Mental Health Talanoa (MHT) Research and Resources: Collaborative Community Engagement Enhancing Mental Health and Wellbeing Across Pacific Communities

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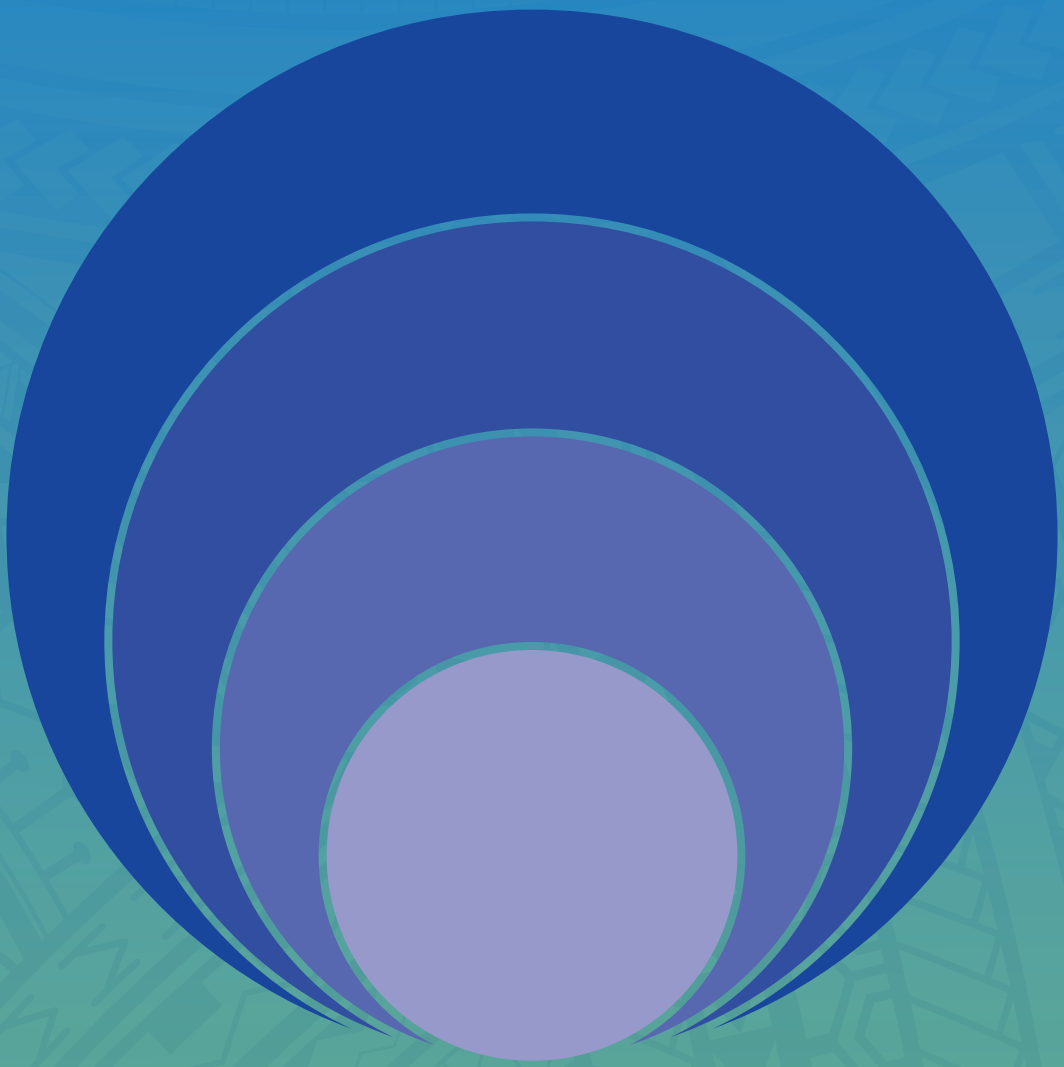
MENTAL HEALTH TALANOA (MHT) RESEARCH AND RESOURCES

COLLABORATIVE COMMUNITY ENGAGEMENT ENHANCING MENTAL HEALTH AND WELLBEING ACROSS PACIFIC COMMUNITIES



JIOJI RAVULO
URSULA WINTERSTEIN
SHANNON SAID

UNIVERSITY OF WOLLONGONG
WESTERN SYDNEY PRIMARY HEALTH NETWORK
SOUTH WESTERN SYDNEY PRIMARY HEALTH NETWORK
NEPEAN BLUE MOUNTAINS PRIMARY HEALTH NETWORK
NSW MINISTRY OF HEALTH

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- CORE group who were instrumental in establishing the funding for the research project: Seini Afeaki, Maherau Arona, Melissa Baleilekutu, Malaemie Fruean, Jioji Ravulo, Alimoni Taumoepeau, Thelma Thomas.
- Funders: WentWest Western Sydney Primary Health Network, South Western Sydney Primary Health Network, Nepean Blue Mountains Primary Health Network, NSW Ministry of Health.
- Mental Health Talanoa Steering Group (MHTSG) responsible for the strategic direction of the project: Seini Afeaki, Maherau Arona, Melissa Baleilekutu, Sarah Bowe, Jayke Burgess, Malaemie Fruean, Rosemary Glassock, Sumithira Joseph, Leslie Morrison, Josh Onikul, Jioji Ravulo, Marc Reynolds, Shannon Said, Rhonda Simpson, Rowena Tagaloa, Alimoni Taumoepeau, Thelma Thomas, Ursula Winterstein.
- Mental Health Talanoa Reference Group (MHTRG) responsible for practical application and community engagement: Pelenaise Baileilekutu, Alana Blake, Barbara Faauiga E'e, Clifford Isaia, Joylene Kahotea, Kamihi Minhinnick, Losa Paterson, Sovaia Ravatudei, Jioji Ravulo, Shannon Said, Sela Siale, Albert Tevita, Margret Toga, Deacon To'o, Ursula Winterstein.
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Pacific communities across region, and broader Oceania region has been instrumental in shaping this project, and we are grateful for the way in which our indigenous Pacific cultures continue to thrive within the Islands, and through their disapora globally.

We'd like to acknowledge the Darug and Dharawal people of the lands in which this work was carried out, and to pay our respects to elders past and present. We also acknowledge that such lands are still considered stolen, as sovereignty was never ceded. We strive both personally and professionally to work collaboratively with Aboriginal and Torres Strait Islander communities. Too often, Indigenous ways of knowing, doing, being and becoming are seen as irrelevant or outmoded; but we strongly disagree. We should be striving to work together to meaningfully include such perspective to influence and impact what we do across our various spaces and places, and to ensure a collaborative approach can occur.

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Mental Health Talanoa (MHT) Research & Resources

Pacific Indigenous Mental Health Lexicon (PIMHL)

UNIVERSITY OF WOLLONGONG

Design: Roy Peake http://roypeake.net

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We sweat and cry salt water, so we know that the ocean is really in our blood

Teresia Teaiwa

INTRODUCTION

Alii, Aloha mai e, Fakaalofa lahi atu, Fakatalofa atu, Hảfa adai, Halo, Halo olaketa, Iakwe, Ia orana, Kia ora, Kia orana, Malo e lelei, Malo ni, Mauri, Ni sa bula vinaka, Noa'ia, Tālofa ni, Talofa lava, Welkam and G'day!

Welcome to ***Mental Health Talanoa (MHT) Research and Resources*** that outlines the work undertaken to improve mental health literacies across Pacific communities in Australia. The work presented outlines a yearlong research project that worked collaboratively with Pacific people and the wider community.

This document is presented across the following four sections that closely guided the research project's activities and outcomes:

- *Formation*: foundation of the project, where we've come from, and how our key stakeholders have shaped the development and implementation of the project
- *Research*: survey data on the possible symptoms of common mental disorders, alongside key findings from our talanoa sessions with community members
- *Education*: A desktop review of web-based resources, an annotated review of literature and media resources, and our Pacific Indigenous Mental Health Lexicon (PIMHL)
- *Training*: the development of this resources alongside our suite of other online resources to assist in putting our applied research project into practice

The Mental Health Talanoa (MHT) research project was funded to work through the University of Wollongong, and comprised of a Project Manager (Associate Professor Jioji Ravulo), Project Officer (Ms. Ursula Winterstein) and a Research Officer (Dr Shannon Said). Supporting the project was an active steering group and a reference group who were consulted formally on a quarterly basis. These two groups had the role of guiding decisions and providing valuable feedback between the community and the MHT research team.

The concept of talanoa as a shared, collective and collaborative conversation has been evoked to promote the underpinning of the research project. Our aim was to enhance the way in which Pacific people understand mental health and wellbeing within their individual, family and community contexts. We strove to support the possibilities to understand what a mental illness may look like including possible signs and symptoms that may be unique to Pacific populations. Its associated impacts and how we promote scope to assist Pacific people to improve help seeking behaviour has also been pertinent to this Talanoa. At the same time, we anticipate changes to occur across community-based health and education providers to work more effectively in a culturally nuanced and safe manner.

We hope you will gain insight into Pacific mental health and wellbeing from this research and suite of resources, with the aim of continuing a mental health Talanoa within Pacific communities locally, regionally and within our countries of origin.

HISTORICAL OVERVIEW

For many years, greater western Sydney has been home to a large Pacific diaspora, having migrated from across the Pacific Islands including Samoa, Tonga, Fiji, Cook Islands, Vanuatu and from within and via Aotearoa New Zealand. The population in western Sydney's Pacific community is emerging and growing strongly.

Due to having such a big urbanised population of Pacific people, as well as other ethnically diverse communities from around the world, western Sydney has a rich multicultural fabric that such members of the community are able to experience daily. This ranges from religious celebrations and cultural festivals to community events for independence days for their countries of origin. Pacific communities itself benefits and contributes immensely amongst other diverse groups of people living there, enriching the area through their own foods, songs, dances, cultural traditions and celebrations.

Noting the many positives with having a large number of the Pacific diaspora living across western Sydney, inevitably there are gaps and barriers to services and resources that the Pacific diaspora may not be aware of when in need of support.

As a result, knowledge on mental health services and how to access resources has been an issue for Pacific communities across the western Sydney region and broader Oceania region.

Mental health has long been a topic of contention within Pacific cultures and is also evident amongst the various Pacific diaspora groups in Sydney, Australia. Considering that there are some cultural practices and traditions that make a conversation about mental health a topic of taboo, 'talking about mental health' may be perceived as impossible.

In recent years there has been an increase in the number of completed suicides across Pacific communities in western Sydney. The reoccurring nature of completed suicides have stunned individual and family members who directly felt the impacts and witnessed ongoing social and health needs. Pacific communities from across western Sydney felt there was a limited response from existing services and organisations responding to the people who were greatly affected by these suicides. As a community, an evolving awareness was forming around the need for such services to reach out and provide effective support.

Due to the perceived taboo nature of mental health and suicides in Pacific cultures, Pacific people have often turn to more religious beliefs or spiritual methods and strategies when needing to address and heal from such an event. While religious beliefs and spiritual strategies can be immensely helpful and an integral part of Pacific cultures that enable healing and support for some, there were also those left feeling unsupported.

From this comes an implicit importance and validity of Pacific people seeking support through religious beliefs and spiritual strategies as methods of healing, alongside a growing belief that has evolved amongst Pacific people towards the importance to seek healing and support through other social and community means.

Following the outcry from the Pacific community, several Pacific professionals came together to form the *CORE Group*. Instigated and chaired by Seini Afeaki, this community-oriented group consists of seven individuals working across the western Sydney region in order to enact change to provide service delivery options for the Pacific community.

As a direct result of the formation of the CORE group, the **Pacific Mental Health Initiative (PMHI)** was officially formed in June 2018. The Pacific Mental Health Initiative encompasses two aligned projects that have received external funding to operate from July 2019 – September 2020.

The **Pacific Mental Health First Aid (MHFA) Facilitators** project provided funding to train four Pacific people to become Mental Health First Aid (MHFA) Accredited Trainers. They assist in training Pacific groups across the community to become mental health first aiders through the Standard Mental Health First Aid course. WentWest Western Sydney Primary Health Network provided funding for this project.

The **Mental Health Talanoa (MHT)** research project strives to increase mental health literacies across Pacific communities. Through its four phases as outlined in the project overview section that follows, the research examines the prevalence of mental health illnesses, the impact of such health issues, and help seeking behaviour. Areas of workforce development, where health professionals and those who provide services to Pacific people, has been a feature of this project. Practical tools and resources presented across this report have been created for this intended purpose. WentWest Western Sydney Primary Health Network, South Western Sydney Primary Health Network, Nepean Blue Mountains Primary Health Network, and the NSW Ministry of Health worked together for the first time to provide funding for this project.

In combination, all three components (as shown in the diagram below) are designed to complement each other whilst working collaboratively with Pacific communities and other partners who have made this project and work possible.

PACIFIC MENTAL HEALTH INITIATIVE (PMHI)

Figure 1: Pacific Mental Health Initiative

PROJECT OVERVIEW

RATIONALE (WHY WE ARE DOING THIS)

In a study undertaken in Aotearoa, New Zealand (Vaka et al., 2016) Pacific people have experienced higher rates of mental health illness than the general population, but unsurprisingly were about half of the expected mental health visits. Interestingly, Pacific people have higher access to mental health services through justice routes and lower rates of community and in-patient use, therefore suggesting barriers for Pacific people accessing mental health services (ibid). The research from New Zealand further highlights the limited research in Australia and need to develop opportunities to create new knowledge for Pacific people residing in this country-especially as the Pacific population continues to grow nationally in both urban and rural settings (Ravulo, 2015).

Such limited knowledge and insights into the impact and prevalence of mental illnesses may continue to perpetuate barriers and stigmas to seeking support and assistance (Henderson et al., 2013). This in turn can create secondary and multiple issues including risk of disengagement from education and employment, insecure finances and accommodation arrangement, and other physical and mental health concerns (Knaak et al., 2017). The prevalence of both youth and adult suicide amongst indigenous communities across Oceania is a growing concern, with prevention measures needing further support and development (Tiatia-Seath et al., 2017) there were 380 total Pacific suicides (4.1%).

Currently, there is no specific mental health framework in Australia for Pacific people that provide culturally appropriate strategies and responses. Additionally, there is no specific funding source to promote scope to develop mental health literacies. Health literacy is a significant issue for Australia. Health information and systems have become increasingly complex and harder to understand (Australian Commission on Safety and Quality in Health Care, 2014). Low health literacy is associated with poorer health outcomes and poorer use of health care services (Jayasinghe et al., 2016).

There is no specific education or tools developed to cater for Pacific communities in Australia. Without specific resources in place, it leaves the vast majority of Pacific people living with a mental health illness without adequate resources and lack of access to services to help them. Working with Pacific people may prove to be difficult because of cultural norms and traditional expectations, so having an insight in to 'their worldview' would provide a better understanding for all stakeholders (Ravulo et al., 2019). There is an imperative to respond to such a need within Pacific communities by raising awareness, with view to utilise the talanoa approach about mental health issues and wellbeing, whilst striving to ultimately remove the stigma of having a mental health illness.

Proactively, we need to provide better opportunities to engage Pacific communities and effectively utilise their input to contribute to any findings and recommendations found. In our collective approach, we strive to work collaboratively with Pacific communities; including the diverse people groups from differing heritages and ethnicities residing in the region. Inclusively, we also strive to utilise indigenous perspectives and practices from across Oceania.

OBJECTIVES (WHAT WE ARE GOING TO DO)

The *Mental Health Talanoa* (MHT) research project targets workforce and system improvements to improve mental health literacy of health workers and Pacific people with lived experience of mental illness and their carers, family and supporters.

This project aimed to:

- Conduct a contemporary and place-based study on the prevalence and impact of mental health illnesses in Pacific communities in Western Sydney and their help seeking behaviour.
- Design and create sustainable resources to provide Pacific people with further understanding and insight into the prevalence and impact of mental health issues and enhance access to services.

- Design and create sustainable resources to increase the skills and knowledge of the NSW health workforce in supporting health literacy and partnering with Pacific people with lived experience and their carers, families and supporters.
- Raise mental health literacies through community engagement, using community events and activities as a platform to provide Pacific people with information and education about mental health and wellbeing.
- Develop a specific Pacific framework to assist engagement between services and community groups.
- Promote the importance of cultural appropriateness when working with Pacific people as their cultural backgrounds influence the way in which they may engage with services.

ANTICIPATED OUTCOMES (WHAT WE WOULD LIKE TO ACHIEVE)

- NSW health workforces increasingly skilled and knowledgeable in supporting health literacy and partnering with Pacific people with lived experience and their carers, families and supporters.
- Increased access to mental health services, by way of removing the stigma of receiving help from appropriate government and non-government services and agencies.
- Improved health outcomes for Pacific people with lived experience through the increased uptake of tailored and appropriate stepped care options early in the course of an illness across the spectrum of care provided by Primary Health Networks (PHNs), Community Managed Organisations (CMOs) and Local Health Districts (LHDs).
- Enhanced mental health literacy within Pacific communities.
- Enhanced research on the prevalence of mental health issues both within the Pasifika diaspora in Western Sydney, and wider population across Oceania.
- Improved and inclusive language, phrases and definitions of mental health issues and wellbeing in Pacific languages and dialects across the region.

PROJECT PHASES AND DELIVERABLES (ACTIVITIES)

To assist in the practical implementation of our goals and objectives, the FRET model was developed to represent the flow of small waves from each individual activity, that gradually creates a ripple effect of progress and sustainable change. Just as the different FRET phases speak to and overlap with each other, so the MHT team weaved together the component parts of this document, collectively reflecting on our approaches and methods across the entire MHT project. Our Project Officer worked closely with the Research Officer and Project Manager, providing and gaining feedback from them in order to remain consistent throughout the project. Like the FRET model, we informed each of our set tasks and were able work in 'Talanoa' style.

FRET represents the following four key outputs and parallel phases all underpinned by the notion of *Community & Workforce*:

- Formation (Community & Workforce Engagement)
- Research (Community & Workforce Collaboration)
- Education (Community & Workforce Resources) and
- Training (Community & Workforce Development)

Each phase is outlined below alongside general and cultural rationale and the intended deliverables of the project.

PARALLEL PHASE 1: FORMATION (COMMUNITY & WORKFORCE ENGAGEMENT)

As part of the *Formation* phase of the FRET model, the establishment of the Mental Health Talanoa Steering group (MHTSG) and the Mental Health Talanoa reference group (MHTRG) were formed in order to assist the research project. Over the course of the MHT research project we had four meetings schedule with both groups over a twelve-month period (a meeting every quarter). The structure of the MHTSG and the MHTRG is flat and encourages all members of both groups to provide feedback to the research team whenever needed. The flat structure was intended to provide a safe space for members to discuss issues openly for the research team to then take on board.

The MHTSG was made up of members from the *CORE group* and also consists of our combined funding bodies headed up by WentWest Western Sydney Primary Health Network as well as other key stakeholders including representative and partners from NSW Health, NSW Department of Education, headspace and One Door Mental Health who helped form the Pacific Mental Health Initiative (PMHI).

The MHTRG was made up of Pacific professionals and community members who work within the community and provided the MHT team with feedback regarding how our research should be delivered into the community. They also assisted in sharing valuable insight into what the needs are across Pacific communities in western Sydney.

Throughout the research process the MHT research team utilised the expertise of both the MHTSG and the MHTRG in order for our research to remain relevant to the community.

Table 1: Formation (Community & Workforce Engagement)

PROJECT PHASE	RATIONALE	DELIVERABLES
PARALLEL PHASE 1: FORMATION (Community & Workforce Engagement)	• Among Pacific communities talanoa is an acknowledged format for generating conversation about complex topics, and an effective way to communicate within a communal and shared context. • To support the development and implementation of the other subsequent phases, an ongoing talanoa process will occur with key stakeholders, including government departments, peak bodies, community-based agencies and groups, including cultural leaders.	• **MHT Steering Group** established to help lead the consultation and ongoing conversations around raising mental health literacies • **MHT Reference Group** established to advise and promote strategies on the dissemination of information developed from research and educational resources.

PARALLEL PHASE 2: RESEARCH (COMMUNITY & WORKFORCE COLLABORATION)

The research component had two distinct stages.

Firstly, we conducted online surveys via Qualtrics that gained a general overview on the basic demographics of research participants, including their Pacific ethnicities, employment, age and other demographics, followed by a 20 factor questionnaire called the Self Reporting Questionnaire 20 (SRQ-20) that asked about general mental health symptoms (explored in the 'Research' sections of this document). A total of **192 participants** completed the survey from January to March 2020, which took place at community events and across local shopping centres prior to COVID-19 restrictions with support from our employed Pacific Survey Assistants. We also had participants undertake the survey via an online link that was profiled via social media platforms (@MHTalanoa – Facebook, Twitter & Instagram). Those who completed the surveys were asked to take part in the talanoa sessions by leaving their contact details at the end of the online questionnaire.

Secondly, potential talanoa group participants were contacted via email and SMS text by our Research Officer to arrange a time when they would like to take part in the arranged groups. Due to restrictions, the talanoa sessions were conducted via Zoom, with a total of **16 participants** across three groups held across April & May 2020.

Table 2: Research (Community & Workforce Collaboration)

PROJECT PHASE	RATIONALE	DELIVERABLES
PARALLEL PHASE 2: RESEARCH (Community & Workforce Collaboration)	• There is limited empirical data and information on the prevalence of mental illness, its morbidity and help seeking behaviour within Pacific communities in Australia; yet there is a recent growing trend amongst Pacific young people and suicidal behaviour and completion across the country. • Low health literacy limits mental health consumer access to necessary mental health care.	• Survey to be conducted in order to gather data from participants • Conduct a contemporary and place-based study (talanoa sessions) on the prevalence and impact of mental health illnesses in Pacific communities in Australia (NSW) and their help seeking behaviour.

PARALLEL PHASE 3: EDUCATION (COMMUNITY & WORKFORCE COLLABORATION)

Specific educational resource was developed in the phase as a means of complementing the research data and findings from parallel phase 2. Additional resources were created to support the broader need to promote mental health literacies across Pacific communities (Table 3).

DESKTOP & ANNOTATED REVIEW

We complied a desktop and annotated review as part of this phase. The desktop review of web-based resources references general mental health resources available in Australia. Given there is no specific Pacific mental health resources, the MHT team felt that having the desktop review based on the general resources as the most relevant to our demographic of the Pacific diaspora in western Sydney. The desktop review is a guide on how to access these resources and what resources or services they provide.

Through the desktop review, various resources have been reviewed for its relevance and suitability for the community and broader community, health and education workforce to access. This includes understanding the cultural relevance and safety of accessing and incorporating these resources in individual, group and community work practice.

To complement this desktop review, we carried out a broader annotated review that consists of mental health literature and media resources for:

- Pacific people to access from Aotearoa New Zealand
- First nations people from Australia, Canada and Aotearoa New Zealand
- Culturally and Linguistically Diverse (CALD) backgrounds based in Australia
- General public, based in Australia

Further, we discussed the strengths and limitations of each of the resources and provide recommendations for the resources referenced in order to make them more targeted to our demographic.

PACIFIC INDIGENOUS MENTAL HEALTH LEXICON (PIMHL)

The Pacific Indigenous Mental Health Lexicon (PIMHL) was developed due to limited strengths-based terminology in Pacific languages to adequately describe mental health. The MHT research team felt strongly that this was something that needed to be created as a deliverable because it is important for Pacific communities to use their languages when having conversations about mental health. It strives to enhance understanding of mental health terminologies for Pacific people from different ages and generations.

The PIMHL working group consisted of Pacific professionals living and working in the mental health space in four Pacific countries: Vanuatu, Fiji, Samoa and Tonga. We had four meetings with our members in order to complete the PIMHL.

It is important to note that there is already a thorough mental health lexicon for Māori entitled Te Reo Hāpai (Opai, 2017), therefore this language was not included in our Mental Health Talanoa PIMHL.

MENTAL HEALTH TALANOA (MHT) RESEARCH AND RESOURCES

This Mental Health Talanoa (MHT) Research and Resources document was created as a deliverable within this parallel phase in order to make the entire MHT research project available for public consumption. It has been granted an ISBN and published by the University of Wollongong and will be made available for download through the National Library of Australia catalogue.

Table 3: Education (Community & Workforce Collaboration)

PROJECT PHASE	RATIONALE	DELIVERABLES
PARALLEL PHASE 3: EDUCATION (Community & Workforce Resources)	• Pacific communities are collectively orientated, with view that the *talanoa* approach supports the dissemination of information across the community.	• Conduct a desktop and annotated review of available mental health resources targeting Pacific people and communities. • Conduct an analysis for the design and production of a suite of sustainable resources tailored to Pacific people living in Australia to increase health literacy and further understanding and insight into the prevalence and impact of mental health issues. • Creation of Pacific indigenous Mental Health Lexicon and formation of PIMHL working group • Design and create sustainable resources (toolkit) to provide Pacific people with further understanding and insight into the prevalence and impact of mental health issues. • These resources may include interactive online resources that promote a wider uptake and participation from schools, sporting and community groups.

PARALLEL PHASE 4: TRAINING (COMMUNITY & WORKFORCE COLLABORATION)

As noted in parallel phase 3, the creation of the desktop review, toolkit and YouTube channel alongside its accompanying web-based resources were outlined as deliverables in Parallel Phase 3. Such tangible resources have shaped the development of training strategies that are outlined in parallel phase 4 (Table 4).

JOURNAL CLUB

The Mental Health Talanoa team delivered a bimonthly online journal article discussion groups called the Journal Club. These discussions highlighted key concepts to consider when working with Pacific populations in health and mental health sectors, how cultural safety can be practices within workplace settings, and exemplified practical service delivery models and ideas that could be utilised for Pacific and non-Pacific practitioners within this space.

INFOGRAPHICS FROM KEY FINDINGS OF MHT RESEARCH

A suite of infographics has been developed to further complement the resources developed from this research project. These visual representations of the key finds have assisted in ensuring various level of the community can access this information in a helpful manner. These are:

- Mental Health Talanoa (MHT): Possible symptoms related to mental health issues across Pacific communities
- Mental Health Talanoa (MHT): Research Key Themes
- Pacific Indigenous Mental Health Lexicon (PIMHL) – Bislama
- Pacific Indigenous Mental Health Lexicon (PIMHL) – Samoan
- Pacific Indigenous Mental Health Lexicon (PIMHL) – Tongan
- Pacific Indigenous Mental Health Lexicon (PIMHL) – Fijian

MULTIMEDIA RESOURCES

Our Mental Health Talanoa (MHT) YouTube channel showcases our various videos that were developed as part of this research project, and be located at the following link:

- https://www.youtube.com/channel/UCd6cEK9xSAHyjbhUtLCeMfw

MHT also communicated information through:

- Facebook: https://www.facebook.com/MHTalanoa
- Instagram: https://www.instagram.com/mhtalanoa/
- Twitter: https://twitter.com/MHTalanoa

Such social media platforms provided an opportunity to profile our project updates including links to resources and our research survey. Utilising these platforms have been an important component of ensuring our resources are readily available and accessible during and beyond the life of the funded project.

PACIFIC MENTAL HEALTH FIRST AID (MHFA) FACILITATORS

As mentioned and depicted in Figure 1, the Mental Health First Aid (MHFA) facilitators are a part of the Pacific Mental Health Initiative. The MHFA facilitators were selected from a number of Pacific people who expressed interest in the program. Four people were selected to receive the training to become qualified MHFA facilitators and once completed, were able to go into the community and facilitate the MHFA course. Resources developed from this research project are being used by Pacific Mental Health First Aid (MHFA) facilitators to further assist the delivery of their role across the community with Pacific communities.

Table 4: Training (Community & Workforce Collaboration)

PROJECT PHASE	RATIONALE	DELIVERABLES
PARALLEL PHASE 4: TRAINING (Community & Workforce Development)	• By training up individuals and groups to be peer educators and advocates, a greater impact may be developed; assisting in a greater uptake of new and improved knowledge around mental illness and wellbeing. • Health literacy is important for healthcare providers because it affects the way that they manage their relationships with consumers and deliver health care.	• Develop a journal club, where assigned relevant readings will be distributed for members of the club to read and share feedback when club meets. • Design and create sustainable resources to increase the skills and knowledge of the NSW health workforce in supporting health literacy and partnering with Pacific people with lived experience and their carers, families and supporters. • This resource will inform other related training material including the Pacific Mental Health First Aid (MHFA) facilitators project funded under the Pacific Mental Health Initiative (PMHI).

MHT OVERARCHING ANTICIPTED IMPACT

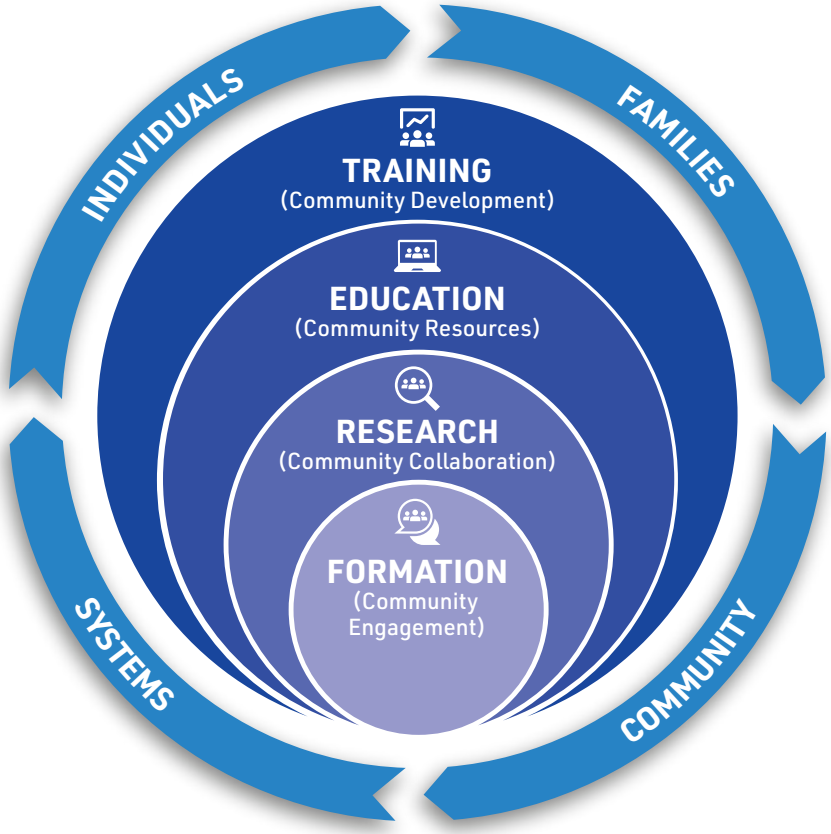
As we examine the parallel phases, it becomes evident that throughout their implementation, four overarching key elements surround the model. These elements influence the way in which the movement occurs in the FRET (wave) whilst also reciprocally benefiting from the changes that are developed from achieving such key outputs within. These four elements:

- *Individuals* (children, young people, adults, elders),
- *Families* (immediate, extended and kinship),
- *Community* (local, regional, national and international) and
- *Systems* (health, education, legal, welfare)

further represent a Pacific cultural context in which the project operates. This in turn provides a grounded focus in promoting proactive and sustainable change towards better access to mental health knowledge and services across Pacific communities in Australia and beyond.

These four foundational elements that have helped shaped the implementation of the MHT project also represent the need to think holistically when striving to make a difference in improving mental health literacies and help seeking behaviour more broadly. The ability to support individuals, who make up families, who are located within communities, who then interact with various systems across society, can be provided with sustainable solutions that are cyclical in nature. Individuals are subsequently impacted by the societies in which they are located, and then rely on their support structures that are also influenced by them alongside their familial and communal contexts.

Figure 2: MHT overarching anticipated impact



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APPENDIX
MHTSG & MHTRG TERMS OF REFERENCE

MENTAL HEALTH TALANOA STEERING GROUP (MHTSG) & MENTAL HEALTH TALANOA REFERENCE GROUP (MHTRG) TERMS OF REFERENCE

INTRODUCTION

In order to deliver a consistent and effective initiative across the collaborating organisations, the management for Mental Health Talanoa (MHT) has established the Mental Health Talanoa Steering Group (MHTSG) & Mental Health Talanoa Reference Group (MHTRG) to help lead the consultation and ongoing conversations around raising mental health literacies across Pacific communities in greater western Sydney.

AIM OF THE MHTSG & MHTRG

The MHTSG & MHTRG is a representative body of the various number of multidisciplinary professionals and individuals established to drive and support communication, engagement with the community and provide feedback relating to project development, implementation and outcomes.

The aim is to ensure that the **MHTSG** maintains focus and energy required for the MHT initiative. It also provides strategic feedback and supported leadership to ensure outcomes for the MHT initiative are realised.

The **MHTRG** engages community-based stakeholders to provide feedback and reflection on the topics intersecting mental health issues for Pacific communities. It will raise potential opportunities and concerns as part of the development, implementation and outcomes for the initiative

Feedback from both the MHTSG & MHTRG are equally weighted – as the structure of the research project is flat in nature, and strives to promote a collaborative, and collective response to mental health, its illnesses and wider wellbeing across Pacific communities.

OBJECTIVES OF THE MHTSG & MHTRG

- Drive, inspire and maintain a positive and energetic approach to the MHT initiative
- Promote the principles of MHT and values for responsive and proactive change.
- Ensure timely and consistent communication of information, strategies, timelines and progress is maintained throughout the MHT initiative.
- Make recommendations to the MHT Project Manager, MHT Project Officer, MHT Research Officer and other members of the MHTSG & MHTRG on project development, implementation and outcomes.
- Support outputs and strategies aimed at effectively achieving outcomes of MHT initiative.

MEMBERSHIP

MHTSG:

- The principal steering group will consist of the MHT Project Manager, MHT Project Officer, MHT Research Officer, representative(s) of WentWest PHN, Nepean PHN and South West Sydney PHN and NSW Ministry of Health.
- The Project Manager of the MHT initiative is the Chairperson of the steering group.
- In addition to the principal Steering Group there will be representatives from
  - CORE Pacific Group
  - NSW Department of Health
    - Western Sydney Local Health District (WSLHD)
    - South Western Sydney Local Health District (SWSLHD)
  - NSW Department of Education
  - One Door Mental Health
- A maximum number of 20 people will sit as members of the MHTSG.
- Depending upon the issues arising, additional members can be appointed as appropriate with approval of the Chairperson.

MHTRG:

- The principal reference group will consist of the MHT Project Manager, MHT Project Officer and MHT Research Officer
- The Project Manager of the MHT initiative is the Chairperson of the Reference group.
- In addition to the principal Reference Group there will be representatives from a number of different services and agencies
- These representatives will be selected by MHT Project Manager and MHT Project Officer based on their suitability.
- A maximum number of 15 people will sit as members of the MHTRG.
- Depending upon the issues arising, additional members can be appointed as appropriate with approval of the Chairperson.

ADMINISTRATION

- The Chair will nominate the MHT Project Officer from within the group to cover leave or unexpected absences, and the MHT Project Officer will record minutes and co-ordinate meetings.

MEETINGS

- The group will meet quarterly at a minimum with frequency increasing as the level of development, implementation and finalisation of the project occurs or issues arising increases.
- MHTSG & MHTRG meetings may be held via video and or telephone conference depending on availability of video and or telephone conference facilities.
- The agenda will be prepared and distributed by the MHT Project Officer. Members can forward agenda items to the MHT Project Officer no later than three working days before the meeting. Matters requiring significant time or resources to address may be dealt with outside of the meeting and reported against at the next meeting.
- Special meetings of the MHTSG & MHTRG may be convened depending on the urgency of matters raised or included in the Agenda.
- Agreement on decisions shall be by consensus; that is, MHTSG & MHTRG collectively will come to a shared agreement on decisions made.
- Minutes of each meeting shall be prepared by the MHT Project Officer, who will maintain a file of confirmed minutes.

KEY DELIVERABLES

The Mental Health Talanoa (MHT) initiative will target workforce and system improvements to improve mental health literacy of health workers and Pacific people with lived experience of mental illness and their carers, family and supporters.

This project will:

- Conduct a contemporary and placed based study on the prevalence and impact of mental health illnesses in Pacific communities in greater western Sydney and their help seeking behaviour.
- Design and create sustainable resources (within the project allocated budget) to provide Pacific people with further understanding and insight into the prevalence and impact of mental health issues and enhance access to services.
- Design and create sustainable resources (within the project allocated budget) to increase the skills and knowledge of the NSW health workforce in supporting health literacy and partnering with Pacific people with lived experience and their carers, families and supporters.
- Raise mental health literacies through community engagement, using community events and activities as a platform to provide Pacific people with information and education about mental health and wellbeing.
- Develop a specific Pacific framework to assist engagement between services and community groups.
- Promote the importance of cultural appropriateness when working with Pacific people as their cultural backgrounds influence the way in which they engage with services.

For further information on the overall initiative, please consult with the project overview available from the MHT Project Manager and MHT Project Officer.

RESEARCH

- Background of research instruments
  - *Survey*
  - *Talanoa Sessions*
- Combined Overarching Trends
  - *Survey key findings*
  - *Talanoa key findings with Survey*
- Talanoa Sessions
  - *Talanoa theme summary*
  - *Narrative analysis*

My writing, therefore, is not something only for quiet reading in bed or in a library. It is meant to be read aloud so that some of the beautiful and not so beautiful sounds of the voices of the Pacific may be heard and appreciated

Epeli Hau'ofa

BACKGROUND OF RESEARCH INSTRUMENTS

SURVEYS

The SRQ-20 was developed by the World Health Organisation in 1994 as a tool that recognises symptomology of common mental disorders (CMDs) that is context-specific, recognising the unique ways of doing and being that communities around the world engage in, the language used around mental disorders and their symptomologies, and how particular communities may internalise or emote particular experiences in response to mental health concerns. This knowledge is context-bound and relies not only upon survey data that the instrument yields, but also upon clinicians' experience with and ongoing listening to the experiences of the peoples they serve, be they in a developed Western country or elsewhere.

The survey can be self-administered or issued by an interviewer, the latter being the case for this research project. It asks 20 questions in everyday language about CMD symptomology that may have been present in the past 30 days, and avoids using mental health jargon, so that it is more accessible to a general audience. The instructions of how to administer the survey are important, to ensure that all participants are treated the same, so that data is not impacted by the interviewers' disclosure of particular kinds of information. The protocol for how the surveys were administrated by Mental Health Talanoa research staff can be viewed in Appendix A.

Our survey asked a range of demographic questions prior to the commencement of the SRQ-20 questions, in order to understand the demographic profile of the participant group, trends associated with these and how these may impact on overarching patterns in the data. The full range of survey questions can be seen in Appendix B.

A Participant Information Sheet with more details about the research project and contact details for the research team, was included on the first page of the survey. At the end of the survey, we provided a list of telephone numbers of support services that could be contacted by survey participants for free, if they felt the need for further support after completing the survey.

It should be stated that the SRQ-20 is not an assessment tool – it does not confirm the presence of CMDs, but can be the first step in identifying potential symptoms that may be arising from a mental health condition. Upon using the SRQ-20, further screening and/or assessment tools would need to be used by an appropriate mental health clinician to make a further judgment concerning the presence of a mental health condition.

Surveys were distributed in person at a range of community events and local shopping centres prior to COVID-19 restrictions, after which it was promoted online via the Mental Health Talanoa Facebook page, where participants could access the online version via a URL. A total of 192 completed surveys were completed, after the survey was open for 2 months from February to March 2020.

TALANOA SESSIONS

At the end of each survey, participants were asked if they wanted to participate in a talanoa session, that talked about the issues of mental health in a more detailed way. 45% who stated they were willing to participate in a talanoa focus group, we had a total of 16 participants take part in the *talanoa* sessions, representing a little more than 10% of total survey participants.

The *Talanoa* sessions focussed on three primary areas of concern pertaining to mental health and Pacific Communities.

These are:

1. The prevalence of mental health conditions amongst this group
2. The impacts of these conditions, and
3. The help seeking behaviour of Pacific peoples

The *Talanoa* sessions were conducted as the name suggests – in a fashion that promotes the autonomy of the research participants, who direct the ebb and flow of the conversations, and reveal their personal and professional experiences in the context of these overarching areas the research sought to address. The five questions that guided the *Talanoa* sessions were:

- Are mental illnesses common amongst Pacific people?
- How do Pacific people generally perceive and understand mental illnesses?
- What impact do mental illnesses have on individuals, their family members and community?
- Who do Pacific families turn to when experiencing issues with mental health and their wellbeing?
- What could health, education and community services do to better support Pacific people?

Participant consent was discussed prior to the commencement of each *talanoa* session, and the same support service contact numbers offered in the survey were offered at the end of the *talanoa* sessions, to ensure that participants had relevant support on hand as needed.

COMBINED OVERARCHING QANTATITATIVE AND QUALITATIVE TRENDS

SURVEY KEY FINDINGS

The MHT team worked with Dr Grenville Rose to undertake the formal statistical analysis from the data collected from the SRQ-20 with Pacific communities.

The SRQ-20 quantitative data analysis was performed using SPSS 26[1]. Principal Components Analysis (PCA) was performed with Varimax rotation and Kaiser normalisation. Sampling adequacy was tested using the Kaiser-Meyer-Olkin (KMO) test. Differences in proportions of yes/no answers for each question were tested using the Binomial Test. The Friedman test for related variables was used to test for differences in the factor scores with post-hoc pairwise tests adjusted using Bonferroni-Holm stepdown comparison procedure.

The PCA analysis resulted in an excellent KMO of 0.879 indicating strong correlation amongst the variables in the analysis and therefore excellent factorability. A four-factor solution was decided upon despite there being 5 factors that had an eigenvalue of greater than 1. The fifth factor had an eigenvalue of 1.5 in the rotated solution which was a drop of 0.5 from the eigenvalue of the 4th factor which itself was a drop of 0.3 from the eigenvalue of the previous factor. Thus it could be termed an 'elbow' on a scree slope and be considered for deletion as a factor on that criterion alone. Additionally, however, the inclusion of the fifth factor resulted in a considerable expansion in the strength of cross loadings on a number of variables thus resulting in a less interpretable and perhaps less stable result in exchange for a small gain in the amount of variance accounted for (7% VAF) in the model.

The four-factor rotated model accounted for 52% of the variance in the data and resulted in the factor loadings on the 4 factors as described below. The factors were of approximately equal value the strongest factor, factor 1 accounting for approximately 15% of the variance and the weakest factor, factor 4 accounting for approximately 11% of the variance. Two questions from the SRQ 20, questions 9 and 13, had cross loadings that prevented their interpretation as being related to a factor, as seen in Table 1.

Table 1: Factor loadings of quantitative research data across the SRQ20 questions

	DEPRESSION	ANXIETY	CAPACITY/ EXHAUSTION	SOMATIC
1) Do you often have headaches?	-0.137	0.27	**0.513**	0.185
2) Is your appetite poor?	0.25	-0.074	**0.636**	0.155
3) Do you sleep badly?	0.209	0.337	**0.495**	0.112
4) Are you easily frightened?	-0.058	**0.677**	0.158	0.09
5) Do your hands shake?	0.311	0.094	-0.015	**0.518**
6) Do you feel nervous, tense or worried?	0.171	**0.621**	0.153	0.334
7) Is your digestion poor?	-0.115	0.103	0.432	**0.597**
8) Do you have trouble thinking clearly?	0.287	**0.674**	0.208	0.109
9) Do you feel unhappy?	0.411	0.411	0.048	0.476
10) Do you cry more than usual?	0.177	0.364	0.071	**0.629**
11) Do you find it difficult to enjoy your daily activities?	**0.581**	0.271	0.305	0.259
12) Do you find it difficult to make decisions?	0.395	**0.598**	0.145	0.193
13) Is your daily work suffering?	0.342	0.457	0.258	-0.049
14) Are you unable to play a useful part in life?	**0.587**	0.234	0.178	-0.271
15) Have you lost interest in things?	**0.592**	0.001	0.371	0.339
16) Do you feel that you are a worthless person?	**0.693**	0.298	0.036	0.224
17) Has the thought of ending your life been on your mind?	**0.72**	0.049	0.1	0.171
18) Do you feel tired all the time?	0.234	0.278	**0.699**	-0.006
19) Do you have uncomfortable feelings in your stomach?	0.071	0.047	0.313	**0.563**
20) Are you easily tired?	0.217	0.284	**0.607**	0.153

The number of 'yes' responses that each participant gave on the questions contained in each factor were summed and tested for significant differences. The Friedman non-parametric test showed an overall significant difference (c^2=12.66, p=0.005). The Bonferroni-Holm stepdown found significant differences between factors 3 and 1, and factor 4 with both factors 2 and 3 (p<0.05). These results suggest a lower prevalence of somatic difficulties, a higher prevalence of capacity/exhaustion difficulties and depression related factors which also have a lower incidence compared to capacity/exhaustion. They also suggest that anxiety related factors have a higher incidence than somatic type difficulties.

Table 2 below highlights the factor loadings for each of the 4 factors from Table 1.

The specific name given for each of the four factors were developed by the MHT research team and were based on how these symptoms may be sign of a common mental disorder. For example, factor 1 was labelled "Depression" as we believe the five symptoms that were strongly loaded against this factor may be possible symptoms of depression for a Pacific person. Similarly for factor 2, the four symptoms that were strongly loaded to this factor, which we labelled "Anxiety" could be possible symptoms of anxiety for a Pacific person. The five symptoms listed under factor 3, which we labelled "Capacity/ Exhaustion" may help a Pacific person to understand that what they are experiencing may be related to this area. Finally, factor 4, labelled "Somatic" had four symptoms that strong loaded, and may be an indication of a Pacific person experiencing unhelpful behaviours related to a common mental disorder.

Table 2: Survey data factors and their loadings

FACTOR NUMBER AND NAME	STRONGEST FACTOR LOADINGS AND QUESTION NUMBER
1: Depression	11) Do you find it difficult to enjoy your daily activities? 14) Are you unable to play a useful part in life? 15) Have you lost interest in things? 16) Do you feel that you are a worthless person? 17) Has the thought of ending your life been on your mind?
2: Anxiety	4) Are you easily frightened? 6) Do you feel nervous, tense or worried? 8) Do you have trouble thinking clearly? 12) Do you find it difficult to make decisions?
3: Capacity/Exhaustion	1) Do you often have headaches? 2) Is your appetite poor? 3) Do you sleep badly? 4) Do you feel tired all the time? 20) Are you easily tired?
4. Somatic	5) Do your hands shake? 7) Is your digestion poor? 10) Do you cry more than usual? 19) Do you have uncomfortable feelings in your stomach?

One of the members of the steering committee addressed the idea that clinicians may look upon these results and equate 'yes' responses to particular combinations of questions with a diagnosis of a particular mental health concern. It is worth reiterating at this point that the SRQ-20 is *not* an assessment tool, but rather can be used by clinicians to help ask more specific questions to gain insight into the lived realities of those they engage with from Pacific backgrounds. Equating particular 'yes' responses to a CMD, and then assuming that this was done in a culturally responsive/competent way as a result of using these findings, is erroneous, and these quantitative findings should not be used in such a manner.

Rather, these results can provide a new layer of questions/perspectives from which the clinician can gain insight, with further assessment screening required prior to any kind of diagnosis being given.

TALANOA KEY FINDINGS PAIRED WITH SURVEY FINDINGS

Throughout the *talanoa* sessions, a range of key topics were discussed. After conducting thematic analysis across the three sessions that were conducted, the following key themes were negotiated by the research team:

1. Judgment, stigma, barriers to access of mental health
2. The need for education, psychoeducation and/or lack of appreciation for the complexity of mental health concerns
3. Interventions and treatments for mental health concerns
4. Pacific perceptions of mental health
5. Cultural impacts of mental health
6. Cultural expectations and practices, described by participants as maintaining the "cultural script"
7. Church engagement and its associated practices
8. The need for developing more nuanced policy and research

Overall, the results of the SRQ-20 questionnaires highlight the symptoms that may be present in one-on-one interactions with and between Pacific peoples. This information may be used by laypeople as questions that can be asked to facilitate conversations that may differentiate what may be interpreted as common realities, such as feeling tired, and losing interest in daily tasks, from potential symptoms of a common mental disorder (CMD).

As stated previously, these questions *do not* determine the presence of a common mental disorder (CMD), but can be conversation/talanoa starters that may lead to pursuing assessment under the care of an appropriate healthcare professional.

The *Talanoa* sessions have revealed what some of the underlying causes of the symptoms expressed in the surveys may be. The *Talanoa* key themes find some general resonances to the survey factors; they have been expressed in Table 3 in an attempt to show these overarching connections, though these are not definitive, and the survey findings were not discussed with the talanoa participants in specific detail.

Key theme 8, the need for developing more nuanced policy and research, is relevant for all factors here, and therefore has not been placed in any of them. Participants spoke of the need to have programs and supports in place that are long lasting, and that take into consideration the very real impacts culture and cultural expectations can have upon Pacific mental health for individuals and families.

Table 3: Synergies between survey data and talanoa responses

SURVEY FACTOR	CONNECTION(S) TO TALANOA KEY THEME	SYNERGY
1. Depression 11) Do you find it difficult to enjoy your daily activities? 14) Are you unable to play a useful part in life? 15) Have you lost interest in things? 16) Do you feel that you are a worthless person? 17) Has the thought of ending your life been on your mind?	1. Judgment, stigma, barriers to access of mental health	Common mental health symptoms such as those described in this factor can be met with advice such as the need to be strong and press on in spite of life's difficulties. Another common experience is the shame and stigma that can be associated with speaking about these concerns to mental health professionals, as the care of friends and consolations of one's faith, particularly prayer in a church setting, are seen as the solutions to feelings of worthlessness and internal struggles.
	7. Church engagement and its associated practices	Barriers to accessing mental health in this regard stem from the premise of understanding depressive symptoms as being spiritual in nature, and/or being the result of an individual's or family's transgressions, and not having a biopsychosocial genesis. As such, mental health is seen as a concept that arises from the Pala(n)gi/ Pakeha (White European) world, and therefore does not resonate often with Pacific interpretations of symptoms that Western medicine would associate with mental health.
	5. Cultural impacts of mental health	The impacts of mental health were considered in the context of family particularly and touched on issues of shame for a family member who may show symptoms of a mental health condition. A noted diminishing of one's role within the family setting, and therefore an impact upon the health of the family, was noted here – considerable resources and dependence upon church practices can be drawn upon when a family member has a mental health concern, which can be extremely taxing upon family members, and last much longer due to the lack of mental health assessment and intervention. Questions around one's role within the family setting can lead to considerations of one's internal sense of worth and purpose in life, which may be connected to suicidal ideation.
	6. Cultural expectations and practices, described by participants as maintaining the "cultural script"	The importance of one's role and function, and the relationship of the individual in relation to their obligations and familial expectations, can challenge one's belief in their own worth and usefulness. Whether one maintains these expectations or challenges them, participants noted the strain and challenge this can provide to mental health and can rupture familial relationships in the extreme.

SURVEY FACTOR	CONNECTION(S) TO TALANOA KEY THEME	SYNERGY
2. Anxiety 4) Are you easily frightened? 6) Do you feel nervous, tense or worried? 8) Do you have trouble thinking clearly? 12) Do you find it difficult to make decisions?	2. The need for education, psychoeducation and/or lack of appreciation for the complexity of mental health concerns	Symptoms described in this factor may be interpreted as individuals having spiritual ailments or concerns but may also be interpreted as them being 'weak minded'. These conceptualisations of what could be symptoms of a mental illness tend to oversimplify the realities of mental health concerns, perhaps due to fear of what having a mental health illness means, and associations with being 'crazy' and in the extreme, perceived as beyond recovery or help. A lack of strengths-based language to describe different mental health conditions in helpful terms in Pacific languages may further negate deeper understandings of mental health presentations amongst Pacific communities. As with factor one above, providing psychoeducation can widen perspectives of how these realities can be symptoms of mental illness, and the reality of recovery-oriented mental health service provision.
3. Capacity/ Exhaustion 1) Do you often have headaches? 2) Is your appetite poor? 3) Do you sleep badly? 4) Do you feel tired all the time? 20) Are you easily tired?	4. Pacific perceptions of mental health	Due to a range of demanding priorities – church commitments, immediate and extended familial obligations, work and study commitments, and others – tiredness and fatigue appear as common realities amongst Pacific peoples engaged in this research project. These cultural practices promote strong connections to others but may mask the presence of a mental health concern. As these obligations are often shared and common, they can be normalised and therefore disregarded as anything more than the result of being busy caring for others.
4. Somatic 5) Do your hands shake? 7) Is your digestion poor? 10) Do you cry more than usual? 19) Do you have uncomfortable feelings in your stomach?	3. Interventions and treatments for mental health concerns	As with the above factors, treatments for mental health concerns are typically through family/friend/cultural community support – talking, sharing emotions, and bearing each other's burdens – or otherwise taken to spiritual leaders within the community. Interventions can include spiritual practices that may or may not assist the individual, and familial and other supports may suffer from a lack of education about presentations that this factor highlights could be connected to a mental health concern.

TALANOA SESSIONS

We now consider the key themes arising from the talanoa sessions, first in a more condensed table form and then in narrative form, to elaborate on the discussions shared by research participants. All thematic data analysis was conducted the MHT research team. Subthemes were colour-coded in the following way:

ORANGE Issues within Pacific communities

YELLOW Systemic changes needed to assist Pacific communities

GREEN Participant recommendations

Most topics contain the most relevant quotes drawn from the talanoa sessions; those that do not were spoken of generally though not in detail by participants but were identifiable throughout these discussions.

TALANOA THEME SUMMARY

The following overview provides direct quotes from the 16 Talanoa participants in support of the 8 key themes derived from the research. We provide this data as a means to further outline how each key theme was developed. This thematic analysis was interpretative in nature – where we reviewed the key quotes as a means to represent the key theme. We also saw this as being summative, where quotes provided an insight into the way in which Pacific communities may view mental health issues and its impacts to individuals and their collective wellbeing.

THEME	SUBTHEME	QUOTE *(in italics)*
1. JUDGMENT, STIGMA AND BARRIERS TO ACCESS	Judgment and stigma [embarrassed and afraid]	*Everyone's always scared to talk about [mental illness] because you always think I'm going to end up in [a mental health institution]... There's nothing, there's no way to lift them up or having [sic] the services helping them through the journey.* *So small and you'd be embarrassed or afraid or just not supported or loved, so you just didn't talk about it and it was joked about.*
	Collectivist orientation	*Because [discussing or addressing mental illness] doesn't serve the greater good...in fact it might kind of bring shame or all this other stuff.*
	Taboo topics	[A sense of] *fear of the community...of the labelling and being judged...*
	Mental health as weakness	*Toughen up, kind of get over it...any indication of weakness...was seen as a weakness...not strong.*
	Mental health as a Western idea	*More a European or Western illness...mental health isn't a thing in our culture. You know mentally you should do better.*
	Writing off people due to lack of support	
	Lack of early intervention supports	*Once things had just become really bad and in some ways...almost violently thrust into services...perhaps they've had police involvement in ... finding them being quite unwell in the community and then they're...violently thrown into this world so there isn't the same sort of early help seeking behaviour we see in some other communities.*
	Judgment within a religious setting	
	Shame for accessing services [cultural resistance to accessing services]	*Why are you going to talk [to a counsellor]? You can talk to us? ... Why are you going to counsellors? You've got your friends to talk to or you can pray to God.*
	Involvement of community and church leadership	

THEME	SUBTHEME	QUOTE *(in italics)*
2. EDUCATION/ PSYCHOEDUCATION/ LACK OF APPRECIATION FOR COMPLEXITY OF MENTAL HEALTH	Lack of understanding of characteristics and possible manifestation of mental health concerns	*They turn to the only think that they know and it's either family or God. The things that they know and then they start to blame things. They blame colonisation.* *We don't have the tools and the knowledge.*
	Promotion of mental health via social media vs. need to reflect on their own mental health	*[We] weren't taught to express ourselves in many ways and faults.*
	Childhood trauma going unaddressed + Addictive behaviours impacting on other domains	*Have a lot of friends my age in their forties…who are dealing with a lot of childhood trauma and they vary from different backgrounds. They've developed bad habits from alcohol abuse and gambling and then when they go to their therapy sessions and they dig deep then they come back and say it all stems back to their childhood trauma.*
	Young people's environments + Forfeiting of opportunities to pursue tertiary education	*Reaching up to the HSC I was always checking in on them. What are you doing? […] And then they just go into a lull…* [this] *had a lot to do with their surroundings. Teaching these kids…resilience…[teaching them] to have a lot of pride in themselves, self-confidence, which is what a lot of them do lack. Probably because they're not getting that from home.* *A whole bunch of them…they put their studies on the back burner and they've just gone into the working world. But even still they're not happy with what they're doing but they're doing something, right?* *I think from a parental stance a lot of mothers…a lot of the parents that I do speak with, there is a lack of understanding and they feel helpless. A lot of them don't know how to help their kids, particularly those with behavioural issues, and challenging behaviours, a lot of them, they feel at a loss.* *A lot of them are…pulling their hair out….What I am doing wrong, you know, I'm juggling this?*
	Having conversations about mental health with family members/feeling safe to do so + Nature of banter in Pacific conversations	*I think that responsibility, it lies with us and it's now. If we can have those conversations not only with our sisters and our cousins and friends and hopefully they will… [do so] with their family and their friends and…regular honest conversations.* *Oh you're 'crazy' or 'you've got a mental health issue…' [we] trivialise the issues…[we are]…doing ourselves a disservice when we actually participate in those kinds of conversations and not challenge when people are perhaps using phrases or descriptions or language about mental health issues.*
	Language around mental health	*I think the first thing is language because it sounds condescending sometimes when you say, 'the weak mind'…* *I think the language unit should start changing first…* *Just allowing people to understand that it's kind of a simply normal thing…There are different forms of mental health that probably everyone has and for people to understand that. It doesn't make you stupid just because you have a mental illness.*

THEME	SUBTHEME	QUOTE *(in italics)*
Similar themes	Communication of relevant cultural resources	
	Communicating across generations	*Things have changed and different ways of starting a conversation with young people, in particular their own children and their grandchildren and just opening up the opportunity to let their kids know that it's okay to talk about things that they don't usually talk about.*
Similar themes	Lack of understanding of mental health jargon	
	Storytelling approach to explain mental illness	*You know things aren't happening in the usual way for how we would expect so let's start there to try and work out what's happening.*
	Peer support for Pacific youth	*My suggestion would be, because I've seen it work particularly with working with young people, is educating peers of where to go to access the support because we know research says they're going to go to their peers to talk about it rather than to seek help or to an adult, so it's that sort of type of space.* *How do they bring their culture into their space who they are? How do they take this and be successful out there?*
	Cultural Curiosity [Community education comes after cultural exchange]	*How do we, with almost like a cultural curiosity, how do we engage within understanding and knowing these processes and what is very obviously so important for the community? How do we bridge that gap and how do we bring the two together?* *I think some broad educational training around [cultural curiosity] regardless of who you are or where you come from to embrace and engage…and to be open to the possibility that we need to be educated in culture so we can better engage and that we can't disregard, we can't discount, we can't take away culture because if we can understand what's valuable and what's important then that's our foot in the door to be able to better engage and to come in to meet with people at their level.*
	Reflective practice amongst service providers	*So if we can start to actually frame things in terms of what that actually looks like from a Pacific perspective and then educating our communities in terms of what that looks like from a service perspective and trying to bridge that gap…I think that's the only way forward for our people, because it's got to be done on both sides and not just on a service perspective but from a community perspective.*
	Mentoring and guiding young Pacific professionals + Engagement with Pacific parents [upskill Pacific professionals]	
	Punitive measures used in Islands, impact on present attitudes towards mental health	

THEME	SUBTHEME	QUOTE *(in italics)*
3. INTERVENTIONS AND TREATMENTS	Merging knowledges of mental health together	*Bring both non-Indigenous and Indigenous ways of knowing together to conceptualise the whole mental health thing…Ways of realigning the spirit, mind and body*
	Starting the conversation	*Let's talk about it. Like it's not going to start outside, we've got to start within ourselves in this little group. So when we talk about it it's something, they look at us in a different way I'll say because nobody has talked about it.*
	Need to consider spirituality in crisis intervention	
	Promote professional engagement with direct experiences of culture	
	Advocating for more Pacific Islander and Maori people in helping professions + Trust	*If [clients] are wanting to deal with their mental health…it just shuts down everything if there's not a Pacific Islander or a Maori worker.* *A lack of trust with the system as a whole because our people have been let down many times in the past by the system and…trust is probably one of the biggest things.* *[We need] more culturally appropriate policies around dealing with Maori and Pacific Island people's mental illness and try to deviate away from the tokenistic approach.*
Similar topics	Creative therapeutic interventions	*They don't speak but once they get on the mic they're sharing absolutely everything that they're feeling inside and they don't like to recognise it as mental health because the world 'mental' is, for young people, not cool.*
	Labelling of 'mental health'	
Similar topics	Lack of awareness of resources	*You get given a whole list of numbers to call but then you don't really get into the door because then you have to call another number and then that gets tiring and then we ended up just sort of trying to support her ourselves through it.*
	Lack of familial support	
	Ongoing financial, emotional and spiritual costs	
	Translation of psychoeducation	*Mental health education into our language for Pacific Islanders and in that way we can reach out to members of our community who are interested in doing that*
	Utilising church leaders to encourage *practical help*	

THEME	SUBTHEME	QUOTE *(in italics)*
4. PACIFIC PERCEPTIONS	Conceptualising mental health as curses + Biblical stories showing mental health concerns as demonic manifestations + Genuine demonic possession	[Mental health concerns are] *brushed over and the implication was that if you've got enough prayers and you have enough church time then you're going to be fine.* *When someone has mental health…or if you're religious then to talk about mental health then it must be evil so it's not addressed.* *[The person's] voice transcended and like he changed his voice and everything and so it was really like they were possessed*
	Pathologising mental health	*How do people understand it? How do they perceive it?*
	Derogatory perceptions of those with mental health [Lack of understanding] [lack of validation of mental health symptoms]	*Stupid* [or] *dumb, like there's something wrong with their head and…need to go to the mental hospital but it was joked about, it wasn't anything serious.* *I was brought up with my kaumatuas, my elders. They had no idea what a mental illness was. You were called … poorangi which means sick in the head and how would they respond to it? They'd just give you so much aroha, so much love. They'd bring you in close. Their way of thinking was they just need love but once again it's yes people need love but we also need to address what's the illness?* *Being a first generation Tongan we're expected to know without being told…we learnt by seeing other people act, and so there's no room for that space of growing up to share your thoughts with your parents in a sense of, 'Oh, I feel like this, I feel like…'* *The moment you feel invalidated you're going to shut down, you don't want to speak anymore, forget about it. It's not a safe space for me to tell someone that I love how I'm feeling at the moment.*
	Lack of development in dealing with mental health	*We kind of seem to be floundering with moving ahead with the times. I'm not too sure if that's because of our people are resisting or maybe it's their lens that they're looking through I'm not too sure.*
	Lack of connection to culture for diaspora communities, especially youth	

THEME	SUBTHEME	QUOTE *(in italics)*
5. CULTURAL IMPACT	Identity impact from mental health + Ability to contribute to family	*Depending on the severity of it or what kind of mental illness it is, it can be quite debilitating for the person. They lose something in their being. Something is just completely lost.* *They can't give back to their family. And sometimes it just spirals downwards for them and they think, 'Well, I'm no good to my family. I can't contribute to my community. What good am I?'*
	Experiencing mental health firsthand	*Like something that you've never experienced and then it's how do you cope? Does the rest of the family manage with it? Are there other family members that are within the household who might also have mental health? And does that allow another person in the family to admit that they have it? And then who looks after who?*
	Communication and being stuck between worlds	*One of the biggest issues...*especially for those who *migrated from the motherland and we're the first generation that grew up here you know we're sort of stuck in between that medium of the old ways and the new ways. And you know for us actually to find a better way to move forward for our future...we have to action it and support is as best as possible.*
	Intergenerational communication	*If they say once or twice and you're not listening they take it as, well you're not interested, they walk away, without us realising.* *Harsh to say but it's what they're not saying is even worse you know what they're not doing is worse for them.*
	Static remembrance of culture	*Get[ting] stuck in a time warp of what their culture was like at the time that they migrated without realising that actually back home things have progressed and changed as well.*
	Generational trauma	[My cultural group doesn't] *take it seriously. They just think it's a bad behaviour, put it in gaol and it's not fair.* [Those with mental health concerns] *need help because people are suffering from their actions...I get a bit emotional talking about it because...it's hard to know that people in your own family...I see it so strong in my family now in these days... we're in need in all levels – elderly, our generation, the young generation...generational trauma that continues to perpetuate...and that intergenerational gap which exists across the board.*
	Passages of negotiation	*I've seen really impact [for] young people's mental wellbeing and how they go and have conversations about things that in Western culture take for granted but for us it's really difficult.*
	Difficulty to speak out in family contexts	*So I think that starts the process of questioning how do we function or how do we operate with then impacts our self-esteem and the way we probably see ourselves in those spaces.*
	Harmful cultural practices	*Within our culture there's...so many regulated practices or behaviours that seem to cause us trauma...I think...about it all the time and I'm like this is causing us like to feel some type of way but we just can't get away from it, we still do it.*

THEME	SUBTHEME	QUOTE *(in italics)*
	Resilience of young people	
	Cultural responsiveness when working with Pacific people + Heterogeneity of Pacific peoples, based on geographical areas and other factors	*With Pacific Islander people the way you work with us is different. The language we use within Sydney is different... from Mount Druitt to Campbelltown to Bondi you might as well go to a different country. That's what I find that that's completely unique when you work with Pacific Islander people.*
	Lack of families talking about it + Families being 'hardest audience'	*[They] don't speak about it. They don't touch on it because there's that self blame...fear of that self-blame.* *[...] Is it a cultural thing within us that we don't speak out, we don't seek help?*
	Differences in cultural practices	*[There is] hierarchical business [that] does wedge a difficult path for a lot of us young Pacific Islanders growing up.*

THEME	SUBTHEME	QUOTE *(in italics)*
6. CULTURAL SCRIPT, PRACTICES AND EXPECTATIONS	Impact of cultural expectations	[Participant 1] *It doesn't matter how old they are – don't have the opportunity to speak openly and honestly to a lot of the like parents and older people. So telling your parent that you're going through something, even as a teenager, could be really quite daunting for a Pacific young person who has never said boo to their parents or their older siblings so maybe the way that our culture is could have an impact in why we aren't kind of openly having these conversations maybe.* [Participant 2] *I do agree with that. As a child our culture plays a part in how we perceive mental health.* [Participant 1] *And I just bring that up because I know when I have young Pacific clients they have all the education. You know they go to the school counsellor and they're able to talk about it with their friends but when it comes to their parents it's quite difficult for them to communicate that to their parents and when they're at home and even the thought of going on medication some parents may not be open to that just given their background or what's happened to them.* *[A]cross generations is this need to control young people's thinking. The thinking in young people, teenagers, even young adulthood, even in some cultures – and you would know which one you fit in here – even as adults and married yourself and having families yourself, the need for the older generation to control the thinking, to control other aspects. Finances, who you associate with, who you don't associate with, what kind of employment you will have and what you won't, how you relate to your extended family, in-laws and so on, that need to control. You cannot think for yourself and if you should you know there's going to be disharmony. There's going to be a huge cost.* *It's that need to control. You can't think for yourself. I won't let you think for yourself. It's dangerous to think for yourself because I know better. You know the previous generation knows better. I think that really does impact on their mental health, the need to be free from that dominance.* *And I say this with some level of emotion myself because growing up in a Pacific Island family the first female of eight kids I had a script and that script was very strong in my life and dominated my life. It dominated my thinking. It didn't matter if I was blooming well climbing in the Himalayas I was still living that script.*
	Barriers between Western and Pacific cultures	[There are] *definite cultural barriers between Pacific Islanders and Western society…There's still a definitely a big break down and cultural barriers.*
	Expectations of Pacific young women	*Like our Pacific Island young women especially between the 18 to 26 year olds they have this image where they just have to be happy and show that everything is awesome and they just have this real image of showing that everything's fine when really they're dying inside. Our young Pacific women I don't know what's going on but they're just not talking. They just have this image thing about them – something maybe specific for our Pacific young women as well.*

THEME	SUBTHEME	QUOTE *(in italics)*
6. CULTURAL SCRIPT, PRACTICES AND EXPECTATIONS	Separation of true and expected self	*No, you stop talking about that. You see what we do, you follow that. So you kind of like you separate yourself from being yourself and you have to be a person.* *So personally growing up I want to do this and this and that and I was told no, you do what you're told. You have to be an accountant. You've got to be this and that and I feel like they ignored me and I thought I was the only person like that but when I realised my friends, other Pasifika friends the same thing. They lost that sense of touch and I kind of envied my Anglo-Saxon friends because they were able to tell their parents their thoughts and they were able to tell them, oh okay I'll be really deep now…*
	Internalised invalidation + Hierarchical status in Pacific communities + Taking direction, socialisation and lack of development of critical thinking	*Yeah, this is a safe space. Especially with sexual abuse. And when I went through that I couldn't speak up because from a young age I was told to shut up. I know it sounds pretty up front, full forward but I wasn't good enough to be heard. And I think from a little person if you're not valued then why would you speak up? So I think I grew up fighting me and fighting the expectation that my community was expecting of me. You're a young girl, you should be in church, you should be this and that, you should be that. So I grew up in life being "what I should be" and I was ignoring what I wanted to be. Obviously I grew up drinking, smoking, partying, whatever but I think the connection that I really wanted was to be my authentic self to my parents and I wanted them to hear me and hear my voice and if I had, as a little kid, I think I would have spoken the first time a man touched me.* [Taking direction] *works to an extent and then we get to a point where we then have to function in a world where we have to start critically thinking and that's when we get to… school age and we're…behind the eight ball.*

THEME	SUBTHEME	QUOTE *(in italics)*
7. CHURCH ENGAGEMENT AND ASSOCIATED PRACTICES	Engagement with local churches + Only perceived pathway for support is churches due to perception of mental illness as spiritual	*No one has stepped up and reached out within the church, not only going to church every Sunday…reaching out at the services [explaining] what services that we have in there to help out.* *I can only talk for my community because we value church, like it's like God,…church is everything. If church was involved and those ministers and youth leaders had an arm in any mental health programs I swear to God it would be the best marrying off, the bridging that we are looking for.*
	Policies and resources that can support churches + Targeted training that assists on the ground development	
	Being shunned due to presence of mental illness + Spiritualising mental health concerns	*We were actually pushed aside because it was, 'don't deal with that. We don't want to deal with it'.* *It was, 'Oh, just pray about it you know, something must have happened to her as a child or someone's done something to her from Fiji', like that's what we got from the community. It wasn't anything of substance.*
	Hierarchy within the church + Influence of elders and leadership + Impact on younger generation	

THEME	SUBTHEME	QUOTE *(in italics)*
8. POLICY AND RESEARCH	Offering training courses and degrees that teach understandings of CALD and Pacific concerns and experiences	[Bringing these issues] *to the forefront of these practises.*
	Values attached to some school subjects over others, diminishes value of particular knowledges in favour of others	*That's my point like intelligence is contextualised so just because you don't come first in the class doesn't mean that you're not intelligent. Like the measurement that education uses I think it's ludicrous because it doesn't reflect real life. I think education in high schools is not giving the tools for our young people to be able to move into society especially if you're a straight A student and getting a pat on the back all the time then all of a sudden you walk into the big wide world. It doesn't work like that. Like you might have got an A in your literacy test but guess what? You're still going to have to do this job. I think a part of education has to play a key in whatever this leads into.*
	Identification of Pacific heritage as policy practice + prevalence of mental health concerns in minority of minority group	
	Methods of engagement between governmental organisations and Pacific young people	*Governmental organisations…deal with issues when they're coming across angry Pacific Islander kids and they just make it ramp up even higher…*rather than *deal with different cultural and communicate in different ways.*
	Need for longevity in community programs + Reactive community funding	*What organisations don't realise is people make that service not the service doesn't make that service so if you lose your staff you lose that connection. The connection wasn't with TAFE NSW or Mission Australia or anything like that it was with the staff that worked in those organisations. It's about retaining these programs…This is a plan that should be like for the next 10, 20 years. It's not a program or whatever to be happening for the next one to two, it has to be a long term plan and something that is sustainable and something is looking after the generational aspect of our people not just something short term because that's what often we feel a lot of people in the community…So that's probably the most frustrating thing with organisations. They come in and they do stuff and they talk a big game and they're gone and then a couple of weeks later, a couple of months later, a couple of years later it's a new organisation that comes through, someone else that is here to pick up the baton and it's like you're trying to reinvent the wheel.* [Issues] *die down a bit and then they took the funding away and then a new group of community initiatives came.*

THEME	SUBTHEME	QUOTE *(in italics)*
8. POLICY AND RESEARCH	More holistic responses from health systems	*NSW Health can engage with Pasifika communities not how Pasifika communities can access that support. Yeah, so whether that was intentional or not but I think that's critical that we recognise that there is an onus and responsibility as they've got a charter, they've got a mandate, they've got a mission to do that and so taking into account all cultural factors and nuances and language barriers and the whole deal.*

NARRATIVE ANALYSIS FROM TALANOA SESSIONS

This section strives to connect the 8 key themes sourced from the Talanoa alongside a broader narrative that may assist in creating sustainable recommendations and strategies to support Pacific communities alongside their mental health and wellbeing. Quotes have been utilised extensively throughout to highlight the voice of the participants, with their contributions presented in *italics* within sentences, and as stand alone points.

1) JUDGMENT, STIGMA, BARRIERS TO ACCESS

When discussing the prevalence of mental health concerns amongst Pacific communities, many of the participants stated that disclosing information about themselves or family members having a mental health concern would lead to judgment and stigma. In the words of one Fijian participant,

Everyone's always scared to talk about [mental illness] because you always think I'm going to end up in [a mental health institution]...There's nothing, there's no way to lift them up or having [sic] the services helping them through the journey.

Other participants mentioned feeling

So small and you'd be embarrassed or afraid or just not supported or loved, so you just didn't talk about it and it was joked about.

There is a clear sense of embarrassment and stigma that comes with admitting a mental health concern, and a potential lack of familial support when this is a reality.

Another participant speculated that due to the collectivist orientation of many Pacific peoples, it may be harder to admit the presence and impact of mental health concerns,

Because it doesn't serve the greater good...in fact it might kind of bring shame or all this other stuff.

A sense of *fear of the community...of the labelling and being judged* was also highlighted as reasons that mental health concerns are not typically addressed amongst Pacific communities. The role of anxiety and particular topics being taboo may also be barriers to speaking out about mental health concerns, especially where domestic violence in the home is present. This double-layered taboo – not speaking about domestic violence, and subsequently not addressing mental health concerns that may arise as a result – keeps victims in *a vicious cycle*.

Other participants have highlighted how there are *cultural factors [that] have masked [mental health prevalence],* as well as coping mechanisms such as *toughen up, kind of get over it,* and to express *any indication of weakness...was seen as a weakness* or *not strong.* Further, the concept of mental health being a *Palangi* (Western) idea may be a reason that mental health illness itself is considered a *more a European or Western illness.* Other participants pondered that *mental health isn't a thing in our culture. You know mentally you should do better.* As a result of this conceptualisation of mental health,

The moment you mention mental health it's stigmatised...they just so no, I'm not sick, I'm not sick, I'm just feeling like this.

Stigmatising perceptions of mental health concerns, therefore, keep the issue from being addressed in a meaningful way, and/or validating its existence, which severely limit the likelihood or desirability of accessing services. This idea was further extrapolated by another participant who mentioned

There are so many people that I could pin from my generation to my older generation who have [behavioural diagnoses], who have those traits. They haven't got diagnosed and a lot of those kids in our community have been written off. They were written off because they didn't have the right support.

Foisting shame and stigma onto mental health concerns can lead to people being "written off" due to a lack of appropriate supports. As a result of this treatment of mental health, early interventions and discussions about mental health often do not occur within the family setting, which therefore heighten the impact of these issues in later life:

Sometimes [children and youth are] trying to get the message to [parents] but we're not listening so I think communication overall becomes the biggest impact.

It is often the case that when Pacific people, and especially young people, access mental health services, they are doing so

Once things had just become really bad and in some ways...almost violently thrust into services... perhaps they've had police involvement in ... finding them being quite unwell in the community and then they're...violently thrown into this world so there isn't the same sort of early help seeking behaviour we see in some other communities.

Another participant mentioned that within a religious setting, the same judgment and stigma can be present, with little understanding of the underlying issues that impact on the emergence of mental health concerns.

Accessing counselling services at a university was mentioned by one participant, who disclosed to her friends that she was accessing such support. She was met with her friends questioning why she would access counselling:

Why are you going to talk? You can talk to us? … Why are you going to counsellors? You've got your friends to talk to or you can pray to God.

This participant then described how she wants to advocate for access to mental health services, as *it's not about being a colour. Mental health has no discrimination.* There is a clear sense in which there is cultural resistance to the rationale for accessing mental health services.

One of the possible solutions offered to counter this sense of judgment and stigma is to involve community and church leadership to begin having conversations around mental health, develop rapport, and use that to shift conversations to begin to address mental health concerns in an organic way.

2) EDUCATION/PSYCHOEDUCATION/ LACK OF APPRECIATION FOR COMPLEXITY OF MENTAL HEALTH

Participants highlighted mental health not being readily understood by families and communities, and as a result there as a lesser uptake of services. The concept of underlying mental illness and the differences between *trauma, mental illness* [and] *drugs* are not readily apprehended due to a lack of education of these topics amongst Pacific communities, though it is recognised that the impacts of mental health concerns, such as an increase in suicides, is becoming more prevalent. As a result of this lack of understanding of the characteristics and possible manifestations of mental health concerns, family members and community elders may not know how best to assist, and therapeutic interventions are not utilised. In speaking about the mental health of a family member, one participant stated

[We] had to step up to the plate and say we need to do this in a professional – I'm talking about doctors – in a therapeutic way incorporating different ways of addressing this mental illness because my parents had absolutely no idea because they were brought up not understanding what a mental illness was.

Participants highlighted that community members can often become scared when they don't have the answers, and

They turn to the only think that they know and it's either family or God – the things that they know – and then they start to blame things. They blame colonisation.

The complexity of mental health concerns is seemingly underappreciated in the eyes of this participant, and recourse to usual supports, such as family and God, can turn into blame towards external forces for that which is not understood. Another participant mentioned that *we don't have the tools and the knowledge* to adequately address mental health concerns.

Social media platforms have been used to promote a general sense of awareness for mental health; participants mentioned, however, that this promoting of mental health issues is not turned inward, which is perhaps more needed, so that individuals reflect on their own mental health, to consider if they might be displaying symptoms themselves.

The need for such research was strongly articulated by participants, who mentioned that they or their forebears *weren't taught to express ourselves in many ways and faults.* As a result of this lack of articulating mental health concerns, one participant stated how they

Have a lot of friends my age in their forties…who are dealing with a lot of childhood trauma and they vary from different backgrounds. They've developed bad habits from alcohol abuse and gambling and then when they go to their therapy sessions and they dig deep then they come back and say it all stems back to their childhood trauma.

This participant went on to highlight how sexual abuse within communities *is rife and a lot of them are dealing with that now*, coming out in later life, which can result in addictive behaviours that impact on other areas, such as financial literacy and being able to meet one's basic necessities of requiring food and shelter, due to the ongoing impacts of such unaddressed trauma.

As discussed above, there is strong resistance and internalised stigmatisation to conversations around a family member's mental health concerns. One participant, whose son has a mental health condition, mentioned how surprised she was to hear of another community member wanting to discuss their son's diagnoses. Informal meetings such as *play dates* allow for discreet discussions to take place about these circumstances.

Concerns were also expressed around young people's environments, particularly around completion of secondary school. One participant highlighted how students may have set plans to aspire towards particular goals during their final year of study, *and then they just go into a lull*. This participant believes that this *had a lot to do with their surroundings*. Although these young people are offered opportunities, there is often a need for a hand holding process to link them into different avenues. Other areas of importance are

Teaching these kids…resilience…[teaching them] to have a lot of pride in themselves, self-confidence, which is what a lot of them do lack. Probably because they're not getting that from home.

Pacific students aren't learning these skills at school either, which results in

A whole bunch of them…they put their studies on the back burner and they've just gone into the working world. But even still they're not happy with what they're doing but they're doing something right.

The forfeiting of opportunities to pursue tertiary education can arise from a desire to help the family by working to alleviate financial pressures but can come at the expense of developing career goals and higher paying jobs. As long as young people are working, this is perceived as doing something useful, although this may not be meaningful for the young person. This participant continues:

I think from a parental stance a lot of mothers…a lot of the parents that I do speak with there is a lack of understanding and they feel hopeless. A lot of them don't know how to help their kids, particularly those with behavioural issues, and challenging behaviours, a lot of them, they feel at a loss. A lot of them are…pulling their hair out….What I am doing wrong, you know, I'm juggling this?

Challenges arise for students, who may experience a lack of motivation and drive to attain their goals, and attempt to balance family expectations with entering the workforce, and parents who may not understand how to assist their children through developmental life stages that shift from child to adult in a Western capitalist context.

Participants considered their personal roles in facilitating discussions around mental health, and some of the issues they can face when seeking to do this:

I educate myself to be able to feel comfortable. I don't know if you ever feel comfortable but just to have some of these conversations with your own family and friends. Sometimes you come off as the villain because you bring it up…but I'm not afraid to have [them]…I think that responsibility, it lies with us and it's now. If we can have those conversations not only with our sisters and our cousins and friends and hopefully they will… [do so] with their family and their friends and…regular honest conversations.

One of the research team members then mentioned how they were often

Criticised, eye-rolled, told *whatever, you don't know…take your Palagi way of thinking and all that other stuff. And ultimately I think it's because I don't feel safe enough to have these conversations with [my family] so maybe that could be a contributing factor as to why Pacific people don't. They probably don't feel safe. They won't feel validated maybe.*

The strong cultural resistance towards addressing mental health concerns plays out with stigmatising those who may seek to address it within family settings.

Another participant highlighted the nature of banter within Pacific conversations, and that comments such as *'Oh you're crazy' or 'you've got a mental health issue´* often *trivialise the issues*, which can lead to

Doing ourselves a disservice when we actually participate in those kinds of conversations and not challenge when people are perhaps using phrases or descriptions or language about mental health issues.

This same participant highlighted the need for advocating for understanding mental health concerns within family contexts, to promote *more awareness and understanding*.

The language used around mental health was compared to how physical injuries such as a broken leg are considered:

Maybe that's how for us to reach out to our community or teach our community about mental health is that mental health illness is an illness like a broken leg… Maybe the language that we use in that way.

Another participant spoke of the need for those *who have higher roles in school or church* to address this issue of the language used regarding mental health:

I think the first thing is language because it sounds condescending sometimes when you say, 'the weak mind'…I think the language unit should start changing first…

An extension of this is the communication of relevant cultural resources, often from Aotearoa New Zealand, in Pacific languages that provide information on mental health concerns and ensuring that the sources of this information are credible and authoritative. Providing this information online was stated as a key strategy, as *we do have a heavy presence online*. Psychoeducation also needs to extend to all generations, and not only target one, according to this same participant:

Looking at the signs, understanding the signs, understanding triggers, understanding anything and everything about mental health pretty much is what I'm looking for.

Promoting relevant resources can also be done across generations, and understanding

How things have changed and different ways of starting a conversation with young people, in particular their own children and their grandchildren and just opening up the opportunity to let their kids know that it's okay to talk about things that they don't usually talk about.

Examples of culturally relevant communications tools for young people were not the usual *brochures and flyers*, but rather *rap or a song or something like that*. The *labelling* of these concerns as 'mental health' was also highlighted as a potential stumbling block, with a focus on

Just allowing people to understand that it's kind of a simply normal thing…There are different forms of mental health that probably everyone has and for people to understand that. It doesn't make you stupid just because you have a mental illness.

A lack of awareness of mental health jargon may be present in the home environment. One participant mentioned how they adopt a storytelling approach, and describing mental health as *something's not quite right* may be a more appropriate way to highlight underlying or overt mental health concerns:

You know things aren't happening in the usual way for how we would expect so let's start there to try and work out what's happening.

This participant found that when engaging with Pacific families in this way, there seems to be a greater openness to engaging with service providers. Use of this kind of language dismantled what can be intimidating and confusing clinical terminology and promote a more collaborative approach to understanding mental health concerns within Pacific family settings.

Another participant affirmed the *handholding process* mentioned above, as well as the need to provide peer support for Pacific young people, as it is known that young people will turn to their peers before they turn to service providers:

My suggestion would be, because I've seen it work particularly with working with young people, is educating peers of where to go to access the support because we know research says they're going to go to their peers to talk about it rather than to seek help or to an adult, so it's that sort of type of space.

This consideration was coupled with questions around how to educate young Pacific people who come through tertiary education in how to operate within the two worlds of their culture and the Western society they are surrounded by:

How do they bring their culture into their space who they are? How do they take this and be successful out there?

The concept of 'cultural curiosity' was highlighted as an approach that can assist services be more responsive to the needs of Pacific and CALD communities more generally:

How do we, with almost like a cultural curiosity, how do we engage within understanding and knowing these processes and what is very obviously so important for the community? How do we bridge that gap and how do we bring the two together?

Reflective practice amongst service providers and an ongoing attitude of cultural curiosity may assist in creating bridges that can engage more meaningfully with Pacific and other CALD communities.

Another participant acknowledged the important role of Pacific professionals educating Pacific people about mental health:

So if we can start to actually frame things in terms of what that actually looks like from a Pacific perspective and then educating our communities in terms of what that looks like from a service perspective and trying to bridge that gap…I think that's the only way forward for our people, because it's got to be done on both sides and not just on a service perspective but from a community perspective.

Further to this, mentoring and guiding young Pacific professionals who access tertiary education was also highlighted as a key consideration for effective community engagement in this space. These same professionals could engage with their parents who have not been exposed to and/or don't have these kinds of conversations.

Previous experiences of family members with mental health concerns were discussed, highlighting the previously punitive measures that those in Pacific Island nations endured as a result of a lack of awareness of the realities of mental health and how it manifests. People were placed in gaol without any kind of interventions, apart from prayer.

Ongoing development of cultural curiosity within service providers for all cultures that present at a service was highlighted as a tool for better engagement:

I think some broad educational training around [cultural curiosity] regardless of who you are or where you come from to embrace and engage…and to be open to the possibility that we need to be educated in culture so we can better engage and that we can't disregard, we can't discount, we can't take away culture because if we can understand what's valuable and what's important then that's our foot in the door to be able to better engage and to come in to meet with people at their level.

Community education, for this participant, must be preceded by *cultural exchange,* so that there is a mutual respect and development of rapport, upon which education can be easily be received.

Other participants highlighted the need to upskill Pacific professionals to be able to address a range of different issues, thereby creating more opportunities for Pacific communities in a range of areas, including business and home ownership.

3) INTERVENTIONS AND TREATMENTS

Participants highlighted that mental illness is perceived as

Something that could be healed or something that could be cured by using traditional medicines

One mental health practitioner underscored the need to *bring both non-Indigenous and Indigenous ways of knowing together to conceptualise the whole mental health thing*, such as the need for psychosocial supports, such as from extended family networks and spiritual practices such as prayer, ritualistic practices and spiritual healing as *ways of realigning the spirit, mind and body,* as well as Western treatments and understandings of mental health concerns. One participant summarised this concept in the following way:

The point is that something has worked and the person is improving in what's happening for them. So I think trying to find that balance around well how do both lean in and how do we work collaboratively within what is important from a cultural perspective to really engage and draw people in? … The thing that works really doesn't matter, the main thing is we need something to work and I think if we do things together we're more likely to have better outcomes anyway.

This is in contrast to some experiences of participants, where those in need of care were *prayed for but then they were put away you know, out of sight*.

A key aspect of developing these synergistic or other ways of providing interventions and treatments is to start the conversation in a transparent fashion:

Let's talk about it. Like it's not going to start outside, we've got to start within ourselves in this little group. So when we talk about it it's something, they look at us in a different way I'll say because nobody has talked about it.

Within crisis intervention, it has been considered that the client's spirituality or religious practice is very rarely taken into consideration. Rather, meeting physical needs are paramount, to the exclusion of others that Western systems may not prioritise, even though spirituality can be understood as one of the most important elements of social work practice. Furthermore, despite a range of intervention strategies and policies and procedures being in place to assist with these issues, there is a question around why they are not working.

A possible remedy to this is to promote professional engagement with direct experiences of culture, such as attending a *hangi* (oven pit cooked meal), so that culture moves from an abstract concept to a grounded experience, and shades of meaning are conveyed in meaningful ways to practitioners.

An extension of this point is the consideration of Pacific practitioners being aware of the authority and power they have in their positions, the position they have and whether they trust themselves to do this kind of work, and questioning whether the *whanau* (family) of the client trust the practitioner to do their work with the client. One participant advocated for more Maori and Pacific workers to be in these fields, so that more culturally safe practice can be provided for Maori and Pacific staff members that access service. Another participant recounted that in their context of working across the community:

If [clients] are wanting to deal with their mental health…it just shuts down everything if there's not a Pacific Islander or a Maori worker.

Trust is more easily and sometimes instantaneously established by the presence of Pacific and Maori workers who work with clients from their same cultural backgrounds, *simply because we are who we are*. There is also the lived experience of

A lack of trust with the system as a whole because our people have been let down many times in the past by the system and…trust is probably one of the biggest things.

A means of developing trust within the system may be the development of *more culturally appropriate policies around dealing with Maori and Pacific Island people's mental illness and try to deviate away from the tokenistic approach* in relation to the justice system, mental health or any other service that Pacific people may be involved with.

One of the ways that young people may communicate their experience is through performing arts, that can provide a platform to convey emotions and experiences they may not be able to express in other ways:

They don't speak but once they get on the mic they're sharing absolutely everything that they're feeling inside and they don't like to recognise it as mental health because the world 'mental' is, for young people, not cool.

The labelling of 'mental health' can be a reason why some young people shrink away from accessing services, yet providing cathartic spaces to be able to tap into the realities of what they are experiencing can be a form of intervention that reduces stigma and promotes further conversations to take place in an organic and safe setting.

The stigma around mental health can lead to a lack of awareness of the resources that are available to young people, such as those available from youth centres. There was an awareness amongst participants that previous modes of engagement, such as sharing a *kava* (alcoholic drink from a plant root) bowl with younger and older community members can help but may not always work in various places. As such, a *more modern approach* could evolved from this, *something that speaks to them more* within diverse contexts.

One participant spoke about the general lack of support they received for a family member who experienced drug induced psychosis. While resources were provided, there were many options to choose from but no specific support or direction on which ones to access. As a result, this did little to assist the family support their loved one:

You get given a whole list of numbers to call but then you don't really get into the door because then you have to call another number and then that gets tiring and then we ended up just sort of trying to support her ourselves through it.

This same participant made clear that there is a need for reform within the entire mental health system, not only for Pacific Islander and Maori communities. The ongoing financial, emotional and spiritual costs for this family were considerable, alongside the complicating factors that affected the family member – these issues could have been addressed in a more holistic fashion through greater and clearer supports at the initial point of engagement with mental health services.

Other participants identified the need to have *mental health education into our language for Pacific Islanders and in that way we can reach out to members of our community who are interested in doing that.* Another aspect of creating sustainability is in utilising church leaders as those who would encourage *practical help* to access mental health services, rather than trying to be *help workers* in this area, and the importance of using churches and church leaders as conduits for referrals to mental health services, so that *we link into those processes and maybe work together*.

The act of self-medicating rather than seeking assistance from a complex and daunting system was addressed as something that limits service access.

4) PACIFIC PERCEPTIONS

Mental health concerns are historically conceptualised as curses in some Pacific cultures, that was highlighted as something that requires prayer to alleviate and/or eliminate. Some found that mental health concerns were

Brushed over and the implication was that if you've got enough prayers and you have enough church time then you're going to be fine.

Associations were made between Biblical stories showing manifestations of what by today's standards would be understood as manifestations of mental illness, and how these are realised in the text as demonic possession, with the possible interpretations being that

When someone has mental health…or if you're religious then to talk about mental health then it must be evil so it's not addressed.

One participant narrated how people with mental health concerns were prayed over and

Bound in a room so that they wouldn't hurt themselves because they were hearing voices.

Another participant recounted how they witnessed interventions for those who were suffering from long-standing chronic mental health concerns:

I recall things that I seen not at home but within the church that my mother went to and what seemed to be the management plan for mental health or even like some form of injury that's inflicted on the body physically it was more of a spiritual type healing where there was a few leaders within the church would have set aside a specific day.

They'll get the person to come in and then they'll have the whole congregation come as well and we would witness and pray and sing songs over this one person who's getting prayed upon with water, like holy water and so forth trying to what they call it was a ma'i or like they would say they were trying to get the aitu out or the devil out because they have referred this type of illness or something to do with mental health as the devil's inside them so now we need to take the devil out and they'll be better and that's why they held these type sort of like prayer group type ritual ceremony things.

This same participant stated that they had seen this work, and another instance where someone who was prayed for completed suicide after the intervention. It was later understood that this individual was suffering from post-natal depression, though the community was not aware of the realities and impacts of this condition, emphasising the need for psychoeducation around such conditions within community settings.

Another participant shared an experience of their cousin:

And then [participant's cousin] said that she had some kind of episode and that her aunties actually used mosquito coils to burn her face to get the spirit out. And I started crying because I was like oh my goodness, like I guess knowing that they don't really have that support there and they automatically think that it must be like a spirit or something.

And then she touched on the fact that her family thinks that maybe one of her ancestors did something bad in the village back in the days and like that's another reason why people I guess they just use that as the excuse. But yeah like just this discussion got me thinking about that experience.

The participant explained that the young person who experienced this did not remember having the fit, but due to respecting community elders, she did not question their method of intervention. This example highlights the different cultural views of mental health concerns, highlighting the usefulness of having recourse to interpreting 'episodes' such as the one above through another perspective, which might have resulted in less pain being inflicted upon this young person.

Another participant highlighted the difference between mental health concerns and what they perceived as genuine demonic possession – *[the person's] voice transcended and like he changed his voice and everything and so it was really like they were possessed.* This participant then differentiates this to how people with mental health concerns are generally treated in her Pacific home island:

There was…this institution for disability people [sic] who stayed there and they weren't looked after properly. They were literally like the outcasts…they were found walking around mumbling. They were put in that institution.

Participants also highlighted the pathologising of mental health, where the *biomedical model discourses completely* overshadows other forms of interpreting the origin and impacts of mental health concerns. Key questions that ought to be asked of those with mental health concerns include

How do people understand it? How do they perceive it?

A lack of diagnosis and validation of mental health as mental health, alongside considerations of mental health as *weakness*, were also considered an important aspect for the prevalence and impact of mental health concerns amongst Pacific peoples.

Consideration was also given to the lack of dissemination of community supports available, and the need for a heightened awareness of systems that are in place to offer support, which challenges mindsets about mental illness that may be present amongst those raised in their homelands but live in Australia.

A member of the research team suggested a possible dualism between mental health being both spiritual and biomedical in nature. Any kind of synthesis between these two worldviews are not being genuinely considered, valued or validated by health professionals, the broader research agenda on mental health and wellbeing or the general population.

Other perceptions of individuals wo had mental health concerns include being called *stupid* or dumb,

Like there's something wrong with their head and...need to go to the mental hospital but it was joked about, it wasn't anything serious.

One participant described the response from Maori community leaders thus:

I was brought up with my kaumatuas my elders. They had no idea what a mental illness was. You were called...poorangi which means sick in the head and how would they respond to it? They'd just give you so much aroha, so much love. They'd bring you in close. Their way of thinking was they just need love but once again it's yes people need love but we also need to address what's the illness?

Considerations were also made around the impacts of colonisation, which was contrasted with the concept of

We kind of seem to be floundering with moving ahead with the times. I'm not too sure if that's because of our people are resisting or maybe it's their lens that they're looking through – I'm not too sure.

Community attention and treatment of mental illness may impact on how relevant services are perceived by these communities.

Undergirding these concerns is the lack of trust Pacific peoples tend to express towards mental health services, which is *the biggest issue* for some participants. The impact of being disconnected from cultural traditions from the Pacific Islands/Aotearoa New Zealand and the psychosocial impacts of these upon the next was a consideration by one participant.

Prevalence of mental health issues were attributed to a lack of diagnosis and validation of mental illness as mental illness.

Home environments were identified as places where particular expectations were not conducive to understand and appreciating the impacts of mental health:

Being a first generation Tongan we're expected to know without being told...we learnt by seeing other people act, and so there's no room for that space of growing up to share your thoughts with your parents in a sense of, 'Oh, I feel like this, I feel like...'

5) CULTURAL IMPACT

The impacts of mental health upon the holistic wellbeing of individuals have been articulated as deeply impacting on their sense of identity and role within the family unit and wider society:

Depending on the severity of it or what kind of mental illness it is, it can be quite debilitating for the person. They lose something in their being. Something is just completely lost.

This same participant went on to describe how mental illness affects individuals' ability to contribute to the family as:

They can't give back to their family. And sometimes it just spirals downwards for them and they think, 'Well, I'm no good to my family. I can't contribute to my community. What good am I?

From there, individuals can go deeper into this sense of hopelessness, which can affect the family unit as a whole. They then become part of the mental health system, which as mentioned above is not trusted by many in the community, and is *tokenistic when it comes to Maori and Pacific Islanders.*

Other participants described the lived experience of having a family member with mental illness, and despite efforts to be educated via resources, it is an entirely different reality when experienced firsthand:

Like something that you've never experienced and then it's how do you cope? Does the rest of the family manage with it? Are there other family members that are within the household who might also have mental health? And does that allow another person in the family to admit that they have it? And then who looks after who?

As Pacific individuals within family units often have specific roles around nurturing and caring for others, the presence and persistence of mental health concerns can therefore prove a great challenge and may even disrupt the roles that are associated with being part of the family unit. The symptomology of the mental illness is not the only issue present but is compounded by strong interpersonal interdependence that is deeply affected by it.

Communication was also highlighted as *one of the biggest issues*, particularly for those who

Migrated from the motherland and we're the first generation that grew up here you know we're sort of stuck in between that medium of the old ways and the new ways. And you know for us actually to find a better way to move forward for our future…we have to action it and support is as best as possible.

Intergenerational communication was also considered – the need to engage with Pacific Islander and Maori young people in more relevant ways, and appreciating the impacts of language and migration, and employment (or lack thereof) and how religion impacts upon Pacific Islander and Maori wellbeing. The importance of getting the message across to young people is seen as urgent by participants:

If they say once or twice and you're not listening they take it as, well you're not interested, they walk away, without us realising.

It can be that young people can present with issues that seem to be about stress pertaining to schoolwork, and not addressing these may escalate into greater mental health concerns in the short or long term. Parents may perceive that:

They can't cope with their kids. They see it as they're just naughty kids but in fact there is something else there.

Another participant reminisced on their upbringing, and how their parents similarly felt a strain raising a child in Australia when the parent was raised in the Pacific Islands. This was exemplified through the dissonance between expectations:

At school we're encouraged to speak your mind but at home you're only seen, not heard.

This also involved young people providing care to other family members, a reality that may not be present in non-Pacific families.

Another participant stated this idea of being bound in a static remembrance of culture for those who migrated from the Islands:

Get[ting] stuck in a time warp of what their culture was like at the time that they migrated without realising that actually back home things have progressed and changed as well.

This can result in a loss of culture, as the home culture as they remember it is no more, and there is difficulty in engaging with the dominant culture of the host country. Another participant spoke proudly of one of their students of Tongan descent who is critically investigating other worldviews, whilst bringing

Tongan culture into the classroom…he was given the opportunity to explore other patterns of thinking and I thought he is a fine example of why I'm here [as a teacher] and I'm backing him to go to university and that's exactly where he was going.

This same participant said that *sometimes our community still live in denial.* Another participant said, *it's so harsh to say but it's what they're not saying is even worse you know what they're not doing is worse for them.* In complement to these comments, another participant stated that:

[My cultural group] doesn't take it seriously. They just think it's a bad behaviour, put it in gaol and it's not fair. They need help because people are suffering from their actions…I get a bit emotional talking about it because…it's hard to know that people in your own family…I see it so strong in my family now in these days…we're in need in all levels – elderly, our generation, the young generation.

Others considered the *generational trauma that continues to perpetuate…and that intergenerational gap which exists across the board,* and the reality of operating across two different worlds: the one inside the four walls of the home, and the one outside of it. These various passages of negotiation that young people from CALD backgrounds, and specifically Pacific Islander and Maori go through being in Australia, is *take[n] for granted but for us it's really difficult.*

There was an awareness amongst participants that although it is difficult to speak out about these issues within family units, there is a need to advocate on their behalf. One participant discussed the reality of utilising their voice, and how this was a challenge for them:

So I think that starts the process of questioning how do we function or how do we operate with then impacts our self-esteem and the way we probably see ourselves in those spaces.

There is a recognised lack of culturally specific and safe support for Pacific young people that is more readily available in their homelands – their *extended support networks.*

Another participant highlighted that

Within our culture there's…so many regulated practices or behaviours that seem to cause us trauma,

Providing the examples of how a child born out of wedlock was given to an aunty to raise, and as a result,

She didn't really grow up…feeling the love that she would've with her maternal mother because they were forcibly separated.

Another example raised by this participant is the practice of donating large amounts of money to the local church, with their mother complaining about doing this, but still doing it:

I think…about it all the time and I'm like this is causing us like to feel some type of way but we just can't get away from it, we still do it.

The resilience of young Pacific Islander and Maori people was highlighted, considering the difficulties they may be experiencing in daily life. One participant mentioned being in Australia has heightened awareness of the symptoms of mental health concerns.

By extension, the ways that service providers interact with Pacific peoples ought to be unique if it is to be effective amongst these groups:

With Pacific Islander people the way you work with us is different. The language we use within Sydney is different…from Mount Druitt to Campbelltown to Bondi you might as well go to a different country. That's what I find that that's completely unique when you work with Pacific Islander people.

Different geographical contexts therefore demand a different approach when engaging with Pacific Islander and Maori peoples, and any sense of treating these individuals in the same manner simply because of shared cultural background denies their heterogeneity as individuals and families with unique experiences that shape their present realities.

On the issue of youth suicide in Pacific Islander and Maori communities, participants drew attention to the fact that many families *don't speak about it. They don't touch on it because there's that self-blame…fear of that self-blame.* Another participant wondered,

Is it a cultural thing within us that we don't speak out, we don't seek help?

Different cultural understandings of issues like migration to Australia and purchasing a home, and having one's children pay off the mortgage, were also discussed as *hierarchical business [that] does wedge a difficult path for a lot of us young Pacific Islanders growing up.*

6) CULTURAL SCRIPT, PRACTICES AND EXPECTATIONS

Participants highlighted the impact of cultural expectations and how they impact upon the lived experience of Pacific Islander peoples, particularly within a diaspora setting:

[Participant A] *It doesn't matter how old they are – don't have the opportunity to speak openly and honestly to a lot of the like parents and older people. So telling your parent that you're going through something, even as a teenager, could be really quite daunting for a Pacific young person who has never said boo to their parents or their older siblings so maybe the way that our culture is could have an impact in why we aren't kind of openly having these conversations maybe.*

[Participant B] *I do agree with that. As a child our culture plays a part in how we perceive mental health.*

[Participant A] *And I just bring that up because I know when I have young Pacific clients they have all the education. You know they go to the school counsellor and they're able to talk about it with their friends but when it comes to their parents it's quite difficult for them to communicate that to their parents and when they're at home and even the thought of going on medication some parents may not be open to that just given their background or what's happened to them.*

The idea of Pacific individuals with mental health concerns being *validated* was also raised as a key factor in having conversations around mental health within a family setting:

Because the moment you feel invalidated you're going to shut down, you don't want to speak anymore, forget about it. It's not a safe space for me to tell someone that I love how I'm feeling at the moment.

Another participant highlighted the presence of *definite cultural barriers between Pacific Islanders and Western society,* especially for Pacific young people. Programs and services for young people aren't engaging with the cultural and social practices that impact their lives, such as music and dance amongst other examples:

There's still a definitely a big break down and cultural barriers.

Participants have found that their family and friends *were the hardest audience* to address these concerns to, due to the nature of culture and how it can influence the kinds of discussions that happen between Pacific peoples. Another participant mentioned how Pacific women carry a particular expectation of projecting a positive persona, even though they may be struggling personally:

Like our Pacific Island young women especially between the 18 to 26 year old they have this image where they just have to be happy and show that everything is awesome and they just have this real image of showing that everything's fine when really they're dying inside. Our young Pacific women I don't know what's going on but they're just not talking. They just have this image thing about them – something maybe specific for our Pacific young women as well.

One of the most potent impacts of cultural expectations was described by one participant as a division between her authentic self and what she was expected to be. This participant is quoted at length, to honour her personal story:

No, you stop talking about that. You see what we do, you follow that. So you kind of like you separate yourself from being yourself and you have to be a person.

So personally growing up I want to do this and this and that and I was told no, you do what you're told. You have to be an accountant. You've got to be this and that and I feel like they ignored me and I thought I was the only person like that but when I realised my friends, other Pasifika friends the same thing. They lost that sense of touch and I kind of envied my Anglo Saxon friends because they were able to tell their parents their thoughts and they were able to tell them, oh okay I'll be really deep now...

[...]

Yeah, this is a safe space. Especially with sexual abuse. And when I went through that I couldn't speak up because from a young age I was told to shut up. I know it sounds pretty up front, full forward but I wasn't good enough to be heard. And I think from a little person if you're not valued then why would you speak up? So I think I grew up fighting me and fighting the expectation that my community was expecting of me. You're a young girl, you should be in church, you should be this and that, you should be that. So I grew up in life being "what I should be" and I was ignoring what I wanted to be. Obviously I grew up drinking, smoking, partying, whatever but I think the connection that I really wanted was to be my authentic self to my parents and I wanted them to hear me and hear my voice and if I had, as a little kid, I think I would have spoken the first time a man touched me.

This participant explains that through the process of not being heard repeatedly throughout their life, this led to the suppression of abuse, due to a learned pattern of expectations that was placed upon them, together with cultural attitudes that didn't allow space to express struggles that they were going through.

Another participant highlighted the impact upon their upbringing, and how even as a grown adult the 'cultural script' played a very significant role in creating barriers to independent thinking and critically analysing cultural practices that did not promote wellbeing. This participant has also been quoted at length to honour their personal story:

Come to this country and I'm still involved in church. I've been Pentecostal, Charismatic, Uniting Church, not Catholic but back to Pentecostal and one thing that really surprises me but then doesn't surprise me either cross generations is this need to control young people's thinking. The thinking in young people, teenagers, even young adulthood, even in some cultures – and you would know which one you fit in here – even as adults and married yourself and having families yourself, the need for the older generation to control the thinking, to control other aspects. Finances, who you associate with, who you don't associate with, what kind of employment you will have and what you won't, how you relate to your extended family, in-laws and so on, that need to control. You cannot think for yourself and if you should you know there's going to be disharmony. There's going to be a huge cost.

It's that need to control. You can't think for yourself. I won't let you think for yourself. It's dangerous to think for yourself because I know better. You know the previous generation knows better. I think that really does impact on their mental health, the need to be free from that dominance.

And I say this with some level of emotion myself because growing up in a Pacific Island family the first female of eight kids I had a script and that script was very strong in my life and dominated my life.

It dominated my thinking. It didn't matter if I was blooming well climbing in the Himalayas I was still living that script. I'd call home to Niue. My dad says only God knows where [Participant] is. But I only needed to hear his voice and I went back to the script. My mother's voice, went back to the script. I was 28 years of age then and I think I'm not alone in that experience when it comes to Pacific Island and the way it impacts our mental health, our spiritual health.

Another participant similarly addressed the concepts of how hierarchical status within Pacific communities deeply impacts upon how people interact with one another at community gatherings, and the costs that are associated with thinking independently, especially in a way that differs from the cultural worldviews that are held by those in power within these minority communities. This hierarchy was identified as an issue that inhibited one's ability to speak freely about challenges they faced, even when given the opportunity to speak. The high expectations played upon young Pacific people were also highlighted, and how cultural expectations and how one should be in life was *planned out for you*. Another participant mentioned:

And I think that could also, like being a close knit family and a close knit church it can be a bit culture like so like everything you do together the moment one person branches away it's like how dare she? You know she's got the devil in her and stuff. It's like you can't be independent being in the family, you've got to be dependent. You've got to be part of us and once you break out to do your own thing you're against the family.

This is especially true for the eldest in the family, and the pressures faced by them as those who most significantly impact their younger siblings and other cousins. Another participant considered how these realities impact Pacific peoples across generations, and that it might take until the second generation for the impacts upon communities to be known and potentially challenged.

The impacts of socialisation and being *socialised from day dot how to take direction* were also mentioned as realities that stand in direct conflict with an education and other systems that promote, and later in life assume, critical and independent thinking:

[Taking direction] works to an extent and then we get to a point where we then have to function in a world where we have to start critically thinking and that's when we get to…school age and we're…behind the eight ball.

This participant went on to say how this can result in a lack of self-esteem and how Pacific young people and adults then function in these spaces – due to socialisation.

7) CHURCH ENGAGEMENT AND ASSOCIATED PRACTICES

One of the main issues participants highlighted the need to engage with local churches to promote mental health services. This has the potential to reach a lot of people:

No one has stepped up and reached out within the church, not only going to church every Sunday… reaching out at the services [explaining] what services that we have in there to help out.

Another participant clarified that there is a need to provide these services for those in the church, and not only to promote services therein:

There's a lot of issues that [are] going within our churches for the young people. Incarceration and drug problems and everything, we still don't know how to deal with it.

There is also a desire from these participants to offer a range of services via the church, not only mental health services, including getting on board with government services and other initiatives, alongside the need to work on policies and resources that can support churches. Other participants considered what engagement with churches actually looks like, and how this can be realised beyond just having the intention to do so.

There were considerations around whether or not trust is present between churches and mental health services, and further how young people relate to church elders, who could either be listened to, or perhaps young people will not truly speak their mind due to the seniority of church eldership. One suggestion was *targeted training* rather than the more usual *flyers and pamphlets* – someone who provides meaningful engagement rather than only dissemination of information.

One participant recounted how they had a sibling who had ongoing mental health and substance abuse issues, who reported not getting relevant support that was needed to provide appropriate interventions. When it was found out that the family member had mental health challenges that derived from drug use, the family was shunned by the church:

We were actually pushed aside because it was, 'don't deal with that. We don't want to deal with it'.

Another participant recounts how when they sought support from their local community for a family member's mental health concern:

It was, 'Oh, just pray about it you know, something must have happened to her as a child or someone's done something to her from Fiji', like that's what we got from the community. It wasn't anything of substance.

When responses are spiritualised in such a way without providing any other kind of support, participants stated that this is *disheartening* and is a *revolving circle within the community*.

One participant who is a Church Minister highlighted the reality of hierarchy within cultural churches, and the respect for those in positions of power, and how shame and respect impact upon interactions. Another aspect of this reality is the expectation to be able to assist congregants despite not knowing much about mental health, as this is not a minister's area of training. Participants hoped that as surrounding culture changes towards a more holistic approach to mental health, Pacific communities will be more drawn into accessing and learning about mental health services.

One member of the research team noted that due to the spiritual orientation of how mental health is perceived within Pacific communities, it is likely that the only pathway to receive support will often be to church leaders and elders, which appears the *modus operandi* as per participant views on the topic. As such, a key recommendation of this research project is the need to engage with churches as community bastions of communication and authority, in order to be utilised more throughout all tiers of the community. Another participant echoed these sentiments, in other words:

I can only talk for my community because we value church, like it's like God,...church is everything. If church was involved and those ministers and youth leaders had an arm in any mental health programs I swear to God it would be the best marrying off, the bridging that we are looking for.

8) POLICY AND RESEARCH

Participants emphasised the need to include issues such as the impact, prevalence and help seeking behaviours of Pacific peoples in training courses and degrees such as social work, counselling, and other professions that draw upon the biomedical model when engaging with clients/patients. Doing so would ensure that governments and the wider community realise these concerns and could bring these issues *to the forefront in the practises*.

The value placed on some subjects over others in particular formal secondary school system were seen to be a hindrance to showcasing knowledge that Pacific young people have, especially when these young people *learn from modelling*. Formal learning in a diversity of ways, including for students who are *good with their hands*, could show knowledges that they have that current forms of assessment tend not to recognise:

Those knowledge [sic] are not being tapped into so that you can['t] see the full potential.

Another participant extrapolated upon this point:

Intelligence is contextualised so just because you don't come first in the class doesn't mean that you're not intelligent. Like the measurement that education uses I think it's ludicrous because it doesn't reflect real life. I think education in high schools is not giving the tools for our young people to be able to move into society especially if you're a straight A student and getting a pat on the back all the time then all of a sudden you walk into the big wide world. It doesn't work like that. Like you might have got an A in your literacy test but guess what? You're still going to have to do this job. I think a part of education has to play a key in whatever this leads into.

Work can also be done in education policy so that these concepts become a practice of those working in the sector. Identification of one's Pacific heritage in a range of government and other systems would also assist in providing more relevant supports; at present, this is only captured when the individual speaks their heritage language, which is not always the case for the Pacific diaspora living in Australia.

Collective data on Pacific communities in Australia does not help this situation, especially when considering that Pacific peoples are the *1% of the 1% of other that make up* ABS data. The prevalence of mental health concerns that lead to physical and other health impacts, alongside economic and other *adverse outcomes on our community*. Identification of gaps as these is important if Pacific Island communities are to see changes in these areas, which can lead to advocacy and lobbying government to better fund community services.

Participants working in the youth services sector addressed how:

Governmental organisations…deal with issues when they're coming across angry Pacific Islander kids and they just make it ramp up even higher,

Pointing to the need for a deeper understanding of issues surrounding young people from these backgrounds, and how to *deal with different cultures and communicate in different ways*. This same participant highlighted how other CALD groups, such as refugees and migrants, are engaged with in more culturally responsive ways, but it seemed like *the Pacific people kind of got left behind*.

Another participant highlighted the need for longevity in program delivery, which is severely lacking amid constantly changing governments and funding priorities in Australia:

What organisations don't realise is people make that service not the service doesn't make that service so if you lose your staff you lose that connection. The connection wasn't with TAFE NSW or Mission Australia or anything like that it was with the staff that worked in those organisations. It's about retaining these programs. It's not only about building them and developing them and implementing them, it's making sure that they're sustainable not only for my kids but for my kids' kids and for generations to come.

This is a plan that should be like for the next 10, 20 years. It's not a program or whatever to be happening for the next one to two, it has to be a long term plan and something that is sustainable and something is looking after the generational aspect of our people not just something short term because that's what often we feel a lot of people in the community. They see programs come and they go and they see people, they come and they go, and you're still living in the area that you're living. You're still going through the stuff that you're going through. So that's probably the most frustrating thing with organisations. They come in and they do stuff and they talk a big game and they're gone and then a couple of weeks later, a couple of months later, a couple of years later it's a new organisation that comes through, someone else that is here to pick up the baton and it's like you're trying to reinvent the wheel.

When it comes to Pacific communities, funding opportunities are *reactive* to social problems that these communities encounter, and when the issue

Die[s] down a bit and then they took the funding away and then a new group of community initiatives came.

This is counterproductive to build community resilience, especially in light of the above statements about the need for longevity in these contexts.

There is a complex interrelationship between relational, cultural, socio-economic and other realities for Pacific people that need to be addressed in order to promote *sustainability and capacity building* within these communities. Primary Health Networks (PHNs) have a role to play in addressing these concerns, as addressed by one participant:

NSW Health can engage with Pasifika communities not how Pasifika communities can access that support. Yeah, so whether that was intentional or not but I think that's critical that we recognise that there is an onus and responsibility as they've got a charter, they've got a mandate, they've got a mission to do that and so taking into account all cultural factors and nuances and language barriers and the whole deal.

They've got the resources to do it and I think that they need to be much more creative and innovative and intentional about how they engage with Pasifika communities in particular because that's the basis for our discussion here.

Consideration was also given to the role of governments consulting with Pacific communities in a meaningful way, and the role Pacific communities have to play in the development of how advising would take place, and what such *frameworks* would look like:

What are the objectives? What are we trying to achieve here? … I think that's the way forward…It's got to be on both sides and…we need a voice across it.

Another participant highlighted the need to develop cultural competence, and how Pacific peoples can speak into this space.

RESEARCH APPENDIX

APPENDIX A – OVERVIEW OF SURVEY ADMINSTRATION

SRQ-20 Instructions for Administrators
Note: It is very important that all interviewers follow exactly the same procedure. It is preferable that the survey is self-administered, rather than interview-administered, and it should not be a mix of self *and* interviewer administered.

To ensure this takes place, you can:

1. Introduce yourself to participants in the same manner
2. Ensure that you are alone with the participant and not in a group, so that participants don't ask each other questions and/or explanations of terms. This might mean explaining that you need to do the survey one-on-one, especially if the participant is with family or friends.
3. Give a standard introduction of why these questions are being asked i.e. these questions are being asked as they are tools to help us better understand the mental, physical and other symptoms that may indicate mental ill-health, and how we as Pacific people can better understand and have conversations about mental health, including how we can get help when we need it.
4. Read the below to the participant:

Please read the participant information sheet before you fill in the questionnaire. It is very important that everyone taking the questionnaire follows the same instructions.

The following questions are related to certain pains and problems, that may have bothered you in the last 30 DAYS. If you think the question applies to you and you had the described problem in the last 30 DAYS, answer YES.

On the other hand, if the question does not apply to you and you did not have the problem in the last 30 days, answer NO.

Please do not discuss the questions with anyone while answering the questionnaire.

If you are unsure about how to answer a question, please give the best answer you can.

We would like to reassure that the answers you are going to provide here are confidential.

5. You may need to make clear that the participants need to answer these questions independently, and not to discuss with those around them. You can, however, go over the questions again after all 20 questions have been asked.

"This second round of stating the questions should not be used to change any ratings, but only to allow participants to feel that they are being listened to, and discourage them from insisting on discussion during the first round" (WHO, 1994, p.8).

Encourage the participants to answer Yes or No, even if this is an approximation. If the participant fails to give an answer, the question will be repeated once more before moving onto the next item. Try to get answers for all questions, without creating a sense of pressure or coercion for the participant.

6. You as administrator cannot discuss the items with the participants. Part of the research in using this tool is to determine how language is understood within the SRQ-20, and if this is a barrier to capturing mental health experiences of Pacific people living in Australia.

APPENDIX B – SURVEY TOOL

MENTAL HEALTH TALANOA:
Raising awareness around wellbeing across Pacific Communities in Australia

Purpose of the research *This is an invitation for you to participate in a research project being conducted by staff at the University of Wollongong. The purpose of the research is to target workforce and system improvements to improve mental health literacy of health workers and Pacific people with lived experience of mental illness and their carers, family and supporters. The first stage of the project involves completing an online survey, hence this invitation for you to participate.*

Researchers
Associate Professor Jioji Ravulo
Faculty of Social Sciences, University of Wollongong
jioji@uow.edu.au , (+612) 8763 6009

Ms. Ursula Winterstein
Faculty of Social Sciences, University of Wollongong
ursulaw@uow.edu.au

Dr. Shannon Said
Faculty of Social Sciences, University of Wollongong
ssaid@uow.edu.au ,0448 476 282

Method and demands on participants
If you agree to be involved you will be asked to participate in an online survey conducted in your local area/local event/shopping centre/local Headspace clinic which is likely to last around 10 minutes. You will be asked questions relating to some basic personal information (Pacific background, age, gender, sexuality, highest level of education, employment, and others), and complete a self-reporting questionnaire (SRQ) that asks questions about your mental health, including questions about self harm, suicide, mood and interest in daily activities. Following the SRQ, you will also be offered information on support services that you can contact in future if you feel the need to. These support services are:

Headspace
Phone: (03) 9027 0100
Website: https://headspace.org.au

Lifeline
Phone: 13 11 14
Website: https://www.lifeline.org.au/

Black Dog
Phone: (02) 9382 2991
Website: https://www.blackdoginstitute.org.au/

Mental Health Line
Phone: 1800 011 511
Website: https://www.health.nsw.gov.au/mentalhealth/Pages/Mental-Health-Line.aspx

Suicide Callback Service
Phone: 1300 659 467
Website: https://www.suicidecallbackservice.org.au/

Men's Line Australia
Phone: 1300 78 99 78
Website: https://mensline.org.au/

We will also offer you to take part in the next part of the research, a talanoa focus group, to discuss your experiences in more detail. Information for this next step will be provided if you provide your contact details, which will be asked of you at the end of the online survey.

Possible risks, inconveniences and discomforts
Apart from the 10 minutes it will take to complete the survey, you may feel uncomfortable during or after you have finished it. You are welcome to use any of the services listed above to talk about how you are feeling with trained counsellors these services provide. Your involvement in the study is voluntary and you may withdraw at any time and withdraw any data you have provided by contacting the researchers before the end of the project (June 2020). Declining this invitation to participate will not adversely affect your relationship with your employer or the University of Wollongong.

Funding and benefits of the research
This research is being funded by the NSW Ministry of Health, Western Sydney Primary Health Network, South Western Sydney Primary Health Network, and the Nepean Blue Mountains Primary Health Network. Findings will be of immediate practical benefit to Pacific communities in Western Sydney, as the survey data will create a dataset to show the prevalence of mental health issues within Pacific communities. This allows the research team to collaborate with funding bodies to develop strategies for how to help Pacific peoples in Australia based on these responses. Results may lead to the development of resources to assist Pacific peoples for future use once this project is complete, and may also be published in journal articles or presented at conferences. Results will only be reported in ways that ensure the identity of participants remains confidential.

Ethics review and complaints
This study has been reviewed by the Social Sciences Human Research Ethics Committee at the University of Wollongong (Reference: 2019/402). If you have any concerns or complaints about the way this research is conducted you can contact the Ethics Manager on (02) 4221 4457 or email rso-ethics@uow.edu.au.

QB Please select which Local Government Area (LGA) you live in.

QC What is your suburb/postcode?

_____

QD What is your Pacific background?

_____

(Tick all that applies)

- ☐ Cook Island Maori (5)
- ☐ Fijian (3)
- ☐ Maori (4)
- ☐ Naurun (12)
- ☐ Niuean (6)
- ☐ Palaun (10)
- ☐ Papua New Guinean (9)
- ☐ Samoan (1)
- ☐ Solomon Islands (8)
- ☐ Tokelauan (13)
- ☐ Tongan (2)
- ☐ Tuvalu (7)
- ☐ Vanuatuan (11)
- ☐ Wallis and Fortuna (14)
- ☐ Other (please specify) (15)

_____

QE What is your age?

- ☐ 18-24 (1)
- ☐ 25-34 (2)
- ☐ 35-44 (3)
- ☐ 45-54 (4)
- ☐ 55-64 (5)
- ☐ 65-74 (6)
- ☐ 75 years and older (7)

QF What is your gender?

- ☐ Male (1)
- ☐ Female (2)
- ☐ Transgender (7)
- ☐ Intersex (8)
- ☐ Queer (10)
- ☐ Non-Binary (9)
- ☐ Fafafine/Fakaleiti/Vakasalewalewa (5)
- ☐ Other (please specify): (3)

_____

- ☐ Other (choose not to answer) (4)

QG What is your sexuality?

- ☐ Straight (1)
- ☐ Lesbian (3)
- ☐ Gay (10)
- ☐ Bisexual (2)
- ☐ Queer (5)
- ☐ Asexual (6)
- ☐ Pansexual (11)
- ☐ Other (8)

QH What is your religion?

- ☐ Anglican (14)
- ☐ Assemblies of God (AOG) (20)
- ☐ Baha'i (7)
- ☐ Buddhist (6)
- ☐ Catholic (1)
- ☐ Ekalesia Faapotopotoga Kerisiano Samoa (EFKS) (21)
- ☐ Jehovah's Witness (19)
- ☐ Jewish (3)
- ☐ Latter Day Saints (LDS) (18)
- ☐ Maronite (23)
- ☐ Methodist (16)
- ☐ Muslim (4)

- [ ] Orthodox (22)
- [ ] Presbyterian (24)
- [ ] Hindu (5)
- [ ] Pentecostal (15)
- [ ] Traditional Maori/Pacific (please specify) (8)

_____

- [ ] Ratana (9)
- [ ] Ringatu (10)
- [ ] Rastafarian (11)
- [ ] Seventh Day Adventist (SDA) (27)
- [ ] Uniting (17)
- [ ] Other (please specify) (12)

_____

- [ ] Not religious (13)

QI What language(s) do you speak at home? (Choose all that applies)

- [ ] Bislama (7)
- [ ] English (1)
- [ ] Fijian (2)
- [ ] French (17)
- [ ] Futunan (16)
- [ ] Cook Island Maori (3)
- [ ] Te Reo Maori (4)
- [ ] Nauran (5)
- [ ] Niuean (11)
- [ ] Palauan (6)
- [ ] Pijin (Solomon Islands) (9)
- [ ] Samoan (8)
- [ ] Tokelauan (10)
- [ ] Tongan (12)
- [ ] Tuvaluan (13)
- [ ] Vanuatuan (14)
- [ ] Wallisian (15)
- [ ] Other (please specify) (18)

_____

QJ What is your highest level of education?

- [ ] No schooling completed (1)
- [ ] Completed Primary School (2)
- [ ] Completed junior high school (Year 10 or equivalent) (3)
- [ ] Completed senior high school (Year 12 or equivalent) (4)
- [ ] TAFE, college or diploma course (or equivalent) (5)
- [ ] Associate degree (6)
- [ ] Bachelor's degree (7)
- [ ] Master's degree (8)
- [ ] Professional degree (9)
- [ ] Doctorate degree (10)
- [ ] Other (please specify) (11)

_____

QK What is your type of employment?

- [ ] Accounting (1)
- [ ] Administration and support (2)
- [ ] Advertising, arts and media (3)
- [ ] Banking and financial services (4)
- [ ] Call centre and customer service (5)
- [ ] CEO and general management (6)
- [ ] Community services and development (7)
- [ ] Construction (8)
- [ ] Consulting and strategy (9)
- [ ] Design and architecture (10)
- [ ] Education and training (11)
- [ ] Engineering (12)
- [ ] Farming, animals and conservation (13)
- [ ] General labour (34)
- [ ] Government and defence (14)
- [ ] Healthcare and medical (15)
- [ ] Hospitality and tourism (16)
- [ ] Human resources and recruitment (17)
- [ ] Information and communication technology (18)

- ☐ Insurance and superannuation (19)
- ☐ Legal (20)
- ☐ Manufacturing, transport and logistics (21)
- ☐ Marketing and communications (22)
- ☐ Mining, resources and energy (23)
- ☐ Real estate and property (24)
- ☐ Retail and consumer products (25)
- ☐ Sales (26)
- ☐ Science and technology (27)
- ☐ Self employed (28)
- ☐ Sport and recreation (29)
- ☐ Trades and services (30)
- ☐ Not currently employed/looking for work (31)
- ☐ Student (32)
- ☐ Unable to work (33)

QL Do you have a disability?

- ☐ Yes (1)
- ☐ No (2)

QM If so, what kind?

- ☐ Choose not to answer (14)
- ☐ Specific Learning Disability (SLD) (1)
- ☐ Other health impairment (2)
- ☐ Autism spectrum disorder (ASD) (3)
- ☐ Emotional disturbance (4)
- ☐ Speech or language impairment (5)
- ☐ Visual impairment, including blindness (6)
- ☐ Deafness (7)
- ☐ Hearing impairment (8)
- ☐ Deaf-blindness (9)
- ☐ Orthopedic impairment (10)
- ☐ Intellectual disability (11)
- ☐ Traumatic brain injury (12)
- ☐ Multiple disabilities (13)

The following questions are related to certain pains and problems, that may have bothered you in the last 30 DAYS

- If you think the question applies to you and you had the described problem in the last 30 DAYS, answer **YES**.
- On the other hand, if the question does not apply to you and you did not have theproblem in the last 30 days, answer **NO**.

Please do not discuss the questions with anyone while answering the questionnaire.

If you are unsure about how to answer a question, please give the best answer you can.

All answers provided are confidential.

Q1 Do you often have headaches?

- ☐ Yes
- ☐ No

Q2 Is your appetite poor?

- ☐ Yes
- ☐ No

Q3 Do you sleep badly?

- ☐ Yes
- ☐ No

Q4 Are you easily frightened?

- ☐ Yes
- ☐ No

Q5 Do your hands shake?

- ☐ Yes
- ☐ No

Q6 Do you feel nervous, tense or worried?

- ☐ Yes
- ☐ No

Q7 Is your digestion poor?

- ☐ Yes
- ☐ No

Q8 Do you have trouble thinking clearly?

- [ ] Yes
- [ ] No

Q9 Do you feel unhappy?

- [ ] Yes
- [ ] No

Q10 Do you cry more than usual?

- [ ] Yes
- [ ] No

Q11 Do you find it difficult to enjoy your daily activities?

- [ ] Yes
- [ ] No

Q12 Do you find it difficult to make decisions?

- [ ] Yes
- [ ] No

Q13 Is your daily work suffering?

- [ ] Yes
- [ ] No

Q14 Are you unable to play a useful part in life?

- [ ] Yes
- [ ] No

Q15 Have you lost interest in things?

- [ ] Yes
- [ ] No

Q16 Do you feel that you are a worthless person?

- [ ] Yes
- [ ] No

Q17 Has the thought of ending your life been on your mind?

- [ ] Yes
- [ ] No

Q18 Do you feel tired all the time?

- [ ] Yes
- [ ] No

Q19 Do you have uncomfortable feelings in your stomach?

- [ ] Yes
- [ ] No

Q20 Are you easily tired?

- [ ] Yes
- [ ] No

Q21 Would you be interested in participating in a follow up Talanoa about Pacific mental health?

- [ ] Yes
- [ ] No
- [ ] If Yes, please provide your name, phone and email details below

Name _____

_____

Phone _____

Email _____

You are also welcomed to contact the following support services if you feel the need to. All are free services.

Headspace
Phone: (03) 9027 0100
Website: https://headspace.org.au

Lifeline
Phone: 13 11 14
Website: https://www.lifeline.org.au/

Black Dog
Phone: (02) 9382 2991
Website: https://www.blackdoginstitute.org.au/

Mental Health Line
Phone: 1800 011 511
Website: https://www.health.nsw.gov.au/mentalhealth/Pages/Mental-Health-Line.aspx

Suicide Callback Service
Phone: 1300 659 467
Website: https://www.suicidecallbackservice.org.au/

Men's Line Australia
Phone: 1300 78 99 78
Website: https://mensline.org.au/

EDUCATION

- Introduction
- Desktop Review of Web-based resources
- Annotated Review of literature and media resources
- Pacific Indigenous Mental Health Lexicon (PIMHL)
  - Overview
  - PIMHL worksheet

Aware too of how terribly lucky
we are to call ourselves
Descendants of the mountain
Descendants of the whetu moana
Descendant of the banyan tree...

Sia Figiel

INTRODUCTION TO EDUCATION

The Mental Health Talanoa (MHT) research project was birthed out of an awareness of the limited Pacific mental health resources available to the Pacific diaspora in Western Sydney.

It has been noted through our research that Pacific people may not access mental health services and may not be aware of mental health resources available to them, effectively leaving the Pacific diaspora unsupported.

The following section endeavors to analyse current models of mental health service provision and practices and to promote the need to develop culturally safe spaces for Pacific communities to increase the uptake of relevant health services and resources.

As per the prescribed deliverable listed under the parallel phase of Education, three key activities were undertaken and documented:

- Desktop Review of web-based services
- Annotated Review of Literature & Media
- Pacific Indigenous Mental Health Lexicon (PIMHL)

Why does this matter?

In order to understand Mental Health perspectives in the Pacific context, it is imperative to first unpack the cultural significances and the meanings of mental health within various Pacific cultures. Literature highlights Pacific understandings of mental health can be linked to spiritual unrest due to an indiscretion within the family or village context.

Therefore, mental health resources, documentation and treatments with Pacific peoples ought to seek Pacific-based understandings of addressing spiritual concerns, such as consulting with a traditional healer or use traditional medicines, alongside Western intervention approaches.

For example, it is clear within the Samoan culture that mental health is viewed within a cultural context. These perspectives are complex and need to be understood prior to attempting to working with these communities (Tamasese et al, 2005). There are certain differences that may exist in and across Pacific communities. This includes an evolving understanding of mental health and wellbeing as a concept within traditional views that permeate Pacific culture (Ravulo, Malfie'o and Yeates, 2019).

Historically, mental health was seen as being embedded into Western medical models of health. This is made clear through the ongoing prevalence and reliance of the medical model around the delivery of services. Over time, this has evolved and created a platform for the development of the biopsychosocial model where a more holistic view of health is practiced (Deacon, 2013). The *bio* includes an understanding of the biological influences and impacts on wellbeing, the *psycho* strives to incorporate the psychological factors, and the *social* looks at all things related to society and the individual within. Utilising all three areas can create a synergy with the way in which Pacific cultures view health, which is holistic by default. Encouraging health workers and others involved in supporting the wellbeing of Pacific people in Australia to incorporate the biopsychosocial with Pacific perspectives can make, we believe, a significant difference to the engagement and outcomes achieved. Hence, our resources within this section strives to provide helpful strategies to evolving the resource base available for professionals and Pacific people to promote holistic health and wellbeing.

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Tamasese, K, Peteru, C, Waldegrave, C, Bush, A (2005), Ole taeao afua, the new morning: a qualitative investigation into Samoan perspectives on mental health and culturally appropriate services. Australian & New Zealand Journal of Psychiatry, 39(4): 300-309. 10p.

DESKTOP REVIEW OF WEB-BASED SERVICES

OVERVIEW OF REVIEW

The desktop review was conducted in order to find mental health services for the Pacific diaspora in greater western Sydney where one of the largest urbanised diasporas of Pacific people in Australia reside.

At the time of publication, there were no Pacific specific web based mental health services available to the Pacific diaspora, although there were specific mental health services for First Australians and culturally and linguistically diverse (CALD) communities. In Aotearoa/New Zealand, there are multiple services and resources dedicated to the tangata whenua (first peoples of the land – Māori) and Pacific communities. Further, there were resources available for the indigenous communities in Canada, as shown in the annotated review. Despite the lack of specific Pacific web-based services in Australia, some of the mainstream/CALD items presented below can be adapted into the Pacific context.

The following desktop review strives to:

- Highlight possible gaps within web-based services for Pacific communities in Australia
- Further develop web-based health services from a Pacific perspective

When searching online, we deliberately excluded New Zealand in keyword combinations, because we wanted to ensure that the resources found were based in Australia, as per our research demographic. We also searched broadly on Google the term 'Pacific mental health resources in Australia'. Although a number of different articles and research appeared, no relevant web-based services came up as a result of this particular search.

The below search criteria was used when conducting the desktop review:

SEARCH ENGINES

- Google

SEARCH TERMS

- Pacific mental health resources
- Pacific mental health resources Australia
- Mental health resources for Pacific Islanders in Sydney
- Pacific diaspora in Sydney
- Pacific Islanders in Sydney

INCLUSION CRITERIA

- Resources from Australia
- Resources in Pacific languages
- Resources that could be adapted into the Pacific context
- Resources for CALD communities

YEAR RANGE

- No start or end year, to capture as wide an offering of relevant resources as possible.

TOTAL NUMBER OF SOURCES FOUND

- Only journal articles, newspaper articles and other scholarly articles available online.
- **Zero number of relevant mental health resources found as per our target demographic**

EXCLUSION CRITERIA

- Resources from New Zealand
- Resources outside of Australia
- Resources that did not have Pacific language translations

As a result of the limited relevant web-based services found after the initial desktop review, the annotated review previously developed was also referred to. This desktop review has utilised resources listed in the annotated review in order to provide a guide to accessing these web-based resources.

While there are presently no extant Pacific specific mental health web-based services, the below services are a starting point and could possibly be adapted into the Pacific context or delivered to Pacific people with cultural consultation, understanding and engagement.

After compiling the desktop review together with the annotated review, it became evident that there is not an adequate number of services or resources targeted to the MHT demographic. In fact, there are no specific mental health resources for the Pacific diaspora in Western Sydney.

In order to provide services to the Pacific community adequately, we need to develop a framework/ mental health resources for Pacific communities that address their mental health needs. Further, service providers ought to work towards creating culturally safe spaces for Pacific people to meaningfully engage and access support.

WEB-BASED SERVICES ACCESSED

Eheadspace

When Mental Health is understood differently in your culture (Group Chat)

https://headspace.org.au/eheadspace/group-chat/when-mental-health-is-understood-differently-in-your-culture/transcript/

This group chat was created by eheadspace to discuss with young people who access the resource to discuss different ways their cultural background affects their mental health. Mental health is understood differently among individuals, families, ethnicities, cultures and countries. It can feel as though they're caught between two sets of cultural values.

This resource, although not specifically focused for Pacific people, provides a safe space, as well as clinical support for Young People to express some issues they experience as a result of being from a CALD background

It allows a range of different cultures to share their personal experiences.

1. In order to participate in the group chat, click on to the 'Login' option at the top right-hand corner of the webpage
2. Login using an already existing account OR
3. Scroll down to 'create an account'
4. Once you have logged in with an account, you are free to join the group chat.

Transcultural Mental Health Centre

Multicultural Mental Health Outcomes and Assessment Tools

https://www.dhi.health.nsw.gov.au/transcultural-mental-health-centre-tmhc/resources/multicultural-mental-health-outcomes-and-assessment-tools

This is a 66-page document that was developed by Multicultural Mental Health Australia the Cultural Awareness Tool aims to assist health care providers to understand the influence of cultural diversity in mental health.

This resource is readily available on the Transcultural Mental Health centre website, making it accessible to all. Although the resource is not specifically focused on the Pacific community in Western Sydney, it is easy to follow and allows the reader/mental health professional to gain insight into different cultures and what people from CALD backgrounds might be experiencing.

Head to Health

Support for Culturally and Linguistically Diverse People

https://headtohealth.gov.au/supporting-yourself/support-for/culturally-and-linguistically-diverse-people

This resource is helpful in providing useful information to people from CALD backgrounds, assisting them to feel comfortable in seeking support for their mental health. This webpage offers resources and links to other useful services for people from CALD backgrounds who are looking at ways in which to support themselves.

This resource is also helpful in providing helpful information to people who are supporting family or friends from CALD backgrounds. This could potentially enable carers to feel comfortable in seeking support for their loved one's mental health.

Beyond Blue

Who does it affect? Multicultural people

https://www.beyondblue.org.au/who-does-it-affect/multicultural-people

There are a number of resources for multicultural people including transcripts from people, videos, translated resources, one option with an option to translate in to Samoan and Tongan language, sad feelings after childbirth a 'hidden' problem.

Black Dog Institute

Clinical Services

https://www.blackdoginstitute.org.au/education-services/clinical-services/

A suite of services are profiled from Black Dog Institute, including their Depression & Biploar Clinic, Exercise Physiology Clinic and Psychology Clinic.

The resources available from Black Dog are not specifically designed for Pacific but rather the Australian community at large. Overall, there are a number of useful resources across the website in general that would be adaptable to the Pacific context and use.

Smiling Mind

Smartphone App

https://www.smilingmind.com.au/

This Smartphone App is a daily mindfulness and meditation app, that the user is able to access at any time of their smart phone.

The app provides resources and services for the user free of charge. Once the app is downloaded, you will need to create an account to customise the app to their needs.

The app is evidence based and is the leading wellness app in Australia. The app is not Pacific focused and may need to be adapted in order to engage the Pacific community.

Additionally, their website does provide other useful information on mental health and wellbeing.

ReachOut

ReachOut WorryTime App

https://au.reachout.com/tools-and-apps/reachout-worrytime

This app was developed in consultation with Centre for Clinical Interventions using evidence-based practice, although it is not Pacific focused which may be a barrier in engaging Pacific people.

Once downloaded, you can create an account to access the app. This will ensure that the app will be customised to suit your needs.

The webpage provides an overview of what the key features are of the app alongside access to other resources available from ReachOut.com.

Innovative Resources

Apps

https://innovativeresources.org/apps/

There are two apps available to download from this section of their website. Previously known at St Luke's Innovative Resources, they continue to provide tools to support the engagement of individual and groups in both dialogical and therapeutic contexts.

The *Scaling Kit* app provides an opportunity for participates to track their progress over a period of time and require a subscription of $9.99 per month

The *Growing Well* app supports the development of mental health literacies, enabling people to gain a better insight into mental illness and its impact on wellbeing. It requires a monthly subscription of $9.99 per month.

Teach-Back

Web based resources for professionals

http://teachback.org/

Teach-back resources were developed by the NSW Health South Eastern Sydney Local Health District and the Health Systems Improvement Unit at Deakin University. The website provides various resources to support effective engagement between health professionals and their patients.

The main resource on this website is an online learning module with 3 parts. There are additional videos, presentations and resources available along with other useful links to access, that show how Teach-Back is used in different health settings.

Overall, this resource strives to assist in reducing possible miscommunication and misunderstanding when working with consumers in a health context.

Health Literacy Hub

Web based resources for professionals

https://www.healthliteracyhub.org.au/

Developed in partnership with The University of Sydney and the NSW Health Western Sydney Local Health District, the Hub provides helpful information on improving health literacies for consumers and their providers. As per their website, "our goal is to make health choices easier for everyone by connecting people to information and ideas to improved health." Health literacy refers to a person's ability to find, understand and use information to make decisions about their health.

The website provides information for consumers on an array of topics including "Talking to Health Professionals" and "Finding a Health Services"

ANNOTATED REVIEW OF LITERATURE AND MEDIA RESOURCES

OVERVIEW OF REVIEW

The following annotated review was developed to assist in understanding the availability and suitability of literature and media resources related to mental health and wellbeing that is currently made available online to the public. The following four key areas of literature and media resources was explored:

- Pacific Focused Mental Health Resources
- Culturally and Linguistically Diverse (CALD) Backgrounds Mental Health Resources
- Global Indigenous Mental Health Resources
- General Mental Health Resources

Each area strives to understand how further use of each piece of literature or media resource can assist in development mental health literacies amongst Pacific people in western Sydney whilst also providing recommendations to adapt, develop and build upon such work in an Australian context.

PACIFIC FOCUSED MENTAL HEALTH RESOURCES

Weaving together knowledge for wellbeing: Trauma informed approaches (Le Va, 2019)

https://www.tepou.co.nz/uploads/files/resource-assets/180219%20Trauma%20informed%20care%20WEB%20V%C6%92.pdf

This resource describes recognizing, understanding and responding to trauma for people and whanau (family) in Aotearoa New Zealand. The intended audience are Māori and Pasifika people living in Aotearoa New Zealand as indicated in the resource.

The resource is reliable in describing trauma and the importance of using trauma informed perspectives when working with Māori and Pasifika people. The resource uses infographics to highlight trauma statistics making the resource easy to follow. Moreover, the resource introduces the 'Te Whare Tapa Wha' approach, "which is based on the four interconnected aspects of wellbeing" (p. 3). This approach provides the reader a Maori perspective on health, however, also offering a broad concept of wellbeing relevant to everybody.

A very helpful video is also available to assist in unpacking key concepts associated with this resource: https://www.leva.co.nz/resources/a-trauma-informed-approach-when-working-with-pasifika-people

The main limitation of the resource is that it is based on statistics and population of Māori and Pasifika people living in Aotearoa. Therefore, making the services and organizations irrelevant for people living in Western Sydney. Le Va have referenced a number of cultural approaches, that may not be available to practitioners in Western Sydney. In addition, Le Va have used the Māori language through the resource without translations, that could potentially make it difficult for people who cannot understand Te Reo Māori to understand the resource in its entirety.

Therefore, while this resource is extremely useful in recognising, understanding and responding to trauma, the limitations of the resource listed will require further adaptation in order to reflect the statistics and population of Pacific people living in Western Sydney, as well as needing to provide translations of Pacific and/or Māori languages.

Recommendation:

- Use Australian statistics to reflect Māori and Pacific people residing in Australia.
- Replace the links to practitioners and services based in New Zealand named in the resource with Australian based practitioners and services.
- Māori & Pacific language terms and phrases provided in English, in order to make resource accessible for the wider Australian population including health workforce members.

Did You Know (NZ Drug Foundation, 2019)

https://www.drugfoundation.org.nz/news-media-and-events/ava-malosi-multi-lingual-did-you-know-free-info-drugs-young-people/

Did You Know is a series of videos and downloadable documents that provide an opportunity for young people to develop their health literacies around alcohol and other drugs. Focussed on problematic usage, the resource enables parents and carers to develop ongoing conversations about harm minimisation strategies, harm reduction and access to support services.

The resource has been translated into the Samoan and Tongan languages through the support of Le Va to assist Pacific communities to meaningfully engage with such material: https://www.leva.co.nz/resources/did-you-know

The resource is easy to navigate and engaging. The 'Did You Know' series is limited to alcohol and drug use only and that all the contact information for services and organisations are in New Zealand making it difficult for people in Western Sydney to access.

In order to utilise this particular form of resource to address mental health concerns it would need to be adapted to the Australian context alongside developing a factsheet with more mental health presentations.

Recommendation:

- Produce comic strip resources of a variety of Mental Health presentations including the negative impacts of unhelpful Alcohol and Other Drugs usage on wellbeing.
- Incorporate local Australian based links and services in the documentation.

The Mental Wealth Project (Le Va 2019)

https://mentalwealth.nz/

The Mental Wealth Project is a mental health literacy education program for young people. "The aim is to equip young people and their families with knowledge, tools and skills to reduce stigma, improve wellbeing, spot warning signs of mental distress, and enhance access to the right care and support when they need it" (The Mental Wealth Project 2019). This website includes multiple developed resources and links to services that address mental health and wellbeing including gaming and social media.

The Mental Wealth Project is based in New Zealand. This is a limitation for young people living in Western Sydney because they would not have access to the services listed on the website.

Therefore, while this resource is extremely useful and has a variety of services and partners who are working collaboratively to produce this interactive and engaging resource, it would need to be adapted into the Australian context.

Recommendation:

- Create a website using the Mental Wealth project as a template.
- Use links, tools, services and partners based in Australia.

Le Va Pasifika YouTube Channel

https://www.youtube.com/channel/UCpsfHhtVmTVM_JQbhw-jfcg

The Le Va Pasifika YouTube channel has an entire library of videos, interviews and playlists of different campaigns they are involved with. The videos are all themed around Mental Health and wellbeing, as well as testimonials of Pasifika people in different workforces based in New Zealand.

The channel is a helpful resource because it demonstrates the importance of the 'Talanoa' aspect. The videos have Pasifika people in all of them, further reiterating the target audience. Moreover, the channel partners with athletes, and well know television personalities and uses a variety of Pacific languages (with subtitles) further breaking down communication barriers.

The videos are all based on Aotearoa New Zealand, that could be considered a limitation, although a Pacific person living in Australia could watch the YouTube channel and the videos would still be relevant and relatable.

Therefore, this resource would be useful with minimal adaptations to the Australian context.

Recommendations:

- Produce videos in Australia, with Pacific people living in Australia.
- Profile links and services named as partners on resource, with partners in Australia.

Aunty Dee (Le Va, 2019)

http://www.auntydee.co.nz

Le Va is the NGO and team behind 'Aunty Dee'.

As per their website: "Aunty Dee is a free online tool for anyone who needs some help working through a problem or problems. It doesn't matter what the problem is, you can use Aunty Dee to help you work it through. Aunty Dee will guide you to list your problems, generate ideas then find a solution."

"Aunty Dee is a systematic approach to decision making that is based on Structured Problem Solving. Structured Problem Solving is a strategy based on the principles of Cognitive Behavioural Therapy (CBT), and has been shown to reduce depression symptoms in both adults and young people."

Aunty Dee is useful because it does not generate content or provide answers, instead it guides the person accessing it to think about and explore your problems in a structured way. In doing so, it will help the person move proactively towards a solution to their problems, as oppose to allowing problems to become overwhelming.

Aunty Dee is a helpful resource for all people to access, although there would need to be minimal adaptions to the Australian context.

Recommendation:

- Profile links and services named as partners on resource, with partners in Australia.

Le Va (2019)

https://www.leva.co.nz

The aim of Le Va as stated on their website is *"to support Pasifika families and communities to unleash their full potential".* Le Va support and encourage Pasifika families and communities by designing and developing evidence-based resources, tools, information, knowledge and support services for the best possible health and wellbeing outcomes. Additionally, Le Va strives to maintain traditional values and apply them safely to their resources in a contemporary way.

The Le Va website is a gateway that weaves the traditional values and customs of cultures across the Pacific tastefully and appropriately into their resources, tools and information. Le Va is a 'one stop shop' for people requiring assistance with mental health, addiction, disability, suicide prevention, public health, general health, sport, local government and education, as well as helpful resources for families, carers and practitioners working with Pasifika people.

Le Va presents a thorough catalogue of resources and have a wide range of partners they work collaboratively with, providing them with a lot of exposure across New Zealand. They profile the option of translating resources into a number of Pacific languages making the resources accessible for everyone.

However, Le Va is based in New Zealand and is tailored for Pasifika communities living there. The services and partners working with Le Va are not available to people living in Australia. Therefore, there would need to be a considerable number of adaptions in order to be locally available to Australian audiences.

Recommendations:

- Profile links and services named as partners on resource, with partners in Sydney and Australia.
- Create Pacific specific resources, research and partnerships in order to curate similar resource in Sydney and Australia, using Le Va as a service and site for good practice.

Te Pou o te Whakaaro Nui (2019)

https://www.tepou.co.nz

Te Pou o te Whakaaro Nui is a national centre of evidence-based workforce development for the mental health, addiction and disability sectors in Aotearoa New Zealand. They work with a range of organisations and people including service providers, training and education providers, researchers and international experts. Te Pou's resources, tools and support are available to access online.

Te Pou's resources are useful and provide straight forward information and tools for service providers and organisations to access if wanting to engage with Pacific communities. In addition, Te Pou have partnered with different Pacific services to create their resources. Working specifically with the disability and addiction sector also adds to the resource's value.

The main limitation of this resource is that they are based in Aotearoa New Zealand making it difficult to facilitate and access training profiled on the resources. Similarly, it may be difficult to access the services that work collaboratively with Te Pou.

Overall, this resource provides a number of strategies and frameworks for working with Pacific people, although being based in Aotearoa New Zealand would mean that there would inevitably need to be adaptations into the Australian context.

Recommendations:

- Compliment links and services named as partners on resources, with partners in Sydney and Australia.
- Create Pacific specific resources, research and partnerships in order to curate similar resource in Sydney and Australia.
- Create a similar resource using Te Pou as a template, although in the Australian context.

Pacific Suicide Postvention: Supporting Pacific Communities (Le Va 2019)

https://www.leva.co.nz/resources/Pacific-Suicide-Postvention-Supporting-Pacific-Communities

This helpful resource was developed by Dr Jemaima Tiatia-Seath to assist in meaningfully engaging and supporting individual and families affected by suicide. As per the website, *"Suicide postvention is supporting and caring for those who have lost someone to suicide. Supporting loved ones is an important step towards reducing risk of further suicides".*

This resource is helpful in providing support to people who have been affected post-suicide; it provides understanding into what a person could potentially be going through and how to support them after such an event. Overall, this resource is useful and provides insight. Although the research was conducted in New Zealand it can support the development of frameworks and services available in Sydney.

Recommendations:
- Conduct similar research in the Australian context.
- Create similar resource using this one as a template.

FLO: Pasifika for Life – Pasifika community perspectives on suicide prevention in New Zealand, (Le Va, 2014)

https://www.tepou.co.nz/uploads/files/resource-assets/flo-pasifika-for-life-pasifika-community-perspectives-on-suicide-prevention-in-nz.pdf

As per the downloadable document (p.6):

"Suicidal behaviour is increasing across Pasifika communities in New Zealand. Pasifika peoples have higher rates of suicidal ideation, suicide plans and suicide attempts than all other ethnic groups in New Zealand".

"Le Va's programme FLO: Pasifika for Life is Aoteraoa New Zealand's first national Pasifika suicide prevention programme. It aims to build strong, resilient Pasifika families and communities, address at-risk groups within Pasifika communities and assist Pasifika families who have been impacted by suicide."

"Community engagement is key to suicide prevention and is one of four workstreams within the FLO programme, which aims to enhance understanding of Pasifika suicide and suicide prevention; empower communities to lead initiatives, and prioritise ethnic specific, youth specific and rainbow Pasifika groups so that they are enabled to seek their own solutions."

This resource breaks down population groups and provides info graphs to illustrate statistics of Pacific people affected by suicide including risk factors in Pacific communities, making it easy to follow. The resource also explores ways in which to engage communities for effective outcomes. The resource introduces Pasifika theoretical frameworks and the outcomes of using those frameworks.

This resource is helpful, although the framework would need to be practiced in Australia in order for Pacific people, practitioners and the community to gather accurate information.

Recommendations:
- Practitioners would need to become familiar with the Pasifika theoretical framework, in order to use resource in Australian context.

Preventing suicide for Pasifika Top 5 Tactics – wallet card (Le Va, 2018)

https://www.leva.co.nz/resources/Preventing-suicide-for-Pasifika-Top-5-Tactics-wallet-card

As per the website:
This wallet card lists Le Va's top five tactics for helping to prevent suicide for Pasifika people. It is based on research, evidence and best practice. The top 5 tactics are: connect, strong families, talk, cultural identity and spirituality.

This resource is useful because it is compact and discreet and has a lot of helpful information and services for people who might need to access them. It explains the top 5 tactics and how they can affect a person positively. These 5 tactics can be helpful for Pacific people within an Australian context, with specific support agencies listed to include services in Australia.

Recommendations:
- Wallet card should provide numbers/websites for services available in Australia.

CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) BACKGROUNDS MENTAL HEALTH RESOURCES

Supporting yourself- culturally and linguistically diverse people (Head to Health, 2020)

https://headtohealth.gov.au/supporting-yourself/support-for/culturally-and-linguistically-diverse-people

As per their website:
Head to Health can help you find digital mental health services from some of Australia's most trusted mental health organisations. Provided by the Australian Department of Health, Head to Health brings together apps, online programs, online forums, and phone services, as well as a range of digital information resources.

Australia is culturally diverse –about 40% of the population is made up of migrants or those from migrant backgrounds. So, if you come from a different cultural background, or speak a different language, you are not alone.

Specialised support can help people from CALD backgrounds stay healthy as well as get help with mental health issues.

Many major mental health organisations have support workers who speak many languages. They also have translated mental health support information on a range of topics. Interpreter services are also available to help you talk with mental health professionals and support services.

Looking after yourself is vital for your overall mental health and wellbeing. This can include eating well, sleeping well, finding meaningful things to do, and connecting with your community.

This resource is helpful because it is based in Australia and has links/programs and information to relevant sources.

Head to Health have entire pages dedicated to different target audiences, including CALD people. It recommends websites, approaches and provides insight into the differences between cultures and emphasises the importance of engaging effectively with those communities. Further, this resource provides an interpreter service for those people who might have limited communication.

Overall, the resource is helpful, it is not Pacific specific, though at times the information can seem generic.

Recommendation:
- To tailor specific resources to be Pacific focused through the inclusion of Pacific case studies, examples, cultural views and values.

Cross-cultural Mental Health Care: A resource kit for GPs and health professionals (Transcultural Mental Health)

http://www.dhi.health.nsw.gov.au/transcultural-mental-health-centre-tmhc/health-professionals/cross-cultural-mental-health-care-a-resource-kit-for-gps-and-health-professionals/cross-cultural-mental-health-care-resource-kit

As per their website:
This online resource kit has been developed by Trans-cultural Mental Health Centre (TMHC) as a one stop portal where GPs and health professionals can locate information that will assist in providing effective mental health care for culturally and linguistically diverse patients.

This resource kit contains a number of helpful cross-cultural and multilingual assessment tools, access to interpreters and links to bilingual mental health professionals.

This resource kit is useful in providing practitioners literature and tools that explore cultural awareness and diversity. Although the resource kit is helpful, it is not specific to Pacific people and can be utilised in a general manner.

Recommendations:
- Kit could be developed to include the experiences of Pacific people.
- Kit should utilise Pacific focused frameworks when using assessment tool (such as the Fonofale model and incorporate other Pacific related services outlined in the resources from New Zealand).

GLOBAL INDIGENOUS MENTAL HEALTH RESOURCES

The following set of literature and media resource were reviewed to provide good practice examples of promoting mental health and wellbeing services and support for Indigenous people across the globe. Creating tailored resources for Pacific-Indigenous people and their diaspora may benefit from utilising these examples from Australia, Aotearoa New Zealand and Canada.

AUSTRALIA

Beyond Blue: Aboriginal and Torres Strait Islanders

https://www.beyondblue.org.au/who-does-it-affect/aboriginal-and-torres-strait-islander-people

As per the website:
Reducing the impact of depression and anxiety among Aboriginal and Torres Strait Islander communities is a priority for Beyond Blue. A range of research, information, education and support strategies have been developed and will continue to be developed in consultation with Aboriginal and Torres Strait Islander communities and organisations.

This is a useful resource because it covers a range of services/links/campaigns and projects that may be relevant to an indigenous person living in Australia.

It provides a number of resources that are available to people online or via phone, if accessing a service in person is difficult due to location/transport etc.

Although being able to access all those services online is very convenient, the service provided is not a face-to-face service, which might potentially discourage a person from accessing Beyond Blue.

Overall, Beyond Blue strives to provide resources online and via telephone for Aboriginal and Torres Strait Islanders, allowing the community to access their services conveniently without navigating their location or transport.

Recommendations:
- Work collaboratively with First Nations in Australia in order to gain cultural understanding for successful engagement with Indigenous peoples.
- Strive to premise and platform indigenous theoretical frameworks in developing Australian based services for Pacific people
- Where possible, provide face to face services in order to cater for the needs of community and possible preferences to engage in person

Mind Blank

https://www.mindblank.org.au/our-programs/aboriginal-torres-strait-islander-collaborations/

As per their website:
Mind Blank's aim is to reduce the risk of suicide through interactive performances in schools and communities. We are a unique community led response to a national mental health priority.

There is a strong need for more proactive community initiatives to promote mental health and wellbeing and offer support to those in high-risk groups to help reduce suicide risk in young people. When addressing young people from Aboriginal and Torres Strait Island backgrounds, culturally adapted mental health education programs are required and profiled within Mind Blank.

Mind Blank is a useful resource due to the interactive and performative activities. It provides the people participating in the performance a different way of communicating what they might be going through.

The programs are evidence-based that work in parallel with health professionals and researchers to develop script content and methodology. Typically, in these programs, an individual is selected to share their story with one of the actors. The selection process is commonly through a partnership with the local health district or a school. This story is turned into a stage script. The actors then host a rehearsal session with health professionals present to ensure that the team are capturing true integrity of the story, as well as avoiding portraying stereotypes to encourage authenticity of the lived experience.

Although this service provides a unique experience for the participants, the website does not state clearly other links to resources/services for people from Aboriginal and Torres Strait Island backgrounds. Mind Blank works directly in the community, which by all accounts is helpful, but if a person does not feel comfortable in that setting it may become unhelpful.

Overall, Mind Blank strives to meaningful engage Aboriginal and Torres Strait Islander communities in a unique way.

Recommendations:
- That direct input and permission is sourced from local Pacific elders/leaders prior to conducting any program work with Pacific communities to ensure culturally relvance and safe approaches are undertaken
- Such support needs to promote and operate from an element of sustainability beyond the initial interactions and involvement with the program

AOTEAROA NEW ZEALAND

Let's get real (Te Pou o te Whakaaro Nui)

https://www.tepou.co.nz/initiatives/lets-get-real/107

As per the website:
Let's get real is a framework of knowledge, skills, values and attitudes for working with people and whānau with mental health and addiction needs.

Developed in 2008 by the Ministry of Health, Let's get real was first designed for people working in mental health and addiction services. In 2017 Te Pou o te Whakaaro Nui led a refresh of *Let's get real* on behalf of the Ministry of Health.

Following sector consultations, the framework has been refreshed and published in 2018. It now has a broader focus for everyone in health working with people and whānau with mental health and addiction needs. *Let's get real* has three components – values, attitudes and the seven Real Skills.

This framework is in depth and provides an insight for professionals in to working with Māori people and whānau as well as communities. It touches on the importance of language and cultural practices in order for successful engagement.

Overall, the resource is thorough and insightful, allowing a practitioner to gain knowledge and skills they are able to utilise when working with Māori, whānau and the wider community. The resource will need to be adapted for the Australian context.

Recommendations:
- Partner with services in Australia to create framework using this resource as a template.
- Due to resource based in Aotearoa New Zealand, the 'applying law, policy and standards' section of resource cannot be applied in Australia due to differences in legislation. Therefore, create the resource alongside local legislation.

Te Rau Ora

https://terauora.com/

As per their website, the purpose of Te Rau Ora is:
"To improve Māori Health through leadership, education, research and evaluation, health workforce development and innovative, systemic transformation. We strengthens Māori health and wellbeing through nationally navigated and locally led solutions."

Te Rau Ora has services, programs and campaigns in a number of different areas such as addiction, suicide prevention and suicide postvention, mental health and education and training, research and workforce development.

Te Rau Ora also provide a list of links to external services and other resources that a person might want to access, where appropriate.

This is a useful resource because people can freely access and are able to read their publications, and strategic plans Te Rau Ora have developed alongside feedback regarding how successful they have been. In addition, it provides links to other services that might better suit the needs of person accessing the website.

Overall, this resource allows the user to gain an in-depth view of what projects and programs Te Rau Ora are a part of with links to additional services and resources that might better serve the person seeking help for self and/or others.

Recommendations:
- Profile the work of Te Rau Ora in Aotearoa New Zealand alongside the meaningful inclusion of Te Reo Māori language and terminology.
- Adapt this work in Australia by including the lived experience of Māori and Pacific people across the Australian context.
- The links to services profiled from the local Australian context in order to be locally relevant for the population.

CANADA

Mental Health Programs for Aboriginal Peoples in Canada

http://www.namhr.ca/mental-health-programs/

As per their website:
This database describes existing mental health promotion, prevention and intervention programs and models for Aboriginal peoples in Canada. The database was developed through a scan conducted for Health Canada and is presented here with their permission. The database will be maintained by the Network for Aboriginal Mental Health Research with support from Health Canada and updated periodically.

This resource is helpful because it allows the user to narrow down their search for mental health resources by using the database in order to locate a specific service/resource for the intended target group.

It allows the user to search across Canada and within the different ethnicities of Aboriginal people in Canada. In addition, this resource is user friendly because it is straightforward to use and is provides a thorough database for the public to access.

Recommendation:
- To develop a similar tool modelled off this resource in the Australian context relating to Pacific Communities.

Inequalities in Perceived Mental Health in Canada (Infographic)

https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research-data/6.PerceivedMentalHealth_EN_final.pdf

This infographic displays the inequalities in perceived mental health in Canada. It breaks down the different factors which contribute to poor mental health such as inadequate housing and experiencing trauma.

This resource is helpful because it is presented in a visually appealing manner that promotes a better insight into the key concepts being profiled making it easy to follow and user friendly. The resource is interesting to look at because it is eye catching and succinct, as opposed to lengthy sections of text based on the research or broader report. The resource is easy to follow due to the graphics, therefore making it to be accessible for people regardless of their capabilities i.e. literacy levels.

The resources also include First Nations people of Canada, although the resource is not a dedicated infographic for First Nations people.

Recommendations:
- To have a similar resource modelled on this type of infographic, dedicated to Pacific people in the Australian context.
- In order for resources to be relevant the infographic will need to use statistics relevant to the Australian context.

GENERAL MENTAL HEALTH RESOURCES

These resources are available for the general population to access across Australia and can provide a great platform for local communities to access further support and assistance. Ideas on how to adapt and nuance these offerings in supporting Pacific communities are provided.

headspace

https://www.headspace.org.au

headspace is the national youth mental health foundation for young people aged between 12-25. There are many ways to access information and support about mental health and wellbeing.

As per their website:
"headspace centres act as a one-stop-shop for young people who need help with mental health, physical health (including sexual health), alcohol and other drugs or work and study support."

Information and resources for young people as well as for family members and friends to learn about mental health challenges and ways to maintain a healthy headspace are available on this website.

Additionally, headspace have online and phone services, so you are able to chat online, email, or speak on the phone with a qualified professional. It's free, confidential and can be anonymous. People are able to explore eheadspace, Digital Work & Study and Digital Industry Mentor Service.

headspace is a useful service/resource because it addresses a number of concerns a young person may have and providing different ways in which a young person can access mental health supports. In addition, headspace have a number of information, psychoeducation, infographics and tool kit resources available. headspace has translated information in the Samoan language, making it helpful for the Samoan community in Australia.

headspace has many useful resources and information available, although the headspace model is not specific to the Pasifika community. Therefore, there would need to be adaptations made in order further nuance engagement with Pasifika communities.

Recommendations:
- Provide translations for headspace psycho education, resources and tools into more Pacific languages.
- Work collaboratively with the Pacific communities in Australia in order to gain cultural understandings for successful engagement with Pacific communities.
- Use a Pacific theoretical framework where possible.
- Where possible, access Pacific clinical staff at headspace centres.
- Explore the possibility to develop specific Pacific cultural safety training for non-Pacific staff.

Eheadspace

http://headspace.org.au/eheadspace

As per their website:
eheadspace provides free online and telephone support and counselling to young people 12 – 25 and their families and friends. If you're based in Australia and going through a tough time, eheadspace can help.

Here you can talk one-on-one with an eheadspace clinician via online chat, email or over the phone. You can also join group chats which cover a variety of helpful topics such as lived experiences of having a mental illness, how to support your wellbeing, and access support, and are a great way to learn from other people's experiences.

eheadspace has an extensive library of resources that young people can access from their smart phones/ computers. eheadspace provides a group chat option that allows the young person to connect with other people going through similar experiences, and is led by a headspace professional, allowing you to explore a range of helpful topics.

Another helpful eheadspace resource is 'spaces'- a place where a young person can collect and manage resources to build their own personalised mental health toolkit.

eheadspace is youth friendly and useful in providing resources and assistance to young people that is easily accessible via phone and online, but it also allows a young person to connect with headspace one-on-one for a chat with a headspace professional.

eheadspace is not Pacific focused, although it is broad enough to access for people from a range of different backgrounds. Overall, eheadspace is helpful although there would need to be adaptations to the Pacific context in order to support culturally relevant and nuanced engagement.

Recommendations:

- Adapt resource contents to the Pacific community in order to be relevant for Pacific people, including the ability to create a eheadspace group chat about Pacific lived experiences.

Black Dog Institute

https://blackdoginstitute.org.au

The Black Dog Institute was founded in 1985 as the Mood Disorder Unit at Prince Henry Hospital, Sydney and is a pioneer in the identification, prevention and treatment of mental illness, and the promotion of wellbeing. Black Dog aims to improve the lives of people affected by mental illness through the rapid translation of high-quality research into improved clinical treatments, increased accessibility to mental health services and delivery of long-term public health solutions.

Black Dog Institute resources are useful tools for individuals seeking support and especially for health professionals. Black Dog Institute also offers education and training for health professionals, schools, community groups and workplaces.

The Black Dog Institute are visually represented on a number of social media platforms, which allow them to be visible to a broad audience.

The resources available from Black Dog Institute are not specifically designed for Pacific peoples but rather the Australian community at large. Overall, there are a number of useful resources that we would be able to adapt to the Pacific context.

Recommendations:

- Provide translations for psycho education, resources and tools into Pacific languages.
- Work collaboratively with the Pacific community in Australia in order to gain cultural understanding for successful engagement with the Pacific community.
- Use a Pacific theoretical framework where possible.

Clinical Centre for Interventions

https://www.cci.health.wa.gov.au

As per their website:
The Centre for Clinical Interventions (CCI) is a specialised clinical psychology service. They develop and provide evidence based psychological treatment for people living with a number of different mental health presentations. The Centre for Clinical Interventions also provide training for professionals in order to deliver effective psychological intervention. In addition, the Centre provide free online resources for individuals and professionals to assist in overcoming mental health concerns.

The Centre's free online resources are useful in providing psycho education for individuals and professionals alike. The resources are easy to follow and provide entire modules about anxiety, depression, trauma, body dysmorphia to name a few for people to utilise.

The main limitation is that the Centre is located in Western Australia making it difficult for people in Western Sydney to access the service in person or access the training and psychological intervention. The resources are provided online are useful but are not Pacific specific or available for translations into Pacific languages.

Recommendations:

- Translate into Pacific languages resources from CCI on psycho education, resources and modules.
- Use a Pacific theoretical framework where possible.
- Map similar services provided in Sydney & NSW when profiling CCI resources amongst Pacific people in western Sydney.

Smiling mind

https://www.smilingmind.com.au

Smiling Mind is an app available to young people to access on their smartphones and other devices in order to be used when young person needs support. The Smiling Mind app uses the Mindfulness theoretical framework and evidence- based solutions, equipping young people with the integral skills they need to thrive in life.

Smiling Mind is considered to be one of the world's leaders in the pre-emptive mental health space and Australia's go-to expert for youth- based mindfulness programs. Smiling Mind pride themselves on pioneering innovative ways to support good mental health and wellbeing across all our programs. The Smiling Mind app is a daily mindfulness and meditation guide at your fingertips. The app is free and reports that only using the app for 10 minutes a day will show real changes.

The Smiling Mind app is useful because it has utilised technology in order to make access to the resource extremely accessible, a young person can access the app from wherever they might be comfortable. The resource use breathing and mindfulness strategies that can be relevant to all people in the community, and promote the development of increased psychological flexibility by increasing practical skills for the person using the app.

Overall, although the app is evidence based and is the leading wellness app in Australia the app is not Pacific focused and may need to be adapted in order to engage the Pacific community.

Recommendations:

- Adapt resource to Pacific communities in order to be relevant for Pacific people by incorporating narratives of lived experiences, strategies that are helpful, and gaining support within a communal context.

ReachOut WorryTime

https://au.reachout.com/tools-and-apps/reachout-worrytime>

As per their website:
Everyone has worries pop into their head from time to time, but sometimes they won't go away and start to impact your everyday life. ReachOut WorryTime interrupts this repetitive thinking by setting aside your worries until later, so you don't get caught up in them and can get on with your day. This means you can deal with worries once a day, rather than carrying them around with you 24/7.

Some key features of the ReachOut WorryTime app are:

- decide on a time, place and length of time to deal with your worries each day.
- when you notice yourself worrying about something, add it to WorryTime and get on with your day.
- use your WorryTime to review the worries you've added and ditch the ones that no longer matter to you.

Produced in consultation with the Centre for Clinical Interventions, ReachOut WorryTime is based on cognitive behavioural techniques that are used by health and wellbeing practitioners to assist people with anxiety and stress.

This is a helpful resource and is free, allowing access to all people with a smart phone. The resource is interactive and allows the person using the app to tailor it in order to suit their needs. Furthermore, this resource is can be used by people ages 11 to 26.

This resource was developed in consultation with Centre for Clinical Interventions using evidence-based practice, although it is not Pacific focused which may be a barrier in engaging Pacific peoples.

Recommendations:

- Adapt resource to the Pacific community in order to be relevant for Pacific people by including Pacific-Indigenous concepts around collectivist cultures and identities that can support recovery and wellbeing.

St Luke's Innovative Resources

https://innovativeresources.org/

As per their website:
St Luke's Innovation Resources consist of card sets, stickers, books and picture books are used to enrich conversations about the important stuff in life—feelings, hopes, strengths, relationships, values, stories and goals.

The card sets are sold internationally and are known for their originality, practice wisdom and striking visual styles. They have found their way into boardrooms, kitchens, jails, classrooms, school camps, conferences, job interviews, hospitals, meetings, research papers, workshops, university courses, family dinners, community houses, celebrations, big business planning days and team building events.

St Luke's Innovative Resources is a highly respected publisher, operating as a social enterprise. Profits generated are used for social purpose to further the work of Anglicare Victoria.

St Luke's Innovative Resources is committed to advancing best practices across all areas of human services work and developing tools and resources to enhance service delivery.

The Innovation Resources available from St Luke's are helpful because they can be used across a range of different ages, and over various issues might be concerning people. The strength cards are straight forward to use, engaging and interactive. Some resources have been translated into different languages, making it accessible to people with limited English.

Overall, St Luke's have useful and engaging resources that are available to order online that can be used with Pacific communities with limited adaptations.

Recommendations:
- Adapt St Luke's cards in order to be relevant to Pacific communities by including visual representation of Pacific People in the cards and using images relevant to Pacific people.
- Translating strength cards into Pacific languages.
- Professionals who use the cards should have had some cultural safety training around Pacific cultures in order to use the cards in a relevant manner.

Teach-Back

http://teachback.org/

As per their website:
Teach-back is a simple, yet effective communication tool used to check understanding. Using Teach-back makes a difference because it allows you to check if someone understands you. This can help people to better self-manage their health and may lead to improved outcomes.

This learning module will provide you with in formation and skills around the use of Teach-back. Videos and other learning tools are used to show how teach-back is used in different health settings.

This module was developed as a collaboration between the Community Partnerships Unit, Directorate of Planning, Population Health and Equity, South East Sydney Local Health District (SESLHD) and the Health Systems Improvement Unit, Deakin University.

While Teach-back is not a new concept it is often not routinely used across health services. The aim of this project is to clearly demonstrate the value of teach-back and to provide a greater understanding of how to use it in your practice. This module has been piloted tested with health professionals to inform its usability and accessibility.

This resource is useful because it places responsibility on the practitioner to be clear when communicating with the consumer. This allows space for practitioners to check their current client's understanding, explain misunderstandings until understanding is achieved and asking your client to explain back in their own words, all contributing to more effective communication.

Overall, this resource is helpful in attempting to limit misinterpretation. Although the resource does not discuss or cover engaging with Pacific people or Pacific cultural traditions or norms that may be helpful when working with Pacific people.

Recommendations:
- Can be useful to promote practitioner's understanding Pacific cultures.
- Adapt resource in order to be relevant to Pacific communities by including cultural traditions and norms to improve understanding the client group.
- Use a Pacific theoretical framework where possible.

Health Literacy Hub

https://healthliteracyhub.org.au/

As per their website:
The Hub hosts the best and most trusted online health literacy resources. Our aim is to make it easier for consumers to find and understand health-related information, to be able to make the decisions about their health.

The Hub is an initiative of Western Sydney Local Health District (WSLHD), in collaboration with the University of Sydney.

Our goal is to make healthy choices easier for everyone by connecting people to information and ideas to improve health. Members of the public can use this site to find advice on how to:
- get the most from conversations with their health provider.
- find a health service.
- access reliable information about their health.
- connect with other websites offering consumer advice on health and specific illnesses.

Health professionals who register with the Hub can access a wide range of educational materials and programs, practical tools and advice on health literacy.

The Hub helps people with their health literacy, and allows a person to find, understand and use information to make decisions about their health. The Hub helps people to develop service user's health literacy by improving communication skills and by making the health system easier to use. By changing the way, support is offered to people to understand health information, the Hub's information sharing can help to prevent illness, improve the management of illness, improve medication use and speed up recovery after illness.

Overall, the Health Literacy Hub is useful in helping consumers and practitioners alike increase their knowledge around health literacy to gain better understanding of health concerns. However, this resource does not have any Pacific focused health literacies available.

Recommendations:

- Adapt resource in order to be relevant to Pacific communities by including cultural traditions and norms to improve understanding the client group.
- Use a Pacific theoretical framework where possible.
- Health literacy resources to be inclusive of Pacific traditions and cultures.

PACIFIC INDIGENOUS MENTAL HEALTH LEXICON (PIMHL) OVERVIEW

It became clear to the MHT team that we needed to create the Pacific Indigenous Mental Health Lexicon (PIMHL) because in our research we found that there was limited strengths-based terminology to adequately describe mental health terms. We decided as a team that we wanted to create the PIMHL in order to enhance understanding around mental health presentations. At the time we were undertaking the research project, there was nothing of its kind in Pacific languages.

Members of the MHTSG and members of the MHTRG advised the MHT team that there was already a lexicon in te reo Maori that was created in Aotearoa New Zealand, which is why the PIMHL does not included te reo Maori. Further, due to the limited time constraints we were mindful that we wanted the PIMHL to be achievable and complete within the time frame that the MHT had to adhere to.

The MHT team focused on four Pacific languages: Tongan, Samoan, Fijian and Bislama. We worked with a number of professionals who live across the Pacific and work in the mental health space. The MHT team would feel compelled to acknowledge all the mental health professionals we have corresponded with throughout the MHT research project make the PIMHL possible.

We are thankful to (in alphabetical order): Seini Afeaki, Violet Erasito-Tupou, Jimmy Obed, Rebecca Olul, Mapa Puloka, Jerry Qalabulailakeba, Jioji Ravulo, Shannon Said, Jope Tarai, George Leao Tuitama, Jofiliti Veikoso, Ursula Winterstein.

We worked together with all the people listed to create something that we are very proud of. We had four PIMHL meetings via Zoom and corresponded via email with the members in order to complete the document.

PIMHL WORKING GROUP TERMS OF REFERENCE

Introduction

The Mental Health Talanoa (MHT) research project aims to examine the prevalence of common mental disorders (CMD), its impacts and its related help seeking behaviour amongst the Pacific diaspora. The MHT was developed due in part to the increasing rate of mental health presentations across Pacific communities in western Sydney, Australia.

Through our ongoing conversations (talanoa) across the community within the diaspora and Oceania, the MHT team is striving to create the Pacific Indigenous Mental Health Lexicon (PIMHL) due to a burgeoning need to enhance specific Pacific terminology (Fijian/Samoan/Tongan/Bislama) describing mental illnesses and experiences. The PIMHL working group will provide succinct feedback of the development of the Lexicon/Glossary, on terms that enhance the understanding of Mental Illness and experiences across the Pacific in the respective Pacific languages.

Aim of the PIMHL working group

The PIMHL Working group is a representative body of various multidisciplinary professionals across the Pacific involved in the Mental Health space that were selected by MHT management, to drive and support communication and engagement with the community by creating correct terminology, phrasing and language for the PIMHL.

The aim is to ensure that the PIMHL Working group maintain focus and energy required for the MHT initiative. Furthermore, to provide strategic feedback and supported leadership to ensure that the PIMHL will be nuanced across specific Pacific Languages.

Objectives of the PIMHL working group

- Drive, inspire and maintain a positive and energetic approach to the PIMHL Working group.
- Work collaboratively with MHT team in order to produce accurate PIMHL.
- Ensure timely and consistent communication of information, strategies, timelines and progress is maintained throughout the MHT initiative and beyond.
- Make recommendations to the MHT Project Manager, MHT Project Officer, MHT Research Officer and other members of PIMHL on project development, implementation and outcomes.
- Support outputs and strategies aimed at effectively achieving outcomes of MHT initiative.

Membership

- The principal Working group will consist of the MHT Project Manager, MHT Project Officer, MHT Research Officer and representative(s) from across the Pacific: Fiji, Tonga, Vanuatu and Samoa.
- The Project Manager of the MHT initiative is the Facilitator of the PIMHL working group.
- A maximum number of 12 people will sit as members of the PIMHL.

Administration

- The Facilitator will nominate the MHT Project Officer from within the group to cover leave or unexpected absences.
- The PIMHL is an egalitarian structure, members are working in a collective framework.
- The MHT Project Officer will record minutes and co-ordinate meetings.

Meetings

- The PIMHL Working group will meet quarterly at a minimum with frequency increasing as the level of development, implementation and finalisation of the project occurs or issues arising increases.
- The Working group meetings will be held via video and or telephone conference depending on availability of video and or telephone conference facilities, due to members location and availability.
- Members can forward agenda items to the MHT Project Officer no later than three working days before the meeting.
- Matters requiring significant time or resources to address may be dealt with outside of the meeting and reported against at the next meeting.
- Special meetings of the PIMHL Working group may be convened depending on the urgency of matters raised or included in the Agenda.
- Agreement on decisions shall be by consensus; that is PIMHL collectively will come to a shared agreement on decisions made.
- Minutes of each meeting shall be prepared by the MHT Project Officer, who will maintain a file of confirmed minutes.

Key Deliverables

The PIMHL working group will work in conjunction with the MHT team, in order to create adequate phrases and terminology in Pacific languages that sufficiently describes CMD to allow efficient communication with members of the Pacific community.

The PIMHL working group will:

- Design and create sustainable resources (within the project allocated budget) to provide Pacific people with further understanding and insight into the prevalence and impact of CMD and enhance access to services.
- Raise mental health literacies in the Pacific community through creating the PIMHL.
- Promote the importance of cultural appropriateness when working with Pacific people as their cultural backgrounds and their Pacific languages influence the way in which they engage with services.

PACIFIC INDIGENOUS MENTAL HEALTH LEXICON (PIMHL) WORKING SHEET

TEAM MEMBERS

Bislama: Jimmy Obed, Rebecca Olul

Fijian: Jerry Qalabulailakeba, Jofiliti Veikoso, Litea Meo-Sewabu, Jope Tarai

Samoan: Ursula Winterstein, Fraser Leavasa, George Leao Tuitama

Tongan: Mapa Puloka, Seini Afeaki, Violet Erasito-Tupou

English [keywords]: Jioji Ravulo, Shannon Said

TRANSLATED TERMS

In developing the lexicon for each Pacific language, we strive to ensure phrases and terms are inclusive and provides a broader appreciation of such experiences. Phrases developed support the externalisation of symptoms beyond the individual presentation. Suggested keywords are listed across each term to translate. We hope the PIMHL will be used by clinicians to better describe mental health issues enabling a broader appreciation for such needs, leading to promoting help seeking behaviour.

Methodological approach was reiterative in nature and narrative driven. We utilise symptoms to help describe each word being translated; but within a strength-based context. Some of the key words chosen were also taken from the way in which the English terms were formed from Greek or Latin origins.

As noted below, the key word used to translate into Pacific languages from English is in the set of square brackets [ ] to assist in providing an understanding of the Pacific words/phrases being developed. This then allows Pacific and Non Pacific people to also convey and express these suggested terms between English and our respective Pacific languages that form the PIMHL.

Pacific languages have heart and mind at the base of their notion of health – where phrases used to describe mental illnesses are also reflective of such concepts. The idea that your heart and mind is being impacted also attests to a more holistic view of wellbeing, rather than siloed as separate to each other.

MENTAL HEALTH
[translate: healthy thinking]

- Bislama
  - Helti [healthy] tingting [think]
- Fijian
  - Tiko bulabula [healthy] ni vakasama [thinking]
- Samoan
  - Mafaufauga [thoughts] lelei [good]
  - Mafaufauga [thoughts] aoga [useful]
- Tongan
  - Mo'ui [life] Faka'atamai [brain/head]

MENTAL HEALTH ILLNESS
[translate: unhelpful thinking]

- Bislama
  - Sik [sick] blong [particle] tingting [thoughts]
- Fijian
  - Na sega ni tuvinaka [not in the right place: brain] ni vakasama [thinking]
  - vakacacani [illness] ni vakasama [thinking]
- Samoan
  - Mafaufauga [thoughts] Le aoga [unhelpful]
  - E a'afia ai le mafaufau [negatively affecting thoughts/the mind]
- Tongan
  - Puke [sick] Faka'atamai [brain/head]

WELLBEING
[translate: holistic health]

- Bislama
  - Helti [Health]
  - Stap [In] long [particle] gud helt [Healthy]
- Fijian

Tiko bulabula [healthy]

- Samoan
  - Soifua Maloloina [health]
- Tongan
  - Mo'ui [Life] Lelei [Good/Healthy]

MAJOR MOOD DISORDERS
[translate: serious disruptive feelings]

- Bislama
  - Ol siries [Serious] filing [Feelings] we i save afektem (o distebem) bigwan laef blong wan man o woman [that can disrupt the life of an individual]
- Fijian
  - Tu vakaca [not in right place: feelings] ni yalo [feelings]
  - Vakacacani [disruptive] ni yalomu [feelings]
- Samoan
  - ogaogā [serious] lagona [feelings] fa'afitauli [disruptions]
- Tongan
  - Maveuveu Lahi Fakaeongo [Major Mood Disorder] (the word 'maveuveu ' in Tongan it does not mean that a person is sick unless we use the word 'mahaki or 'puke'. So a Maveuveu Lahi Fakaeongo (Major Mood Disorder) just mean there is some disruption but does not mean the person is sick, person may or may not be sick)

DEPRESSION
[translate: really sad/heavy heart]

- Bislama
  - Harem [Feel] nogud [Bad] tumas [Very]
  - Hat [Heart] i hevi [Heavy]
- Fijian
  - Rarawa [sad] ni yalo [feelings]
  - Loma [heart] bibi [heavy]
- Samoa
  - Fa'agoagoa [really sad]
  - Mafatia le mafaufau [heavy on the mind]
- Tonga
  - Lotota'ta'omia [depression]
  - Mo Lotomafasia [depression]

BI POLAR
[translate: two opposites/parts thinking & feelings]

- Bislama
  - Tufala [Two] difdifren (o oposit?) [Different/ Opposites] pat blong [Parts] tingting mo filing [Thinking and Feeling]
- Fijian
  - Veicoqaqa [clash] ni vakasama [thinking] kei na [and] vakarau ni yalo [feelings]
- Samoan
  - Lua itu aiga [two kinds] o fe'ese'ese'ina [difference] o mafaufauga ma lagona [of thinking and feeling]
- Tongan
  - 'Avanga [possession] Femaleleaki [something that oscillate between two opposite poles – manic and depression]

ANXIETY
[translate: heightened/unhelpful fear/ unhelpful thinking & feelings]

- Bislama
  - I kam bikwan [Get bigger]/Fasin blong fraet we i no helpem man [unhelpful fear]
  - I kam antap [Get higher]/Fasin blong fraet we i no helpem man [unhelpful fear]
  - Fasin blong Tingting mo Filing we i no save helpem man o woman [way of thinking and feeling that does is not helpful to a man or woman]
- Fijian
  - Lomabibi [heightened] ni vakasama [thinking]
  - Veiladeyaki [jumping] ni vakasama [thoughts]
- Samoan
  - Popole [worry] Popolega [anxiety]
- Tonga
  - Puputu'u [too many things standing/crowded] mo Lototailiili [(tailili) – scared (loto) heart; both for Anxiety]

PANIC ATTACK
[translate: unhelpful panic]

- Bislama
  - Fasin blong fraet we i no helpem man o woman [unhelpful to man or woman]
  - Fasin blong o panik we i no helpem woman [unhelpful to man or woman]
- Fijian
  - Vuka [fly/panic] ni yalo [feelings]
- Samoa
  - osofaiga [attack] fa'afuase'i [sudden]
  - atuatuvale [panic]

- Tonga
  - Lotopuna Tamaki [Word ' Tamaki" mean something that is bad, unpleasant, offensive , irritating or obnoxious]

PANIC DISORDER
[translate: fearful of having a panic attack]

- Bislama
  - Fraet [afraid] blong gat [of having] wan panik atak [a panic attack]
- Fijian
  - Taqaya [fearful] ni vuka [fly/panic] ni yalo [feelings]
- Samoa
  - Fefe [afraid] i maua [of having] i se osofaiga fa'afuase'i [a sudden attack]
- Tonga
  - ilifia or manavahee [fearful], ongo'I (feeling), Lotopuna Tamaki [panic attack]. Another problem here is the word "disorder" in Tongan is translated directly as " maveuveu " so "Loto puna maveuveu" or "Maveuveu Lotopuna" sound very odd. At times I used the word 'disorder' to have the same meaning as' disease' ,' illness', and 'sickness' which can be translated as "Mahaki" (disease) or " Puke" (sickness or illness). So a much better translation is " Mahaki Lotopuna Tamaki"

PSYCHOSIS
[translate: break in reality]

- Bislama
  - Wan kondisen we i mekem bren i no save prosesem infomesen [condition where the brain is not able to process information] we i mekem se yu save luk, harem o bilivim ol samting we i no ril o tru [can cause you to see, hear or believe things that are not real]
  - To translate directly "break in reality" would be "gat wan brek long realiti" or "luk, harem or bilivim ol samting we i no tru"
- Fijian
  - Ciri [in an ocean, floating/break from mainland] yawa [far] ni vakasama [mind]
- Samoa
  - Lagona [feelings] poo [or] mafaufauga [thoughts] i mea e le moni [of things that are not real]
- Tonga
  - 'Avanga Fua [Break Mole/Mavahe e reality mo'oni]. But 'Avanga in Tonga can be also mean loss contact with reality. Fua means something that is big but its not normal or is a disease. So a major psychiatric disorder. But to say " Mole or Mavahe e Mo'oni " is also mean other things in everyday life which sound ridiculous. Word "neurosis' as a minor psychiatric disorder and no loss contact with reality I use a word "iki" (derive from "iiki" which mean small) . So neurosis is translated as " 'Avanga –iki ". The concept is borrowed from the way how some of our islands are named such as the island of Eua and the closest very small island to Eua is known as Euaiki . Another island is known as Nomuka and the closest small island is known as Nomukaiki. So 'Avanga Fua for Psychosis and Avanga-iki for Neurosis.

SCHIZOPHRENIA
[translate: split mind]

- Bislama
  - Wan sik blong tingting [sick of the mind] we i save mekem man i kat ol tingting we i no tru, i save luk samting we i no stap, mo i soem ol fasin we i save afektem ol aksen blong hem evri dei laef blong hem[may result in hallucinations, delusions, and disordered thinking and behaviour]
  - To translate directly to "Split mind" would be "maen i split" (o lusum [lose] tinging [thinking/mind]?)
- Fijian
  - Lomaloma rua [split] ni vakasama [mind]
  - Yali [gone] ni vakasama [mind]
- Samoa
  - Vavae'ina le [split] fai'ai [brain]
- Tonga
  - Avanga [possession] Motu'a [old] (an old word used by Tongan Traditional Healers with the support of the Anthropologist in which Schizophrenia fit in the Tongan concept of 'Avanga Motu'a]
  - Well to translate directly to "Split mind" will be 'split' (mafahi or Kamaa) and mind ('atamai).
  - If you say 'Atamai mafahi or 'Atamai Kamaa , it sound very rude and it is an insult (sound as a swear) to patient.

SUBSTANCE USE DISORDERS

[translate: disruptions caused by alcohol and other drugs]

- Bislama
  - Sik we i afektem bren mo aksen blong man [a disease that affects a person's brain and behaviour] we i save mekem hem i lusum kontrol long wei we i tekem alkol mo ol narafala drag [can lead to a person's inability to control use of alcohol and other drugs]
  - Or to translate directly "ol rabis samting [bad things] we alkol mo ol narafala drag i save mekem [that can be caused by alcohol and other drugs
- Fijian
  - Na vakacacani [disruptions caused] ni wai veivakamatenitaki [alcohol & other drugs]
- Samoa
  - Puapuagatia [consequences/suffering/discomfort] e tupu mai i le [caused by] ava malosi [alcohol] ma fuala'au fa'asaina [illicit drugs]
- Tonga
  - Ngaue [usage] Tamaki'aki [bad/bitter use] e Faito'o Kona [drugs]

TRAINING

- Journal Club
  - Articles and concepts discussed
- Infographics
  - Mental Health Talanoa (MHT): Possible symptoms related to mental health issues across Pacific communities
  - Mental Health Talanoa (MHT): Research Key Themes
  - Mental Health Talanoa (MHT): Research Recommendations
  - Pacific Indigenous Mental Health Lexicon (PIMHL) - Bislama
  - Pacific Indigenous Mental Health Lexicon (PIMHL) - Samoan
  - Pacific Indigenous Mental Health Lexicon (PIMHL) - Tongan
  - Pacific Indigenous Mental Health Lexicon (PIMHL) - Fijian
- Multimedia Resources
  - YouTube Videos: Mental Health Talanoa (MHT) Channel
  - Facebook, Instagram & Twitter

In receiving and accepting these offerings, the recipient is obliged to accept or recognised the donors' wishes, and to appreciate the feelings being conveyed during the presentation

Asesela Ravuvu

MHT JOURNAL CLUB

Starting from March 2020 and ending in June 2020, the MHT Journal Club was established to investigate key scholarly articles that explore concepts that could be utilised by practitioners within a range of service contexts, including child and family support services, youth and adult mental health, and education. These articles were offered by journal club members. Discussions of these articles were facilitated and conducted through a *talanoa* approach. Some of the key concepts discussed included the nature of multicultural services within Australia and how to promote more authentic forms of culturally specific practice, the impacts of trauma and colonisation upon those from Indigenous and Culturally and Linguistically Diverse (CALD) backgrounds, and the impacts and imports of drawing upon Pacific epistemological and ontological realities when engaging in mental health service provision.

The MHT research team's heartfelt thanks are expressed to those members who contributed to the Journal Club. The discussions shared across these four gatherings raised significant points that impacted upon the formation of the perspectives and conceptualisations of this research project and report, and we recognise how these collective contributions have highlighted key issues that would have otherwise remained undisclosed.

MEETINGS

A total of three journal articles were discussed at the bimonthly MHT Journal Club meetings. They are mentioned in this section as the purpose of the club was to provide health professionals with practical ideas of how they can better serve Pacific and other minority communities in ways that are culturally safe, and promote a more multicultural style of engagement, even when organisational structures do not necessarily recognise the need for such concepts to be incorporated into practice.

Each of the articles and a summary will be provided, highlighting the key points of each, the practical ideas that were derived from them, and how they might be applied in practice.

Article #1:
Duthie D, Steinhauer S, Twinn C, Steinhauer V, Lonne B 2019, Understanding Trauma and Child Maltreatment Experienced in Indigenous Communities, in Lonne B, Scott D, Higgins D, Herrenkohl T (eds) *Re-Visioning Public Health Approaches for Protecting Children: Child Maltreatment (Contemporary Issues in Research and Policy)*, vol 9. Springer, Cham.

This article explores a framework for how practitioners can understand and respond to "the primary causes of maltreatment" (p. 327) for Indigenous children, within a context of colonization, inequality and intergenerational trauma. Australia and Canada are treated as case studies throughout the article, and the impacts of Western epistemologies and ontologies upon peoples from these backgrounds, which compound "grief, loss and trauma in the lives of Indigenous peoples" (ibid).

Considerations arising from this article

Discussion focussed on the nature of service delivery, and whether there is an obligation to work in a multicultural fashion when working with those from other cultural backgrounds. There were also some key considerations around cultural safety, and how to promote this in practice. Below are some paraphrased excerpts of this conversation, shared here as they inform some of the overarching considerations that all three journal club sessions addressed:

> [Participant 1]: When I work with non-Pacific clinicians, the importance of child protection, there are some Pacific Islander practices that aren't perceived as putting a child in harm (e.g. not having own bedroom, having place to put clothes a cupboard). Considerations of extended families. When speaking with non-Pacific colleagues, they said that all of this stuff is reportable, but worker didn't want to. Sharing with family member is usual practice. There are many things that non-Pacific people need to learn.

> [Participant 2]: This is where assessment becomes really important, in the context of their culture, and even their family culture. Regarding church work, our HQ is in the United States. I need to qualify clients' resilience. I will spell it out and give examples, especially when from DV homes, and why this person is now able to do this, when they have had so much contention in their homes. Eurocentric screenings…that isn't going to work for our people, and knowing how to answer in response, how responses take place. That will always be the issue: the culture is misunderstood, assessing from a Eurocentric worldview.

> [Participant 1]: People from Pacific backgrounds working in non-Pacific peoples, can put our Western hat on, and think with Western views, but feels like they aren't putting their hat on. I get sick of being the authority on this.

Some of the participants noticed that they constantly adapt to working with different cultural groups, though this isn't reciprocated in some workplaces where their cultural backgrounds are not responded to meaningfully.

> [Participant 3]: When issues like this arises in our respective workplaces, I know that it takes years for people to get into their heads, as Pacific Islanders in Non-Pacific workplaces, we can support each other, but also a consensus approach is needed. How many consultations do we have? Why don't you stand up to your boss and say something when there is an issue? How many research/ consultations can the community endure?

> [Participant 4]: There are similar concerns with Australian Indigenous peoples – "why am I constantly speaking for the whole community?" There is a small number of individuals called upon to represent the community, rather than a more widespread understanding of how professionals can engage with Pacific peoples.

This is an important consideration – the frequent practice of referring to one staff member from a particular culture as the expert on a given cultural topic, without other colleagues growing in their understanding of the impact and function of culture. How do other non-Pacific or non-Indigenous professionals gain more insight into truly operating in a multicultural way, so that there is a more 'widespread understanding' of such concepts?

> [Participant 2]: Formation of a professional body one day … ? Is it our role to help [Aboriginal and Torres Strait Islander] communities? We can work as allies to further help their position in Australian society.

> [Participant 5] : How do we make cultural safety/ culture understandable in clinical and other health settings? All of the assessment questions that are asked are impacted by culture, yet we do not acknowledge its pervasiveness in assessments. Should a new kind of assessment be formed, should future research seek to explore this?

> [Participant 3]: What country are you from? Connection do you have in your current states? Are you involved in any aspect in your cultural background?

> [Participant 1]: People who have visibly recognisably belonging to a culture, but not wanting to identify, yet they are showing the same issues as clients who do identify as coming from the same cultural background.

The notion of how service users engage with their own culture, and how this is assessed within practice, is highlighted as a key concept that could be developed in workplace settings for professionals from a range of different cultural and other backgrounds. Development of these skills can serve to address in a more nuanced way the issues of intergenerational trauma and the impacts of colonisation.

Article #2:
Ravulo, J, Faleafa, M & Koro, T 2019, Understanding Mental Health and Wellbeing From a Pacific Perspective, in Ravulo, J., Mafile'o T & Yeates, BD (Eds.), *Pacific Social Work: Navigating Practice, Policy and Research* (pp. 47-57), London: Routledge.

This chapter was written to further support people's understandings of Pacific perspectives, and how to include that into other settings. In concepts and in the context of mental health, it was recognised as important to be able to apply community collaborative co-optive approaches. This means talking with service users to ascertain what they want in service provision; it seems that service providers are not engaging with these perspectives.

Considerations arising from this article

Participants perceived this lack of engagement within western settings as a kind of "intellectual arrogance", or "workplace colonisation". While services highlight the importance of cultural supervision, clinical supervision is esteemed as the "gold standard", which is problematic if a truly multicultural service delivery is the aim of such organisations. Other considerations include English as a second language, the impacts of poverty, and the role of religion and church in how Pacific peoples interact with health services. The concept of Pacific people having to navigate between two worlds was also highlighted, and the *Vā* (sacred space) created by these services, and if this space is safe, even when the need to be confrontative arises.

Article #3:
Curtis, E, Jones, R, Tipene-Leach, D, Walker, C, Loring, B, Paine, S-J, Reid, P 2019, 'Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition', *International Journal of Equity in Health*, vol. 18, no. 174, https://doi.org/10.1186/s12939-019-1082-3.

This article explores the various definitions and understandings of cultural competence, respect, humility, and other such terms, and compares these to cultural safety. The first group of terms tends to focus on practitioners developing skills, knowledge and understanding in how to engage with service users from a variety of backgrounds, showing respect and acknowledgement to key cultural practices that are important to them. Cultural safety disrupts this approach, in that it promotes an ongoing conversation that 1) requires practitioners to have individual and/or group conversations regularly with service users, to gain a more nuanced understanding of how they relate their cultural background and its practices, and therefore 2) eliminates the accumulative approach towards knowledge that cultural competence particularly can be accused of, wherein the practitioner being 'expert' to a static, homogenised culture-as-monolith that may not engage accurately with the needs of service users.

Considerations arising from this article

Various participant examples were given that highlighted how cultural safety can be promoted across a range of service providers. One of these included a study assessing the prevalence of diabetes amongst Pacific communities, the use of traditional ceremonies and the importance of food within them, and the need to ensure that food is nutritious and portion controlled. In this example, cultural practices were maintained through cultural events, augmented by a deeper understanding of food properties and its connection with better wellbeing outcomes. This case study shows how principles of Pacific and Western knowledges can be synthesised to promote cultural practices that provide a safe *Vā* for service users – a foundation of cultural practice that also incorporate Western understandings of medicine and food.

INFOGRAPHICS

MENTAL HEALTH TALANOA (MHT): POSSIBLE SYMPTOMS RELATED TO HAVING A MENTAL ILLNESS ACROSS PACIFIC COMMUNITIES

The following infographic provides information on the possible symptoms a Pacific person could be experiencing that may relate to having a mental illness. **This can have a significant impact on themselves, their family and the wider community.** It should be used as a guide and starting point to seek further assistance and support from a health professional that promotes an ongoing mental health talanoa. This includes seeking help from a local General Practitioner (GP), Psychologist, Mental Health Nurse, Social Worker or Counsellor.

This infographic is from Mental Health Talanoa Research & Resources (Ravulo, Winterstein & Said, 2021)

DEPRESSION

- Finding it difficult to enjoy your daily activities
- Unable to play a useful part in life
- Lost interest in things
- Feeling that you are a worthless person
- Thought of ending your life has been on your mind

ANXIETY

- Easily frightened
- Feeling nervous, tense or worried
- Trouble thinking clearly
- Finding it difficult to make decisions

LACK OF CAPACITY & EXHAUSTION

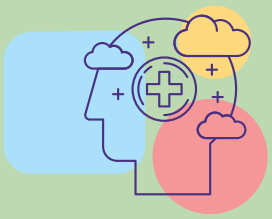
- Often having headaches
- Poor Appetite
- Sleeping badly
- Feeling tired all the time
- Easily tired

SOMATIC

- Hands shake
- Poor digestion
- Cry more than usual
- Uncomfortable feelings in your stomach

MENTAL HEALTH TALANOA (MHT):

This infographic is from Mental Health Talanoa Research & Resources (Ravulo, Winterstein & Said, 2021)

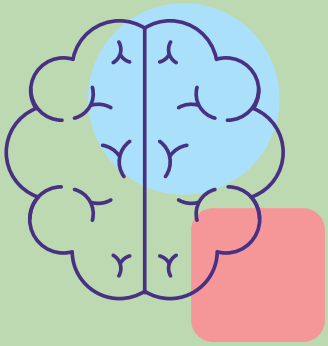


JUDGEMENT, STIGMA AND BARRIERS TO ACCESS MENTAL HEALTH CARE

Common mental health symptoms can be met with advice such as the need to be strong and press on in spite of life's difficulties. Another common experience is the shame and stigma that can be associated with speaking about these concerns to mental health professionals, as the care of friends and consolations of one's faith, particularly prayer in a church setting, are seen as the solutions to feelings of worthlessness and internal struggles.

INTERVENTIONS AND TREATMENTS FOR MENTAL HEALTH CONCERNS

Treatments for mental health concerns are typically sourced through family/friend/cultural community support – talking, sharing emotions, and bearing each other's burdens – or otherwise taken to spiritual leaders within the community. Interventions can include spiritual practices that may or may not assist the individual, and familial and other supports may suffer from a lack of education about presentations that this factor highlights could be connected to a mental health concern.



THE NEED FOR EDUCATION, PSYCHOEDUCATION AND/OR LACK OF APPRECIATION FOR THE COMPLEXITY OF MENTAL HEALTH CONCERNS

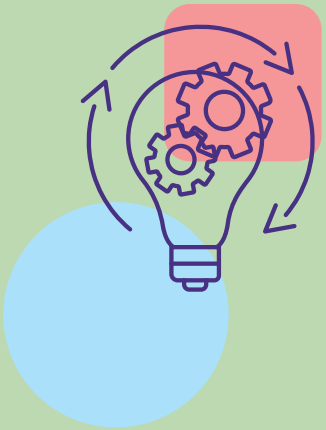
Symptoms associated with having a mental illness may be interpreted as individuals having spiritual ailments or concerns but may also be interpreted as them being 'weak minded'. These conceptualisations of what could be symptoms of a mental illness tend to oversimplify the realities of mental health concerns, perhaps due to fear of what having a mental health illness means, and associations with being 'crazy' and in the extreme, perceived as beyond recovery or help. A lack of strengths-based language to describe different mental health conditions in helpful terms in Pacific languages may further negate deeper understandings of mental health presentations amongst Pacific communities. Providing psychoeducation can widen perspectives of how these realities can be symptoms of mental illness, and the reality of recovery-oriented mental health service provision.

THE NEED FOR DEVELOPING MORE NUANCED POLICY AND RESEARCH

Participants emphasised the need to include issues such as the impact, prevalence and help seeking behaviours of Pacific peoples in training courses and degrees such as social work, counselling, and other professions that draw upon the biomedical model when engaging with clients/patients.

Doing so would ensure that governments and the wider community realise these concerns and could bring these issues to the forefront in the practises. The need to create and nuance educational and health policies to proactively support local primary and high school, community-based agencies and churches that engage and interact with Pacific communities can also make a sustainable difference.

RESEARCH KEY THEMES



PACIFIC PERCEPTIONS OF MENTAL HEALTH

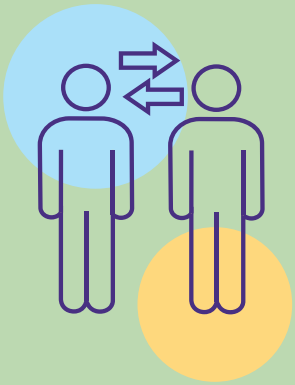
Due to a range of demanding priorities – church commitments, immediate and extended familial obligations, work and study commitments, and others – tiredness and fatigue appear as common realities amongst Pacific peoples engaged in this research project.

These cultural practices promote strong connections to others but may mask the presence of a mental health concern. As these obligations are often shared and common, they can be normalised and therefore disregarded as anything more than the result of being busy caring for others.

CULTURAL IMPACTS OF MENTAL HEALTH

The impacts of mental health were considered in the context of family particularly and touched on issues of shame for a family member who may show symptoms of a mental health condition. A noted diminishing of one's role within the family setting, and therefore an impact upon the health of the family, was noted here – considerable resources and dependence upon church practices can be drawn upon when a family member has a mental health concern, which can be extremely taxing upon family members, and last much longer due to the lack of mental health assessment and intervention. Questions around one's role within the family setting can lead to considerations of one's internal sense of worth and purpose in life, which may be connected to suicidal ideation.

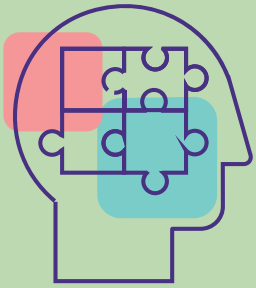
CULTURAL EXPECTATIONS AND PRACTICES, DESCRIBED BY PARTICIPANTS AS MAINTAINING THE "CULTURAL SCRIPT"



The importance of one's role and function, and the relationship of the individual in relation to their obligations and familial expectations, can challenge one's belief in their own worth and usefulness.

Whether one maintains these expectations or challenges them, participants noted the strain and challenge this can provide to mental health and can rupture familial relationships in the extreme.

CHURCH ENGAGEMENT AND ITS ASSOCIATED PRACTICES



Barriers to accessing mental health in this regard stem from the premise of understanding depressive symptoms as being spiritual in nature, and/or being the result of an individual's or family's transgressions, and not having a biopsychosocial genesis. As such, mental health is seen as a concept that arises from the Pala(n)gi/Pakeha (White European) world, and therefore does not resonate often with Pacific interpretations of symptoms that Western medicine would associate with mental health.

MENTAL HEALTH TALANOA (MHT):

This infographic is from Mental Health Talanoa Research & Resources (Ravulo, Winterstein & Said, 2021).

Based on our talanoa sessions with Pacific people across western Sydney, the following recommendations were developed to assist individuals and families, community groups and services alongside broader health and education systems to better respond, engage and manage mental health issues.

PROMOTE THE MEANINGFUL INVOLVEMENT OF COMMUNITY AND CHURCH LEADERSHIP IN REDUCING STIGMA WHILST STRENGTHENING ACCESS TO PRACTICAL HELP AND SERVICES.

UTILISING A STORYTELLING APPROACH TO EXPLAIN MENTAL ILLNESSES AND THEIR IMPACTS.

DEVELOP AND IMPLEMENT PEER SUPPORT APPROACHES FOR PACIFIC YOUTH.

SUPPORTING CRITICALLY REFLECTIVE PRACTICES AMONGST SERVICE PROVIDERS ON HOW THEY DELIVER SUPPORT AND ACCESS TO RESOURCES.

CREATING AN APPROACH FOR *CULTURAL CURIOSITY* AND *HUMILITY* TO OCCUR – WHERE COMMUNITY EDUCATION PROGRAMS HAPPEN AFTER CULTURAL SAFETY AND ENGAGEMENT IS ESTABLISHED.

MENTORING AND GUIDING YOUNG PACIFIC PROFESSIONALS WITHIN THE HEALTH AND COMMUNITY SERVICES SECTOR TO CREATE AND CONTRIBUTE TOWARDS CULTURALLY NUANCED RESPONSES.

RESEARCH RECOMMENDATIONS

MEANINGFUL ENGAGEMENT WITH PACIFIC PARENTS TO SUPPORT THEIR FAMILIES.

DEVELOPING A PROACTIVE APPROACH TO STARTING THE ONGOING TALANOA ABOUT INTERVENTIONS AND TREATMENTS.

DRAWING ON ECLECTIC AND CREATIVE THERAPEUTIC INTERVENTIONS TO ENGAGE.

OFFERING TRAINING COURSES AND DEGREES THAT TEACH UNDERSTANDINGS OF CULTURAL AND LINGUISTICALLY DIVERSE (INCLUDING PACIFIC) CONCERNS AND EXPERIENCES OF WELLBEING.

MERGING PACIFIC-INDIGENOUS KNOWLEDGES OF MENTAL HEALTH ALONGSIDE WESTERN APPROACHES.

ENGAGE LOCAL CHURCHES TO INSTIGATE AND SUPPORT HOLISTIC APPROACHES IN RESPONDING TO MENTAL HEALTH AND WELLBEING NEEDS AND ASPIRATIONS.

TRANSLATE PSYCHOEDUCATION MATERIAL INTO PACIFIC-INDIGENOUS LANGUAGES.

FOSTER FUNDING MODELS THAT ARE SUSTAINABLE AND PROACTIVE TO COMMUNITY NEEDS.

PACIFIC INDIGENOUS MENTAL HEALTH LEXICON (PIMHL) – BISLAMA

The following set of words and phrases have been put together to support a shared, helpful and ongoing mental health talanoa on wellbeing and common mental illnesses. It is through this resource that we hope Ni-Vanuatu and their health professionals can further assist in promoting an effective response to mental illness and its impacts on individual, families and wider community.

This infographic is part of the ***Mental Health Talanoa Research & Resources*** *(Ravulo, Winterstein & Said, 2021) and developed by the Pacific Indigenous Mental Health Lexicon (PIMHL) Working Group.*

Tangku Tumas to our Bislama translators, Dr Jimmy Obed & Rebecca Olul, who continue to work across the community supporting the mental health and wellbeing of people across Vanuatu and their diaspora globally.

MENTAL HEALTH

- Helti tingting *(healthy thinking)*

MENTAL HEALTH ILLNESS

- Sik blong tingting *(sick thoughts)*

WELLBEING

- Helti (healthy)
- Stap long gud helt *(in good health)*

MAJOR MOOD DISORDERS

- Ol siries filing we i save afektem o distebem bigwan laef blong wan man o woman *(serious feelings that can affect or disrupt the life of an individual)*

DEPRESSION

- Harem nogud tumas *(feel very bad)*
- Hat i hevi *(heart is heavy)*

BI POLAR

- Tufala difdifren o oposit pat blong tingting mo filing *(two different or opposite parts to thinking and feeling)*

ANXIETY

- Bigfala fraet o wari we i save krietem ol tingting mo filing we i no helpem wan man o woman *(heightened fear or worry that creates unhelpful thinking and feeling in people)*

PANIC ATTACK

- Fasin blong fraet we i no helpem man o woman *(unhelpful fear to man or woman)*
- Fasin blong panik we i no helpem man o woman *(unhelpful panic to man or woman)*

PANIC DISORDER

- Fraet blong gat wan panik atak *(afraid of having a panic attack)*

PSYCHOSIS

- Wan kondisen we i mekem bren i no save prosesem infomesen *(condition where the brain is not able to process information)*
- We i mekem se yu save luk, harem o bilivim ol samting we i no ril o tru *(can cause you to see, hear or believe things that are not real)*

SCHIZOPHRENIA

- Sik blong maen we i mekem wan i kat ol tingting we i no tru, i luk ol samting we i no stap, mo i soem ol fasin we i save afektem ol aksen mo tingting blong hem *(sick of the mind which may result in hallucinations, delusions, and disordered thinking and behaviour)*

SUBSTANCE USE DISORDERS

- Sik we i afektem bren mo aksen blong man we i save mekem hem i lusum kontrol long wei we i tekem alkol mo ol narafala drag *(a disease that affects a person's brain and behaviour that can lead to a person's inability to control use of alcohol and other drugs)*

PACIFIC INDIGENOUS MENTAL HEALTH LEXICON (PIMHL) – FIJIAN

The following set of words and phrases have been put together to support a shared, helpful and ongoing mental health talanoa on wellbeing and common mental illnesses. It is through this resource that we hope iTaukei Fijians and their health professionals can further assist in promoting an effective response to mental illness and its impacts on individual, families and wider community.

*This infographic is part of the **Mental Health Talanoa Research & Resources** (Ravulo, Winterstein & Said, 2021) and developed by the Pacific Indigenous Mental Health Lexicon (PIMHL) Working Group.*

Vinaka vaka levu to our Fijian translators, Jerry Qalabulailakeba, Jofiliti Veikoso and Dr Litea Meo-Sewabu alongside foundational support from Jope Tarai. We appreciate your ongoing work across the community in supporting the mental health and wellbeing of people across Fiji and their diaspora globally.

MENTAL HEALTH

- Na kena tu vinaka na vakasama *(healthy thinking)*

MENTAL HEALTH ILLNESS

- Na kena sega ni tu vinaka nai tuvaki ni vakasama *(not in the right place with brain & thinking)*
- Na kena dau vei seseyaki nai tovo ni vakasama *(illness with thinking)*

WELLBEING

- Na bula sautu kei na bula taucoko *(healthy)*

MAJOR MOOD DISORDERS

- Tu vakaca ni yalo *(not in right place with feelings)*
- Na dau veinanuyaka na vei ka *(disruptive feelings)*

DEPRESSION

- Rarawa ni yalo *(sad feelings)*
- Loma bibi *(heavy heart)*

BI POLAR

- Na kena sega ni vei raurau nai tuvaki ni vakasama kei nai tovo ni bula se yalo vua e dua na tamata tabuyani *(clash in thinking and feelings)*

ANXIETY

- Na lomabibi kei na lomaocaoca (heightened thinking)
- Na kena sega ni dei nai tuvaki ni vakasama (jumping thoughts)

PANIC ATTACK

- Na kena sega ni dau dei na yalo se na vuka na yalo *(flying and panicked feelings)*

PANIC DISORDER

- Na taqaya kei na vuka ni yalo *(fearful of flying and panicked feelings)*

PSYCHOSIS

- Na leca i ka se na ciri ni vakasama ka sega ni veirau kei na kena itovo *(floating in ocean, break away from mainland and far in mind)*

SCHIZOPHRENIA

- Lomaloma rua ni vakasama *(split mind)*
- Na leca i ka kei na ciri ni vakasama *(mind is absent)*

SUBSTANCE USE DISORDERS

- Na vakacacani ni wai veivakamatenitaki *(disruptions caused by alcohol and other drugs)*

PACIFIC INDIGENOUS MENTAL HEALTH LEXICON (PIMHL) – SAMOAN

The following set of words and phrases have been put together to support a shared, helpful and ongoing mental health talanoa on wellbeing and common mental illnesses. It is through this resource that we hope Samoans and their health professionals can further assist in promoting an effective response to mental illness and its impacts on individual, families and wider community.

This infographic is part of the ***Mental Health Talanoa Research & Resources*** *(Ravulo, Winterstein & Said, 2021) and developed by the Pacific Indigenous Mental Health Lexicon (PIMHL) Working Group.*

Fa'afetai tele lava to our Samoan translators, Ursula Winterstein and Fraser Leavasa alongside foundational support from Dr George Leao Tuitama. We appreciate your ongoing work across the community in supporting the mental health and wellbeing of people across Samoa and their diaspora globally.

MENTAL HEALTH

- Mafaufauga lelei *(good thoughts)*
- Mafaufauga aoga *(useful thoughts)*

MENTAL HEALTH ILLNESS

- Mafaufauga le aoga *(unhelpful thoughts)*
- E a'afia ai le mafaufau *(negatively affecting your thoughts)*

WELLBEING

- Soifua Maloloina *(healthy)*

MAJOR MOOD DISORDERS

- Ogaoga lagona fa'afitauli *(serious disruption to feelings)*

DEPRESSION

- Fa'agoagoa *(really sad)*
- Mafatia le mafaufau *(heavy on the mind)*

BI POLAR

- Lua itu aiga o fe'ese'ese'ina o mafaufauga ma lagona *(two different kinds of thinking and feeling)*

ANXIETY

- Popolega *(worry/anxiety)*

PANIC ATTACK

- Osofa'iga fa'afuase'i *(sudden attack)*
- Atuatuvale *(panic)*

PANIC DISORDER

- Fefe i maua i se osofa'iga fa'afuase'i *(afraid of having a sudden attack)*

PSYCHOSIS

- Lagona po'o mafaufauga i mea e le moni *(feelings or thoughts of things that are not real)*

SCHIZOPHRENIA

- Vavae'ina le fai'ai *(split brain)*

SUBSTANCE USE DISORDERS

- Puapuagatia e tupu mai i le ava malosi ma fuala'au fa'asaina (*consequences, suffering and discomfort caused by alcohol and illicit drugs)*

PACIFIC INDIGENOUS MENTAL HEALTH LEXICON (PIMHL) – TONGAN

The following set of words and phrases have been put together to support a shared, helpful and ongoing mental health talanoa on wellbeing and common mental illnesses. It is through this resource that we hope Tongans and their health professionals can further assist in promoting an effective response to mental illness and its impacts on individual, families and wider community.

*This infographic is part of the **Mental Health Talanoa Research & Resources** (Ravulo, Winterstein & Said, 2021) and developed by the Pacific Indigenous Mental Health Lexicon (PIMHL) Working Group.*

Malo 'aupito to our Tongan translators, Dr Mapa Puloka and Seini Afeaki alongside foundational support from Dr Violet Erasito-Tupou. We appreciate your ongoing work across the community in supporting the mental health and wellbeing of people across Tonga and their diaspora globally.

MENTAL HEALTH

- Mo'ui faka'atamai *(life of the brain & head)*

MENTAL HEALTH ILLNESS

- Puke faka'atamai *(sick brain & head)*

WELLBEING

- Mo'ui lelei *(life is good & healthy)*

MAJOR MOOD DISORDERS

- Maveuveu lahi fakaeongo *(major mood disorder)*

DEPRESSION

- Lotota'ota'omia *(depression)*
- Mo lotomafasia *(depression)*

BI POLAR

- 'Avanga femaleleaki *(something that oscillates between two opposite poles)*

ANXIETY

- Puputu'u mo lototailiili *(too many things standing, crowded & scared heart)*

PANIC ATTACK

- Lotopuna tamaki *(something that is bad, unpleasant, offensive, irritating or obnoxious)*

PANIC DISORDER

- Mahaki lotopuna tamaki *(disease of a panic attack)*

PSYCHOSIS

- 'Avanga fua *(psychosis)*
- 'Avanga iki *(neurosis)*

SCHIZOPHRENIA

- 'Avanga motu'a *(old possession)*

SUBSTANCE USE DISORDERS

- Ngaue tamaki'aki e faito'o kona *(bad & bitter usage of drugs)*

MULTIMEDIA RESOURCES

YouTube Video: Mental Health Talanoa (MHT) Channel
As part of our desire to provide sustainable and widely available resources, a specific YouTube Channel has been created. Titled Mental Health Talanoa (MHT), a series of videos have been recorded and uploaded for a wide range of audiences to access, including:

- Pacific individuals, family members and community
- Pacific health professionals working across the Pacific and wider community
- Health professional working with Pacific communities
- Mental health researchers and policy makers

All videos are available at the following link:

- https://www.youtube.com/channel/UCd6cEK9xSAHyjbhUtLCeMfw

FACEBOOK, TWITTER AND INSTAGRAM

Our social media platforms were on:

- Facebook: https://www.facebook.com/MHTalanoa
- Instagram: https://www.instagram.com/mhtalanoa/
- Twitter: https://twitter.com/MHTalanoa

These three social media platforms were utilised to promote deliverables from the research project, including:

- Posting the Qualtrics survey link for Pacific people in western Sydney to complete
- Key community-based resources available to support mental health and wellbeing
- COVID-19 public health messages translated into Pacific languages
- Promote the use of Pacific oriented hashtags that support the development of mental health literacies across these postings (#CollectiveCare #MentalHealthTalanoa)

Such platforms also promoted the notion of creating an ongoing mental health talanoa, and strives to mobilise a shared approach to profiling possible pathways to support healthy, happy and resilient Pacific communities across the region and beyond.

Photo by Old Youth on Unsplash