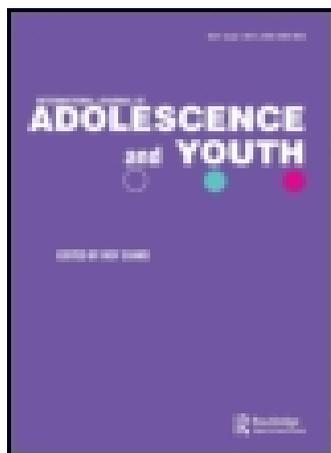


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Kahu McClintock^a, Roimata Tauroa^a & Graham Mellsop^b

^a Te Rau Matatini, Workforce Solutions Portfolio, Wellington, New Zealand

^b Waikato Clinical School, School of Medicine, Auckland University, Auckland, New Zealand

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An examination of Child and Adolescent Mental Health Services for Māori rangatahi [youth]

Kahu McClintock^{a*}, Roimata Tauroa^a and Graham Mellsop^b

^a*Te Rau Matatini, Workforce Solutions Portfolio, Wellington, New Zealand;* ^b*Waikato Clinical School, School of Medicine, Auckland University, Auckland, New Zealand*

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This article offers a review of the literature illustrating factors that can contribute to responsive Child and Adolescent Mental Health Services (CAMHS) for Māori (indigenous population of Aotearoa/New Zealand) rangatahi [12–19-year-old youths]. The development of a relevant CAMHS rangatahi tool to capture rangatahi views is also discussed. Literature searches using the keywords ‘Māori rangatahi’, ‘Māori health’, ‘mental health’, ‘mental health services’, ‘adolescent health’, ‘child health’ and ‘youth services’ were undertaken using the Medline and Index New Zealand databases as well as Google Scholar. The search was restricted to journals, books, and reports published in English from 1990 to 2012. High unmet CAMHS need for ethnic minorities and indigenous populations has prompted investigations relevant to improving mental health service delivery. Cultural interventions and service user views have provided some guidance. Two tool developments in the international literature (the Youth Services Survey – Families and, nationally, the Te Tomokanga – Caregivers Perspectives) capture a number of these issues. However, there is still an absence of a CAMHS tool in Aotearoa that seeks the specific views of rangatahi. In conclusion, CAMHS research is important for improving practice and CAMHS efficacy. Development of a CAMHS tool that allows specific rangatahi feedback is relevant to service provision in Aotearoa and globally.

Keywords: adolescent; mental health services; Maori

Introduction

Internationally, Child and Adolescent Mental Health Services (CAMHS) are underdeveloped (Chow, Jaffe, & Snowden, 2003, Day, 2008). A survey of more than two-thirds of European countries revealed a deficit in youth services in spite of the Convention on the Rights of the Child, which recognises the ultimate right of the child to protection and treatment of his or her physical and mental health (Levav, Jacobsson, Tsiantis, Kolaitis, & Ponizovsky, 2004).

Ethnic-minority adolescent populations have been identified as having particularly high unmet mental health needs (Commander, O’Dell, Surtees, & Sashidharan, 2003; Garland et al., 2005; Yeh, McCabe, Hough, Dupuis & Hazen, 2003; Yeh et al., 2005). Cultural factors and misinformed perceptions by medical practitioners have been suggested as contributors to this situation (Yeh et al., 2003, 2005).

It is proposed that improved access to healthcare services by indigenous people occurs if the services are founded on indigenous world views (Atdjian & Vega, 2005;

*Corresponding author. Email: K.McClintock@matatini.co.nz

Gurung & Mehta, 2001). Culturally relevant services for distinct populations are viewed as a means to increase engagement and commitment to treatment programmes offered by mental health services (Atdjian & Vega, 2005; Bhui et al., 2003; Dogra, 2004; Fitzgerald & Galyer (2007); Snowden, 2003).

In addition, evaluation of services is viewed as a vital component of CAMHS development. Youth involvement in this process is imperative (Brunk, 2001; Brunk, Liao, Santiago, & Ewell, 1998; California Department of Mental Health Systems of Care, 2005; Davies & Wright, 2008; Harris, Edlund & Larson, 2005; Riley & Stromberg, 2001; Riley, Stromberg, & Clark, 2005). Development of such user feedback tools for North American CAMHS provides a means to gauge service efficacy and ensure best practice.

Such instruments allow responses that can be used in the search for the continuous improvement in practice and delivery (Brunk, 2001; Brunk et al., 1998; California Department of Mental Health Systems of Care, 2005; Riley & Stromberg, 2001; Riley et al., 2005)

For Māori, the indigenous and an ethnic-minority population in Aotearoa/New Zealand, CAMHS experience of high unmet need is consistent with other indigenous and ethnic-minority populations (Baxter, 2007; Baxter, Kingi, Tapsell, Durie, & McGee, 2006; McClintock, Moeke-Maxwell, & Mellisop, 2011; Ramage et al., 2005; Tapsell & Mellisop, 2007). Access to effective mental health services for Māori is a stated priority inclusive of their youth population (Baxter, 2007; Baxter et al., 2006; Oakley Browne, Wells, & Scott, 2006; Ramage et al., 2005). National statistics reveal that Māori *rangatahi* have the highest annual prevalence of mental health illness at 29.5% (Adolescent Health Research Group, 2004). Despite high mental health need, Māori *rangatahi* appear less likely than non-Māori to make contact with mental health services (Adolescent Health Research Group, 2004).

Aligned with the need to improve access and better cater for the mental health needs of Māori *rangatahi* in Aotearoa is the essential development of a CAMHS evaluation tool specific to this population (Barnett & Lapsley, 2006; McClintock, Moeke-Maxwell, Frampton, Mellisop, & 2012; Merry et al., 2004). The development of such a tool provides a means to improve CAMHS efficacy and ensure service delivery is relevant (Brunk, 2001; Brunk et al., 1998; California Department of Mental Health Systems of Care, 2005; Riley & Stromberg, 2001; Riley et al., 2005).

Examining culture and CAMHS

Culture is proposed as integral to effective intervention for indigenous populations (Glover, 2001). Cultural knowledge and skills are important to address individual, family and community identity issues (Chandler & Lalonde, 1998; Fleming, 1994). A youth study in North America revealed that a viable future for themselves and their communities was seen as requiring understanding traditional values, beliefs and practices (Government of Canada, 1996). Furthermore, a holistic world-view that promotes social, physical and spiritual connection is proposed as important to indigenous well-being (Durie, 1994; McCormick, 1995; Swinomish Tribal Mental Health Project, 1991; Van Uchelen, Davidson, Quressette, Brasfield, & Demerais, 1997).

In a North American study, health services that promoted cultural identity, understanding culture, language and different communication styles were proposed as necessary when working with indigenous people (Poonwassie & Charter, 2001). Culturally relevant services that support identity for ethnic populations are also viewed as important to increasing engagement and commitment by these groups to treatment programmes (Atdjian & Vega, 2005; Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Dogra, 2004; McClintock et al., 2011; Snowden, Masland, Ma, & Clemens, 2006).

In another North American study, access to mental health services by Afro-Americans was influenced by their own negatively held perceptions about the health service before engagement (Diala et al., 2000). Unfortunately these negative attitudes increased for them after contact (Diala et al., 2000). Unsurprisingly, culturally appropriate health providers with culturally competent staff are considered to increase positive health experiences for ethnic minorities (US Department of Health & Human Services, Office of the Surgeon General, 2005).

There is a need to develop a better understanding of the way that involvement of different CAMHS user groups, particularly parents and carers and children and young people, can add to CAMHS efficacy. The development of evaluation tools addresses this issue (Brunk, 2001; Brunk et al., 1998; California Department of Mental Health Systems of Care, 2005; Riley & Stromberg, 2001; Riley et al., 2005).

The Youth Services Survey – Families (YSS-F) is a parent-friendly instrument used in North America to establish a baseline of parental satisfaction with CAMHS (Brunk et al., 1998; Riley et al., 2005). It was used to measure satisfaction with services with a random sample of parents' of youth (5–17-year-olds) in the United States (Riley & Stromberg, 2001). The YSS-F was employed with 14 State of Kentucky community mental health services that received referrals from a population of low-income families, children in the care of child welfare and children with disabilities. The racial origin of the families who participated included 77% Caucasian, 13.3% African-American and 9.6% other categories. These demographics differed slightly from the general child population of that area, which was recorded as 86% Caucasian, 9% Black and 5% other races (Riley & Stromberg, 2001, p. 12). The population was both urban and rural.

The YSS-F had undergone a factor analysis to establish its specific scope and the aspects applicable for effective CAMHS delivery according to parents. The results validated the domain structure and the following five factors were identified:

- access;
- family involvement;
- cultural sensitivity;
- satisfaction with services; and
- outcomes (Riley & Stromberg, 2001).

Internal consistency for the YSS-F was assessed by calculating the Cronbach's alpha value. The results for each factor included:

- (0.66) access;
- (0.79) family involvement;
- (0.88) outcomes;
- (0.89) cultural sensitivity; and
- (0.94) satisfaction with service (Riley & Stromberg, 2001).

Overall the internal consistency of the YSS-F was high.

The YSS-F (Riley & Stromberg, 2001) also included open-ended questions to provide in-depth subjective information. They were as follows:

- (a) What has been the most helpful thing about the service you and your child received over the last six months?
- (b) What would improve the services your child received at this centre?

The Youth Services Survey – Youth (YSS-Y) tool followed the development of the YSS-F. The YSS-Y provided an opportunity to collect both quantitative and qualitative data from youth aged 13–19 years to shape and improve services (California Department of Mental Health Systems of Care, 2005). Of the participants in the YSS-Y, 54.8% identified as males, 44.8% as females and 0.4% as others.

The racial origins of the participants were recorded as 37.4% white/Caucasian, 37.0% Mexican/Hispanic/Latino, 19% Black/African American, 4.0% Asian, 8.3% American Indian/Alaskan Native, 3.5% Native Hawaiian/Other Pacific Islander, 26.2% other and 3.4% unknown race. The respondents were given the option to identify race categories that they felt were applicable so the numbers will be over the 100%.

A total of 97.7% of the surveys were completed in the English language. In total, 96.1% reported that the services they received were provided in the language they preferred and 94.3% responded that information was provided in the language they preferred (California Department of Mental Health Systems of Care, 2005).

The YSS-Y is a 21-item consumer-completed instrument developed to report respondent views of: access, cultural sensitivity, consumer participation, general satisfaction, and service outcomes (California Department of Mental Health Systems of Care, 2005). This tool appropriate for youth was confirmed as a reliable and validated questionnaire (California Department of Mental Health Systems of Care, 2005).

The YSS-Y underwent a factor analysis to establish the specific scope of the survey and the aspects applicable for effective CAMHS delivery according to parents. The results validated the domain structure and the following five factors were identified:

- access;
- family involvement;
- cultural sensitivity;
- satisfaction with services; and
- outcomes (Brunk, 2001).

The Cronbach's alpha results for each factor included:

- (0.705) access;
- (0.823) participation in treatment;
- (0.896) cultural sensitivity;
- (0.941) satisfaction with service; and
- (0.864) outcomes (Brunk, 2003).

Overall the internal consistency of the YSS-Y was high.

Again open-ended questions were also included as part of the survey:

- (a) What has been the most helpful thing about the service you received over the last six months?
- (b) What would improve the services your child received at this centre?

Examination of Māori *rangatahi* and CAMHS

Little examination has occurred on how to best deliver and improve CAMHS in Aotearoa for the Māori adolescent population. Services delivered in a culturally appropriate way have been identified as essential to this progress (Baxter et al., 2006; McClintock et al., 2011; Ramage et al., 2005). Cultural alienation from mainstream services' clinical paradigms may intimidate and repel many Māori (Durie, 1994, 2001; Murchie, 1984;

Ramage et al., 2005). Cultural variables have been suggested as the basis for this situation (Adolescent Health Research Group, 2004; Baxter et al., 2006; Durie, 1994; McClintock et al., 2011; Ramage et al., 2005).

The investigation into whether providing culturally appropriate mental health services improves access for Māori, including the child and adolescent population, is important given the poor mental health statistics and access rates for the Māori population (Baxter et al., 2006; Oakley Browne et al., 2005; McClintock et al., 2011). A pilot qualitative study in Aotearoa sought to identify matters relevant to participants aged 7–12 years who had accessed CAMHS (Mitchell-Lowe & Eggleston, 2009). Twenty-one children who had participated in an initial assessment at one of two outpatient clinics were invited to contribute to the study. Only nine consented. The participants were asked through semi-structured questions to describe their experiences and views of the CAMHS assessment processes (Mitchell-Lowe & Eggleston, 2009).

The general response of their experience with the CAMHS assessment process was positive. Five themes were identified from the interviews, and issues included:

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

The study limitations included a low participation rate, particularly Maori and Pacific people, as well as an under-representation of those who viewed CAMHS negatively (Mitchell-Lowe & Eggleston, 2009). Despite these restrictions this youth study of CAMHS from 7–12-year-olds provided valuable data to a limited pool of Aotearoa CAMHS-specific research.

A measure focussing on *whānau* [family] perception of CAMHS delivery to Māori was developed from the YSS-F (McClintock et al., 2012). The Te Tomokanga tool had demonstrated construct validity and reliability. The survey sampled the perceptions of 50 Māori caregivers who accessed the support of CAMHS (McClintock et al., 2012).

One of the study hypotheses explored the significant differences for Māori in their perceptions of the extent of *whānau* involvement between the three CAMHS types of mainstream,¹ bicultural and kaupapa Māori in the Midland health region, Aotearoa.

The second hypothesis focussed on the belief that Māori desire therapeutic methods consistent with the Whare Tapa Whā,² such as involving the *whānau* and recognising the importance of culture and spirituality (McClintock et al., 2012).

The collected data confirmed that acceptability of CAMHS was related to *whānau* involvement and service delivery that takes into account cultural differences, all at statistically significant levels. The project sample also supported the concept that Māori desire therapeutic methods consistent with the Whare Tapa Whā, such as *whānau* involvement and the importance of recognising culture and spirituality. If these components are delivered, this leads to satisfaction with CAMHS.

A qualitative phase followed the survey testing, and reported similar results (McClintock et al., 2011). Two different cohorts participated. One completed the survey and an interview, and these participants had positive experiences. Cohort two only wanted to participate in an interview. This cohort had negative experiences and demanded more recognition and support of culture to be delivered by a Māori-specific CAMHS workforce.

A CAMHS cultural framework aligned to the *Pōwhiri* process of engagement and participation was developed as a result of the qualitative phase. This process values respect, responsibilities and commitment and can be utilised by CAMHS to specifically support Māori cultural processes (McClintock et al., 2011).

As with the North American case, there is also a need in Aotearoa to develop a youth-focused tool that provides an opportunity to collect both quantitative and qualitative data from youth aged 13–19 years that will shape and improve CAMHS (California Department of Mental Health Systems of Care, 2005).

Discussion

Given that *rangatahi* are an important population within society, maintaining their mental health is understandably a priority. Consistent with this is the need to provide appropriate CAMHS to support *rangatahi* with mental health issues.

The advancement of appropriate CAMHS evaluation frameworks and tools are supported by both international and Aotearoa studies. Conducting an investigation into the development of a tool to specifically assist Māori *rangatahi* access culturally appropriate CAMHS is both essential and timely.

Notes

¹ Mainstream (Waikato, Taranaki) services in this study had no dedicated Maori positions available. Bicultural (Voyagers, Te Au o Hinetai, Te Whare o te Rito) services in this study had some dedicated Maori positions available. Kaupapa Maori services (Te Puna Hauora) in this study had dedicated Maori positions available.

² The Whare Tapa Whā framework relies on a Māori world view of health, a holistic approach advocating a balance between the four dimensions of the Taha Whānau (family), the Taha Tinana (physical), the Taha Hinengaro (cognitive/intellectual) and the Taha Wairua (spiritual) (Durie, 1994). It is believed that if one aspect is in distress then this anguish impacts on the others, causing tension and increased risk of poor health. Optimal health requires balance between all four dimensions.

Notes on contributors

Kahu McClintock is a research manager with Te Rau Matatini, the National Māori Health Organisation of Aotearoa/ New Zealand.

Roimata Tauroa is a researcher with Te Rau Matatini, the National Māori Health Organisation of Aotearoa/ New Zealand.

Graham Mellsop is professor of psychiatry at the Waikato Clinical School, School of Medicine, Auckland University.

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