

Exploration of Pacific perspectives of Pacific models of mental health service delivery in New Zealand

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Abstract

There is increasing concern about the inequalities, overall health outcomes, and mental health of Pacific peoples residing in New Zealand. The New Zealand Mental Health Survey (Te Rau Hinengaro), conducted in 2003/2004, identified Pacific peoples as having a higher 12-month prevalence of mental disorders than the general population. The burden of mental health amongst Pacific peoples was identified as high and associated with other socioeconomic correlates. Pacific peoples were also more likely not to access professional mental health assistance.

The aim of this study was to provide indepth qualitative data that explored Pacific perceptions and experience of the theory, practice, and utilisation of Pacific mental health services in New Zealand. This paper documents: (i) the different models of care practiced in the Pacific mental health sector, and (ii) the specific components that: (a) make these models uniquely Pacific, and (b) that consumers and families identified as integral to the recovery process.

Pacific peoples' views of mental health from the following three perspectives were studied: (i) the service provider, (ii) the mental health consumer, and (iii) the family member, using focus group interviews in Auckland, Hamilton, Wellington, and Christchurch.

The results report the different perceptions of the Pacific focus group and interview participants. Our findings indicate that firstly, having appropriate family and community support networks (psycho-social and community), appropriate living environments and meaningful work for consumers, and secondly, access to culturally competent mental health staff, contributes towards consumer recovery and assisting families.

In conclusion, Pacific models of care (service delivery) were found to be informed by Pacific models of health belief and existed in implicit rather than explicit forms. To develop clearer or specific articulations of Pacific models of service delivery, the first step for services is to develop written expositions (a theory) of how these models might be framed taking into equal account cultural, clinical, and service management issues.

Introduction

Mental illness has been acknowledged by the New Zealand (NZ) Government as a major public health issue.¹⁻³ In NZ, there has been increasing concern about the inequalities in overall health outcomes and the mental health of Māori (who comprise about 15% of the population), and Pacific people living in NZ who comprise about 6.5% of the population.^{1, 2, 4-8} In terms of prevalence, Te Rau Hinengaro found while the burden of mental disorder was found to be high among Pacific peoples, the excess burden was attributable to the age, gender structure, and socioeconomic correlates of the Pacific population.⁸ Pacific peoples were less likely to access any professional health service for mental health problems.^{7, 8} Only in the last 10-20 years, with deinstitutionalisation and greater advocacy by Māori, have mental health services begun to recognise the significance of ethnic culture in service delivery.

Pacific peoples generally do not consider mental illness to necessarily originate entirely from within a person.⁹ Pacific peoples often view mental disorder as 'spiritual possession' caused by the breach of a sacred covenant between peoples or between peoples and their gods.¹⁰⁻¹³ The traditional Pacific approach to healing is to seek the input of traditional healers believed to have the spiritual powers necessary to restore spiritual, physical, mental and social balance.

Pacific health experts have proposed a variety of metaphorical frameworks for thinking through how Pacific health is conceptualised and how Pacific service approaches should be framed. These frameworks include the: (i) Samoan Fonofale^{12, 14} and Faafaletui models¹¹, (ii) Tongan Kakala model¹⁵, and (iii) Cook Islands Tivaevae model.¹⁶ These models all point to the importance of focusing on the process of interventions and understanding of Pacific concepts such as the use of Pacific languages, spirituality, gender, familial and community responsibilities and intergenerational ethnic concepts of care.

As with many other indigenous and ethnic minority

populations there is a paucity of indepth information, qualitative or quantitative, regarding Pacific mental health service delivery in NZ. The need for ethnic specific research is global. In the United Kingdom there is a call for more "ethnographic inputs into policy".¹⁷ In the United States and Canada similar sentiments underline calls for the development of cultural competency frameworks or approaches.¹⁸⁻

²¹ These calls for culturally specific ethnographic information are premised on the recognition, in social and health governance circles, that there exist real disparities in the health outcomes of ethnic minorities compared with their mainstream counterparts.²¹⁻²³

Pacific peoples often view mental disorder as 'spiritual possession' caused by the breach of a sacred covenant between peoples or between peoples and their gods.

The aim of this article is to provide some indepth data exploring

Pacific perceptions and experience of the theory, practice and utilisation of Pacific mental health services in NZ and how these informed their Pacific models of service delivery. This paper summarises key findings from the 2004 "Pacific Models of Mental Health Service Delivery in New Zealand" study. (see <http://www.crrc.co.nz/publications.php>).

Methods

The 2004 study provides a snapshot of Pacific peoples' views of mental health from three perspectives: (i) the service provider, (ii) the mental health consumer, and (iii) the family member. Data collection involved qualitative focus group interviews with Pacific service providers, relevant community and consumer advisors, and Pacific mental health consumers and their family members in Auckland, Hamilton, Wellington and Christchurch.

Ethical approval was obtained for the study utilising the national process via lead application to the Auckland Region Ethics Committee.

Data collection

Pacific principles such as the Samoan *va fealoaloa'i* (caring for interpersonal relationships) and the Tongan *feveitokai'aki* (respect) were adopted throughout the process of organising the focus groups, collecting, and

feedback of data.²⁴ Adopting these principles involved ensuring that cultural, ethical, and professional concerns surrounding the relationship between the researchers and the participants were considered.

All consumer, family, and service provider focus group sessions were held simultaneously for the Wellington (n=6), Christchurch (n=3) and Auckland (n=11) sites. An additional two individual interviews were conducted at the request of a service provider in Wellington and another in Hamilton.

The focus groups were conducted using a topic guide. Discussions were unstructured i.e. aside from general areas that needed to be covered, the specific discussion direction was guided by how people responded to each other, rather, than by set questions. This is generally referred to as the inductive qualitative grounded theory approach.^{25, 26}

Each taped focus group was transcribed verbatim by one of four Pacific researchers. Non-English discussions were firstly transcribed verbatim in the language of origin and then translated using a double-checking process. The first stage involved transcribers fluent in the Pacific language. Their transcriptions were double-checked for spelling, meaning, and nuance by an 'expert' in the ethnic language. All Samoan, Tongan, Niuean and Cook Island data underwent this process. The bulk of the data gathered was in English. All original verbatim transcriptions, language translations, and meeting and observational notes were included in the material analysed.

Data analysis

Themes arising from the data were analysed and discussed following compilation of verbatim transcriptions. Twenty-three themes arose in total (Table 1). A draft report was compiled and the research team together with the Reference Group organised feedback forums to participants from each of the three main sites. All three forum attendees affirmed the key findings and were appreciative of the feedback process.

Results

The results are presented in a four-part summary format with specific research questions being addressed.

Part I: This section presents discussions about: (a) models of 'mental health care' known to participants, and (b) what participants thought were the uniquely Pacific 'styles' within these models.

Participants explicitly raised eight different "models" (Table 2). Whilst most of these models were offered in passing and by only a few participants, one model,

the *Fonofale* model, was frequently mentioned.

What was uniquely 'Pacific' about these eight models (Table 2) was expressed in terms of the emphasis these models placed on the 'holistic' context of care, where the 'spiritual' sat alongside the 'physical'.

The resource implications of these noted models were acknowledged by participants as "huge". To deliver a holistic Pacific model of care required access to a large pool of resources. In such a resource competitive environment, a case for 'appropriate' funding of these models is likely to be difficult. Participants argued, however, this was no reason not to look for ways to find some accommodation from "both sides" (i.e. the "capitalist" side and the "holistic" side to use their words).

As suggested by one opinion leader participant, there are many different Pacific models of care available today for Pacific service providers. This person doubted that "*we can ever find one that can apply all across the board*" and suggested that, "*there is a number of things...that can assist us*" and that "*if we can have a collection of these [models], some understanding [of these models], then we may use [them in our] practice*". This supports the value of having a range of model frameworks perspectives. Providing cost-effective services requires (among other things) building better understanding of what each model refers to and how they might play out in different mental health service practice settings.

Part II: This section presents a summary of the discussion about how participants perceived Pacific mental health services to be delivered to Pacific consumers and families today and what participants thought were uniquely Pacific "styles" within those delivery approaches.

Cultural assessments, holistic models of care, an inviting atmosphere using Pacific motifs and hospitality practices, use of Pacific languages and recognition of co-existing 'spiritualities', were each raised by participants as uniquely Pacific elements in the service delivery approaches adopted by Pacific services.

In terms of Pacific practice standards, Pacific opinion leaders advocated for the review of Pacific alongside mainstream practice standards to ensure that the logic between them is consistent and that expectations of Pacific mental health services are not unrealistic and standards set were culturally and/or professionally safe.

In terms of documentation and reporting requirements, some Pacific service provider managers and service workers argued that the expectations from funders was merely a "number crunching" exercise that could not capture the 'extra mile' tasks they carried out as part of their 'holistic' Pacific models of care. They

argued that these tasks are done “from the heart” rather than because of a ‘job description’. A review of reporting requirements for Pacific service workers was therefore requested by these participants, alongside a survey of Pacific service worker competencies in this area.

In terms of Pacific mental health workforce competencies, participants argued that these were twofold: either ‘clinical’ or ‘cultural’. From their discussions it seems that Pacific cultural competence is measured largely in terms of an ethnic ‘island-born’ Pacific (Christian and pre-Christian) understanding of ‘culture’. From this ethnic language, traditional protocols, values, and philosophies were cited as key indicators of ‘cultural’ competence. Actual discussion on clinical competence was minimal but where it was offered it assumed a bio-medical understanding of what constituted ‘the clinical’. Participants identified that there was still work to be done on how these two parts of competency may come together and what other aspects of both parts needed to be incorporated within a Pacific model of mental health care and service delivery.

To work with Pacific consumers often meant also working with their families. Families were understood to comprise both extended and immediate family members. Families were recognised as important to the Pacific consumer’s healing process.²⁷ Some participants argued, however, that service workers needed to be mindful of the fact that not all Pacific families were the same and that while family involvement was desirable, it may not necessarily be appropriate in the circumstances. Notwithstanding, the ‘extended’ family was still perceived by many participants to be characteristic of Pacific cultures, forming part of what they described as the ‘uniquely Pacific’ aspects of working with Pacific consumers.

Despite participant acknowledgement that Pacific cultures are not homogenous, it was generally agreed that there were a number of core values, such as the centrality of kin-based relationships and belief in an ancestral spirituality that were shared. This made it possible to speak generally about a *Pacific* philosophy, *Pacific* values and practices. From this it was noted that there was within this the spiritual and cultural concept of *tapu* (the sacred and taboo) that was implicit in a Pacific philosophy and psychology of self.²⁸

Pacific social relationships were also identified as socio-centric in nature. This socio-centrism was defined as much by secular political relations between people as by the spiritual connections they had with each other (as individuals and collectives), with nature, and with their god(s).

When talking about the term ‘spirituality’ in particular, participants conceived this in two ways i.e. as

Christian or indigenous spirituality. Ideas of *tapu* were implicit in their discussions of the indigenous self and of spirituality.

Within these frameworks of self and spirituality sit principles of reciprocity, love and compassion (e.g. *ofa* in Tongan); respect and deference (e.g. *faaloalo* in Samoan); and notions of family interconnectedness (e.g. *magafaoa* in Niuean; or *kopu tangata* in Cook Islands Maori). The self was understood within this framework to be a relational self; time and space, rights and responsibilities were similarly relationally situated.^{28, 29} For many participants, this philosophical framework and its value system underpinned holistic Pacific models of health care and service delivery. This was what was for them the uniquely Pacific aspects of Pacific mental health services.

When exploring the “Pacific for Pacific by Pacific” mantra closely some Pacific health worker participants asserted that in practice it promoted an island-born adult matrix of care that seemed exclusive of the cultural values of NZ-born on the one hand, and NZ-born Pacific youth on the other. This was raised by Pacific opinion leaders and Pacific youth consumers to be a fundamental barrier to Pacific youth participation in Pacific specific services. The question of how to work best with Pacific youth challenges current models of Pacific service delivery that seem to bias the ‘island-born’ Pacific adult perspective. The institutionalisation of the role of *matua* (elders) in Pacific mental health services, most whom are adult and ‘island-born’, is something that was considered by participants as also uniquely Pacific to Pacific health services. It was perceived a necessary role for the formal development of Pacific cultural competence in health services. However, in light of claims of ‘elder’ bias, a tension point arises.

Part III: This section presents a summary of the discussion about what helps Pacific mental health consumers “get well”. The views and perspectives of the consumer informed this section. Some information was also offered by families and service providers.

The participants upheld that a range of things from medication to ‘spirit lifting’ activities (e.g. engaging in Pacific group therapy; exercise; holding a ‘normal job’; looking after grandchildren) helped Pacific mental health consumers “get well”. While some noted the benefits of medication, others cautioned against adopting a naive belief that doctors would always get the medication right. A suggestion was raised by a consumer that Pacific consumers visit psychologists rather than psychiatrists if they wished to avoid the over-prescription of medication and/or be listened to in the terms of the ‘spiritual warfare’ they believed they were experiencing at times when they were ‘unwell’.

Family involvement in consumer recovery was important to many of the consumers of this study in terms of “what makes them well”. One opinion leader suggested that this was not necessarily the case for all Pacific consumers, especially youth consumers.

Pacific family caregivers often had multiple caregiving responsibilities and some had found it difficult to juggle these and look after their mentally unwell family member. Asking for help was not easy for these family members and usually only occurred in times of crisis. Family participants recognised that drawing on extended family help was also not necessarily possible, for both practical and cultural (shame) reasons. Turning to the State for help, was often seen as a last resort, something they initiated out of desperation or something imposed on them by the Court.

Asking for help and receiving appropriate help meant that communication between services, hospitals, families, and consumers needed to be kept open at all times. Ensuring that there were culturally and clinically competent workers, who were able to follow up on tasks where necessary, was important in keeping these communication lines open and ultimately to assisting the Pacific consumer to get well.

Helping consumers get well meant dealing with issues of stigma. Many of the Pacific consumer participants noted that destigmatisation needed to begin at home with many of our Pacific families. How best to promote these messages within the Pacific family or home in culturally appropriate ways was considered important to getting the recovery model, the model of care, right. To begin with, some consumers pointed to the need for the promotion of positive messages, such as those promoted by the ‘Like Minds Like Mine’ campaign, not only in Pacific settings such as with families and churches, using where appropriate ethnic specific Pacific languages, but also within the workplace. Within the mental health workforce there existed stereotypes about consumer capability levels (or lack thereof) that caused unfair discrimination. Limiting career opportunities was one example. Such discriminatory practices contributed to creating and/or perpetuating barriers to consumer recovery.

Getting the appropriate frontline community support worker (CSW) was for many Pacific consumers the key to their successful recovery. These CSWs provided the ‘people-interface’ between stressed families, unwell consumers, and unfeeling bureaucracies.

Part IV: This section presents a summary of the discussion about how Pacific families supported family members with mental health problems to “get well”.

Pacific family members of this study adopted a range

of support mechanisms to assist mentally unwell family members ‘get well’. These included gaining access to key community support workers for their family member; utilising respite care for themselves ‘stay well’; assisting in the administration of appropriate medication where necessary; engaging and/or transporting their family member to appropriate treatment processes and/or community (or church) support networks; and/or generally keeping their family member’s ‘spirit lifted’.

Most family caregivers who participated in the study, whose mentally unwell family member was of the ‘older’ generation (e.g. their mother or aunt), found that the traditional ethnic-specific approach of many Pacific mental health services well suited the needs of their older family members. For younger consumers the fit was not as neat. Finding a service and/or service worker who could relate to the consumer at his/her ‘youth’ level was important to the mother of one youth consumer.

Extended family assistance was relatively uncommon despite the perception that Pacific families can easily draw on the resources of extended family members for support. It was often logistically more convenient for primary family caregivers to organise for State rather than extended family assistance.

Not knowing how to access support mechanisms such as appropriate CSWs respite care, appropriate medication, treatment processes and community and/or church support was a common barrier to Pacific consumers and/or families accessing these services.

Discussion

This study raised some core issues about how models of health belief inform models of health service delivery. A number of ambiguities arose when discussing these models, however, what was clear from participant commentaries was that there existed many different types of health models and that often they overlapped or were used interchangeably. Tracing the evolution of the different health models or explicating in detail each health model was not within the purpose of this research. Rather, we sought to document what Pacific peoples believed to be their models of health care and what they thought was unique about these models. In summary, the following key themes emerged from this study.

What is unique about Pacific models of care?

To talk about ‘what is uniquely’ Pacific about Pacific approaches is to inevitably highlight the philosophical value system adopted by these approaches. This value system is inherent in many of the different service techniques adopted by the Pacific service providers of this study. These include understandings of spirituality, the cultural value of group therapy and

use of Pacific language and hospitality practices. More specifically, these involved the privileging of interpersonal relations, of building trust and rapport between consumer, families and service workers, of understanding the importance of the spirit of a person to his/her mental health. Literature examining indigenous and ethnic minority health issues overseas, however, suggests that similar value frameworks operate in other indigenous and/or ethnic minority communities.³⁰⁻³²

The claim of 'going the extra mile' was suggested by other studies to be a situation that arose more out of systemic failures to address the holistic needs of consumers than anything else.^{30, 31} The Alaskan Southcentral Foundation system provides an excellent example of how, with right support and skills, the holistic value-based service delivery model they adopt can operate and operate successfully without having to exploit people who want to go 'the extra mile'.^{30, 31}

In Pacific philosophy there needs to be balance in mind, body and soul if there is to be health and wellbeing, encapsulated in the Tongan and Samoan metaphorical saying: *piki piki hama* (Samoans would say *ama*), *vae vae manava* (lit. *piki piki hama* means "hold onto the outrigger"; *vae vae manava* means sharing the womb/sharing breath).³³ This idea of cosmic balance is also implicit in Asian principles of yin and yang.^{31, 34, 35} Moreover, the Niuean idea of *fakalilifu* (respect) is similar to the Hispanic principles of *respeto*. And, Cook Island Māori concept of *kopu tangata* and Māori concepts of *whanau* come from the same family tree. Knowing both what is shared in common and what makes people unique is what provides balance and idiosyncrasy. These principles of cosmic balance, respect and family, while perhaps expressed in different – uniquely – Pacific ways, they are principles shared by many other ethnic indigenous groups. In terms of Pacific health service delivery in New Zealand, for Pacific health services it is important to recognise that while they do share some points in common with other ethnic health services, to claim their uniqueness they must equally understand where and how they might differ.

Like the need to recognise the difference between a health belief model and a service delivery model, there is also a need to recognise that the 'Pacific for Pacific by Pacific' approach to service delivery is more a strategic tool for political leverage than an ideological goal. So long as Pacific peoples are over-represented in lower socioeconomic and health statistics, there is always value in interrogating the appropriateness of those strategies set up to address Pacific health and wellbeing.

Models of health-belief and models of service delivery.

Mandiberg notes, "whole models cannot and should not ever be lifted out of social, cultural and economic contexts and imposed somewhere else".³⁶ What can be transported, he argues, are principles of what works. Models themselves do not necessarily influence systems; rather it is the principles upon which models are based that make the difference. The term 'model' was employed in this project in line with the funders (the then Mental Health Research and Development Strategy) research terms of reference.

When participants referred to a model they did not elaborate on what they understood these models to mean possibly because within the focus group setting it was assumed that participants implicitly understood these models without need for detailed discussion. Alternatively, perhaps those participants who raised it/them were themselves not sure of the details of the model/s and so discussion was limited. Thus, when exploring the question of Pacific models of service delivery the ambiguity associated with what was meant by the concept 'model of service delivery' stood out. It became clear that many of the Pacific models that

fono participants referred to, including the commonly referenced *Fonofale* model, were more models of health belief rather than of service delivery.

The question of what constituted a 'service delivery model' as opposed to a 'health belief model' raised considered discussion with the Reference Group. What emerged from this was an understanding that a Pacific 'service delivery' model required address not only of what the health beliefs or values adopted by the Pacific service were but also of how these values or beliefs were to be explicitly implemented within the clinical and service management arms of the service. At this point issues of workforce competency and service performance also came to light, particularly how competence and/or performance criteria might be defined and/or assessed. Models that failed to address these issues could therefore technically not be considered models of service delivery. They would more accurately be termed models of health belief.

Of the models raised by participants the '*faafaletui* model' coined by Tamasese et al,¹¹ did not fit comfortably within either the definition of health belief model or service delivery model. It seemed more accurate to refer to the *faafaletui* model as a process model. The Samoan notion of *faafaletui* (meaning to form a gathering or meeting group to discuss an issue of importance) speaks more to the task of forming an appropriate process or method for discussion and interaction than to the task of delivering a service. It is of course part of the process of determining the key

In Pacific philosophy there needs to be balance in mind, body and soul if there is to be health and wellbeing.

components of a service and its styles of delivery, but it is not in and of itself a model of service delivery.

The traditional healing model is perhaps the only model of those raised by *fono* participants that might well be perceived as a 'service delivery' model. Implicit within traditional healing practices are traditional codes of conduct and service management, as well as accepted 'treatment' practices based on cultural and medicinal knowledge that suggest that within the traditional healing model there do exist frames for measuring traditional healing competency and performance.³⁷ More recent Pacific work in New Zealand, such as the "Seitapu"³⁸ and the CRRC "Exploring Cultural Competency" publication²⁷ has begun this.

Pacific youth consumers and the Pacific matrix of care

For the Pacific mental health sector to agree that there are key differences between NZ-born and island-born peoples and key differences between Pacific youth and Pacific adults, the Pacific mental health service sector has to 'come of age'. With an increasing NZ-born Pacific population³⁹, Pacific born values and worldviews must find some accommodation with NZ born Pacific values. A Pacific matrix of care must accordingly take account of what could be competing values between them.

It is useful to note that stigma attaches differently according to age, gender, class, religion and ethnicity.⁴⁰ It is wrong to assume that Pacific youth consumers experience the same stigma as those Pacific consumers considered mature adults and/or elderly. In this case, the Pacific youth consumer may feel more in sync with non-Pacific youth consumers than older Pacific consumers. Participants of this study hinted at the likelihood of each of the above. These issues of stigma and cultural and generational differences reinforce the need for the Pacific mental health sector to constantly review current models and matrices of care for their appropriateness to the Pacific population as a whole.

Family versus state help

Within Pacific cultures, even in NZ, the extended family is touted as the model support network. Responsibility for the care of mentally unwell family members is ideally shared between extended family members. In NZ, participants recognise that with travel costs the ideal is often not achievable. The importance placed by Pacific peoples on the extended family as key support networks for unwell members is something also characteristic of non-Polynesian groups such as the Hispanics in the USA.³¹

The low socioeconomic status of many Pacific peoples in NZ, coupled with the high levels of cultural obligation imposed on some to act as carers/caregivers to immediate and/or extended family

members, means that the knowledge and ability of when and how to access help when it is needed is imperative. Ensuring that Pacific communities are well informed of the various respite care services available for families with members who have high caring responsibilities is essential.

The spirituality of evangelism and the Pacific matrix of care

Culture and religion are inextricably linked in Pacific communities, whether in the island homelands or in the metropolitan settings of NZ. Evangelical spirituality has its roots in Christianity and is growing rapidly in different Pacific population groups, but particularly within its youth population. The spirituality of Christianity is differentiated from the spirituality of ancient Pacific cosmologies. Evangelical spirituality moves away from the ritualistic basis of traditional Christian worship towards a more charismatic approach to worship that can challenge holding on to traditional spiritual beliefs and practices (whether traditionally Christian or indigenous). This third form of spirituality adds another layer to the dimensions of 'the spiritual' that participants refer to in their suggested Pacific matrix of care and/or models of Pacific health service delivery.

Developing workforce competencies

In developing workforce competencies for health and social service workers working with NZ-based Pacific consumers and their families, the participants of this study argued that there needed to be a complement of cultural, clinical and management-type skills. An understanding of the heterogeneity of Pacific peoples in New Zealand is a prerequisite to achieving balance in operationalising those skills. Moreover, in working with Pacific families workers must understand their pressures and have the skills to communicate effectively with them. Being open to understanding notions of spiritual possession is but one example of the complexities of the Pacific cultural worldview that workers must grapple with.

The need to review Pacific practice standards alongside mainstream practice standards, as advocated by a number of participants, is a useful step forward. Within these practice standards the complex relationship between NZ born Pacific youth and Island born Pacific adults and between "cultural" and "clinical" models of care and/or service delivery needs to be accounted for. From participant narratives there are misperceptions surrounding what constitutes the clinical and the cultural. In terms of the clinical: first, there is the idea that the clinical is synonymous with the bio-medical. Second, that the bio-medical is an actual model of practice and/or is *the* model of practice under which the medical profession train. This is problematic and unsurprisingly creates misperceptions. In relation to the cultural: the idea that the cultural is ethnic only and based only on a traditional value system permeates

a number of participant responses. Each of these misperceptions needs address within workforce training programmes.

It is recognised that the development of mental health workforce competencies for working with Pacific consumers and families is far from straightforward. This study provides a starting point for debate. Each of these points combines to form a compelling argument for taking the necessary time to tease out the theoretical and practical implications of different workforce competency equations.

Pacific NGO and DHB-based mental health services

Those participants who were part of an NGO service suggested that they had more relative autonomy to carry out Pacific specific service delivery and care approaches compared to their DHB-based colleagues. Whether this was and is indeed the case is a question for further research. Given the small Pacific workforce population of New Zealand (compared with Māori and Pakeha communities), and the competitive environment of contract services, gaining real inter-institutional, inter-service collaboration is not easy. Nevertheless, given the complexities of Pacific mental health in New Zealand, all services, whether DHB-based or NGO, would do better by working together than apart.

Conclusion

In conclusion, we found that by and large Pacific models of service delivery raised by our participants were in fact, in their current form, models of health belief. The process for translating those health models into Pacific models of service delivery is yet to come.

Limitations of the study

The qualitative research findings, on which the primary study is based, is not representative of all Pacific mental health consumer, family member or service worker perspectives.

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Table 1: Themes that emerged from the qualitative focus group data

Assessment
 Physical environment ('bricks and mortar')
 Infrastructural design
 Communication
 Competencies
 Documentation
 Employment
 Ethnic specificity
 Family
 'Going the extra mile'
 Programme interventions and consumer use of time
 Language
 Matua
 Medication
 Philosophical foundations and cultural values
 Mental health promotion
 Relationships
 Resources
 Spirituality
 Standards
 Training
 Treatment
 Youth

Table 2: The eight models of mental health care identified by participants

The Wellness model: This model focuses on 'health as wellness', where care for the consumer is considered in terms of restoring him or her to a state of wellness.

The Illness model: This model focuses on 'health as illness', where care for the consumer is considered in terms of repairing the disease, hurt or pain.

The *Fonofale* model: This model utilises the metaphor of a Samoan meeting house to make the point that in order for the house to stand firm its core structure must exist and hold together – from the foundation to the posts and roof.

The *Te Vaka* model: This model utilises the Pacific canoe metaphor to symbolise the process of journeying through the complexities of health and wellbeing.

The *Faafaletui* model: This model utilises the Samoan concept of dialogue to frame a methodological approach to health and wellbeing.

The Strands or Pandanus Mat model: This model utilises the Pacific metaphor of a pandanus mat (considered a cultural treasure in a number of Pacific cultures) to symbolise the interwoven nature of health and wellbeing.

The Strengths-based model: This model focuses on notions of empowerment and positive development.

The Traditional Healing Treatment model: In this context this model refers to the indigenous traditional healing beliefs and practice frameworks of Pacific peoples.

Table 3: Examples of participant's quotes

"...I believe that our Pacific people understand in our own way what discrimination and stigma is, through their own personal experience, can help see people for who they are, that they aren't just being mental health [consumers], they are actually consumers who have communities, who have value outside of the label that's forced on them."

(Pacific mental health consumer)

"As Pacific Island people we are still very community minded, we are not from the capitalist world. There is a danger of working too much from our heart, with our calculating financial cost and all that. We need to balance it. But I think they [Pacific mental health service providers] are very much...working from the heart in a way that people who were brought up under the capitalist system are not...and I think those are the things that make us, makes our [Pacific] service uniquely Pacific and makes it work well, because you can connect."

(Pacific family member)

"the model that needs to work for us [Pacific peoples] has to make sure that it is robust enough to stand up clinically [and] that it is robust enough to stand up culturally"

(Pacific opinion leader)

"...One most significant and very important [thing] I see, is the culture.[...] It is not only the way we talk but [the] way of bringing people together and talk about our own understanding of the sickness"

(Pacific service provider participant)

"You have a death wish all the time, because your life is not worth living, because you are drugged to the eyeballs"

(Pacific mental health consumer)