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 Te 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

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
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, mihimihit, whakikōrero 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

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 CAMHS1 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 Kowhai Anawhau (Canterbury DHB), and Te Oranga Tona 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, mihimihī, 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; mihimihī 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
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 articul-
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**


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.


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).

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