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Pilot of Te Tomokanga: A Child and Adolescent Mental Health Service Evaluation Tool for an Indigenous Population

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Pilot of Te Tomokanga: A Child and Adolescent Mental Health Service Evaluation Tool for an Indigenous Population

Abstract
Background

The acceptability of Child and Adolescent Mental Health Services (CAMHS) to Indigenous peoples is little studied. There has been a lack of evaluation tools able to take account of the more holistic approach to the attainment of mental health that characterises Māori, the Indigenous population of *Aotearoa* (New Zealand). This study aimed to develop such an instrument and establish some of its psychometric properties. Then, to use the measure to establish *whānau* (family or caregiver) views on desirable CAMHS characteristics.

Method

A self-administered survey, Te Tomokanga, was developed by modifying a North American questionnaire, the Youth Services Survey for Families (YSS-F). The intent of the tool was to record *whānau* experiences and views on service acceptability.

The Te Tomokanga survey is unique in that it incorporates questions designed to examine CAMHS delivery in light of the *Whare Tapa Whā*[1], a Māori comprehensive model of health with a focus on *whānau* involvement and culturally responsive services. This mail or telephone survey was completed by a cohort of 168 Māori *whānau*. Their children had been referred to one of the three types of CAMHS, mainstream, bicultural, and *kaupapa Māori*[2], of the District Health Board (DHBs) in the Midland health region, *Aotearoa*. The Midland health region is an area with a large Māori population with high levels of social deprivation.

Results

The Te Tomokanga instrument was shown to have a similar factor structure to the North American questionnaire from which it had been derived. It identified issues relevant to Māori *whānau* satisfaction with CAMHS. The work supports 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.

The participants were generally positive about the services they received from the three different CAMHS types, which shows good acceptability of CAMHS for Māori. Results found satisfaction with CAMHS was related to *whānau* involvement and culturally delivered services.

Conclusion

The Te Tomokanga instrument should prove useful in *Aotearoa* or other similar cultural settings. It is a means of determining the cultural acceptability or improving CAMHS delivery for Indigenous populations.

[1] The *Whare Tapa Whā* framework relies on a Māori worldview 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 or intellectual) and the *Taha Wairua* (spiritual). It is believed if one aspect is in distress then it impacts on the others causing tension and increased risk of poor health. Optimal health requires balance between all four dimensions.

[2] *Kaupapa Māori* mental health services provide Māori dedicated clinical and cultural workforce for Māori service users.

Keywords
Indigenous, child and adolescent mental health, service measurement

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Pilot of Te Tomokanga: A Child and Adolescent Mental Health Service Evaluation Tool for an Indigenous Population

In *Aotearoa* or New Zealand, access to effective mental health services for Māori, the Indigenous population, is a priority (Baxter, Kingi, Tapsell, Durie, & McGee, 2006; Ramage, Bir, Towns, Vague, Cargo, & Niumata-Faleafa, 2005). It is, therefore, important to assess whether these services are addressing the issues crucial to *whānau* (family or caregivers). The development of a culturally attuned tool would play a significant role in developing and refining such services (World Health Organisation, 2005).

Measuring satisfaction with mental health services by identifying service users' concerns and issues is essential in assessing effectiveness (Merry et al., 2004). The lack of an appropriate tool for examining satisfaction with the Child and Adolescent Mental Health Services (CAMHS) among Māori has been an impediment to this process. Developing a specific tool for CAMHS would provide the opportunity to support caregivers, children, and adolescents from Indigenous and/or colonised populations. It is expected that if parents have positive experiences it will likely influence ongoing dealings with CAMHS and, thus, contribute to better mental health outcomes for their children.

Māori may well desire a different style of therapeutic service particularly given that the *Whare Tapa Whā* conceptual model of health (Durie, 1994) has wide currency within the health sector in *Aotearoa*. The framework relies on a Māori worldview of health, a holistic approach, and advocates for a balance between the four dimensions of the *Taha Whānau* (family), the *Taha Tinana* (physical), the *Taha Hinengaro* (cognitive or 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 (Durie, 1994).

The first aim of this study was to develop a measure that focuses on the caregivers' perceptions of whether the CAMHS delivery to Māori supports the inclusion of a Māori identity and Māori cultural beliefs (McClintock, 2010). The resulting survey instrument is the Te Tomokanga (see Appendix). Our second aim was to conduct a pilot survey to sample the perceptions of Māori caregivers who accessed the support of three CAMHS types. The study hypotheses are as follows:

> **Hypothesis 1**: There are significant differences in perceptions of the extent to which whānau are involved among the three CAMHS types (mainstream, bicultural, and *kaupapa Māori*[1]) among Māori in the Midland health region of *Aotearoa*.
>
> **Hypothesis 2**: Māori desire therapeutic methods consistent with the *Whare Tapa Whā*, such as involvement of the *whānau* and recognition of the importance of culture and spirituality.

Method

Study Protocols

A *kaupapa Māori* philosophy, consistent with Māori aspirations and development, guided the methodology (McClintock, Mellsop, Merry, & Moeke-Maxwell, 2010). This approach is founded on self-determination and the legitimisation of Māori knowledge and processes, such as the traditional *Pōwhiri* process of engagement and participation (Durie, 2003; McClintock, et al., 2010; Smith, 1999). This process relies on mutual respect and reciprocity where the researcher is dependant on the participant to consent to the research process. Māori control over involvement in research of Māori issues is also integral to a *kaupapa Māori* research

[1] Mainstream (Waikato, Taranaki) CAMHS in this study had no dedicated Māori staff positions available. Bicultural (Voyagers, Te Au o Hinetai, Te Whare o te Rito) CAMHSs had a or some dedicated Māori staff positions available. *Kaupapa Māori* CAMHS (Te Puna Hauora) had dedicated Māori staff positions available.

approach. Ultimately, Māori health research outcomes must benefit Māori by providing solutions that address Māori health issues (Durie, 2003; Smith, 1999).

Development of Te Tomokanga

The Youth Services Survey for Families (YSS-F) is an instrument utilised in North America to gauge parental satisfaction with CAMHS (Brunk, Liao, Santiago, & Ewell, 1998; Riley & Stromberg, 2001**;** Riley, Stromberg, & Clark. 2005). Slight modifications were made to the wording of this instrument, based on the author's views, and questions 9, 19, and 20 were added to construct the Te Tomokanga (Appendix). Question 9 relates to the cultural background of *the client's interviewer*, which was added to address the issue of CAMHS delivery in light of the *Whare Tapa Whā* and focus on the importance of services to support a Māori cultural identity for Māori clients (Durie, Gillies, Kingi, & Waldon, 1995). Questions 19 and 20 relate to *inter-sector collaboration* and imply that mental health services will, at times, need to work collaboratively with other health services and sectors, such as education and social development, to increase effectiveness (Ramage et al., 2005).

A Likert scale was used for all questions scored from 1 – strongly disagree to 5 – strongly agree. A purposive sample of Māori caregivers had an opportunity to respond to questions on CAMHS acceptability with the 21 item Te Tomokanga survey (McClintock, 2010). All analyses were undertaken using SPSS v17.

Recruitment

The Te Tomokanga, a self-administered survey, was distributed by mail or telephone if services provided telephone contacts. The recruitment process, in line with the ethical approval, was administered by the lead investigator to all Māori *whānau* who had accessed one of the three CAMHS types in the Midland health region of *Aotearoa* from 2003 to 2005. The recruitment process aligned with the *Pōwhiri* process of engagement and participation, which included the *karanga* or invitation and consent to complete the survey; *mihimihi* or information sheet explaining the study; *whaikōrero* or completion of the survey; and *koha* or payment of a $10 voucher in acknowledgement of each participant's commitment to complete the survey (McClintock et al., 2010).

Ethics

The Multi-Region Ethics Committee (MEC), Ministry of Health, *Aotearoa* approved the study (MEC 06/02/0101). District Health Board (DHB) locality approval from all six participating sites was gained to conduct this project.

Analysis

Tests that do not make assumptions about the normal population distribution are referred to as non-parametric tests. The handling of rank-ordered data is considered a technique of non-parametric tests as evident in the study analysis. Non-parametric rank order statistics (Spearman's rho) were applied to the co-relational data.

Aim one: Tomokanga survey validity. The validity of the survey instrument was assessed by relating the survey results to those from an existing, validated tool , the YSS-F (Myers & Winter, 2002). Establishing the construct validity of the tool relied on an exploratory factor analysis of the survey questions utilising varimax rotation. Results from the Te Tomokanga based on a Māori sample are compared to the factor structure identified using the YSS-F with a North American sample (Brunk et al., 1998; Riley & Stromberg, 2001; Riley et al., 2005). The assessing the robustness of domains relied on quantifying internal consistency using

Cronbach's alpha, which indicates the extent to which the individual items of a domain are related to each other (Myers & Winter, 2002).

Aim two: Tomokanga survey results: Experiences and acceptability.

Hypothesis 1: The analysis compared the responses to the seven *whānau* involvement questions (#10, 11, 12, 15, 16, 17, and 21 in Appendix) across the three service types (mainstream, bicultural, and *kaupapa Māori*). The test process involved calculating the mean[2] of the responses to these seven questions for each of the three distinctive service types and then comparing these statistically with pair-wise comparisons using independent sample t-tests (Armitage, Berry, & Mathews, 2002). Pairwise comparisons using independent t-tests were used as it was thought that different questions would have different relevance to each of the three service types.

Hypothesis 2.: This analysis sought to identify the aspects of *whānau* involvement and cultural relevancy that related most to the acceptability of the service. The associations between the key acceptability question (#11 in Appendix), *My child received services that were right for him or her*, and the items in the survey relating to *whānau* involvement and cultural relevancy were tested using Spearman's rank correlation coefficient (r). No correction for multiple testing was applied and a two-tailed p-value <0.05 was taken to indicate statistical significance (Armitage et al., 2002). This approach is justified because of the study's exploratory nature and the fact that it focuses on identifying a consistent pattern of associations among correlations.

Results

The questionnaire was distributed by mail or telephone to 400 caregivers from participating CAMHS and resulted in 168 study participants. This represented a 42% response rate. The participants were evenly distributed amongst the three CAMHS types. Two percent were under 4 years of age, 36% were under 14 years, and 62% were under 19 years. The ratio of males to females was 4:1. The demographics show a response bias from caregivers of males over 14 years of age.

Aim One: Validity and Reliability

The factor analysis to establish construct validity produced five factors with eigen values greater than one, collectively explaining 60% of the variance (Table 1). The five factors are:

- *Whānau* involvement included seven items (Questions 10, 11, 12, 15, 16, 17, and 21) and explained 21% of the variation).
- Satisfaction with services explained 12% of the variation and included five items (Questions 1, 2, 7, 8, and 18).
- Access (convenience) explained 11% of the variation and included four items (Questions 3, 4, 5, and 6).
- Cultural sensitivity included two items (Questions 13 and 14) and explained 9% of the variation.
- Satisfaction with inter-sector collaboration explained 7% of the variation and included two items (Questions 19 and 20).

Question 9, *It is important to be interviewed by a staff member of the same race or culture,* remained on its own explaining less than 5% of the variation, but did not warrant being included as a single variable domain because the eigen value was less than 1.0 (McClintock, 2010).

The Cronbach's alpha reliability results were good for all factors apart from the fifth factor, which describes inter-sector collaboration (Table 2). The focus on inter-sector support is a developing initiative, which may

[2] The mean is calculated from the responses to the questions, which range from 1 - strongly disagree to 5 - strongly agree.

Table 1
Summary of Exploratory Factor Analysis for Te Tomokanga Survey Instrument

	Factor Loadings					
Item	**1 *Whānau* involvement**	**2 Satisfaction with services**	**3 Access (convenience)**	**4 Cultural sensitivity**	**5 Satisfaction with inter-sector collaboration**	**6 Services support Māori cultural identity**
1. Information about the CAMHS was easy to obtain.		0.406				
2. The location of the CAMHS was simple to find.		0.666				
3. An appointment was given when my child needed it.			0.563			
4. Allocated appointment times were convenient.			0.757			
5. The clinic venue for the appointment was convenient.			0.593			
6. Transport cost to the CAMHS appointment was affordable.			0.761			
7. CAMHS consultation cost was affordable.		0.673				
8. Medication was affordable.		0.772				
9. It is important to be interviewed by a staff member of the same race or culture						0.868
10. Staff asked important questions about my child.	0.659					
11. My child received services that were right for him or her.	0.727					
12. Staff asked important questions about my *whānau* or	0.726					

Item	Factor Loadings					
	1 *Whānau* involvement	2 Satisfaction with services	3 Access (convenience)	4 Cultural sensitivity	5 Satisfaction with inter-sector collaboration	6 Services support Māori cultural identity
family.						
13. Staff respected my spiritual beliefs.				0.788		
14. Staff was sensitive to my cultural beliefs.				0.862		
15. 15. My *whānau* or family received support that was right for us.	0.708					
16. I felt I had a say in the assessment process.	0.732					
17. I understood the treatment options for my child.	0.740					
18. I understood that medication would help.		0.611				
19. The involvement of Group Special Education was important in helping my child.					0.608	
20. The involvement of Child Youth Family was important to helping my child.					0.778	
21. The involvement of CAMHS was important to helping my child.	0.705					
Eigen value	4.5	2.5	2.3	1.9	1.5	0.8
% of variance	21%	12%	11%	9%	7%	< 5%

Note. Factor loadings with an absolute value greater than 0.40 reported.

account for the outcome. The remaining results were very similar to those of the parent instrument, YSS-F (Brunk et al., 1998), as indicated in Table 2.

Table 2
Comparison of Cronbach's Alpha for Factors in Te Tomokanga and YSS-F

	Survey	
	Te Tomokanga	**YSS-F**
Whānau involvement	0.88	0.79
Satisfaction with services	0.69	0.94
Access (convenience)	0.71	0.66
Cultural sensitivity	0.84	0.89
Satisfaction with inter-sector collaboration	0.38	Not included

Aim Two: Experiences and Acceptability

Hypothesis 1. The participants in this study were mostly positive about the services they received from the three different service types (Table 3). The mean ratings were greater than a score of 3.5, indicating that on average participants agreed or strongly agreed that the three CAMHS types offered these aspects of *whānau* involvement.

Hypothesis 2. The key acceptability question in the Te Tomokanga survey – Question 11, *My child received services that were right for him or her* – correlated positively ($p < .001$) with the Te Tomokanga items identified in Table 4, including *whānau* involvement and cultural factors. Most t-tests were not significant with the exception of Question 17, *I understood the treatment options for my child*, which suggests that those who accessed bicultural services had higher satisfaction ratings than those who accessed *kaupapa* or mainstream services. Bicultural services had the highest number of participants who completed the survey.

Discussion

The first aim of the study was to develop and test a measure that focused on *whānau* perceptions of the acceptability of CAMHS delivery to Māori. The result was the development of the Te Tomokanga survey by adapting the YSS-F, which has demonstrated construct validity and reliability. The second aim was to use this survey to sample the perceptions of Māori caregivers who accessed the support of the three CAMHS types.

Two study hypotheses were tested. The first hypothesis focused on the significant differences for Māori in their perceptions of the extent of *whānau* involvement between the three CAMHS types, mainstream, bicultural, and *kaupapa Māori*, in the Midland health region of *Aotearoa*. The second hypothesis tested the assertion that Māori desire therapeutic methods consistent with the *Whare Tapa Whā*, such as involving the *whānau* and recognising the importance of culture and spirituality.

The results suggest a general satisfaction from the respondents with the CAMHS delivery from the three service types. The data collected from Māori caregivers revealed five factors, *whānau* involvement, satisfaction with services received, access or convenience, cultural sensitivity, and satisfaction with inter-sector collaboration, that contributed to responsive CAMHS for Māori. Whether or not CAMHS services were perceived to be acceptable was related to *whānau* involvement and service delivery that takes into account cultural differences. This study sample supports the concept that Māori desire therapeutic methods consistent

Table 3
Mean Ratings of CAMHS Service Types across *Whānau* Involvement Questions

Q: *Whānau* involvement	**Bicultural (B)**	***Kaupapa* (K)**	**Mainstream (M)**	**Overall[a]**	**B vs K p values**	**B vs M p values**	**K vs M p values**
10. Staff asked important questions about my child.							
Mean	4.34	4.27	4.26	4.31	0.79	0.672	0.79
N	93	22	50	163			
Std. Deviation	1.068	1.032	1.275	1.124			
11. My child received services that were right for him or her.							
Mean	4.09	4.29	3.72	4.01	0.521	0.127	0.094
N	89	24	50	165			
Std. Deviation	1.302	1.083	1.578	1.372			
12. Staff asked important questions about my *whānau* or family.							
Mean	4.15	4.00	3.81	4.03	0.63	0.165	0.582
N	84	23	47	154			
Std. Deviation	1.275	1.477	1.454	1.362			
15. My *whānau* or family received support that was right for us.							
Mean	4.03	3.91	3.7	3.91	0.744	0.221	0.557
N	80	23	46	149			
Std. Deviation	1.359	1.535	1.547	1.444			
16. I felt I had a say in the assessment process.							
Mean	4.03	4.04	3.74	3.95	0.929	0.255	0.405
N	91	24	50	165			
Std. Deviation	1.394	1.301	1.626	1.454			
17. I understood the treatment options for my child.							
Mean	4.43	3.82	4.1	4.24	0.037*	0.0124*	0.372
N	88	22	51	161			
Std. Deviation	0.98	1.622	1.404	1.239			

Q: *Whānau* involvement	**Bicultural (B)**	***Kaupapa* (K)**	**Mainstream (M)**	**Overall[a]**	**B vs K p values**	**B vs M p values**	**K vs M p values**
21. The involvement of CAMHS was important to helping my child.							
Mean	4.31	4.37	3.92	4.2	0.837	0.096*	0.173
N	93	24	51	168			
Std. Deviation	1.26	1.06	1.57	1.34			

[a] In this column mean and standard deviations are overall averages and N indicates the total number of participants from each CAMHS type.
* $p < .05$.

Table 4.
Significant Positive Correlations Between Factors and Acceptability Question

		Factor	r values	p values
10.	Staff asked important questions about my child.	*Whānau* involvement	0.561	<.001
12.	Staff asked important questions about my *whānau* or family.	*Whānau* involvement	0.581	<.001
13.	Staff respected my spiritual beliefs.	Cultural sensitivity	0.587	<.001
14.	Staff were sensitive to my cultural beliefs.	Cultural sensitivity	0.547	<.001
15.	My *whānau* or family received support that was right for us.	*Whānau* involvement	0.694	<.001
16.	I felt I had a say in the assessment process.	*Whānau* involvement	0.586	<.001
17.	I understood the treatment options for my child.	*Whānau* involvement	0.525	<.001
21.	The involvement of CAMHS was important to helping my child.	*Whānau* involvement	0.625	<.001

Note. The acceptability question refers to Question 11, *My child received services that were right for him or her.*

with the *Whare Tapa Whā*, such as *whānau* involvement and the importance of recognising culture and spirituality. If these components are delivered, Māori caregivers tend to be satisfied with CAMHS.

The qualitative phase that followed the survey testing reported similar results (McClintock, Moeke-Maxwell, & Mellsop, 2011). Two cohorts participated in this stage: Cohort one completed the survey and an interview and were generally positive about what CAMHS offered. Cohort two chose not to complete the survey and wanted only to be interviewed. This cohort was dissatisfied and demanded that more cultural recognition and support 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 can be utilised by CAMHS to specifically support Māori cultural processes (McClintock et al., 2011).

Limitations

The 42% response rate limits the confidence and generalizability of the results. The participants in the Te Tomokanga survey were generally positive about the CAMHS. The qualitative phase uncovered the presence of a less-than-satisfied cohort whose views were not included in the survey and, therefore, revealed a survey bias. Considering this was an initial study of the instrument, the tool warrants further investigation for inclusion as part of CAMHS in *Aotearoa.* Even though the testing results reveal that reliability is poor for the three added items – Question 9, *It is important to be interviewed by a staff member of the same race or culture,* and Questions 19 and 20 regarding *inter-sector collaboration* – they will remain in future applications of the survey because they are relevant to the *Aotearoa* CAMHS context.

Conclusion

Accessing culturally responsive CAMHS is a priority for all, but especially for Indigenous, colonised populations such as Māori. This is the first study in *Aotearoa* to attempt an investigation that supports this important issue. It has been valuable in determining the appropriateness of these services using a culturally attuned tool to assess details of Māori *whānau* satisfaction with CAMHS. The results of the study can contribute to ongoing service improvement and quality CAMHS provision. It is suggested that the instrument can be utilised in conjunction with the cultural framework of engagement and participation developed from the qualitative phase and embedded as a CAMHS best practice with Māori clients. This can play a significant role in developing and refining Māori culturally responsive CAMHS in *Aotearoa.* With future modifications to the instrument, it may be appropriate for other Indigenous cultures.

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Appendix

Te Tomokanga: Acceptable Child and Adolescent Mental Health Services (CAMHS) for Māori in Aotearoa Survey

This survey contains a list of statements asking for your view of the CAMHS that your child was referred to. Beside each statement there is a scale which ranges from **1 ('Strongly disagree'**) to **5 ('Strongly agree') or 6 ('Not applicable').** For each item please **circle** the number that represents the extent to which you agree with the statement. Please answer **every item** and make only **one** choice per item. Please respond as honestly as you can remember.

Question	NAME OF THE SERVICE	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree	Not Applicable
1.	Information about the CAMHS was easy to obtain.	1	2	3	4	5	6
2.	The location of the CAMHS was simple to find.	1	2	3	4	5	6
3.	An appointment was given when my child needed it.	1	2	3	4	5	6
4.	Allocated appointment times were convenient.	1	2	3	4	5	6
5.	The clinic venue for the appointment was convenient.	1	2	3	4	5	6
6.	Transport cost to the CAMHS appointment was affordable.	1	2	3	4	5	6
7.	CAMHS consultation cost was affordable.	1	2	3	4	5	6
8.	Medication was affordable.	1	2	3	4	5	6
9.	It is important to be interviewed by a staff member of the same race/culture.	1	2	3	4	5	6
10.	Staff asked important questions about my child.	1	2	3	4	5	6
11.	My child received services that were right for him/her.	1	2	3	4	5	6
12.	Staff asked important questions about my *whānau*/family.	1	2	3	4	5	6
13.	Staff respected my spiritual beliefs.	1	2	3	4	5	6
14.	Staff were sensitive to my cultural beliefs.	1	2	3	4	5	6
15.	My *whānau*/family received support that was right for us.	1	2	3	4	5	6
16.	I felt I had a say in the assessment process.	1	2	3	4	5	6
17.	I understood the treatment options for my child.	1	2	3	4	5	6
18.	I understood that medication would help.	1	2	3	4	5	6
19.	The involvement of Group Special Education was important to helping my child.	1	2	3	4	5	6
20.	The involvement of Child Youth Family was important to helping my child.	1	2	3	4	5	6
21.	The involvement of CAMHS was important to helping my child.	1	2	3	4	5	6