

APPROPRIATE CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS): MĀORI CAREGIVER'S PERSPECTIVES

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ABSTRACT

The development of Child and Adolescent Mental Health Services (CAMHS) that meet the needs of Maori (indigenous people of Aotearoa/ New Zealand) is critical. This study, Te Tomokanga, investigated the acceptability of mainstream¹, bicultural,² and kaupapa Māori³ CAMHS access and delivery to young Māori and their whānau.⁴ Detailed factors contributing to potential areas for improvement are identified in this examination. This includes, most specifically, a cultural framework based on the traditional Māori *Pōwhiri* process of access and engagement provided by a culturally relevant workforce.

Method

A kaupapa Māori (Māori driven) research paradigm, based on the traditional *Pōwhiri* process of engagement and participation guided this qualitative research approach, particularly the components of *karanga*, *mihimihi*, *whaikōrero* and *koha*. These components are discussed in more detail in this article.

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1. Mainstream services in this study had no dedicated Māori positions available.
 2. Bicultural services in this study had a/some dedicated Māori positions available.
 3. Kaupapa Māori services in this study had dedicated Māori positions available.
 4. Whānau, parents and caregivers are used interchangeably in this thesis.

Participants were invited from the six District Health Boards (DHBs) CAMHS of the Midland health region.⁵ Semistructured questions were utilized to collect the data from two groups:

1. Whaia te Ara Whanui; a whānau, interview-based phase that involved 25 self-selected participants, some of whom had also completed a quantitative phase (McClintock et al., 2012) and
2. Te Hononga; a whānau, interview-based phase that involved another 25 self-chosen participants who had not consented to completing a quantitative phase.

A thematic analysis was conducted on the narrative data from the 50 participants who completed face-to-face interviews

Results

The 25 whānau in the Whaia te Ara Whanui phase who had completed the survey in a quantitative phase were generally satisfied with what the CAMHS provided. This acceptance was based on respectful partnerships and the development of appropriate cultural support. This assistance was offered by both non-Māori and Māori workforce.

The participants in the Te Hononga phase, who declined to complete the study survey but agreed to be interviewed, reported less positive experiences. They generally believed that the non-Māori CAMHS workforce they came in contact with struggled to provide appropriate cultural support. These participants were also frustrated by the lack of information on medication and its benefits.

Conclusion

Results from both the Whaia te Ara Whānui and Te Hononga phases identified the importance of cultural support for Māori referrals who access CAMHS. However these two cohorts held distinct views on the ability of CAMHS with largely a non-Māori workforce to deliver culturally appropriate services. Their opinions were influenced by their own expectations and experiences with CAMHS. Despite these differences, the views are useful contributions to a conceptual development of a CAMHS best practice model. When aligned with the traditional *Pōwhiri* process of engagement and participation such a framework values respectful relationships, commitment and reciprocity. The challenge for CAMHS is therefore to provide a

5. Midlands health region includes Waikato, Taranaki, Lakes, Bay of Plenty and Tai Rawhiti DHBs

collaborative workforce with culturally appropriate responses to the needs of a diverse range of Māori whānau.

Keywords: Māori mental health, indigenous mental health, child and Adolescent Mental Health Service

INTRODUCTION

The Māori experience of colonial contact has, for a disproportionate number, been associated with dislocation and deprivation. Māori fare poorly in comparison with non-Māori on many social indices, such as education, housing, and health (Coupe, 2005; Durie, 1994; Smith, 1999; Walker, 1990). National statistics repeatedly demonstrate Māori overrepresentation in a variety of areas including rates and duration of hospitalization, alcohol and drug dependence, child abuse, and offending (Oakley Browne et al., 2006; Ramage et al., 2005). Currently one of the greatest reported health risks to Māori is the high prevalence of mental health disorders (Durie, 2003).

Providing culturally appropriate health services is considered important (Durie, 1994; Oakley Browne et al., 2006; Ramage et al., 2005). Mental health programs that promote belonging and secure cultural identity are part of this development (Huriwai et al., 2000). Mental health services placed in culturally sensitive environments are believed to increase positive client experiences (Bhui et al., 2007).

Improving the delivery of mental health services to Māori young people and their whānau has been identified as a priority (Mental Health Commission, 2004, p. 34; Oakley Browne et al., 2006; Ramage et al., 2005). Parental involvement in the assessment and treatment processes is thought to be essential to this development (Martin et al., 2003). Positive CAMHS contact for parents is more likely to influence ongoing dealings with the service that could lead to better mental health outcomes for their children (Boynnton and Greenhalgh, 2004; Riley and Stromberg, 2001). By extension, parental satisfaction is more likely to occur when parents feel valued and their opinions are respected (Werrbach and Perry, 1996).

International views suggest that an effective evaluation process of CAMHS by parents goes beyond global satisfaction measures to a framework that is detailed appropriately and contributes to service improvement (Brunk et al., 1998; Riley and Stromberg, 2001). Family involvement in decision making and access to culturally sensitive providers are important to parents and are more likely to affect their willingness to access services (Brunk et al., 1998; McClintock et al., 2012; Riley and Stromberg, 2001).

Effective CAMHS engagement with parents can improve access to subsequent assessment and/or treatment for children (Brunk et al., 1998; Ramage et al., 2005; Riley and Stromberg, 2001). Including parents' ideas in this process could contribute to a foundation of national norms for access and treatment completion in CAMHS (Riley and Stromberg, 2001). A study to gain the views of Māori caregivers' whose children have accessed CAMHS is expected to contribute to this development.

METHOD

PŌWHIRI PROCESS

A kaupapa Māori research approach was utilized in this study. It incorporated 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 the notion of 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).

The following commentary explains the traditional elements of the *Pōwhiri* process specific to *karanga*, *mihimihi*, *whaikōrero*, and *koha*. Consideration is given to their relevance to the engagement and participation protocols as they apply to the research process in this study.

Karanga

The right of entry into a designated area is initiated by a *karanga*, a physical call of invitation. This ritual of access is controlled by the *tangata whenua* who in contemporary times usually have knowledge of the intentions of their visitor/visitors.

Mihimihi

Following the *karanga* is the *mihimihi* stage. This is an important time to make connections, reconnections, as well as acknowledging the reason for meeting. The researcher can utilize this time to clarify the research intent and outcomes. This process increases the chance of a satisfactory completion of the project and also ensures the participants feel they are partners in the study (Boynton 2004; Boynton and Greenhalgh, 2004).

Whaikōrero

This involves a time for respectful listening, in-depth focused discussion, questions, and answers. This process must also provide sufficient time for the exchange of information which is crucial for robust research (Boynton and Greenhalgh, 2004).

Koha

The final element of the *Pōwhiri* process, pertinent to this study, is the *koha*. *Koha* refers to a physical demonstration of appreciation offered to those who have both shared their knowledge and hosted.

RECRUITMENT

This qualitative study engaged with 50 Māori caregivers who accessed the support of the six CAMHS in the Midland health region. The aim was to record their experiences and ultimately their views on the acceptability of CAMHS. A purposive sample from the Kaupapa Māori, mainstream and bi-cultural services from the Midland health region were invited to participate to provide an opportunity to compare and contrast responses from whānau who accessed the different types of CAMHS.

ETHICS

The Multiregion Ethics Committee (MEC) of the New Zealand Ministry of Health approved the study (06/02/01). Each DHB had its unique ethical process to conduct this research. Gaining site approval from each DHB presented unanticipated challenges. Main issues included multiple research committees (Māori, Mental Health, Health Research) in the same DHB, that didn't communicate with each other and DHB research committees that lacked understanding of the MEC process.

QUESTIONS

The qualitative study utilized three open-ended questions which focused on gaining responses to the following 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 encouraged to expand on these areas in the interview sessions. The study provided an opportunity to bring together data sets from

two distinct qualitative groups (Creswell, 2003). The same semistructured questions were utilized with both groups. Face-to-face interviews occurred at a venue chosen by the participant, which was for most in their homes and for the remainder in their work environment. The interviews lasted 30–60 minutes. All interviews were audio taped, transcribed, then the transcripts returned to whānau 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, obtaining 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 method involved a process of naming the themes, providing a description of these, and utilizing raw narrative data to expand the significance of the themes (Thomas, 2005). The narrative data collected through the face-to-face interviews was 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. This method allowed for multiple placing of the data under more than one theme or node.

NVivo7 software facilitated the ordering of the data through a thematic approach after which the findings were sorted into themes (Thomas, 2005). Independent coding and the comparison process with selected samples ($n=10$ 20%) from both data sets assisted this process.

RESULTS

Narrative data was collected through face-to-face interviews from two cohorts:

1. Whaia te Ara Whanui; (Table 1) a whānau, interview-based phase that involved 25 self-selected participants, some of the respondents from a quantitative phase; and

2. Te Hononga; (Table 2) a whānau, interview-based phase that involved another 25 self-chosen participants who had not consented to completing a quantitative phase.

Participants were from the six DHBs CAMHS of the Midland health region.

Table 1: Whaia te Ara Whānui

Respondents to the Survey	Kaupapa Maori Te Puna Hauora BOP DHB	Bicultural Te Au o Hinetai Lakes DHB	Bicultural Voyagers BOB DHB	Bicultural Te Whare o te Rito Tai Rawhiti DHB	Mainstream CAMHS Waikato DHB	Mainstream CAMHS Taranaki DHB	Total
n (%)	4 (16)	2 (8)	5 (20)	5 (20)	6(24)	3(12)	25 (100)

Table 2: Te Hononga

Non-respondents to the Survey	Kaupapa Maori Te Puna Hauora BOP DHB	Bicultural Te Au o Hinetai Lakes DHB	Bicultural Voyagers BOB DHB	Bicultural Te Whare o te Rito Tai Rawhiti DHB	Mainstream CAMHS Waikato DHB	Mainstream CAMHS Taranaki DHB	Total
n (%)	5 (20)	4 (16)	1 (4)	3 (12)	8 (32)	4 (16)	25 (100)
Total	9 (18)	6(12)	6 (12)	8 (18)	14 (28)	7 (14)	50 (100)

The Whaia te Ara Whānui and Te Hononga cohorts identified the importance of cultural support for Māori referrals to CAMHS. However they held diverse views on the ability of a non-Māori workforce to deliver culturally appropriate services. Their opinions were influenced by their own expectations and experiences of cultural engagement with CAMHS.

Despite these differences there were commonalities which can contribute to the conceptual development of a CAMHS best practice model for working with Māori. This framework, discussed below, has been aligned with the traditional *Pōwhiri* process. Part one to this section acknowledges what parents in this study experienced as helpful from CAMHS. The details have not been sectioned into the three service types, but intermingled to provide a focused approach to an ideal CAMHS. Part two identifies the challenges caregivers faced in accessing CAMHS. These have been framed as future areas of development, *ngā moemoea* which are the caregiver’s aspirations for an improved CAMHS delivery. This structure informs the notion of a good CAMHS as determined by Māori.

PART ONE: PŌWHIRI PROCESS FOR POSITIVE CAMHS DELIVERY

Karanga

Appropriate to the *karanga* stage, parents appreciated entry and referral pathways into CAMHS that accommodated both formal and informal processes. Whānau identified, for example, general practitioners, schools, and

well-informed extended whānau, in addition to CAMHS acceptance of self referrals, as being pivotal to the ease of access for Māori into CAMHS.

Mihimihi

Appropriate to the *mihimihi* stage, parents appreciated the quick response time and the positive initial contact processes with CAMHS. They also felt welcomed in a CAMHS clinic environment with Māori images and felt that a respectful receptionist encouraged whānau to engage with the service. Clinicians who demonstrated considerate listening skills and valued whānau input were viewed as being more likely to achieve successful engagement and participation with Māori. Kaupapa Māori services were viewed in a positive light because they provided support in a culturally respectful and considerate manner.

Whaikōrero

Appropriate to the *whaikōrero* stage, parents appreciated a CAMHS that provided conditions which allowed maximum support for their child. This included appropriate time and space for communication that valued partnership with whānau.

Caregivers also appreciated a CAMHS that provided them with the conditions that enhanced the concept of a Māori identity. This included the ability of CAMHS to offer a service both culturally and clinically appropriate. The ability of CAMHS to build positive respectful relationships with parents was articulated by parents as a priority.

Koha

Appropriate to the *koha* stage, parents appreciated a CAMHS that worked in partnership with them. Parents acknowledged success with CAMHS was dependant on appropriate cultural approaches being offered by CAMHS clinicians and providing parents with appropriate cultural choices of care and a commitment to delivering these options.

PART TWO: NGĀ MOEMOEĀ, ASPIRATIONS FOR POSITIVE CAMHS DELIVERY

Karanga

Appropriate to the *karanga* stage, parents desired a Māori mental health workforce with cultural capacity and capability who could inform whānau about what cultural and clinical support CAMHS could provide for them.

Mihimihi

Appropriate to the *mihimihi* stage, parents desired an Aotearoa (New Zealand) trained mental health workforce that could provide cultural and clinical appropriate services at the assessment stage. This was desirable for better engagement and participation with Māori. A mental health workforce that would work to enhance the quality of the relationship between whānau and CAMHS was also viewed as essential.

Whaikōrero

Appropriate to the *whaikōrero* stage, parents desired CAMHS to factor in the appropriate time and space for communication that values partnership, relationships, responsibility, and reciprocity with whānau. This was seen as essential to ensure positive engagement and participation.

The provision of a mental health workforce appropriate to the Aotearoa context with *Te Reo me Ona Tikanga* (language, values, and beliefs) and culturally competent health professionals was conveyed as a priority to ensure success for Māori who access CAMHS. The correct and timely information regarding medication and its benefits were viewed as essential to assist compliance with medication regimes offered by CAMHS

Koha

Appropriate to the *koha* stage, parents desired the development of a culturally appropriate mental health workforce. Parents wanted appropriate cultural approaches to support the notion of a Māori identity. Whānau also wanted opportunities to be informed and access Māori alternative healing approaches not offered by CAMHS.

CONCLUSION

This study represents the first in depth investigation into the acceptability of CAMHS for Māori. A *kaupapa* Māori research approach that progresses Māori development and aspirations ensured successful completion of this qualitative project. This research offered participants from two different cohorts — the *Whaia te Ara Whanui* phase and the *Te Hononga* phase — an opportunity to contribute to a useful CAMHS framework. This project gained the views of Māori caregivers' whose children had accessed CAMHS to identify the achievements and challenges in current CAMHS delivery.

These perspectives should prove useful to guide future CAMHS delivery to Māori young people and their whānau. Included is the concept that suc-

cessful access, engagement, and participation of Māori, with CAMHS are more likely to occur when whānau involvement is encouraged and valued. Improved access to assessment and/or treatment for children is expected to lead to better CAMHS outcomes for Māori young people and their whānau.

Caregivers advocated for access to culturally appropriate CAMHS processes and providers. This would increase their willingness to access CAMHS. As a result this study proposes a culturally appropriate framework to contribute to CAMHS improvement. The recommended development 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 therefore to provide a workforce that works in a collaborative manner and is culturally appropriate to respond to the needs of a diverse range of Māori whānau.

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