

What Pacific people think of online mental health information

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Abstract

The purpose of this research was to examine how the attitudes and beliefs of Pacific people impact on their propensity to use online mental health service www.depression.org. The mental health of the Pacific population in New Zealand is concerning - there is a real need to address this health concern. One method of doing so is through online mental health information for support and self-help. Little has been documented about the attitudes, perceptions and propensity of Pacific people to use online mental health information.

Data was collected through means of a questionnaire and a paired discussion with Pacific participants. The findings revealed mixed opinions amongst the participants about their view of online mental health information due to place of birth, experiences and language. We conclude that the attitudes, beliefs and propensity of Pacific people to use online health resources are dependent on their upbringing, experiences and cultural values. This research is exploratory and therefore more research is required to gain a reflective understanding of how Pacific people view online mental health resources.

Keywords: mental health, Pacific, culture, etherapy.

1 Introduction

According to the first mental health survey in New Zealand in 2006, Pacific people have been reported to experience mental health disorders at higher levels compared to the general population (Browne et al., 2006, Agnew et al., 2004). With the researcher being of Samoan ethnicity, it was with great interest and curiosity that the topic of e-mental health be looked into to gain a Pacific perspective. Pacific people appear less likely to use mental health services and make mental health visits in comparison with the general population (Browne et al., 2006). Although there may be varying issues behind the underutilisation of mental health services, little has been documented about Pacific people and the usage of online mental health information and/or services (Finau, 1994).

A major benefit of online mental health information is that it allows one to overcome geographical barriers and access health information/services more readily (Cline

and Haynes, 2001). The Internet allows the search for mental health information in the privacy and discretion of an individuals home or other private spaces. (Cline and Haynes, 2001, Griffiths et al., 2006, Wellman and Haythornthwaite, 2002). If people are able to easily access mental health information and/or services online and privately, then are Pacific people doing so and what obstacles do they face? The purpose of this research was to examine how the attitudes and beliefs of Pacific people impact their propensity to use an online mental health service.

The website chosen for our research was www.depression.org.nz (see Figure 1) fronted by Sir John Kirwan, a well-known All Black, and has himself experienced depression (Kirwan and Thomson, 2010). The site is an interactive online service based on cognitive behavioural therapy, which is widely used for the treatment of depression and other mental illnesses. Currently, four types of mental health interventions exist that can be delivered online (Barak and Grohol, 2011):

1. Psycho-educational sites providing information only
2. Online counselling and therapy, where the patient and therapist use the Internet to communicate
3. Online self-help support groups and blogs
4. Interactive self-guided interventions.

An interactive self-guided intervention is defined as ‘a technology, most often a website, that offers an individual the opportunity to interact with a structured, self-guided software program online that steps them through a program of self-help. These programs are usually drawn from the cognitive-behavioral literature and offer interactive exercises to the user.’ (Barak and Grohol, 2011)[p.18]. We chose *The Journal* (website) as an example for Pacific people to review in order to examine how their attitudes and beliefs impact their propensity to use online mental health services.



Figure 1: Screenshot of www.depression.org.nz

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The current form of the website was launched in June 2010 as a central component of the New Zealand National Depression Initiative. This is a multimedia campaign that creates awareness and understanding of depression and guides people towards the website for help. The website provides further in-depth information and education about depression and available services. The website also has an integrated self-management program that users can sign up for called 'the Journal'. The Journal guides users through a sequence of evidence based lifestyle changes, and aims to develop problem solving skills. The Journal includes a range of expert advice interviews and integrated animation. In addition John Kirwan acts as a coach or guide connecting each component and facilitating the discussion of key issues with psychiatrist and psychologist experts. An integrated clinical support component Ia for those who wish to use it by clicking on the link provided. The Journal contains many of the components of e-therapy but is described as an e-learning programme; it aims to complement other services and forms part of a broader integrated stepped care model.

2 Methods

Since this was an exploratory study, we chose to use a qualitative approach to seek the 'why' and 'how' aspects of the topic (Denzin and Lincoln, 2005), and therefore build a richer picture surrounding the research question. This approach provides opportunities to access in-depth conversations and to gain insights and information from participants (Silverman, 2001).

Ethics approval was granted on 2 November 2011 by the Northern Y Regional Ethics Committee (Reference Number: NTY/11/EXP/061). The research was conducted as part of the first author's Masters thesis. Participants were recruited and data gathered over a three month period in 2011.

The overall research project's methods consisted of a systematic literature review on mental health, e-therapy, online health information, and Pacific people; a set of interviews with five key informants; and interaction with four Pacific island volunteer participants who completed a questionnaire and interacted with the researcher in paired interviews (described below). The key informants included a consultant psychiatrist (specialist in Pacific islander mental health), two general practitioners from primary care, the Chief Executive Officer and Director of Interaction (social marketing and design) of two of the organisations that established the website. For the purpose of this article, we are reporting on the data collected from the four participants' questionnaires and interviews.

To be included in the study, participants were required to meet all of the following eligibility criteria:

- Pacific ethnicity
- 24 – 45 years of age
- Able to read, speak and understand English to participate in the survey and understand the content presented for paired discussion with the researcher (first author)
- Not already be diagnosed with a mental illness as an ethical concern

- Be available for approximately 1.5 hours to complete the questionnaire and participate in the paired interviews.

Initial attempts at 'conventional' recruitment activities were not productive, e.g. an advertisement on notice boards at churches and word of mouth recruitment through the researcher's network. A more directive approach was used in which an invitation letter was distributed to the friends and family members of personal friends through an acquaintance of the researcher (first author). The purpose of sending the letter through an acquaintance was to overcome the 'friend get friend' power and the likelihood that the researcher knew a participant personally. People who were willing to participate contacted the researcher and were screened for eligibility. Once it was established that a participant met the eligibility criteria and was still willing to participate, a convenient time for the participant to meet up at their house or location of convenience was established to complete the questionnaire and the interview. Due to research time constraints, of the ten invites, four participants volunteered to take part. It is most likely however that more participants would have taken part if more time was permitted.

The data collection consisted of the following steps at the appointment time:

1. A brief introduction that included the purpose of the study, what participating in the study would involve, and an opportunity for the participants to ask questions.
2. Upon agreement to take part in the research, participants signed the consent form. The consent form was signed to ensure that each participant agreed with terms such as the storage of their information for ten years, the interview being digitally voice recorded and the delivery of information in this study to be adjusted for anonymity.
3. The questionnaire was completed by each individual.
4. The researcher played a television advert from YouTube (DraftFCB NZ, 2010) about the website, featuring Sir John Kirwan.
5. Participants were shown the website, www.depression.org.nz and invited to browse through it in preparation for the interviews.
6. Participants were interviewed one by one with the researcher.
7. Once the interviews/discussions were completed, the participants were thanked and the appointment drawn to a close.

2.1 Questionnaire

The questionnaire consisted of 21 questions. The structure of the questionnaire comprised four sections:

- *General Background*, to capture the details of the participant such as age, gender and ethnicity.
- *Propensity to use online information services*, to build a picture of the participants' knowledge about the Internet and computers or laptops, e.g. frequency of use and terminology used or understood. This was to provide a picture of what it may be like for most Pacific people in

New Zealand and the possible reasons why Internet and computers are used or not used.

- *Attitudes*, to provide a picture of the participants' attitudes and behaviour towards seeking health information for either themselves or others.
- *Beliefs*, to provide insight into the beliefs of the participants' ethnic group and how mental illness is interpreted.

Responses were recorded on a five point Likert scale, e.g. ranging from 'very comfortable' to 'not comfortable at all'. The data were analysed by counting them up and creating tables to compare and contrast answers to groups of questions.

2.2 Interview

A semi-structured interview was conducted once the participants had completed the questionnaire, watched the advert and browsed through the website. Before participants were left to navigate and look through the website, the researcher explained what the 'my journal' feature was (as displayed in bottom left hand corner of Figure 1). Participants were asked not to look into this feature as this required them to fill out the patient health questionnaire (PHQ-9) 'self-test', subsequently creating a personalised journal for depression management. The website provides therapeutic routines and activities, e.g. cooking and exercise, as part of a broader cognitive behavioural therapy programme specifically designed for online self-directed delivery.

To avoid any suggestion that the participants themselves may be suffering from mental health, the researcher described what 'my journal' contained and asked them not to explore it during the interview session. Participants were otherwise welcome to investigate further if they wanted to, after the interview ended. Following this discussion, each participant was left for a few minutes to navigate and read through the other features of the website. Participants were asked to alert the researcher when they were satisfied they had browsed through the website for long enough. Upon this signal, the researcher conducted the semi-structured interviews that were digitally recorded. Interviews lasted approximately 45 minutes to an hour.

The interviews were analysed thematically and compared and contrasted with the questionnaire analysis.

3 Findings

The findings of the questionnaire and interviews are presented separately.

3.1 The questionnaire

All participants were female and were in the age brackets between 24-30 or 41-45 years of age. Of the four women, two were of Samoan ethnicity, one Niuean and one Tongan ethnicity. Three of the four participants were currently employed whilst the fourth identified herself as a 'full time student'. Two women specified that they were born in the island of their ethnic groups, indicating migration to New Zealand while the remaining two were 'New Zealand born'.

No-one was suffering from a chronic illness. All participants indicated that they had access to the Internet and owned either a computer or laptop. Notably, each

participant indicated they had completed either secondary school or tertiary education. Although all four participants owned a mobile phone, only two had the feature of Internet access available on their phone. Neither of them had ever used the Internet feature on their phones to access health information.

3.1.1 Propensity to use online services

Only three out of the four women noted that they were 'very comfortable' with using a laptop or computer on their own and required no assistance from someone else. These individuals knew how to operate the device, create documents, to write a letter and to connect to the Internet. In contrast, the fourth participant indicated that she was not comfortable using a computer despite secondary schooling in New Zealand and owning a computer or laptop. When asked the question, 'How comfortable are you using the Internet?' only two answered that they were very comfortable using the Internet and were familiar with aspects of the Internet such as using a search engine and emailing. One specified that she was not confident in her skills of using the Internet whilst the fourth indicated that she was not completely confident in her usage and knowledge of the Internet. The usage of the Internet per week by participants varied from a rating of 3 (5-6 times) to 5 (8-10 times) whereas the usage of a computer or laptop outside the hours and facility of work places varied from a rating of 2 (3-4 times) to 5 (8-10 times).

When asked 'Have you ever used the Internet to search for health information for yourself?' two participants answered 'no' whilst the other two answered 'yes'. Of the two who answered 'yes' one said, 'I think it was two weeks ago,' and the other, 'A year ago'. The nature of the search was not specified by either participant. Likewise, when answering the question 'Have you ever used the Internet to search for health information for another person?' two answered 'no'. The remaining two responded 'yes' with the following descriptions of 'Checking a suitable rest home within South Auckland for an elderly relative,' and, 'To research a relative's ailments/symptoms and the medication diagnosed to them from their GP'. These answers indicated a difference in how one interpreted or understood 'health information' to be. The question 'What do you think a 'trusted website' is and why?' was met with the following answers:

'One that is based on evidence i.e. relevant research: research in numbers. It is a secured website i.e. has the lock symbol in the web address.' (A)

'Security with my information which is very important or I am hesitant to use it.' (B)

'Trusted website is one with quality health information given by legitimate health professionals.' (C)

'A website that has credibility towards it of some sort, that the public can trust to use, that it is not made created on falsified facts.' (D)

These answers show how differently people interpret the word 'trust' with regard to Internet websites. When asked, 'Have you ever used the Internet to search for online mental health information?' only one participant responded with 'yes' stating they were 'curious about the ad with ex-All Blacks player John Kirwan on depression'. Interestingly, this answer was provided

before the participant was asked to look at the website or any mention of the depression campaign fronted by Sir John Kirwan. Participants were then asked to answer three questions about attitudes.

3.1.2 Attitudes

This section covered questions that were related to the behaviour and attitudes participants had towards seeking health information for either themselves or others (family members or friends). Tables 1 and 2 show the responses to these questions.

Participant	Rating	Reason for rating
A	5	<i>Because I know the importance of information and know there is no harm in taking a look.</i>
B	5	<i>I would like to know more information of what services are out there to cater for my condition. Also to know more about the condition that I have been diagnosed with.</i>
C	3	<i>Having it from a doctor themselves suits me best.</i>
D	3	<i>I chose the 'maybe' option because if someone tells me to check stuff out online about health, I probably wouldn't really care and won't check it out. But then I might because I'm so used to being on the Internet all the time. So, yeah, half and half.</i>

Table 1: Summary of Participant Responses about attitude to using a health website

Participant	Sources participants turned to for health information
A	<i>GP clinic (GP or nurse) Relative – she's a nurse (RN)</i>
B	<i>Doctor Word of mouth (friends, relative, church...) Internet TV</i>
C	<i>Hospitals Clinics</i>
D	<i>The doctors My parents (my dad used to practise a lot of medical-related treatment – so I get most of my knowledge from him.)</i>

Table 2: Summary of participant responses about sources of health information

The first question asked, 'When encouraged by others for example, doctors, specialists, friends and family, to use a health website, how likely are you to follow through?' Participants were asked to circle their answer on a Likert scale and then indicate why they selected that answer. The scale ranged from 1(very unlikely) to 5 (most likely). Although two participants circled 3 for 'maybe' and the other two circled 5 for 'most likely' each gave a different answer (see Table 1). The answers

varied from an attitude of 'don't care' to a preference to see a doctor. Of the two who answered with a 5, these participants had indicated that they did search for health information either for themselves or for a friend in the previous section of the questionnaire, in the computer and knowledge section.

The next question was asked to capture feedback concerning where they sourced health information. The most common responses amongst all four were either 'doctors', 'clinic' or 'hospital'(Table 2).

In the list provided by the participants only one mentioned the Internet. This aligned with their previous answers - they did look up health information for another person and rated they were 'most likely' to use a health website if informed by another. Though there was no mention of these in the questionnaire, two responses included family members as sources of health information as they were currently working within the health sector or used to work in a health-related position.

The final set of questions concerned the influence of beliefs on the use of online health information sources.

3.1.3 Beliefs

The questions asked in this section related to the individuals' ethnic group and how mental illness is interpreted within this group. Only two questions were asked. The first question was met with similar responses. This similarity relates to the issue of stigma or discrimination still being present within the ethnic groups the with which participants identified themselves (Samoan, Tongan and Niuean). Table 3 presents the answers, showing how the issues of stigma and discrimination are still present within ethnic groups with which the participants identified.

Participant	Response
A	<i>Traditionally quite a taboo or religious phenomenon. But I think it is becoming a more common topic that is being talked about among Samoan people, mainly due to more awareness about mental illness – adopting Western views on it.</i>
B	<i>Lack of knowledge. In my upbringing we were told that people with mental illnesses were 'crazy/naughty' and 'difficult'. Definitely not to associate ourselves with them whether they are a relative or very close family friend.</i>
C	<i>Mental health is not really talked about. Those with a mental illness are usually left to do their own thing. Not really shunned by the family but also not embraced.</i>
D	<i>In my Tongan culture, I think and believe that it is a taboo to even talk about mental illness. So therefore I don't hear it much – as in there's no talk that I know of which has to do with mental health. The only times that I do hear about it is when someone is talking about ghostly stories back in the Islands. This is called 'puke faka tevolo' which means the devil's sickness. Its typically seen as crazy and not part of society.</i>

Table 3: Responses that explain how mental illness is explained, viewed or talked about

One participant acknowledged that these views are slowly changing due to New Zealand's effort to 'normalise'

mental health and raise awareness. Participants were asked, ‘Based on the views and beliefs of your ethnic group, how is mental illness explained, viewed or talked about?’ The responses in Table 3 indicate that mental illness has negative connotations for Pacific ethnic groups. In other words, the issue of mental health problems is often reflected and portrayed in a negative light. It is of no surprise then, that Pacific Islanders hesitate or refuse to seek help until they are too ill (e.g. severe depression). When such an outlook against mental health issues persists, it is no wonder that stigma and discrimination continue to be obstacles to overcome within the Pacific population.

The next question asked was ‘What words are used by your ethnic group to explain or understand depression and or mental illness?’

This question was asked to provide an indication of what words were used in the participants’ ethnic languages to communicate the issue of mental health or depression. Table 4 summarises the responses to this question. The most common term or understanding was ‘crazy’.

Ethnic group	Word	Participants’ understanding or meaning of the word
Samoan	Ma’i	= Sick
	Leaga le ulu	= Crazy or sick in the head
	Valea	= Crazy, dumb
Tongan	Puke faka tevolo	= Devil’s sickness (refers to the mind sickness)
	Fakasesele	= Crazy
	Siasi	= Crazy
English	Crazy	= Dumb in the head – crazy

Table 4: Summary of responses about ethnic language for mental illness

The participant of Niuean descent noted that she could not think of any words but, because she was married to a Samoan man, she knew one Samoan word commonly used to describe the mentally ill. Another participant noted that they could not remember specific words or the spelling of Samoan words. Instead she stated she knew the English equivalents and provided these. As a result only Samoan and Tongan words were gathered (with the addition of the English equivalent as provided by one participant). Notably the word ‘crazy’ appears to be a common word to explain depression or mental illness. When the participants indicated that they had completed the questionnaire the session moved to the paired discussion.

3.2 Paired Discussion

Once the participants had viewed the advert and navigated through the website (minus the ‘my journal’ feature), a semi-structured interview took place between the researcher and the participant. This paired discussion was based on questions from the questionnaire and in relation to the website. For example, questions included ‘As a Pacific Island individual, what are your beliefs

about using online health information?’ and ‘What features of online health information would you like to change or improve to increase the likelihood of your using online health information?’ The purpose of repeating questions from the questionnaire was to allow room for further explanation, because participants may not have had the patience to write a meaningful response, may have provided broad statements or points, or did not answer in writing. The paired discussion meant that participants had the opportunity to tell stories and elaborate on what they may have already provided. This allowed for a richer picture to develop and provided the opportunity to capture information that may not have been included in the questionnaire.

Before the researcher began the paired discussion, some of the participants made comments after they were satisfied with looking at the website and its features. Although all participants were familiar with the ‘John Kirwan’ adverts about depression and website, some found the website as ‘something new’ they had not looked into or considered, as expressed by one participant.

‘That was interesting...I had seen it on TV but this is actually the first time I’ve looked into it.’ (A)

Some participants felt that the interface for the website was ‘good’ and ‘easy to follow’. This was because the website interface was clean (clearly labelled), not cluttered with tabs and had an ‘inviting’ feel with an image of a park and bench. Being able to navigate easily through a well-labelled and simple website proved to be a helpful feature that encouraged them to use online mental health information. This is illustrated through the following responses.

‘Navigation in the website is good. The tabs and headings are pretty good, and it kinda flows from left to right. The tabs take you from the info to the resources and content...an easy logical flow – you don’t get confused on where to go and its clearly labelled.’ (D)

‘It’s really easy to follow and very simple. Initially it looks really good, you just go off the first page just scrolling through it. I think for me it will depend on my mood because there’s quite a lot of reading to go through, but, it would definitely be good for me because it explains things in more detail and has the options to watch a video; it’s not just reading, it’s about those other options. I think more so the interactive part I would be more interested in.’ (B)

‘It’s easy, it starts off describing what depression is, then the causes, it goes through the steps if you have it, then giving information of where to get help.’ (C)

When asked if there were any cultural improvements they wished to see in a mental health website, participants identified that the translation of the content into their ethnic language would be helpful. Interestingly, one participant mentioned the issue of cost.

‘... I know that there’s a cultural barrier especially with Pacific people and understanding health knowledge...I have a feeling it works...there’s still older Pacific people that still don’t have good English...I know it’s worked because my dad does work with the smoking thing and he’s helped people stop smoking with his resources and stuff and part of those resources are Pacific specific pamphlets.’ (D)

'It's hard because I don't speak any language, I don't know personally if it would help. I think on behalf of like my grandparents it would be helpful but then that generation isn't good with computers anyway...I don't think there's any harm if it doesn't cost much. I think if you were to translate it, maybe something more hands on like a pamphlet or something.' (A)

'Maybe if it offered it in maybe languages, so maybe in the option of their preferred language that they understand.' (B)

Participants had mixed reactions about which method they preferred to seek health information. Some preferred to see a doctor because of a lack of confidence with searching and the trustworthiness of online health information. Another preferred searching the Internet whilst one was not too sure because they had not practised searching health information online enough times to comment in greater depth.

'For me, I would just prefer to see a doctor. I think it's just coz I don't really know how to get health information online. I don't really do that, so I don't know...and confidentiality. I mean, yeah, you probably get that with a website as well but like if I was to find out more stuff, the doctor could, you know, help with that. The websites might have it but with a doctor you can ask whatever questions you want...and with that you can get confidentiality around your concerns and questions.' (D)

'I haven't really used it that extensively to answer that.' (A)

'The Internet. I think because it's quite a sensitive topic that it's not personal – I don't have to speak directly to someone, coz I still feel self-conscious with a sensitive topic. The Internet is my preferred choice but I think to get something to be more sure, I'd probably go to see my doctor.' (A)

When asked if they would search for online health information for another person other than themselves, the answer became dependent on the situation and context.

'I could look up [health information] like here are the symptoms for...but if I wanted a serious and in-depth knowledge about the issue...then I'd actually want to ask a doctor face to face. It would be good.' (D)

'It depends what it is, if it's something common I'd probably go to the doctor but if it isn't I'd definitely go online and find some information...I would probably look at service information...depending on what it is, I'd probably look at the condition first and how bad it is, and then service and treatment' – common meant that cell needs to be checked out, go to the doctor, if someone said that's a cancerous looking cell I'd look into health information.' (A)

Although participants were mindful of using online health information as a source, it appears that because mental health is regarded as a serious health issue amongst Pacific Islanders, as opposed to a rash or infection, participant responses indicated that stigma issues are still present, possibly detracting from their usage of online health information. One participant noted that mental health issues were kept within a tight circle of family members. Further to this, she felt that being able to look at information online meant it held her responsible to look after the mentally ill family member. In other words it would be her burdening responsibility because

she would then know where to source contacts, help and information. As a result family members may be heavily dependent on her to oversee the well-being of the mentally ill family member.

'I don't want to take on the responsibility [of looking after a mentally ill family member] if I find out the information online because where health is concerned, it becomes a family thing. I'd rather take them to the doctor's with other family members so we can all talk, understand and ask questions, rather than me saying I found this, this is who we see, where we go...' (A)

When participants were asked about the advert used to promote the usage of the depression.org website, there was a general sense that the advert was not relatable to them. This was because Sir John Kirwan was not necessarily a figure they were able to relate to easily even though they knew who he was. With this in mind, these Pacific participants did not feel they needed to investigate or look into the website.

'I just feel like that ad was made for another group of people, I shouldn't be listening to it.' (D)

'Oh, so like turn it off or turn the channel...' (B)

'Yeah or like go get a cup of tea or something [laughs] If there was a Pacific person standing there instead of him, I'd probably feel more comfortable to check it out coz I know we're the same people – they've probably experienced the same thing from being in the same situation and environment.' (D)

'I mean you see it [John Kirwan advert] but it's not really anything people take seriously if you're Pacific...but if I saw an Islander guy, I think so.' (C)

'Yeah probably, I never thought of it that way, I think it's enticing because it's John Kirwan, a famous face, but maybe. If it was someone like David Tua I think I would definitely be more interested to go in [and look at website] because it would be more relatable.' (A)

'Maybe the ad could be maybe with a PI [Pacific Islander]. It could not be just the individual but the family. You know how they either have two people or someone on their own...maybe advertise the help and how they went seeking for help...Maybe that's where PIs will think 'oh that's what we need to do'...maybe that could be the way to target the PIs because PIs are more family orientated. The story might help other families think 'well they did it, maybe we should'.' (A)

The above suggests that social marketing through television advertisements is being picked up by Pacific Islanders. These participants were able to identify that they were familiar with the advert, what he talks about and the website address he mentions. Despite this, participants felt they could not relate enough to investigate the website. Thus it appears that the underutilization of online health information by Pacific Islanders is also influenced by promotional material lacking cultural relativity. This means that there may be few aspects in social promotion surrounding online mental health information that Pacific Islanders can familiarise themselves with to investigate online health information websites.

4 Discussion

The purpose of this research was to examine how the attitudes and beliefs of Pacific people impact on their

propensity to use online mental health service www.depression.org. The findings from the questionnaire and paired interviews with four participants show that although people own computers and use them at work or as students they don't seek mental health information or services online unless certain cultural considerations are integrated into the online services/information. The four female participants indicated that they did not relate to John Kirwan. This could be because he was male, older than they were, not a Pacific islander, and fronts the website alone (outside of the context of a family). One suggested that perhaps David Tua (a wrestler of Pacific island origin) could replace John Kirwan.

Trustworthiness of online information was an issue, especially considering the different views on what that could mean. Even if the trustworthiness were guaranteed, there were some disadvantages to seeking information online. If a person doesn't understand what is written or said online they don't have the same ability to pursue an understanding if they were talking to a doctor. It appears that education is an influential factor in the limited use of online mental health information amongst the New Zealand Pacific population.

Reasons for participants preferring not to use online mental health information were because they were unsure of how to identify trustworthy health information and how to search properly for health information. This could be because English is a second language for many Pacific people. Literacy problems further act as an explanation of why Pacific people prefer not to use online mental health information. The researcher notes that although each participant received a secondary education or higher, participants still identified they were unsure of how to search for mental health information or what to consider 'trustworthy'. Although they gave good indication of what a trustworthy website is and were well educated, participants remained unable to search for health information online confidently. It could be noted that greater education around the usage of the Internet and computers is required. Education still remains a barrier for the uptake of online mental health information by Pacific people (Britannica, 2008).

Stigma and discrimination influence desire and comfort levels in seeking out information – taboo, low awareness, uncomfortable talking about people with mental illness, and negative connotations when referring to mental illness, e.g. 'devil's illness'. This may be due to the high incidence of mental illness among Pacific people relative to other cultures in New Zealand (Suaalii-Suani et al., 2009).

Those who were not 'New Zealand born' would struggle with English and may benefit from being able to access online information in their own language. Getting information face to face from a doctor means that a family can do it together rather than an individual with Internet skills doing it on behalf of a family. The Pacific culture is socio-centric and relies on families working together for health improvement and maintenance, as evidenced in the different models of care (Suaalii-Suani et al., 2009).

This interaction cannot happen with online mental health information. When using online health information

especially regarding mental health, patients or users may be unable to get direct answers to specific questions and or understand the information provided. In either case the patient or user is forced to open further screens and other websites to find out bits of information to answer their question. This process alone may discourage the user from searching for health information and more specifically mental health information online.

Looking up information for a family member is associated with adopting responsibility for that family member.

Limitations of the study

This was a very small study - five key informants talking about building and delivering a e-mental health tools, i.e. www.depression.org.nz, and four Pacific island people to answer a questionnaire and discuss their perspective of the website. The Pacific population within New Zealand accounts for 6.9% of the general population (Paterson et al., 2008). Of this 6.9%, the participation of four individuals does no justice in representing this population adequately. Furthermore, the participants are of ethnicities that fall into the Polynesian category of the greater Pacific. It is not known whether these answers of attitudes, beliefs and propensity are also reflective of the Micronesian and Melanesian ethnicities present in New Zealand. Each region has its similarities yet within each region the ethnic groups must be considered unique and independent of each other (Lal and Fortune, 2000, Thomas et al., 1989). Hence to help build a rich picture surrounding the usage (or lack of usage) of online mental health information for Pacific Islanders in New Zealand a greater number of participants incorporating the diversity of the Pacific is required.

The gender and age brackets of the women may have provided a biased outlook. Where questions about the advertisement, a promotional tool for social marketing, were asked, these were met with answers along the lines of 'not being able to relate to it'. Participants were all female. Because the promotion surrounding online mental health information involved a male sportsperson this may have provided an instant issue of not being able to relate. Furthermore, more of the participants (three out of four) fell within the youngest age bracket of 24 to 30 years of age. Again, these participants may not have been able to relate to the promotion because of an elder figure delivering the message of using online mental health information. This visual presentation may not have appealed to the participants both because he was older than the participants interviewed and because John Kirwan was male.

5 Conclusion

In conclusion, the exploratory study resulted in some interesting findings. Although the researcher notes that the participant number was small, these findings call for further investigation. Such findings include:

- Relevance to the Pacific people in social marketing strategies surrounding online health information is necessary for increased uptake. Unless Pacific people are able to relate or align themselves with both the message and visual presentation, it is unlikely they will investigate online mental health websites for information

- Regardless of the level of education, gaps still exist around the usage of the Internet and computers. This further inhibits the use of online mental health information. This is due to confidence issues to explore the Internet and what is considered valid health information.
- Mental health remains a sensitive topic amongst Pacific people, involving stigma and shame (Mak et al., 2007, Vaughan and Hansen, 2004). Although participants are aware of the discreetness and privacy the Internet provides when seeking mental health information, a doctor is still preferred as the source of health information. Reasons can relate to the above bullet point and the comfort found in face-to-face interaction regarding this sensitive health issue.

Further research is needed with a larger number of participants for replicate studies and the need to capture as many ethnic groups within the three regions of Polynesia, Melanesia and Micronesia to gain a more reflective stance on the issue of online mental health information usage for Pacific people.

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