go against that when we're treating our own staff…That was a firm belief on me…So very much how we as a practitioner deal with our own families and TWO. Just as real as in the working relationship, and frontline, they also need that process." – Samoa/NZM41-50A*

For Samoa/NZM41-50A, the extension of familial connectedness and 'ofa/alofa to colleagues is a matter of course; they too are connected to one another through shared divine descent and "they also need that process" of connection and family-like care. Other participants corroborated this perspective, sharing about the importance of treating one another like family, and about how much they valued the strong relationships, support, and sense of purpose and belonging this created:

> *"We had created within the team a sense of family and we had those values of family, collective, and caring for each other…our relationships within the team were really strong." – Samoa/NZF31-40*

> *"I wonder whether that's another difference between Pacific and mainstream. There's that sense of belonging. Again, family ties, part of the family. We've got a purpose. We belong… That's wellbeing for us, having a role and having some place to belong. You contribute... Pacific services do that really well and create a community where we're all clear on what we're doing here. We actually belong. We've all been called here." – Dwaine Faletanoa'i*

Participants shared a variety of ways in which the "work family" was nurtured, with the team often coming together to share in activities and daily practices usually undertaken in the family home. *Lotu* (prayer) and *pese* (songs) played a significant role, with colleagues in the Pacific MH space spending time together to share in devotional reading, prayer, and song.

> *"We did that really well…we tried to mirror processes as much as the organisation allowed of how Pacific families or Pacific communities would operate; we had a lot of peses, lotu, songs…"– Samoa/NZF31-40*

> *"When you're in a Pasifika team I think there's something about that team and the relationships built within that team, the way we pray, sing, remind ourselves of our values and try to live those out… that stuff is always more at the surface so we're reminded of it on a daily basis, whereas maybe in non-Pasifika teams those values that drew people into those roles can kind of fade away, or aren't as present with all the stress that's going on." – Samoa/NZF31-40*

> *"Here…we always start with our devotion…it makes all the difference…we're trying to shift from deficit models in MH to positivity, more positive outcomes, strengths based...and we can start our working day in MH and addictions on a positive note. It really sets up the day well. And when it's structured, it's regular, its daily, people come to expect that...I think people respect the process and that's one of our Pacific values…You work in a Pacific team, when there's respect ingrained in everything we do, we respect this is a Pacific thing to do. We start with the lotu. We start with a reading. We sing. And then, we get on to business…I know people with mainstream or other providers who might frown on it… [but] it sets up our workforce in the right space, spiritually, mentally, physically to be able to do a better job..." – Dwaine Faletanoa'i*

Faletanoa'i also shared about "matua time", when the entire team would come together to spend time with and learn from the Matua who oversaw the cultural elements of their work and provided cultural supervision:

> *"We have Matua time as a team…If you think of a family, we all got our busy lives, right? The kids go to school, parents go to work. But there's always that special time with family where you sit down and have heart-to-heart open discussions, usually at the dinner table. For us, our Matua time is that. We have a protected time where you can sit down… to talanoa under the guidance of a Matua...it feels like a bit of a family get together…The topics are very broad. There's no agenda." – Dwaine Faletanoa'i*

Taking the time to engage in these family activities – noted as usually being excluded from the mainstream professional sphere – supported the PMHP involved by nourishing them socially, culturally, and spiritually, helping them to commence their work with a positive mindset, and ensuring they have the necessary internal resources to undertake a very demanding job. It also connects them to each other, to their culture, and to the "why" of their work, keeping motivating factors at the forefront of their minds and reminding them of the support network available to them. While activities such as pese, lotu, and matua time may not directly relate to the provision of MH services, they do contribute to their more effective provision:

> *"We're more open and transparent. That creates a culture of trust and only good things come when there's trust. If there's division in the team, or unresolved things…the clients can see…but they also see if there's an open team that are really meshing well together." – Dwaine Faletanoa'i*
>
> *"Hopefully, that's reflected in our relationships with our clients. They'll be able to see that and also have a place they belong." – Dwaine Faletanoa'i*

TWO can see the strong relationships between the members of these "work families". Seeing the trust, respect, and care PMHP show each other and perceiving the connection, belonging, and purpose shared amongst them helps to reassure TWO this is a team who will include and look after them as they include and look after each other.

It is also noted above activities like lotu, pese, and matua time help to nurture trust, so divisions and unresolved conflicts are more easily addressed, and people are freed up to focus on the

needs of TWO. This was also reflected in a story shared by Samoa/NZF31-40, wherein the fala (and the processes associated with this) were used to bring the "work family" together to address some challenges they were facing:

> *"At one time we were going through a lot of transformational change and people were feeling stressed out and this was when [the MH unit I worked in] was becoming disestablished and we had talanoa on the fala, we had a fala process and we were able to use that to tausi le Vā. Everyone on the fala was crying…including myself. I think everyone was able to share and I've never seen that anywhere. " – Samoa/NZF31-40*

This process – typically used in the context of family life – brings everyone together on the same physical level – metaphorically challenging hierarchical relationships – and remains open until a state of noa/equilibrium (56, 60) is reached, facilitating the expression and exploration of issues and genuine emotional healing. Recognising the need to connect personally, socially, and spiritually with each other as a family of practice (and as a family in all the other senses already discussed in this chapter) – and making time and space for those connections to take place – is very much a strength of Pacific MH practice.

The strength of the "work family" also manifests in respectful communication dynamics, where everyone can have a say and where all contributions are valued and considered:

> *"…family is really important in Pacific communities, in the home as well as in the workplace and understanding…the relationships we have with each other, the respect for sacred relationships. If you understand your role in the family and where you sit in your family, a lot of those values, you just naturally…take these across into the workplace conversation and talanoa…I've sat in meetings where people are yelling at each other across the table and…so it's about actually having that moment to just allow people to have their say, to hear people out, remain calm, take a break and allowing an opportunity to respond and resolve." – TokelauF51-60*

Not only does this excerpt re-affirm that one's colleagues are seen and treated as family, but it highlights how the respect underpinning sacred relationships is operationalised in and through respectful professional communication. As colleagues are family, and relationships with them are thus sacred, it is imperative they be treated with respect, demonstrated by allowing them to have their say and giving their words due consideration. While one might hope such behaviour is expected professional conduct, even outside of Pacific settings, it was shared that this has not always been the case, and this respectfulness and provision of space *is* distinctly Pacific:

> *"What worked well for the Pasifika team is we all had that shared understanding of how we interact and talk even in meetings. Everyone had space to talk, that's quite different [from] a mainstream setting where everyone fights to talk…[but in our team] there's silences in between and that's ok, and people are giving each other space to talk, and that happens where everyone is of that same kind of culture and shared understanding…"– Samoa/NZF31-40*

Respectful communication of this sort helps to nurture a more cohesive team, minimise tension, and heighten the sense of belonging and inclusiveness highlighted above. Importantly, it also supports better outcomes for TWO as multiple perspectives, ideas, and reflections can be tabled, respectfully considered, and discussed. This reduces the risk of vital information being overlooked and increases the likelihood plans for TWO will represent the best the collective has to offer.

The "work family" paradigm also supports better practitioner wellbeing and better outcomes for TWO through shared responsibility. Samoa/NZF31-40 discussed how her "work family" assumed collective responsibility for client wellbeing:

> *"Especially being a collective team and seeing clients not as a caseworker's clients, but as [belonging to] a team, the team's client…we really supported each other which is NOT like most services ." – Samoa/NZF31-40*
>
> *"We had clients that weren't just ours, but we shared it and we supported each other when we had more work to do and that's really important when you have a*

> *crisis environment. Sometimes a clinician might have three of their clients in one day going into crisis, but because you've already established relationships, that young person hasn't just had contact with their case worker but has had contact with [the service and staff] as a whole, when the team is supporting with that crisis work - it's not the first encounter they've had. You know - and its cliché - it does take a village. – Samoa/NZF31-40*

In this approach, TWO were supported to develop relationships with multiple staff, so no one team member was exclusively responsible for that person's care. This freed PMHP up to be flexible and responsive in dealing with crisis situations and ensured – for example, should they become overwhelmed – they have the option of stepping back for a moment without compromising care. The benefits of this approach for TWO are also highlighted; they have multiple people around them who care about and are invested in their wellbeing (which, incidentally, creates more of a family feel) and they have more options of who they might comfortably talk to in a time of crisis.

Mutual support was also provided amongst the "work family" through an increased willingness to take on additional work during high-pressure periods and through undertaking community MH work in pairs:

> *"When we were at team meetings people would always put their hand up to take more clients and that was a real strength because of that team culture we had. In other teams there would be dead silences, there was a real sense in our team that this was a shared responsibility; we need to support each other in that." – Samoa/NZF31-40*

The experience of genuinely caring for and feeling committed to one's colleagues as family encouraged an attitude of responsibility and pro-activity, where there was a mutual desire to provide support and to reciprocate support by volunteering to take on new clients. This is noted as being tangibly different to other, non-Pacific teams wherein there was a tendency to avoid taking on more. In terms of working together in pairs:

> *"We would go out on visits together - that is really good practice anyway for safety reasons, clinical reasons - but actually feeling supported and being able to do things together so you're not so alone. Spending the whole day out on the road by yourself going to see families is quite different to doing that same thing with someone else…when you have someone else, you're still kind of connected and having the support… then also having two clinicians' different perspectives, [or] you might go see a young person with their parent and you need to split." – Samoa/NZF31-40*

> *"Because we had the family and we had the backup and support - we know going the extra mile can lead to burnout - but in our team, because we had created that sense of support, that network in our team, we were able to do that." – Samoa/NZF31-40*

Samoa/NZF31-40 notes how this pair-approach also provided access to multiple perspectives, as well as facilitating talking to different members of the family, and creating a sense of safety. Furthermore, it nurtured collegiality and positivity, helping to prevent burnout and overwhelm. Though not made explicit above, reducing burnout has profound positive impacts for TWO, supporting consistency of care and helping ensure the MH workforce grows in size and experience.

The concept of "work family" also extends to the idea of close, supportive relationships between services. Participants noted it was important for services to be connected to each other, sharing information, resources, and support to ensure the best possible outcomes for TWO, their families, and communities.

> *"If we have an organisation where part of our organisation was a trusted budget advisor, a counsellor, a family therapist, working intimately together, forming strong relationships with the people using that service…and that wider set of supports is actually connected to a community…and that community can participate in the life of the person you're trying to help." – TongaM51-60A*

TongaM51-60A extends the concept of intimacy (referred to in Section 4.1.3.1) out to the relationship between services, using the proximity and familiarity it implies to describe how different service providers might connect to each other and to the community:

> *"When I speak of intimacy, I'm thinking not just about the intimacy that happens between somebody requiring some support and help and a person that's in a position to provide some support…there's [also] intimacy between that person providing some support and other people in a position to provide a wider set of supports…And that wider set of supports is actually connected to a community…That's intimacy at a level where I think indigenous cultures got that right." – TongaM51-60A*

When working intimately with other practitioners and providers, PMHP are able to access a wider range of knowledge and skills, deploying these to ensure the various needs of TWO can be more effectively met. Furthermore, there are no gaps for TWO to fall through as services are connected, communicating, and actively working alongside each other.

Not only does a closely connected family of services help to ensure the provision of holistic, seamless support for TWO, but it also supports success through more efficient use of time and resources:

> *"The Pacific community there is very small. It's very limited what they can do…You're not going to have the critical mass in the population to be able to justify funding…what do you do as a small organization like that? I think the answer has always been, jump on board with a bigger organization. That's how you increase your capacity..." – TongaM41-50A*

> *"When I worked in an NGO…we worked together in that environment, forming a network so we can all support each other. With the sole purpose of making good outcomes for our community, for our people…I think with the five years I have worked in [this particular aspect of MH], I see having a network outside the main system, the hospital, the DHB, is really important... Relationship building and connections will enable the discussions, the conversations, the whatever we need to do to be able to move things forward. If we are planning something for our community, with the right connections, you can get things done. That's how I see it. Because going in to work in a big machine like the DHB... There's so many layers you have to go through to get anything approved, for example, for any funding. And it delays the progress of anything you want to do for the community." – Manu Fotu*

TongaM41-50A recognises the challenges faced by small organisations serving smaller, ethnic specific populations, and reflects on how operating as a family of services can increase capacity, reduce the amount of time spent fighting for funding, reduce the need to fight for funding (as it is a collaborative rather than competitive approach), and support the sustainability of the organisation. The second examples highlight the benefits in terms of time; for him, nurturing a family of services is a means of taking action – flexibly, responsively, and in a timely manner – to meet community needs larger organisations such as DHBs simply cannot.

Recognising and treating one another as family strengthens PMHP – both as people and as professionals – and supports them to provide more consistent and inclusive care for TWO. Manifesting through shared engagement in family-like activities and the use of traditional family processes, through respectful communication, and through the willingness to work together and assume shared responsibility, this extension of the familial into the professional supports PMHP to keep their values and TWO front-of-mind as they work. It also provides them with support, with a network of colleagues and services who they can rely on to assist when situations are complex or overwhelming, helping to reduce stress and minimise burnout. These benefits for MH practitioners are reflected in benefits for TWO, as they find themselves with access to connected services, a range of known and caring practitioners, and environments that feel safe and inclusive.

O le e lave i tiga, ole ivi, le toto, ma le aano

He who rallies in my hour of need is my kin.

4.1.4 Putting Tāngata Whai Ora First

Another significant strength demonstrated by the PMHP in this study was their ability to put TWO first, to keep them and their needs at the centre of their practice despite an array of internal and external pressures. Their ability to put TWO first and – through this – to meaningfully enact "people-centred" (6) care has supported PMHP to deliver care that meets TWO wherever and however they are, nurtures growth and builds resilience, grapples with the root causes of distress, and supports connectedness, spiritual wellbeing, and healthy relationships.

This strength has already been hinted at, with participants describing numerous ways in which they have prioritised TWO and their needs. This chapter will examine this theme in greater detail and with more focus, exploring how PMHP offer presence, time, and space to those in their care, how they prioritise heart/soul-work over cognitive work, and how they maintain an attitude of humility and service orientation in order both to keep TWO at the centre of their work and to ensure that the care they provide is as effective and beneficial as possible. I will also reflect on how this strength relates to the onto-axiological position expressed by the Vā, upholding the importance and sacredness of relationships and the imperative to position oneself "below" others in relationships.

4.1.4.1 Presence, time, and space

Participants clearly and frequently articulated the importance of not rushing when working with TWO, of taking time, making space and being present with them to provide "people-centred" care. Both the recognition of time, space, and presence as important, and the willingness to apply this understanding were understood as key strengths and PMHP shared that taking time to build

relationships *and* to reflect, giving the therapeutic relationship their full attention, and positioning TWO in the centre of their model of care (and then moving around them) all supported them to provide MH care more effectively. This section will explore how taking time, making space, and being present ensure TWO feel seen, heard, and cared about leads to better informed assessment and diagnosis, and improves accessibility.

Reflecting the Vā as the "positive core" of both their work and of Pacific ways of being, the practitioners in this study recognised strong, genuine relationships as fundamental to the provision of effective MH care:

> *"…the bread and butter of MH is the human relationship, the relationship that you have as a clinician or therapist with your patient." – Sipaia Kupa*

They also recognised such relationships take considerable time to build. For example, SamoaF41-50 described how, in Samoa, you "put your watch in your pocket" when working with people, reflecting how time pressure is antithetical to building meaningful relationships. This was echoed in reflections on the role of whakawhanaungatanga/fa'afeiloaiga/fakafe'iloaki and their implications for/relevance to MH practice:

> *"…some of our processes, they're very similar, like the Powhiri, the way the seats are, the separation, [this practice reflects that] it takes so much time for two partners to come together. And this, as health practitioners, we need to recognize it." - MāoriM41-50*

Participants recognised taking time to build genuine relationships – to bring the parties involved in the therapeutic relationship together in a meaningful way – was both something they did well and a significant point of difference:

> *"The policies in some mainstream services, you see the person three times, they don't engage, you discharge them. A Pacific Island service like ours…we can see people up to 12 times or more…When they engage, they engage." – DHB Pacific MHA Team Member 5*

> *"I know that's one of the big differences between Pasifika/Māori and mainstream; [mainstream] don't make time, they don't understand the value of it, and what it really means, if they do it, it's like, 'Well what do you do, what's your hobby?' and that's it and they go straight to, 'Tell me about your cannabis use?'" – MāoriM41-50*

They also recognised this difference was explicitly linked to traditional Pacific ways of life and to an understanding of time and relationship developed separately from Western capitalism (with its emphasis on measurability and productivity):

> *"[It's about]…living life in real time, not being dictated to by the pace of capitalist algorithms; the knowledge systems are simply village life in action." - Samoa/NZM61-70*

Māhanga-Lear et al. (119) note in their reflection on Tongan notions of Tā and Vā (time and (relational) space) that time is a "vessel of existence" socially organised in different ways in different cultural contexts. It is evident Western and Pacific cultural contexts organise time differently; the idea of not "*being dictated to*" by time, phrases like "*when they engage, they engage*", and the reflection that mainstream don't understand what taking time "*really means*" affirm this. Where Western cultures tend to focus on time as a fixed, finite, and demanding reality (e.g., "I must complete × by ɣ", "× starts at ɣ and finishes at ɑ", "× took ɣ minutes"), Pacific cultures instead see things in terms of "relational timelines"(125), wherein our experiences – particularly our experiences of relationships and relational space/Vā – give form to and direct the flow of time (119, 125). Just as the Ethics of the Vā requires an orientation towards knowledge that privileges context and relationship, it requires an orientation toward time that privileges context and relationship, centring that relationship and the time/(relational) space it requires over other concerns more distant in time/(relational) space (125).

This difference in temporal organisation and the privileging of Western understandings of time presented a barrier for PMHP, making it harder for them to take the time they needed to build meaningful relationships with TWO:

> *"Did you find it was easy to stay on top of the deliverables while still giving sufficient time [to TWO]? //No way. It was horrible. It was hard." – Dwaine Faletanoa'i*

PMHP recognised a need to *make* time to take time with TWO. For some, this meant a commitment to completing paperwork before/after appointments or developing systems to minimise the time spent on paperwork. Such strategies helped by ensuring the entire duration of appointments could be spent engaging with TWO and building relationships, rather than being divided between engagement and administration:

> *"People so often feel like they're being rushed.//Or you've got your notes and your referral forms. Leave the referral form.//Exactly.//Leave the assessment forms." – Phil Siataga and MāoriM41-50*

> *"How did you manage [to make time for TWO]?//…having good systems in place to make sure your paperwork's done. Sometimes, it means working earlier in the morning or after hours. We found ways to get it done." – Dwaine Faletanoa'i*

Coming in early and staying late has been a key strategy, allowing PMHP to make time for TWO by giving of their own (echoing the theme of self-sacrifice that emerges in earlier chapters). PMHP also shared how having a high level of clinical knowledge and experience was a key support, enabling them to make and take time while working with TWO:

> *"So, I have a strong clinical background in assessment, diagnosis, and you know management of patients. I think for me one of my strengths would be I think, and successes of mine would be, a strong clinical understanding." – Sipaia Kupa*

> *"I think there's all the psychology competencies and stuff like that, that's just a given." – Samoa/NZF41-50*

Where MH practitioners have a high level of professional competence, where they know what to look out for, what to probe, and what to make note of, they are able to move away from questionnaires and checklists of symptoms, thus enabling them to connect with TWO as people, engaging them in purposeful but unhurried, conversational dialogue where genuine relationships can more readily develop.

Making and taking the time to build relationships, connect with, and get to know TWO created numerous benefits. Reflecting what was discussed in Section 4.1.2.2, participants shared that this helped them to understand TWO and their needs in context, supporting more accurate formulation and diagnoses as well as the development of more relevant treatment plans. PMHP pointed out people will be more open and will share more freely when you take the time to talk with them and build a relationship, supporting both the efficiency and effectiveness of the assessment process:

> *"When you're doing whanaungatanga, you actually build an assessment. It's not just about building rapport and relationship, but you're also doing your assessment. You find out about protective factors, what connection they've got to their own identity, family, support, what they do, what their interests are in. Sometimes people name it as a wishy-washy thing, like we need to get to the work, we need to get to the problem… to actually to build trust takes time, and to build proper assessment takes time." – MāoriM41-50*

> *"You'll get more out of a cup of tea than you will out of a clinical interview... People are a lot more open with what goes on, they're very forthcoming, they're very honest." – Cook Island/NZF31-40*

Participants also shared how more open and conversational forms of assessment can double as interventions (thus compounding their effectiveness and their efficiency):

> *"…You can have an intervention as an assessment, and they're together at the same time…One of the things we used to do was use some of the Mana Moana construct as a theoretical orientation…and the people didn't even really know they were having an assessment. Then all of a sudden, they had an assessment, and it was done…I got critiqued for it and it was like, 'aren't you influencing the outcome of the assessment by what you're doing?' Of course, we are. We're always influencing the outcome. There is this mentality that you shouldn't, but that's the whole point of us being in these jobs is to be influencing the outcomes, right?" – Cook Island/NZF31-40*

Mana Moana (98, 198) – which asks participants to connect with and explore a pan-Pacific, ancestral landscape, and the stories, language, metaphors and concepts associated therewith – doesn't look or feel like a typical assessment or intervention. However, this "theoretical orientation" activity in which personal stories, genealogical connections, reflections etc. are shared allows Cook Island/NZF31-40 to build relationships, assess issues, *and* nurture participants' sense of self and culture at the same time. Even where a framework such as *Mana Moana* is unavailable, and the assessment/intervention simply manifests as an in-depth conversation, TWO still feel heard, understood, and cared about, and thus leave the interaction better off. Taking time to build relationships and get to know TWO not only supports more effective assessment but is healing in and of itself.

Participants also recognised engaging at a more leisurely pace created greater comfort for TWO:

> *"We're under pressure to make targets, you have a small window for clinical assessments, but really, it's the time that makes a difference. How that looked in practice is sometimes shooting hoops or having lunch together. No clinical assessments, no written work, no documentation, but just time, having talanoa like we're doing now. And it's so much more natural for me. Our youth, they're open and comfortable. Situations where they come to a room with four blank walls and an odd person in front of you with a pen and paper, it's never a winning formula." – Dwaine Faletanoa'i*

Echoing what was shared by Cook Island/NZF31-40, SamoaNZM31-40 notes talking over food or shared activities, with no paperwork and no formal examination or interrogation of their experiences helped to ensure TWO felt more relaxed and able to open up. Another participant – Samoa F41-50 – noted this trust-building and front-end investment also saves time later; spending two hours with TWO when they first meet (rather than the standard 30 mins she would typically be afforded as a DHB psychiatrist) helps TWO to feel safe and means follow-up appointments can be much shorter (54). These reflections highlight, again, how taking time in the initial stages of the therapeutic relationship supports efficiency in the longer term.

Beyond the relationship-building stage, making and taking time was also seen as valuable for enabling reflection and learning:

> *"I say, 'Just relax and see what comes up'. And we sit, at first, they are uneasy, I say, 'Don't worry, you can stop twitching your feet. Pretend you're going to sleep.' And then when they, open their eyes and they come to, you can't stop them. It just flows, all this insight…My contribution is to allow that to happen in this space, and to wait." - Cabrini 'Ofa Makasiale*

> *"'Now let's have a look at this and what was it that could be helpful from this experience?' And they go, 'Wow! I can use this; I can use that'. It's the space to reflect back on the experience and learn. And sometimes we call that prayer, and sometimes we call it insight, and sometimes we call it the ability to wait; if I don't wait for things to come together, I could miss what the learning factor is in that event." - Cabrini 'Ofa Makasiale*

Makasiale highlights the value of taking time not just to build relationships with TWO, but to let realisations and understandings unfold within that carefully built space. Creating a therapeutic environment where time is available to reflect and wait, allows things to surface that otherwise might not; TWO are supported to access and engage with their own experiences and the insights that emerge in therapy. Faletanoa'i frames this in terms of a pace that will "*be more meaningful in the long run*":

> *"[In mainstream services] there is a lot of pressure just to get your results and focus your time into your outputs. More than the time and space to learn and watch and go at a slower or a pace that's going to be more meaningful in the long run." – Dwaine Faletanoa'i*

Related to the concept of making and taking time with TWO – and to investing that time into relationship and reflection – is the concept of presence. For PMHP it was important to be present to and with TWO, not mentally occupied with other aspects of their job or life:

> *"You can't be thinking of other things then, you have to be present, in the moment..." - Asiata Malagaoma Lealofi Sio*

> *"For me, personally, it's the sense when you're near the client, you're really present, 100% fully, and you make sure they're your total focus, and their story, their journey, and you're really active-listening."- MāoriM41-50*

For these practitioners, putting TWO first means keeping their experiences at the centre of their attention, focussing on the person in front of them to the exclusion of other concerns. A number of participants constructed the importance of this focus specifically in terms of the Vā and the sacredness thereof:

> *"Prioritizing them is key. When you are present with people and practicing, you're actually present with people. Everything else takes a step back. With MH services, clinicians are not present. They're whizzing around doing this, this, and this. When they're with people, it is like moving people through a process just bump, bump, bump, bump, rather than actually making that time kind of sacred…"– Cook Island/NZF31-40*

> *"You shift yourself from 'I have this', 'I need that', into simply just being, and being able to engage in that sacred space." - Samoa/NZM61-70*

This understanding of the therapeutic space as not only important but *sacred* (and the attendant recognition of presence in that space as a spiritually significant act) is a strength of PMHP and their

practice. It subverts the corporate and medical tendency to reduce people to outputs/KPIs, and calendar appointments, instead encouraging and empowering practitioners to approach TWO deferentially, respectfully – even reverentially – and to work in ways that honour TWO as tuātagata, sacred beings co-present in sacred relationship.

Carrying this understanding and making oneself fully present to and with TWO requires complete and close attention:

> *"I was with the doctor who was trying to do a quick assessment and get out, she wanted to wind up her cases, but because I was working with this young lady…It was just her presentation [and posture] was different. And doc went out to do a script and I kind of had to recheck in with her and I found out she was sexually abused on the weekend." - Asiata Malagaoma Lealofi Sio*
>
> *"I remember working with a young person…and I say 'You'll know this kid has life experiences [that are] quite traumatic because some of the words I used, he didn't react, like it's a normal thing for him'... [If it's shocking to them] they come to and they engage in that conversation. Whereas if it's something you already know about [you don't get a reaction]..." - Asiata Malagaoma Lealofi Sio*
>
> *"There are certain things you need to look at, we're able to pick up their body language because sometimes when you're in a conversation with them, or an assessment… You capture a lot. The body language and then, you know too when to stop when you see them bored. You say, 'All right. Maybe we better have a cup of tea.'" – DHB Pacific MHA Team Member 1*

In the quotes shared above, presence with TWO, keeping them at the centre of one's attention meant focussing on their body language and their reactions to certain topics or wording. This focused awareness of the paralinguistic – uninterrupted by the desire to "wind up" cases or by thoughts of future appointments – supported these PMHP or them to notice things other rushed, distracted colleagues had missed. It also supported practitioners to subtly probe for potential trauma or adverse experiences, and to monitor for fatigue and distress, helping to avoid re-traumatisation, overwhelm, or disengagement. This focused awareness can also look like hearing "what people are not saying",

with another participant sharing how he listens for the shame, embarrassment, rage, and sorrow *behind* peoples' words, and – in recognising and acknowledging these unspoken feelings – creating a safe, trusting space for these difficult feelings to be made explicit (TongaM51-60A).

This idea of presence as a means of creating a safe space where trust can be built is echoed by others:

> *"We talk a lot about presence. People, before they hear, and our brains, the amygdala, is going to feel you before it hears you. It's going to sense you're someone I can be safe with…So bringing people into a calm and safe space." – Phil Siataga*

For Siataga, one's own "presence" – in the sense of how one presents and might be perceived or felt – is key to creating safety for TWO. This means approaching the relational space calmly, confidently, and with the intention of providing 'ofa/alofa; these intentions can be subconsciously read and signal safety to TWO. Conversely, if one is distracted, frustrated, or overwhelmed, this too is tangible and can have profound negative impacts on engagement. In the same talanoa, NZM41-50 reflected on the need for "authentic" presence – honouring the sacred space by being one's honest and genuine self – and on how this too can support the therapeutic relationship:

> *"I used to work in youth justice as well, with young people, and often the conversation would be you're 'just another person'. That's the narrative they have before you even see them…so you've got to be on the front foot, in terms of how you work, in terms of your presence and being authentic." – MāoriM41-50*

Bringing one's authentic self into the relational space supports success by helping TWO who have negative experiences with dismissive or distracted MH practitioners to see and experience PMHP as "real people" who genuinely care and who want to build a genuine relationship with them.

The participants in this study also discuss putting TWO first through positioning them – and their families/communities – in the centre of a metaphorical and of physical space, with the practitioner, their service, and other services moving flexibly around them to meet their needs:

> *"When you put the benefit for your community in the middle, then you're willing to look at "how can we achieve that, move around that?", isn't it? Whereas if you put your organizations in the middle, you can say, "Well, I'm flexible, but as long as people bend to me.""* – *Manu Fotu*

Fotu notes the tendency in current MH models to place the organisation at a fixed point in the centre, expecting TWO to adjust their schedules, priorities, and locations to align with their operational model. In the Pacific services where he has worked, this has been avoided by shifting the onus of movement and flexibility onto the service itself. This recognition is echoed by Cook Island/NZF31-40:

> *"…their answer was always well you can't do that for everybody. And it's like, 'Well, why not? You make up that you can't have people going out doing all these home visits.'"* – *Cook Island/NZF31-40*

> *"…the way the MH model typically works, is people come into the professional MH world. And then they get what they get from that, and then they go back to their own worlds and use that. And that's just not how people work. People work within whatever environment they're in, and it's our job to go into that environment and help them change things about that, to change outcomes and flow from there..."* – *Cook Island/NZF31-40*

Used in Section 4.1.2.3 and 4.1.3.2, these quotes also highlight how positioning TWO in the centre – with services moving around them – is both unusual in mainstream contexts, and genuinely beneficial. Such an approach helps to make services more accessible, to ensure the care provided is relevant to the needs of TWO and is provided in a way responsive to those needs and the context in which they occur (rather than the needs and context of the organisation).

It should also be noted Pacific teams often deliver this flexible and highly responsive care while operating with the same or fewer resources afforded to clinic-based non-Pacific teams:

> *"We were working under a Pacific model, naturally being an assertive outreach team, but we only had the same amount of resources as the mainstream team who saw most of their clients in house and didn't have as much of the socioeconomic stuff to kind of consider that we did." – Samoa/NZF31-40*

Herein Samoa/NZF31-40 highlights both the strength of her team and their success in putting TWO and their needs first, whilst simultaneously drawing attention to the inequitable resourcing of their approach. As with the earlier reflection on coming in early and staying late to make time for TWO, this both echoes previous discussions of self-sacrifice and the willingness of PMHP to give of their own time, energy, and resource in the care of TWO, and affirms the need for these person-centred approaches to care to be appreciated and resourced.

For the participants in this study, putting people first requires putting deadlines and organisational priorities second. Operating with an understanding of time grounded in the pairing of Tā and Vā and of the relational space as sacred, PMHP are uniquely well placed to be able to do. There is also strength in their persistence with approaches that enable this prioritisation of time/presence to TWO, ensuring they have a high level of clinical competency to facilitate a more relaxed approach and being willing to put in significant additional effort to ensure paperwork and other institutional pressures don't intrude into the therapeutic space. This persistence and effort is shown to be worthwhile, as being present to and prioritising time with TWO supports the building of genuine, trusting relationships, creates a sense of safety and comfort, facilitates thorough assessment and prompt intervention, helps to overcome past negative experiences of care, and enables healing through deeper reflection and learning. Adding to the benefits of centring TWO in their attention, PMHP also reflected on the literal centring of TWO in terms of SDMs as a strength. By shifting the

burden of taking action from the person who is struggling to those who are employed to provide support, PMHP are able to meet TWO where they are, improving accessibility and helping to ensure the relevance and positive impact of treatment.

4.1.4.2 Loto mo e Fakakaukau: heart/soul and mind

Another crucial way in which PMHP demonstrate their ability to put TWO first is through their ability to address the heart and soul before the mind, to engage with peoples felt experiences of pain and distress, their need for emotional and spiritual healing, *before* engaging with the thought processes around these. Through their recognition of the heart/soul's importance and the use of practices which reflect this recognition, PMHP were able to support connectedness and spiritual healing; work to address the root causes of distress, disorder, and anguish; demonstrate a persistent focus on holism and healing (as opposed to controlling symptoms); nurture hope and purpose; and embrace Pacific worldviews to affirm cultural identity/alleviate cultural alienation. This section will explore the importance of the heart/soul in Pacific MH practice as well as discussing how sensing and stillness and the use of narrative, ritual and symbol manifest this importance in the therapeutic space.

This section is called "Loto mo e Fakakaukau" (Tongan for "heart/soul/interior and thought-from-the-mind"):

> *"There is this Tongan word "loto." Loto is quite key. We Tongans don't say "what do you think?". Think is Fakakaukau. We ask "ko e hā ho loto?" - "what's inside?" Loto is a massive word…I put a lot of stuff there…heart, soul, inner being, but it's way deeper than that." – TongaM41-50B*

In using this linguistic reference, TongaM41-50B highlights a conceptual difference between what is prioritised by Western psychology and MH interventions – Fakakaukau, thought-from-the-mind – and what is prioritised in Tongan approaches to MH care, which is Loto – heart/soul/interior (and the emotional-spiritual inner world associated with these). This focus on interiority and the emotional-spiritual has already been noted by Makasiale in Section 4.1.2.1:

> *"In the mainstream its very head centred, theory centred, and science centred, which has a place. "In the Polynesian framework we are very heart centred, spirit centred and what scientists today would call, in quantum theory, the non-local position…you might call it faith, or spirituality, but I think mainstream is slowly beginning to realize for Pasifika and Māori, the wairua, the Mauri ora, the faith, for want of a better word, believing in things that can't be seen, that is, and needs to be, on the same level of health and healing as science, psychology, and medicine. It must be because it works for us." - Cabrini 'Ofa Makasiale*

This recognition of emotional-spiritual knowledge as being of equal value to psychology encourages both humanising, holistic practice and an emphasis on healing and restoration over controlling symptoms and behaviours:

> *"I think, treatment nowadays focused more on controlling symptoms. It's about control rather than healing" – TongaM41-50B*
>
> *"You want to look at the holistic person, their spirituality, the other parts that make that person. You can get that real good engagement really quickly by doing that. That way, it's not a deficit model, that's a hope filled space. You're going to make them feel valued." – MāoriM41-50*

NZM51-60 reflects that engaging with the whole person, including the loto – the heart, soul, and inner world – supports better engagement in and of itself, as well as creating a space wherein hope can be restored. He notes TWO experience hope, experience recognition as people whose worth and potential extends beyond their present circumstances and struggles through the experience of being fully seen and acknowledged. Once that hope is felt, *then* there is energy available to address issues such as intrusive thoughts and cognitive distortions. Echoing this, Samoa/NZM61-70, points toward

the words of Pacific advocate Vito Malo (147), and the consideration of how engagement with people's hearts facilitates the subsequent sharing of more theoretical, "head-centred" knowledge:

> *"Go back to the Vito Malo quote of, 'people don't care about what we know until they know that we care.'" - Samoa/NZM61-70*

There is a clear recognition here of the need to make people feel safe, supported, and cared about – to engage with and connect to the loto – before moving on to fakakaukau and the more cognitive components of support.

Other practitioners echo the focus on healing, sharing how an emphasis on loto moves their practice beyond managing symptoms and toward the desire to heal spiritual-emotional wounds and to support TWO to experience wellness, thrive, and enjoy a "fantastic life":

> *"At a deep level, what drives me is I'd like you to have a fantastic life…to be able to figure out what it is you need to do to have a fantastic life." – TongaM51-60A*

Success for these practitioners is not measured primarily by how frequently or infrequently certain symptoms are present, how often TWO might be displaying certain behaviours, or how efficiently they might be managing their thoughts (though these factors are still considered important). What is of utmost importance is how TWO *feel* about themselves, and *feel* about their place in the world:

> *"It's so important. Because you want them to walk away feeling empowered about who they are as a person…not just about some stuff you might work with them around CBT and their head... Make them feel valued. Make them feel good about who they are. That's what's important." – MāoriM41-50*

This emphasis is driven by a recognition that *"…for half of our clients, they don't care whether it's ADHD or reactive attachment disorder. It makes no tangible difference [to them]..." (Cook*

Island/NZF31-40). Rather, it is their experiences of their own spiritual-emotional state – of distress and anguish or the alleviation thereof – that takes precedence over assessment, diagnosis, and other manifestations of a cognitive focus. Their felt need for warmth, care, recognition, mana-enhancement, validation, and encouragement *must* come *first*. Recognising the importance of loto and putting loto before fakakaukau is thus a strength that supports effective MH practice as it puts the person and their experiences before the "problem".

Engaging with the heart/soul/inner world – as the site of emotional-spiritual experience – was also considered to be vital for addressing the existential questions that all human beings face:

> *"There's a supernatural realm. And that realm has a part to play with the natural realm. It's not a realm that we should spend a whole lot of time in…But there's stuff that we can know about it that is helpful for us. In terms of life after death, the big religious questions, where we come from, origins of life, why we're here, is there a life after death, is there immortality? All of those are important considerations…those questions are the questions that stir up in every person's soul. It's part of the journey of reflecting on life." – Phil Siataga*

Siataga shares that working in a loto-centric way – acknowledging both the soul and the questions that stir up within it –can support TWO to make sense of their existence, to understand themselves, their experiences, their relationships, and to find and live-out their purpose. Such explorations are positioned as a central element of the human experience, necessary in order for care to be truly holistic. Siataga also acknowledges a need for balance, a recognition we exist in this "natural realm" and oughtn't spend too much time in and with the supernatural; his isn't an argument for a turn to faith-healing or an exclusive emphasis on spiritual injury, but a recognition of the role of the spirit in wellbeing. It is also not framed in terms of any particular faith or cultural belief system, but simply a need to engage with the "supernatural", with complex experiences beyond the "natural" as an essential aspect of MH care.

The idea of taking time and being present with TWO resurfaces here and requires further development regarding the question of engaging with loto before fakakaukau. Time and presence are both absolutely vital to engaging with loto as a less immediately obvious aspect of human experience, particularly as they enable sensitivity and stillness. MāoriM41-50 describes how both he and his colleague are skilled at "*listening with all their senses*", tuning in to the inner experience and inner being of the TWO they work with:

> *"Phil does this naturally, and sometimes it's hard to describe, but I think it's that when you listen, you're not just listening with your ears, you're listening with all your senses, and then sometimes you bring that up. 'I sense there's more to this, I might be wrong, but can you tell us more about that, what's happening for you?' And I do that a lot [too]…one of my biggest tools is not actually listening with my ears, it's listening with my senses." – MāoriM41-50*

This type of presence to and with what someone is feeling and experiencing goes beyond leaving the assessment forms behind, beyond not allowing oneself to be distracted by other concerns, and beyond minute attention to body language and changes in demeanour. It requires an openness to and mindfulness of the loto, and to the shifts in wairua, to the flow of spiritual-emotional energy this generates. This openness and mindfulness are only possible when one both recognises the need to practice them and when one has the time and presence to do so. Makasiale shares an anecdote about what such stillness is like for her:

> *"The thought comes up, 'I could go to the library, or I could go to the butchers, or I could go straight home'. Pause. Put down capital P, pause…And then I'd say, now I see which one comes up, and the one that keeps coming up is go to the library…Now if I follow this map, this compass, I shall go to the library…so I decide to be obedient to the spirit, we call it in theology and spirituality study…and there I meet my old school friend from Fiji. She's been looking for me. She couldn't find me, but she knew I was somewhere in the vicinity of [the library]. She went to the library…I turned up and guess what, her only son had just committed suicide and she needed to talk to me. We had lost touch for years. That's what I mean." - Cabrini 'Ofa Makasiale*

Through sensitivity and stillness Makasiale is able to access spiritual guidance/intuition/the shakings of the interconnected web of existence and make her way toward what is essential, what is true and necessary for her as a being-in-relationship. Through her own skill in doing this she is then able to support others to do the same, empowering them to access their inner experiences and mindfully act on these. TokelauF51-60 highlights how nurturing this stillness and reflection can also act as a precursor for critical thought, facilitating the move *from* loto *to* fakakaukau:

> *"The value of Supervision is an opportunity to reflect and tell your story from a personal or professional perspective. It's about allowing people to access a safe space to talk through events or situations we encounter in practice each day and possibly impact on practice ethically, professionally, culturally, or legally." – TokelauF51-60*

Taking the time to be still and sensitive in one's own presence with TWO, as well as supporting stillness and sensitivity in and for TWO is an effective means of centring TWO and their experiences when providing MH care. The openness to something beyond the five senses in the therapeutic space – and the carefully cultivated sensibility of this – support success by bringing attention to factors not yet made conscious and creating space for those factors to be perceived and processed.

In addition to being still and sensitive, PMHP also described using narrative, ritual, and symbol to enable a more loto-centric approach to MH care. Ritual was frequently discussed in terms of prayer, particularly as a means of opening and closing the therapeutic space:

> *"They feel that…When we say prayer before beginning a meeting with our patient there's almost an audible sigh of relief as if to say "'Oh, I feel safe. I'm okay here. I feel safe enough to share my story.' Once that prayer is established and starts the meeting off it's amazing how much they share without us even having to ask them what their story is about. That's a success in itself." – DHB Pacific MHA Team Member 5*

DHB Pacific MHA Team Member 5 describes how opening and closing the therapeutic space with prayer – particularly prayer for TWO and their healing – creates a safe space where TWO feel their story can be shared. They describe how it acts as an invitation for TWO, in and off itself, to bring their experiences of their loto into the space. The purposeful creation of spaces where emotional-spiritual experiences are welcome and can safely be shared – without judgement or awkwardness – was also noted by Mila regarding a colleague's practice:

> *"She was onto it - she knew beginnings and endings were important so she would always open in karakia. Not in a tokenistic way like, 'Should we say a karakia because you're Pacific?', but because it was part of her practice, and then at the end she would always end with a creative visualization or some form of meditation. Because she instinctively knew ritual of some kind was really important." – Dr. Karlo Mila*

Mila explicitly identifies her colleague's practices as ritual, as a formalised, spiritual process of *whakatapu* (making sacred/sanctification/consecration (327)) and *whakanoa* (making free/clear/removing tapu (328)). She also points towards the importance of ensuring this spiritual-emotional engagement is non-tokenistic, a reflection echoed by other participants who pointed out such acts had to come from a place of authenticity and genuine belief, and noting the awkwardness of these gestures when they were not heartfelt:

> *"We go to meetings within the DHB, and it used to be they really acknowledged if one of us or a Māori is there, they'd say "would you like to pray for us today?", but it really doesn't feel right//[it feels] Tokenistic." – DHB Pacific MHA Team*

Related to this was the importance of operating flexibly so that the differences between peoples' inner worlds and spiritual-emotional experiences could be navigated, accepted, and addressed:

> *"No one left out or alienated. And no one's belief system devalued, disregarded, or disrespected." – Dwaine Faletanoa'i*
>
> *"He is Palagi, but he's been asked to participate in our sessions like this. If he's not comfortable in saying prayer the way we say prayer, we give him the option, he's most welcome to bring a poem or sing us a song." – DHB Pacific MHA Team Member 5*
>
> *"It has to resonate from a client's perspective….we can have stuff that might resonate really well for me, but if it doesn't resonate with them there's no point." – Cook Island/NZF31-40*

The openness to and importance of the spiritual-emotional within the therapeutic space is tempered with a strong sense of respect for different worldviews. The emphasis on making a sacred, spiritually safe space in which therapeutic activities can occur persists regardless of who is being worked with. However, reflecting what was shared by Siataga, this is not bound by undue preference for any one spiritual mode; it is always undertaken as respectfully as possible and with deference to the beliefs and preferences of the TWO engaged in care.

Once a sacred space for the therapeutic relationship has been created, a number of strategies are engaged to work in a more loto-centric way. Some practitioners highlight a focus on narrative and metaphor in this space. This could look as simple as letting TWO weave a narrative of their own and their families' experiences:

> *"We look at whakapapa to find those stories to bring those narratives out…'" – MāoriM41-50*
>
> *"People relay stories and really listening to their stories, and highlighting different parts of their stories..." – Cook Island/NZF31-40*

Recalling earlier discussions of drawing on Pacific knowledge as well as bio-medical knowledge, and of the different pathways to understanding and healing offered by this, it could also look like bringing

mythological and cultural narratives into the space to explore how these might resonate with TWO. In the psychology of religion, symbols and myths are posited as *"the path to truth…the making present of something absent – something that would remain absent and inaccessible without these symbols"* (329), inviting human participation in transcendent meaning making (329, 330). Mila described the work of a Pacific psychologist who was able use her knowledge of Pacific stories and symbols alongside her clinical knowledge to highlight such pathways:

> *"Right from the outset she was already using archetypal concepts from our Pacific matauranga. She would talk about Hine Nui te Po with girls that had experienced sexual violence… about Ru the navigator and the story of him going navigating into the whirlpools in the storm and then finally calling out to Tangaroa for help after he realized his own ego wasn't going to get him out, and she used that clinically…I've watched her use those stories, she activated that deep archetypal mythological narrative in the context of what she was doing." – Dr. Karlo Mila*

In addition to supporting TWO to participate in transcendent meaning making – to make sense of their experiences by connecting these to the experiences, emotions, and relationships present in traditional narratives – Cook Island/NZF31/40 also highlights how myth and symbol, as expressions of poetic and spiritual truth, can provide alternative perspectives, access to new ways around seemingly immovable feelings and problems:

> *"I use a lot of storytelling, narrative, and metaphor. I use a lot of the Mana Moana stuff. I'm an eclectic practitioner… The foundation of the session might be based around a metaphorical construct, and from that we'd weave in clinical principles on top. For one session we might use the languaging of a storm, constructing their experiences in that way…It gives you alternative perspectives. Because if you feel it, then often you feel it in a singular, heavy way… and there's very little that can dislodge that. But if you can look at it in a poetic way, it gives you other ways of moving on it, of looking at it, and of understanding it." – Cook Island/NZF31-40*

The use of narrative, symbol and metaphor was used by PMHP to help TWO find the words needed to communicate what is found in the loto, to engage with and express that intangible inner world as well as offering them different perspectives on those experiences:

> *"A lot of it is around getting them to have language that allows them to describe one level, and then the next level down, and then the next level down. I find metaphor is a powerful way to be able to do that. It gives people different ways of describing, and from that, different ways of understanding it…looking at it and exploring it." – Cook Island/NZF31-40*

The use of metaphors drawn from nature specifically were discussed in terms of opening up a more experiential and tangible engagement with the less-tangible emotional-spiritual:

> *"Dirt is real. It's there, it's real. Water is there. MH can be very abstract and very heady, and there's a real danger in that. If we become too verbal without any action, that doesn't help. //So, there's something very grounding about the metaphorical framework then?// Yeah. It allows people a whole heap of real, tangible, visceral engagement with things and quite often, it's not as pretty as it sounds. These things all sound beautiful and poetic, and quite romantic. But often, they are painful, and dirty, and sore. They're real. For example, when we talk about ngaru, waves, it's easy to get romantic notions. But then, when you go and you're in your experience, and you realize, 'That's right, the salt gets in your eyes.'" – Cook Island/NZF31-40*

> *"In villages at home we don't have all the wherewithal about what the weather's like, we stand at the shore, we see where the wind blows our hair and our face, we see which way the boat moves.//There's a degree of attunement to nature, but a nature that is resonant with spiritual life?//Yes…and if I could tune into that, wherever I needed, you're home and hosed." - Cabrini 'Ofa Makasiale*

This approach aligns with the recognition "*Metaphors structure our understandings about our experiences; they influence our thoughts and actions without us noticing them. They allow us to use what we know about our physical and social experiences to understand and make meaning of our world…shaping not only our communications but also our perceptions and our behaviours*." (331). The rituals, narratives, and symbols used in the examples above support both MH practitioners and TWO both to enter into the inner world of spiritual-emotional experience, and to then bring that inner world

out, making sense of said experience through expression and ordering, and through physical connection.

Drawing on examples from 4.1.3.2, it also becomes clear these metaphorical and metaphorical-experiential sense making processes are particularly meaningful for TWO who had experienced disconnection from culture and family:

> *"What happens if you've got a Māori kid has been fostered to eight different homes and doesn't know their parent's name? I had a kid like that. For him to engage with his Whakapapa was a universal one around Papatuanuku and Ranginui and helping him to make sense of what that connection for him was..." – MāoriM41-50*

Engaging with a world of spiritual meaning and with a spiritually resonant natural world can support TWO to engage with who they are and where they come from, in and through a growing relationship with kāinga, with notions of family, home, and of land/the natural world. By drawing on the Pacific landscape (both metaphorically and physically) and on Pacific stories and culture heroes as part of therapeutic engagement, these PMHP create positive opportunities to connect deeply and personally with culture and strengthen cultural identity in and through the therapeutic process. They affirm the identities of TWO and address their experiences in a way that brings them more closely into sacred selfhood and sacred relationship.

These strategies for engaging with the heart/soul/loto put TWO first by centring their spiritual-emotional worldviews and supporting their meaning making processes in spiritually safe environments. PMHP use stillness and engage a deep sensitivity to connect with what TWO are experiencing and to support them to do the same for themselves. Further to this, they make effective use of ritual, narrative, and symbol to create safe, sacred spaces in which a balance between feeling and thought can be found. Through these approaches they validate TWO as whole people by

acknowledging their emotional-spiritual experiences and bring the intangible into the tangible, bridging the gap between loto and fakakaukau. This provides hope for TWO, eases them into engagement with more cognitive/head-led approaches, and supports them to express and make meaning of their inner world, integrating this with a wider cosmic and natural order so they can find and affirm their place within it.

4.1.4.3 Loto maualalo ma tautua: humility and service

Putting tāngata whai ora first, as a significant strength of Pacific MH Practice, was also expressed in terms of humility and service. As noted in Section 2.1.2, humility – loto maualalo – and service – tautua – are values central to and relevant across Pacific ethnicities, manifest in the moral imperative to position oneself "below" others in relationship, and to express respect for others and deference their needs. Loto maualalo and tautua play a vital role in informing and guiding the practice pf PMHP, supporting them to put TWO first by viewing themselves as a "tool" to be used, acknowledging reciprocal impact, getting involved in aspects of MH care that are "below" their role, and responding to mistakes and challenges as learning experiences. Through these approaches and attitudes PMHP provide person-centred care that enacts relational mindfulness, empowers TWO and affirms their dignity, and supports growth and resilience.

Many of the PMHP in this study understood their professional roles in terms of both humility and service to the community:

> *"There's never any sense of entitlement with our Pacific services and that comes back to the fa'aaloalo we have ingrained in us. We always want to give to our community. We're a generous people. There's no sense of "what can I get out of*

this job for myself?"…Those values of reciprocity, humility, servitude." – Dwaine Faletanoa'i

"That sense you are there for a purpose and it's your duty to do your best for that community... for Pacific, it's almost like part of your identity, how well you are doing in your job and how well you are serving your community." – Samoa/NZF31-40

These quotes highlight the understanding of service as an expression of humility, a duty to others, and a core component of one's identity, an expression of the Vā in terms of ontology and Ethics. Sio summarises this beautifully, linking the sacred relationships between himself and others (experienced in and through God), to his felt and practical responses towards them: 'ofa/alofa and tautua.

"[The way of working] I've developed for myself is, 'Le Atua, Alofa, Tautua'. //God, love, and service. //God is, "How am I treating this person?", it's around my head space and how I am approaching this person. When I speak, are my words and my actions demonstrating alofa? And my tautua, my behaviour, is it demonstrating service?" - Asiata Malagaoma Lealofi Sio

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This service orientation/focus was well recognised as a strength amongst participants, with the desire to serve motivating PMHP to persist, regardless of remuneration or conditions, and supporting them to bring a high level of passion, enthusiasm, "keen-ness", and commitment to their professional lives:

"Mostly, the people that work in MH, I don't think they're there for the money. These are people who have passion…are always enthusiastic about the work they do. It might be a small service. It could be a big service. But people are keen to do it… the workers are really, really good." – FijiM51-60

One way in which PMHP demonstrate service is by humbling themselves, letting their professional status and role as "expert" take a back seat, so TWO can be engaged with as equals, or even allowed to lead within the therapeutic relationship. This often started with an acknowledgement of the unhelpful power dynamics and hierarchy that frequently play out in traditional therapeutic

relationships:

> *"Within a strictly clinical context, there are a lot of power dynamics at play, particularly in terms of the clinician being expert. 'You do what we say and then you'll be better'. And it's actually just not like that, it just doesn't work." – Cook Island/NZF31-40*

> *"One half of the workforce does not save the rest of the population and if they think they do, then they are probably in the wrong job." – Dr. Karlo Mila*

PMHP knew that TWO are aware of and are negatively impacted by this dynamic. For example, Samoa/NZM41-50A shared how – because of the hierarchical nature of the traditional doctor/patient dynamic – TWO often feel they have to assume a subordinate role when interacting with clinicians:

> *"Our TWO could pick that up. They're very smart and I think there's a brilliance to [how they] downplay, [acting] to not look like they're more brilliant than the clinician. Because it's like our TWO know, they understand the power dynamic." – Samoa/NZM41-50A*

The PMHP in this study countered this dynamic so TWO could be put first, by valuing and actively affirming the capabilities of and input provided by TWO:

> *"Some of these young students I work with…I can't believe the amount of wisdom and knowledge they've got, and the leadership. But you've got to give them the opportunity to really speak, and you've got to listen. Often there will be teachers that think these kids have been overpowering, and 'How can I allow this when I've got to be the expert, I've got to be the teacher?' You've just got to step back." – MāoriM41-50*

By choosing to step back from that "expert" role, MāoriM41-50 creates a space the young people in his care can inhabit instead, empowering them to share their knowledge and wisdom. For him, TWO are as entitled to speak into that therapeutic space as he is and, recognising that as valuable, he is then also able to learn from them. This need to step back and learn is echoed by Faletanoa'i:

> *"For us in Pacific health, there's always humility. We have the humility to be able to take a step back and just enjoy the learning we can get from other people." – Dwaine Faletanoa'i*

Another participant described how she worked with TWO in a way that upheld them as equal knowledge holders, by encouraging them to reflect on previous experiences of success, to draw on their own knowledge and inner resources rather than emphasising the importance of her insights as the clinician and "expert":

> *"One of the things we always do straight off the bat, would be looking at what has worked for them previously. And what hasn't worked. Incrementally building that sense with them that 'You've done these things, you've done other things, you've done very similar things, you can do this.'…if they can discover it, and if they own it, then it's their solution and then they end up being winners, because they've figured it out and they feel better, and more empowered and able to make a difference…Our job isn't to rescue people. It's actually to give them the tools to rescue themselves…the experience of being able to rescue themselves and pull themselves out." – Cook Island/NZF31-40*

Such encouragement helps TWO to tap into strategies that have been effective for them historically. When TWO are supported to access, explore, and draw on their own knowledge and skills thus – to "save themselves" so "they end up being winners" – they emerge more resilient, more confident in their ability to find solutions and take action to achieve them.

For TongaM51-60A, upholding the equal status of TWO was a matter of recognising reciprocal impact, of understanding the practitioner does not empower TWO through a one-way bestowal of insight or assistance, but rather through both positively impacting *each other*. TongaM51-60A humbly acknowledges the profound impact TWO have had on his own personal and professional becoming:

> *"It's funny, the word empowerment, it feels so…'We're experienced, we can empower people'. We really don't see the world that way. Even this conversation, the importance of this conversation in terms of how it shapes me. Every person I've*

> *ever tried to be of value to has shaped me, you know… I don't become the person that I am without allowing myself to be shaped and exposed to other people's distress." – TongaM51-60A*

This is echoed by TokelauF51-60 who views working with TWO and their families as a privilege, as something special she gets to be a part of:

> *"It is a privilege because it is their lives, they're opening up to us at a critical point, and at a very distressing time when they are at their most vulnerable. Yes, absolutely it is a real privilege to be a part of that." – TokelauF51-60*

The stories shared with her and the openness with which those stories are shared is a gift, an opportunity to make a positive difference in someone's life that simultaneously brings joy and purpose to her own. That opportunity, joy, and purpose do not exist unless TWO are willing to share and be open. Latent in this is the recognition that the MH practitioner does not have a role, professional meaning, status, or expertise, without TWO to partner with. To serve, they must have someone to serve, and there is gratitude for the purposefulness and meaning the therapeutic relationship creates in their own lives. This recognition is deeply equalizing and affirms the dignity and strength of TWO.

In addition to valuing and affirming the capabilities of and input provided by TWO, PMHP also repositioned themselves as "tools" to be used by TWO and their families. This positioning not only enacts humility, but is also an active expression of service; the PMHP who discussed working in this manner viewed themselves in terms of how their skills and knowledge might be "put to work" for TWO:

> *"I see myself as resource for families, the tuluma - the toolbox. I provide families the tools, show them how to use the tools and allow them to take from it what is useful for their needs at that point and time. It may take some practice to get used to them, and to figure out whether it works for them or not…" – TokelauF51-60*

TokelauF51-60 uses the *tuluma* (a carved, floating storage container carried on every vaka and containing the tools needed for the journey) as a metaphor. The proportionality expressed in this metaphor is particularly resonant as the vaka and its passengers are larger, whereas the tuluma is only a small – albeit vital – part of the picture. Thinking of oneself in this way – small, filled with useful bits and pieces, but ultimately there to serve the purposes of those undertaking an important mission – demonstrates how such a perspective of oneself and one's role serves to de-centre the practitioner and recentre TWO, putting them first in the therapeutic relationship. Makasiale echoes this idea of carrying tools to assist TWO as they make a journey:

> *"I say, 'I have some tools, but you know the territory, cause it's your soul. I have an umbrella, gumboots, a map.' But you can tell me, 'There are three holes coming ahead. I know this territory.' and that's what I need you to tell me… the client knows the ground of their suffering, far better than we, who are looking on with some kind of formula." - Cabrini 'Ofa Makasiale*

The sense of humility here is heightened by explicitly recognising that, while she may have the tools, she does not know the "ground" of her client's suffering; for her, being of service necessitates humility both through the positioning of herself as a "tool" to be used and through the admission of a lack of necessary knowledge. Such recognition positions TWO themselves as "expert", possessing knowledge vital to success, capable of leading their own healing journey. Furthermore, when the practitioner sees themselves as a tool that exists to serve the needs of TWO and their families, those in their care are given more control and are supported toward a greater sense self-efficacy:

> *"…because if [TWO and their families] feel like they're in control, they feel like they can contribute to the journey...able to navigate certain barriers or challenges… [services] are there to support, not to drive." – Manu Fotu*

When PMHP act with humility and focus on serving TWO and their families, TWO and their families can ask for the tools and support *they* need to reach the destination *they* want to reach, with practitioners supporting that journey rather than setting the course.

Humility and a strong service orientation also supports PMHP to put people first by nurturing a readiness to undertake duties that might be considered "beneath" their professional roles. This echoes and reiterates what has been discussed regarding "going above and beyond". However, rather than going above, it can also be conceived of as "going below", undertaking tasks that might otherwise be done by someone in a role less respected and not as well paid. Fuemana uses the metaphor of "getting one's hands dirty" to convey this idea:

> *"Person-centred is reaching into the other person's heart, feeling that heartbeat, and figuring out how you can join that person's journey. That might mean for us to actually get our hands dirty with that person." – Tony Fuemana*

For him, putting the person first means moving beyond the confines of his clinical role and mucking in with the harder parts of care, the complex or otherwise messy parts. This can involve doing things like going to food shelters, helping TWO get to sleep, teaching people how to use the bus, and otherwise undertaking additional, voluntary work:

> *"Like when the clients don't have food, they take them to the food shelters and just support them to be able to meet those basic needs." – Fereni Masoe-Afamasaga*
>
> *"It might mean a few late nights helping that person sleep by just listening to them talk…" – Tony Fuemana*
>
> *"I've often seen [my colleague] take people, and these are adults, for bus rides to show them where to get off the bus, where to go, where to catch the train and things like that." – DHB Pacific MHA Team Member 1*
>
> *"With the community work, a lot of it is voluntary…Most of the workers that work with their communities are working full time jobs… this is the reality for a lot of Pacific people who work in full time jobs but still are trying to help their community by doing whatever they can in whatever time they can give." – Sipaia Kupa*

Participants acknowledged much of this is work that might be undertaken by those in non-clinical/unregulated roles, however, the willingness to do this oneself also honours another aspect of putting TWO and their needs first; TWO often want to work with the person they *know and feel comfortable with* as it is the *relationship* that matters, rather than the role.

> *"Some people may say, 'we have navigators, and we have support workers and what have you.' For us nurses, we have patients who don't want a navigator. They want [the person they know]. They trust [that person]. Whereas it will take some time for the patient to get to know a navigator." – DHB Pacific MHA Team Member 5*

These examples of putting the needs of TWO first – rather than the prestige of one's role or the parameters of one's contract – highlight how deeply understandings of tautua and loto maualalo guide PMHP and shape Pacific approaches to mental health.

Humility also appeared in the talanoa regarding attitudes toward making mistakes and learning different ways in which to do things. Throughout their reflections, PMHP show humility and open-mindedness when faced with their own errors of judgement or developing understandings:

> *"The mistakes make you understand what it is you're not understanding; If you keep making a mistake, it's because you don't understand something. The mistakes actually help. And each conversation, each interaction, it refines my understanding of what I think needs to be done. And if you do that from a non-arrogant place, what happens is this really amazing responsibility." - TongaM51-60A*

TongaM51-60A describes how mistakes help him to identify gaps in his own understanding and guide him towards ways in which he might improve his practice. Cook island/NZF31-40 shares a similar sentiment:

> *"As practitioners in this area, we need to be open to making errors and to having those corrected, and I think there are certainly processes in place to have self-*

> *reflective practices to look at that, but I know that's not widespread throughout the MH field." – Cook Island/NZF31-40*

When humility is valued, the ego can take a back seat in favour of reflection, learning, and improvement. Through this one is able to shift the focus away from feelings such as frustration or fear and toward the consideration of how to be more effective, how to serve TWO better in future. Both the willingness to undertake tasks "beneath" one's role and the ability to decentre the ego in favour of exploring what will best serve TWO are lived expressions of the moral imperative to position oneself "below" others in relationships, understanding oneself and one's dignity as less important than the needs of those in one's care.

Humility and a strong service orientation are demonstrable strengths of the PMHP in this study and are strengths that play a vital role in the provision of person-centred care. PMHP draw on the values of loto maualalo and tautua to reframe their understanding of themselves and their roles in the provision of MH services. Eschewing "expert" status and valuing the input and contribution of TWO enabled the PMHP cited above to build affirming, genuine relationships with TWO as equal partners, as peoples who stories brought joy and purpose to PMHP and who are knowledge holders in their own right. This both empowered TWO to recognise and acknowledge their own strengths, and nurtured resilience and self-confidence as well. Humility and a strong service orientation also supported PMHP to put people first by being prepared to get their hands dirty and carry out tasks that might otherwise be considered "beneath" them, and by helping to ensure opportunities to learn from mistakes and build competence are maximised for the benefit of TWO.

Tonga mo’unga ki he loto

Tonga’s mountain is inside the heart/soul.

4.1.5 Leadership

Although the intention of this thesis was to focus on strength and success in Pacific MH *practice*, it became evident throughout the talanoa PMHSM played a significant role in facilitating, making space for, and growing such practice. Those participants that held leadership roles in Pacific MH services described a variety of understandings of and approaches to management that helped to ensure an environment wherein Pacific worldviews and identities could be embraced and affirmed, the holistic needs of TWO could be addressed (including socioeconomic and wider health needs), community connection could be supported, and in which the Pacific MH workforce felt seen, valued, and cared for.

The next three sections will explore the importance of humility and service in the context of Pacific MH leadership, of balance and big-picture-little-picture thinking, and of the intergenerational lens in workforce development. As has been the case in previous chapters, relevant aspects of the Vā will be integrated into this discussion, with a particular emphasis on deference to the needs of others and the persistent recognition of connection and interrelationship. The value of reciprocity will also play a significant role in this chapter, feeding into the discussion of both balance and intergenerational thinking.

4.1.5.1 O le ala i le pule o le tautua - the path to leadership is service.

As with the PMHP discussed in Section 4.1.4.3, an attitude of humility and a strong service orientation were significant strengths of the PMHSM that participated in this study. This section will explore how humility and a strong service orientation manifest amongst them, informing an attitude

of non-competitiveness, a learning and growth centred approach to managing performance issues, a willingness to engage in collective decision making, and a strong focus on supporting and nurturing staff. The benefits of such leadership will also be explored, particularly in terms of its contribution to ensuring the provision of consistent, holistic, culturally affirming care.

In my discussion of the axiological implications of the Vā, I not only addressed humility and service, but also acknowledged these values were upheld and enacted by those in positions of structural power, such as matai, with the role of the family chief being focused on guardianship and care for the families, villages, and land over which they govern (see Section 2.1.2). This understanding of leadership in terms of loto maualalo and tautua was carried over into the professional sphere by participants, many of whom expressed a strong belief that their position as leader was not about authority, power, or prestige, but service to others:

> *"My leadership style is of the le tautua order. It's about leadership through service. A non-Pacific person asked me about my leadership style and said, 'It should be you out there in the front. You should be the biggest voice in the group because you've got a lot of strong personalities in there…' I said, 'No. That's not the way I go.'" - Samoa/NZM41-50C*

> *"I'd say that's my leadership style, servant leadership...It's always been taught at a young age…And then, through the church, servant leadership is the one that's taught to us and modelled by Jesus Christ himself. Naturally, it applies to work as well." – Dwaine Faletanoa'i*

For PMHSM, being given a leadership role served less as an affirmation of one's own importance or success, and more as an invitation to assume greater responsibility to and for others. There was a clear expectation that, as a leader, one would work hard, using one's skills, insight, experience, and energy to seek understanding of any issues and challenges, maintain relationships, and make hard decisions, not for personal reward or glory, but for the sake of supported staff, thriving TWO, and strong, connected communities.

Through their understanding of leadership as service – and of themselves as individuals-in-service – PMHSM demonstrate a particular willingness to exercise their structural power *with*, rather than *over* their staff, engaging in collective decision-making processes and involving their team in policy reviews, proposal preparation and other activities typically restricted to management. The importance of collective decision making and of involving the team in such activities was emphasised throughout the talanoa and it was also recognised by participants as a strength of PMHSM:

> *"... the thing people commented on was my ability to facilitate authentic collective decision making…I wasn't a clinician, I had to rely on the collective decisioning model...I was quite dependent on my clinical coordinators, the professional leads, the OTs [Occupational Therapists], the psychology and the nursing areas…that was very important." - Samoa/NZM41-50C*
>
> *"Within any team, you do need the right leader to lead. A leader doesn't have to make all the decisions and come up with all the ideas… it's important for all those in the team to commit, communicate and share ideas and actively participate and contribute to the talanoa to successfully achieve goals." – TokelauF51-60*
>
> *"Every time we went for a proposal…the leadership team came and spoke to us about it…They'd explain, 'This is what we're going for. This is the process we will go through to get that information.' They would tell us how it's being scaled, how it's being marked, and what's required from us to be able to go for it…They really thought about their team, the direction they wanted to go, and how to inform their team, and get them involved. That's why I'm like 'You look after your team, and they'll look after the work that needs to be delivered.'" - Asiata Malagaoma Lealofi Sio*

The PMHSM quoted/discussed above enact a humble recognition that – despite their depth and breadth of experience – they cannot possibly know, be aware of, or do everything themselves. They seek input and buy-in from those they are leading, recognising that this helps them ensure decisions, processes, proposals etc. are well-informed; are practical/achievable, understood by, and will be consistently carried out by the team; and are relevant to and will serve and benefit both the team and the TWO they serve. In addition to humility, immense respect for others and their contributions is evident in this collective approach, echoing the Vā-led recognition that all are valuable in their shared

divine descent and a vital part in the collective web of existence (45). This respect was heard in the way PMHSM expressed their dependence on and appreciation for the expertise and strengths of their staff:

> *"I looked at how we could get some good male clinicians in there…to change that it was very nurse-dominated, and so we started hiring in more... psychologists, OTs, social workers…It actually provided different viewpoints into someone's care or their family dynamics, [and] you can see a lot of them were really learning off each other, as well…it's around respecting a different viewpoint. Respecting everyone that's in my workforce, even though they might not be as productive as another…You've got to really respect that person too." - Samoa/NZM41-50C*

> *"Really get to know, really value each of our team members, their contribution, and their bodies of knowledge they're building…Get their help with the mahi. Because you've got people who are playful, peaceful, precise, and powerful. And not everyone has that, but you want a team to have all of those things…"– Samoa/NZM41-50A*

These PMHSM deeply value having access to diverse perspectives, attitudes, and approaches, across roles and genders. Furthermore, getting to know, respecting, and drawing on the strengths of their staff was also noted as contributing to a more positive and affirmative work environment, where each staff-member's strengths were seen and used and where staff were provided with opportunities to learn from one another.

The importance of involving the team in decision making and other high-level tasks was also discussed with specific reference to the importance of including diverse cultural perspectives, of valuing and making space for different experiences of culture and different forms/domains of cultural knowledge:

> *"Within our Pacific team we had people of varying cultures but also varying perspectives and connections to their cultural heritage…you had people born in New Zealand and knew a little bit of the language, you had people that were very entrenched in the culture as well, you had highly expert clinical people, highly expert cultural people, you had some with both of those qualities so people that*

> *were coming to [our] team, all Pacific, we were able to match…we valued the spectrum of cultural identity." – Samoa/NZF31-40*
>
> *"When you have an MDT you have representatives from the different professions…and we'd all kind of robustly discuss, at times debate, what's going on for a young person…and how we can support them…But the same thing also applies to the cultural formulation and I think that is what's lost when you don't have Pacific for Pacific teams because there's the assumption you can put one Pasifika person in to a group of non-Pasifika and that person is able is going to be able to really robustly provide information about what's going on for that young person…to have someone in the room as a cultural expert to be the be all and end all, puts a lot of pressure on that person, but you're also unlikely to get the best understanding. It's quite different to having a group of Pasifika because every one of their cultural understandings will bring something to the table." – Samoa/NZF31-40*

This in-depth, multi-faceted analysis of the experiences and needs of TWO strongly supported her team in their clinical *and* cultural formulation and their treatment planning, in turn supporting them to provide more relevant and responsive care. Contrasting this culturally-diverse-team approach with the cultural liaison approach – wherein one person, with the limitations of their individual cultural experiences and knowledge, is expected to provide a comprehensive "Pasifika perspective" to an otherwise non-Pacific MH team – reiterates the importance of collective decision making, and gestures towards the need for diverse cultural understandings and approaches to be valued. In addition to supporting the formulation and treatment planning process, SamoaNZF31-40 also valued the diversity present within her team as their wide range of experiences and approaches to care helped to ensure TWO could be matched with someone who would empathise with their experiences and affirm their cultural identity, thus helping to meet their holistic needs and support engagement/relationship building.

Humility in leadership – alongside the idea of leadership as a form of service – was apparent not only in the idea of using structural power *with* staff and working alongside them, but also using power *for* them, ensuring they have what they need to thrive personally *and* professionally. Echoing

what was shared in Section 4.1.3.3, this was understood as a natural extension of the familial feeling extended to TWO and staff alike, and was undertaken with a genuine sense of enjoyment:

> *"We wouldn't treat TWO [one way], and then go against that when we're treating our own staff." – Samoa/NZM41-50A*
>
> *"I enjoy the educational, professional, and cultural development aspects of supervision best. I like to support nurses to realise what success looks like for them and assist them to successfully achieve leadership career roles…especially for Pacific."– TokelauF51-60*

One of the ways in which PMHSM supported their staff, keeping the wellbeing of their team at the heart of their leadership practice, was through protecting the time and space needed for the activities and daily practices that strengthened connections amongst the "work family" (see Section 4.1.3.3). Rather than leaving it up to staff to squeeze lotu and pese in amongst their daily duties, to schedule meetings with matua or to organise group get togethers, PMHSM consciously put in place the structures to support these practices, lead activities themselves, and otherwise worked to ensure respectful, trusting, familial relationships could be established and nurtured amongst their staff:

> *"…when it's structured, it's regular, its daily, people come to expect that...we respect this is a Pacific thing to do. We start with the lotu. We start with a reading. We sing. And then, we get on to business…[but] it sets up our workforce in the right space, spiritually, mentally, physically to be able to do a better job..." – Dwaine Faletanoa'i*
>
> *"So, a lot of the fono, the hui, we would ensure there were always opportunities…and we have supervision, and team-building events. All those things are crucial for me." – Samoa/NZM41-50A*

By ensuring such practices – supervision, prayer, song, team building etc. – are maintained, and the team has time to share, connect, and uplift each other, these PMHSM help to ensure their teams are in "the right space" to collaborate, which in turn supports them to do their jobs more effectively, working with and supporting each other while being present to and caring for TWO.

In addition to protecting the time and space for activities that strengthen team relationships and foster spiritual, mental, and physical wellbeing, PMHSM also described actively and explicitly checking in with how their staff are *feeling*, engaging not only with how there are doing in terms of their professional performance, but engaging with their personal lives as well:

> *"I don't know if that's a thing about being a Pacific leader or someone that's been more on the empathic side is something ... just making sure we're checking in with people's feelings, how they're all going..." - Samoa/NZM41-50C*

PMHSM recognised one cannot leave one's emotional self "at the door" when working, and it is just as necessary to care for staff as complex, whole people as it is for staff to care about TWO in this way. The PMHSM quoted above centre the holistic wellbeing of their staff – prioritising this support role as a key part of their job, despite the push to achieve KPIs etc. – and, in doing so, they improve their team's capacity to centre the holistic wellbeing of and care for TWO, whilst role-modelling that centring and care in the process. Through their engagement in collective decision making and their consistent prioritization of holistic wellbeing, PMHSM created workplaces where staff felt valued, heard, and supported; understood and were committed to the decisions being made; and had the emotional, spiritual, and physical resources they needed to care for TWO.

> *"We were seen as the shining example of what a good, strong team is." – Samoa/NZF31-40*

While these are significant benefits in and off themselves, this approach was also understood as vital to addressing the need for improved staff retention and the development of an experienced and effective workforce:

> *"Do you think those relationships help support retention of staff?// Yeah, of course. Absolutely... We've got some people that have about 25 plus years here." – Dwaine Faletanoa'i*

It was not only through serving their *teams* that the humility and strong service orientation of PMHSM was apparent as a strength. In Section 4.1.4.3, it was noted an attitude of humility encouraged a particular attitude towards making mistakes, wherein mistakes could be understood as learning opportunities rather than failures, and self-judgement minimised. This attitude was also present amongst PMHSM and was extended beyond the self to both the team and the organisation. In the aforementioned section TongaM51-60A reflected on how his own mistakes helped him, as a practitioner, to *"understand what he wasn't understanding"*. He also shared how, as a leader, humbly admitting and accepting his own mistakes in front of his team and normalising honest, reflective behaviour had helped to both minimise anxiety and shame amongst staff and to create an environment where mistakes were associated with learning, growth, and strengthened relationships rather than the fear of disciplinary action:

> *"And I think what it is, is an acknowledgement we will make mistakes, we won't always get it right…And that's okay, which is really important for people to recognize. But we don't stop trying to maintain or achieve the standard… [acknowledging our mistakes] stops the staff from being frightened of making mistakes …. And then what happens is, take away some of the fear and people make less mistakes. And when people like me, the more senior people, talk about the mistakes they've made and how they've had to deal with that and the stress you go through…the junior staff feel much more connected to the seniors in a much more humane way." – TongaM51-60A*

The importance of creating such environments was reiterated by Fotu. He describes taking a Vā-led approach to addressing mistakes and performance issues, so mending and nurturing relationships amongst the team takes precedence over a regulation-based approach; for him the goal is to ensure

everyone is genuinely – personally and emotionally – committed to each other and to the shared goal of supporting TWO, learning to paddle in time and work together to face oncoming storms.

> *"It's about maintaining the Vā…You can either strengthen it or weaken it, depends on how you operate within it. But when staff have been brought in for a disciplinary process, we can choose to go through the corporate part. There's rules and regulations, criteria, and guidelines we can utilize. But if we do it by mending that Vā in our way, it becomes stronger in terms of relationship. Because…we are all on a vaka, we have our destinations, we have our visions we strive for. And we work hard to achieve that. When the Vā is mended that way, we're keener to contribute to the journey. If you are disciplinary by the rules and regulations, the Vā will still not be mended…And sometimes the staff will think, 'Oh, okay, I'm being disciplined, so I'm just going to do my minimum part for the journey. When there is a storm, I don't care. I'll let you guys work because I'm just here to get paid'. This was my way…looking at mending the Vā, because when the storm hits…people put their hands up and really contribute to get over the storm." – Manu Fotu*

Here, performance issues amongst staff do not require leaders to exercise authority and exert structural power *over* others. In fact, such an approach is understood as counterproductive, contributing to the alienation of team members and the build-up of resentment. Rather, where leadership is undertaken humbly and in acknowledgement that we all make mistakes, such mistakes become an opportunity to demonstrate acceptance, to share with and learn from each other, and to reaffirm and re-orient towards the goal of effectively serving TWO and their families. This, in turn, also supports staff to feel safe in their roles and to dedicate their energies to being consistently present to and with TWO, rather than dwelling on ill-feeling toward management, anxieties around compliance, or other distractions emerging under more authoritarian leadership styles.

The recognition of mistakes as opportunities for learning was also discussed in terms of organisational performance. The PMHSM who participated shared how system failures, complaints, audits, and incidents were valued as they prompted both reflection on the effectiveness of current policies, processes, and practices and efforts to improve these.

> *"Whenever we had complaints at our Pacific team, and there were complaints and a lot of them would be, "Your staff member looked like they weren't interested, or they weren't focused." Obviously, mindfulness and whatnot would be some of the training for them, being present. People like [our consumer rep], they would remind us. "Hey, I heard you speak to the way, that directive approach."" – Samoa/NZM41-50A*

Samoa/NZM41-50A shares how, at one point, both TWO and the consumer representative in his workplace had provided negative feedback regarding how staff engaged with those in their care. His response to this was not to become defensive, blame or become angry with his team, nor to argue against the feedback, but rather to humbly accept the criticism offered and to provide opportunities for his staff to grow the skills and attitudes needed to remedy the issue.

> *"I love participating in projects…workforce development, clinical policies, and procedures. Often, I would cover for the team leader and responding to complaints was a priority area… This means contacting the complainant directly to explain the process and their rights before I listen to their story. Listening, being humble, acknowledging the concerns raised and clearly stating the service improvements needed to prevent situation occurring again. If any staff involved, I would investigate and speak with them. Complaints and compliments were standing items at our business meetings, all complaints and outcomes were raised…" – TokelauF51-60*

TokelauF51-60 demonstrates a similar attitude: for her, the opportunity to engage with complaints against her team was actively welcomed as a way to gather insights into what might support her team and her service to perform better. "Negative" feedback was received with humility and engaged with as a positive opportunity to better serve TWO and their families. This participant also shared a story about an incident where cultural needs and factors had not been adequately analysed and consultation with a cultural expert had not occurred, resulting in harm to TWO. As painful as the situation was for TokelauF51-60, she reflected on the ensuing review with equanimity and a focus on how the mistakes made could inform positive change and better outcomes in future:

> *"Those things were missed, such as clear service entry and exit pathways for young people…there remains a service wide issue with regular reviewing of policies and procedural guidelines and definitely room to improve service delivery. It can make a difference to health outcomes for Pacific communities." – TokelauF51-60*

Another participant reflects on his approach to auditing services and on how, for him, the emphasis is not on judgement and the withdrawal of contracts and funding, but on service improvement. For him, audits are a positive experience and a chance both to help services recover from performance issues and mistakes and to help them recognise and grow their strengths:

> *"We're trying to help the service. Our stand is the service improvement perspective, right? You're doing something right. We try to look at it as how they can align that with their contract - we can support you to talk to your contract managers." – FijiM51-60*

While the role of the auditor is, traditionally, to assess compliance and identify areas of non-compliance, FijiM51-60 does not exercise his authority to chastise or punish the organisations he audits, but rather supports them to work out how they might re-align/better align themselves with their existing contract and/or engage with their contract manager to create space for the growth of current effective innovations. As with taking a non-judgemental, accepting, and learning/growth-oriented approach to mistakes made amongst the team, this attitude towards system failures, complaints, audits, and incidents promotes a safe and supportive work environment and helps to ensure the focus remains on service to TWO, delivering care relevant to and effective for them.

Humility and a strong service orientation also appeared in the non-competitiveness and active collaboration of many Pacific MH services. The PMHSM interviewed for this research discussed the importance of working, not in competition, but together toward the common goal of wellbeing for Pacific communities. For FijiM51-60, this meant actively and explicitly taking the emphasis off the ego

– off the importance of oneself as a leader/off the prestige and success of one's organisation – to focus on this shared goal.

> *"But for that [collaboration] to happen, you need to take the shift and the focus away from how important people [in leadership roles] are and really look at the people you're wanting to help. Because when it comes down to it, we all want to do the same. We all mean the same." – FijiM51-60*

The importance of looking beyond oneself and/or one's organisation towards a common goal was shared by TongaM51-60A and Fotu:

> *"The focus is on Pacific. We want to achieve good outcomes for Pacific. And the staff, obviously they are part of their community…They come along with that knowledge…and with a common focus of achieving the best outcome for our peoples." – Manu Fotu*
>
> *"And I saw that when I worked in NGOs, forming relationships with other organizations…forming a network that we can all support each other. With the sole purpose of making good outcomes for our community, for our people." – Manu Fotu*
>
> *"All of this individual work I've done. What it's helped me understand is [leadership's] not about me… [it's about] how do we use our knowledge and skill, we build relationships with others where the goal is what drives us. And how do we provide structures that lead us to the goal..." – TongaM51-60A*
>
> *"I believe we can't do these things as individuals. You know, the problems are so big that if we don't put up collective effort in, we're not going to solve big problems." – TongaM51-60A*

This attitude of humility, coupled with the recognition of both mutual purpose and the power of mutual support nurtures collaboration and cooperation amongst PMHSM, PMHP, and amongst the services in which they work. It encourages PMHSM and PMHP to consider how they might build relationships and networks, systems and structures which promote progress towards the shared goal, keeping attention on the bigger picture and making it easier to acknowledge, draw on, and grow one another's strengths rather than being threatened by them:

> *"Everybody's got good things going on. [That Pacific service over there] has good things going on. Mainstream has good things going on. I think it's good we share, because…If we're really about our Pacific, we need to replicate these things, sustain these things, and grow them, make sure they keep going to the next level." – Dwaine Faletanoa'i*

One of the key ways in which non-competitiveness and collaboration manifests is through the support of other services during the initial phases of their development:

> *"We got a lot of support from other Pacific services [in New Zealand] as we were trying to evolve this service." – DHB Pacific MHA Team Member 8*

Participants shared numerous stories – the details of which lie outside the scope and consent process for this thesis – regarding the "early days" of Pacific MH in Aotearoa and of how leaders in this field contributed to the development of their own services, supported others in developing theirs, and worked tirelessly to grow the next generation of the workforce and garner support for the Pacific MH sector to grow. Rather than seeing new Pacific MH organisations as a threat to their own, the anecdotes shared highlighted how attempts to meet the needs of the community were welcomed, valued, and supported. Participants also shared about organisations running workshops to teach each other, such as larger organisations teaching smaller organisations how to prepare RFPs – "*We started the workshops for RFPs so all the providers would come and get equal footing."* (Asiata Malagaoma Lealofi Sio) – and other such supportive gestures.

Echoing what was shared in Section 4.1.3.3, non-competitiveness and collaboration was also present in the decision to partner with other organisations or groups to form a larger, more effective service:

> *"From an effectiveness point of view, in terms of Pacific organisations working with our Pacific communities, it's the big organisations [such as these two Pacific organisations], that are doing the good work…They have the people to do it. They have the infrastructures to do it. They have technology to do it. That's the huge capacity they have. Because this connection and maintaining that relationship with your community and all of that, that's on top of your normal business. You don't get paid to do that. But because they have the capacity, they're still able to deliver their service, using Pacific models of care." – TongaM41-50A*

TongaM41-50A reflected on the effectiveness and efficiency of two Pacific health providers – one of which is an entity operating under a large mainstream non-profit organisation, and the other an amalgamation of smaller Pacific health organisations – and on how their collaborative attitude, their prioritisation of effectively supporting Pacific communities over and above their own identity and contracts, has supported their success. The greater capacity afforded by collaboration has enabled these organisations to have a greater positive impact in their respective communities. This approach is also seen as a way of effectively mitigating some of the challenges associated with addressing the needs of a smaller population group:

> *"That's how you increase your capacity; jump on board with maybe a PHO or another community organization that has bigger capacity. Otherwise, you'll be arguing for funding every year with the DHB. You're not going to get it. You just don't have that population." – TongaM41-50A*

Another participant shared about the service where he works which operates under a co-location model. Through this model, building costs and other overheads can thus be shared, referral pathways streamlined, and strong working relationships built:

> *"If you spend enough time with people in the same space, you get to know them. And through that you're able to do things organically." – Phil Siataga*

These excerpts recall and enact what TongaM51-60A idealises in his discussion of the need for intimacy between not just PMHP and TWO, but between practitioners and services. The need for intimacy *between* organisations and communities was also recognised:

> *"I see having a network outside the main system, the hospital, the DHB, is really important...Relationship building, and connections will enable the discussions, the conversations, whatever we need to do to be able to move things forward. If we are planning something for our community, with the right connections, you can get things done." – Manu Fotu*

The above excerpt highlights further the efficiencies collaboration supports. Working together not only allows for costs to be shared, processes to be streamlined, resources to be pooled etc. but, when undertaken with communities, it also allows for responsive design and evaluation, and for the collective manpower of the community to be engaged to "get things done". Moving beyond competitiveness and seeking to transcend that aspect of current funding and business models both helps to ensure the sustainability of organisations – facilitating more consistent care for TWO – as well as helping to ensure the services they provide are grounded in and accountable to the experiences and needs of the community.

The importance of a humble, collaborative, and non-competitive attitude was also raised in terms of the relationship with tāngata whenua. Participants reflected that Pacific and Māori were – at times – "matched" against each other in terms of access to funding and resources:

> *"I think in the beginning it was fortunate, we were almost in parallel with Māori as Māori progressed and developed their own services...Sometimes they match us against each other and lots of different things that slows it right down." – DHB Pacific MHA Team Member 8*

This was seen as counterproductive, with upholding and honouring Te Tiriti o Waitangi and the tuakana-teina relationships that exist between tāngata whenua and Pacific peoples being recognised

both as something PMHSM are already doing well, and as an area in which there was a strong desire to do more. As noted in the Methodology section, one participant – Samoa/NZM5160, brought a Māori colleague along with him to the talanoa: a welcome and direct expression of the importance of including tāngata whenua in the discussion, of the relationship between them as co-practitioners, and of the relationship between their cultural communities. Other PMHSM were also clear in their belief working together with tāngata whenua and supporting Māori health was imperative, a core responsibility and an important part of caring effectively for Pacific communities:

> *"If you want to work with children, or adults or anywhere…no "buts" … it's Treaty, working with Māori. It's not, 'That's their job', it's actually part of your competencies as a worker…You can't be ignorant anymore." – Samoa/NZM41-50A*

> *"This is why we've become Treaty centric. All of those things are really important because if it doesn't happen [for Māori], it's not going to happen for Pasifika. It might happen in different little ways but it's not going to happen the best." – Phil Siataga*

> *"We have a responsibility to ensure everybody participates in their health, not just Pacific but, if you work with Māori, because this is their house…my first position is to support Māori initiatives. And then, because we work with Māori, it's the reciprocal thing. It's we support and they spearhead. If they're well, we'll receive the overflow." - Asiata Malagaoma Lealofi Sio*

In these quotes the needs of tāngata whenua are humbly deferred to by PMHSM, as it is recognised that this is "their house". There is also a recognition that ensuring all is well for those within the house, means – as visiting relatives – Pacific people will then be well taken care of; supporting Māori is not only the ethically correct choice for PMHSM, an upholding of a sacred, ancient Vā relationship, but it is a pathway towards wellbeing for Pacific communities, with the reciprocal and mutually reinforcing nature of this collaboration being well acknowledged:

> *"You know that the Māori culture, we can piggyback on some of that. They can charter the way and we can follow. Māori, they have the right…They can pave the way." – Manu Fotu*

An excellent example of such “piggybacking” and of the support Māori provide to Pacific was shared by participants in the DHB Pacific MHA group talanoa. They related how the internal Māori reference group at the DHB in question had supported Pacific by providing them with a seat at the table and assisted them by advocating for the reinstatement of the Pacific advisory group after this was dissolved:

> *“…We are now latching on to the [internal Māori reference] group…We didn't have a reference group - they dissolved that - so, we went over...[and they helped us out]." – DHB Pacific MHA Team Member 1*

The significance of collaborating with tāngata whenua – and the senselessness of a competitive approach – was also acknowledged in terms of the increasing intersection between Māori and Pacific communities and cultures through intermarriage, social engagement etc.

> *“It’s part of where I'm heading, to understand context and relationship within te Tiriti o Waitangi. And because also in my practice base, there's Māori and Pacific…//Yeah, increasingly that's our community, right.//…[MāoriM41-50 has] been talking to me about some of the Pacific young people he's working with, the families, and he's linking people up from Auckland down. All of that, there's a richness to that… //And I've got a lot of Pacific in my family as well.” – Phil Siataga and MāoriM41-50*

In a funding and contracting environment where organisations and – sadly – ethno-cultural communities are made to compete for resources, the propensity of PMHSM to focus on the benefits of putting others first and working together is a real strength, one offering vital insights into the attitudes and understandings needed to support the full and positive realisation of Te Tiriti in Aotearoa/New Zealand.

By exercising structural power and authority *with* and *for* their teams; taking a learning and growth centred approach to managing performance issues; focusing on the shared purpose amongst

and between organisations; and respecting and partnering with tāngata whenua, the PMHSM quoted in this section demonstrate how the values of loto maualalo and tautua support the success of MH services and practitioners. The humble, service-focused approaches to leadership they demonstrate helps ensure both consistent and holistic care are provided to TWO; adopting goal-focused, non-competitive attitudes and facilitating collaboration between practitioners and services with different specialisations sustainably builds capacity and capability and provides access to skills, knowledge, and support across a range of domains. Consistency is further supported as, when PMHSM work to serve and support their staff, their staff feel safe to make mistakes and know they are valued, connected, and cared for. This sense of connection and safety heightens commitment and reduces turnover so that staff both develop experience and can provide the type of consistent, connected, family-like care to TWO described in Section 4.1.3. Furthermore, the humble, service-oriented leadership of PMHP also affirms diverse cultural, personal, and professional backgrounds and experiences through the honouring of Māori – upholding their status as both tuākana and tāngata whenua – and through valuing and drawing on the presence of diversity amongst their teams.

4.1.5.2 A Balanced Approach to Leadership

As noted in Section 2.2, balance is an important philosophical principle in Pacific cultures. A profound appreciation for and focus on balance emerged as a significant strength of the PMHSM interviewed for this project, manifesting in their ability to balance the "big picture" (the structure of their organisation, for example) against the "little picture" (how TWO experience the service) and to deploy balanced SDMs, wherein multiple areas of concern (e.g., business, clinical care, and culture) could be successfully and simultaneously managed. This section will explore how balance manifests in the leadership practice of PMHSM, – supporting the delivery of MH services strongly connected to the

communities they serve, incorporating overlapping areas of health practice, and embracing Pacific worldviews and holistic understandings of health.

The importance of having a balanced perspective – one that grants insight into the "big picture" *and* the "little picture" and allows one to see where they connect and diverge – was well understood amongst the PMHSM and leaders interviewed for this study:

> *"Not losing that lateral view, that bigger picture, and I think being able to have the courage to see different views from moana." - Samoa/NZM61-70*
>
> *"You have to look at how the system is structured… For patients who present to the Emergency Department, we know that's the front door for the hospital system, there's all the activities that occur at that level, the systems level. But there's also systems at a community level that are not often aligned to, or well connected to the system… There's also the crevasses in the community that often are difficult to reach, and it requires a different approach as well…In order have an effect or impact you have to understand the structures and how it works and at what levels and layers…" – Sipaia Kupa*

Samoa/NZM61-70 invokes the central metaphor of the Fa'afaletui research approach (106, 331, 332), reflecting on the importance of having a view from the moana (the ocean, the "little picture", in this case the experiences of TWO and their families), as well as from the treetops (clinicians, service managers, organisations) and the maunga (the mountain, "big picture", the aims and understandings of DHBs and government departments). This metaphor recognises that all perspectives are necessary to gain a comprehensive understanding of a phenomenon or field. For Kupa, positioning herself at a point where she can see not only the daily ins and outs of MH practice, but also systemic structures, community structures, and the mechanisms able to bridge these is vital to ensuring her work (and the work of her team) has a meaningful impact. By maintaining a balanced perspective, she can see how systems fit together, merge and diverge, identifying where there are opportunities to build connection, to reach out to people or bring people in.

Participants provided numerous examples of how this balanced perspective supported them in their efforts to provide effective care for TWO and their families. For example, FijiM51-60 shared that many NGOs apply to access multiple funding streams to facilitate the provision of whānau-ora style[8] support for TWO and their families:

> *"You need to be smart when you're thinking how you're gonna work with [a more holistic approach]. Most of the services, they have multiple contracts, small amount of MSD, MBIE. And if you think about it…they're doing whānau ora, but they're getting funding from different services. Right? You can have whānau ora, doing that, if you put in a good framework to support it. This is part of the innovation you see from NGOs. The ones doing it well, you look at how many contract streams they have." (44)*

Another story related how a DHB-based PMHSM had developed the Pacific MH service he worked in by strategically deploying his understanding of "big picture" mechanisms – such as departmental funding allocations and internal HR processes – alongside his "little picture" knowledge of both the challenges faced by his team and the needs of the TWO in their care:

> *"We learned the number one person you make a relationship with… is the accountant. Because the accountant will know who's got Pacific money that's not being used... what [our manager] used to do is he'd ask for that money, turn it into an FTE aligned to whatever that [money was for], say, the parenting program... He made it permanent for the crucial reason that once someone's permanent you can't fire them. If you want the funding back...When it comes to the [end of] financial year…you report back on their things, and they'll be happy for you to utilize that funding." - Asiata Malagaoma Lealofi Sio*

This proactive and innovative approach helped to grow and build security for the Pacific MH service in question and brought in money and FTE relevant to a range of overlapping areas of health. This then facilitated the provision of care in a holistic, family-focused way – a way better aligned with Pacific worldviews and models of care – so TWO were more likely to have the full spectrum of their needs

[8] Whānau Ora is a family-centred approach to wellbeing, centred in Māori culture and on the wellbeing of the family groups as a whole. It builds on the strengths and capabilities of families and wraps the necessary health, education, housing, employment, and cultural services and support around them to get better outcomes and create positive changes. (333)

seamlessly met and staff were significantly less pressured to use their own resources to achieve this. Balance was also present through reciprocity; as the service in question received more funding and human resource, other departments were supported to meet their KPIs and had their workloads lightened.

Maintaining a balanced perspective, where there was a clear line-of-sight from the "big picture" to the "little picture" also helped to ensure management decisions and initiatives were well-informed and positively impactful:

> *"I remember asking one of my senior clinicians….'Is there any way we can work with this woman. She rings our acute teams, maybe three or five times a day…Can we start with putting a limit or cap on how many times she calls our services?' And she goes, 'Maybe you should come out and have a look.'…And I actually had the honour of meeting this woman…she had had a lot of trauma in her life. It was her main thing that helped her stay safe... it was a good lesson for me to go ... keeping in touch with what's happening for the people we saw and then, also for the clinicians that have to deal with that while I'm sitting in my office saying, 'All right. We need to do this and that.'" - Samoa/NZM41-50C*

Samoa/NZM41-50C shares how stepping down from the "big picture" level of KPIs and service outputs to engage directly with the "little picture" of TWO-staff interactions helped him to reconsider a potentially harmful decision. Had he not sought a balanced perspective, one that considered the view from the treetops and the view from the moana, he may have ended up imposing limits on staff practice that – while appearing to increase efficiency and effectiveness at the organisational level – would actually harm TWO and negatively impact their wellbeing. Samoa/NZ41-50A describes how balancing the perspectives associated with the organisational context, clinical practice, and TWO experiences can also help to ensure professional development activities are meaningfully applied and contribute to positive change:

> *"The key success factor for [implementing meaningful professional development], was actually having a couple of people working on that [who] knew the context of*

> *the DHB, the clinical and referral pathways. And acknowledging, 'They've done the training, but how do they implement that across their own [departments]' and 'How would that improve some of the barriers to access or treatment for their Pacific families within their clinical wards?'…they were actually able to get down to that level, develop a program or plan for their group, and check in." – Samoa/NZM41-50A*

By maintaining a balanced perspective, this PMHSM is empowered to recognise and acknowledge the complexities of implementing professional development (and through it changes to practice) as well as the varied areas of potential impact. He sees the value in providing dedicated support for this process, engaging staff to work across and between levels and ensuring the benefits of training for staff translate to benefits for TWO and their families.

Remaining aware of and attentive to the "big picture" and the "little picture" was also understood as vital to effective community engagement and to ensuring services were able to build and maintain relationships with the communities they serve. Fotu highlights the importance of understanding how the community connects to service representatives, and of being honest, clear, and direct about what is going on at an organisational level and why:

> *"Like any relationship, it's the trust you have, isn't it?...if you are representing an organisation…they don't see the DHB, they see whoever's in front of them…they put their trust in you that what you are bringing, there's no hidden agenda. Just be honest about the whole thing…And by doing that, they can see you are genuinely interested in what's best for the community, not the organisations you come over to represent…//So you're quite open with the barriers in your way?//Yes. I will say it straight up…"[Within my DHB] I'm one person that looks after two huge organisations. How many people in [this city]…and one person that looks after all that on this program.'" – Manu Fotu*

Participants recognised – in many instances – this requires some translation, and the ability to understand how the view from the maunga might be effectively and meaningfully (re)presented to those at the treetops, and at the moana (and vice versa):

> *"You have to adjust the language you use. Because you're going to the board, and they want a report. That's one level. And then you go onto talking to other agencies when you want to partner-up, [so] we can all work together towards this common goal. And then you come down to the organizations in the community, a church group, or, you know... It's another language, so you can talk to them on their terms." – Manu Fotu*

> *"That ability to deconstruct and reconstruct… through my education, training, and my life experiences…I now have an ability to be able to work across different paradigms if you like…. I found I could use my ability to deconstruct things and then reconstruct them in ways that connect with patients and family." – Sipaia Kupa*

This transparency and honesty – coupled with a tailored, audience focused approach to communication and a commitment to meaningfully sharing information across and between the different levels/perspectives – helps to nurture connectedness, to build open, trusting relationships between state entities, services, practitioners, families, and communities. This connectedness and trust facilitates reciprocity, encouraging families and communities to use and engage with services and to actively contribute to the development and delivery thereof, which, in turn, helps services to ensure what they develop and deliver will actually reflect and meet the needs of the community (thus supporting their effectiveness and sustainability). It was also recognised such relationships supported services to connect and work with those providing care grounded in and affirming of Pacific worldviews and identities, thus helping ensure TWO were supported to receive care aligned with their understandings of their needs:

> *"We have a MH system made up of different components people can tap into and access…So there's all the activities that occur at that [system] level…the community function in a different way …[but] you might find that within the community they offer alternative indigenous medicines and approaches…and you can't access that kind of resource through the health system." – Sipaia Kupa*

The ability to balance the "big picture" and the "little picture" also supports the collaborative, non-competitive attitude discussed in Section 4.1.5.1. For many of the PMHSM in this study, the "big picture" was the goal of wellbeing for Pacific communities, and the "little picture" was the role their

organisation played in achieving that. Keeping that "big picture" in mind made it easier for PMHSM to work alongside and share resources and information with others, avoiding defensive, self-protective, or competitive attitudes.

In addition to balancing the "big picture" against the "little picture", PMHSM also manifest balance in their leadership practice by deploying holistic service delivery and business models. Manu Fotu describes working with a model that expresses the need for balance between the business side of managing a service as well as the cultural component and the clinical work:

> *"I view our journey as a vaka or kalia. The main boat is our cultural aspects because we all bring that to the vaka. The hama, it's like the corporate, business-like concepts, because you need those to balance a vaka…You can't negotiate it//They both need to be there. I love the way you positioned corporate as the hama as well. Because to me what that shows is the role of the business side of things is to support and balance the main body.//Yes, that's right. support and balance..." – Manu Fotu*

For him, the main part of the work is carried forward by culture, by values and ways of knowing and doing embedded in Pacific worldviews. Staff bring their skills and understandings – including their clinical skills and understanding – into the vaka with them, so those skills and understandings are deployed in a way supported and borne out by culture. The corporate aspect of the model exists to support this main body of the work and is decentralised in this model; however, it is still vital to the functioning of the vaka as a whole. Samoa/NZM41-50A shared another model called "5C":

> *"We talk about the five Cs…C for consumer. [C for] Community…we all have elements of the community…[but] actually getting people from outside who aren't tainted by the dynamics and politics…they bring a fresh voice. And then you've got the other C is your Cultural. And C, Clinical. And then C, Corporate. And there's heaps of Cs. It's not an exhaustive list. I mean it was a health governance model where it was essentially two Cs. It was clinical and corporate…But then we added the third C, if you were Pacific, Cultural. And then you realize actually there's other Cs…"– Samoa/NZM41-50A*

His reflection that the mainstream model consists of only two Cs only - clinical and corporate - was reinforced by Samoa/NZ41-50C:

> *"I looked around different leadership models and I saw there wasn't that leadership model, which is a blend of cultural, clinical, and corporate." - Samoa/NZM41-50C*

Integrating culture into MH delivery was obviously a priority for these PMHSM, as were consumer and community/family perspectives.

Participants shared that engaging people as consumer and cultural advisors – in line with the business models/SDMs described above – has been a valuable strategy for ensuring services are managed in a more balanced and holistic way. Often this advisory work is undertaken voluntarily, and paid consumer and cultural roles (such as "matua") have been formalised in only a very few services (participants shared that these roles do not tend to be seen as particularly important by funders). These roles are highly valued by PMHSM and are recognised as making meaningful contributions to both service success and staff wellbeing. Previous chapters have discussed several positive impacts resulting from the presence of someone in a cultural leadership or matua role (see Section 4.1.3.2 and 4.1.3.3). The inclusion of cultural leadership as well as cultural values and processes as a matter of course has also been noted as helping to ensure services are welcoming:

> *"That makes you feel welcome…if you can bring in the cultural side of things - usually when we do start our session it is with a prayer, and we can bring in the kaumatua or our team leader to bring in that cultural safety aspect and to start that off." – DHB Pacific MHA Team Member 6*

Consumer representatives were understood as being a particularly important support for service development and a key means of ensuring accountability. As with the Matua mentioned in

Section 4.1.3.2, consumer representatives are valued by Pacific MH leadership for the feedback and insight they provide regarding the experiences of TWO and their families, and for their ability to call staff back to their purpose. I call attention back to a quote mentioned in Section 4.1.5.1:

> *"People like [our consumer rep], they would remind us. 'Hey, I heard you speak to them that way, that directive approach.'" – Samoa/NZM41-50A*

The deep empathy for and lived experience shared by consumer representatives was also appreciated in terms of how it enabled the development of respectful, meaningful, and relevant programmes:

> *"One of our Matua here is our consumer advisor as well. He's here too making sure there's benefits [for TWO] ... all our approaches always go through him. His oversight, his input, his advice, so they are a benefit to our consumers." – Dwaine Faletanoa'i*

Echoing Section 4.1.2.2, the positive impact of consumer representation was also discussed in terms of the inspiration provided to others:

> *"He's been a long-time champion for consumer voice. It's good. It's modelling in itself, for our consumers we can aspire to be leaders as well." – Dwaine Faletanoa'i*

This reflects how the inclusion of consumer voice as part of a well-balanced and holistic business/SDM also has wider ranging positive impacts, not only supporting improved service delivery, but reducing stigma, increasing hope, and inspiring other people with lived experience to step forward and share their expertise.

Roles focused on connecting with and representing community interests were not widely discussed and it appears, by and large, connection with community is either undertaken on a voluntary basis/incidentally (through the lived connections and experiences of staff), or as a part of the work of

Matua and consumer representatives, where these roles exist. This reflects the understanding expressed earlier in this section whereby "*…we all have elements of the community…*"(40) and reiterates the value of supporting staff to bring themselves as whole people into their work.

Utilising a more holistic, balanced business model/SDM was also seen as a helpful way to help manage unhelpful power dynamics that play out in corporate and clinical hierarchies:

> *"Did you have any strategies for managing the power psychiatry holds, ensuring other people had a voice, and that locus of power shifted?//Well I think that was ensuring the five Cs…But see [our psychiatrist] is a leader in that regard anyway, so he was open to that." – Samoa/NZM41-50A*

The 5C model – in which voices beyond the clinical and the corporate are integral – helps ensure not only the understandings of the psychiatrist or the manager are prioritised. Culture, consumer, and community voices are afforded structural power through this model and equipped to share their perspectives in a way more likely to be given equal consideration. Humility in leadership is reiterated here as well, with Samoa/NZM41-50A pointing out how the psychiatrist in his service was willing to make space for other perspectives, acting collaboratively and non-competitively to ensure TWO receive the best care.

This section shows that the deep appreciation of and commitment to maintaining a balanced perspective amongst PMHSM is a clear strength. Participants shared how keeping the "big picture" and "little picture" in view supported them to grow sustainable, holistic services where wider health needs could be addressed and where available funding, management decisions, and staff development more consistently translated into benefits for TWO and their families. Such perspective was also seen as enabling PMHSM to move and translate between state, organisational, and community spaces, building strong connections and trusting relationships across all levels; to increase

understanding of community needs; and to support connection with healing approaches embedded in traditional Pacific worldviews. The benefits of recognising and including multiple viewpoints through the formalisation of these in inclusive business models/SDMs and non-corporate, non-clinical leadership roles was also discussed, with these models and roles being valued not only for their contribution to providing holistic care for TWO, but also for nurturing a more supportive and reflective practice environment and breaking down harmful power dynamics.

4.1.5.3 The Intergenerational Lens

PMHSM also demonstrated strength in their leadership practice through their tendency towards legacy thinking, applying an intergenerational lens to both their own roles and their responsibilities towards their service and its staff. This section will explore these strengths, reflecting on how an intergenerational lens is applied, particularly through PMHSM's understanding of themselves as the result of the support and investment of previous generations and their sense of commitment to growing and nurturing those who will come after. It will also consider the application of this lens to the wider Pacific, with PMHSM reflecting on previous and future generations at the level of their international ethno-cultural communities. The impacts of this on workforce development will be considered, particularly in terms of affirming and embracing Pacific worldviews and ensuring consistent care through sustainable services.

PMHSM noted that those who came before them had invested heavily in them and their development, and that this investment represented a conscious effort to not only develop and support them on their journey (another example of servant leadership), but to help ensure the future success of Pacific MH services:

> *"That succession planning is really coming through to fruition. So many of us have stuck around or come back to the DHB…[it's us reciprocating] the generations that have stepped before us and invested all the time in developing us to be able to carry on through the next stages of workforce delivery." – Dwaine Faletanoa'i*
>
> *"There was a whole stream of us back then that were being mentored to come through." - Asiata Malagaoma Lealofi Sio*

Awareness of this support inculcated a deep-seated sense of gratitude toward those who had mentored them, as well as a desire to make good on their investment, to repay what had been given through both reciprocal service – reinvesting their time, energy, skills, and knowledge into the service that had invested in them – and through investing in and building up the next generation of the workforce in turn:

> *"I wanted to come back; this particular team…they invested all the time. That's where I got all my learning from, was from this team. Cultural, clinical knowledge... I knew nothing before I came here. In true values of Pacific reciprocity, this is it. This is my chance to give back." – Dwaine Faletanoa'i*
>
> *"As I age in time and experience in Nursing, it motivates and encourages me with urgency, to grow our young ones…our future generation and workforce." – TokelauF51-60*
>
> *"Retention is everything for the workforce…Better look after the gems we've found ...we need them to develop a next generation too. Can't do it with a fresh team right across the board." – Dwaine Faletanoa'i*
>
> *"What I use around workforce development is I just don't give up. The courage to mentor and supervise our people to come into the workforce… It's like a plum tree. We plant, we find the right environment, all that kind of stuff. We set it up, and then we get the right plants and then we nurture. We start to grow, but the plums don't get to full fruition because as the plants grow and the trees grow, everyone starts to notice…and they get plucked before they're ripe, and what happens then?…I've seen how many of our young workforce come, two years, they're burnt out and they're gone, or they get plucked too early to do this and this and this, and then they feel isolated. The one and only brownie, on their own..." - Samoa/NZM61-70*

The PMHSM and leaders interviewed clearly recognised the need to think and lead in terms of "generations", echoing the idea of tuātagata by recognising the people behind them and

understanding themselves as being behind the "young ones" in their teams. They explicitly acknowledge the need to nurture a workforce for the future just as they were nurtured, to invest in and protect the "gems" they are working with now so strong, effective MH services are consistently available for TWO and their families in years to come. In the quote from Samoa/NZM61-70, we also see recognition of the harm that occurs when staff are removed from these nurturing, protective, and investment-focused environments too soon and transplanted into mainstream services (for the implied purpose of fulfilling diversity requirements/gaining access to a Pacific voice), and of the damage this does to the Pacific MH workforce. This reinforces the positive role of an intergenerational lens and of being focused on nurturing, protecting, and investing in staff over time as a means of preventing burnout and of ensuring the long-term sustainability of Pacific MH services.

Investment in the next generation took a number of forms throughout the talanoa. There was a clear orientation towards teaching and towards sharing one's skills, knowledge, and experience. For SamoaF41-50, a love of teaching and sharing knowledge looked like making herself available to speak with young doctors while they are training and being willing to share freely of her knowledge to support and upskill others. TokelauF51-60 engages in teaching through her role as a clinical supervisor:

> *"As a new nurse with career goals, I was fortunate to have been inspired by my clinical supervisor. She was Pacific as well. She really challenged me and supported me to reflect and think critically about my career pathway… when you have a well-established and trusting relationship with your supervisor, it can build confidence, knowledge base and skillset to progress clinically, and to then give you the confidence to develop other nurses and clinicians. I do love that part my job. I love the teaching and discussions of clinical exemplars that demonstrate competency in Professional development portfolios…and acknowledges the wonderful work nurses do." – TokelauF51-60*

Of note is the fact she was inspired to do so by her own supervisor, again highlighting the impact of an intergenerational lens. The investment in her as a young nurse is translated into a mutual investment in those entering the workforce now. For Makasiale, teaching others has always been a

key part of her work, although she noted that her teaching had now taken a more Freirean tone; she shared that her ultimate goal is her own obsolescence through the conscientization and empowerment of others:

> *"Before I used to do a lot of teaching, now I do a lot of encouraging and giving the space for the person to discover their own ability to self-heal and heal others. And my words for that is, planned obsolescence. I have to become redundant... And let the next lot move in." - Cabrini 'Ofa Makasiale*

In addition to teaching, nurturing the next generation of the workforce also manifested as ensuring systems were less hostile to new Pacific MH staff. For example, SamoaF41-50 described how she fought for psychiatrists in her service to be allowed two hours instead of thirty minutes for their initial appointments with TWO. By using her status as a leader in the workplace to push for this change, she has thus made it easier to deliver care in a way better aligned with and embracing of Pacific worldviews, and thus fostered a workplace more comfortable for and accepting of Pacific staff and TWO. TongaM41-50A builds on this idea of influencing the system from inside by reflecting on the impacts of Pacific success:

> *"We have the first ever Pacific CEO for a DHB. We had a director of public health that was Niuean…and what I like is those positions are not Pacific specific. They get to those positions because they are as good as anybody else…I would like more and more of those people to show up in key positions in our system…I think we need more [people like these role models], people like [the first Pacific CEO of a DHB], to get into those influential positions." – TongaM41-50A*

He acknowledges how these leaders – by demonstrating excellence as Pacific peoples in mainstream spaces – have helped to disestablish barriers to success by reducing the degree of discrimination and doubt Pacific people face when entering leadership roles outside of Pacific-specific spaces. Their legacy of success in the face of a negatively biased system creates opportunities for future generations

to lead, both inspiring them to do so and increasing the receptiveness of others to Pacific leadership. Cook Island/NZF31-40 shares about the impacts of disestablishing barriers and supporting success much earlier in the careers of PMHP, through the example of establishing a mentoring group at her university:

> *"There was a group of maybe six of us that were all Māori and Pacific and we all studied together, and it formed the foundation for the science faculty's mentoring program for Māori and Pacific students, and within that, psychology. At that point in time, we had to write applications to get a funded position to support Māori and Pacific students through first, second, and third year to finish their degrees... And it's still going, which is really encouraging." – Cook Island/NZF31-40*

Recognising university environments can be challenging in a number of ways for Māori and Pacific students, Cook Island/NZF31-40 and her peers applied for funding and established a group to support those that studied after them. Even before entering into formal leadership roles, that intergenerational lens was present and acted on, helping to ensure fewer barriers for the next generation.

PMHSM and leaders also shared about engaging in work with Pacific communities overseas. Calling back to the idea of kāinga, it makes sense intergenerational thinking would involve respect for the investment of previous generations "back home", a desire to reciprocate the gifts they have bestowed, and explicit concern for what happens to the next generation of indigenous Pacific Islanders. Cook island/NZF31-40 shared about giving back to the Cook Island community by undertaking MH work in the Pacific; based in the Cook Islands at the time of interview, she was actively engaged in supporting the development of specialist MH services there, helping to ensure the people of the Cook Islands have access to quality MH care both grounded in and responsive to their ways of life. TongaM41-50 also reflected on his involvement in MH work in the islands:

> *"One of things I really enjoy now is working within the Pacific. I've been doing some work in Niue, Cook Islands, and Tonga. I just started with building stuff in Fiji, as well. It's a really good network around the Pacific…In the future, I've got some stuff coming up with Samoa, which is quite exciting." – TongaM41-50B*

Not only is this work about sharing what he has and reciprocating the knowledge, 'ofa, and support he has received, but it is also about affirming and embracing Pacific worldviews. TongaM41-50B reflected on how engaging with Pacific communities overseas can often serve as a valuable opportunity for undoing the harm of colonial involvement and reflecting back to Pacific communities the importance and value of their indigenous knowledge:

> *"When I was in Fiji, they asked me if I can speak to the Fijian nurses about research…My first sentence was like, "Who in here likes research? Can you put up your hand?' No one put up their hand, which was expected. Then, I said to them 'That's okay. If you don't like research, then be prepared for the rest of your life for non-Fijians coming in to tell you what to do here in Fiji.' I said to them, 'That's why I went into research, because I'm sick and tired of sitting in meetings and a non-Tongan person will come and tell me this is what you do for Tongan people.'…I like Epeli Hau'ofa's saying, 'Look. It's about time for us to write our own story.'" – TongaM41-50B*

> *"In Tonga they'll have policies and say things like 'We adapted this from Singapore'…I went to a meeting in Europe, and we adapted this from there'…And I said, 'Have you looked at the local context?' And they said, 'No, we need to learn from the developed countries', and I said, 'It's okay, but that doesn't really fit our stuff.' – TongaM41-50B*

TongaM41-50B recognises the impacts of colonisation and its epistemological violence, noting how students (the next generation) and colleagues (present and previous generations) have been influenced to believe non-indigenous approaches are intrinsically right or even better than indigenous ones. He exhorts the next generation to engage in research and reaffirms the value of Pacific worldviews and the approaches that issue from them. This too has a Freirean tone in its encouragement of communities and cultures to participate in liberating and embracing their own capabilities and knowledge, creating healthcare environments that have been determined by them and align with their worldviews. TongaM41-50B also shared about the importance of having his

culturally embedded knowledge about MH validated and reflected back to him, so, there is an additional element of reciprocity to this approach too; he supports the next generation to embrace and celebrate their indigenous knowledge just as he was supported to do the same. This intergenerational and international lens helps to ensure growth is shared throughout "our sea of islands" (318) and effective MH support is made accessible to Pacific families, regardless of where they are living.

Throughout this section, we see how the adoption of an intergenerational lens is a strength of PMHSM, and one that serves to support the success of PMHP and of MH services. By understanding themselves as existing at a point between previous and future generations, and by enacting the gratitude and commitment engendered by this recognition, PMHSM and leaders contribute to a reciprocal cycle of support, growth, and constant reinvestment. This supports both the development and sustainability of the workforce (in turn supporting the provision of consistent care for TWO), reduces systemic barriers and increases acceptance of and space for Pacific worldviews, and contributes to the strengthening and advancement of the wider Pacific community.

‘Ikai ha to’a ‘e tu’u tokotaha

No warrior stands alone.

4.1.6 Summary of "Discover" Findings

The "Discover" section of this thesis sought to answer the question:

> ***Discover:*** *What has been successful in Pacific MH practice here in Aotearoa/New Zealand, and what unique strengths of Pacific MH practice have empowered this success?*

Participants reflected on the Vā as the "positive core" of their practice, with this concept – and its associated ontological, axiological, and epistemological position – acting as an underlying source of strength, underpinning, shaping, and informing the way in which PMHP provided MH care for TWO and distinguishing their approaches to MH care from those of their non-Pacific colleagues. The findings above show how Vā has contributed to the success of PMHP, informing their delivery of MH care that affirms the dignity of TWO, addresses the root causes of distress, supports TWO to build strong, healthy, and 'ofa/alofa-filled connections to family and to others that genuinely care about them, nurtures hope and a sense of purpose, addresses wellbeing holistically (including – in particular – spiritual and socioeconomic needs), values the strengths and capabilities of TWO, embraces and affirms diverse cultural experiences, worldviews, and identities, and supports TWO and their families to heal, to grow, and to participate as fully as possible in their care and in their communities.

The descriptors used above to represent the success of PMHP in their delivery of MH care are based on those found in *HAO* (62), the *HAO Wellbeing Outcomes Framework* (80), and in *New Visions: Collective Solutions* (72). This highlights how well aligned Pacific approaches to MH care are with the vision outlined in these documents, with the aspirations for a renewed MH system in Aotearoa/New Zealand. Importantly, the Vā-led ways in which this care is provided also reflect and enact the literature available regarding Pacific understandings of and approaches to MH and the types of care

Pacific communities have been seeking for decades (see Sections 2.2, 2.3, and 2.4). The PMHP who participated are thus both already enacting what is needed to improve MH outcomes for Pacific communities *and* what is desired for the wider MH system. The problem lies in the fact – as shown throughout this chapter, and quite despite the relentless emphasis on strength and success – PMHP are often working in the face of personal, systemic, and epistemological bias, a lack of institutional support and resourcing, and at their own personal and professional expense. In following, the next section of the thesis will explore a range of policy actions that would serve to acknowledge and amplify this strength and success in and through public, mainstream MH policy, as well as reflecting on the relevance of these actions and their potential for not only Pacific communities, but for all of Aotearoa/New Zealand.

4.2 "Dream" – imagining public, mainstream mental health policy that amplifies Pacific strength and success

Having explored the numerous strengths of PMHP and reflected upon the areas of practice in which they have been successful, I now move on to address the research question associated with the "Dream" stage of the AI 4-D cycle (1-3):

> ***Dream:*** *What might mainstream, public MH policy in Aotearoa/New Zealand look like if these strengths and successes were valued, acknowledged, and affirmed? What potential does such policy show to support the MH of all New Zealand communities? What results might such policy achieve and what differences might we see?*

As noted in the Methodology and Methods Section, the "Dream" stage is focused on "exploring what might be" (3) and amplifying the "positive core" of a field or organisation to imagine a more vital future, improved outcomes, and a shift towards a more positive, equitable, and affirming world (1-3). In following, this section will begin by synthesising participant reflections on what public, mainstream (non-ethnic-specific) MH policy would look like if it amplified the Vā-led approaches described in the "Discover" chapter and enabled their growth. This will include both a description of the policy document itself (in terms of certain key features) as well as detailing a range of actions PMHP and PMHSM would like to see prioritised within such policy. Reflections on the efficacy of Pacific approaches to MH care for non-Pacific people will then be picked up, and the potential benefits of amplifying Pacific approaches to MH care in and through this public, mainstream MH policy - not only for PMHP, PMHSM, and their communities, but for all New Zealanders – will be reviewed.

4.2.1 Re-imagining Public, Mainstream Mental Health Policy

This section explores what public, mainstream MH policy in Aotearoa/New Zealand could look like if it valued, acknowledged, and affirmed Pacific strength and success, amplifying the Vā-led approaches described in the "Discover" chapter to enable their growth. It will begin with a reflection on potential changes to the policy document itself, considering how the attitudes, paradigms, and ethics informing these documents and their presentation might be altered to create a policy environment better aligned to and supportive of such approaches. This will be followed by a section presenting a purposeful selection of participants' policy recommendations, a synthesis of insights regarding specific actions and strategies that - if included in mainstream MH policy - would facilitate the development and growth of the Pacific approaches described earlier. These recommendations have been organised into four main sections; growing Pacific leadership and services; funding, contracting, and reporting; workforce development; and SDMs. Throughout the discussion of both the policy document itself and the policy recommendations, I will integrate the anticipated results of implementing the suggested changes, reflecting on the expected positive impacts of these and on how they will nurture the growth of the strengths and successes highlighted earlier in the thesis.

4.2.1.1 The Policy Document Itself

The participants in this study expressed that - beyond the inclusion of specific actions and strategies - there would need to be some significant changes to the foundations of mainstream, public MH policy in Aotearoa/New Zealand if it were to value, acknowledge, and affirm Pacific strengths and grow the successes emerging from these. The PMHP and PMHSM who took part discussed the need for fundamental shifts in the attitudes and paradigms underpinning the policy document as well as a stronger commitment to honouring the treaty and addressing the impacts of colonialism. Further to this they described a range of ways in which the policy document might be made more accessible and useful to the practitioners and communities it is intended to benefit.

The "dream" for mainstream MH policy was built on ethical frameworks, values, understandings, and approaches indigenous to the south Pacific.

> *"I think indigenous or cultural intelligence need to be part of that… built in or needs to underpin the new policy" – Sipaia Kupa*
>
> *"There's talk about restructuring and the restructure should reflect Māori and Pacific values." – Fereni Masoe-Afamasaga*

Participants reflected on the harm caused by the persistence of some of the ethical frameworks, values, and understandings that underpin and inform current MH policy:

> *"a Patricia Deegan quote, is 'refuse to be dehumanized in this age of managed profit'…when we talk about access and improving responsiveness and all that kind of thing, what does that really mean?" - Samoa/NZM61-70*
>
> *"When I think about where current bio-psycho-social practice comes from, it's whakapapa is to lunatic asylums…to locking up, separating, and treating in an inhuman way, people that are in crisis. No matter how flash you make current services, that hard line is still there...the ways Pacific people are operating are just not from that same genealogy." – Dr. Karlo Mila*
>
> *"We need to start with how bad ideas have infected our [systems]...the flavour of eugenics, social Darwinism…We need to think deeply about that cultural poison… This is why indigenous theorizing is really refreshing..." – Phil Siataga*

"The ways Pacific people are operating" and "indigenous theorizing" were seen as a pathway forward from this harm, providing a different paradigm, a new foundation upon which to begin a much-needed reconstruction of MH care in Aotearoa/New Zealand.

The dream mainstream MH policy would thus be grounded in the ontological, axiological, and epistemological position of the Vā, in principles of sacred, respectful, 'ofa/alofa filled relationships. It would be an inspiring policy document…

> *"If you could touch on inspiration; if it could inspire the reader a bit." – TongaM51-60A*

…one that spoke to the hearts of the people….

> *"If you really want to get collective effort, you have to talk to people's hearts rather than minds." – TongaM51-60A*
>
> *"If you really want to move from peripheral to transformational change, talk first to the heart, because then the ears will open, and you hear in a different way." - Samoa/NZM61-70*

…and that expressed a vision focused on bringing people together and nurturing the connections between them, strengthening relationships at all levels, from families through to crown agencies:

> *"I believe we should strengthen families…That's how services should be designed…so how do we create policies… [that] strengthen that innate bond groups and individuals and communities have? …I want policies that allow crown agencies to do something with us and strengthen the community's ability to do something for each other." – TongaM51-60A*
>
> *"I think if we can be really clear around what we're trying to do - which is to empower, to give hope, to help to connect, some really basic stuff - then we'll do much better." – Cook Island/NZF31-40*

It would communicate this vision and speak to people's hearts through the use of different metaphors and different narratives. Where current policy is embedded in the language of deficit, illness, and problem solving, the dream policy would be constructed in a more mana enhancing way, and would use the language of resilience, wellbeing, and journeying or navigating (notably, a physical expression of seeking out and making connections between places and people):

> *We need to change the narrative. The narrative needs to change…if we have people in society thinking that this is their lot, that's all they're going to get. You're not going to be able to rise above that…Rather than coming from warriors. We come from resilient people. – MāoriM41-50*
>
> *Quite often when we talk up MH, what we're really doing is we're talking up mental illness. How confusing is that?" - Samoa/NZM61-70*
>
> *"We are navigators. Looking back at our seafarers…We'd navigate the biggest oceans in the world, and we can use that same kind of thinking around navigating on dry land, different challenges but still having that function of navigators." – Manu Fotu*

Participants reflected that any transformation of mainstream MH policy borne of the shift towards a more Vā-led, respectful, relational, and 'ofa/alofa filled lens would necessarily take the shape of policy embedded - first and foremost - in mātauranga and kaupapa Māori and would be directed by tāngata whenua. Participants thus shared dreams of a mainstream MH policy that not only mentions Te Tiriti o Waitangi, but enacts a true understanding of its importance (SamoaF41-50), putting it and tāngata whenua first, allowing Māori and Te Tiriti to guide policy development rather than developing policies and *then* trying to integrate these after the fact:

> *It's really going back to the Treaty. Policy needs to follow the Treaty, goodness' sake." – Samoa/NZM41-50A*

Participants understood prioritising Māori as the right thing to do from a relational perspective…

> *My first position is to support Māori initiatives…This is their house." - Asiata Malagaoma Lealofi Sio*

…an acknowledgment of Māori as tāngata whenua (of their relationship to the land) and as tuākana (in Aotearoa) and tēina (in Te Moana-nui-ā-Kiwa) (319) (of their status as both respected older sibling and protected younger sibling), as well as being a key strategy for addressing inequity and injustice.

Beyond this, they also knew it would – through an increasingly successful expression of *bi*-cultural relationship – lay the groundwork for more effective *multi*-cultural relationships, inclusive of and responsive to non-Māori-non-Pākehā groups (Pacific peoples included):

> *"I think if they get working better with Māori right, then it's going to be easier for other cultures as well." – MāoriM41-50*
>
> *"This is why we've become treaty centric. All of those things are really important because if it doesn't happen [for Māori], it's not going to happen for Pasifika." – Phil Siataga*

Building on the more credible expression of biculturalism present in having meaningfully addressed Te Tiriti and its relevance, this dream mainstream MH policy would *then* also recognise the relationships that exist between tāngata whenua and Pacific peoples (tuākana/tēina, as above), and between the crown and Pacific peoples. It would acknowledge the trauma caused by colonisation and racism for *both* Māori and Pacific peoples, and would position addressing this trauma as a key responsibility of the state and of all of the MH services it funds, ethnic-specific *and* mainstream:

> *"Understanding actually [the racism] Māori and Pacific deal with on a day-to-day basis…really understanding the impacts of colonization on Māori…we know we have to deal differently with people with trauma. It's the same when we're dealing with communities that are marginalized and alienated." – MāoriM41-50*
>
> *"They're set in their mind that's not their thing...I've heard them say 'we are not a Māori service'…and 'we're not a Pacific service'. But that's beside the point…we should do it." – Tony Fuemana*

Reiterating the point made earlier that mainstream MH policy would need to be Māori-led, participants were clear that manifesting this transformational, inspirational dream policy document would require the empowerment of Māori MH leaders, policymakers, kaumatua, and communities to head its development. They were also clear that, subsequent to this, Pacific peoples would need to be

represented in the leadership and development of the document to a level *at least* equal to Pākehā, to address some of the bias, blocking, and vetoing that takes place:

> *"[The writing of this government document] was watered down by the white chair, who didn't understand Māori issues. He was okay with Pacific because you're allowed a Pacific bubble. But when Māori are talking about power sharing and devolving services to iwi, [many Pākehā in policy spaces are] not okay with that." – Dr. Karlo Mila*
>
> *"It's not because [Pacific people in governance are] not saying what needs to be said, it's because the people who are seeking the advice don't actually need to take the advice…I do think perhaps to get a cultural shift in all of this is we need leaders who are Māori and Pacific, to actually be leading us. I just really don't believe Palagi people, even if they are very sympathetic or really agree, can work this out." – Samoa/NZF41-50*

The dream of a Vā-led, respectful, relational and 'ofa/alofa filled approach is further reflected in the description of mainstream MH policy that includes and expresses both respect and enthusiasm for and warmth towards TWO generally, regardless of ethnicity…

> *"A lived experience voice, rather than a pathological victimized voice." – Phil Siataga*
>
> *"That's how I think about it in terms of the people I live with and work with…'How do I look at that beauty and see them as a rich contributor to life? Because what often happens is they're not seen that way - they're sick or they're poor or they're old or they're disabled or they're not really this narrow kind of mortgage holding... You know what I mean?" – Phil Siataga*

…and, most importantly in terms of *this* thesis, enthusiasm and warmth towards diverse Pacific peoples *and* their ethical frameworks, values, understandings, and approaches. It would actively engage with these, presenting them in a positive and nuanced way that embraces, validates, and uplifts rather than leaving Pacific peoples *"fighting to be the bottom two bullet points"* (Dr. Karlo Mila):

> *"I think it will recognize the strength and the depth of Pacific knowledges." – Samoa/NZF41-50*
>
> *"I think at policy level what needs to be recognised is those [Pacific] approaches are valid and needed…"– Samoa/NZF31-40*

The dream policy described by PMHMP and PMHSM would reflect a deep understanding of and commitment to upholding the integrity of and enacting these ethical frameworks, values, understandings, and approaches…

> *"That's the most dangerous, because they can talk us up…but when it comes to doing it… a lot of our narratives have been exploited… we have seen many of our innovations heralded as the flavour of the month, and slowly, the system wears it down. And then, it just goes back to what it always has been..." - Samoa/NZM61-70*

…and would both celebrate tradition whilst also moving past narrow/patronising interpretations thereof. It would instead reflect their relevance in contemporary life, their potential to inform and improve MH (as per the discussion of puke in Section 4.1.2.1):

> *"We all need to celebrate our traditional beliefs and the values of our beliefs… they form our tikanga, way of living. Kaitiakitanga in Māori is something we're all born with - to be protectors - and it's around manaakitanga, caring…That's a beautiful thing." – MāoriM41-50*
>
> *"[There has been] a lot of focus on unique Pacific interventions like fofo and traditional healing. That's one minute aspect of Pasifika, and what we do differently. [focussing exclusively on that is] very old school and very narrow. – Dwaine Faletanoa'i*

Significantly, this recognition would extend beyond acknowledging their relevance to Pacific peoples alone, and would challenge the idea Western knowledge is for/relevant to everyone, while "other" knowledges are limited in their value, of use only to those that created them:

> *"[Pacific values, understandings, and approaches] are already starting to seep into mainstream…and those things are shown to have benefits. I think that's something worth exploring and connecting back to some of those roots because a lot of the third wave of therapies and ways of thinking are the old traditional ways, they've dismissed in the past…what might be appropriate is using some of the principles and values underneath those..." – Samoa/NZF31-40*

Such respect, enthusiasm, and warmth – where shepherded by Pacific leadership and accompanied by an in-depth understanding and strong commitment - would enable Pacific ethical frameworks, values, understandings, and approaches to be taken more seriously and engaged with and utilised more widely. Connecting to the heart of the research questions and rationale for this thesis, Pacific peoples would thus have more access to mainstream services that better respect and reflect their worldviews, and non-Pacific people would have access to the richness and strength of Pacific approaches in *their* care too. The explicit articulation of enthusiasm, deep understanding, commitment, and relevance in this dream policy would then also facilitate and lead into the positioning of cultural ethical frameworks, values, understandings, and approaches as being of *equal* relevance to the provision of effective care:

> *"To be really good clinically you have to consider cultural context." – Samoa/NZF31-40*

> *"It's actually understanding cultural perspectives and world views…I've been hit up by people in a university environment, that have questioned the utility of what we do, have questioned the value of it, have questioned the relevance of it, and these are people who are going on to be clinicians…Because the way it is being still taught at universities… is the information people get from a clinical perspective or from whatever their training background is, is the be-all, end-all and it's the most important thing and that is what is right or wrong." – Cook Island/NZF31-40*

And to appropriate respect and support for cultural knowledge holders and cultural labour:

> *"Pacific are being used [for translation and interpreting, cultural liaison, family work etc] without compensation, or without recognition, or without [it being in the job description]." – DHB Pacific MHA Team Member 5*

> *"When I mentioned some putea [for] half a day's training, they were like, "Oh no, that's way too expensive." It's like they wanted to give me a sack of spuds." – MāoriM41-50*

Emerging from a more Vā-led, respectful, relational, and 'ofa/alofa paradigm, the dream policy would also reflect the relationships between different aspects of health and wellbeing and between different parts of the systems, community, and wider world. The dream policy would incorporate aspects of care extending well beyond what is typically considered "MH" and would have a much stronger focus on meeting presenting needs (as opposed to specific, discrete service types), whatsoever those needs might be. As a policy it would recognise and acknowledge that MH is complex and that there are no simple, quick solutions. In following it would include provisions for a wider range of expressions of care, such as feeding and housing people, taking them to the marae or the whenua/fenua/fonua, exploring their ancestral connections and family history, helping with their housework and child care, or sitting with, talking to, and spending time with them as a person (Cook Island/NZF31-40; Fuemana; Mila; SamoaF41-50). It would consider the provision of care for peoples' spirits and the relationships, connections, and service types needed to achieve this…

> *"You want to look at the holistic person, their spirituality, the other parts that make that person." – MāoriM41-50*

…and those needed to help them explore and make sense of their life in context, to find a sense of purpose, and to locate and pursue their aspirations for their life:

> *"Spaces where more conversations are held about the meaning of life and meaningful living is what it's about. It's not just that old formula: Go to school, graduate from school, get a job or go to college, work for 45 years, get a mortgage, and between times raise a family, put them into school. Yeah, no. It's got to be meaningful." – Phil Siataga*

The dream policy would acknowledge the connections needed between team members, families, services, communities, and government bodies to achieve such care, and would make plain the practical implications of this, providing not only statements of aspiration but clear guidance regarding how it might be achieved. Such guidance would be grounded in indigenous/south Pacific peoples' expertise regarding familial and community connectedness and collaboration:

> *"I think in general, the Pacific community is very inclusive and by that, I mean, if I think about village settings, in a particular village you might have someone with a disability, they have Fa'afafine or MVP FAFF, you have elderly, you have babies, you have young, single people, you have widows, you have widowers. We all coexist together and that's very natural and normal…we all come together." – Samoa/NZF41-50*

Through its pervasive emphasis on strengthening families, the dream policy would also explore how services and the teams working within them could operate more inclusively and more collaboratively:

> *"It's not one individual's job to support a family in a thing, but it's actually the whole team and shared responsibility and [they need to be] allowing that in practice on the ground." – Samoa/NZF31-40*

As well as this, the document would look at how the policies are relevant to and could/should be enacted within each ministry, at the state service level, the NGO level, and the community level, presenting that information in a way that makes sense to and can be used by individuals and groups at all of these levels:

> *"But policy, there's something around...the continuum of our practice from prevention to frontline, secondary and tertiary services need to be stronger." – Samoa/NZM41-50A*

> *"If you were to do it differently, it would have the really high level statements that are definitely evidence-based but then they would need flow charts almost, around like multiple streams of what this actually means if it's operationalized, in terms of both contracting level and then practice level…Like "This is the river and these are all the tributaries" at each level… almost like a visual diagram of it... It would need to keep splitting, and then like keep splitting around strategies for that, how it might flow, as well as potentially maybe some little things that would go, "Barrier alert." – Dr. Karlo Mila*

Not only would operationalisation be considered, but evaluation, with participants noting the need to explore and represent the potential impacts/outcomes of policies – both positive/hoped for and negative – in and through the policy document, as well as providing detail of how change will be monitored (especially with regards to factors that are usually considered harder to evaluate, such as values and principles):

> *"We're always going to have unintended consequences, but can we just think a little bit more about what those might be in terms of how it gets implemented... people will create the policies because of what they want to see happen, I don't know if people necessarily think about all of the what ifs." – Samoa/NZF41-50*

> *"[What's needed] is something in policy that describes or mandates how those [principles] are operationalised in some sort of system that monitors the operationalisation of those principles. Something like "love for the community", it would [look like] going the extra mile, doing what is needed to be done for that young person, always putting the young person and the family at the centre of every decision and their wellbeing and the impact on them [and evidencing/evaluating that]." – Samoa/NZF31-40*

While such changes would result in a significantly longer and more detailed policy document, participants expressed a hope such changes would also create a more useful, transparent, and accessible policy document, one that demonstrates respect for those it impacts through efforts to include, engage, and communicate with and for them. Importantly, and finally, the need to communicate with and for those using and being impacted by policy was also discussed with regards to the legislation underpinning it. In the dream policy, legislation such as the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (311) - its purpose, scope, and implications - would

be explained in plain English (and in a range of Pacific languages), and in a way that reflects the cultural and lived contexts of families dealing with someone experiencing psychological distress:

> *"I was thinking about explaining what will occur when someone's come through under the act, rather than saying the person's unwell and needs to go under the act….It's [saying] the same thing, but it needs to be... [explained in a way that makes clear what needs to happen to a family member or client and why and] put in the context of what the cultural environment is…I kind of align it to 'having a line of sight'." - Asiata Malagaoma Lealofi Sio*

These changes to the underlying paradigm, the leadership of, and the presentation of mainstream MH policy were all put forward as mechanisms that would support the creation of a mainstream MH policy environment where the actions and strategies described below would be well supported and where the strengths and successes of PMHSM would be valued, acknowledged, and affirmed. Participant contributions show how this dream policy - beginning with the sacred connections between people, place, and entities and building from there – would have wide ranging benefits, empowering Māori and encouraging Pacific leadership (and thus helping address the impacts of colonisation and cultural alienation); focusing on a vision of resilient, connected, capable communities that can strengthen and nurture families; demonstrating love and respect to truly embrace and learn from Pacific paradigms; and communicating transparently and practically to support families, communities, services, and the state to connect more effectively.

4.2.1.2 Policy Recommendations

This next section of the thesis will build on the foundation above by exploring a purposeful selection of recommendations regarding actions and strategies that could be included in the dream public, mainstream MH policy described above, expanding on what such a policy would look like and

what it would seek to resource support, and encourage. These recommendations have been organised into four main sections; growing Pacific leadership and services; funding, contracting, and reporting; workforce development; and SDMs. They highlight clear pathways towards developing public, mainstream MH policy and a MH system that affirms and acknowledges the Pacific strengths and successes discussed in Section 4.1, and, in following, to the creation of practice environments and services that will do the same.

4.2.1.2.2 Funding, Contracting, and Reporting

Funding, contracting, and reporting was an area of emphasis amongst the participants in this study. It was recognised that policy actions and strategies targeted toward the transformation of current funding and contracting mechanisms - and of how contracts were reported against and evaluated - would make a profound difference, helping to create an environment where Pacific strength and success in MH could be supported to grow.

> *"It's the money. It's the contracting, the way the contracting's done….it needs to happen at multiple levels. You've got this high-level policy that gives permission to operate in a particular way. [But it] needs to be kind of a little bit more than just policy [in order for that to be translated into practice]…" – Dr. Karlo Mila*

> *"They call it Māori and Pacific Services, but all the specs and the contracts and their expectations are written exactly the same as mainstream services. What then happens is you might have a Pacific name, you might have a Māori name, but you get your funding and you [are expected to] behave exactly as Mainstream Services." – FijiM51-60*

The tailoring of contracts is not only permitted but *encouraged* under the *Commissioning Framework for Mental Health and Addictions* (238), however participants shared that such customisation was the exception rather than the norm. This often leaves services and practitioners hamstrung in terms of what they can/can't fund as part of their service delivery, and results in significant parts of their work

being excluded from reporting or overlooked during evaluation and audit processes. In following, the dream policy would not only "give permission to operate in a particular way" - both encouraging and funding Pacific-affirming SDMs (see Section 4.2.1.2.3) – but would take a firmer line on the form, content, and evaluation of contracts.

In addition to having Pacific people leading the funding and contracting process (as per the need for empowered Pacific leadership at all levels), the dream public, mainstream MH policy would not only encourage, but *require* funding agreements and contracts to be developed on a case-by-case basis and in collaboration with the people and services who would deliver them (FijiM51-60). This would help ensure contracts more accurately reflected what could be delivered, would be delivered, and how, and that resourcing was adequate for the work to be done. This would better support services to deliver in alignment with their contracts and, crucially, would help to ensure services and staff aren't punished – defunded, accused of fraud, or pushed into the use of personal resources – for applying effective and responsive approaches to care currently considered non-standard (such as those applied by PMHSM and PMHP). Naturally, for PMHP and PMHSM, said funding agreements and contracts would ensure additional resourcing – financial and human - to ensure time could be spent on relationship building:

> *"It goes back to mainstream policy…they fail to consider with cultural delivery, you need, for instance, a first assessment. It can take you five or six days to try and get information out of clients, and we don't want to push to get information because they just stop talking to you…they never come back." – DHB Pacific MHA Team Member 1*

Requiring contracts to make provision for increases to permanent full-time equivalent staff (FTE) in clinical roles (relative to the SDM used and to any increases in delivery) was seen as another key mechanism for enabling this (DHB Pacific MHA Team; Siataga and MāoriM41-50), as was implementing a policy-level cap on caseloads at a variety of levels/for a variety of roles:

> *"Some of them have ridiculous caseloads. Once you start getting clientele numbers of over sixty, you can't keep track, you can't remember who you're seeing. How on earth are you supposed to maintain any humanity in that? I think these things need to be capped." – Cook Island/NZF31-40*

> *"I think the number, your caseload is unmanageable. You get a hundred kids, and you might be doing brief intervention…I think we've got to have a model where we're only working with a certain number." – MāoriM41-50*

Participants also suggested the dream policy could and should require funding agreements and contracts to commit a portion of the funded FTE to health promotion and community education (FijiM51-60; SamoaF41-50; Siataga and MāoriM41-50). Explicitly allocating FTE to health promotion and community education was expected to reduce the burden of trying to do both clinical and community work using FTE already overburdened with clinical cases. It would also contribute to the prevention of poor mental wellbeing and the strengthening of families and communities to better support each other, freeing PMHP up to spend more time with the TWO who most need them.

The dream policy would also focus on developing funding and contracting models designed with holistic wellbeing, flexibility, and the complexity of MH in mind; echoing what was shared in Sections 4.1.2.2 and 4.1.5.2, participants expressed a desire for funding agreements and contracts that empowered them to work holistically, addressing the various needs of TWO and their families and eliminating significant stressors that contribute to/exacerbate psychological distress (FijiM51-60; Fuemana; Mila; Samoa/NZF31-40; Sio). Whānau ora was cited as a promising model for this reason:

> *"It's at policy level. They've got to design contracts actually addressing the needs of Pacific and... whānau ora does... It's the first time anything that's ever been done actually looks different." – FijiM51-60*

> *"Whānau Ora was able to address their actual needs. Someone might be having a MH crisis and it's partly because their fridge is broken down and their car's not working, and because 40% of us are fundamentally in poverty, that's such a big driver and lack of resource to cope with stress. Through Whānau Ora…this actually*

enables us to meet whatever their tipping point is which is so often financial." – Dr. Karlo Mila

Flexibility and the freedom to provide wraparound care that addresses a wide range of needs was also noted as vital to reducing the risk of TWO falling into the cracks between services:

The dream and challenges are to see increased funding and more flexible funding for Pacific people. Services are currently provided based on tick boxes therefore can create barriers and restrictions to meet service criteria…and then they fall through cracks and present in crisis." – TokelauF51-60

In addition to funding agreements and contracts being tailored and allowing for holistic provision, it was also hoped there might be a way for funding agreements to operate with enough flexibility that so-called "over-delivery" and other examples of on-the-ground responsiveness could be appropriately compensated after-the-fact:

"You're contracted for counselling for gambling, but you're helping with their budgets, linking them with food bank services, financial services, all these other things. But that's not part of the work you're funded from government to do... the funding suits the hospital but doesn't suit the community environment." - Asiata Malagaoma Lealofi Sio

"There shouldn't be restrictions…you should be able to turn up at the MH thing, and you say you need [access to other supports], it should be all right there...Because it stops a lot of people, if someone says, 'Oh, no, we are not funded to do that.'" – FijiM51-60

While it is recognised there are mechanisms in place to record declined services so additional funding can be sought *in future*, these are not well used, and do nothing to address additional demand and/or the immediate needs of TWO and their families, thus contributing to the risk of TWO "falling through the cracks".

Participants also discussed how a dream public, mainstream MH policy might shape funding and contracting to better support collaboration. Two different approaches to this were tabled. The first of these suggests a move away from the focus on "services" and the direct employment of individual contractors by the state:

> *"That's already happening in Wellington, at the Ministry of Justice. 'Here is this person. You get allocated 8 hours, and I want a report at the end of it.'…It's a different way of contracting people." – FijiM51-60*

While shifting to a more individualised model of contracting may seem counterintuitive in terms of collaboration, the approach shows strong potential for creating more organic communities of practice and for allowing flexible, around the clock, multi-locational support that is genuinely person-centred:

> *What happens when the person needs housing?// Well, you talk to the people who provide housing….the focus is about people who need help, rather than services setting up…//So, more like small scale collectives?// Yeah….You don't have a manager. Everybody has their [allocated funding and their] own code of ethics in what professional organizations they come with." – FijiM51-60*
>
> *"This doesn't mean nine to five. That means I can spend maybe two hours this evening, three hours, two hours for lunch tomorrow, five hours next week. //And if somebody needs your help at three in the morning, you can go give them some help at three in the morning, and then sleep until nine tomorrow." – FijiM51-60*

Notably, such an approach may also facilitate the growth of the MH workforce through the provision of greater flexibility for staff.

The other approach to supporting collaboration discussed involved an emphasis on contracts that supported the formation of/rewarded participation in "umbrella organisations", wherein smaller services come together – ideally in a shared location – to share overhead costs and to deliver either

on various aspects of a contract according to their relative strengths or on different – but mutually supportive – contracts:

> *"There's the whole competitive nature of contracting, which is incredibly detrimental instead of playing to people's strengths, instead of celebrating what people are really good at…if funding was based upon that, what people can contribute, then that would be a better angle." – Cook Island/NZF31-40*

> *"[Funders and planners] should organize these providers. Support them, give them advice. Instead, they are driven to compete, and it should be a collaborating model…There has to be a balance; you don't go from 10 to one…but I think there should be some directions from the funders..." – TongaM41-50A*

Not only was this seen as a useful way to minimise costs and strengthen collaboration between services, but it was also understood as a way of sharing knowledge, expertise, and human resource more effectively. It was also valued for its potential to ensure TWO didn't fall through the cracks between services, as – particularly in the different-but-mutually-supportive version of this approach - they could be connected, on-the-spot, to others who could help.

Reporting on funding and contracts – both in terms of the state reporting to services and communities, and services reporting to communities and the state - was also discussed as a key area for change. With regards to the state reporting to services and communities, PMHSM and PMHP expressed a desire to see policy actions that would facilitate a clear line of sight regarding Pacific funding, ensuring funding committed to Pacific services and communities is finding its way to and creating benefits for those services and communities:

> *"[A Pacific politician and PMHSM] when he talked about policy, [he said] 'track the money because the money will be allocated to a Pacific response and there's a set budget, track the money and what you'll find is, it's not being used for what it was intended for', it hasn't been reported back as well. - Asiata Malagaoma Lealofi Sio*

"I looked at [the governmental budget]? But we were, like, "What is this?" Thousands of dollars going here, but it's not clear as to what exactly this is." – Dwaine Faletanoa'i

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It was widely perceived that the state did not hold itself accountable to Pacific communities, and transparency around where Pacific funding was going and how it was being used would help to change this perception. Other means of increasing accountability to Pacific communities were also tabled, including ensuring Pacific auditors audited not only Pacific services but mainstream services (FijiM51-60) and improving mechanisms for reporting back to communities regarding how their input into co-design, review, inquiry, and policy processes is being applied (and, when not applied, why) (Samoa/NZF41-50; Samoa/NZM61-70).

In terms of services reporting to the state and to communities, participants saw a dream policy that both made significant changes to existing KPIs as well as a move beyond KPIs to more of an emphasis on the outcomes and impacts achieved. Current KPIs were seen as being too narrow - too focused factors such as patient turnaround - and thus at risk of mistaking efficiency for efficacy. Participants thus wanted to see the inclusion of indicators related to client and family experience/satisfaction, staff wellbeing, and the use of existing quantitative impact measures such as (a culturally validated version of) the HoNOS suite (Health of the Nation Outcome Scales) (334) or other relevant outcome-and-impact-oriented tools.

"There is no consumer rating stuff …I think there should be mandated measures…[and]…team wellbeing needs to be made more explicit…if there was a mandate for wellbeing of clinicians to be factored in and measured consistently, I imagine the cultures would change." – Samoa/NZF31-40

"What are your staff feeling? Are they feeling like they're being valued?" – Tony Fuemana

"And use HONOSCA. It's probably best of the worst…Test this - and our Pacific people are testing this - but we've got to be able to underpin it with our indigenous frameworks..." – Samoa/NZM41-50A

"We need to move away from just quantity tick boxing to measures that reflect some of the good work being done…like the HONOSCA…It has a really low completion rate, because it's not seen as very important…the main KPI's I believe MOH track are the ninety days and the face-to-faces." – Samoa/NZF31-40

It was also raised that KPIs currently operate in a way overlooking both team-based approaches and approaches that engage the whole family. The dream policy would direct that mechanisms be established which allow for the recognition of the involvement and contribution of multiple staff members and of instances in which staff members are working with multiple people as part of the care they are providing:

"Within MH services, everything is done against an individual, right? You see X number of individuals, but actually when you think it, there's the individual, then there's the family, and then you might be seeing others involved in it…"– Cook Island/NZF31-40

"At the moment they have a model where KPIs are based on the number of face-to-faces and when two people are going in, only one of them will count for the KPI...those KPI's should count for both." – Samoa/NZF31-40

Beyond KPIs, participants wanted to see policy placing more of an emphasis on qualitative reporting against funding and contracts, on high quality and well-resourced engagement with the voices of TWO and their families, and with their experiences of services and the positive changes that had (or hadn't) happened in their lives through engagement therewith:

"In the Ministry, reporting's always strongly quantitative…But the narratives in Talanoa really express - to a better degree - the outcomes...Maybe we look at reconfiguring the way we report, we can truly capture the essence of what we're doing." – Dwaine Faletanoa'i

"One of the KPIs in the health system is family contact and normally this is just a tick. That doesn't capture all the really important stuff like when a health clinician talks to the mother or the father…how they facilitated a family meeting. How they

talked to the main caregiver about the best way to talk to their son or daughter if they're starting to show their personal early warning signs." - Samoa/NZM41-50C

"That's why I like the RBA approach. Because the story is the baseline. If you get a story that conveys a baseline, out of that comes all the activities and all those activities, the extra stuff you have to do as a service..." - Asiata Malagaoma Lealofi Sio

"The policy should enable resource allocation adequate to doubling our consumer voice." – Samoa/NZM41-50A

"A true outcome focus would look like is hearing it straight from the horse's mouth…there's [need for] more capacity for consumers to share from their own words how the services benefit them. I'm sure that would go a lot further than our word for it…but there's never any resource for it." – Dwaine Faletanoa'i

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It was recognised that this would require a longer terms lens than was currently applied when evaluating the success of services against their contracts, as well as the development of better connected, more flexible, and more user-friendly approaches to gathering and recording data while in the flow of providing care:

"I think as a society we are so used to there has to be a direct impact now that we can measure, and we're not very patient on the long-term goal." - Samoa/NZM41-50C

"That's the biggest one, the recording of information, collecting the data…if you collect data, put it in places where you can find it, when we come to argue for certain things, we've got evidence to argue for those positions…how we record what we're doing needs to change to facilitate that." - Asiata Malagaoma Lealofi Sio

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In addition to reporting, the auditing of funding and contracts was also highlighted as an area the dream policy could influence for the better, with changes being made to increase the accountability of services to TWO and their communities and to support services to address what's not working and grow what is. Participants suggested policy facilitate the engagement of cultural,

consumer, and youth audits/auditors, strongly emphasising the need for services to be appraised by those they were designed to serve:

> *"There's very few Pacific auditors. There's very few Māori auditors. You got to have people who can actually go and understand and can see what's happening; if we go in black and white…contract auditors will come in and say, "Nah, I've got recommendations for this and that…they're not doing this and not doing that." I say, "What do they do? Tell me."…It's not exactly what the contract asked, but that's what they are facing in their own community." – FijiM51-60*

> *"Young people make some people uncomfortable. That's why we should have young people come in and just do an audit every now and then… Having youth going in and sussing out places for their friendliness and warmth." – Phil Siataga*

It was also recognised current auditing processes do not paint a representative picture of what is happening on the ground, and a significant amount of masking goes on. The idea of "drop-in" audits was tabled, as these would allow for the state of service delivery to be appraised *in vivo*:

> *"We know audits are planned, that services can change stuff just for that audit…you're mainly talking to managers and making sure they're ticking the box…not 'When was the last time you guys went and cleaned these rooms? Let's see how you're actually caring for these people you're getting paid for'. I bet you with a lot of these agencies they would fail….Maybe at random they go to an organization and say I want to pick these four residents; I want to come in whenever and see the work they're doing. – Tony Fuemana*

The importance of a long-term lens was emphasised here too. PMHSM and PMHP expressed a need for services to be seen as precious investments rather than cost units, and to be supported and nourished accordingly. They spoke of the need to abandon strategies such as keeping services in the "pilot" stage or defunding services when they fail to perform, and instead using external evaluation as a means of reviewing service specifications in light of community needs, identifying and solving problems, addressing barriers to effective delivery, and nurturing the strengths services *are* demonstrating:

"I've been [working on this particular project] now for maybe ten years, but it's still called a pilot. I think this is how it's done in Wellington; they call it a pilot. If it works well, they just let it go [on], but if it doesn't work well, they can just pull out…" – FijiM51-60

"How do we create policy settings, that allow people to make mistakes?" – TongaM51-60A

"In 10 years', time, I'd like to see the services we do have really well looked after. Resource-wise. Support-wise. Rather than the emergence of a whole lot of new services. Hopefully some investment in the ones we already have." – Dwaine Faletanoa'i

"There needs to be a long-term commitment and investment there?//Yeah. Yeah. That's huge." - Samoa/NZM61-70

The discussion above highlights a range of ways in which the dream public, mainstream MH policy could support the transformation of the funding and contracting environment. Requiring the collaborative, Pacific-led development of bespoke contracts, prioritising the contracting and funding of "front-end" heavy, holistic approaches to care, ensuring the availability of flexible funding to accommodate responsive delivery, focusing on collaboration over competition, developing outcomes-focused KPIs and more meaningful and accessible approaches to reporting on the impact of funding, and reconsidering the "why" and "how" of auditing are all actions that would help to affirm, acknowledge and grow Pacific approaches to care. Further to this, they would facilitate the development of a responsive, sustainable MH service environment where organisations are better supported to embrace diverse worldviews and modalities, address both the socioeconomic determinants of health and root causes of distress, and to meet people where they are.

4.2.1.2.1 Growing Pacific Leadership and Services

Growing Pacific leadership in MH spaces and increasing support and resourcing for BP4P services were two crucial strategies for supporting the growth of Pacific strength and success in MH. The dream public, mainstream MH policy– having both recognised the *"strength and the depth of Pacific knowledges."* (Samoa/NZF41-50) and acknowledged the responsibility of mainstream MH services to provide responsive care for all TWO and not just the dominant ethnic group – would actively seek to bring more of the ethical frameworks, values, understandings, and approaches indigenous to the south Pacific into the MH system as a whole. This would help ensure mainstream services are better equipped to support Pacific peoples…

> *"I think it's something that's making more our non-Pacific mainstream services more culturally responsive. It doesn't have to be just Pacific itself…we've got to make sure our mainstream services are culturally and appropriately done, are responsive as well too." - Samoa/NZM41-50C*

…whilst also, enhancing the services provided to non-Pacific peoples through that aforementioned "strength and depth". Participants shared that the quickest and most effective route to bringing these ethical frameworks, values, understandings, and approaches into the MH system was to ensure Pacific leadership at every level, from state through to service. It was recognised by participants that the employment of Pacific people into mainstream/non-ethnic specific leadership roles would organically lead to positive change, to a more Pacific way of providing MH care both through the ability to influence the decisions being made "upstream" and through the "embedding" of their *modi operandus*:

> *"It requires Pacific decision making power and Pacific calls at every level…the best way [to get more Pacific approaches in mainstream MH services] is to employ talented Pacific people in and after a while a certain way of practice sort of becomes embedded…"- Dr. Karlo Mila*

> *"What I'd like is that those positions are not Pacific-specific… I want Pacific to be on the main boat. Not as less, not as an afterthought, and not as a token...mainstream organisations need to take more Pacific people into the main*

boat, so we can influence the policies and the funding upstream." – TongaM41-50A

In order to mitigate the risk of being ignored, obstructed, or overridden by Pākehā policymakers, it was particularly important these leadership roles were not tokenistic or limited to consultation on/input into others' plans. Rather, the leadership roles offered would be meaningful ones and the Pacific people employed into them would be empowered to make meaningful change. They would be listened to, would have genuine decision-making power, and would be holding both the pen *and* the purse strings:

"We have to focus on who's got the power to put a red line through things." – Phil Siataga

"It's a hard one because Palagi hold the purse strings in a lot of the services. It's really hard to convince them if they're set in their mind that's not their thing." – Tony Fuemana

The policy actions and strategies that could support this - beyond the explicit articulation of the value of and need for Pacific peoples to be employed into and empowered within meaningful, mainstream/non-ethnic specific leadership roles - were debated. While some saw merit in a quota system, others were wary of this and the risks it created in terms of tokenism, box-ticking, and of promising Pacific leaders being pulled into roles they are not ready for (DHB Pacific MHA Team; Faletanoa'i; Samoa/NZF41-50; Samoa/NZM61-70; TongaM41-50A). Many participants felt a better approach would be for policy to focus on committing more resource – human and financial - to the identification and development of promising PMHSM and PMHP for leadership roles, helping to ensure they are equipped with the skills and knowledge needed to undertake these:

"You can think "Okay, if we've got 50% brown people in our workforce, that'll do", but it's not about that…//It's about listening to those brown people?//Yeah, and

also developing them and actually not having them just come in to your white kaupapa." – Samoa/NZF41-50

"Our Pacific people need to be developed, we need smart people, but we also, on the other side, need mainstream organizations to be more open to Pacific and Pacific workers." – TongaM41-50A

It was noted that developing health systems knowledge would play a particularly important part in this (FijiM51-60). Acknowledging the challenges of leadership and of representing the aspirations and interests of a diverse and rapidly changing population group, it was also suggested the dream policy would look at mechanisms to better support Pacific leaders in their roles. For example, it was suggested a more collective approach to leadership could be useful, with a council of sorts being appointed to inform and support individual leaders:

"It's a big job. It's a big job for one person to cover all that…looking at a person being there, but a supporting group with that person." – DHB Pacific MHA Team Member 8

Not only would this help to ensure Pacific leaders were more empowered to maintain connections with and insights into the needs and experiences of diverse Pacific communities, but it would also help to alleviate both the risk of burnout and the isolation experienced when one is "*The one and only brownie …*" (Samoa/NZM61-70). Relatedly, the dream policy would also direct the establishment of more paid cultural leadership (e.g., matua) and consumer leadership roles:

"The big thing around equity is actually resourcing that stuff. Resources like the likes of [our matua, there's] only one of him. Oh my gosh..." – Samoa/NZM41-50A

"If we could have a much stronger value and importance placed on our cultural leaders, then we might start to see a more natural progression of environments such as these cropping around the place when it's firmly in policy…Same with a consumer advisor. Maybe that's another thing we could do with policy. Same. Cultural leaders and more consumer perspectives ingrained in policy." – Dwaine Faletanoa'i

Participants recognised paid cultural and consumer leadership roles as another mechanism through which appropriately resourced and remunerated insights into the needs and experiences of the communities being served could be provided. It was also noted the establishment of such roles would - as highlighted with regards to Pacific leadership in general – contribute significantly to organic changes within mainstream environments.

In the paragraph above, and echoing others quoted throughout the thesis, TongaM41-50A also noted that *"…[we] need mainstream organizations to be more open to Pacific and Pacific workers."* This gestures toward the fact that growing Pacific leadership and services will also require some personal and attitudinal growth amongst non-Pacific leaders. While Section 4.2.1.2.3 will present a number of actions that would support attitudinal change through both pre-service and in-service education, participants also saw the dream policy working to impose more openness from the top, down. It was suggested the dream policy could support acceptance of Pacific leaders and the ethical frameworks, values, understandings, and approaches they bring with them by directing changes or additions to both relevant legislation and to the codes of registering bodies (such as the Medical Council of New Zealand and the Royal Australian and New Zealand College of Psychiatrists) (Fuemana; Sio; Siataga and MāoriM41-50). Such changes or additions would be designed to bring both the law and the documentation dictating professional ethics and practice into line with the Ethics of the Vā and other more relationally grounded ethical frameworks. It was hoped the codification of Pacific ways of knowing and doing as "right" - or at least as acceptable alternatives - by sources current leaders typically defer to would not only help to shift attitudes but would also provide Pacific leadership with recourse to support and backing from higher authorities when challenged.

While the strategies above reflect how Pacific leadership in mainstream spaces could be supported to grow (and, through this, the "Pacific-ness" of mainstream services), participants were

also clear the dream policy would support the growth of BP4P services (and would *require* Pacific leadership of these). It is important to note participants did not feel creating a more culturally acceptable mainstream MH environment - even one with strong Pacific leadership - would do away with the need for BP4P services:

> *I'm hoping in 10 years' time, there's policies to support us to remain our own. I hope so... if there's policy around supporting Pacific for Pacific, you know? – Dwaine Faletanoa'i*

The ongoing availability of such services was seen as important for a variety of reasons . Participants recognised that while many Pacific people do opt for mainstream services (a significant factor contributing to the need both for Pacific leadership in mainstream services and for mainstream services to include the ethical frameworks, values, understandings, and approaches indigenous to the south Pacific), many either need or would benefit from access to BP4P services. Participants noted that in fact BP4P services are better able to address the specific needs of different ethnic groups and to carry out care in a more nuanced way than occurs with a Pan-Pacific approach:

> *"We have very good, similar values amongst Pacific….[but] in practice those values are quite different. Tongan, Samoan, it's very, very different. And also, they're very different in presentation." – TongaM41-50B*

This was considered to be particularly important for meeting the needs of older Pacific peoples and for those who are first generation migrants. While it was recognised the demographic profile of the Pacific population in New Zealand is changing and ethnic-specific or traditional approaches might not always be the *most* appropriate choice for Pacific families who have been in New Zealand over several generations, it was *also* acknowledged that young Pacific TWO and Pacific TWO operating in multiple cultural worlds do have needs distinct from those of non-Pacific. BP4P services provide a promising space for developing an awareness of, navigating, and finding appropriate responses to these changes and shifts:

> *"We know the population is changing…the New Zealand born subset of Pacific people is growing, but then their needs are still unique to non-Pasifika, but really traditional ways of responding are not necessarily gonna be appropriate moving forward as well." – Samoa/NZF31-40*

It was also recognised BP4P services provide Pacific communities with a degree of autonomy and with the freedom to grow both traditional and contemporary Pacific approaches to MH care:

> *"Operating in mainstream means it's never on our own terms. And it's hard to align with your own values and then actually operationalize them in a system that is geared up along a whole other worldview…" – Dr. Karlo Mila*

> *"Giving us a bit more space to be Pacific. You know? Rather than ingrained in a strong, mainstream system. Giving us a little bit more independence; autonomy. All those things. To really grow and flourish as Pacific people." – Samoa/NZF31-40*

These benefits of BP4P services to/for Pacific communities were discussed alongside a range of potential benefits to the mainstream MH system. For example, participants reflected on the potential of such services to provide consultation services and both strategic support and practical clinical and cultural support for mainstream services as they seek to improve their responsiveness to Pacific TWO and families (DHB Pacific MHA Team; TongaM41-50A). They also noted BP4P services can serve – particularly when supported to properly evaluate and formally document their practices – as hubs for innovation and for the development of new SDMs, therapeutic interventions, and even bio-medical approaches to providing MH care that will benefit to only Pacific peoples, but many communities both in Aotearoa and throughout the world (Mila; Sio; TongaM41-50B).

The PMHSM and PMHP involved in this study suggested a range of policy actions that could be used to help support the ongoing existence of BP4P services and that would maximise their positive potential. The dream policy would, first and foremost, recognise and express the importance of empowering Pacific communities to deliver BP4P services and would ensure funding, strategic

attention, and human resource would be directed toward these. It would also, crucially, explicitly require Pacific-specific services be overseen by Pacific leadership, from funding and contracting, through governance, management, and both team and clinical leadership roles. This was seen as vital to ensuring the integrity of what BP4P services delivered and to avoiding the erosion of BP4P services into mainstream services with Pacific names:

> *"…Whether it was Winston or whether it was one of the other Māori politicians, he said something along the lines of it's funded from Māori, delivered by white people…[that's] something I think is really important we don't forget with the "by Pacific for Pacific." That is what we are aiming for, but there is a lot of control of finances and funding." – DHB Pacific MHA Team Member 8*

> *"…the Pacific specific services that build a culture of practice…there aren't too many Palagi people like fiddling around in there or managing them. Usually, I know that probably sounds awful to you and, but a Palagi manager of a business-Is the kiss of death because, to me, it seems to require Pacific decision making power and Pacific calls kind of at every level, as well as Pacific practitioners." – Dr. Karlo Mila*

Participants – particularly those who worked/had worked in DHB-based services - also dreamed of policy that ensured BP4P services were offered to Pacific TWO first:

> *"Can there be a mandate stating all Pacific people referred to MH be offered the option of Pacific Services [first], rather than first mainstream." – Fereni Masoe-Afamasaga*

PMHSM and PMHP described how, in many cases, Pacific TWO are required to attend a mainstream service *first* and can then *opt into* Pacific services, should they wish. This has a range of potentially adverse impacts, both in terms of how Pacific TWO experience their first interaction with MH services and in terms of the uptake of BP4P services and subsequent negative interpretations of their value and relevance. The ideal was for Pacific TWO to be offered ethnic-specific services first, with TWO opting out of BP4P and into mainstream if that was their preference. In cases where this had been done, it was noted as having positive impacts:

> *"What was good in that model was making the default the Pacific team" – Samoa/NZF31-40*

It was hoped this would not only create more positive and affirming experiences of the MH system for Pacific TWO (thus leading to improved engagement and participation in MH services, and, in following, better long-term outcomes), but it would also help to challenge fears and negative beliefs about BP4P services (e.g., that confidentiality would be an issue or that treatment would exclusively focus on traditional aetiologies and remedies). It would also help ensure BP4P services were being actively used as often as possible and that the importance of investing in them would be more obvious to funders, thus supporting their long-term sustainability. Outside of the DHB environment, it was suggested mainstream services could be required by policy to have formal agreements with BP4P services to support with caring for TWO and their families:

> *"They should contact a Pacific organization, have some sort of formal arrangement with a Pacific organization, so when a Pacific person comes through the door, you should get a Pacific worker to work with this person." – TongaM41-50A*

This would – in a similar way to making BP4P the default within the DHB – help to ensure more positive experiences of MH care for Pacific TWO, whilst also ensuring the uptake of BP4P services and reinforcing their value to funders. Furthermore, it would allow for the organic cross pollination of ideas and for mainstream organisations to work alongside and learn from Pacific practitioners.

Actively supporting research and evaluation within BP4P services was also highlighted as something to be emphasised by the dream policy. PMHSM and PMHP spoke of policies that both invested in new and innovative Pacific MH services and approaches and that resourced their evaluation, documentation, and dissemination:

"That is probably the most meaningful thing they could do…even just as a research experiment, create a Māori specific and a Pacific specific acute unit, and monitor the crap out of it to see what the outcomes are. And then whatever practice comes out that is clearly working, transfer that over to mainstream….And unless you have that kind of evidence, that incredible evidence, you're not going to shift anything."- Dr. Karlo Mila

"Some policies to provide more resources to explore. You know, we talk about biomedical, Western biomedical, but we forget the biomedical material in the Pacific which hasn't been tested…It would be really good to have some policies to direct research to explore that and also look more into the effectiveness of the traditional healing, and the concepts of that healing…effectiveness around that area." – TongaM41-50B

"With regards to the interventions and therapies, talking therapies and all that. There are processes within that that needs to be documented a little bit more clearly and explained out. But we don't have enough allocation time to do that." - Asiata Malagaoma Lealofi Sio

"[From a state perspective] 'We have invested heavily in Pacific, but there is no evidence of having done any better, so did we get it wrong? Are they right? How can they be right if there's no evidence things have improved?'." - Samoa/NZM61-70

As indicated, the issue of time and human resource would need to be addressed; the fact that clinicians and other MH staff are already overwhelmed constitutes a major barrier to research around and the evaluation of Pacific approaches to MH care (SamoaF41-50; Samoa/NZF31-40; Sio). Participants described a dream policy that funded the establishment of a separate research entity whose role it would be to both coordinate and undertake such activities, developing a clear and well prioritised research agenda, supporting clinicians on the ground to determine what is working and what isn't, and showcasing the strength and success in what they do:

"I think support in those settings [is needed]…to have research arms…so we can grow the evidence base and [show] the validity of Pacific approaches, but then there has to be capacity to do that, and coordination to do that. We have some Pacific research places around that are doing Pasifika research and that's all great, but how connected are they to the frontline people in the DHB that are actually doing the mahi that are on the go?...And not expecting clinicians to do that but actually having support to be able to do that…"– Samoa/NZF31-40

Supporting BP4P services to gather information about, evaluate, and share findings regarding their practices was expected to have wide ranging benefits. It would, of course, help such services to evidence good practice, in turn helping them to highlight the efficacy and worth of their services to funders and further support their sustainability. Beyond this, however, it would essentially double their value as an investment, enabling them to not only provide effective services to meet the needs of Pacific communities, but also to develop, test, and share unique innovations grounded in a more holistic, relational, and collectivist worldview with the wider MH community. Investing in research and evaluation within BP4P services is a clear win for everyone.

This section has explored both how and why the dream public, mainstream MH policy could seek to grow Pacific leadership and services. Understanding that Pacific approaches are broadly valuable, Pacific peoples often access mainstream MH services, and the demographic profile of the Pacific population is changing, it would seek to empower meaningful Pacific leadership at all levels of mainstream services. It would ensure these leaders were well supported in their roles, providing both professional development and access to other leaders whose moral support and insights and perspectives would help to ensure they were successful and effective in their roles. It would recognise the value and utility of BP4P not only to a range of subsets of the Pacific community but to the development of MH services in general. It would then – through ensuring Pacific leadership, making them the default, and adequately funding and resourcing support for research and evaluation – support these services not only to exist but to contribute to Pacific communities and to MH as fully as possible. In doing this the dream policy would facilitate the shift to a MH service environment and to MH practices that – through embracing Pacific worldviews and modalities – more effectively focus on wholeness, healing, and holistic wellbeing, affirm cultural identity, and in a myriad of other ways bring the strength and success of Pacific MH practitioners to bear.

4.2.1.2.3 Workforce Development

Participating PMHP and PMHSM described a range of actions and strategies related to workforce development, recognising that changes to community, pre-service, and in-service education all had a significant role to play in ensuring a more Vā-led, respectful, relational, and ‘ofa/alofa approach to providing MH care was not only valued, acknowledged, and affirmed, but also grown and shared. The talanoa frequently reiterated the importance of leadership development for Pacific MH staff, and of nurturing and supporting strong cultural and consumer leadership (see Section 4.2.1.2.1). It was recognised that there is a need to provide focused support for the development of the cultural and consumer workforce in particular, especially in terms of the intersection of cultural and consumer experience:

> *“If you look at the Pacific consumer workforce and you look at the opportunities for it, I'm the only Pacific consumer adviser in the whole country that has a full-time paid job [].” - Samoa/NZM61-70*
>
> *“[In addition to addressing stigma and discrimination] the other part is the strengthening of the peer support services to MH. I think those are two areas that, if it is done well, will really address the needs of our MH clients.” – Manu Fotu*

The presence of lived experience of culture and lived experience of mental distress were valued by participants, and so it was shared that the dream, mainstream, MH policy would direct the funding of more permanent FTE dedicated to ensuring such experience is both widely available and equitably remunerated. Equitable remuneration was also discussed with relation to the MH workforce in general, and to the roles PMHP are expected to play within MH services. Participants shared about the difficulties of attracting and retaining skilled staff when the majority of MH roles are not accompanied by fair or competitive - let alone attractive – pay:

> *"Policy does need to recognise the workforce, and with appropriate remuneration" – Samoa/NZF31-40*

This was noted as a particular challenge for BP4P services, who often received less funding than mainstream MH services, and were thus less able to offer competitive remuneration to prospective staff or pay progression to support the retention of existing staff:

> *"There's psychologists, there's doctors out there, but they're getting captured elsewhere. And they're getting better money in the industrial area. We need to up the ante so we can compete…so it is by Pacific for Pacific." – DHB Pacific MHA Team Member 8*

> *"We can't compete. That's what's inequitable. We just don't have the capacity to say, 'Okay, I got a contract, I can use you in here,' we don't have that kind of capacity. It's people, their right to choose who they want to go, and you can't hold people, but…" - Samoa/NZM61-70*

Given Pacific men, and particularly Pacific women, experience significant pay inequity in Aotearoa (37), recognising and addressing this issue through policy will both help to address a significant human rights issue, whilst also helping to ensure BP4P services have the workforce they need to operate sustainably. In addition to ensuring services were contracted and funded to provide holistic care, and were thus able to remunerate staff for doing so (see Section 4.2.1.2.2), participants also dreamed of a policy that directed and supported services to consider their expectations around cultural labour, to incorporate this into job descriptions, and to remunerate accordingly (SamoaF41-50):

> *"We're not getting recognized for this extra work if we do the cultural assessment and other stuff….Even for interpreting, translating, [mainstream services] pull them off the floor...//And there's no policy for that. Pacific are being used without compensation, or without recognition [for work that's not in the] job description. Is it in the job description to provide translation?" – DHB Pacific MHA Team Members 2 and 5*

Finally (in terms of remuneration) they also suggested the dream policy would address the ways in which existing pay structures reinforce entrenched, problematic professional and epistemological

hierarchies (e.g., the authority of psychiatry being subtly reinforced by psychiatrists' comparatively high rate of pay) (Mila; Siataga and MāoriM41-50), with this being seen as a means of ensuring less biomedically-oriented perspectives and paradigms are – quite literally – more valued.

It was this need for an epistemological shift that dominated in the talanoa, and it was hoped the dream mainstream, MH policy would support changes to the education prospective and current MH staff receive. This, in turn, would help ensure that Pacific ethical frameworks, values, understandings, and approaches were appreciated and incorporated into the MH system and MH practice. Participants were clear there needed to be closer working relationships between the health and the education sector, with the dream policy directing collaboration between the Ministry of Health, the Ministry of Education (MOE) and the Tertiary Education Commission (TEC), and between the services overseen by these ministries:

> *"DHBs need to have closer working relationships with community and education, with schools so its across sectors as well. You're [also] going to have to look at a centralised way of coordinating all the different sectors to all be on the same page." – Sipaia Kupa*

Such intersectoral collaboration would, for PMHP and PMHSM, be focused on ensuring the wider availability and greater accessibility of MH training programmes, particularly advanced training programmes such as psychology (Cook Island/NZF31-40), and on developing and growing Pacific-specific (mental) health training programmes (such as the extant Bachelor in Pacific Nursing currently delivered by Whitireia and WelTec/Te Pukenga (335) and at MIT/Te Pukenga (336)). These programmes were valued for providing a culturally safe learning environment for aspiring Pacific healthcare workers, allowing them to undertake their training in a way that not only affirmed their identity but strengthened their cultural knowledge and competencies:

> *"There's a Pacific nurses programme which is great, having more Pacific principles embedded - especially for Pasifika people wanting to work with Pasifika - in their actual study as well." – Samoa/NZF31-40*
>
> *"It's awesome and I love it that the class, my peers, are also Pacific so we can share stories and hear each other's experiences and encourage and inspire each other." – TokelauF51-60*
>
> *"When I decided to become a nurse, it was like 'Okay, I'm going to go hit up mainstream and start my studies.' I didn't realize there were two other programs; a Māori and a Pacific program...I was like 'Oh my gosh. Let me try my chances there.' I got in and it was the best thing ever." – DHB Pacific MHA Team Member 6*

Most emphatically, however, it would also focus on changes to mainstream curricula, on both ensuring mainstream programmes are not culturally unsafe learning environments for Pacific students…

> *"I struggled a little bit at uni because I don't think that gave any room for culture, for your identity…I do feel like I had to decolonize myself after uni…" – Samoa/NZF41-50*
>
> *"Our people get quite damaged through that process...I see it with the academics as well; there's this internal wound from being so vulnerable and finding that so hard…[there's damage to] their humanity, which was compromised through that process of getting training."- Dr. Karlo Mila*

…and that students – regardless of ethnicity - emerge from their studies well informed about the impacts of colonialism and cultural bias, with meaningful knowledge of both Māori culture and Pacific cultures, the ability to operate in a culturally competent manner, and a strong awareness of the value of doing so (SamoaF41-50). It was noted that openness to this as a core component of health care training needed to be modelled by those *delivering* that training, to ensure students were receptive to and could see the value of engaging with understandings and approaches from outside the Western canon:

> *"When I have done guest lecturing I've been hit up by people - I don't know whether they're being well meaning or whether they're being critical because they're in a university environment - that have questioned the utility of what we do, questioned*

the value of it, questioned the relevance of it, and these are people who are going to be clinicians…and I just think, "Man, actually, if this is the way it is being still taught at universities…" - Cook Island/NZF31-40

Furthermore, it was noted cultural competency education in mainstream health programmes needed to begin early, be given sufficient time and resource to facilitate meaningful learning, be linked to the achievement of papers or standards, be reinforced throughout the duration of the qualification, and include the development of practical skills for working cross-culturally. It was hoped this would both make for a more satisfying and engaging learning experience for students as well as ensuring healthcare workers arrived in the workforce with both knowledge around and a positive attitude toward engaging with and connecting to diverse worldviews:

"Going on students we've had over the years, it [cultural competency education] needs to happen way before they get to us." – Sapina Petelo

"Can we not have [at least] a one-week workshop for Pacific?…we've had a lot of nursing students from mainstream [courses at two local providers]…A lot of them, probably 80%, have never heard of Pacific. They've heard of Samoa, but don't know shit, sorry." – Fereni Masoe-Afamasaga

"It can't be tokenistic, there can't just be one lecture on it. There needs to be like an assessment standard linked to the cultural competency." – Samoa/NZF31-40

"All of the clinical programs need to have a much stronger cultural component…we need to be doing it as a legitimate paper." - Cook Island/NZF31-40

"Inside curriculum or inside training for example we didn't have a paper on deconstructing and reconstructing into different paradigms…You need to look at how you can teach others to do [that]." – Sipaia Kupa

PMHSM and PMHP also saw real value in the dream mainstream, MH policy placing more emphasis on "on-the-job" learning. The cost of engaging in study in relation to the cost-of living was noted as an issue for many prospective Pacific MH workers (and prospective health workers in

general). A return to qualifications gained in and through paid MH work – a "learn-while-you-earn" or apprenticeship-style approach – was positively discussed:

> *"I think there's [need for] a lot more practical learning. [Paid] internships and the like. Rather than us fixing and supporting Pacific with course fees for example, at that kind of level…I think that would be great." – Dwaine Faletanoa'i*

> *"People need to have jobs [to pay their bills] and placements [to meet the requirements of their studies]. We have to work creatively and proactively with tertiary providers to review our agreements to meet the evolving tertiary provider climate as well as the health sector…There is an urgency to implement recruitment and retention strategies due to the increasing number of nurses relocating to across the ditch."– TokelauF51-60*

It was noted that such approaches not only support the growth of the workforce through reducing the impact on family income as a barrier to gaining qualifications, but they also help to ensure trainees are able to experience what their working life will be like (thus helping to reduce attrition related to conflict between the expectations and realities of working in MH) and to begin building relationships with both colleagues and TWO, nurturing connections and a sense of community that will support them as they transition into their career:

> *"In my early twenties, I applied for a support worker job at the local hospital. I didn't have any experience but had family who were nurses, and I was familiar with hospitals. After completing the psychiatric assistant training, I went on to do my enrolled nurse training in '86 and a decade later completed my BA Nursing… These are certainly things we can learn from in terms of workforce development and career pathways in healthcare…I learnt so much [in an enrolled nurse scope] and there's nothing more rewarding and real than hospital-based training that provides clinical supports, peers, and patients to learn from." – TokelauF51-60*

It was even suggested that a live-in approach be considered, as this would not only completely alleviate the costs of accommodation and food for those undertaking training, but would provide an immersive environment in which "formation" could occur, in which students could "live the content" of their qualification and process that, whilst also developing a strong sense of purpose and being inculcated into a culture of care, respect, and collaboration:

> *"You've got to go through formation. [Change] from within...You can't just pick up a textbook…. It's not just brain, it's deeper than that... [so] I'd have a formation school. Where they don't come to just listen to content and pass an exam, they live. That's what monasteries do. You live the content and process it."- Cabrini 'Ofa Makasiale*

Even where apprenticeship/"learn-while-you-earn" approaches weren't discussed, increased exposure to MH environments in and through one's training were seen as something that needed to be prioritised. Such exposure was seen as being particularly important for those undertaking general health qualifications such as nursing or medicine (rather than MH specific qualifications such as psychology, or MH support work) as it would help to destigmatise MH as a field, and thus encourage people to consider a MH specialisation more seriously:

> *"You've heard from our student nurse that she was fearful coming to this placement because there continues to be a stigma in the community about MH nursing, that it's a dangerous job… there's quite a few students that have come and have made decisions to pursue working in MH after coming through our service…that's a big deal when we have a student go, 'I'm going to go for MH in my nursing career.' That's one way we try to grow our workforces." – DHB Pacific MHA Team Member 5*

In-service education was another aspect of workforce development PMHP and PMHSM wanted to see prioritised within the dream policy. MH education for the primary care workforce was highlighted as a priority by a number of participants, particularly given the role GPs play as a first port-of-call, as prescribers, and as referrers:

> *"It's about asking the right questions so we're not just medicalizing issues and prescribing…it might be that part of their questions they ask on a regular basis is around [mental and social wellbeing]. They might come with some physical ailments. But the doctors [should] ask the questions anyway and if they explore a little bit more rather than looking at the time, they could unearth [what's going on]... So definitely the GPs might need to have a bit of training." – Manu Fotu*

> *"From a system point of view, the GPs aren't trained to be effective in their context, working across cultures…Primary health are responsible for most prescribing for things like mild/moderate depression…so they [also] blur the boundary between doing the work of psychiatry, though they're not trained." – Phil Siataga*

> *"We need to make sure we change the model in primary care so they can manage [TWO with low-moderate needs] because at the moment, most of the people coming from primary, they never met up our team because they weren't sick enough. We're turning away lots of people, and that's so frustrating when the GPs go, 'You need to get in touch with the doctors [at the DHB].' "- Samoa/NZM41-50C*

However, as with pre-service education, cultural competency was a core focus. While participants dreamed of a future workforce that would begin their careers with a high level of cultural competence, it was recognised that more needed to be done to support change amongst the current workforce. Participants shared about strong internal resistance to cultural competency training, reflecting how it's not seen as a priority in MH, but as a "nice to have" (DHB Pacific MHA Team; Samoa/NZF31-40; Samoa/NZM41-50A; Siataga and MāoriM41-50). In following, participants indicated the dream policy would place more emphasis on cultural competence as a *requirement* for practice and would direct resources toward the creation of a rubric (or similar) detailing the skills and knowledge practitioners are expected to demonstrate at various levels of cultural competence. Professional and pay progression would then be linked to development against this:

> *"I know that for Māori, they have Takarangi competencies, which is amazing. But I don't know if Pacific have similar." – TokelauF51-60*

> *"If you're practicing competently here in New Zealand…your cultural approach should demonstrate that…we're supposed to be paying these senior clinicians to operate in a culturally appropriate manner. But all they've done is the foundational stuff....nothing that clearly demonstrates the technique, the practice…If you put a policy in place [that ties it to pay and seniority] it helps shift that attitude because everybody wants to get paid.' - Asiata Malagaoma Lealofi Sio*

Increased funding for and emphasis on cultural supervision was seen as vital to effectively implementing this:

> *"There's nothing to support the ongoing learning and application and then monitoring…policy needs to ensure that these processes are seen as valid and there is a requirement for a cultural supervisor in these services…easily accessible and that can support the implementation and review of cultural knowledge and skills." – Samoa/NZF31-40*

It was acknowledged that addressing the cultural and general education needs of the current workforce is a complex issue. Participants knew the dream, mainstream, MH policy would also need to address the capacity and caseload issues currently faced across the sector to make space for both cultural competency training and for other forms of in-service education:

> *"Mainstream need to be equipped enough to be able to deal with the more immediate issues they are facing; culture [and other aspects of professional development] become kind of an add on when you have got someone wanting to kill themselves." – Samoa/NZF31-40*

While increasing Pacific enrolments into (mental) health qualifications and increasing the overall size of the MH workforce – Pacific and non-Pacific alike - were seen as important, participants did make a number of other suggestions regarding long-term strategies for addressing these capacity issues and ensuring staff had time to learn and grow within their roles. For example, it was felt the development of a dedicated recruitment strategy would support the sector to address capacity issues…

> *"Nurses and healthcare workers are burnt out and stressed. Managers must ensure staff are supported and encouraged to take regular leave to maintain good health and wellbeing. Colleagues, however, often don't take leave when they should, because they feel obligated to help out their peers and currently, we don't have the workforce to actually fill those gaps hence a recruitment strategy is desperately needed." – TokelauF51-60*

….as would ensuring services were funded with an adequate number of *permanent* FTE (that are, as noted earlier, both competitively remunerated and contracted to deliver holistic care):

> *"We have struggled in every aspect because we don't have the [human] resources. We don't have the full discipline of staff we need…We're not being encouraged to increase staff…We've been in existence now for 20 years and we're still the same staff. Four clinicians in the adult team and a 0.4 psychiatrist." – DHB Pacific MHA Team Member 1*

> *"It's a vicious cycle; people leave because they are so under pressure but then as they leave, the remaining people get [even more] under pressure and it gets out there 'don't go there because they've got not enough staff''." – Samoa/NZF31-40*

As reflected by the quotes above, funding enough FTE to effectively provide holistic care would not only reduce burnout and staff turnover, but would also ensure there were enough staff to "fill those gaps" when practitioners need to take time, regardless of whether that time is needed to look after their health or to participate in in further education. It was also suggested capacity issues could be alleviated and participation in professional development better supported by requiring services to offer greater flexibility, recognising that more people will be willing to participate in the MH workforce if the available roles can be tailored to meet the needs of their family or to fit around study:

> *"When you advertise work, all you need to mention is that, if you want to work for part time hours, you can negotiate with us. But most of the job advertisements doesn't even say that…most people aren't given options… [why can't you] say, 'Hey, would you like to maybe do thirty or twenty hours? Would that fit in with what else you want to do?'. Nobody offers those kinds of things." – FijiM51-60*

> *"Those different ways of working, if they can be flexible about it...if there are perks, then people will do things better." - Cook Island/NZF31-40*

Further to this, participants tabled that the dream mainstream, MH policy could require the allocation of FTE within each role to professional development as a means of making time for in-service learning (and for self-care, reflection, and other practices that nurture staff wellbeing):

> *"The time needs to be made for it…like put in you're looking at 0.05 FTE…even half a day a week on improving practice, on reflection, it's going to have payoffs. I think people should be encouraged to be doing learning…You can't expect people to grow if they don't…[and] one of the things that bosses will turn around and do is*

they'll say, 'Well you need to be doing a bit of self-care.' It's just a load of bollocks, unless you get the time and space to do that." - Cook Island/NZF31-40

Participants also spoke to community education, both as a means of reducing the load carried by the workforce, and as a means of engaging with the community-*as*-workforce. It was suggested the dream policy would – echoing the need for greater collaboration with MOE and TEC - require education for and about MH to be provided to young people, and, ideally, integrated into the primary and high school curriculum:

"Our education system teaches our young people about numeracy and literacy…they don't teach them how to manage relationships and how to manage and regulate their emotional responses to stress and all that kind of stuff. Policy needs to start young…give young people the tools they need to develop their ability to manage and to cope with the stresses of life. We can't just wait for when a crisis happens and then everything kicks into action… it needs to be a part of curriculum, it needs to be mandatory. It shouldn't be an add on to maths and science and French and all those subjects." – Sipaia Kupa

It was also hoped the dream policy would support both young people and the wider community to develop the skills needed to identify and respond to those in distress, providing a limited/safe amount of support themselves (SamoaF41-50) or assisting them to access services as and when this was needed:

[Thinking of gatekeeper training for suicide prevention etc.], we know kiwis won't be looking out for each other, but you can say, 'Look. Here's something to help you look after your mate.' And then, they're all onboard with that. Community up skilling is really important...They could be train up moms, dads, teachers, and stuff like that…"- Samoa/NZM41-50C

These forms of community education - where both self-management and the support of others are the focus - were expected to help strengthen individuals, families, and communities, supporting people to look after themselves and their circle of influence:

> *"If you have a personal rhythm, personal goals, [and are able to] examine how you are going and progressing in important areas in your life… [a sense of] personal responsibility to family, to wider family, church, community – we have to take care of each circle properly - fundamentally we take care of community things by taking care of our small circle of influence." – TongaM51-60A*

Through such education personal resilience would be built, relational harm minimised, access to natural supports increased and the risk of mental distress and disorder reduced, so not only are communities stronger, but services and the staff working within them are less overwhelmed. PMHP and PMHSM also highlighted the need for policy to support community education in the form of improving health literacy[9]:

> *"Health literacy makes a big difference, eh? If we get that out to our communities in some way that's digestible to them, that's relevant. That makes a big difference as well." - Samoa/NZM41-50C*

> *"I'm big on health literacy. My wife she's New Zealand born but …It's an assumption that those that are New Zealand born will know the language [of the health system]. It sounded simple to me a lot of the stuff they were saying to my wife, but when I spoke to her, she couldn't connect to that information, so health literacy is really important for me." - Asiata Malagaoma Lealofi Sio*

Digital and systemic literacy were also mentioned as key components of this (FijiM51-60; Samoa/NZM41-50A; Samoa/NZM41-50C; Sio), recognising that both being able to find and evaluate information online and understanding how the different parts of the health system work together and can be accessed and engaged with are crucial to achieving functional health literacy. Not only would this support individuals to make better decisions about their own health and the health of their families (thus reducing the workload of the (mental) health workforce), it would support practitioners to enact reciprocity and would empower communities to take collective action, identifying their own needs, generating relevant and well-informed solutions, and then using their knowledge of how to

[9] "Health literacy is the capacity to find, interpret and use information and health services to make effective decisions for health and wellbeing." (79)

seek support and funding to action these (further alleviating pressure on the (mental) health system). Participants also suggested developing and resourcing workshops for community organisations regarding how to prepare RFPs, committing a portion of every FTE to health promotion and community education (as noted in Section 4.2.1.2.2), and ensuring the availability of support and funding for community-led health interventions and those that deliver them:

> *"This includes supporting the community for all the additional mahi they do, a lot of it is voluntary…but most of the workers that work with their communities are working full time jobs on top of [that]…But when you think about small communities and the level of availability of human resources to carry out some of the deep dive work. It's not really a lot… this is the reality for a lot of Pacific people who work in full time jobs but still are trying to help their community by doing whatever they can in whatever time they can give" – Sipaia Kupa*

Participants also noted a range of service types that would facilitate the provision of community education and health literacy; however, these will be discussed in the next Section.

Participants reflected that efforts toward community education and improving health/system/digital literacy would not only help to ensure the (mental) health system is less overwhelmed but would significantly support recruitment into the MH workforce. It was hoped that - through developing a deeper understanding of MH and mental illness and through growing and practicing the skills needed to support their friends and family in mental distress - communities would develop more of an appreciation for the importance of MH as a field, would have an understanding of how rewarding providing MH care could be, and would feel more confident in their own abilities, more drawn to participate in the MH workforce:

> *"I see that within a family, and again it's looking at the possibility of getting workforce through that kind of system. Because the families can look after their loved ones. They find out they have skills, and they learn from that, they can move*

on to work as a peer support maybe…But I think there's a potential to get workforce that way." – Manu Fotu

While outside the scope of what can be shared from the talanoa, many of the participants' experiences of growing up with a family member who worked in MH or of supporting a family member in mental distress validated these hopes and the importance of family experiences as a motivation to pursue a career in MH. Participants noted the dream, mainstream MH policy would support this emerging appreciation for and attraction to MH as a career through the active promotion of inspiring stories, the dissemination of promotional media geared towards highlighting the positive experiences of and impacts of MH work on practitioners and TWO alike:

I think capturing those narratives from our clients and our staff….There's been the odd thing where we're promoting…But nothing that's gone far and wide, reached the multitudes at school, thinking of careers; 'What am I going to do with my life?' 'Oh wow, who's all these videos I keep seeing on the ads?'…If people had access to those stories, and could hear about the impact MH staff make…" – Dwaine Faletanoa'i

"If you highlight some of the positive parts to the work, they might see it as a pathway for them to be involved in…we talk to a lot of groups in the community, church groups, students, schools. And when you talk about your journey and the challenges you have, but be honest and upfront with what you do, they see a positive spin to it, that there will be challenges, but the ultimate goal is to find a way to benefit our community… I firmly believe in highlighting some positive stuff that we do." – Manu Fotu

This was seen as being particularly important in light of widespread public discourse that paints MH services and their staff as ineffective:

"[There are] people that are espousing this idea that MH services are terrible…but if we build up the brand of MH services, in the way that's actually true; I know MH services are getting better, they are providing quality care. Push that message out there…there are people put off by MH [as a career] because it's almost like we need a rebranding of MH" – Samoa/NZF31-40

The above discussion makes plain the importance of actions and strategies related to workforce development amongst the participants in this study. Although significantly focused on education, PHMP and PMHSM offered a range of actions and strategies that could support the growth and maintenance of the MH workforce, including improved and more equitable pay, increases to permanently funded FTE, the normalisation of flexible working arrangements, and the widespread promotion of the more positive and rewarding aspects of a career in MH. In terms of education, on-the-job training for prospective MH staff, psychoeducation and improved health/digital/system literacy for the community, and support for the primary health workforce were all discussed; however, participants strongly emphasised the need for action to be taken to ensure greater cultural competency across the board. They suggested a range of actions targeting both the prospective and current workforce and it was hoped these would help, at a fundamental level, to nurture more positive attitudes toward, a deeper understanding of, and increased use of the frameworks, values, understandings, and approaches indigenous to the south Pacific. It is expected the wide-ranging actions and strategies discussed in this chapter would all help not only to support the development of a large, committed, purposeful, well-informed, valued, resilient, and well-supported workforce, but of one that is capable of effectively providing holistic and person-centred care, embracing diverse worldviews and modalities, and of empowering families to care for themselves and each other.

4.2.1.2.4 Service Delivery Models

The last key area of policy action to be discussed relates to the specific SDMs and approaches to providing care participants wished to see prioritised, supported, and encouraged by the dream, mainstream MH policy. For them, said policy would recognise the importance of more balanced SDMs, such as the 5C approach described in Section 4.1.5.2. The policy would support the growth of organisations that are already effectively incorporating cultural, consumer, and community voices into

their design, delivery, governance, and implementation; fund the development of new services that have demonstrated how they will incorporate these voices; and provide support and funding to assist organisations that are still restricting themselves to a more corporate-clinical model to help them expand their lens:

> *"We talk about the 5 Cs…C for consumer. [C for] Community…we all have elements of the community…[but] actually getting people from outside who aren't tainted by the dynamics and politics…they bring a fresh voice. And then you've got the other C is your Cultural. And C, Clinical. And then C, Corporate. And there's heaps of Cs. It's not an exhaustive list. I mean it was a health governance model where it was essentially two Cs. It was clinical and corporate…But then we added the third C, if you were Pacific, Cultural. And then you realize actually there's other Cs…" – Samoa/NZM41-50A*
>
> *"I think that model, again, around culture, community, clinical. You have to have that sort of model…you can't just have one of those tripods stronger than the other." - Samoa/NZM41-50C*

This would be coupled with an emphasis on services that not only incorporate community voices, but are based in and present to the community, focused on the provision of holistic health care, and are welcoming to/supportive of families. Participants dreamed of a mainstream MH policy where assertive and proactive community outreach, extended opening hours, home visits, and pick up services were standard practices, where services reflected the needs of and actively sought to connect with the community of which they are a part:

> *"A lot of community MH nurses have a lot more scope to go out and to be at people's homes, which I think is a really good thing to be doing, because we want to be encouraging that policy-wise." - Cook Island/NZF31-40*
>
> *"Go back to home visits and visiting people in your community." – Phil Siataga*
>
> *"Have you ever seen any service that actually opened late from the afternoon to early evening or late evening, and then caters, to people who are maybe cleaners, or have three or four jobs?" – FijiM51-60*
>
> *"Additional funding for Pasifika services based on an assertive outreach model" – Samoa/NZF31-40*

> *"We actually survey each household, so we get a sense of what they need ... in time we'd know every household, what they need, and a way to respond, and hopefully replicate that in the other areas... And the stuff we're doing here, means we're connecting neighbours, and then supporting their strengths." – Samoa/NZM41-50A*

> *"Have someone their dedicated job is to pick people up and bring them in or whatever, because we can see these are genuine barriers and they're really well established."- Dr. Karlo Mila*

This would allow for the provision of preventative care, for people to be supported to thrive in their current environments, for the increased comfort of TWO, and would address a range of barriers to the accessibility of services, including transport costs and difficulties with arranging childcare.

> *"Coming up to the hospital or office might've worked for us, but for them it just created huge hassles and they just weren't comfortable there…Our job is to come into their world and then help people through their worlds…People work within whatever environment they're in, and it's our job to go into that environment and help them change things about that, to change outcomes and flow from there..." - Cook Island/NZF31-40*

It would also better manifest the model described by Fotu wherein services move to meet and serve the community rather than asking the community to bend to them:

> *"When you put the benefit for your community in the middle, then you're willing to look at "how can we achieve that, move around that?", isn't it? Whereas if you put your organizations in the middle, you can say, "Well, I'm flexible, but as long as people bend to me."" – Manu Fotu*

The dream policy would also actively fund, support, and mentor the establishment of community-led-and-owned services. These would be services where community voices are not only incorporated, where community members are not only feeding into the design and delivery of MH care services - though co-design was definitely considered to be a step in the right direction - but rather where they are empowered to take ownership and to make decisions about said services, about the needs present in their communities and how these might best be met:

> *"Community being empowered to manage themselves you know; they know the issues better than we do, and they will you know what their need is. At the community level there's opportunity to enable them to decide and determine what and how their needs would be best met." – Sipaia Kupa*

> *"My aspiration, I was always wanting [the service we set up] to turn into an institution that could mobilize the Tongan community, so the Tongan community could be equal partners in the care of themselves… I wanted the doctors to be a resource the community use… wanted it to be a genuine partnership between the community, creating a society. I wanted it to be owned by the community and I wanted the community to tell us as professionals what was important to them and for us to use our qualifications to set up structures that could get funding to do things like this." – TongaM51-60A*

It was anticipated that supporting the development of such community-led-and-owned organisations would help to ensure their relevance, their cultural safety, and the creation of space for Pacific-led innovation, as well as contributing to a stronger, more capable, more autonomous, and more prosperous community, one that was better off as a result of state intervention rather than increasingly dependent on the state:

> *"If you do things for people, they don't get an opportunity to gain the knowledge and wisdom and expertise they need to govern themselves. I really believe in what Tariana Turia was saying; we've got all these agencies involved with people, and when the agencies pull out, are people any better off? Have we done something that's growing them to be able to be autonomous and independent and to have the knowledge and skills, [are they] learning to run effective lives? [Are they] more effective at managing the things that are important in their own lives." – TongaM51-60A*

The dream, mainstream public MH policy would also place significantly more emphasis on supporting the establishment and growth of services capable of providing holistic care, of addressing whole people, in context and meeting their presenting needs, no matter what these are:

> *"There shouldn't be restrictions…you should be able to turn up at the MH thing, and you say you need [access to other supports], it should be all right*

there...Because it stops a lot of people, if someone says, 'Oh, no, we are not funded to do that.'" – FijiM51-60

"[Poor] MH manifests itself because of the worries and stress of other things that go on; housing, financial situations…family violence, the distress that causes and all that. It's about the navigation around social issues and really addressing it…then it's coming back to a holistic approach…making sure we explore all the elements that could contribute to [poor MH]." – Manu Fotu

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While Whānau Ora has already been recognised and noted as a promising SDM, Youth One Stop Shops[10], "hubs" and other similar co-location models were also discussed (FijiM51-60; Fuemana; Fotu; Siataga and MāoriM41-50; TokelauF51-60). Participants linked these to a "village" approach and hoped any dream policy would naturally support the development of more services like these. Current manifestations of such models focus on mental, physical, and socioeconomic health of young people, with doctors, nurses, psychologists, counsellors, social workers and youth workers on staff (338). Participants suggested, however, that the dream policy would not only fund adult/family versions of One Stop Shops/Hubs, but would also expand their scope further, encouraging and resourcing the incorporation of traditional remedies, pastoral care and spiritual wellbeing, budgeting services, both education support and public health promotion/education, and even aspects of care such as growing and preparing food at home/in community gardens (Fuemana; Makasiale; Samoa/NZM41-50A; Sio; TongaM51-60A):

"If we got that hub, we got our [doctors, nurses, social workers, and we've also]… got people that can meet all the different needs…spiritual healing, could be part of it. It could include traditional medicines and practices. If you've got all the access to that, then you can just support and navigate them to those other services…you

[10] "Youth One Stop Shops provide primary healthcare (including drop-in services) plus a range of other services…actively model youth development principles, are open at least 20 hours per week and take a holistic approach…The aim of these services is to provide range of accessible, youth-friendly health and social services at little or no cost to rangatahi aged about 12–24 years." (338)

can take them to sit and to meet with people, and they can decide if they engage..." - MāoriM41-50

"Services need to be closer to home, and not feel like a clinical environment but more like a community hub that provides free access to all government funded health and social sectors." – TokelauF51-60

In addition to being able to engage with people holistically, meet a wider variety of their needs and address the underlying stressors contributing to poor MH, such services were valued for their ability to nurture relationships and collaboration amongst representatives of different services and/or disciplines. The PMHSM and PMHP who discussed this SDM saw it facilitating both face-to-face relationships building amongst practitioners and the more effective sharing of information, expertise, and resources (echoing the reflections regarding "umbrella organisations" in Section 4.2.1.2.2). They also - as indicated by the quote below – appreciated the "warm handover" such a model enables, recognising this contributes to experiences of consistent care and of safety for TWO.

"And that's has been demonstrated to work well; the warm handover and then away, address the needs." – Manu Fotu

"I really like hubs and village thinking...We're moving in that space here with the agencies that are being put together; if you spend enough time with people in the same space, you get to know them. And through that you're able to do things organically…we've all got similar ethical codes and our client management systems ensure we aren't breaching [confidentiality]..." – Phil Siataga

The importance of effective client and information management systems – capable of balancing confidentiality/privacy against the need to minimise stress and repetition for TWO – was emphasised by others:

"If you look at a person's healthcare journey…how many times would they have to tell their story over and over again to various clinicians? I hear often from service users they're tired of retelling their story…and why couldn't we just read their notes on file. There is a need for a more integrated digital electronic system…to enable a consistent, accurate and intelligent means of sharing people's health information

> *across health sectors to address the concerns of service users. This should be a priority for our government for IT funding." - TokelauF51-60*

Participants expressed that the dream policy would thus also support the establishment of co-located and collaborative approaches (as well as the delivery of wider health and social services) by developing integrated, flexible, cross-sector patient/client and information management systems.

Another key feature of the talanoa was the desire to see more services designed to actively include and work with families. Echoing what was shared in Section 4.1.3.2, participants reflected on the absolute importance of including families in the care of TWO and of this importance being upheld by policy. It was noted that while the *Mental Health (Compulsory Assessment and Treatment) Act 1992* (311) does require families to be involved in the care of TWO, this requirement is both inconsistently met and – significantly - *only* applies to those who have been compulsorily detained for assessment (and *not* to those receiving non-compulsory MH care) (SamoaF41-50; Samoa/NZF41-50).

> *"We've even got that in the Mental Health Act when we're sectioning someone, consulting with their families, their whānau, [but] that very rarely happens in practice…we still are in an age where we've got that mentality of individual rights. I think while that is important, that needs to be balanced with 'actually these people belong in a family, to society'…it is very rare to meet someone who categorically does not want anyone involved in their care." – Samoa/NZF41-50*

There was a desire for the dream, mainstream MH policy to require changes to the legislation underpinning the delivery of MH services so family engagement is a required component of *all* MH care (and not just compulsory assessment). It was also noted that - while policy and legislation changes would help - philosophical beliefs, entrenched practices, and lack of knowledge were all barriers to the implementation of more family-oriented SDMs (Cook Island/NZF31-40; Fuemana; SamoaF41-50; Samoa/NZF41-50). In following, there was a need for the dream policy to direct resources toward growing services that are routinely, respectfully, and effectively engaging with families, toward

documenting what they do and how they do it, and toward using this evidence to develop guidance and training for the wider sector (SamoaF41-50; Samoa/NZF41-50). PMHSM and PMHP also shared that - beyond requiring and supporting family involvement in MH care - the dream mainstream MH policy would also encourage and resource the growth and promulgation of SDMs more focused on support and navigation, on providing care in a way that empowers family decision making and leadership:

> *There's still a power in the clinical teams to dictate the destinations, rather than having the family and the clients is in control…[we need] policies to enable families to be in more in control of their destinations because if they feel like they're in control, they can contribute to the journey better." – Manu Fotu*

A couple of participants wove together this desire to include and empower family, the idea of a holistic "hub", and the importance of services that are present in and to the community, by tabling the idea of "fale"-style MH services; caring, open, collaborative spaces where TWO could seek help with a wide variety of needs and where their families could not just accompany them to appointments or visit with them, but could stay with them and actively participate in their care:

> *"Funding and space to allow family to stay with TWO when they're in care. Like a Ronald MacDonald House, but for MH…that would incorporate family involvement, relationship building, some ideas around forgiveness, and less control of the symptoms…I think that may benefit the whole of New Zealand."– TongaM41-50B*

> *"[In 10 years, once the dream, mainstream MH policy has been published] we would've developed our own fale, where somebody could go and get some help…a place that has all the services in one area, in one building…it would accommodate families to stay there and be a part of the journey…They would have access to the professional people, but also the professional people could help the families to manage their loved ones…the idea would be the person goes in, family are able to live with that person and look at how they're helping and then on the other side, being empowered to go out, live back in community with their loved one…By the time they came out [they could be] certified as support workers. They'll be able to have money, get financial support to support their loved one, but also be able to tap back into that fale of expertise [as needed]. By empowering the families, we*

> *will take that stress off the whole MH machine…It's like a one stop shop but it's a long-term thing, where-it's more about giving that power to the families to manage it, so our communities get bigger and stronger so they can manage their own people, but also manage what's happening in the community as well." – Tony Fuemana*

The benefits of such a model are *many*. The quote above highlights how this model would support improved communication and the development of strong, supportive, long-term relationships between practitioners, TWO and their families. It also highlights how it would facilitate community education, supporting services to deliver health/digital/system literacy education and upskill families in intervention and support. In following, such a model would help to alleviate pressure on the MH system by empowering families with the skills and knowledge needed to care for their loved ones at home, as well as supporting the growth of the workforce through nurturing interest in and entry level skills for a career in MH, reflecting what was discussed in Section 4.2.1.2.3. Furthermore, this "fale" model would help to ensure TWO experienced reduced fear, anxiety, and stress, through both access to/connection with family and through reinforcement of their family's care and support. It would also help ensure MH practitioners were better placed to identify any challenges faced by the families of TWO, empowering them to provide the necessary support and facilitate healthier home environments and stronger family relationships.

The dream policy would not only focus on engaging with and supporting the families of TWO when they are in distress but would extend to engaging with and supporting families *before* mental distress becomes an issue. In addition to actions related directly to MH - such as resourcing and coordinating psychoeducation through school and community settings - participants stated the dream policy would also emphasise actions and strategies focused on strengthening families in a more general manner. For example, participants wanted to see policies that support families during the first thousand days of a child's life and that nurture parental MH. For them, the dream, mainstream MH policy would work across sectors to fund and coordinate services focused on providing practical

and financial support to new families, addressing income and housing, offering psychoeducation, and work with new parents to develop their parenting and relationship management skills:

> *"Child poverty…focus on mums and dads. Even basic stuff like first time mums learning how to breastfeed… there's so much stress….and there's so much anxiety, pain, and guilt around that…and that has flow on effects on the mum's wellbeing, and then the child as well…how can you strengthen that?…Let's make sure we have some really good support packages around them." - Samoa/NZM41-50C*

> *"I would go back to the beginning of life. If you think about policy settings, where would you put your efforts?...the real opportunity when people are most open to change, most open to help; there's the arrival of a new child…that's a very intimate time in a family's life, you could have systems that could interface with that in quite a trusted way." – TongaM51-60A*

Such services were seen as vital to preventing poor MH, minimising mental distress amongst the current generation as they navigate the myriad challenges of parenting, as well as helping to minimise mental distress amongst the next generation, helping to ensure children grow up in healthy home environments, supported by resilient parents who not only love them but have the skills and knowledge needed to support their emotional development and resilience in turn. In addition to supporting families throughout those first thousand days, PMHSM and PMHP also expressed a desire for the dream policy to support and encourage services that incorporate strengthening families' connections to each other and to their culture, environment, and community into their delivery model:

> *"If we look at issues around displacement and the disconnect of cultural value systems for our younger people, then you have to look at policies that will try and either restore a lot of that or policies that will help to rebuild some of that connectedness for our younger population group." – Sipaia Kupa*

> *"When we grew up in Tonga, our grandmothers play a lot of roles, our aunties play a lot of roles. When we moved here to this society, we neglected them, and I think... some of our young people are lost because the teaching and the network is disconnected from those wise people." – TongaM41-50B*

> *"Going back to family time, with creativity, or nature walks…during COVID we were rich with time, and we were able to do stuff. We miss it…COVID, forcing us to realize the simple things in life are actually the things we need to [focus on]...You can cover all those six issues around improving the problem [policy, practice, SDMs, workforce, power, mental models], but it is those things that are [most important]... family, the land, the connection to the water…" – Samoa/NZM41-50A*

The protective role of such connections were well recognised and incorporating the strengthening of these was seen as a vital preventative measure, helping to reduce potential causes of distress (such as family conflict, disconnection, confusion, and loss) whilst also building resiliency and increasing natural supports.

Strengthening families – both generally and in terms of their understanding of and ability to support TWO - was also seen as vital to creating the conditions for several other SDMs suggested for inclusion in the dream policy. For example, it was suggested services be developed that facilitate a supportive, mentor-style relationship between "pro-social" adults and young people who were struggling with their MH, identity, and/or general wellbeing:

> *"Government could do things in a way…moving away from paid employment of external people to go into a family, [instead] using the family mechanisms, finding a prosocial adult, supporting them financially to assist an at-risk young person for the rest of their lives…" – TongaM51-60A*

This type of approach, where individuals who are thriving are supported to connect with, care for, and encourage individuals who are struggling was also extending out to the family and community level, through a SDM where the organisation facilitates connections between families who are experienced in effectively managing mental illness at home with families who are needing some support to do so:

> *"We could go to other families who are [caring effectively for TWO] and say, look we've got a family out in West Auckland that's facing the same as you guys but they're just really struggling. Let's go and have a meal and let's have a talk about ways we can help each other. And so, you strengthen the community network…We*

> *[the MH service] are not going to get involved, but let's facilitate them meeting together. Let's get food and let's get these families in, and let's get them talking about what's working…MH's job would be to facilitate those meetings, provide food, and then if they still struggle then you go in with a bit more help. But you still do that in a whānau situation where you bring those families in. So this family doesn't feel like, 'oh we're doing this really badly'." – Tony Fuemana*

There was scope for this SDM to be provided pro-actively, in a more preventative way, with services providing training and coordinating intentional networks of holistic care and support within neighbourhoods:

> *"I would train leaders…put them into small groups…keep it like a village scene…send them out to each family//So, you want people connecting with families before they presented with any kind of mental illness?//Absolutely. You don't wait until we have a drought to have a farm… [each leader can be responsible for] well-being groups in their streets, cook, have prayer, have singing, have meetings, have the concepts, share…or whoever's garden needs gardening, and keep it like that. Then everyone twice a year, we're going to bring the whole lot in together, and have seminars, and share the big learning, and back we go back to our little streets." - Cabrini 'Ofa Makasiale*

It was also suggested that families who are experienced in providing care for TWO could be funded and supported to work together to provide a network of care and respite, giving each other a break from providing care by offering family-like spaces to TWO from other families:

> *"Having alternative places to the inpatient unit, outside in the community, run by families…If the family's feeling that their loved ones just need a little bit of respite away from the family - because in reality there will be issues that come up - they can go to a place where runs by a similar [family], a similar kind of environment…not a foreign hospital setting." – Manu Fotu*

As with the "fale" model described earlier, these SDMs would all act to alleviate stress on the MH system, both by upskilling the community (and growing the community MH workforce) and by reducing the need for TWO to engage directly with services/ensuring TWO are able to receive quality care in the community. More than this, however, they strengthen community networks and natural supports, act preventatively by providing practical support with stressors, nurture positive

relationships, and – crucially - help to increase exposure and understanding, thus reducing stigma, and helping to ensure TWO are able to participate in and enjoy community:

> *Because the family, when they're really involved, the elders, the neighbours, the church…they do community. They don't leave them at home, and I think that will go some way of addressing the stigma that comes with MH…They're not useless, they're not hopeless." – Manu Fotu*

This section has presented a range of both tested and innovative SDMs whose inclusion in mainstream MH policy would serve to both acknowledge and affirm Pacific strength and success as well as creating opportunities for said strength and success to grow. Participants shared visions of a dream mainstream MH policy that prioritised a more balanced and holistic approach wherein both a range of voices and range of wellbeing domains were incorporated into business as usual. They dreamt of services which pro-actively connected with and participated in the lives of the communities around them, of services that built strong, positive relationships with families, had in-depth awareness of their needs and the capacity to meet these, and were able to host, nurture, support, and inform families as they walked alongside TWO in their home lives. The PMHSM and PMHP who contributed also reflected on the importance of SDMs that engage with and nurture families that are *not* experiencing mental distress, recognising the protective and preventative impact of such models, as well as the potential they offer in terms of both increasing the workforce and reducing strain on MH services longer term. The encouragement and resourcing of such SDMs through relevant policy actions and strategies was expected to help create a MH system that meets people where they are; focusses on holistic wellbeing; helps to addresses socioeconomic determinants of health and the root causes of distress, disorder, and anguish; and – crucially - that empowers families and communities to care for each other.

4.2.2 By Pacific for Aotearoa New Zealand

As noted in Section 2.4, Pacific MH needs and aspirations have been given little consideration in mainstream, public MH policy. Pacific understandings of and approaches to MH have been given even less, with their potential to support not only the wellbeing Pacific communities but of New Zealand as whole only recently having been acknowledged. Every effort has been made throughout this thesis to highlight how Pacific strength and success in MH – and the epistemological frameworks, values, understandings, and approaches underpinning this – serves to generally benefit TWO, families and communities, regardless of ethnicity. These efforts have relied on demonstrating alignment with the aspirations expressed through *HAO* (62), *the New Visions: Collective Solutions* (72) and the *HAO Wellbeing Outcomes Framework* (80), however, in the interests of ensuring the second half of the "Dream" question[11] has been clearly answered, this section will both explore participant reflections on the generalisability of Pacific approaches to MH care/their efficacy for non-Pacific people, as well as participant reflections on the positive impacts and changes that might be seen in Aotearoa if the strength and success of PMHP and PMHSM were valued, acknowledged, affirmed, and grown through a dream public, mainstream MH policy.

4.2.2.1 Do Pacific Approaches Work for Non-Pacific?

When asked if Pacific approaches to MH care work for non-Pacific TWO – particularly those approaches put forward for inclusion in mainstream, public MH policy - PMHP and PMHSM replied with a resounding "Yes!". It was recognised that these approaches to MH care - grounded in the ethical frameworks, values, understandings indigenous to the Pacific - were innately flexible/tailored and

[11] "What potential does such policy show to support the mental health of all New Zealand communities? What results might such policy achieve and what differences might we see?"

innately humanising, based on attention and responsiveness to the specific context and experiences of TWO and on 'ofa-alofa-and-respect-filled, reciprocal, and deferential relationships between practitioners and TWO. Further to this, it was understood that Pacific approaches to MH care were genuinely and broadly holistic, and thus often capable of meeting needs – particularly cultural and spiritual – that are overlooked or excluded by approaches grounded in Western science and bio-medicine, making them valuable to non-Pacific TWO in their ability to provide otherwise unavailable care and support related to these aspects of human experience.

As reflected in the demographic information provided in Section 3.3.2, many of those who participated in this research were currently working in or had worked primarily in mainstream services - rather than BP4P – and had significant experience in working with non-Pacific TWO. These PMHP were asked if they applied the same approaches when working with non-Pacific TWO as they used when working with Pacific TWO:

"The only time I've ever worked for an ethnic specific organization was for [a DHB based Pacific MH service]… And I work with everybody in the same way. From my English mama I work with at the moment, to Cook Island families." - Cook Island/NZF31-40

"I feel [and work] like that [in a relationally oriented, loving, and family-focused way] even with my Palagi clients …I think that is because… it comes back to who you are, your personality. Like, I can't go into a situation and go, 'Okay, I'm going to be a mainstream person in this role and I'm going to be a cultural person in this role.'." – Samoa/NZF41-50

"You talked a lot about walking in both worlds and integrating Tongan approaches and Western approaches; have you done that much while working with non-Pacific?//My role at the crisis team, liaison psychiatry, and early intervention is not a Pacific role…those things I've used work quite well with other people…those can be universal eh, those philosophies can run through. – TongaM41-50B

"[For example] with telephone triages, clinicians are trained to assess people from a holistic approach, therefore acknowledging people of different cultures is important – Culture does not only apply to one's ethnicity, but it also includes young people and older adults, gender, identity, people with disabilities etc.

Ultimately, it's about respecting differences, engaging in their narrative, not make assumptions, and asking the question if unsure."– TokelauF51-60

These participants were clear they worked in the same way with Pacific and non-Pacific TWO, and furthermore that their way of working was effective. One of the most significant reasons for this efficacy is - as implied by the last of the quotes above – the fact that flexibility and adaptability are absolutely central to said way of working. In Section 4.1.2.1, flexibility and adaptability were discussed as key features of Pacific approaches to MH care…

"If you're a young person, we adjust a model of care for you to fit your world. If you're a traditional person who grew up in Tonga and came here, you would still have those traditional ideas and stuff, but we can adjust the model for that. Pacific organizations can adjust to whoever you are. And I think one of the problems for mainstream is they apply the same blanket approach to everybody." – TongaM41-50A

…and it was noted in various places throughout Section 4.2.1.2 that contracts needed to be tailored to facilitate flexible, responsive delivery aligned with the unique needs of each TWO and their family. The importance of this flexibility was strongly reiterated in the context of applying Pacific approaches with non-Pacific TWO and their families, with participants restating their willingness to adapt and to tailor their approaches, and framing this as an expression of teu ma tausi Vā, of demonstrating fa'aaloalo, of respecting TWO and their worldviews, and of deferring to them and their needs within the (therapeutic) relationship:

"We did a lot of schools and alternative ed where there's not strictly Pacific youth there.//Did you work in the same way with them?//Absolutely.//Was it as effective?//All in all, I think there's a lot of elements they enjoyed. They enjoyed the humour and the creativity; we had drama going and sports. But then, there are other things, such as specific language we might have used…That's where the strength of adaptability [comes in], isn't it? We develop and adapt our programs to make sure they hit the mark with non-Pacific youth as well…Not forcing any one particular view over the other. Respecting both. Like we did in all Pacific teams." – Dwaine Faletanoa'i

"One of the great things about Mana Moana is you can tailor it... Because you're tailoring it to somebody's worldview anyway...you're fitting it to their perspective, and their understanding…and so therefore, if that person comes from the Highlands of Scotland, then you can tailor it to what they understand, their lochs and their knolls, right? You just use whatever is rich in their knowledge…You just tailor it to whatever because you're working from the premise of their world view." - Cook Island/NZF31-40

"These approaches you've talked about…do you use these when you're working with non-Pacific consumers? And are they effective?//Yes because I always make sure the tool can be used by the person within their own context…I always ask the person, can they use this tool, 'can you show me how it's done in your culture?' and I will assist...I will go alongside you." - Cabrini 'Ofa Makasiale

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It naturally follows that Pacific approaches to MH care will be effective for non-Pacific TWO and their families, as these relationally focused, Vā-led approaches to MH care *begin* with honouring TWO, their understandings, and their contexts, and then tailoring care to suit. Pacific approaches can thus be understood as being more widely applicable than those which are grounded in or have emerged through Western science and bio-medicine, not because they have established any kind of singular, over-arching approach that is valid regardless of time, place, or person, but rather, because they embrace the need to *always engage with the particular*.

Participants also highlighted that the empathy, compassion, 'ofa/alofa, and reciprocity innate to Pacific approaches to MH care and to attitudes, types of training, and SDMs advocated for in Sections 4.2.1.1, 4.2.1.2.3 and 4.2.1.2.4 play a vital role in ensuring said approaches are effective for both Pacific and non-Pacific TWO:

"What I do bring into my individual practice [with my current practice base of primarily non-Pacific TWO] that I like to think is from my Pasifika side and my psychologist side is I'm a very empathic, compassionate person…I never just want to assess someone…and I spend a lot of the time in the beginning of sessions trying to get people to feel comfortable…"– Samoa/NZF31-40

"My last clinical team being in mainstream, with anyone…it's the same process…just going through that process of 'Am I treating them respect?', and the

> *values, that kind of thing, 'Am I demonstrating alofa?', 'Am I showing I'm really caring and calming?' I'm really... It's helped us [be effective in all situations]." - Asiata Malagaoma Lealofi Sio*

> *"I find that the whole 'listen to my heart beat' approach…just works right across the spectrum. I found that when I was working [with an NGO focused on] dealing with families that experienced suicide where I didn't come across many Pacific islanders. That approach always worked. Just listen to them and to try and understand them and understand what they were going through, have some empathy with them, that connection, it helps. It works, yeah." – Tony Fuemana*

Similar to *beginning* with TWO, this type of care – wherein the focus is less on observation, assessment, and judgement and more on presence and co-feeling - was seen to support the generalisability of Pacific approaches, as it facilitates a deep engagement with and appreciation for the particulars of each TWO and their experiences (and, through this, the ability to tailor a uniquely, appropriate response). Further to this, however, it was also seen to nurture a therapeutic relationship based on genuine care, understanding, and human-to-human connection, a desirable experience regardless of ethnic or cultural background. SamoaNZF31-40 also went on to highlight how reciprocal sharing amplifies this humanising, equalising effect:

> *"…[Getting people to feel comfortable is] about sharing a bit about yourself. With strict psychological approaches you should be a blank canvas, but I think a Pasifika thing I have kind of brought over is I will share about myself to create that more reciprocal relationship and I find that when people see me not just a clinician but as a person wanting to really support them, they're more likely to feel comfortable and open up, and that is from my Pasifika culture." – Samoa/NZF31-40*

This reflects the recognition amongst participants that - no matter who one is, or where one comes from - having someone there for you as a fellow human being who is willing to give of themselves and who really wants to support you is beneficial at a transcultural level.

In addition to these innate features and their role in supporting Pacific approaches to MH to be effective for and amongst non-Pacific TWO, participants also recognised that said approaches are

often particularly valuable in their ability to address aspects of human experience TWO are unable to find support with in mainstream MH environments. The holistic approaches advocated for throughout Section 4.2.1.2 include, as a matter of course, engagement with the cultural and the spiritual. In terms of the spiritual, experiences related to the afterlife, ancestors, and/or engagement with the spirit world were discussed. Such experiences are usually excluded from approaches to MH care that is grounded in Western science and bio-medicine. These experiences are conceived of in terms of "culturally bound disorders" relevant only to specific non-Western populations, dismissed explicitly as superstition, and/or pathologized as schizophrenia or another psychotic disorder (and subsequently heavily medicated). While the diagnoses mentioned do have a place and can provide pathways to vital support, it has also been noted that the limited understanding of such experiences and the failure to engage with them appropriately has been harmful to Pacific TWO (see Section 4.1.2.1):

> *"There's a [matua I know], and he's talking to me about his daughter… she heard voices. She had been diagnosed with schizophrenia, and her father could identify all the voices. They were all people that had passed within her family and yet, she still just got all the drugs and no real cultural treatment…I interviewed Pacific consumers who were completely traumatized by their experiences. Knew it was something else…For most of them their dignity had been completely squashed. They hoped there was another way of understanding their experiences that gave them some dignity, but it was beyond their reach." – Dr. Karlo Mila*

This exclusion has however, also been harmful to non-Pacific TWO. Recognising this harm, participants spoke of a need for greater openness to and inclusion of knowledge and practices related to navigating the spirit world in mainstream MH care:

> *"At one school there was a South African boy who had come over and was boarding, come and saw me, and I was really grateful he could talk about it, and he said there's a ghost, a spirit that comes in his room, and he described it, and there was a teacher who had died in that area… I brought a healer, and she came in and did a few things and he never had a problem with it ever again, he was one of the top students in the school, in the first fifteen.// Having those experiences, if you put them into a straight MH, psychiatric or situation where you're diagnosed,*

what do they diagnose them with?//But he came from a family of gypsies. His mother was a seer." – Phil Siataga and MāoriM41-50

Integrating such knowledge not only helps to minimise misdiagnosis and overmedication, but it also helps people from all backgrounds to navigate and address spiritual experiences in a way that is meaningful to them, that aligns with and makes sense within *their* worldview. By virtue of their holistic approach and ensuing acceptance of spirituality as important; of their recognition of the sacred connections between all life; and of their tendency to operate in a more collaborative way (whereby practitioners from other disciplines/fields are more readily sought out and engaged), PMHP and Pacific approaches to MH care are better positioned than Western approaches to engage with such experiences and to support TWO to make sense of these regardless of their cultural background and to interpret and address them through a variety of lenses (including - *where appropriate* but *not limited to* - psychiatry). It should also be noted that consideration of spiritual safety (e.g., through processes of whakatapu and whakanoa), of the spiritual participation and practices of TWO, and of their sense of purpose and place at a cosmological level were all also seen as potentially relevant to non-Pacific TWO. It was of course recognised these considerations, and the consideration of visitation-like experiences, should – in accordance with the Ethics of the Vā - be addressed carefully and in a way that respects and reflects the understanding of TWO and their families, and never compulsorily or dogmatically imposed (Cook Island/NZF31-40; DHB Pacific MHA Team; Faletanoa'i; Makasiale; Mila; Siataga and MāoriM41-50; TongaM51-60A).

Participants also highlighted that cultural identity and connectedness is an aspect of holistic wellbeing missing from Western science/bio-medicine-based approaches to MH care, but that is strongly present in Pacific approaches, and that non-Pacific TWO may benefit from:

"When I've presented my wellbeing model, a lot of Europeans have cried and will come and see me and say they see themselves in the model…[for]Pākehā there's

> *lots of stuff they used to do in the old days that is very similar to what we [Māori and Pacific peoples] are doing today." – MāoriM41-50*

The PMHP who participated in this research recognised that many non-Pacific people – with this being discussed particularly regarding Pākehā - keenly feel the loss of connection to their cultures, ancestors, and lands, but lacked the language or frameworks to express and reflect on this. Holistic and culturally inclusive Pacific approaches to MH care show the potential to work for non-Pacific TWO by not only acknowledging diverse worldviews and the importance of these to wellbeing, but by nurturing knowledge of and supporting stronger connections to culture:

> *"I remember running a group for guys in prison…and we were using Mana Moana…within this group…three of them were Pakeha boys, a couple of them had - not white supremacist - but similar perspectives. In the first session there was real reticence from them…but by the second, third session, not a problem, despite these guys being racist…the first session they were quite openly like 'Why do I need to? Why are we talking about this? What has this got to do with us?' But then, by second, third one, they'd bought into the whole lot [and it was really helpful for them]." - Cook Island/NZF31-40*

> *"Learning about your own cultural heritage and background like what you [the researcher] did.//It's so rewarding.// Isn't it fulfilling?//It's rich hey. And knowing how rich it is and then you bring it into your practice.//You're less threatened by other people.//Because now you've got a cosmic geography where you can build your sense of home. Not disconnected. And then we're finding the common ground with some of the Pasifika cosmic geographies." – Phil Siataga and MāoriM41-50*

Frameworks such as *Mana Moana* (98, 198) (where adapted to reflect, for example, *"Scottish lochs and knolls"* (Cook Island/NZF31-40)), and activities such as exploring one's genealogy, reflecting on one's family and ethnic history, and learning more about the narratives and symbols associated with deities, culture heroes, landmarks, and ancestors were recognised as helping to create a more concrete and positive sense of self, both for Pacific and non-Pacific TWO. This was seen as particularly important not only for increasing individual wellbeing, but for nurturing bi- and multi-culturalism, helping to ensure people felt stable and proud enough of their own identities that they wouldn't be

threatened by others and could find common ground on which to build positive and respectful cross-cultural relationships.

Throughout the talanoa, participants also shared insights from non-Pacific family members and colleagues who had a high level of personal and professional exposure to Pacific approaches. These insights confirm what has already been shared in this section, with one quote in particular beautifully summarising:

> *"My wife is Palagi [and works in healthcare]. She loves it, and she gets it…she firmly believes there's an attraction to the Pacific model. Because…you know you're going to get loved, you know you're going to be respected. Like…Who wouldn't want that? And I've always said the Pacific way, and we talk about here, the Pacific way is a way for everyone, because it meets the human need in such a genuine way." – Samoa/NZM41-50A*

It should be noted, of course, that no one approach will meet the needs of everyone, and that this is true of Pacific approaches to MH as well as Western/mainstream approaches. However, based on what has been shared above - and with due recognition of the emphasis on relationship, context, and flexibility - Pacific approaches to MH care *do* show strong potential to work for non-Pacific TWO in a wide range of circumstances. Considering this in tandem with the consistent evidence of alignment with the aspirations expressed in *HAO*(62), *New Visions: Collective Solutions* (72) and the *HAO Wellbeing Outcomes Framework* (80) throughout the thesis, in can confidently be stated the inclusion of these approaches in mainstream, public MH policy has the potential to make enormous contributions to the wellbeing of both Pacific communities, and all New Zealanders.

4.2.2.2 What Positive Changes and Impacts would be seen in Aotearoa as a Result of Including Pacific Ethical Frameworks, Values, Understandings, and Approaches to Mental Health Care in Mainstream, Public Mental health Policy ?

Having determined that the inclusion of Pacific approaches in mainstream, public MH policy has the potential to make enormous contributions to the wellbeing of both Pacific communities *and* all New Zealanders, this next section will seek to outline what some of those contributions would be, to explore what positive changes and impacts would be seen as a result of said inclusion. It will begin by recapping anticipated changes and impacts that align with the aspirations communicated through *HAO* (62), *New Visions: Collective Solutions* (72) and the *HAO Wellbeing Outcomes Framework* (80) and that have been focused on throughout the thesis. From there it will review a number of the additional benefits that were identified by participants, before moving on to explore participants responses to the questions "What would TWO-" and "What would staff say if a mainstream, public MH policy like this was implemented?". It should be noted that these insights into the benefits of including Pacific approaches in mainstream MH policy are grounded in participant reflections regarding the positive impacts that they have observed (as per the "Discover" component of AI) as well as in the collective envisioning of what could be, of indicative and potential positive impacts (as per the "Dream" component of AI). They do not reflect the results of a comprehensive or systematic evaluation and should not be read as such.

As noted throughout the thesis, Pacific strength and success in MH has contributed to a wide range of positive changes and had a wide range of positive impacts in the lives of both Pacific and non-Pacific TWO. It has been shown how of these changes and impacts align with the aspirations for the New Zealand MH system communicated by current guiding documents (62, 72, 80), and it can be seen that amplifying Pacific strength and success and Pacific approaches to MH care through public, mainstream MH policy has clear potential to contribute to even more positive change. Pacific approaches to MH care are Vā-led, strong and successful in their focus on honouring the sacred origins of TWO as human beings and the sacred connections and contextual positioning that accompany these origins. In following, greater inclusion of Pacific approaches would - through encouraging an

understanding of the therapeutic space and relationships as sacred, and through requiring and practically supporting wholehearted and genuine presence – help to create therapeutic environments where the care provided is more "people centred". It would also support TWO, their families and communities to "thrive together" and feel "connected and valued" , by prioritising and nurturing relational spaces, such as the spaces between practitioner and TWO and the spaces between TWO and family/community. Beyond this, Pacific approaches would encourage 'ofa/alofa, respect, reciprocity, and a strong service orientation to be brought into those relational spaces, so MH care is more consistently delivered with love, compassion, empathy, and relational mindfulness. In turn, this would help to ensure TWO and their families feel safe and nurtured and are provided with care environments in which healing can take place and the root causes of distress, disorder, and anguish can be more comfortably addressed. Including Pacific approaches would also support the transition to models of care that prioritise wholeness, healing, and holistic wellbeing (at both an individual and collective level). Through this TWO and their families would be more likely to be provided with MH care in a way that means they actually get what is needed and that the social and economic determinants of health are being consistently incorporated into their assessment and care. Including Pacific approaches to holism – wherein the issues faced by TWO are addressed in the context of a range of internal, relational, and external factors - would also help to ensure that addiction, suicide prevention, disability and other overlapping areas of health practice are incorporated into service delivery and that TWO experience improved spiritual, physical, and relational wellbeing by virtue of seeking MH care. Particularly in terms of their inclusion of spiritual and cultural wellbeing into holism, Pacific approaches would also help to ensure TWO find hope and purpose, experience the affirmation and strengthening of their cultural identities, and can address the impact of cultural alienation. Greater inclusion of Pacific approaches would also, through said approaches' emphasis on collaboration, community leadership, and assertive outreach, support services to meet people where they are, to be more present to communities and families, to empower TWO to participate in their families and communities, and to empower communities and families to care for each other.

In addition to supporting progress towards these published aspirations, a number of other beneficial changes have both been noted both by participants and implied throughout the thesis. Perhaps the most significant of these, given the current political and economic climate, is that the inclusion and amplification of Pacific approaches in policy will lead to reduced healthcare and social service costs long term. By investing in the preventative approaches and in the front-end of service delivery, in family-oriented services, and in holistic services wherein a variety of physical, social, spiritual, and economic needs can be met, interventions are more likely to be successful and repeat interventions will become less necessary. Participants identified that investing time and money to teach young people the skills they need to have healthy relationships and to manage their own mental wellbeing, as well as teaching families/communities the skills needed to identify and support people experiencing mental distress would result in a reduced need for MH support overall (SamoaF41-50; Samoa/NZM41-50C; TokelauF51-60). They also identified that funding SDMs wherein practitioners are allocated time and have capacity to build trusting relationships with TWO and their families (so a deep understanding of context could be developed and a tailored, relevant treatment plan prepared) would lead to reduced DNAs/greater participation in and engagement with treatment, longer term positive changes in mood and behaviour, better access to natural supports (such as friends and family), and reductions in repeat admissions (Cook Island/NZF31-40; SamoaF41-50; Samoa/NZF31-40; Samoa/NZF41-50; Siataga and MāoriM41-50; Sio). Furthermore, addressing needs related to family dysfunction and harm, food, housing, education, financial management, and employment were all understood as helping to both minimise distress contributing to mental illness and strengthen aspects of wellbeing that would support good (mental) health (DHB Pacific MHA Team; Kupa; Makasiale; Mila; Siataga and MāoriM41-50). All of these approaches, while initially expensive, would have meaningful and persistent positive impacts on the wellbeing of both individuals and communities – regardless of ethnic or cultural background - and would, in turn, reduce the need for health spending later in the life course. Participants also suggested that embracing the collaborative aspect of Pacific approaches

through supporting the development of co-located services/services administered under an "umbrella organisation" would further help to reduce the costs associated with health and social service provisions through reductions in overheads, management, and administration, as well as helping to make services more streamlined, minimising delays and reducing the risk of TWO "falling into the gaps" between services (FijiM51-60; Siataga and MāoriM41-50; TongaM41-50A). The changes detailed above, as well as the anticipated reduction in public expenditure long term, are relevant to all New Zealanders; resilient young people, strong holistic wellbeing, healthy families, and a less-pressured economy yield benefits for everyone.

Another significant and beneficial change anticipated by participants was increased workforce stability, capacity, and capability; staff shortages and workforce attrition have been recognised as significant barriers to the development and efficacy of both BP4P and mainstream MH services in New Zealand and addressing these as a key mechanism for positive change (218). Participants reflected that designing policy and investing in strategies to support staff development and wellbeing – in accordance with Pacific approaches wherein leadership is conceived of as service to those being led – would help to reduce burnout and staff turnover (Cook Island/NZF31-40; DHB Pacific MHA Team; Faletanoa'i; Samoa/NZF31-40; Samoa/NZM61-70). Strategies such as increasing class sizes for advanced degrees, offering competitive remuneration, capping caseloads, measuring staff wellbeing as a KPI, and including professional development and/or supervision as a portion of FTE were all expected to contribute to the MH workforce not only growing in size and becoming more stable, but in said workforce learning more and becoming more efficacious. Furthermore, by virtue of feeling supported, experiencing personal and professional growth, and being better equipped to create positive impacts in the lives of TWO, practitioners would also be more likely to stay longer in what would be more satisfying and rewarding roles. This, in turn, would lead to TWO having more and more consistent access to MH practitioners with higher levels of experience and expertise, and who are

empowered to be present, build meaningful relationships and offer genuine, 'ofa/alofa-led care; a positive outcome for TWO of *all* backgrounds. The collaborative aspects of Pacific approaches were discussed in terms of this theme as well. Participants noted that actions which support practitioners to work together - such as funding and measuring in a way that allows people to work in pairs or teams – will lead to positive changes and impacts for the workforce through more opportunities for knowledge sharing, and through stronger relationships and increased feelings of safety, support, connection, and reciprocity to/with the organisation (Faletanoa'i; SamoaF41-50; Samoa/NZF31-40). This would, in turn, improve staff retention, increase commitment to both the organisation and to MH as a career, and - reflecting what was shared above - improve access to experienced, expert MH practitioners for TWO.

The inclusion of Pacific approaches in mainstream, public MH policy was also – crucially - expected to affect positive change and create positive impacts through both the provision of an alternative pathway towards wellbeing - one that has not, as identified by Mila, sprung from the soil of prisons, poorhouses, and lunatic asylums – and through drawing attention to the value and validity of that and many other such pathways. Reflecting the idea of walking in multiple worlds (see Section 4.1.2.1), greater inclusion of Pacific ethical frameworks, values, understandings, and approaches would mean the inclusion of more options for practitioners and for TWO and their families, more ways to consider and interpret experiences, and more choices for treatment. It would thus create benefits by ensuring MH practitioners have more in their toolkit (better supporting them to provide tailored, relevant care), and that TWO experience greater self-determination through access to different pathways, a wider selection of services and interventions (the latter being another express goal of the recommendations made in *HAO* (62)). Beyond this, it would also help to broaden perspectives on ethics and what constitutes appropriate, human-dignity-and-rights-affirming action, thus helping to shift ethical conversations away from risk management and practitioner-and-public-focused non-

maleficence towards a more pro-actively beneficent and relationally mindful model (DHB Pacific MHA Team; FijiM51-60; Mila; Siataga and MāoriM41-50). Such a shift – through re-orienting the MH sector towards TWO as tuātagata, sacred beings-in-relationship who are worthy of being known, loved, and served - would help to challenge current understandings and approaches that enact an implicit perception of TWO as incompetent, dangerous, inconvenient, or otherwise objectionable and thus operate in terms of coercion and control (Fuemana; Sio; TongaM41-50B). Furthermore, the inclusion of Pacific approaches in a dream mainstream, public MH policy would constitute a state-level endorsement of these approaches, a public recognition of their value and validity. It would, through official discourse, afford these approaches prestige, thus encouraging a more positive and respectful social attitude towards them overall. Not only is this beneficial for Pacific communities - helping to challenge anti-Pacific racism and rhetoric at a societal level and actively contributing to the decolonisation of Moana-nui-ā-Kiwa through the redressing of the historical exclusion and diminishment of Pacific epistemologies – but it also benefits Aotearoa as a whole. A more positive and respectful attitude towards Pacific peoples and approaches would, first and foremost encourage non-Pacific to engage more deeply with said people and approaches, thus supporting both better relationships between Pacific and non-Pacific peoples (with positive inter-group relationships being seen as an innate good) and increasing the engagement of non-Pacific peoples with the options for interpretation, treatment, and ethical decision making noted above. Beyond this however, it would also encourage non-Pacific peoples to be more open to options for interpretation, treatment, and ethical decision making that stem from other cultures too; participants reflected that getting to know one or two others cultures (e.g. Māori and Samoan) intimately and experientially fosters the ability to walk in the worlds of those cultures, and then - through this - both increases the desire and nurtures the competencies needed to learn to walk in many (Cook Island/NZF31-40; Fotu; Kupa). Such a propensity is of immense value in New Zealand, both strengthening and building upon the foundation of biculturalism necessary for full and effective recognition of te Tiriti o Waitangi as well as equipping the MH workforce to embrace an increasingly diverse national population. Drawing on the work of

Mila and Hudson (120), such a propensity - when developed alongside a respectful, deferential, negotiative, contextual, Vā led approach to knowledge - can provide fuel for co-creation and innovation through dialogue, collaboration, and synthesis, which will then support the development of more and better options for TWO.

As a means of developing a more tangible/lived-experience focused understanding of the potential positive changes and impacts, some participants (dependant on the time available) were also asked to reflect on what the staff delivering and the TWO using services under the Pacific-inclusive, dream policy might say about their experiences. Figure 15 presents participants' answers, with expected TWO responses on the left and expected responses from staff on the right. These moving responses highlight a wide range of positive social and emotional impacts on TWO that participants anticipated would result from the implementation of the dream public, mainstream MH policy they had collectively described. The PMHSM and PMHP who answered this question reflected that TWO would feel less afraid, less judged, and less stressed. They would feel and express hope for the future and a sense of possibility. There would be a greater sense of belonging amongst TWO, a deeper connectedness to their families, and a feeling of being genuinely loved, understood, valued, and cared about by MH services, by those responsible for providing care. They would trust MH services to engage with them respectfully and in an empowering way, and they would trust them to a degree they would recommend those services to their loved ones. All of these responses present a stark contrast to what was shared by those who participated in the Inquiry preceding *HAO* (62), further reinforcing the potential for positive change the amplification of Pacific strength and success represents. Participant contributions regarding positive changes for staff echo this strong potential. Reductions in fear, scrutiny, stress and in the need to fight for the needs of TWO to be meet were anticipated. These would be replaced with positive emotions like joy, gratitude, and a greater sense

What would TWO say if the dream public, mainstream MH policy was implemented?	What would staff say if the dream public, mainstream MH policy was implemented?
"I felt heard. I felt valued as a person. I felt uplifted…Maybe I can do those things. Maybe these things are possible//I've got something to look forward to." – Phil Siataga and MāoriM41-50 "They were there for me when I needed them…they care for me, I could count on them, I was in a bad spot and they helped me through it, I can't believe how much they helped me, and I can't believe how much they understood me, I would recommend them to my friends, everyone should go there, anyone and everyone could benefit from their support, I didn't feel judged, I trusted them." - Samoa/NZF31-40 "People would have much more confidence in them, that they'll take a very human approach. That it would be much more reciprocal and driven by clients and what they want and need, and [who are] the real experts in what they want." – Samoa/NZF41-50 "They would say, 'I'm in a good space' with all the recovery talk…declaring their own positive state of well-being, or recovery…they'd recommend us to the next person…[they would be] sharing how exactly their life has changed. Perhaps they've rekindled a relationship. Or they've got back into work, or something. They belong again. They have a purpose again. That's what we want to be hearing, for many years to come." – Dwaine Faletanoa'i "I think they'd say, 'Wow'." - Cook Island/NZF31-40 "Accepted. They feel counted, they feel more welcomed. They feel that the services are speaking their language. Although not [just] literally their language." – TongaM41-50B "Thank you. Thanks for listening and thank you for caring and thank you for empowering us." – Tony Fuemana "I think that they'll feel like that their needs would be met more efficiently, effectively because if they know that their families have a little bit more intentional involvement in their care…[it'd be] Less scary, less stressful…the consumer would feel like that they're being taken care of. But also, it's the strengthening of the communications between TWO and their families because they will have dialogue more and more about the care." – Manu Fotu	"'I love my job, I'm making a difference and I will never do anything else, I'm very lucky to be in my position, to help others'…there would be a completely different discourse around how it would feel and what it would look like working in that sector…'I feel supported and we're a team, it's a family, we're doing this together'." – Samoa/NZF31-40 "They'd be relieved. They'd be overjoyed and they would want to declare their joy…[they would feel like their time with TWO] has value, rather than the number that they put up each month. They'd probably say, 'Praise the Lord that we can test this research idea, without…getting fully put under the microscope and scrutinized.'." – Dwaine Faletanoa'i "At the moment it's trying to tell the service, 'This is what we want to do', but the service is saying, 'No, because we don't have the policies to support what you are telling us to do.' If I were working in a place that would accommodate those sorts of things that I am fighting for, then I would really enjoy working there, and it would be less of a fight and then I would have more time to spend with TWO." – TongaM41-50B "They would be under less stress….the way that they work would be broader and bigger. They would be able to use a lot of the skills that they bring, their own life skills, and use them better…to contribute to the care [they provide]." – Tony Fuemana "When people are able to align with their values in their professional lives it's just so much better…[it] is just so much more rewarding to be able to work in the way that you're wired for." – Dr. Karlo Mila

Figure 10 - Participant responses regarding what the staff delivering and the TWO using services under the Pacific-inclusive, dream policy might say about their experiences

of alignment, self-efficacy, and purpose. Echoing what has already been discussed in this section, participants saw this shift in emotional climate – particularly where combined with feelings of support and a team environment - leading to an increased commitment to working in MH and longer tenure in MH roles. Those who spoke to what staff might say also noted that being less pressured and having

to spend less time fighting for what is needed would lead to more time spent actively caring for and supporting TWO. These reflections - shared by people with experience of the approaches they are advocating for and of the MH sector – reiterate that ensuring the wellbeing of staff and positive work environments in the MH sector helps to create more positive care environments for TWO.

This final section of the findings and discussion has highlighted a vast array of potential positive changes and impacts that could be expected as a result of including Pacific approaches to MH care in mainstream, public MH policy (as per the dream policy outlined in the preceding chapters). Based on what has been shared it is clear such inclusion would not only benefit Pacific communities but all of Aotearoa, New Zealand. Pacific ethical frameworks, values, understandings, and approaches to MH align strongly with the vision of successful MH services put forward in *HAO (62), the New Visions: Collective Solutions* (72) and the *HAO Wellbeing Outcomes Framework (80)*, and would make significant contributions to reduced long-term health spending, to the growth and stabilisation of the workforce, and to the availability of diverse and humanising pathways to wellbeing. They also – as highlighted through participant reflections on what TWO and staff might say – would inspire hope, joy, belonging, a sense of mutual support, and numerous other positive emotions amongst all those involved in either delivering or receiving care. Importantly, the positive changes and impacts anticipated are both relevant to and would benefit New Zealanders from all walks of life, regardless of their ethnicity or cultural background, reiterating the potential shown by the dream policy to support the MH of communities throughout Aotearoa.

People will say 'Our land has come to fruitfulness. There are all sorts of crops growing in the field, and we're all bloody blooming.'." - Cabrini 'Ofa Makasiale

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4.2.3 Summary of "Dream" findings

The "Dream" section of the thesis sought to answer the following questions:

> ***Dream:*** *What might mainstream, public MH policy in Aotearoa/New Zealand look like if these strengths and successes were valued, acknowledged, and affirmed? What potential does such policy show to support the MH of all New Zealand communities? What results might such policy achieve and what differences might we see?*

All three of these questions were answered, with participants addressing the first by sharing a vision for significant changes to the shape of public, mainstream MH policy both in terms of the document itself and in terms of the actions and strategies it would contain. For them, a dream MH policy would be inspirational, heart-and-relationship-led and built on ethical frameworks, values, understandings, and – in following – approaches indigenous to the South Pacific. The relationship with tāngata whenua and the implications of te Tiriti o Waitangi would be front and centre, with this position being supported by strong Māori leadership of policy, and by the presence of a high proportion of Pacific policy actors (thus helping to shift the balance of power). The document would express a clear appreciation for Pacific peoples, epistemologies, and the Ethics of the Vā and would focus heavily on developing and strengthening relationships at all levels, from the various ministries involved in providing care to the services working to support TWO to the relationships between family members. Furthermore, this dream policy would be a practical document, presenting a clear picture of the outcomes to be achieved and the pathways towards these in such a way that not only those involved in policy writing, but healthcare staff and families, could pick said documents up and understand what needed to be done, how, and why. The policy would then contain a wide range of actions focused on growing Pacific leadership and ensuring Pacific MH leaders are empowered to create meaningful change; on shifting towards more flexible, responsive, and collaborative funding and contracting models; on developing approaches to evaluation inclusive of staff and TWO experience and that focus

on outcomes rather than outputs; on supporting workforce growth through engaging with the community (both as workforce and as a body of people who could be better empowered to care for their own and each other's MH) and through more accessible and appropriate education pathways; on growing the specific and transcultural competence of the workforce; and on implementing a range of holistic, family-focused, service delivery models. Such a policy would amplify the "positive core" of Pacific approaches to MH – this being the Vā – as it sought to build and honour relationships, strengthen, and support families, care for people holistically and in context, and engage with people from all walks of life in a respectful way and guided by the imperative to both serve and show 'ofa/alofa.

The second two questions were then explored through participant reflections on the successful application of Pacific approaches to MH care amongst non-Pacific people and through the consideration of how the actions and strategies presented in the dream policy would create positive results for diverse communities throughout Aotearoa/New Zealand. The discussion related to these questions made it clear a mainstream, public MH policy that affirmed and acknowledged Pacific strength and success (and the Vā as the positive core of this) would support the MH of all New Zealand communities. It would do this by supporting the creation of a MH policy and practice environment that more effectively centred TWO and their families (regardless of their background) and that actively sought to meet and connect with TWO and their families where they are; where services could operate collaboratively, working alongside each other and families to deliver flexible and holistic care relevant to each TWO and their context; and where the root causes of distress - be these relational, emotional, cognitive or socioeconomic – could effectively be addressed. It was shown this would, in turn, contribute to a plethora of positive changes such as the prevention of mental distress; stronger and more resilient individuals, families and communities; long-term reductions in health and social service spending; a happier and healthier workforce who are spending longer in their roles; better

collaboration between different cultural groups and increases in innovation through such collaboration; and – crucially – TWO feeling heard, valued, loved and being supported to access and receive care that not only addresses their needs but affirms their dignity as human beings.

5.0 Conclusion

5.1 Concluding Remarks and Significance

This thesis – *Soso'o le fau i le fau: An Appreciative Inquiry into Pacific Mental Health Practice and its Potential Contributions to Mainstream, Public Mental Health Policy in Aotearoa* – sought to answer the following two sets of strengths-focused research questions:

> ***Discover:*** *What has been successful in Pacific MH practice in Aotearoa/New Zealand? What are the unique strengths of Pacific MH practice that have empowered this success?*
>
> ***Dream:*** *What might mainstream, public MH policy in Aotearoa/New Zealand look like if these strengths and successes were valued, acknowledged, and affirmed? What potential does such policy show to support the MH of all New Zealand communities? What results might such policy achieve and what differences might we see?*

These questions were asked with the aim of supporting the development of mainstream, public MH policy that values, affirms, and acknowledges the strength and success of Pacific MH practice, and that recognises and acts on the potential of Pacific approaches to MH to support the wellbeing of diverse New Zealand communities.

Through the talanoa with PMHP, PMHSM, and Pacific TWO/whānau members of Pacific TWO, it was found that Pacific MH practice has been particularly successful in:

- challenging unhelpful practices and approaches, both directly and indirectly;
- integrating multiple worldviews and approaches to ensure TWO are offered the most effective and appropriate solutions for them and their context;

- resisting labelling and unnecessary categorisation in order to embrace TWO (and themselves) as whole, complex people with rich identities and lives;
- keeping TWO at the centre of practice, prioritising the need to be present and spend time with them, despite significant pressures on time, resource, and attention;
- connecting with the emotional and spiritual worlds of TWO;
- meeting the wider socioeconomic needs of TWO and providing holistic support, regardless of role or contract parameters;
- engaging with both the family context and with the actual family of TWO to identify and address underlying issues, provide support and education, and strengthen relationships;
- ensuring TWO experience love and feel included and valued as family (and ensuring staff feel the same);
- creating positive, connected workplaces by understanding and undertaking leadership as an act of service and an exercise in providing care and support to staff and TWO alike; and,
- ensuring buy-in, participation, and cooperation by operating collectively and consultatively when seeking to make changes or decisions.
- approaching staff and service development using an intergenerational lens to support growth, retention, and sustainability.

These successes echo what is already known about Pacific approaches to and aspirations for MH care and reflect the relational focus; the provision of practical, holistic support; the inclusion and education of family; the affirmation of cultural identity; the acceptance and appreciation of TWO; and the integration of diverse knowledge traditions that have been being described and requested for many years (see Sections 2.2, 2.3, and 2.4). In following, these findings show PMHP and PMHSM are very much "being the change they wish to see", which - while unsurprising – is significant, reiterating the fundamental importance of removing barriers – attitudinal and systemic - to Pacific peoples leading

the development of their own services. *Not only do PMHP and PMHSM know what is needed to improve MH outcomes for their communities, but they know how to meet these needs and are experienced in doing so.*

Alignment with the vision outlined in *HAO* (62), the *HAO Wellbeing Outcomes Framework* (80), and in *New Visions: Collective Solutions* (72) has also been repeatedly evidenced throughout the findings and discussion. The successes described by PMHP and PMHSM reflect that Pacific approaches to understanding and addressing (mental) health issues are already making a significant contribution to achieving this vision. *In doing so they point clearly toward the fact increased engagement with, affirmation of, and practical support for such approaches would accelerate progress towards both equity for Pacific peoples and towards current aspirations for the MH of all New Zealand.*

This thesis also found that the successes achieved by PMHP and PMHSM have, in all cases, been motivated, supported, and shaped by the ontological, axiological, and epistemological position expressed by Vā; the philosophical heart of the Pacific and the "positive core"(3) of Pacific MH practice. This finding is perhaps the most significant in terms of the "Discover" questions, reflecting that the successes of PMHP and PMHSM are not the result of merely adopting Pacific frameworks, learning new therapeutic approaches, or developing innovative SDMs, but rather stem from their inhabiting a fundamentally different orientation towards being, doing, and knowing to that which currently prevails. *This highlights the need for both strong Pacific leadership to nurture a change in culture and for transformation at the most foundational level of the MH system, the reconsideration of the beliefs, values, and knowledge traditions that underpin it.*

This need for fundamental change was strongly reflected in the shared "Dream" of a mainstream, public MH policy that valued, acknowledged, and affirmed Pacific strength and success. It was found that PMHSM, PMHP, and Pacific TWO/whānau members of Pacific TWO wanted to see mainstream, public MH policy grounded in and nourished by the values, understandings and approaches indigenous to Aotearoa and to the wider south Pacific. As a result of this grounding, said policy would be:

- underpinned by a genuine and meaningful commitment to te Tiriti o Waitangi, expressed in and through Māori leadership of policy development and supported by the presence of strong Pacific policy leadership;
- driven by relational ethics and focused on establishing, and strengthening relationships at all levels, from ministries to families;
- inspiring, uplifting, and capable of speaking to the hearts and aspirations of the sector;
- reflective of a deep understanding of, appreciation for, and commitment to upholding Pacific worldviews, values, understandings, and approaches;
- practically oriented with sufficient detail to support its application and translation into action;
- embedded in collective, strengths-based language rather than the language of individual disease and disorder.

It would also contain actions and strategies that:

- facilitate collaborative funding and contracting models that have been designed to flex and respond to changing and varied individual, family, and population needs;
- support evaluation approaches that focus on progress toward outcomes and on the *experiences* of both TWO and staff;
- ensure services are treated as investments rather than cost units;

- seek to grow and support meaningfully empowered Pacific administrative, clinical, cultural, and consumer leadership;
- maintain and grow investment in BP4P services as a vital component of the MH system;
- address inequities in funding and remuneration that disadvantage BP4P services and PMHP;
- emphasise education, from teaching emotional regulation in primary and secondary schools, to improving health literacy and training families and communities to identify and respond to distress, right through to the meaningful, applied teaching of Pacific worldviews and approaches as a part of all (mental) health qualifications;
- reduce barriers to participation in MH qualifications and that encourage the consideration of MH as a career;
- support the development of innovative, agile SDMs and approaches to mental health care that are grounded in Pacific values and knowledge, are community-led/owned, and are oriented toward the provision of care that engages with the health, socioeconomic, spiritual, cultural, and environmental wellbeing of the whole family; and
- resource Pacific-led research to inform and evaluate such SDMs and approaches.

While *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* (67) reflects some progress towards this dream – for example, through its grounding in Pae Ora and its emphasis on developing cultural and TWO leadership - *the findings of this thesis make a significant contribution to the development of future mainstream, public MH policies by highlighting a range of areas where more action is needed, as well as detailing a range of specific actions that might be taken in order to more effectively address these*. There are relevant examples in each of the domains listed above, however, the emphasis on education as an aspect of workforce development provides a particularly clear example of the contributions made. Education has only recently emerged as an area of concern in MH

policy, and actions have primarily focused on integrating wellbeing education into primary and secondary schools (rather than on much needed changes to the curricula of tertiary level health qualifications) (67). The findings of this thesis highlight the need for a review of health qualification curricula in order to ensure they prioritise and celebrate Pacific values, understandings, and approaches. Providing education around said values, understandings, and approaches - highlighting their worth, and modelling appreciation and respect for them during this pre-service period - will make a significant contribution to both ensuring a culturally competent workforce and to ensuring Pacific health students – as a key part of the future health workforce – experience reduced exclusion and discrimination as they work to complete their studies.

The desire to see policy that is both inspiring/uplifting and practically oriented also constitutes a particularly valuable contribution to the development of future mainstream, public MH policies. Participants wanted to see policy that supported collaboration by instilling a shared sense of vision and purpose. They wanted to see policy that facilitated the provision of holistic care by clearly delineating responsibilities across different sectors and at different levels, and by providing detail regarding what should be happening in each of these different sectors and levels. They also wanted policy that was collectively oriented and empowered participation by providing concrete examples of what we should be doing, how we should be doing it, and what we should be seeing as a result, so that anyone from the Chief Executive of a DHB to a health care assistant could pick up the policy and see how to implement the vision in and through their day-to-day work. *This highlights how public MH policy, which is grounded in, acknowledges, and seeks to grow Pacific strength and success would require not only changes to the content of policy - to the areas and actions it emphasises - but to how the structure, purpose, and audience of policy documents is understood and enacted.*

Recognising both the historical perception of Pacific values, understandings, and approaches as contingent/non-generalisable and the emerging understanding that these values, understandings, and approaches do, in fact, have a valuable contribution to make to the wellbeing of all New Zealanders, the "Dream" section also gave consideration to the benefits of affirming and acknowledging Pacific strength and success in mainstream, public MH policy, particularly amongst non-Pacific peoples. Many participants described having worked successfully with non-Pacific TWO, drawing on the deep respect, 'ofa/alofa, service orientation and context-responsiveness of Vā-led MH practice to provide effective care, regardless of ethnic background. They also described a wide range of future benefits – such as stronger communities, reduced public expenditure, and a more resilient workforce - should mainstream, public policy support the growth and spread of Pacific values, understandings, and approaches to MH. By evidencing the wider potential of these, the findings of this thesis expose how discrimination against Pacific peoples – as manifest in the failure to meaningfully include their MH needs, aspirations, and approaches in policy – has not only impeded progress toward equitable MH outcomes for this group but has also limited access to better care for non-Pacific TWO and better conditions for non-Pacific MH practitioners. Everyone in Aotearoa has lost by virtue of this discrimination and exclusion. *This highlights the importance of embracing Pacific values, understandings, and approaches to MH care in mainstream, public MH policy, as this will promote equitable outcomes by ensuring mainstream services are more responsive to and appropriate for Pacific peoples, will improve the range and quality of care available to TWO throughout New Zealand, regardless of their ethnic background, and will support the development of a MH sector in which people actively want to work.*

This study is the first to bring together the voices of PMHP, PMHSM, and TWO/whānau of TWO to generate a collective representation of what PMHP and PMHSM do particularly well in their work. It is also the first to explore these areas of effectiveness with a direct view to how they might

inform and improve *mainstream* public MH policy, and through this, MH outcomes for diverse New Zealand communities, Pacific and non-Pacific alike. It builds on the body of literature regarding Pacific approaches and aspirations for MH services too, by recognising and celebrating the already manifest strengths of Pacific approaches to MH and their tangible positive impacts, as well as highlighting their relevance to the wider NZ community, their ability to meet everyone's needs more effectively. It is hoped - having explored multiple areas of success and strength in Pacific MH practice, presented a vision for mainstream, public MH policy that acknowledges and affirms said strength and success, and described a number of ways in which such policy would benefit both Pacific peoples and diverse New Zealand communities - this thesis will make a valuable contribution to achieving both Pacific and national aspirations from improved MH in Aotearoa, supporting positive change in the following ways:

- Inspiring a deeper understanding of and appreciation for Pacific values, understandings, and approaches to MH amongst non-Pacific policy makers and system leaders.
- Supporting non-Pacific policy actors to see - in more tangible, concrete terms - how Pacific approaches to MH "point the way for all New Zealanders" (62) and will contribute significantly to the provision of more effective care that better aligns with the vision outlined in *HAO* (62).
- Encouraging a willingness to empower Pacific leadership and leadership models in the integration of Pacific values, understandings, and approaches into the development and implementation of mainstream MH policy, services, and practice.
- Increasing support and resourcing for BP4P services, not only as a pathway to equitable MH outcomes for Pacific communities but also as sites of self-determination, where Pacific values, understandings, and approaches to MH can be nurtured, grown, and subsequently shared.

It is hoped this will, in turn, help to:

- reduce Pacific peoples' experiences of discrimination in mainstream (mental) health spaces (both in terms of the services they receive and in terms of their experiences as health practitioners, service managers, and policy actors);

- support an increase in the number and range of mainstream MH services that are able to effectively meet the needs of Pacific people, thus
    - making it easier and more convenient for Pacific peoples to access culturally acceptable MH services earlier and more often, and
    - reducing the strain experienced by the proportionally small number of BP4P services currently operating; and
- create more flexibility and choice for both Pacific TWO and TWO form diverse New Zealand communities.

It is also a particular hope of mine that this thesis will not only help to inform mainstream public MH policy that values, acknowledges, and affirms Pacific strength and success, but also that it will serve as a mirror to the PMHP and PMHSM who read it, reflecting their excellence back to them and providing a well-deserved moment of acknowledgment and recognition.

5.2 Strengths and Limitations

The research undertaken for this thesis demonstrates a number of strengths, including its use of culturally appropriate qualitative methodologies and an emphasis on what is being done well. This approach has helped to ensure the safety and comfort of participants and the subsequent validity of the findings. The analysis of the data was also undertaken in a particularly rigorous manner, through multiple iterations and with an opportunity for participant feedback, further supporting the assertion of the findings' validity. The use of culturally appropriate qualitative methodologies has also facilitated the collection of particularly robust, nuanced, and inspiring information regarding the strength, success, and potential of Pacific approaches to MH, supporting this thesis to present a highly textured representation of the subject matter and comprehensive answers to the research questions. The integration of multiple perspectives from a range of MH roles and disciplines and the inclusion of

participants from a range of Pacific ethnicities is another strength of the thesis, meaning that findings represent a wide variety of views and can be credited with *some* generalisability.

A number of limitations must also be considered. Due to the small sample size, the generalisability mentioned above is limited, and the findings should thus be considered exemplary rather than representative. The small sample size – in tandem with the limited linguistic and cultural competencies of the researcher – has also meant the project has been restricted to a pan-Pacific approach and has not been able to provide insights relevant to the different ethnic groups represented. The sample was formed through personal and professional networks, and while every effort was made to recruit from diverse locations, professional backgrounds, ethnic backgrounds, and gender/sexual identities, this purposive-convenience approach was also a limiting factor. The sample was also heavily skewed toward PMHP and PMHSM, and particularly those in senior roles, with comparatively little representation of the voices of TWO/whānau of TWO and of those who have more recently joined the MH workforce. While fairly balanced in terms of gender, the sample did not provide good representation of diverse gender/sexual identities and of the cultural intersectionality associated with these. This further impacts the generalisability of the findings, and, sitting alongside the reliance on self-appraisal and the researcher's intentional exclusion of criticism of Pacific approaches, potentially contributes to bias-based limitations on both the reliability and validity of the findings. The presence of the researcher as an active participant in all data collection activities may also have limited participants' freedom to respond or had an impact on the tone and content of their responses. The relationship with the methodological foundations of the thesis is at play here, however, with the co-creation of knowledge and the importance of carefully and respectfully participating in relationships being integral to both talanoa and appreciative interviewing (1-3, 59, 89, 91, 92, 94, 95). The reliance on PMHP and PHMSM self-report may also be considered a limitation, with claims regarding the broader applicability of approaches and their benefits for TWO needing to

be tested through further engagement with TWO – Pacific and non-Pacific - and through a comprehensive and systematic evaluation of the approaches described.

5.3 Directions for Future Research and Next Steps

5.3.1 Directions for Future Research

Given its emphasis on the positive potential of Pacific approaches to MH, it is unsurprising this thesis should gesture towards a range of potential projects that might be explored in future. For example, such future research could explore:

- The strengths, success, and potential of MH practices amongst specific Pacific ethnic groups, including the unique features of these, their relationship to practices amongst other Pacific ethnic groups, and the learnings they might offer to the wider community of practice.
- The strengths, success, and potential of MH practices amongst PMHP of diverse genders and sexual identities, including, as above, the unique features etc., but also exploring how the intersectional position contributes to practice.
- Evaluation of specific Pacific approaches to MH care and service delivery - such as Mana Moana, Talanoa, and the “5C model” in terms of their benefits and/or positive impacts on both practitioner and TWO wellbeing.
- Specific Pacific approaches to MH care and service delivery that are currently unnamed/implicit in how PMHP and PMHSM are working, for example, detailing and (re)presenting the ways in which PMHP use and manage time to support presence to/with TWO.

- TWO and whānau perspectives on the provision of care by PMHP and PMHSM, incorporating the experiences of both Pacific and diverse non-Pacific TWO.
- (As suggested by participants) the establishment of a Pacific-led acute care facility, and the subsequent evaluation thereof.

Exploring these areas would provide further insights into Pacific strength and success in MH practice, into the activities that *most effectively* support progress towards equity for Pacific (mental) health outcomes, and into its potential to support the wellbeing of diverse New Zealand communities. Importantly, projects such as those noted above would *need* to be Pacific led. While this stance may seem hypocritical - and while there *is* potential for collaboration, particularly in terms of the projects that explore what might be learned by the wider community of practice - most further exploration requires both specialist cultural knowledge and an ability and commitment to protecting, upholding, and respectfully evaluating Pacific ways of knowing and doing, that would be best achieved by Pacific researchers and Pacific research leadership.

The relationship between (mental) health policy in Aotearoa/New Zealand and (mental) health policy is Pacific Island nations (both realm and non-realm), also warrants exploration. New Zealand public policy has a profound impact in the lives of Pacific peoples living in Aotearoa. By virtue of historical and current relationships between the crown and various Pacific Island nations, between New Zealand Pacific communities and Pacific communities in the Pacific islands, and between Western knowledge structures and the knowledge of indigenous and post-colonial Pacific societies, New Zealand public policy also has a profound impact on the lives of Pacific peoples in the Pacific islands. There are obvious power dynamics and flows of information at play here, as well as more subtle ones, and exploring these would likely yield important insights into how health inequity for Pacific communities might be better addressed, discrimination against Pacific ways of knowing and doing overcome, and the impacts of ongoing colonial and imperial activity identified and mitigated.

As a Pākehā researcher working with Pacific people, on a Pacific oriented research project, another key suggestion emerges; an exploration of how a (cross-cultural) community orientation to research supports the wellbeing, motivation, and likelihood of completion of post-graduate students, particularly those from individualist cultures. I suspect many Pākehā, like myself, will not have strong experiences of community orientation and support, and will, like me, find this way of working new and impactful, particularly with regards to experiences of being welcomed into, invested in, and supported by a community (and the sense of commitment, indebtedness, and gratitude this elicits). Furthermore, I suspect they will, like me, find their way of working, sense of purpose, and commitment to their research radically and beneficially altered by it.

5.3.2 Next Steps

It was noted in Section 3.3.4 that the end of the PhD is not the end of the work; the "Luva", "Mālie" and "Māfana" stages of the Kakala process (4) have yet to be undertaken in earnest. In terms of the "Luva" stage, it is my intention to make the findings of this research available to participants both in full and in summary. The offer has also been made to present on the findings in participant workplaces as requested, or in other situations (e.g., conferences, meetings, community gatherings, lectures etc.) as will best facilitate the accessibility of the content and support the aims and aspirations of the communit(ies) involved. I also recognise the need to follow through on the implications of this research and to realise the "Design" and "Destiny" stages of the AI 4-D cycle (1-3) as an integral part of the "Luva" stage. Given the rapid changes taking place in the MH and wider health sectors at present, and the variety of consultations, data collection, and research activities already underway, I do not believe a structured process external to government feedback mechanisms and coordinated by myself is the best avenue. In following, I intend to support the identification, promotion, and

achievement of priority actions through working alongside my participants, colleagues, and wider professional networks to identify priorities for publication and avenues for strategic advocacy, for participation in in consultation and co-design activities, and for making my findings available to those best positioned to help bring about the vision presented herein.

Naturally, these actions will also contribute to the "Mālie" and "Māfana" stages as they are oriented toward advocacy and action, as well as expressing and drawing on the relational warmth generated throughout this project. In addition to sharing the findings and working alongside my participants, professional networks, and community to achieve positive change, however, I am also excited to enact the more celebratory aspects of "Mālie" and "Māfana". As noted in Section 3.1.1, "Mafana" is not just the final stage of the Kakala Framework, but also an emotional experience the researcher should strive to nurture throughout the research process . Undertaking this research has been one of the most uplifting and inspiring experiences of my life. Not only did I gather an extraordinary amount of reflective, insightful, and hope-giving data, but I forged numerous relationships that have translated into mutually supportive professional alliances and, in numerous cases, meaningful and life-enriching friendships. I started this research with little grasp of what māfana meant, however, in and through the attempt to live and carry out research in accordance with the values of faka'apa'apa, loto fakatokilalo, fe'ofa'aki, and feveitokai – and through the myriad ways in which they have been offered to me – it is now a feeling I know well, experientially and in my very heart. I cannot wait to come together with those who have been involved in this research to express my gratitude, honour their contributions, and joyfully reflect on the hard work, resilience, creativity, strength, expertise, generosity, beauty, strength and potential expressed through this project.

6.0 Bibliography

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Appendix One – Glossary

AI	Appreciative Inquiry
Alofa/'Ofa/Aroha/ Aro'a/Aloha/Aroha	Multiple. Love, care, compassion, empathy, affection, grace, kindness.
Aotearoa	Māori. The indigenous name for the group of islands constituting the nation state of New Zealand, used interchangeably with its official title.
Atua	Multiple. God, gods.
BIM	Briefing to Incoming Minister
BP4P	"By Pacific, For Pacific". A term referring to health, social, and/or education services designed, lead, and delivered by Pacific peoples to meet the specific needs of their communities.
CBT	Cognitive Behavioural Therapy
DHB	District Health Board
DNA	Did Not Attend
DSM	Diagnostic and Statistical Manual of Mental Disorders
Fa'aaloalo	Samoan. Respect, mindfulness of and deference to the other(s) present.
Fa'afeiloaiga	Samoan. A ceremony of welcoming and face-to-face dialogue between/amongst family, the process of getting to know each other and making genealogical, geographical, and other connections to become as family.
Faife'au	Samoan. Minister, church leader, clergyman.
Fakafe'iloaki and Maka Fetoli'aki	Tongan. The process of getting to know each other and making genealogical, geographical, and other connections. Maka fetoli'aki is a particularly lovely metaphor, refering to how maka (rocks/stones) will toli (rub together) to become smooth and aligned with each other.
Fakakaukau	Tongan. The mind, cognitive functioning, thought, intention, consciousness, consideration, idea.
Fale	Samoan. House. Open structure for living and socialising with a floor and evenly spaced poles holding a domed, woven roof.
Feagaiga	Samoan. The sacred covenant that exists between brothers and sisters in Samoan culture and that constitutes a particularly sacred/inviolable/tapu relational arrangement.
Fono	Samoan. Meeting or gathering.
GDP	Gross Domestic Profit
HAO	He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction
Itu Lua	Samoan. Two sides/aspects.
Kāinga/Aiga/'Āina	Multiple. Family and or land, particularly family in and through relationship to land. (Home)land.
Kaupapa Māori	Māori. A Māori topic, approach, customary practice, ideology, agenda, or principles, generally as applied in and through learning or practice.
Koha/mea'alofa/mea'ofa	Various. Gift, love offering. A gesture of appreciation and reciprocity made in recognition of the service, effort, or generosity of another.
Loto	Tongan. Heart, interior, soul, centre, willpower, where emotions happen/are felt.
Loto maualalo	Samoan. Humility, humbleness, humble heartedness.
Lotu	Samoan. Prayer, worship.

Mainstream	English. Herein used to refer to health services and policies geared towards the wider New Zealand population regardless of ethnicity, non-ethnic-specific as opposed to Pacific-specific.
Matai	Samoan. Family chief, can refer to an Ali'I (high chief) or to a Tulafale (oratory chief). Can also refer to the title given to such chiefs e.g., "she has a matai (title)"
Mātauranga Māori	Māori. Māori knowledge, particularly traditional knowledge.
Matua	Various. Elder.
MDT	Multi-Disciplinary Team
Moana-Nui-ā-Kiwa	Māori. "The great ocean of Kiwa", an indigenous term for the Pacific region that emphasises the ocean as a connector, a body of water that links together a diverse array of islands and ethno-cultural groups into a unified and familial whole (as opposed to positioning the ocean as a body of water that separates distinct and constructed/imposed political nation states).
OT	Occupational Therapist
Pacific peoples	English. Throughout this thesis "Pacific peoples" is used to refer to a diverse range of national, ethnic, cultural, and linguistic groups who have come from islands throughout Moana-Nui-ā-Kiwa to visit or live in Aotearoa. It encompasses those visitors, temporary migrants, recent migrants, and citizens who whakapapa to Samoa, Tonga, the Cook Islands, Fiji, Niue, Tuvalu, Tokelau, Kiribati, Hawai'i, Rotuma and a range of other islands/island groups. These groups have as many distinguishing features as they do features in common, and "Pacific peoples" has intentionally been chosen to acknowledge this; through the use of the plural "peoples" it helps to draw attention to the heterogeneity present amongst this transnational collective.
Pākehā	Māori. An indigenous term for white New Zealanders of European descent. This term refers to white New Zealanders from a range of ethnic backgrounds (e.g., Scottish, Irish, English, Dalmatian, Polish, French, German etc.), and, while it can be applied to white visitors and migrants as well, it is more generally used to refer to those who have been born in New Zealand and to connote a New-Zealand specific ethno-cultural group.
Palagi/Palangi	Multiple. A Pacific term for white people. Unlike Pākehā, Palagi/Palangi does not connote any particular nationality nor ethnic background.
Pese	Samoan. Song/singing.
PMHP	Pacific Mental Health Practitioners
PMHSM	Pacific Mental Health Service Managers and Leaders
Puke	Tongan. Literally "Hold", but in the context of mental health, it refers to illness, as the thing that "holds" a person and prevents them from moving to fulfil their social and spiritual obligations.
RFP	Request for Proposal
SDM	Service Delivery model
Tangata whai ora/TWO	Māori. Coined by Tā Mason Durie, Tangata whai ora (pl. Tāngata whai ora), it literally translates as "person/people seeking health" and has been chosen as an inclusive, humanising term to refer to people living in Aotearoa/New Zealand who are the subject of care, assessment, and treatment processes in mental health. While it is a Māori term, it has been selected to refer to all those who are the subject of mental

	health care, assessment, and treatment in New Zealand, regardless of ethnicity. This choice has been made as Māori is one of New Zealand's national languages (alongside New Zealand Sign language) and as there are no suitably inclusive or humanising terms available in the unofficial *lingua franca* (English). A term derived from a Pacific Island language was considered – tagata ola – however this has not been used as participants refer to both Pacific and non-Pacific tāngata whai ora throughout our talanoa and it was felt that a Pacific Island term would incorrectly imply the Pacific descent of tāngata whai ora.
Tāngata whenua	Māori. People of the land, Māori as the first/indigenous peoples of Aotearoa/New Zealand.
Tausi le Vā/tauhi Vā	Samoan, Tongan. To care for or maintain the relational space.
Te Aka Whai Ora	The Māori Health Authority; a national statutory body established to work alongside the Ministry of health and Te Whatu Ora to improve health outcomes for Māori. They have policy development and both commissioning responsibilities (for Kaupapa Māori services) and co-commissioning responsibilities (for mainstream services).
Te Hiringa Mahara	The Mental Health and Wellbeing Commission as (re) established in 2020-2021, and responsible for mental health system oversight, monitoring mental health and wellbeing, system change, and service delivery, and advocating on behalf of TWO and groups disproportionately experiencing inequitable mental health and wellbeing outcomes.
Te Tiriti o Waitangi	Māori. The Treaty of Waitangi, particularly the Māori language version thereof as this is inconsistent with the English text and affords more rights and authority to Tāngata Whenua.
Te Whatu Ora	Health New Zealand; a national body established to take on the operational functions of the Ministry of Health (such as managing national contracts) and to manage public health services across the primary, secondary, and tertiary levels.
Teu le Vā	Samoan. To look after or tidy up the relational space, particularly after a breach.
Tofi	Samoan. Inheritance, birthright.
Tua'oi	Samoa. Boundary, particularly between sections of land, but also around the Vā/relational space.
Tuakana/teina	Māori. Older sibling/younger sibling, referring to a peer relationship that is lightly hierarchical with respect to birth order, and that connotes mentorship and support.
Tuātagata	Samoan. An abbreviation for the phrase "o tua atu o le tagata" (tua meaning behind, thus behind a person) which expresses that behind a person there are always the faces of his or her father, mother, extended family, village, land, sea, ancestral spirits etc.
Tuluma	Tokelau. Wooden box in which fishing lures and equipment are kept, made of a light wood to ensure flotation should it go overboard.
Vā/Va/Vaha/Va'a/Wā	Multiple. The relational space.
Vā Fealoalo'ai/Vā Fealo'ai	Samoan. Respectful relationships; the space that constitutes respectful relationships.
Vā Tapuia	Samoan. Particularly sacred relationships, especially as regards the cosmological order and notions of divine genealogy; the space that constitutes these sacred relationships.
Whakanoa	Māori. To make free/safe/ordinary.

Whakatapu	Māori. To make sacred/set apart.
Whānau	Māori. Family, inclusive of extended kin networks.
WHO	World Health Organisation

Appendix Two – Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)

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

21 August 2019

Marilyn Waring
Faculty of Culture and Society

Dear Marilyn

Re Ethics Application: **19/240 Informing mainstream mental health policy in Aotearoa/New Zealand through an appreciative inquiry into the strength, success, and potential of Pacific mental health practice**

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 20 August 2022.

Standard Conditions of Approval

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

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

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

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

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: ruby.tuesday@leva.co.nz; Juliet Nanai

Appendix Three – Participant Information Sheets and Consent Forms – One on One

Participant Information Sheet: Stage One - One on One

Date Information Sheet Produced:

01/07/2019

Project Title

Informing mainstream mental health policy in Aotearoa/New Zealand through an appreciative inquiry into the strength, success, and potential of Pacific mental health practice.

An Invitation

Talofa lava, malo e lelei, ni sa bula vinaka, kia orana, taloha ni, fakalofa lahi atu, fakatalofa atu, tena koutou and warm Pacific greetings. My name is Ruby Tuesday and I am a student at Auckland University of Technology. I am undertaking this research project in fulfilment of the requirements for my PhD in Health and Environmental Sciences.

I would like to invite you to take part in this research project and to share your thoughts regarding the following questions:

- What has been successful in Pacific mental health practice in Aotearoa/New Zealand? What are the unique strengths of Pacific mental health practice that have empowered this success?
- What might mainstream mental health policy in Aotearoa/New Zealand look like if these strengths and successes were valued, acknowledged, and affirmed? What potential does such policy show to support the mental health of all New Zealand communities? What results might such policy achieve and what differences might we see?

Please note that I am currently employed by Pacific Inc. Limited (trading as Le Va) as a training coordinator and researcher. Your decision to participate in this research (or not) will neither advantage nor disadvantage you in terms of your relationship with Pacific Inc. Limited and/or the availability of services provided by Pacific Inc. Limited.

What is the purpose of this research?

This research aims to support the development of mainstream mental health policy in Aotearoa/New Zealand that values, affirms, and acknowledges the strength and success of Pacific mental health practice and its potential to support the mental health of all New Zealand communities.

The findings of this research may be used for academic publications and presentations, as well as for public presentations. Should you wish, you may choose to be notified if/when academic or public presentation or publications are made using this material.

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

You have been identified and recommended as a potential participant by the person who approached you about this research project.

This study includes Pacific peoples who are or have been Pacific Mental Health Service Managers, Mental Health Practitioners in a Pacific Mental Health Service, and Consumers/Whānau who have used Pacific Mental Health Services in Aotearoa/New Zealand in the past 10 years (2009 or later). This research is not open to those who are under 18 years of age, and/or who are currently experiencing mental distress. The decision to exclude these participants has been made in order to protect the safety and wellbeing of participants.

How do I agree to participate in this research?

If you would like to take part in this research, please reply to me directly at ruby.tuesday@leva.co.nz. You may complete the attached consent form and return this now, or, should you wish to meet or talk with me before making your decision and/or giving your consent, this can be arranged. If you do not wish to provide it beforehand, you may provide written or verbal consent at the time of the talanoa session (please note that verbal consent will need to be recorded).

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as

belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

This research will involve a one-on-one talanoa with me regarding the following questions:

- What has been successful in Pacific mental health practice in Aotearoa/New Zealand? What are the unique strengths of Pacific mental health practice that have empowered this success?
- What might mainstream mental health policy in Aotearoa/New Zealand look like if these strengths and successes were valued, acknowledged, and affirmed? What potential does such policy show to support the mental health of all New Zealand communities? What results might such policy achieve and what differences might we see?

Notes will be taken during the session and audio of the session will be digitally recorded, transcribed (either by me or by an approved third party), and analysed. Your transcript will be provided to you for verification, as will a summary of any sections of the analysis that relate to your contributions. You will have the opportunity to give feedback on both the transcripts and the analysis.

A summary of all participant contributions will be shared with other participants at the end of this stage of the research, and will also be shared with participants in stage two of this research project.

You may be invited to participate in stage two, however information regarding stage two will be provided separately and at a later date, as applicable.

What are the discomforts and risks?

This research project deals with experiences of Mental Health Services and with culturally specific conceptions of Mental Health and Mental Illness. While it is focussed on what has worked well in these services, it may still lead to psychological discomfort. Furthermore, as a participant, you may have to make decisions around sharing information that might be considered tapu or of special cultural significance.

How will these discomforts and risks be alleviated?

I will make every effort to ensure you feel safe and comfortable throughout the talanoa session. You may choose the location for the talanoa session (your office, my office, a neutral location such as a café or library, your home etc.) and are welcome to have a support person or support people with you throughout the session. Please notify me if you would like to have a support person/support people present so that I can provide information about the project and a consent form for them as well. Should you find that you are distressed by the talanoa at any point, you may suggest a break (or may ask someone to suggest this on your behalf) or you may leave the session. You do not need to give notice or explain your decision.

Should you require it, counselling services to support you with any issues raised by the talanoa are available through AUT:

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

If you are based outside of Auckland and unable to access AUT Health Counselling and Wellbeing services, the national telehealth service "Need to Talk – 1737" is available via free-phone or free-text, and will allow you to speak with a trained mental health professional at your convenience.

Furthermore, you are not required to answer any questions that make you feel uncomfortable. You may decline to answer, or request time to consider your response and get back to me.

What are the benefits?

This research project will explore areas of success and strength in Pacific mental health practice in order to generate recommendations for action that are driven by Pacific policy actors, service managers, practitioners, consumers, and their whanau.

As a participant it is hoped that you will benefit from this research project through the opportunity to share your own experiences of strength and success in Pacific mental health services, and to share in the experiences of others in this area. I intend for this to be an uplifting and affirmative experience for you as a participant.

As a current PhD student, I will benefit directly from this research as it will contribute to the attainment of my qualification.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

As a participant in this research project, you may choose to be identified by your real name, however, to protect your privacy, a pseudonym will be used by default. Your ethnicity, gender, age group, and migration experience (e.g. "island born", "New Zealand born", "migrated at a young age" etc) may also be shared, if you give permission for these details to be included.

A summary of all participant contributions will be shared with other participants at the end of stage one of the research project and will also be shared with participants in stage two of this research project. This summary will include the identifying details listed above unless you have chosen to use a pseudonym and/or have indicated that you would like these certain details to be omitted.

Where an organisation and its practices have been discussed and there is a desire to include the organisation's name and/or details of the organisation's practices in a summary or in the thesis, consent to include these details will be sought. Consent to approach the organisation will be sought from you first, and then consent will be sought from the organisation to include the organisation's name and/or details of the organisation's practices in a summary and in the thesis. The organisation will not be approached unless you have given consent. Should you, or the organisation wish the organisation's name and/or details of the organisation's practices to be excluded from the study – for reasons including but not limited to commercial sensitivity – then this wish will be honoured.

Third parties involved in recruitment and transcription will be subject to a confidentiality agreement and will have been approved by the project supervisors.

Your information will be stored on a password protected external hard drive, or – if your information is in hardcopy – it will be stored in a locked cabinet in room AC313 at Auckland University of Technology Akoranga Campus. Your information will be stored for six years after the conclusion of the thesis in accordance with the university's ethics and data storage policies. You may request to view or amend this data at any time, and, if you withdraw from the study then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What are the costs of participating in this research?

It is expected that participating in stage one of this research project will take 3-5 hours of your time (including travel to and from the talanoa location and verification of transcripts and analysis). It is expected that the talanoa session itself will take 1-2 hours.

What opportunity do I have to consider this invitation?

Data collection for stage one of this research project will continue until the end of April 2020. You may take as long as you like to consider this invitation and may respond at any point prior to 31/04/2020, however an initial follow-up will occur in four weeks' time. You are welcome to request an initial conversation or meeting with me prior to making your decision. This request may be made by contacting me directly using the details provided below.

Will I receive feedback on the results of this research?

You will receive a summary of stage one of this research project, as well as a summary of the completed thesis once it has been reviewed and confirmed. By default, this will be a written summary, disseminated via email, however, a verbal summary will gladly be provided if this is preferred. Should you wish, you may also choose to be informed of any academic or public presentations or publications made using this material.

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

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:

Professor Marilyn Waring

marilyn.waring@aut.ac.nz

+64 9 921 9999 ext 9661

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , +64 9 921 9999 ext 6038.

Whom do I contact for further information about this research?

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

Researcher Contact Details:

Ruby Tuesday

ruby.tuesday@leva.co.nz

021 908 058

Project Supervisor Contact Details:

Professor Marilyn Waring

marilyn.waring@aut.ac.nz

+64 9 921 9999 ext 9661

Doctor Juliet Nanai

juliet.nanai@aut.ac.nz

+64 9 921 9999 ext 7560

Approved by the Auckland University of Technology Ethics Committee on 21/08/2019 AUTEC Reference number 19/240

Consent Form: Stage One – One on One

Project title: ***Informing mainstream mental health policy in Aotearoa/New Zealand through an appreciative inquiry into the strength, success, and potential of Pacific mental health practice.***

Project Supervisor: ***Prof. Marilyn Waring & Dr. Juliet Nanai***

Researcher: ***Ruby Tuesday***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 01/07/2019.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that I can have a support person/support people present during the talanoa session (Please TICK below and indicate the expected number of people if you DO WANT a support person/support people present so that the researcher can make the necessary arrangements).
  I want a support person/support people present – I expect to bring _____ (number of people) with me to the talanoa session○
- ○ I understand that notes will be taken during the talanoa session and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I give permission for the researcher to use the following details in any summaries and in the thesis (please TICK those the researcher IS ALLOWED use):

  My Full Name○
  My Gender○
  My Age Group○
  Details of my migration experience○
- ○ I wish to receive a summary of the research findings (please TICK one):

  Yes○ **No**○
- ○ I wish to be notified of any academic/public presentations or publications made using this material (please TICK one):

  Yes○ **No**○
- ○ I would like to be contacted about taking part in stage two of this research project if applicable (please TICK one):

  Yes○ **No**○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (email and/or cellphone number): .....

.....

Date : .....

Approved by the Auckland University of Technology Ethics Committee on 21/08/2019 AUTEC Reference number 19/240

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

Appendix Four – Participant Information Sheets and Consent Forms – Small Group

Participant Information Sheet: Stage One – Small Group

Date Information Sheet Produced:

01/07/2019

Project Title

Informing mainstream mental health policy in Aotearoa/New Zealand through an appreciative inquiry into the strength, success, and potential of Pacific mental health practice.

An Invitation

Talofa lava, malo e lelei, ni sa bula vinaka, kia orana, taloha ni, fakalofa lahi atu, fakatalofa atu, tena koutou and warm Pacific greetings. My name is Ruby Tuesday and I am a student at Auckland University of Technology. I am undertaking this research project in fulfilment of the requirements for my PhD in Health and Environmental Sciences.

I would like to invite you to take part in this research project through a small group talanoa session on [date TBC], and to share your thoughts regarding the following questions:

- What has been successful in Pacific mental health practice in Aotearoa/New Zealand? What are the unique strengths of Pacific mental health practice that have empowered this success?
- What might mainstream mental health policy in Aotearoa/New Zealand look like if these strengths and successes were valued, acknowledged, and affirmed? What potential does such policy show to support the mental health of all New Zealand communities? What results might such policy achieve and what differences might we see?

Please note that I am currently employed by Pacific Inc. Limited (trading as Le Va) as a training coordinator and researcher. Whether or not you choose to participate in this research will neither advantage nor disadvantage you in terms of your relationship with Pacific Inc. Limited and/or the availability of services provided by Pacific Inc. Limited.

What is the purpose of this research?

This research aims to support the development of mainstream mental health policy in Aotearoa/New Zealand that values, affirms, and acknowledges the strength and success of Pacific mental health practice and its potential to support the mental health of all New Zealand communities.

The findings of this research may be used for academic publications and presentations, as well as for public presentations. Should you wish, you may choose to be notified if/when academic or public presentation or publications are made using this material.

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

You have been identified and recommended as a potential participant by the person who approached you about this research project.

This study includes Pacific peoples who are or have been Pacific Mental Health Service Managers, Mental Health Practitioners in a Pacific Mental Health Service, and Consumers/Whānau who have used Pacific Mental Health Services in Aotearoa/New Zealand in the past 10 years (2009 or later). This research is not open to those who are under 18 years of age, and/or who are currently experiencing mental distress. The decision to exclude these participants has been made in order to protect the safety and wellbeing of participants.

How do I agree to participate in this research?

If you would like to take part in this research, please reply to me directly at ruby.tuesday@leva.co.nz. You may complete the attached consent form and return this now, or, should you wish to meet or talk with me before making your decision and/or giving your consent, this can be arranged. If you do not wish to provide it beforehand, you may provide written or verbal consent at the time of the talanoa session (please note that verbal consent will need to be recorded).

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to

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

What will happen in this research?

This research will involve a small group talanoa facilitated by myself and a cultural support person. The talanoa will cover the following questions:

- What has been successful in Pacific mental health practice in Aotearoa/New Zealand? What are the unique strengths of Pacific mental health practice that have empowered this success?
- What might mainstream mental health policy in Aotearoa/New Zealand look like if these strengths and successes were valued, acknowledged, and affirmed? What potential does such policy show to support the mental health of all New Zealand communities? What results might such policy achieve and what differences might we see?

Notes will be taken during the session and audio of the session will be digitally recorded, transcribed (either by me or by an approved third party), and analysed. The transcript will be provided to all members of the group (so that they can verify their individual contributions), as will a summary of any sections of the analysis that relate to the groups' contributions. All members of the group will have the opportunity to make corrections to the sections of the transcripts that reflect their individual contributions and to give feedback on the analysis.

A summary of all participant contributions will be shared with other participants at the end of this stage of the research, and will also be shared with participants in stage two of this research project.

You may be invited to participate in stage two, however information regarding stage two will be provided separately and at a later date, as applicable.

What are the discomforts and risks?

This research project deals with experiences of Mental Health Services and with culturally specific conceptions of Mental Health and Mental Illness. While it is focussed on what has worked well in these services, it may still lead to psychological discomfort. Furthermore, as a participant, you may have to make decisions around sharing information that might be considered tapu or of special cultural significance, as well as working with others whose age, gender, ethnicity, status, or background differs from your own (causing potential conflicts of interest and/or difficulties in respectful communication).

How will these discomforts and risks be alleviated?

I will make every effort to ensure you feel safe and comfortable throughout the talanoa session. Should you find that you are distressed by the talanoa at any point, you may suggest a break (or may ask someone to suggest this on your behalf) or you may leave the session. You do not need to give notice or explain your decision.

Should you require it, counselling services to support you with any issues raised by the talanoa are available through AUT:

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

If you are based outside of Auckland and unable to access AUT Health Counselling and Wellbeing services, the national telehealth service "Need to Talk – 1737" is available via free-phone or free-text, and will allow you to speak with a trained mental health professional at your convenience.

Furthermore, you are not required to answer any questions that make you feel uncomfortable. You may decline to answer, or request time to consider your response and get back to me.

Every effort will be made to provide a co-facilitator for this session who has the requisite cultural knowledge and facilitation skill to mitigate and manage any risks related to age, gender, ethnicity, status, or background to ensure that respectful and culturally appropriate communication can take place.

What are the benefits?

This research project will explore areas of success and strength in Pacific mental health practice in order to generate recommendations for action that are driven by Pacific policy actors, service managers, practitioners, consumers, and their whanau.

As a participant it is hoped that you will benefit from this research project through the opportunity to share your own experiences of strength and success in Pacific mental health services, and to share in the experiences of others in this area. I intend for this to be an uplifting and affirmative experience for you as a participant.

As a current PhD student, I will benefit directly from this research as it will contribute to the attainment of my qualification.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

How will my privacy be protected?

As a participant in a small group talanoa, the other participants in the group will be able to identify you and your contribution. All participants in this small group talanoa will be required to agree to keep the group proceedings confidential as part of the consent process.

As a participant in this research project, you may choose to be identified by your real name, however, to protect your privacy, a pseudonym will be used by default. Your ethnicity, gender, age group, and migration experience (e.g. "island born", "New Zealand born", "migrated at a young age" etc) may also be shared, if you give permission for these details to be included.

A summary of all participant contributions will be shared with other participants at the end of stage one of the research project and will also be shared with participants in stage two of this research project. This summary will include the identifying details listed above unless you have chosen to use a pseudonym and/or have indicated that you would like these certain details to be omitted.

Where an organisation and its practices have been discussed and there is a desire to include the organisation's name and/or details of the organisation's practices in a summary or in the thesis, consent to include these details will be sought. Consent to approach the organisation will be sought from you first, and then consent will be sought from the organisation to include the organisation's name and/or details of the organisation's practices in a summary and in the thesis. The organisation will not be approached unless you have given consent. Should you, or the organisation wish the organisation's name and/or details of the organisation's practices to be excluded from the study – for reasons including but not limited to commercial sensitivity – then this wish will be honoured.

Third parties involved in recruitment, facilitation, and transcription will be subject to a confidentiality agreement and will have been approved by the project supervisors.

Your information will be stored on a password protected external hard drive, or – if your information is in hardcopy – it will be stored in a locked cabinet in room AC313 at Auckland University of technology Akoranga Campus. Your information will be stored for six years after the conclusion of the thesis in accordance with the university's ethics and data storage policies. You may request to view or amend this data at any time, and, if you withdraw from the study then your personal information will be destroyed/deleted. It may not be possible to destroy all records of the group discussion of which you were part, however you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. Every attempt will be made to exclude your contributions to the group discussion from the study, however, this may not be completely possible where your contributions overlap with those of other group participants. Please note, once the findings have been produced, removal of your data may not be possible.

What are the costs of participating in this research?

It is expected that participating in stage one of this research project will take 3-5 hours of your time (including travel to and from the talanoa location and verification of transcripts and analysis). It is expected that the talanoa session itself will take 1-2 hours.

What opportunity do I have to consider this invitation?

You have [#>4] weeks to consider and respond to this invitation, with the small group talanoa sessions scheduled to be held on [Date TBC].

Will I receive feedback on the results of this research?

You will receive a summary of stage one of this research project, as well as a summary of the completed thesis once it has been reviewed and confirmed. By default, this will be a written summary, disseminated via email, however, a verbal summary will gladly be provided if this is preferred. Should you wish, you may also choose to be informed of any academic or public presentations or publications made using this material.

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

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor:

Professor Marilyn Waring

marilyn.waring@aut.ac.nz

+64 9 921 9999 ext 9661

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , +64 9 921 9999 ext 6038.

Whom do I contact for further information about this research?

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

Researcher Contact Details:

Ruby Tuesday

ruby.tuesday@leva.co.nz

021 908 058

Project Supervisor Contact Details:

Professor Marilyn Waring

marilyn.waring@aut.ac.nz

+64 9 921 9999 ext 9661

Doctor Juliet Nanai

juliet.nanai@aut.ac.nz

+64 9 921 9999 ext 7560

Approved by the Auckland University of Technology Ethics Committee on 21/08/2019 AUTEC Reference number 19/240

Consent Form: Stage One – Small Group

Project title: ***Informing mainstream mental health policy in Aotearoa/New Zealand through an appreciative inquiry into the strength, success, and potential of Pacific mental health practice.***

Project Supervisor: ***Prof. Marilyn Waring & Dr. Juliet Nanai***

Researcher: ***Ruby Tuesday***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 01/07/2019.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that identity of my fellow participants and our discussion in the small group talanoa session is confidential to the group and I agree to keep this information confidential.
- ○ I understand that notes will be taken during the small group talanoa session and that it will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the focus group discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I give permission for the researcher to use the following details in any summaries and in the thesis (please TICK those the researcher IS ALLOWED use):

  My Full Name○
  My Gender○
  My Age Group○
  Details of my migration experience○

- ○ I wish to receive a summary of the research findings (please TICK one):

  Yes○ **No**○

- ○ I wish to be notified of any academic/public presentations or publications made using this material (please TICK one):

  Yes○ **No**○

- ○ I would like to be contacted about taking part in stage two of this research project if applicable (please TICK one):

  Yes○ **No**○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (email address and/or cellphone number): .....

.....

Date : .....

Approved by the Auckland University of Technology Ethics Committee on 21/08/2019 AUTEC Reference number 19/240

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

Appendix Five – Appreciative Interview/Talanoa Guide

Interview Guide – Stage One

Introduction:

- Introduce self, employer, and academic background
- Review confidentiality and consent issues from PIS and ensure participant(s) is happy to proceed.
- Introduce study: talking about
    - what has been successful in Pacific mental health practice
    - the unique strengths that have enabled this success
    - what mainstream mental health policy in Aotearoa *might* look like if this strength and success was recognised
- Used to inform later discussions about which elements of strength and success could be included in mainstream policy and how to get them there
- Highlighting success and strength will nurture positive attitudes towards Pacific values, understandings and approaches to mental health amongst mainstream
- Positive attitudes will help to ensure mainstream policy which affirms and acknowledges the potential and relevance of these
- Benefits for Pacific and for all Aotearoa
- Focus on the very best, what is working really well
- Want this to be an uplifting and inspiring experience for us and for later readers
- Request opening prayer

Rapport building:

- Tell me about you - where you grew up and the people you grew up with?
- What do you value most about the work that you do?/What do you value most when seeking support with your mental health and wellbeing?
- Tell me about your beginnings in Pacific mental health?/Tell me about how you first came to use a Pacific mental health service?
- Describe one of the best experiences you have had in Pacific mental health?

Discover:

What has been successful in Pacific mental health practice in Aotearoa/New Zealand? What are the unique strengths of Pacific mental health practice that have empowered this success?

- As a Pacific practitioner/service manager what are you doing really well in your practice?
- Can you think of a specific situation where you were especially successful in your practice? Working with a specific consumer/tangata whaiora or leading a specific initiative?
- How is what you are doing well different from what your non-Pacific peers are doing?
- What Pacific values, understandings, and approaches do you see in what you do?
- How do these values, understandings, and approaches support your success?
- How do these values, understandings, and approaches effectively support the wellbeing of consumers/tangata whaiora?

- Have you ever applied these values, understandings, and approaches with non-Pacific consumers/ tangata whaiora? Can you think of any situations where you were especially successful in your practice with them?

OR

- Can you describe what Pacific practitioners/service managers are doing really well in their practice?
- Can you think of a specific situation where you were cared for especially well when you needed support with your mental health?
- How is what they are doing well different from what their non-Pacific peers are doing?
- What Pacific values, understandings, and approaches do we see in what they are doing?
- How do these values, understandings, and approaches support their success?
- How do these values, understandings, and approaches effectively support the wellbeing of consumers/tangata whaiora?

Dream:

What might mainstream mental health policy in Aotearoa/New Zealand look like if Pacific strengths and successes were valued, acknowledged, and affirmed? What potential does such policy show to support the mental health of all New Zealand communities? What results might such policy achieve and what differences might we see?

Imagine we are ten years in the future and the government is bringing out its next mental health policy. This government is strongly pro-Pacific and recognises the potential of Pacific values, understandings, and approaches to mental health.

- What Pacific understandings, values, and approaches could be included in mainstream policy?
- How would these be affirmed and acknowledged - what would be said about Pacific understandings, values, and approaches that is affirmative and shows acknowledgement?
- What action points or strategies might we see? Think about training, workforce, administration, treatment, measurement...
- What sorts of services and practices would be prioritised in this policy?
- Can you describe the benefits we would we see for Pacific people, families, and communities?
- Can you describe the benefits we would see for people, families, and communities throughout New Zealand?
- What might people, families, and communities say about these services?
- What might the people working in these services say about them?

Concluding questions:

- Review key points I gathered as a listener and confirm accuracy
- Ask
    - What have been the highlights of today's talanoa?
    - Can you share something new that has come to you through this conversation?
- Share what has inspired and uplifted me.
- Outline what to expect next – analysis, review and feedback.
- Give thanks.
- Close with prayer if we opened with prayer.