MENTAL HEALTH IN NEW ZEALAND FROM A PUBLIC HEALTH PERSPECTIVE

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The views expressed in this report are those of the authors and they do not necessarily represent the views of the Ministry of Health.
CHAPTER 4:
PACIFIC PEOPLE IN NEW ZEALAND

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This chapter summarises some views of Pacific people on the causes of mental illness; identifies major risk and protective factors affecting their mental health in New Zealand; and considers the relative importance of particular, clinically diagnosed conditions among first admissions to psychiatric hospitals. It also considers why Pacific people avoid or delay seeking clinical treatment; their use of traditional healers; some of the gaps in our knowledge about the mental health of Pacific people in New Zealand; and the opportunities for primary prevention of mental illness, and mental health promotion.

The considerable diversity of life experience, culture and religion of Pacific people living in New Zealand is emphasised throughout the chapter, for this feature underscores the difficulty of generalising about the mental health of the Pacific population as a whole, or applying a blanket approach to the primary prevention of mental illness.

The task of generalising is made especially difficult by the unevenness of published information available for the various Pacific communities. Much more has been written about the views on mental illness held by Samoan people than those held, for example, by Niueans and Tokelauans. This bias is reflected in the present chapter.

On the whole, research focusing on the mental health of the Pacific population has been quite limited compared with that focusing on Māori and European New Zealanders. Thus, the prevalence of mental illness among Pacific people is still uncertain; information on the recent impact of economic changes on mental health remains sparse; and the cultural beliefs and requirements of all the different groups within the Pacific population that impinge on mental health still need to be identified adequately, especially for the Cook Islands, Tongan, Niuean, and Tokelauan groups. Some of the specific areas where research is urgently required are identified in this chapter. The gaps need to be filled through a co-ordinated research programme aimed at improving the description of the mental health problems of all groups of Pacific people in New Zealand.

Over the last 50 years there has been a steady increase in the migration of people from various parts of the South-west Pacific to New Zealand. In 1945, people of Pacific ancestry made up just 0.1 percent of the total population of the country, but by 1991 this had increased to 4.9 percent. In the latter year, 167,000 people identified with one or several of the ethnic groups making up the Pacific population (Department of Statistics 1992). It is acknowledged that the Pacific population is under-enumerated in New Zealand, and is larger than indicated by the official population censuses (PHC 1994a). A factor contributing to this is that some people who have stayed longer than their visas allow, fear being apprehended and endeavour to remain as anonymous as possible.
The Samoan community is the largest of the ethnic groups (50 percent of the Pacific population in 1991), followed by the Cook Islands community (22 percent), and the Tongan (14 percent), Niuean (9 percent), Fijian and Tokelauan communities. There are also people of Papua New Guinean, Solomon Islands, Vanuatu and Tuvaluan ancestry in New Zealand (Department of Statistics 1992; PHC 1994a). Each group is quite distinct, having its own language and culture, and often its own set of formal social institutions (such as cultural, sporting and other clubs etc) in New Zealand. The Pacific population is heavily concentrated in Auckland (67 percent in 1991) and Wellington (16 percent), but dispersion to other regions has been increasing in recent years.

**HETEROGENEITY OF THE PACIFIC POPULATION**

The term ‘Pacific population’ covers not only people of a wide range of ethnic groups, but also people of multiple ethnicity (eg, Niuean/European), and those who have emigrated from the Islands vis-à-vis those born in New Zealand. The last-mentioned make up a rapidly growing section of the resident Pacific population. In 1991, exactly 50 percent of all people of Pacific ancestry living in New Zealand had been born here.

The experiences and lifestyles of New Zealand-born Pacific people and those of multiple ethnicity can be quite different from those of people who migrated from the Islands. Differences also exist between those born in New Zealand who have spent all or most of their life in this country, and those born in New Zealand who were taken back to the Islands at an early age, or visit for lengthy spells on a regular basis. Of the two groups who have spent significant time in the Islands, it is the New Zealand-born long-term residents who are being referred to in this chapter when the term ‘New Zealand-born’ is used.

Generally, New Zealand-born residents of Pacific ancestry have received a higher level of education than Islands-born people living in New Zealand; they have higher incomes, and a lower level of unemployment (Larner and Bedford 1993; Krishnan et al 1993, 1994). As a result, they are less likely to experience economic hardship to the same extent as recent immigrants from the Islands. On the other hand, the New Zealand-born long-term residents may not know the language of their parents and their attachment to traditional values and beliefs, including those about mental illness, may not be as strong.

Church affiliation is another feature contributing to cultural diversity and the separation of different groups of Pacific people. Various religious denominations are represented in the Pacific, all calling on the financial and labour resources of their communities – including members who have moved to New Zealand. Within New Zealand, the local ‘Island’ church as an institution, each with its own Pacific clergy, remains an integral and important part of the life of Pacific communities. In many cases the congregation of a particular church is focused around a specific ethnic entity (eg, the Samoan or Cook Islands populations). Some churches (eg, Seventh Day Adventist) deliver a strong health message to their congregation, while others do not.

Four themes concerning the mental health of Pacific people in New Zealand provide the focus for discussion in this chapter.

- Pacific people’s beliefs shape the way they respond to mental illness. Beliefs about the causes of mental illness are quite different from those held by medical clinicians, as are the ways in which mental illness is addressed. These views may be quite traditional (eg, among older, Islands-born people) or may have been modified by Christian dogma.
The transition from life in the Islands to life in New Zealand brings to the fore a variety of new economic and sociopsychological stressors affecting mental health (eg, problems with employment, sufficiency of income for family and extended family needs, adequacy of housing – its affordability and quality – and food requirements; conflict between the mores of the host country and Pacific values; changing relationships between parents and children, and changing relationships between individuals and other members of their cultural group in the Islands and within New Zealand).

Because of particular beliefs about the causes of mental illness, the use of traditional healing, and unfamiliarity and unease with psychiatric services, some Pacific people are reluctant to use such services, and are more likely than other groups to come to them as a last resort, and to psychiatric hospitals as committed patients.

The best opportunities for mental health promotion are those that dovetail with, and are conducted through, Pacific organisational structures (churches and other groupings) in New Zealand, in a culturally appropriate manner. Pacific health workers are best placed to assist Pacific families identify mental illnesses and seek treatment at an early stage, but there are few of them at present, especially workers trained in mental health.

**PACIFIC PEOPLE’S BELIEFS ABOUT THE CAUSES OF MENTAL ILLNESS**

Ma’ia’i (1994) and Tamasese and colleagues (1997) have emphasised the importance of culture in understanding Pacific people’s views of health. Ma’ia’i defines culture as ‘a system of implicit behaviour and explicit ideas that underlies and gives meaning to behaviour and society’. The culture-bound views and practices of Pacific people concerning mental illness are very different from those of Western psychiatric diagnosis.

The various Pacific cultures do not have specific words in their languages that translate easily into the term ‘mental illness’. This may be because ‘mental’ wellbeing is not separate from, but considered to be part of, the overall wellbeing of the body, soul and spirit (Kerslake 1988; Ma’ia’i 1994; Crawley et al 1995).

Among Samoan groups in New Zealand consulted by Crawley and colleagues in 1993 to assess their understanding of the term ‘mental health’, they found that one-third of the groups offered the phrase ‘le saogalemu lelei o le mafaufau’, which translates as ‘calmness of the mind’; and just under a third suggested the Samoan word ‘ma’i aitu’, which means spiritual illness or possession by spirits. Among Cook Islands groups the word ‘neneva’ was used, which can refer to an intellectual disability or general sickness in the head (Crawley et al 1995), although the term has a much wider meaning.

In general, Pacific people do not traditionally consider ‘mental illness’ to result from a condition originating within, and totally confined to, a person exhibiting certain types of disturbed behaviour. Instead, most – but not all – disturbed behaviour is considered to be a manifestation of an external spiritual force, especially ancestral spirits who have taken possession of the person because the person or the person’s family have broken a certain custom or offended the spirits in some way. In short, there is a common belief across the Pacific cultures that ancestors have a constant spiritual and physical communication with living people. Similarly, the traditional approach of Pacific people to treating the disturbed person is not focused solely on the individual concerned, but involves the whole family. The curative process centres around the head of the family, or special ‘traditional healers’ who deal with the spiritual world, conducting rites to placate the spirit and restore the individual and family group as a whole to a neutral state with their spiritual environment.
Notwithstanding the above broad similarity in traditional belief and spiritual curative practices across the Pacific cultures, there are considerable differences between them in the terminology used for behavioural disturbances attributed to spiritual forces; and indeed there are considerable differences in the types of customs broken to invoke possession in the first place.

To consider, first, Samoan views on illness, these have been summarised by Gluckman (1977), Kinloch and Short (1979), Metge and Kinloch (1980, 1984), Kinloch (1985), Ma’ia’i (1986, 1994), Kerslake (1988) and Tamasese and colleagues (1997).

Gluckman (1977) and Tamasese and colleagues (1997) have noted Samoans, and older Samoan people especially, consider they suffer illnesses unique to Samoans that are caused by a violation of certain Samoan laws and customs. Samoans use the term ‘Ma’i Samoa’ to refer to illnesses specific to Samoans (as distinct from ‘Ma’i Palagi’, to which Europeans are susceptible), the term meaning sickness and death. Within Ma’i Samoa there are a number of ‘culture-bound’ syndromes (ie, ones specific to Samoans) that come to the fore when there is a breach of ‘tapu’ or ‘sa’ (tapu being things forbidden to the ordinary, and sa, things that are sacred). Some of these are as follows.

- **Ma’i aitu.** Aitu are spirits, who may cause a patient to become bad-tempered, impulsive, use foul language, or manifest out-of-character behaviour.

- **Ma’i fasia.** There are various geographical areas in Samoa that are under the custody of a fasia, or spirit guardian, and if a person visiting such a place does something untoward, such as laugh, then they will be stricken with hallucination that will last a considerable time. There are cases where stricken people have come to New Zealand to escape the fasia.

- **Ma’i valea.** This is an ‘emotional sickness’ considered to be caused by contact with some object that belonged to a deceased person. Christian Samoans, however, consider ma’i valea to result from disobeying the wishes of the father or family chief, the breaking of the Ten Commandments, or lapsing from certain Samoan traditions that are acceptable to the missionary group.

- **Sickness attributed to a curse resulting from the failure of a person to fulfil a dying person’s final wishes (mavaega); the breaching of tapu and sa within the family (malaaumautua); and the breaching of tapu and sa placed by village elders (malaaunu’ua).** The latter two maledictions condemn the offender, bereft of blessing, to live an aimless, despairing existence, seemingly without purpose, characterised by much wandering.

Ma’ia’i (1986) has provided an account of ua sa’ia e Moso. Moso is the fearful god of the land below, and is associated with sudden death. It is not uncommon for children in Samoa to become paralysed with horror about Moso, and act strangely for a lengthy period of time before returning to their normal state. Ma’ia’i considers that Moso is a force to be reckoned with in the psychology of an average Samoan paediatric patient.

In keeping with the Samoan belief that individual wellbeing (spiritual, physical, etc) can be affected by events in the familial realm as much as in the spiritual realm, there is an illness known as ‘fa’anoanoa’ which can occur when there is disruption to, or disharmony within, the family. As described by Metge and Kinloch (1980), fa’anoanoa, or unhappiness, is caused by a death or severe illness in the family, by shame, or a feeling of injustice. When a person is fa’anoanoa they are moved by the belief that no one loves them, and they feel compelled to isolate themselves, seldom talking and perhaps becoming unkempt. In its extreme form, fa’anoanoa evokes bad thoughts that are manifested in undirected violence, murder or suicide.
Much less has been published about the causes attributed to illness in Tonga. However, according to Foliaki, in Tongan society the term ‘fakasesele’ is used to refer to a person who is totally insane and capable of doing ‘all sorts of absolutely wonderful things’. ‘Angaangaua’ (‘two characters’) is a term that refers to people who show two different personalities. In the case of the illness known as ‘te’ia’, a victim is ‘hit by’ and falls under the command of, a dead person’s spirit. This can occur quite suddenly. A person may mention a dead person’s name in a conversation, and suddenly act as though they were talking to them and shifting in their direction (Foliaki, in Ministry of Health 1993). Overall, people in Tonga traditionally believe that all illnesses, from a migraine to severe depression, result from an action that has affected the ancestral spirit (Ministry of Health 1993).

Written information on the views of Cook Islands people is sparse. However, Baddeley (1985) has noted that some mental illness is considered to result from a spiritual sickness associated with the breakdown of social relations. The upsetting of spiritual forces is also considered to be the cause of mental illness in Niue (A Mitikulena, personal communication, January 1997).

In describing these beliefs of Pacific people we have used the word ‘traditional’. This is because there are people in New Zealand who, as a result of belonging to a particular religious denomination, or for other reasons, do not subscribe to the beliefs of their own culture. The extent of change, and differences in attitude between people of the same culture, cannot be measured. Indeed, they can easily be overemphasised. Gluckman noted that despite being Christians, Samoans in New Zealand still retained their traditional view that sickness or death is the result of supernatural forces (Gluckman 1977), and Kinloch (1985) confirmed this. However, Gluckman also noted that older people know more than younger people about the traditional interpretation of illnesses and how they should be treated, although older people do not pass on knowledge if they are ‘strong’ church people.

As part of the generational difference in traditional knowledge about illness, there is a difference between the Islands-born and the New Zealand-born Pacific people. Whereas people born in the Islands may continue to attribute mental disorders to the malevolence of ancestral spirits who need to be placated, and place faith in traditional curative practices, people born in New Zealand are likely to have far less understanding of the causes traditionally ascribed to mental disorders and to view treatment as a matter for psychiatrists and psychologists et cetera. The evidence concerning this difference is largely anecdotal, but attention has been drawn to it by Pacific people themselves (Ministry of Health 1993).

**RISK AND PROTECTIVE FACTORS FOR MENTAL HEALTH**

The foregoing account indicates that, in the traditional context, and especially for older people today, the Pacific view of the risk factors for ‘mental’ health (albeit, undistinguished from other major illnesses) covers:

- the breaking of customs invoking the wrath of spiritual forces
- social discord between family or community members, frequently leading either to self-injury (eg, fa’anoanoa, suicide), violence towards others, or possession by a spirit as punishment.
Similarly, the protective factors for mental health would be considered to include:

- the correct following and maintenance of all customs
- the maintenance of social harmony, to prevent malevolent spiritual and self-destructive forces, and so on, being unleashed.

Leaving aside beliefs, an attempt has been made in Table 4.1 to summarise some key environmental protective and risk factors.

**Table 4.1: Some protective and risk factors for Pacific people’s mental health**

<table>
<thead>
<tr>
<th>Protective factors</th>
<th>Risk factors</th>
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</thead>
<tbody>
<tr>
<td><strong>Support networks and cultural expression</strong></td>
<td><strong>Weakened support networks and cultural expression</strong></td>
</tr>
<tr>
<td>Family support</td>
<td>Lack of family support</td>
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<tr>
<td>Community (culture-bound) support</td>
<td>Lack of community support</td>
</tr>
<tr>
<td>Awareness and esteem for own culture</td>
<td>Lack of awareness and esteem</td>
</tr>
<tr>
<td>Involvement in activities of own culture</td>
<td>Lack of involvement in own culture</td>
</tr>
<tr>
<td>Self-esteem and lack of discrimination</td>
<td>Lack of self-esteem and presence of discrimination</td>
</tr>
<tr>
<td>Exercise of authority by elders and church leaders, and recognition of their decisions</td>
<td>Lack of strong leadership or recognition of authority, and increased need of individuals to make decisions</td>
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<tr>
<td><strong>Parenting</strong></td>
<td><strong>Parenting</strong></td>
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<tr>
<td>Two-parent and extended family life</td>
<td>Sole-parent family life</td>
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<tr>
<td>‘Adequate’ parenting</td>
<td>‘Inadequate’ parenting</td>
</tr>
<tr>
<td>Lack of physical violence within the home</td>
<td>Physical violence with the home</td>
</tr>
<tr>
<td>Successful adaptation to/coexistence with the host culture, its mores, and behaviours</td>
<td>Confusion about host culture and mores; and inappropriate behaviour in the cross-cultural environment</td>
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<tr>
<td><strong>Economic security</strong></td>
<td><strong>Economic insecurity</strong></td>
</tr>
<tr>
<td>Adequate housing</td>
<td>Overcrowded, poor quality housing</td>
</tr>
<tr>
<td>Satisfactory employment</td>
<td>Unemployment or lack of a satisfactory job</td>
</tr>
<tr>
<td>Adequate income to support family and meet church and social obligations</td>
<td>Inadequate income to support family and meet church and social obligations</td>
</tr>
<tr>
<td><strong>Absence of substance use</strong></td>
<td><strong>Presence of substance abuse</strong></td>
</tr>
<tr>
<td>Nil or minimal use of alcohol</td>
<td>Excessive use of alcohol</td>
</tr>
<tr>
<td>Avoidance of illicit drugs</td>
<td>Use of illicit drugs</td>
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</table>
Pacific people are exposed to the suggested risk factors to a far greater extent in New Zealand than in their Islands hearth area. In essence, Table 4.1 summarises some of the major socioeconomic changes that have acted as ‘stressors’ to mental wellbeing for people coming from the Islands to this country over the last three or four decades.

This is not to say that socioeconomic changes are confined only to Pacific people in New Zealand. Development of involvement in the wage economy, urbanisation, the rising use of alcohol, and changes in the fulfilment of family and kinship obligations and social relationships, for instance, are ongoing changes in the Pacific Islands, and are acknowledged to be contributing to the increasing incidence of a range of mental health problems (Baker et al 1986; Howard 1986; Foliaki in Ministry of Health 1993). Secondly, it should not be assumed that village populations in the Islands are untouched by mental illness. Foliaki (in Ministry of Health 1993) observes that there have always been mentally disturbed people ‘floating around’ in villages in the Pacific, causing little social concern in these communities. Nor is it to be presumed that all risk factors for mental health are socioeconomic in nature. In populations such as Tokelau in the 1960s, subject to few social and economic changes, and with little contact with the outside world, medically diagnosed cases of schizophrenia were found from time to time (Wessen et al 1992).

Despite these qualifications, Table 4.1 provides a useful framework for describing the kinds of stressors that Pacific people are exposed to in coming to a different and more complex social, economic and cultural environment than their hearth area. At this stage it is difficult to define protective factors in terms other than the absence of risk factors, although by analogy with studies of protective factors in other groups it may, in time, be possible to define these more specifically in terms of process variables, such as social support, coping skills and factors that promote resilience.

**SOCIAL SUPPORT**

The social support structure of people in the Pacific encompasses not only members of the immediate family, but those of the extended family or lineage (eg, the aiga in Samoa, or the matavuvale in Fiji), and members of the same village community. In addition to respect for parents and elders, Pacific people value hospitality and generosity highly. The meeting of obligations to kin and community members is important, and fulfilled in various ways such as assistance with garden work, gifts of food, and the pooling of resources for weddings and funerals or small business ventures. Fulfilment of these obligations in turn strengthens the interdependence of members of the community. It is recognised that the enveloping social structures, the stability they provide, and the consensus about basic, culture-specific values all facilitate the high level of social support in Pacific societies, especially in the smallest, traditional ones on the atolls, such as Tokelau. This may explain why the incidence of overt mental illness there is relatively low (Wessen et al 1992).

Kinship and community ties are also important in facilitating much migration from the Islands to New Zealand. In a study of Samoan migrants to New Zealand it was found that only half the men and 16 percent of the women made the decision to migrate by themselves. For the remainder, migration resulted from discussions with kin, especially parents, elders and brothers, often with the objective of obtaining money for the extended family or aiga, or for a community project. Three-quarters of the migrants had their fares to New Zealand paid for, mostly by relatives, but with the expectation that the migrants would in turn remit money back to the larger family (Graves et al 1983; Howard 1986).

Kinship and community ties are also utilised by new arrivals in New Zealand from the Islands. The study of Samoan migrants found that on average they lived with relatives in New Zealand for up to two to three years upon arrival and that these relatives also found them jobs (Graves et al 1983; Graves
and Graves 1985). Observations indicate that kinship plays a similar role for people coming from Tonga, the Cook Islands and other parts of the Pacific as well.

The assistance provided to new migrants by relatives would appear to be crucial in allowing them to adjust to life in New Zealand. According to Dodge (1974), there is clear evidence that migrants with community support are much less liable to develop mental ill health than migrants who lack such support. For Pacific migrants, living with relatives, being provided with a job rather than having to look for one, and joining a Pacific church, are important in facilitating a smooth adjustment, within a familiar sociocultural cocoon. Often this is before they have a command of English. For those who have little support on arrival, the stresses in settling down may be considerable.

As residence in New Zealand lengthens, there is often a shift towards a self-reliant adaptive strategy, particularly in seeking new jobs without help from relatives or friends (Howard 1986). However, as members of their resident larger Pacific community, contribution to community affairs (church and cultural socials, weddings, etc) focused largely around the local Pacific church is expected and usual. Assistance to kin coming from the Islands is also expected.

The social networks of Pacific people born in New Zealand, or who have lived in New Zealand for a lengthy time, may be very different from those who were born in the Islands. With time, networks widen to include non-kin of the same ethnic group, and persons of other groups. Attachment to traditional values among the New Zealand-born may not be as strong as it is for the Islands-born. In general, Pacific people often point out that there is a greater tendency among the New Zealand-born to live in nuclear families, to have more restricted contact with people of their own Pacific group and less financial commitment to the affairs of the ethnic community (eg, weddings, or church fund-raising) (Larner and Bedford 1993). It is also claimed they are less regular in their church attendance or less likely to be involved in church activities (Ministry of Health 1993), but this may be an overgeneralisation. There are some Pacific people in New Zealand who maintain stronger ties to culture, especially in relation to the church, than their counterparts in the Islands. However, as Macpherson (1991) and Pulotu-Endemann and Spoonley (1992) point out in the case of Samoans in New Zealand, the nature of change and orientation to the mother culture in the new environment is complex.

CULTURAL IDENTITY

Some of the differences between Islands- and New Zealand-born Pacific people referred to above are indicative of a general weakening of culture-focused social cohesion, support and identity as residence in this country lengthens. Intermarriage is another factor that weakens cultural identity for some people. There are many Pacific people who are descended from two or more ethnic groups. In particular there has been a steady increase in the number of people of mixed Pacific/Māori ancestry: by 1991 there were 14,000 in this category (PHC 1994a). For some of these people, the lack of a specific cultural identity, the search for one, or the confusion resulting from an attempt to follow or accommodate the mores of several cultures, can be important factors affecting their psychosocial adaptation.

The problem of cultural identity can be just as great for some children with parents of the same Pacific culture. There are parents, born in the Islands, who are reluctant to teach their New Zealand-born children their mother tongue or inform them about specific elements of their culture in the belief that it is more important for them to learn and use English and be part of the larger New Zealand, European-oriented culture (Lealaialauloto 1995a). This may reflect either an attempt to adjust to a new environment and advance quickly, or the low esteem of parents for their own culture, or both. Whatever the cause, the failure to transfer cultural knowledge to children can affect their personal development by contributing to confusion about their cultural identity and frustration in their desire to uphold customary
tenets and ways. In some cases it can lead to lower esteem for their parents, themselves and their relatives, and consequent behavioural problems and petty crime et cetera.

A similar situation arises where there is a difference between New Zealand-born children, who adhere to the values of the host culture, and their Islands-born parents and elders, who wish to see them adhere more to the values of their own culture. This can place at risk the family support structure itself.

Yet another process has been the development of a wider ‘Polynesian’ or ‘Islands’ identity among children, alongside, or to compensate for the lack of, an island-specific one. This trend of identifying as a Pacific person or Polynesian rather than, say, a Samoan, was observed in the 1970s among children schooling together who came from different Pacific ethnic backgrounds (Gluckman 1977).

DISCRIMINATION AND SELF-ESTEEM

Pacific people consulted by the Public Health Commission in 1993 and 1994 expressed concern about the negative stereotype of them held by some sections of the community in New Zealand. They referred to their high unemployment, dependence on social welfare benefits, use of poor quality housing, their struggle to learn English and the lack of public understanding of Pacific culture and beliefs as key features contributing to the negative stereotyping of Pacific people. This, they indicated, could be demoralising, and contribute to low self-esteem among some people, especially those experiencing real difficulties in adjusting to the new environment and obtaining economic security. They felt too many Pacific people had low self-esteem. They considered such people were at greater risk than others as far as their health was concerned, because they were less likely to present themselves for medical assistance (PHC 1994b).

People living in New Zealand whose visas have expired experience additional worries and attempt to be as invisible as possible. Fear of detection is a long-standing one, going back to the clampdown on ‘overstayers’ in the 1970s. At that time Gluckman (1977) pointed out that the threat of arrest and deportation forced many to live an underground existence. This, and separation from kinship with legal migrants, did not encourage social or emotional stability.

DECISION-MAKING IN A NEW ENVIRONMENT

In societies in the Islands, extended families and lineages are headed by male elders who make decisions regarding the welfare of the group, to which younger people defer. Church clergy are also respected as decision-makers, particularly in village matters and community affairs focusing on, or conducted through, the church. As a result, social control is relatively ‘tight’ in the Islands, and behaviours that upset the social balance are quickly addressed.

Social control is much looser in New Zealand. One reason for this is that it is primarily young people who migrate, with elders remaining in the Islands. Indeed, people sometimes migrate to remove themselves from the control of elders. Another reason is that residence in New Zealand creates a different social situation, in which people may form socially mixed communities (or church congregations), and where, in the pursuit of returns from the cash economy, there is a greater sense of egalitarianism. This means that Pacific people coming to New Zealand often shift from a situation in which much decision-making was done for them (eg, for Samoans, by their elders or matai), to one in which they take more responsibility for decisions, particularly for everyday living, in an unfamiliar
environment. Owing to lack of skill in the use of English, a relatively low level of education, and unfamiliarity with the workings of New Zealand’s economic, social, health and other structures, some are not able to make this adjustment easily, or at all, and may depend heavily on their church’s clergy in particular for assistance. This, in turn, places a burden on the clergy, among whom there are some who may not have the ability or time to meet all needs. Those migrants who were accustomed to being guided by their clergy in the Islands, but who disassociate themselves from the church when they come to New Zealand, may experience considerable difficulty coping in the new environment.

HOUSING

Owing to the relatively high cost of renting or buying homes, especially in Auckland and Wellington, Pacific families have had to depend on low-cost, poor quality rental housing more than most other sections of the population. In addition, because of larger family sizes, they experience a relatively higher level of overcrowding. In 1991, 42 percent of Pacific households contained six or more members, with an average of 4.2 people per household compared with the national average of 2.8. The disproportionate level of Pacific households with a serious housing need has been commented on by the National Housing Commission (NHC 1988) and Papali’i (1991). According to Waldegrave and Sawrey (1994), Pacific households with a serious housing need represented 16.8 percent of all New Zealand households with such a need in 1993, far in excess of the 4.9 percent of the population they represented two years earlier.

Both overcrowding and poor quality housing are important stressors for ill health, mentally and physically. The impact of such conditions on the wellbeing of Pacific people in New Zealand was pointed out two decades ago by Barnett (1975), who noted that children were being nurtured in unsatisfactory environmental conditions and ‘growing up with feelings of frustration and antipathy towards society’. The difficulties experienced by Pacific families were also highlighted by Kearns and others in their 1988 study of housing in Auckland and Christchurch. Nearly 26 percent of Pacific respondents said their houses were overcrowded and had insufficient space; and 2 percent reported ‘unspecified stress caused or exacerbated by housing’ (Kearns et al 1991). Generally, it was found that Pacific people were not able to solve their housing problems and acquiesced to putting up with poor conditions compared with Europeans who were far more likely – and able – to improve their circumstances.

FAMILY TYPES

In the Islands, the extended family usually live together or close nearby. In New Zealand, however, members of a migrated family may have to live in several separate, dispersed houses, with members of other families. This dispersion and sharing of housing makes parenting and family interaction more difficult. In the case of the Samoan community, the nature of family life in New Zealand is one factor affecting knowledge of and orientation to customary values (Macpherson 1991).

Multiple and extended families remain important family types among Pacific people in New Zealand (Davey 1993), but there has been a rapid increase in the number of sole-parent families. Between 1987 and 1991 the number of Pacific sole parents (as distinct from sole-parent households) increased sixfold, from 1290 to 7959 (ie, from a 3 to a 7 percent share of all New Zealand sole parents) (Rochford 1993). In 1991, 13 percent of all Pacific children under one year of age were being brought up in single-parent households (5 percent in 1981); as were 16 percent of children aged 1–4 years, and 18 percent
of those aged 5–19 years (Davey 1993). Factors contributing to this increase in the proportion of sole-parent families include unplanned pregnancies among never-married young women and a rise in the level of separation and divorce among Pacific people (PHC 1994a). Because of differences in the collection and recording of vital statistics, it is difficult to compare the rates for separation and divorce among Pacific people in New Zealand with those for specific Pacific countries. However the incidence of dissolution of marriages is likely to be much higher in New Zealand. This may reflect the impact of greater social and economic stresses placed on couples trying to adapt to a different environment in which it is harder to meet basic food and shelter needs. Another factor may be less complicated, or complicating, procedures for separation and divorce in New Zealand compared to those in the Islands. These figures suggest that a rising proportion of Pacific children may be experiencing deprivation. This may cover psychological and social needs whose fulfilment requires the presence of both a mother and father, as well as material deprivation. In 1991, 74 percent of Pacific sole parents earned less than $15,000 per annum, with two-thirds not being in the paid labour force but dependent on social welfare benefits. The impact of this high level of dependence on low, state-provided income on the general mental and physical welfare of sole parents and their children is a topic worthy of detailed research.

Another feature affecting family life in New Zealand is the increasing dispersion of family members. Because of rising unemployment in the major urban centres, members of some families have been shifting to small provincial centres or rural orcharding areas to take up jobs. Many have departed for other countries, particularly Australia. Most often, it is young single people and married couples who are shifting, causing change in the size and composition of existing households and the formation of additional, smaller ones. The social impact of this ‘recontouring’ of households and the redistribution of people does not appear to have been researched. However, from a personal knowledge of the process, Pulolotu-Endemann believes that those Pacific people who have had to shift to the smaller centres and rural areas are, generally speaking, worse off than people living in Auckland and Wellington as far as the depth of their own culture-based social support structures is concerned. On the other hand, Pacific people who have moved away from the two major population concentrations have been able to develop organisations that link together people from a range of Pacific cultures. Some of these organisations have been quite successful in identifying specific health needs of the local Pacific people and making representations to health agencies to see that these are addressed.

**PARENTING**

In the Islands it is customary to assign children to the care of other children once they begin to walk, with those adults who are working around the village being expected to play a supervisory role. This allows parents to devote time to other activities, such as gardening. In New Zealand the situation is different. Older children help with the caring of children, but often over a longer period of time. This is because one or both parents may be required to hold several jobs to ensure an adequate income for the family. Because caring for small children can place an unfair burden on older children, who in turn face demands arising from a new way of life, parents sometimes choose shift work so that one parent can remain at home during the day (Social Advisory Council 1985). Part-time, late-night, early-morning paid employment, mostly in unskilled, manual jobs, is a feature of how Pacific women participate in the New Zealand workforce. Such night work can also create problems. A survey of Samoan women engaged in such work indicated they had less time for family responsibilities, and found it difficult to obtain satisfactory child care arrangements (Larner and Bedford 1993).
Metge and Kinloch (1980) have described how children are disciplined. Generally, both approved and disapproved behaviour is rewarded or punished immediately, by a hug or a clip around the ear or by other physical means. Physical punishment is brief, and followed by an indication of affection, to restore the relationship to equilibrium. If physical punishment is prolonged, something has gone wrong. The physical chastisement of children by Pacific parents is an area which intermittently receives much media attention, especially when injuries occur. Ritchie and Ritchie (1993) have expressed the need for a cross-cultural view on child abuse. They note that in all Polynesian societies, status rivalry leads to respect behaviour; and that the need to inculcate respect from the earliest age is the justification given by Polynesian parents for the use of physical punishment in child rearing.

There have been changes in recent years in the nature of the relationship between children and parents. At the Public Health Commission’s meetings with Pacific people in 1993 and 1994, there was continual reference to the greater freedom of choice being exercised by Pacific children in New Zealand, and to the breakdown in parental control. Some parents at the meetings spoke of how little impact they now have in making their children follow their instructions. Others mentioned they now allowed their children to do what they want in some matters in exchange for following the wishes of parents in others. Sole female parents seem to have particular difficulties. Some Samoan sole mothers said they found it difficult to adopt an assertive, disciplining role because it is traditional for men to fulfil this. Other difficulties experienced by parents were attributed, in one way or another, to the influence of European and Black American culture and the adoption of a new lifestyle among the young. The more extreme manifestations include truancy, alcohol and drug use, and departure from home to live in the streets. A trigger for this departure is often physical or sexual abuse (PHC 1994a).

While the contribution of sexual and physical abuse to adverse mental health outcomes is widely recognised, it is difficult to assess the impact without analysing life histories. Such studies are lacking for Pacific people in general, and females in particular. Some of the factors likely to contribute to abuse by men include financial difficulties and unemployment, overcrowding, lack of opportunity for social advancement, and use of alcohol.

**POSITION OF OLDER PEOPLE**

Pacific-born children coming to New Zealand adapt more quickly than their parents and older people to the host culture. Through schooling they pick up and use English more quickly, and participate in a wider range of activities with other people. Similarly, those adults who enter the labour force are more likely to learn new ways and live more comfortably in the new environment than those who do not. In contrast, older Pacific migrants may make very few adjustments, particularly if they come to New Zealand to be with family members rather than to work. Among those older people who have arrived to be supported by their children, there are some who will not gain a good grasp of English, and will never become familiar with all the ways of the host culture. Rather, their life is oriented around their family and the household where much of their time is spent. Pacific people consulted by the Public Health Commission in 1993 and 1994 frequently referred to the non-interactive, often physically inactive, lives of older Pacific people in New Zealand.

With members of extended families in New Zealand undergoing different levels of interaction with the broader society, differences in the acceptance of new values and beliefs can affect relationships between the young and the old. In the Islands, the elderly have a revered and honoured position in families. In New Zealand though, the need for parents to work, and the assimilation of English and the
development of new priorities among children, affects how the elderly are treated at home. There can be a general erosion of respect and reverence paid to them, and a loss of humility in interactions. These changes are clearly perceived as abuse by the Islands-born.

**ECONOMIC SECURITY**

During the last 50 years, Pacific people have been migrating to New Zealand to earn money to fulfil obligations to relatives in the Islands as well as to obtain material benefits for themselves. The availability of unskilled and semi-skilled jobs was essential to this process. Since the mid-1980s, however, economic restructuring has resulted in a contraction of employment opportunities for unskilled and semi-skilled workers. Pacific people have been disproportionately affected by this, especially between 1986 and the early 1990s when unemployment peaked (Brake 1993; Krishnan et al 1993, 1994).

In 1981, 10.2 percent of Pacific males and 10.0 percent of Pacific females in New Zealand were unemployed and actively seeking work. These figures rose to 21.5 and 20.0 percent respectively by 1991 when they were double those for the total population of New Zealand (PHC 1994a). Household labour force surveys conducted by Statistics New Zealand show that the overall unemployment rate for Pacific people peaked in September 1991 at around 30.6 percent, falling to 22.1 percent by March 1994, and 15.3 percent for the quarter ended 31 March 1996 when the rate for Europeans, by comparison, was only 5.0 percent (Statistics New Zealand 1996).

The link between unemployment and mental health has been debated for some time (Ezzy 1993). Generally, overseas studies show that the longer people are unemployed the more damaging it is to their mental health. Their social contacts are restricted; there is a lack of a normal time structure to their day; there is reduced self-esteem, social position and status; and there is increased frustration and humiliation associated with job seeking and rejection (Bethwaite et al 1990).

There is a lack of information on the effect the sustained, high level of unemployment has had on the mental health status of the Pacific population in New Zealand, but it must be considerable, touching all the areas noted above, and affecting especially the ability of men to meet the needs of their families as well as contribute to the activities of their lineages, communities and congregations. Inability to fulfil these functions would undermine the self-esteem of men and their social position. The personal observations of Pulotu-Endemann indicate that unemployment has seriously affected the cohesion of many Pacific families because it has led to greater use of alcohol, more violence, and greater fragmentation of families as members depart for other places in search of work.

Unemployment is only one facet of the economic difficulties experienced by Pacific people in New Zealand since the mid-1980s. For those in employment, or in receipt of state welfare benefits, the levels of income have remained relatively low compared with the total population of the country. In 1991, only 21 percent of Pacific income earners earned more than $20,000, compared with 36 percent of all New Zealand income earners (PHC 1994a).

Pacific people consulted by the Public Health Commission in 1993 and 1994 considered they had experienced a disproportionately high level of hardship during the previous five years. A Quality of Life Survey conducted for the City of Manukau provided an insight into the nature of this hardship. Approximately 53 percent of Pacific people interviewed described their financial situation as ‘bad’ compared with 16 percent of Europeans interviewed; 68 percent indicated they experienced problems meeting their housing costs (Europeans, 50 percent); 68 percent said they could not afford necessary items (Europeans, 29 percent); and 66 percent said they put off visits to doctors (Europeans, 35 percent) (Manukau City 1993).
MEETING CUSTOMARY OBLIGATIONS

Pacific people value hospitality and assisting one another, acknowledging that by giving help they will receive help in return. The majority of Pacific people in New Zealand continue to uphold these values, and provide financial contributions to church and community organisations and activities centred around them. Seen in another way, the contribution of money to churches in New Zealand and in the Islands, the remittance of money to kin in the Islands, the offering of hospitality to relatives and others visiting New Zealand, and contributions for important social occasions such as weddings and funerals, are all necessary for the maintenance of social support structures, expression of cultural identity, social recognition and advancement (eg, to a matai title for Samoans), personal status and self-esteem. As such, the contributions might be considered to be an important protective factor for mental wellbeing among Pacific people, especially men. However, given their low incomes, high rate of unemployment and the needs of their immediate family in New Zealand, Pacific people are faced with a dilemma: to continue to meet their customary obligations at the expense of meeting all immediate family financial needs and future social advancement (eg, in the area of education); or to reduce their customary obligations in order to meet family financial needs better, but in the process endangering their integration with their community.

According to Tukuitonga (1990), many Pacific families have attempted to meet commitments in both directions. He considers this feature has perpetuated an underclass economic existence for many Pacific families in New Zealand. Moreover, because few have budgetary skills, some families live at this low level of existence indefinitely.

Graves and Graves (1985) in their study of Pacific people in Auckland analysed the impact of customary commitments as a stressor in mental health just before the steep rise in unemployment. They compared Pacific people with Europeans living in the same working-class neighbourhoods. The Europeans interviewed exhibited predominantly ‘Type A’ characteristics (ie, self-reliant, arrogant, ambitious, loud and brash, adventurous, adaptable), whereas ‘Polynesians’ were seen as exhibiting mostly ‘Type B’ characteristics (ie, light-hearted, easygoing, unambitious, gregarious, generous, with a lack of time urgency). The investigators concluded that:

... this relaxed, easygoing approach to life could be an important factor in the ability of [Pacific migrants] to sustain a heavy dose of stressful situations in their new urban environment, without even as much as physical breakdown as their European neighbours.

(Graves and Graves 1985: 11)

This conclusion was based on the fact that Pacific people in the study reported fewer health problems than Europeans, being significantly less likely to display the psychological tensions and pressures that manifest themselves in the form of insomnia, nervousness, and a variety of little accidents. A similar finding was reported by Kearns and others in their study of Pacific and European households experiencing serious housing need in Auckland and Christchurch. Despite greater financial problems with housing in these two places, Pacific people reported less stress and mental illness symptoms than European households (Kearns et al 1991).

Surprisingly, Graves and Graves (1985) found that the area of Pacific life that created rather than alleviated stress, and in itself contributed to ill health, was the social support area. Whereas for Europeans relations with authority were a key source of ‘situational stress’, the main sources of stress for Pacific people were money matters and meeting kinship obligations. Detailed analysis showed that although the Samoan community may in itself be helpful to new migrants in buffering against stress, this role was offset by considerable pressure on migrants to reciprocate with monetary contributions that are both costly and stressful in the new environment. Information was provided which showed that the
relative cost of ‘maintaining a good name’ by making contributions is far higher for Samoans than for Cook Islands and other ethnic groups. This may reflect differences in social structure. In Tongan society, for example, there is a hereditary class structure, but in Samoan society matai titles can be earned through continuous fulfilment of obligations and a monetary payment. Samoan men in New Zealand may spend thousands of dollars in pursuit of a matai title, on top of the outlay of substantial sums of money for weddings and funerals. Tens of millions of dollars are remitted from the Samoan community to Samoa every year. According to the Western Samoa Central Bank, Samoans in New Zealand remitted NZ$20 million in the seven months to September 1996, an amount that would be equivalent to NZ$34 per month for every man, woman and child of the Samoan ethnic group living in New Zealand at the time of the 1991 census.

The alternative is not to meet customary obligations, or to reduce financial commitment to a modest level. Gluckman (1977) discussed this option for Samoans in New Zealand, noting that while many of the younger generation in New Zealand resented making gifts and giving money to relatives here, or for them to take back to the Islands, loyalty to the concept of fa’a Samoa (‘the Samoan way’) enforced it. He went on to say that for the younger generation in New Zealand, ‘these individuals must differentiate between their public culture and their private culture, and this may generate anxiety and guilt. Acceptance of the public culture may lead to substantial material sacrifice’. This dilemma has been referred to more recently by Lealaiaulotu (1995b) who noted that despite the rise in unemployment from the mid-1980s, heavy financial demands are still placed by Samoan culture on Samoans in New Zealand. Faalavelave (important events such as weddings, funerals) can occur at any time. To meet them, often in the face of other financial obligations, can result in hardship.

Some families now limit financial contributions for weddings and funerals to a more restricted section of their kin. Such adjustment is especially noticeable among the New Zealand-born. Larner and Bedford (1993) in their survey of Samoan women found that those born in New Zealand were more likely than the Islands-born to have jobs and that their financial commitments tended to be limited to the immediate rather than extended family. They also sent far less money back to Samoa.

USE OF ALCOHOL

The consumption of alcoholic beverages made from juice extracted from the flowering mechanism at the top of the coconut palm (ie, ‘coconut toddy’) has been a traditional feature of community life throughout many of the Islands for generations. However, with the expansion of the cash economy, the importation and local industrial production of alcoholic drinks have increased, as has the level of consumption (Lemert 1976; Stanhope and Prior 1979; Finau et al 1982; Marshall 1987; Hanna and Fitzgerald 1993).

A review of alcohol use in the Pacific Islands indicates that alcohol is consumed mainly by men (especially young men who engage in group drinking bouts), and that ‘typically, Pacific Islanders drink to get drunk’, with drunkenness being neither strongly stigmatised nor viewed as unpleasant by most drinkers. Also notable is that many men drink heavily from their late teens until sometime in their thirties, at which point they either cease drinking entirely or reduce radically the quantity and frequency of their consumption. In this respect, those at highest risk from alcohol-related problems in the contemporary Pacific are young men from approximately their mid-teens to their mid-thirties (Marshall 1987).
The prevalence of alcohol use is greater in New Zealand than in the Islands, according to studies conducted by Stanhope and Prior (1979), Banwell (1986) and Neich and Park (1988). This appears to reflect greater accessibility of alcohol and more common use within the host culture itself. Among Cook Islands people in New Zealand, the prevalence of drinking is highest among those who are New Zealand-born. Sometimes there are even differences within nuclear families, with male members born in the Islands refraining from alcohol but those born in New Zealand using it (Banwell 1986). Nevertheless, the overall proportion of Pacific people in New Zealand who use alcohol remains lower than the figure for Europeans (Casswell 1980). In the 1992/93 Household Health Survey (Statistics New Zealand and Ministry of Health 1993), 53 percent of Pacific people interviewed said they never drank alcohol, compared with 21 percent of Europeans interviewed.

As in the Islands, the proportion of Pacific women in New Zealand who drink is relatively low compared with men. In the 1978 national survey on alcohol use, 57 percent of Pacific women interviewed indicated they abstained (compared with only 12 percent of European women in the sample) (Casswell 1980); while Finau and others (1982) reported in the early 1980s that only 2 percent of Tongan women and 8 percent of Tokelauan women studied used alcohol in New Zealand. Drinking appears to be more common among Cook Islands women (Banwell 1986).

A possible shift towards greater use of alcohol on a regular rather than occasional basis may have been picked up in the 1992/93 Household Health Survey. This survey found that of the 47 percent of Pacific people interviewed who said they drank, 50 percent drank 61–199 grams of alcohol in the previous seven days compared with 37 percent of the European drinkers surveyed (Statistics New Zealand and Ministry of Health 1993).

The pattern for male drinking to decline in the early thirties also appears to be superseded in New Zealand, with a lengthened age range for the male population being at risk from alcohol-related problems. Statistics indicate a relatively high rate of admissions to psychiatric hospitals among Pacific men over the age of 35 years for alcohol dependence or abuse (see Table 4.3).

In 1993, Pacific people consulted by the Public Health Commission expressed concern about the use of alcohol by school children (PHC 1994a). Unfortunately, few statistics are available. However, in 1987 it was found that 16 percent of Pacific secondary-school students interviewed throughout New Zealand were currently using alcohol, a figure well below that of 54 percent among European students interviewed (FADE 1988).

Banwell (1986) and Neich and Park (1988) have provided detailed accounts of the community and family disruption caused by alcohol use as reported by Cook Islands and Samoan women in Auckland. Samoan women referred to the breakdown of relationships across extended families and between brothers and sisters caused by the excessive drinking of males on social and other occasions. The Cook Islands women noted that the use of alcohol is very much part of Cook Islands socials, including fund-raising events, but sometimes leads to brawls, beating of wives, sexual violence, family disputes and shortage of money. The women interviewed by Banwell in 1986 considered that alcohol problems existed in the Cook Islands community in Auckland.
**USE OF DRUGS**

The discussion here is limited to the use of marijuana and painkillers, and solvent abuse. Information on the abuse of prescription drugs by Pacific people has not been found. While there is a lack of reliable information on drug use among Pacific adults compared with young Pacific people, it is not to be assumed from the discussion that drug use is a phenomenon associated entirely with the young. Adults with drug dependence or abuse problems feature in admissions to psychiatric hospitals. Pulotu-Endemann (personal observation) considers that five years ago Pacific people admitted for substance abuse were New Zealand- rather than Islands-born; now the difference between the two groups has become blurred. The same change has been occurring among admissions for alcohol abuse.

In 1987, information on drug-taking was obtained in a nationwide random survey of 10 percent of all secondary-school students throughout New Zealand by the Foundation of Alcohol and Drug Education (FADE 1988). This indicated that students of Pacific ancestry made far less use of painkillers and marijuana than their European counterparts. Whereas 41 percent of European students were currently using painkillers, and 14 percent marijuana, the figures for Pacific students were 24 and 6 percent respectively. Three percent of Pacific students were using solvents, compared with 2 percent of European students.

Pacific children who have left, or been forced, from their parental homes, temporarily or permanently, make up part of the ‘street kid’ population of the major cities of New Zealand, and solvent abuse is a feature of this culture, far more so than among children still attending secondary schools. In 1985 a study of solvent abuse among groups of ‘street kids’ in Hamilton reported that Pacific and Māori children aged 9–16 years made up a high proportion of the groups (Britt et al 1985), and this appears to be the case elsewhere as well. The Hamilton study found that children in such groups using solvents regularly ‘tend to have most of the characteristics of gross social disadvantage, such as low socioeconomic status, unemployment, belonging to a large family, overcrowding, a family history of alcohol abuse and anti-social behaviour, disorganised homes and identification with an often discriminated against ethnic group’. The solvent users were also described as having low self-esteem, poor educational achievement, a high level of truancy, a sense of hopelessness and failure, being apathetic and having no future orientation. In this situation, habitual use of solvents is often socially determined; that is, the use of them is part of a distinctive subculture and provides the participants with a sense of belonging to a group (Britt et al 1985).

Recently, Pacific churches and parents have expressed concern about the need to address the problem of drug abuse among adolescents and young people in their twenties. Unfortunately, there is a lack of statistical information available on the extent of drug abuse among such Pacific people. Data on first admissions to psychiatric hospitals that show that between 1989 and 1993 five Pacific people 19 years of age and under, and 32 aged 20–34 years, were diagnosed for drug dependence or abuse (and eight aged 20–34 years for drug psychoses), are not particularly useful in gauging the extent of the problem. Pacific children and young people with a drug dependence or abuse problem are less likely than European children to be presented for clinical diagnosis and treatment.
VIOLENCE

Statistics suggest that the incidence of violence in the Pacific population in New Zealand is comparatively high. In 1991 and 1992, about 12 percent of all persons convicted of violent offences in New Zealand were of Pacific ethnicity, with 97 percent of these offenders in 1992 being males (PHC 1994a). In 1991, Pacific males aged 20 years and over made up only 3.6 percent of the equivalent section of the total New Zealand male population.

Women’s refuge statistics are also revealing. In 1992, 9.5 percent of all women admitted to a refuge of the National Collective of Independent Women’s Refuges were of Pacific ethnicity (NCIWR 1992). Whereas European women aged 15–50 years and children aged 0–14 years outnumbered Pacific women and children by a ratio of 11.6:1 in the 1991 census, the ratio of European to Pacific people admitted to a refuge in 1992 was a lower 3.7:1. Most abusers are either the husband or partner (80 percent of cases), followed by fathers and brothers (PHC 1994a). While the collective helps women to obtain non-molestation orders and new housing, statistics on what happens to Pacific women leaving refuges are not available. Another deficiency, which is acknowledged by the collective, is that there is an insufficient number of Pacific workers in the refuges.

Ritchie and Ritchie (1993) consider that Islands groups do differ in the way and the extent to which aggression is expressed. They note that traditionally the people of the ‘high islands’ (Samoa, Tonga, Fiji) all had cults of warfare, with tales of heroism, the aggrandisement of aggression, and in some cases human sacrifice and cannibalism. The people of the atolls, however, with their tiny populations, were forced to maintain good relationships with one another because they had nowhere else to go, and hence never developed these cults. While all this is in the past, Ritchie and Ritchie believe this may go some way to explaining why the rates of violence of recent immigrants to New Zealand from atoll cultures such as the northern Cook Islands, Tokelau and Niue are below those for people from the ‘big islands’.

For Samoa, Freeman (1983) documented high rates of assault, rape, murder and other forms of aggression. Keene (1978) attempted to provide a sociocultural explanation for Samoan aggressive behaviour, looking at child-rearing practices and frustrations generated by social patterns. According to Keene, parents provide the models for aggression by spanking children whenever they engage in irritating behaviour and then quickly following this up with displays of affection. Commenting on Keene’s investigation, Howard (1986) considered that parents ‘generate high levels of anger through frequent and severe punishment, and they link pain and love, violence and pleasure in the child’s mind’. Aspects of Samoan social structure have also been considered to influence the level of violence. In Samoa, people live under the tight control of the matai leadership structure, but there are flashpoints of anger, particularly when roles are ambiguous and there are affronts to the self-esteem of people attempting to achieve social position and matai status through various endeavours. Youths in Samoa are told that the path to power is service, but when that path is blocked, then frustrations occur that prompt violence.

In New Zealand some other factors apply. Financial difficulties, the strain in meeting customary obligations, discrimination, racial comments, alcohol abuse and general problems associated with adjusting to the new environment probably all contribute to violent acts within and outside the home, although hard evidence to attest the respective roles is difficult to find. The difference in decision-making and social control in New Zealand may also contribute. On shifting to New Zealand, many young male migrants are separated from their elder leaders who impose controls and make decisions,
and they are required to make more decisions themselves. The lack of social control by leaders on their behaviour, as well as frustration arising from difficulties experienced in making decisions, may lower the threshold for violence. Both Gluckman (1977) and Howard (1986) refer to this feature in relation to Samoans in New Zealand. Howard notes that ‘... aggressive behaviour among Samoan immigrants to ... New Zealand is almost legendary’, and goes on to observe that when Samoans immigrate, the authority structure, including parental authority, is eroded, so that appropriate channelling of underlying anger may not occur, the result being increased variability in ways of handling anger, and greater frequency of socially inappropriate outbursts of hostility.

Anecdotal evidence collected by Pulotu-Endemann suggests violence in the home has increased in recent years. It is not uncommon to meet middle-aged women who have experienced violent acts from their husbands recently, for the first time in their married life, and who attribute them first and foremost to the rise in unemployment and the diminished self-esteem of their husbands. The increase in violence was also reported by Pacific women interviewed by Larner and Bedford who found that, increasingly, they are often the main income earners in households, and that husbands are bitter that their own role as income earners has declined (Larner and Bedford 1993; Bedford 1993). In a study in Tokoroa, Kingston Morrison Ltd (1993) reported that budgeting problems were a key cause of domestic violence, and that these problems were exacerbated significantly by Pacific women gambling on horses and on ‘housie’.

SUICIDE

Familial and social difficulties are a major cause of extreme forms of behaviour among Pacific people (Kinloch 1985). Suicide is one of these behaviours, and often may be resorted to in an effort to atone for seriously failing the family or kinship group. In a review of the literature for Samoa, Howard noted that an analysis by Oliver of inquest records on suicide indicated that the precipitating event in half the cases was a scolding or a rebuke, with parents of the victim being the triggering agent in 55 percent of the cases (Oliver, cited in Howard 1986).

Much of the Pacific literature on suicide has focused on the Samoan population. The suicide rates in both Western Samoa and American Samoa have climbed during the last two decades because of ‘modernising influences’, with the rates being highest among males aged 15–34 years (Howard 1986).

Despite the major changes Pacific people coming to New Zealand have had to endure, and especially their relatively poor economic circumstances compared with Europeans, the suicide and attempted suicide statistics for Pacific people in this country remain lower when compared with those for the total New Zealand population. Between 1988 and 1992, the suicide rates for Pacific males and females, age-standardised to Segi’s World Population, averaged 8.5 for males and 2.0 for females per 100 000 population, both being approximately half those for the remainder of the population excluding Māori (see Chapter 23). From 1989 to 1993, 37 Pacific people died from suicide, representing 1.6 percent of all suicides in New Zealand, a share well below the 4.9 percent share the Pacific population had of the national population in 1991.

Among young people, the rates are higher for males; but the rates among older people are much higher for females (see Table 4.2). The higher rate for older females is quite different from the pattern for the total New Zealand population. However, with the exception of females aged 20–34 years, all rates are below those for the different age groups in the national population.
Table 4.2: Deaths from suicide (ICD codes E950–959). Average annual rates per 100 000 population over the five-year period 1989–1993

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–19</td>
<td>3.8</td>
<td>0</td>
<td>2.0</td>
</tr>
<tr>
<td>20–34</td>
<td>0.9</td>
<td>9.9</td>
<td>5.7</td>
</tr>
<tr>
<td>35 plus</td>
<td>3.1</td>
<td>12.8</td>
<td>8.0</td>
</tr>
<tr>
<td>Total New Zealand population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–19</td>
<td>8.1</td>
<td>1.2</td>
<td>4.7</td>
</tr>
<tr>
<td>20–34</td>
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<tr>
<td>35 plus</td>
<td>24.3</td>
<td>7.1</td>
<td>15.3</td>
</tr>
</tbody>
</table>

Note: Age data from the 1991 census were used to calculate the rates.

Source: New Zealand Health Information Service

The rates for males are well below those of 71.0 and 75.6 per 100 000 per annum reported for males aged 15–24 and 25–34 years respectively, living in Western Samoa between 1981 and 1983 (Howard 1986).

There are two hypotheses to explain the relatively low suicide rates in New Zealand. One, with reference to the Samoan population, lies in changes in the hearth area. It is considered that the dramatic rise in suicide among males in Western Samoa results from blocked social mobility; that is, that rapid population growth, a higher proportion of dependents, and a stagnant economy, along with higher aspirations but reduced employment opportunities and opportunities for advancement within the traditional status system, have contributed to greater frustration, and a greater sense of relative deprivation (Howard 1986). This being the case, it might be hypothesised that residence in New Zealand removes some of these obstacles. The second hypothesis is that the rates for Pacific people in New Zealand are affected by the misclassification of ethnicity. It is known that undertakers responsible for providing information for the registration of deaths sometimes misclassify Pacific people as Māori, and vice versa (PHC 1994a).

Factors that are particularly important in New Zealand in prompting suicide, appear to centre around unresolved family conflicts, inability to meet family and social obligations, shame resulting from misdeeds, sexuality and sexual conduct, failure to meet unrealistic expectations, low self-esteem, abuse, conflict between traditional ways and adopted new ways, and constraints or demands placed by the church. Alcohol consumption also has a link with suicide. Macpherson and Macpherson (1984) found that in some instances a young Samoan male contemplating suicide may drink heavily beforehand; in other cases, use of alcohol may result in behaviour for which the person is remorseful and atones by committing suicide; while for some young people who commit suicide the trigger may have been depression following a bout of drinking.
It is difficult to measure the extent of mental illness in the Pacific population of New Zealand. Because of the small size of the population, people of Pacific ancestry have not featured very often in community-based surveys of mental illness prevalence, particularly those that have been conducted in the South Island where relatively few Pacific people live. See also Chapter 1.

Between 1989 and 1993, 574 Pacific people were admitted to psychiatric hospital units and institutions, 347 of whom were males and 227 were females. Comparatively few of the Pacific people admitted were under 14 or over 45 years of age, the bulk being from the young to middle adult population. The age group 20–34 years, which in 1991 comprised 27 percent of the Pacific Islands ethnic group population, provided 57 percent of all Pacific admissions between 1989 and 1993; while the population over the age of 35 years (24 percent of the population) accounted for 27 percent of the admissions.

The diagnoses at first admission to psychiatric hospital units and institutions for Pacific males and females are shown by broad category in Figures 4.1 and 4.2.

**Figure 4.1: Mental health first admissions for Pacific males, by admission diagnosis, 1989–1993**

![Pie chart showing mental health diagnoses for Pacific males](Image)

Source: New Zealand Health Information Service

**Figure 4.2: Mental health first admissions for Pacific females, by admission diagnosis, 1989–1993**

![Pie chart showing mental health diagnoses for Pacific females](Image)

Source: New Zealand Health Information Service
When the Pacific people’s first admission profiles for 1989 to 1993 (Figures 4.1 and 4.2) are compared with those for the total New Zealand population in 1993, it is found, in the case of Pacific males, that diagnoses for schizophrenic conditions (the leading diagnosis covering 20 percent of admissions) are far more common than among diagnoses for all males (12 percent); but that admissions for alcohol dependence or abuse (17 percent compared with 20 percent) and neurotic and other depressive disorders (4 percent compared with 10 percent) are less common. According to Bridgman (1993), the low proportion of admissions for drug and alcohol abuse possibly reflects the strength of Pacific families and the power of Pacific churches in limiting substance abuse.

For Pacific women, diagnoses for both affective psychoses (23 percent) and schizophrenic disorders (19 percent) are far more common than is the case for all New Zealand women first admissions (ie, 20 and 8 percent respectively). On the other hand, stress and adjustment disorders (7 percent) and neurotic and depressive disorders (5 percent) are much less common among Pacific women than all women admitted (ie, 12 and 16 percent). Proportionately fewer Pacific men, also, are admitted for stress and adjustment disorders (5 percent) than is the case for all New Zealand men (ie, 9 percent).

The occurrence of non-diagnoses in the first admissions statistics for Pacific people is comparatively high, and has been rising. However, this category also includes persons referred by the courts for assessment who are found not to be suffering from a mental disorder.

There are some important differences between the age groups. They are evident in the rates for particular diagnoses listed in Table 4.3. It will be noted that the rates for diagnosed cases of schizophrenia, alcohol and drug dependence and abuse, and neurotic disorders, are highest in the Pacific population aged 20–34 years. However, most of the rates are not as high as those for the total New Zealand population. The exception is schizophrenia, with comparatively high rates being recorded for Pacific admissions over the age of 20 years.

There is an element of bias in the admission statistics. People severely ill with a psychosis, especially schizophrenia, are more likely than those with far less severe illnesses to become known to the system. In addition, Pacific people’s admission rates for severe illnesses are increased – to an unknown extent – by the referral of people living in the Islands to New Zealand for treatment. The admissions statistics do not refer to dual diagnoses. From discussions with staff, Pulotu-Endemann (in Ministry of Health 1993) found that a proportion of Pacific people diagnosed as suffering from schizophrenia sometimes also have a drug (marijuana) dependence problem and those with affective psychoses sometimes also have an alcohol dependence problem.
### Table 4.3: Rates for diagnoses of leading disorders among first admissions to psychiatric hospital units and institutions, by major age group, Pacific (P) and total New Zealand (NZ) population

Average annual rates per 100000 population over the five-year period 1989–1993

<table>
<thead>
<tr>
<th>Diagnosis/ disorder</th>
<th>Males P</th>
<th>Females NZ</th>
<th>Males P</th>
<th>Females NZ</th>
<th>Males P</th>
<th>Females NZ</th>
<th>Males P</th>
<th>Females NZ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>3.8</td>
<td>6.5</td>
<td>2.0</td>
<td>2.4</td>
<td>44.2</td>
<td>36.4</td>
<td>20.7</td>
<td>17.4</td>
</tr>
<tr>
<td>Affective psychoses</td>
<td>3.4</td>
<td>3.2</td>
<td>2.5</td>
<td>4.7</td>
<td>28.2</td>
<td>26.1</td>
<td>24.8</td>
<td>32.0</td>
</tr>
<tr>
<td>Stress/adjustment</td>
<td>–</td>
<td>5.2</td>
<td>1.5</td>
<td>6.4</td>
<td>14.1</td>
<td>22.3</td>
<td>7.4</td>
<td>30.6</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>2.9</td>
<td>7.4</td>
<td>0.5</td>
<td>3.1</td>
<td>23.5</td>
<td>70.7</td>
<td>6.6</td>
<td>27.6</td>
</tr>
<tr>
<td>Drug dependence or abuse</td>
<td>1.0</td>
<td>7.4</td>
<td>1.5</td>
<td>5.2</td>
<td>17.9</td>
<td>38.6</td>
<td>10.8</td>
<td>22.2</td>
</tr>
<tr>
<td>Neurotic and other depressive disorders</td>
<td>1.0</td>
<td>3.2</td>
<td>–</td>
<td>3.1</td>
<td>6.6</td>
<td>20.0</td>
<td>6.6</td>
<td>27.6</td>
</tr>
<tr>
<td>Paranoid states</td>
<td>–</td>
<td>0.3</td>
<td>0.8</td>
<td>0.1</td>
<td>0.9</td>
<td>3.2</td>
<td>0.8</td>
<td>2.1</td>
</tr>
<tr>
<td>Other personality disorders</td>
<td>2.4</td>
<td>5.4</td>
<td>0.5</td>
<td>6.0</td>
<td>1.9</td>
<td>10.4</td>
<td>2.5</td>
<td>11.9</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>5.2</td>
<td>6.0</td>
<td>2.5</td>
<td>2.4</td>
<td>23.5</td>
<td>20.7</td>
<td>9.9</td>
<td>9.0</td>
</tr>
<tr>
<td>Total admissions</td>
<td><strong>26.9</strong></td>
<td><strong>56.1</strong></td>
<td><strong>17.4</strong></td>
<td><strong>42.5</strong></td>
<td><strong>188.2</strong></td>
<td><strong>382.6</strong></td>
<td><strong>105.2</strong></td>
<td><strong>209.5</strong></td>
</tr>
</tbody>
</table>

**Note:** Age data from the 1991 census were used to calculate the rates.

**Source:** New Zealand Health Information Service
AVOIDANCE OF OR DELAY IN SEEKING CLINICAL TREATMENT

The relatively lower first admissions rates for Pacific people, in contrast to those for Europeans, indicate that Pacific people with mental illness are less likely to seek clinical assessment and care. This delay in presentation for clinical treatment contributes to two other features evident in the admissions statistics, namely that the ratio of committed to voluntary admissions to psychiatric hospitals is relatively high compared with that for Europeans, as is the level of readmissions for psychiatric care (Pulotu-Endemann 1994). According to Bridgman (1993), a quarter of all Pacific people’s first admissions in 1991 were through a law enforcement agency compared with 9 percent of European admissions. Bridgman observed the rates of readmissions were rising faster than those for first admissions among Pacific people, whereas they were falling for Europeans. Psychotic disorders featured prominently among the diagnoses for readmitted Pacific people (77 percent of all readmissions in 1991 compared with 56 percent of those of Europeans), with the predominance of such conditions among those readmitted being much higher than among first admissions (ie, 45 percent).

The high levels of committal and readmission reflect a general tendency of Pacific people, especially the Islands-born, to conceal the sickness of a member of their family or use traditional methods or the help of church clergy in an attempt to cure the sickness, and only present the member for formal clinical treatment as a last resort or when their condition has reached a stage when the family itself feels threatened.

On one level, Pacific families who have an ill member may feel ashamed and prefer to keep quiet about the matter, especially if the family is traditional in its beliefs and the illness is not seen as originating in the sick individual alone but is regarded as resulting from the intervention of a spiritual force or a deterioration in social relationships between members of the kin group. On another level, there is the quite different culture of the Western health system with which Pacific people are unfamiliar and may view in a negative way. There is a reluctance to hand over family members for care because they become separated from their family in an alien environment and because clinicians deal primarily with the individual concerned, whereas illnesses for Pacific people are family matters first and foremost. In addition, Pacific people may find it difficult to understand the clinical terminology for mental illnesses of the other culture when they have their own, and attribute the cause to a quite different set of factors (Ma’ia’i 1986; Barker 1993; Ma’ia’i 1994). It is difficult to talk to clinicians about spirit possession, for example, as they are not seen as the appropriate people to cure such conditions, this being the preserve of traditional healers and church leaders.

Traditional healers belonging to the various ethnic groups of the Pacific population are scattered throughout New Zealand. In the case of the Samoan community, particular healers (taualaitu) specialise in the treatment of particular types of illnesses for which elders have identified a specific spiritual cause. As certain spirits are identified with certain matai or families, those possessed by these spirits seek out the appropriate matai to conduct the exorcism. For some illnesses, the remedies provided may include plant matter, pills and massaging. Better-educated Pacific people consider the cures offered not only to be ineffectual but sometimes very dangerous, and that the activities of traditional healers should be monitored. The practice of massaging is less harmful from a physical point of view.

Cook (1983) has described massaging among Samoans, who consider that various illnesses result from the displacement of one’s life essence (to’oala) from its normal location in the upper abdomen to various parts of the body where it may induce pain and other symptoms. This displacement is caused
by occurrences and behaviours that disrupt the normal order of things, such as acting immorally in ways to disrupt interpersonal relations within the family or failing to carry out one’s responsibilities properly towards kin and ancestors. It is believed that massaging, which is usually performed by an older family member and is characterised by directional stroking, returns the to’oala of the patient back to its correct position. Often, massaging is the first step in the healing process, and is the most prevalent treatment (Cook 1983).

According to Howard, quite aside from the relative merits or hazards of traditional Pacific views towards illness and treatment – for which, he argues, cases can be made in either direction – these views do provide people with a coping strategy, and act to strengthen family solidarity and ‘thus reinforce the dominant coping mechanism of kin-reliance’ (Howard 1986).

Pacific people have a pragmatic approach to healers. If a condition does not respond to treatment, an alternative treatment by another healer is sought. The longer the illness remains, the more likely it will be regarded as a sign that something is wrong within the family. A family meeting will be held to identify a possible cause. Those who have grudges against other family members air their feelings, and through confessions and prayers work towards re-establishing family harmony (Cook 1983). Clergy may be involved in this process, and also practise exorcism based on Bible readings for those whose illnesses are considered to result from spirit possession. If the illness continues, or the behaviour of the person concerned becomes unmanageable, then assistance from clinical psychiatric services is sought. As a result, a high proportion of Pacific people receive modern medical treatment at a late stage in their illness, and may enter psychiatric institutions as committed patients.

**SOME GAPS IN INFORMATION**

There are some gaps in information that need to be addressed in order to develop a better picture of factors affecting the mental health of Pacific people. Some of these areas are detailed below.

- Far more has been written about the beliefs and practices of the Samoan people than those of the Cook Islands, Tokelau, Niue, Fiji, Tonga, et cetera, concerning mental wellbeing. Published information about these other groups is required before it will be possible to present a balanced account of the beliefs and practices of Pacific people.

- Pacific sole parents are a rapidly growing group, and research on their circumstances and needs with respect to their mental wellbeing and that of their children is warranted. Other sections of the Pacific population whose mental health needs require research are women and children who enter refuges, ‘street kids’, and men in prison.

- Despite the rapid rise and high level of unemployment among Pacific people, there has been a lack of research on the effect this has had on their mental health. Any study in this area should be combined with a study on the economic and social circumstances of families in the widest sense, as, in general, the Pacific community is especially disadvantaged with respect to employment, income, housing, health, and erosion of culture, all of which, on top of financial commitments to kin and church, place considerable stress on the population.

- There is a need for information on the prevalence of mental illness among Pacific people. There is also a need for current information on the extent and nature of drug and alcohol use, abuse, and dependence.
• There is a need for information on violence among Pacific people, focused around both cultural aspects and the stressors in New Zealand.

• Research is required to identify the extent of the use of traditional healers and community mental health services, and the effectiveness of these services in correctly meeting needs. As part of the research, some attempt should be made to assess the number of mentally ill people who are hidden by family members and are not presented to either the health services or to traditional healers.

In all the areas noted above, research needs to produce information for each ethnic community within the Pacific population, and to identify differences between the Islands-born and the New Zealand-born.

**PRIMARY PREVENTION AND MENTAL HEALTH PROMOTION**

The preceding discussion indicates a wide range of factors affect the mental health of Pacific people in New Zealand. Many centre around sociocultural adjustment to the new environment, and difficulties arising from relatively high unemployment and low incomes.

Very little can be done to address all the sociocultural and economic factors directly, in the short term. For instance, while it is recognised that low incomes and unemployment are key economic factors influencing mental health in one way or another, improvement in these two areas is largely dependent on an improvement in educational attainment. Rather, it appears that the primary focus at present from a public health perspective needs to be on mental health promotion directed at:

• assisting and encouraging programmes that will lead to the modification of behaviours that create a risk for mental wellbeing

• encouraging early clinical detection and treatment of mental illnesses among Pacific people – a need which is clearly evident from the statistics concerning committals and readmissions to psychiatric hospitals.

There are a number of risk behaviours by some members of the Pacific communities that should be amenable to change. These include drug and alcohol abuse and deliberately self-harming behaviour among young people; poor parenting, gambling, lack of good money management, drug and alcohol use and violence among male adults; poor parenting, gambling, and lack of good money management among adult females; inactivity among older people; and reluctance to present those who are mentally ill for treatment and residence outside the home.

In recent years there has been a rapid growth in advisory services developed and operated by Pacific people’s organisations for the Pacific population in New Zealand. These services have been addressing many of the problem social and economic areas noted above. In Auckland and Wellington, for example, a variety of Pacific trusts and community health services have been offering preventive workshops in sexual and physical abuse, family violence, anger management, teenage pregnancy, substance abuse, budgeting skills, gambling addiction, and the needs of the elderly. Advice is also provided to enhance both family support and youth support. Some of these organisations cater for the needs of particular Islands groups; others focus on all Pacific people; and while some are a service offered by churches, others are independent of them. A list of the Pacific organisations providing advice and holding preventive workshops has been compiled by North Health (1996), while the Ministry of Health intends reissuing a list for all centres throughout the country.
Although the number of Pacific people’s social and health services has been growing, there does not appear to have been any overall assessment of the impact they are making in improving the mental health of Pacific people, although such an assessment might be premature given the recent establishment of many of the services.

In the past few years, Pacific people in New Zealand have emphasised that they wish to see mental health services and mental health promotion programmes oriented in a more culturally appropriate way to better serve their needs (see Ministry of Pacific Island Affairs 1993; Pulotu-Endemann 1994; Crawley et al 1995; Lealaiauloto 1995b; Mason et al 1996; Ministry of Health 1996). Some general points that have been made are listed below.

- Clinical services and workshops on mental health promotion need to be focused more on the family group rather than the individual.
-Clinicians need to become more aware of the cultural beliefs and family-based decision-making processes if they are to provide a receptive environment that would encourage more Pacific people to present for clinical treatment, and especially at an earlier stage in their illness.
- Services need to come to Pacific families. Home-based services would be appropriate in cases where there is a reluctance to present family members early – or at all – for clinical assessment because of a fear they will be separated from the family while they are treated.
- There is a need for more accessible, appropriate information explaining mental illness and the need for early presentation, and what to do about drug and alcohol use, violence and so on, written in Pacific languages. This should include material suitable for use in workshops (brochures, charts, videos), and messages in the media.
- More Pacific people need to be involved in mental health promotion work and in the identification of illness within families. For this to occur, there needs to be increased training and employment of Pacific mental health workers.

The latter point is critical. Lealaiauloto (1994) has emphasised that while mainstream mental health services are currently the only mental health services available to Pacific people (excluding traditional healers), these services do need more trained Pacific staff and support from the Pacific community. There is also a shortage of Pacific people trained in mental health working in community mental health centres.

It is important when considering mental health promotion programmes to recognise a continuum of circumstances among Pacific people.

Church-based workshops and the preparation of material in Pacific languages may be a useful avenue for the delivery of mental health promotion messages for Islands-born people. However, a different mechanism for mental health promotion will be required for the New Zealand-born, perhaps focused more through the electronic media, because fewer New Zealand-born attend churches or know their Island language, and a higher proportion have received an advanced level of education.

It may be difficult for the Islands-born, who hold to traditional views about the cause and appropriate treatment of mental illness, to accept the need to change certain risk behaviours and present earlier for clinical treatment. As Kinloch (1985) observed in respect of the traditional Samoan view, ‘health is not seen as something which can be promoted, neither is sickness seen as something that can be prevented or avoided’. This being the case, the New Zealand-born, at least among Samoans, may be the section of the population most receptive to mental health promotion messages.
REFERENCES


Wellington Postgraduate Medical Society and the Wellington Hospital Epidemiology Unit with support from The McKenzie Education Foundation. Wellington: Wellington Postgraduate Medical Society.


