Te Tomo Mai Appropriate Child and Adolescent Mental Health Service (CAMHS) for an Indigenous Population: *Rangatahi* (Youth) Perspectives

Kahu McClintock
Roimata Tauroa
Graham Mellsop

Abstract

The development of Child and Adolescent Mental Health Services (CAMHS) that meet the needs of Māori *rangatahi* (Indigenous people of *Aotearoa*/New Zealand, 12–19 year olds) is desirable. The *Tomo Mai* study investigated the acceptability of CAMHS access and delivery to Māori *rangatahi* as determined by those who accessed CAMHS. The study aims were to investigate barriers to Māori *rangatahi* access to CAMHS and investigate what would constitute a good service to Māori *rangatahi* as defined by Māori *rangatahi.*

This study represents the first in depth investigation into the acceptability of CAMHS for Māori according to Māori *rangatahi*. It proposes a culturally appropriate framework to contribute to CAMHS improvement and advocates for a CAMHS delivery and workforce with the ability to offer these processes. The results are pivotal to the development of an evidence-based framework for improving access to CAMHS for Māori *rangatahi* and therefore contributing to service improvement and better health outcomes for this population.

Keywords: Māori mental health, Indigenous mental health, child and adolescent mental health service

Acknowledgments: The authors wish to acknowledge the funders of this study, the Health Research Council of *Aotearoa* and Health Workforce NZ and the six participating CAMHS: *Te Roopu Kimiora* (Northland DHB), *Whirinaki* (Counties Manukau DHB), *Te Oranga Hinengaro* (MidCentral DHB), *Te Whare Marie* (Capital and Coast DHB), *Te Korowai Atawhai* (Canterbury DHB), and *Te Oranga Tonu Tanga* (Southern DHB).

Introduction

The mental health of children and adolescents remains a concern in spite of the Convention on the Rights of the Child, which recognizes the ultimate right of the child to protection and treatment of his or her physical and mental health (Levav et al., 2004). Globally, ethnic-minority and Indigenous adolescent populations have very high unmet mental health needs (Commander et al., 2003; Garland et al., 2005; Yeh et al., 2003, 2005).

Like their international counterparts Māori, the Indigenous and ethnic-minority population in *Aotearoa*/New Zealand, experience high unmet mental health needs (Baxter, 2007; Baxter et al., 2006; McClintock et al., 2011; Ramage et al., 2005; Tapsell and Mellsop, 2007). Māori *rangatahi* (12–19 year olds) are two times more likely to experience poor mental health but are less likely than non-Māori to make contact with mental health services (Adolescent Health Research Group, 2004; Ramage et al., 2005).

Lack of cultural support offered by health services and misinformed perceptions by medical practitioners are thought to be contributing factors to this situation. (Yeh et al., 2003, 2005; McClintock et al., 2011; Ramage et al., 2005). Employing cultural considerations in health services is believed to increase engagement and commitment to treatment programs offered to ethnic diverse populations (Atdjian

and Vega, 2005; Bhui et al., 2003, 2007; Dogra, 2004; Fitzgerald and Galyer, 2007; Snowden, 2003).

Examining Culture and CAMHS

A holistic world-view promoting social, physical, and spiritual connection is important to Indigenous well-being (Durie, 1994; McCormick, 1995; Swinomish Tribal Mental Health Project, 1991; Van Uchelen et al., 1997). Supporting identity for ethnic populations increases engagement and commitment to treatment programs by these groups inclusive of children and adolescents (Atdjian and Vega, 2005; Bhui et al., 2007, 2003; Dogra, 2004; McClintock et al., 2011, 2012; Snowden et al., 2006). Health providers that employ culturally competent staff increase positive health experiences for ethnic minorities (McClintock et al., 2011; US Department of Health & Human Services, Office of the Surgeon General, 2005).

Examination of Māori *rangatahi* and CAMHS

There is a lack of research on how to best deliver and improve CAMHS in *Aotearoa* for the Māori adolescent population. Current evidence supports culturally appropriate delivery of health services as seminal to this development (Baxter et al., 2006; McClintock et al., 2011, 2012; Ramage et al., 2005). The examination of whether providing culturally appropriate mental health services improves access for Māori, including the *rangatahi* population, adds to this discussion (Baxter et al., 2006; Oakley Browne et al., 2006; McClintock et al., 2011, 2012).

Two qualitative studies in *Aotearoa* identified concerns relevant to CAMHS delivery for Māori *rangatahi*. One study, with 50 Māori caregivers, sought perspectives on what constituted acceptable CAMHS delivery for their children (0–19 years of age) who accessed these services (McClintock et al., 2011). The results contributed to the conceptual development of a CAMHS best practice model aligned with the traditional *Pōwhiri* process of engagement and participation, particularly the components of *karanga*, *mihimihi*, *whaikōrero* and *koha* (McClintock et al., 2010, 2011). This process valued informed consent, respectful relationships, shared commitment, and reciprocity between caregivers and CAMHS.

Caregivers expected these services to work in a collaborative and appropriate way that satisfied Māori. This included partnership with *whānau* (family) and cultural processes (McClintock et al., 2011).

Capturing youth perspectives of CAMHS is also imperative (Brunk et al., 1998; California Department of Mental Health Systems of Care, 2005; Davies and Wright, 2008; Harris et al., 2005; Riley and Stromberg, 2001; Riley et al., 2005). The second *Aotearoa* qualitative study, with participants aged 7–12 years who had accessed CAMHS, described participant experiences and views of the CAMHS assessment processes (Mitchell-Lowe and Eggleston, 2009). Nine participants contributed to the study and five themes were identified from the interviews, which included:

1. Stigma of mental illness;
2. Staff qualities and approaches that included culturally sensitive and age appropriate considerations;
3. Confidentiality;
4. CAMHS environment; and
5. Anxiety about attending CAMHS (Mitchell-Lowe and Eggleston, 2009).

A limitation of both studies was that neither included the views and experiences of 12–19 year-old Māori *(rangatahi)*, who had accessed CAMHS, for their notions of a responsive service. It is therefore timely to conduct a study with this population.

The *Tomo Mai* Qualitative Study

The *Tomo mai* research project utilized both qualitative and quantitative approaches with Māori *rangatahi* (12–19 years old) who accessed support June 2009–June 2010 from one of the six CAMHS[1] located within District Health Boards (DHBs) to gain their views on the acceptability of CAMHS. This article reports only the qualitative phase.

Method

Aim

The study aims were to:

1. Investigate barriers to Māori *rangatahi* access to CAMHS; and

1 *Te Roopu Kimiora* (Northland DHB), *Whirinaki* (Counties Manukau DHB), *Te Oranga Hinengaro* (MidCentral DHB), *Te Whare Marie* (Capital and Coast DHB), *Te Korowai Atawhai* (Canterbury DHB), and *Te Oranga Tonu Tanga* (Southern DHB).

2. Investigate what would constitute a good service to Māori *rangatahi* as defined by Māori *rangatahi.*

Pōwhiri research process

A *kaupapa* Māori research process was utilized in *Te Tomo Mai* founded on the traditional Māori values and beliefs that operate within the *Pōwhiri* process of engagement and participation (McClintock et al., 2010). The *Pōwhiri* elements of *karanga, mihimihi, whaikōrero, and koha* have been described to support a *kaupapa* Māori research paradigm. These protocols are premised on respect and positive relationships between the *tangata whenua* (hosts) and *manuwhiri* (guests). In this *kaupapa* Māori research context the researcher is the *manuwhiri* and the participants are the *tangata whenua* (McClintock et al., 2010).

Recruitment

A purposive sample of 30 *rangatahi* participated from six DHB CAMHS, located throughout *Aotearoa*. The recruitment process aligned with the *Pōwhiri* process of engagement and participation, which included the *karanga* or invitation and consent to complete the interview; *mihimihi* or information sheet explaining the study; *whaikōrero* or conducting the interview; and *koha* or commitment to complete the study by returning the approved transcript for inclusion.

Questions

The qualitative study utilized three open ended semistructured questions:

1. What did you like most about the CAMHS?
2. How could the service best be improved?
3. What would your ideal service be?

Participants were prompted to expand on these areas in the interview sessions. Face-to-face interviews occurred at a venue chosen by the participant, which for most was in their homes. The interviews lasted 40–60 minutes. All interviews were audio taped, transcribed, then the transcripts returned to *rangatahi* for checking before inclusion in the database.

Analysis

The qualitative data analysis utilized a general inductive approach (Thomas, 2005). This method is independent of theory and obtains explanations from raw data to develop themes and ideas through multiple readings and summarizing of key themes. These themes were identified through a close reading of the text (Thomas, 2005). Thematic analysis has the potential to provide descriptive detail and depth to data.

The data collection relied on the sharing of participants' experiences. A thematic analysis involved identifying the meanings associated with their shared experiences and situations (Braun and Clarke, 2006). The narrative data collected through the interviews were transcribed into consistently formatted documents which were read and coded into themes (Thomas, 2005). The data was then organized into main themes and subthemes, and stored using NVivo7 software. Selected passages were placed under the preferred node through a coding framework. NVivo7 software was employed to facilitate the ordering of the data through a thematic approach after which the findings were sorted into themes (Thomas, 2005).

Ethics

The Multiregion Ethics Committee (MEC/10/05/042) of the Ministry of Health *Aotearoa*, approved the study. Each of the six participating DHBs had their own unique ethical processes to endorse this research. Gaining site approval from each DHB presented unanticipated challenges. The main issue included multiple research committees in the same DHB not agreeing with each other (Māori, Mental Health Research, and Health Research committees) and services being overburdened to accommodate a research request.

Results

This section records the results obtained following the interview process identified in the methodology. Table 1 displays the numbers of *rangatahi* from the six CAMHS who participated in the *Te Tomo Mai* qualitative phase.

The themes have contributed to the conceptual development of a CAMHS best practice model for working with Māori *rangatahi*. The approach has been aligned with the traditional *Pōwhiri* process of engagement and participation. Part one to

Table 1

Interviewees	*n*
Te Roopu Kimiora	5
Whirinaki	5
Oranga Hinengaro	6
Te Whare Marie	6
Te Korowai Atawhai	4
Te Oranga Tonutanga	4
Total	30

this section acknowledges what *rangatahi* in this study experienced as helpful from CAMHS. Part two identifies the challenges *rangatahi* faced in accessing CAMHS. These have been framed as future areas of development, *ngā moemoea* which are the *rangatahi* aspirations for improved CAMHS delivery. This structure informs the notion of an acceptable CAMHS as determined by Māori *rangatahi*.

Part One: *Pōwhiri* Process for Positive CAMHS Delivery

Karanga

Appropriate to the *karanga* stage, *rangatahi* appreciated entry and referral pathways into CAMHS that accommodated both formal and informal processes. For example, *rangatahi* identified emergency department referrals and *whānau* who supported them to access CAMHS as important.

Mihimihi

Appropriate to the *mihimihi* stage, *rangatahi* appreciated positive contact processes with CAMHS that included *whānau* accompanying them to the service. *Rangatahi* expressed the desire for the first contact to include *whānau* who often knew about the issues and wanted information on how to assist. Clinicians who demonstrated considerate listening skills and valued *rangatahi* views were thought more likely to be successful in engaging them.

Whaikōrero

Appropriate to the *whaikōrero* stage, *rangatahi* appreciated a CAMHS that was delivered in a *whānau* type environment, more than professional, that supported a *whānau* partnership approach. Services that assisted *rangatahi* through cultural processes to enhance cultural identity; *te reo* Māori (Māori language), cultural connectedness, *whakapapa* (genealogy), and spiritual wellbeing *karakia* (prayers) were valued. *Rangatahi* believed *kaupapa* Māori mental health services often went beyond the call of duty being available 24/7, willing to assist with transport to clinics and appointment venues organized in the community.

Rangatahi appreciated assistance in setting goals and plans, and working with clinicians who were viewed as genuinely there to help them. *Rangatahi* had no gender preference in terms of those who worked with them. *Rangatahi* believed medication was a choice and received and ceased this when in partnership with the CAMHS.

Koha

Appropriate to the *koha* stage, *rangatahi* appreciated a CAMHS that worked in partnership with them and their *whānau* and valued their input. *Rangatahi* acknowledged success with CAMHS was dependant on appropriate cultural approaches being offered by Māori and non Māori CAMHS clinicians as well as a commitment to delivering these options in a genuine manner,

Part Two: *Ngā Moemoea*, Aspirations for Positive CAMHS Delivery

Karanga

Appropriate to the *karanga* stage, *rangatahi* desired a workforce that would inform them of the cultural and clinical support CAMHS could provide.

Mihimihi

Appropriate to the *mihimihi* stage, *rangatahi* desired a workforce that would work to enhance the quality of the relationship between them and CAMHS.

Whaikōrero

Appropriate to the *whaikōrero* stage, *rangatahi* desired correct and timely information about medication and its benefits to assist in compliance with medication regimes offered by CAMHS.

Koha

Appropriate to the *koha* stage, *rangatahi* desired an opportunity to provide feedback on the quality of service, acknowledging the successes and articulat-

ing the improvements needed. Some *rangatahi* also wanted the opportunity to share their experiences with others so they could influence help seeking behaviours for their friends

Conclusion

This study represents the first formal reported investigation into the acceptability of CAMHS for Māori according to Māori *rangatahi*. A *kaupapa* Māori research approach that emphasized Māori development and aspirations ensured successful completion of this qualitative project.

This project interviewed *rangatahi* who had accessed CAMHS to get their perspective on the achievements and challenges in current CAMHS delivery. These perspectives should prove useful to guide future CAMHS delivery to *rangatahi*. Included is the concept that successful access, engagement, and participation of Māori with CAMHS are more likely to occur when *rangatahi* and *whānau* involvement is encouraged and valued in partnership. Improved access to assessment and/or treatment for *rangatahi* should lead to better CAMHS outcomes for Māori young people and their *whānau*.

Rangatahi advocated for culturally appropriate CAMHS processes and providers to increase their willingness to access CAMHS. As a result this study proposes a culturally appropriate framework to contribute to CAMHS improvement. The framework aligns with the traditional *Pōwhiri* process of engagement and participation, founded on cultural respect, partnership, reciprocity, and commitment.

This study advocates for a CAMHS delivery and workforce with the ability to offer these processes. The challenge for CAMHS is to provide a workforce that works in a collaborative and culturally appropriate manner to respond to the needs of Māori *rangatahi*. The results are pivotal to the development of an evidence-based framework for improving access to CAMHS for Māori *rangatahi* and therefore contributing to service improvement and better health outcomes.

References

Adolescent Health Research Group. (2004). *Te Ara Whakapiki Taitamariki Māori Specific Findings of Youth 2000.* Retrieved 20 October 2006, from http://www.Youth2000.ac.nz

Atdjian, S. and Vega, A. (2005). Disparities in mental health treatment. U.S. racial and ethnic minority groups: Implications for psychiatrists. *American Psychiatric Association, 56*(12),1600–1602. http://ps.psychiatryonline.org.

Baxter, J. (2007). Mental health: Psychiatric disorder and suicide. In B. Robinson and R. Harris, eds., *Hauora Māori Standards of Health IV. A Study of the Years 2000–2005.* Wellington, NZ: Te Rōpū Rangahau Hauora a Eru Pomare, pp. 121–132.

Baxter, J., Kingi, T.K., Tapsell, R., Durie, M., and McGee, M.A. (2006). Prevalence of mental disorders amongst Māori in Te Rau Hinengaro. The New Zealand Mental Health Survey. *Australia and New Zealand Journal of Psychiatry, 40*(10), 905–913.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Funke, M., and Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK. *The British Journal of Psychiatry, 182*, 105–116.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., and Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BioMed Central Health Services Research, 7*, 15.

Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*: 77–101.

Brunk, M., Liao, Q., Santiago, R., and Ewell, K. (1998). Psychometric properties of the revised family satisfaction scale. A system of care for children's mental health: Expanding the research base. *In 11th Annual Research Conference Proceedings* (chapter 7). Retrieved 1 March 2007, from www.fmhi.usf.edu/institute/pubs/pdf/cfs/rtc/11thannual/HChapter7.pdf

California Department of Mental Health Systems of Care. (2005). *Youth Services Surveys Survey for Youth Results: Performance Outcomes and Quality Improvement Unit.* Sacramento, CA: Department of Mental Health Systems of Care.

Commander, M.J., O'Dell, S.M., Surtees, P.G., and Sashidharan, S.P. (2003). Characteristics of patients and patterns of psychiatric service use in ethnic minorities. *International Journal of Social Psychiatry, 49*(3), 216–224.

Davies, J. and Wright, J. (2008). Children's voices: A review of the literature pertinent to looked-after children's views of mental health services. *Child and Adolescent Mental Health, 13*(1), 26–31.

Dogra, N. (2004). Commission and delivering culturally diverse child and adolescent mental health services. *Current Opinion in Psychiatry, 17*(4), 243–247.

Durie, M. (1994). *Whaiora: Maori Health Development*. Auckland, NZ: Oxford University Press.

Fitzgerald, J. and Galyer, K. (2007). *Family Inclusion in Mental Health Services: A Child and Youth Focus. Thematic Literature Review*. Wellington, NZ: Wellington Mental Health Commission.

Garland, A.F., Lau, A.S., Yeh, M., McCabe, K.M., Hough, R.L., and Landsverk, J.A. (2005). Racial and ethnic differences in utilization of mental health services among high-risk youths. *American Journal of Psychiatry, 162*, 1336–1343.

Harris, K., Edlund, M., and Larson S. (2005). Racial and ethnic differences in the mental health problems and use of mental health care. *Official Journal of the Medical Care Section, American Publication, 43*(8), 775–784.

Levav, I., Jacobsson, L., Tsiantis, J., Kolaitis, G., and Ponizovsky, A. (2004). Psychiatric services and training for children and adolescents in Europe: Results of a country survey. *European Child Adolescent Psychiatry, 13*, 395–401.

McClintock, K., Mellsop, G., Moeke-Maxwell, T., and Merry, S. (2010). Pōwhiri process in mental health research. *International Journal of Social Psychiatry*

McClintock, K., Moeke-Maxwell, T., and Mellsop, G. (2011). Appropriate Child and Adolescent Mental Health Services (CAMHS) for Māori: Caregivers perspectives. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 9*(2), 387–398.

McClintock, K., Mellsop, G., Moeke-Maxwell, T., and Frampton, C. (2012). Pilot of Te Tomokanga: A child and adolescent mental health service evaluation tool for an Indigenous population. *The International Indigenous Policy Journal, 3*(1). Retrieved from: http://ir.lib.uwo.ca/iipj/vol3/iss1/5

McCormick, R. (1995). The facilitation of healing for First Nations people of British Columbia. *Canadian Journal of Native Education, 21*(2), 249–322.

Mitchell-Lowe, M. and Eggleston, M. (2009). Children as consumer participants of child and adolescent mental health services. *Australasian Psychiatry, 17*(4), 287–290.

Oakley Browne M.A., Wells J.E., and Scott K.M., eds. (2006). *Te Rau Hinengaro – The New Zealand Mental Health Survey: Summary*. Wellington, NZ: Ministry of Health.

Ramage, C., Bir, J., Towns, A., Vague, R., Cargo, T., and Niumata-Faleafa, M. (2005). *Stocktake of Child and Adolescent Mental Health Services in New Zealand*. Auckland, NZ: The Werry Centre for Child & Adolescent Mental Health Workforce Development, University of Auckland.

Riley, S.E. and Stromberg, A.J. (2001). *Parent Satisfaction with Services for Medicaid Youth at Community Mental Health Centres in Kentucky: 2000.* Technical report. Retrieved 29 April 2007, from http://www.mhmr.ky.gov/mh/outcomes/files/finalcmhcREPORT.pdf

Riley, S.E., Stromberg, A.J., and Clark, J. (2005). Assessing parent satisfaction with children's mental health services with the Youth Services Survey for Families. *Journal of Child and Family Studies, 14*(1), 87–99.

Snowden, L.R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health, 93*(2), 239–243.

Snowden, L., Masland, M., Ma, Y., and Clemens, E. (2006). Strategies to improve minority access to public mental health services in California. *Journal of Community Psychology, 34*(2), 225–235.

Swinomish Tribal Mental Health Project. (1991). *A Gathering of Wisdoms, Tribal Mental Health: A Cultural Perspective*. La Conner, WA: Swinomish Tribal Community.

Tapsell, R. and Mellsop, G. (2007). The contributions of culture and ethnicity to New Zealand mental health research findings. *International Journal to Social Psychiatry, 53*(4), 317–324.

Thomas, D.R. (2005). *A General Inductive Approach for Analyzing Qualitative Evaluation Data.* Auckland, NZ: Social and Community Health School of Population Health, University of Auckland.

U.S. Department of Health and Human Services, Office of the Surgeon General. (2005). *Eliminating Disparities*

in Mental Health: An Overview. Retrieved 3 March 2007 from http://www.mentalhealth.samhsa.gov/cre/default.asp.

Van Uchelen, C.P., Davidson, S.F., Quressette, S.V., Brasfield, C.R., and Demerais, L.H. (1997). What makes us strong: Urban Aboriginal perspectives on wellness and racial/ethnic differences in parental endorsement of barriers to mental health services for youth. *Canadian Journal of Community Mental Health, 16*, 37–50.

Yeh, M., McCabe, K., Hough, R.L., Dupuis, D., and Hazen, A. (2003). Racial/ ethnic differences in parental endorsement of barriers to mental health services for youth. *Mental Health Services Research, 5*(2), 65–77.

Yeh, M., McCabe, K., Hough, R.L., Lau, A., Fakhry, F., and Garland, A. (2005). Why bother with beliefs? Examining relationships between race/ethnicity, parental beliefs about causes of child problems, and mental health service use. *Journal of Consulting and Clinical Psychology, 73*(5), 800–807.

Kahu McClintock (Tainui, Ngati Mutunga, Ngati Porou) is a health researcher with vast experience in Child and Adolescent Mental Health Service (CAMHS) delivery and research, Special Education and Kaupapa Māori Education. She has led the development , validation and implementation of a number of Mental Health evaluation and outcome tools for Māori, the Indigenous population of Aotearoa (New Zealand) She is currently a research fellow at Te Rau Matatini (Māori Health Workforce Organisation).
K.McClintock@matatini.co.nz

Roimata Tauroa (Ngaati Korokii, Ngaapuhi, Ngaati Maniapoto, Ngaati Tuwharetoa, Ngaati Kea, Ngaati Tuara) research interests are around kaupapa Māori (Māori philosophy research such as Hauora (Health), Maatauranga (Education), Ngaa Koorero o Neeheraa (Traditional Māori knowledge). She is currently a researcher at Te Rau Matatini (Māori Health Workforce Organisation).
R.Tauroa@matatini.co.nz

Graham Mellsop is an experienced mental Health researcher with more than 170 refereed publications in many areas including medical education, epidemiology, outcomes, pharmacology, classification and forensic psychiatry. He has worked with a number of Māori co-workers on projects related to the delivery of mental health services to New Zealand's indigenous. Currently he is Professor of Psychiatry at the Waikato Clinical School of the University of Auckland.
Graham.mellsop@waikatodhb.health.nz