

Development of a child, adolescent and family mental health service for Pacific young people in Aotearoa/ New Zealand

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Abstract

This paper describes the development of a dedicated Pacific child, adolescent and family mental health service based in Porirua, Aotearoa/New Zealand(NZ). Particular reference is made to, firstly, the social and demographic characteristics of the population we serve, and referrals to our service, and secondly, to key Samoan research findings which emphasize the Samoan relational concept of self as a fundamental concept underpinning Samoan notions of mental wellbeing¹. We discuss the practical application of this concept in our work with Samoan and other Pacific young people and their families, including implications for engagement, assessment and treatment processes.

E lē tulolo fua la'au o le vao

E falala ona o le matagi

(When the trees bend in the forest, there is always a reason)

Samoan proverb

Introduction

Pacific young people and their families living in Aotearoa/NZ often choose not to use mainstream child and adolescent mental health services². In 2003, the Pacific adult and child access rate for Aotearoa/NZ mental health services was only 0.56%². This compared with a Maori access rate of 1.35% and

the remainder of the population at 1.86%. Figure 1 shows Pacific access rates for child and youth age groups, compared with the total population in the first 6 months of 2004, and benchmark targets for CAMHS. These targets were set by the Mental Health Commission in New Zealand.

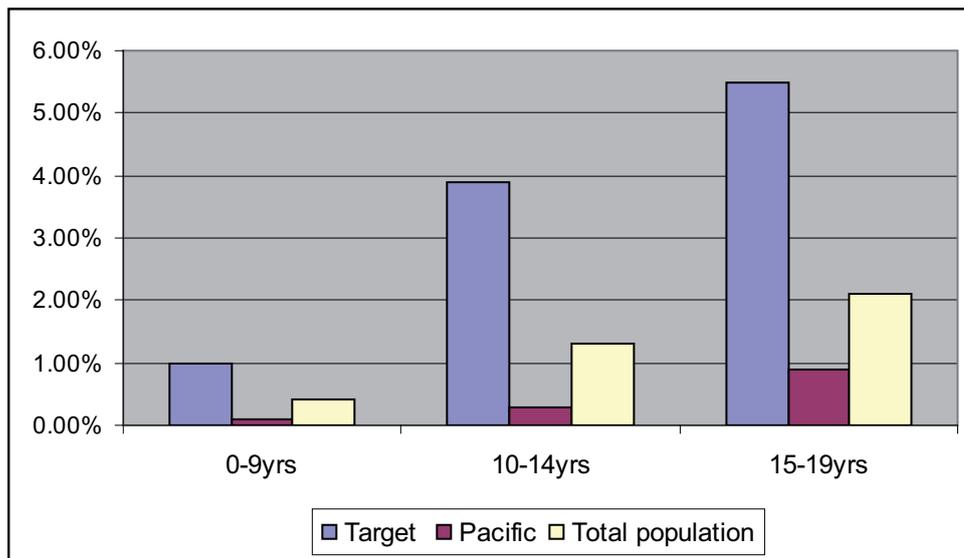


Figure 1. New Zealand CAMHS access rates January to June 2004²

A number of hypotheses have been suggested to explain this low acceptance of mental health services by Pacific people. Pulotu-Endemann et al have observed that mainstream mental health services in Aotearoa/NZ have generally been acute and crisis focused, and have shown a lack of appreciation for holistic perspectives favoured by Pacific people³. Services have often not been “culture friendly” and emphasis on the medical model has meant that practitioners commonly fail to acknowledge a possible role for traditional diagnoses and healing practices, which are often valued by Pacific families. Services have usually been delivered in a hospital or institutional setting rather than in the community³. Following a call from Pacific communities, policy advisors and researchers, New Zealand Ministry of Health initiatives in the late 1990’s led to establishment of dedicated Pacific mental health services in Auckland

and Wellington, catering to the mental health needs of the Pacific adult population.^{1,4,5,6}

The context of Health Pasifika Child, Adolescent and Family Service

The first dedicated Pacific child adolescent and family mental health service in Aotearoa/ New Zealand was established in Porirua in 2005, under the auspices of Capital and Coast District Health Board (CCDHB). This serves the Pacific communities residing in Wellington City, Porirua City and the Kapiti Coast region, in the lower North Island of New Zealand. The total pacific population in this region, from the 2006 New Zealand census, was 22200. Figure 2 shows the geographical/social origin. The ‘Other’ group included Tuvaluan, Kiribati and Tahitian people.⁷

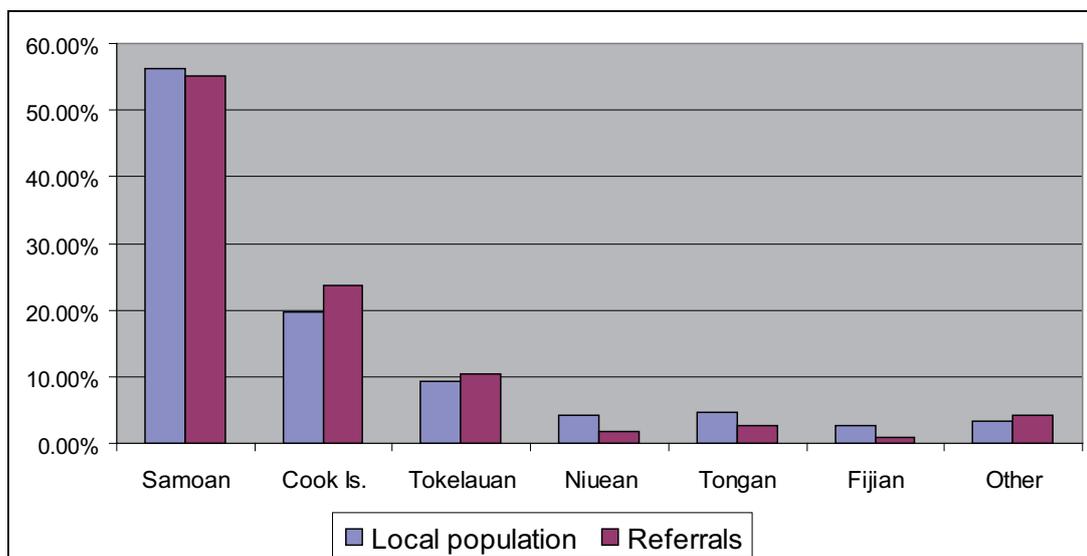


Figure 2. Proportion of different Pacific nations groups in our local community compared with the first 100 referrals to our service.

Pacific people make up 13.5% of the under 20 age group in the area we serve. The highest proportion of Pacific young people is in Porirua city where Pacific children and youth make up 34.8% of the under 20 population.⁷

The service has an outreach approach to meeting with families and young people, offering home visits or school visits for most appointments depending on the family's preference. It has 2 fulltime clinicians, a Samoan registered mental health nurse (TF), and a Samoan family therapist (MD) with prior experience in mainstream CAMHS services. We have 0.5 FTE Palagi (NZ European) child and adolescent

psychiatrist (AB) and our Pasifika consultant is a Samoan matai (Fa'amausili) who works with both our adult and child teams at Health Pasifika. We are fortunate in being able to seek cultural advice from Tokelauan, Tongan, Fijian, and Niuean colleagues in the adult Health Pasifika team. The work of the team is further enhanced by strong support from our Pacific reference group which comprises members from seven Pacific nations in our community.

Referrers

Figure 2 shows the referral sources for the first 100 referrals to our service.

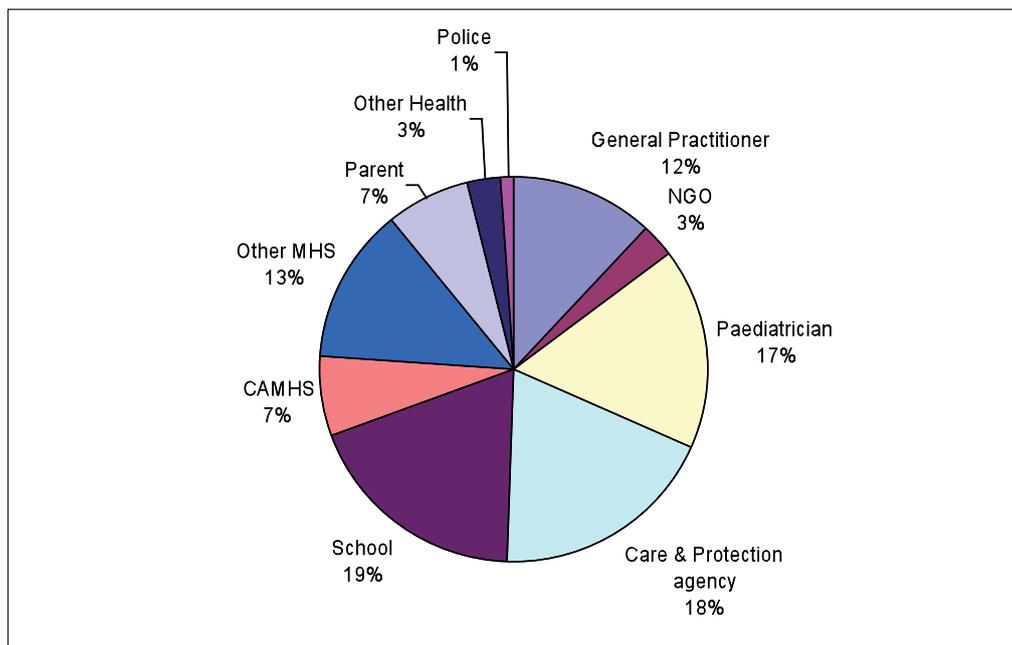


Figure 3. Referrers for the first 100 referrals to our service. (NGO=non-governmental organisation, other MHS=other mental health service eg emergency psychiatry service, other health=allied health practitioner such as audiologist, private psychologist.)

Our service works independently of other local CAMHS services and referrals are forwarded to us by CAMHS intake staff when families identify as Pacific and agree to be referred to Health Pasifika CAFS. Acute assessments for mental health crises with Pacific young people are carried out jointly with other local CAMHS staff. We also participate in joint assessments with other services when this is requested by mental health staff and/or Pacific families, for example in new referrals for young people with first episode psychosis.

Age of referrals

Of the first 100 referrals to our service, 4% were preschoolers (0-4 age group), 41% were primary school age (5-12 age group), 52% were high school age (13-17 age group) and 3% were aged 18-20 years.

Diagnoses

There is evidence supporting the use of DSM-based diagnostic categories in young people from non-Pacific cultures, and they are useful as a guide to assist clinicians in choosing treatment interventions that are likely to be effective for young people in general⁸. They are widely used in CAMHS services, and are essential from a planning and funding perspective.

Of the first 100 referrals to our service we accepted 95 for assessment and met with 81 of the young people and their families. Of those seen and assessed, 70 met criteria for a DSMIVTR diagnosis⁸. Figure 4 illustrates the range of problems affecting this group of young people.

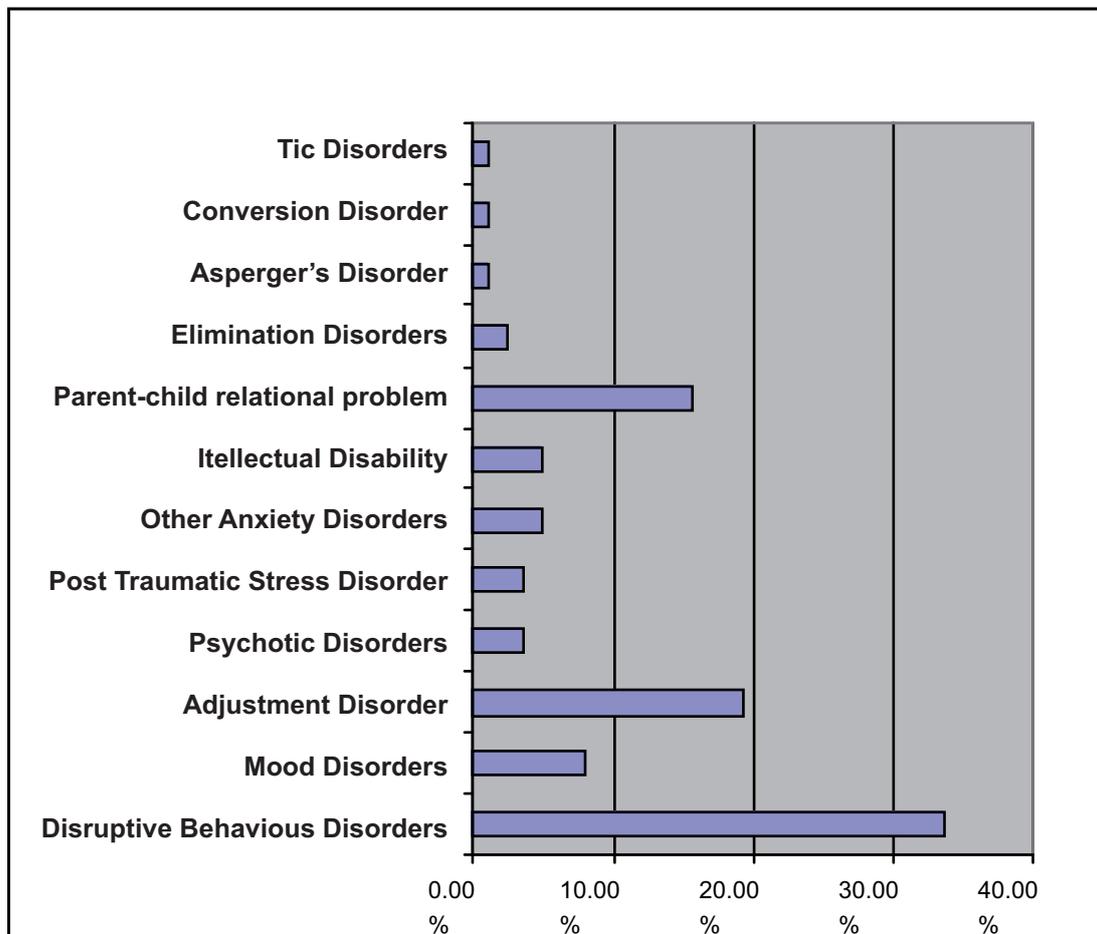
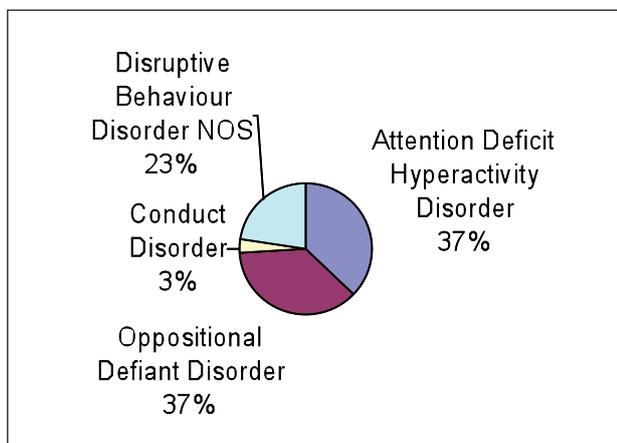


Figure 4. DSMIVTR Diagnostic groups for first 100 referrals to our service

15.7% of these children and adolescents had more than one diagnosis. The low rate of psychotic disorders in this group is explained by local referral patterns in which young people with their first episode of a psychotic illness (including Bipolar disorder with psychosis) are usually seen at a separate early intervention service. Of the seven adolescents with mood disorders, one had bipolar disorder and six had major depressive episodes. Four of these six young people and their families opted for antidepressant treatment for the young person and one required inpatient treatment.

It is clear from this data that the most common presenting problems related to disruptive behaviour. Figure 5 shows the proportions of the different disruptive behaviour disorders.



Of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), six out of ten had a co-morbid diagnosis of another disruptive behaviour disorder or tic disorder. Half of the parents of children with an ADHD diagnosis opted to commence stimulant or other pharmacological treatment for their child's ADHD symptoms. This was more likely when symptoms were more severe and the school was having difficulty managing the young person's behaviour.

Figure 5. Disruptive Behaviour Disorders

Samoan-specific clinical and social practices in our daily work

Despite their common usage, diagnostic labels arising from the DSM system have not been established as an acceptable way of communicating with Pacific families about their young person's predicament. Furthermore mainstream clinical practice may not readily accommodate important social practices that are critical for both credibility and engagement with services. Each of our team members has been influenced by clinical practices handed down by our clinical disciplines, training and relationships with mentors and other colleagues. In developing our service it has been essential for us to make time to reflect on clinical and social practices as they do not always serve Pacific families and young people well. For example greeting rituals in many mainstream CAMHS settings could be considered rather underdeveloped, if not perfunctory and rude from a Pacific family viewpoint.

Our discussions have been informed by the cultural wisdom of our Pasifika consultant, and cultural knowledge and perspectives of Pacific team members and the Pacific families we see. In addition we have turned to key research findings that highlight Samoan concepts of wellbeing and mental ill health.

A Samoan relational concept of self

"Ole Taeao Afua-The New Morning" by Taimalieutu Kiwi Tamasese and colleagues, describes the Samoan concept of self as a relational being rather than an individual entity.^{1,9} This study found that Samoan elders and Samoan mental health service providers described the Samoan self as "a relational self having meaning only in relationship to others". It is "a total being comprising spiritual, physical and mental elements which cannot be separated". It "derives its sense of wholeness, sacredness and uniqueness, from its place of belonging in family and village, genealogy, language, land environment and culture".

Samoan elders and mental health service providers in this study considered this concept to be essential for understanding the world view of Samoan people and necessary as a foundation for any mental health clinical work with Samoan people and their families.^{1,9} Later research with experienced psychiatrists in the Wellington region showed that psychiatrists of non-Pacific origin struggled to understand this relational notion of self¹⁰. In our work this concept informs our practice in many ways.

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Attending to the vā or relational space

In a first meeting with a family with Samoan born or Samoan speaking parents and/or grandparents our Pasifika consultant would take as much time as necessary to attend to traditional Samoan processes of acknowledgement, sacredness and connection. By attending to the "vā" or relational space between people, by taking care to foster and maintain vā fealoaloa'i (particular relationships of mutual respect) in relation to titled heads of families and cultural status of elders in the families we meet, there is much greater chance of rapport building and more chance that families will feel comfortable to share painful stories that may shed light on their young person's predicament. Alternatively attending to these processes can help facilitate difficult processes with a Samoan family with strong traditional values. An example of this was a 12 year old Samoan girl who presented with acute suicidality and major depressive symptoms in a context of physical abuse by her father. In meeting with her family to explain our decision to notify the care and protection services, our Pasifika consultant was able to facilitate traditional Samoan processes which provided containment for an otherwise tense meeting.

Humility is an attitude that is considered implicit in vā fealoaloa'i and is highly valued in fa'a samoa (Samoan customs and traditions). In reflecting on our work we have realized that it is necessary for us as clinicians to retain humility in order to foster rapport and build trust with the Pacific families we meet.

This raises a dilemma about how to balance the more conventional role of clinician as expert, with an attitude of humility. The 'decentred positioning' described in the Narrative Therapy literature allows the young person and family's views to remain central to the therapeutic process while not denying the power and expertise implicit in the therapist role¹¹. This idea has influenced our practice in a number of ways.

Relational self and exploring genealogy

Frequently young people and their families feel anxious about meeting CAMHS clinicians for the first time, perhaps anticipating some kind of interrogation that might focus on their deficits. After greeting the family we would often take some time to explore the young person's genealogy, mapping out a family tree over three or four generations. This allows us as clinicians to step into a 'decentred position', and enquire about key cultural information such as island and village of origin, as well as migration stories, and relationships within the family. Who does the young person live with, and who do they turn to for nurturing? Have they

lost key figures such as grandparents and what did those relationships mean to them? What roles and responsibilities are implicit in their positioning in the family from a cultural point of view? For example, from a Samoan perspective, the relationship between a brother and sister, known as 'feagaiga' has clearly defined roles and responsibilities for both siblings, and significant consequences if there is a breach of 'tapu and sa' in these roles.

From a relational perspective, these details help us to get to know the young person beyond their individual self. In sharing family stories, the family are the experts and they get a chance to experience our responses and attitudes towards these stories and decide if they can trust us with the more painful stories that may have brought them to see us. In the course of such an enquiry sometimes there is an opportunity for the sharing of rich family stories and cultural knowledge that the young person may not have heard before.

An example of this was a family of a 12 year old boy of mixed Pacific descent who presented with symptoms of depression with his family. His grandmother was asked in some detail about her background and began speaking about her own mother's early life on Banaba (Ocean Island, Kiribati), the impact of the Pacific Phosphate Company, the tragic events of the Japanese occupation during WWII and the subsequent removal of the whole population to Rabi Island in Fiji and the difficulties they faced there. It was a very moving story and it transpired that her grandson had never heard the story before. Almost all Pacific families in New Zealand will have stories of migration, of survival, loss and hardship which connect them with the hopes, dreams and purposes of their parents, grandparents, extended family and previous generations. Such stories connect young people with a sense of belonging and identity and to their cultures of origin. For young people who are struggling with making sense of their identity in their complicated school and community environment, connecting with this sense of belonging can help address presenting problems such as depressive symptoms.

Allowing for relational timeframes

Tamasese has referred to "relational timeframes" that may determine a Pacific family's readiness to participate and trust a clinical assessment process¹². A Palagi greeting style and a conventional 1 hour appointment slot in a clinic room, may be an efficient way of operating to meet institutional expectations, but such "Palagi timeframes" may alienate Pacific families and reduce their acceptance and attendance at assessment and treatment appointments. If the relational space or *vā* has been established and a Pacific family feels ready to trust the clinicians they are meeting with, then they may be ready to talk at length and may require an extended period such as 1 ½ or 2 hours or occasionally longer to tell their story.

In meeting with families from other Pacific nations, we would aim to attend to these cultural processes of greeting, acknowledgement, sacredness and connection. Even if we are not able to greet the family more formally in the language of their culture of origin, we know that attending to appropriate greeting rituals will frequently help Pacific families feel more comfortable and able to talk about what has brought them to us.

In other situations we may be meeting with a young Samoan person on their own, and even if they do not consent for us to include their parents or other family members, the concept of the relational self supports us in remaining mindful of the *aiga* or extended family system around this young person, and the roles and responsibilities that may be expected of the young person, and other pressures that may result from this. Cutting themselves off from *aiga* connections may seem like a promising option to some young people, especially after traumatic experiences in their family of origin. However the concept of a relational self alerts us to possible risks of the "cut off" situation for the young person, that could be missed by a Palagi therapist. These risks could include symptoms of anxiety or depression or other manifestations of the stress of alienation from their *aiga*.

An example of this dilemma is a 16 year old New Zealand born Samoan girl who had been removed from the care of her family by care and protection services because of sexual abuse by her stepfather. She was referred individually by her care and protection social worker, for treatment of self-harm, nightmares and flashbacks. After much discussion in the team it was decided that, alongside individual work with this young person, it would be important to offer to meet (with her consent) with her mother and maternal grandparents, using traditional Samoan processes to seek their permission for this work to proceed. This approach was effective in reducing the disconnection associated with her placement away from the family, and paved the way for later family therapeutic work with the extended family.

The relational self and breaches of tapu and sa

Without an understanding of the Samoan relational self, it is not possible to grasp the impact of breaches of 'tapu' and 'sa'. In Ole Taeao Afua, 'tapu' is defined as "that which is forbidden to the ordinary" and 'sa' refers to sacred relationships. Traditionally in Samoa, mental illhealth was viewed as a consequence of breaches of sacred and forbidden relationships or breaches of 'tapu' and 'sa'. Such breaches could be addressed effectively only within protocols laid down in the culture. Even though NZ born Samoan young people might be less familiar with the deeper meaning of some of these cultural ideas they were

still considered relevant when a young person faces a crisis in their life.

A 16 year old Samoan born male was referred to our service after attempting to hang himself. Despite a number of stressors in his life, he was not depressed and did not have another mental disorder. However he was very distressed by the idea that his parents may have disowned him, a Samoan relational sanction known as *fa'a malaia*, because of his disreputable behaviour. For a Samoan young person with a relational sense of self, whose identity may primarily be defined collectively rather than individually, it makes sense that this would be a catastrophic predicament. In this case, the crisis was resolved by his Samoan case manager who realized the cultural predicament this young man was facing, and also knew that the remedy could be found in cultural processes of apology and reconciliation. Contacting the family led to his parents achieving greater understanding of his fears, and this led to a rapid resolution of the crisis.

Relational self and New Zealand born Samoan young people

The situation is even more complicated for Samoan young people who have grown up in Aotearoa/NZ, in a family with strong traditional Samoan values, who may be fluent in the Samoan language but have also been exposed to the individual values embedded in their schools, the news media and peer pressure from other young people. Such young people may well identify with both a relational and individual sense of self and this could lead to substantial role confusion and conflict with parents and grandparents. Understanding the nuances of this predicament and finding a way of naming this dilemma for the young person and their family of origin frequently helps take some of the heat out of battles that may be damaging the young person's relationship with their parents and other elders. Referring to the concept of a relational self, helps us in illuminating this predicament for Pacific parents, who often find this idea easy to relate to.

Relational self and 'itu lua'

Findings from Ole Taea Afua make it clear that Samoan people view the Samoan self as having physical, mental and spiritual aspects that cannot be divided up (a concept known as *'itu lua'*). From this perspective it does not make sense to think of a broken leg as a non-spiritual problem, let alone a mental health problem such as depression. In contrast there is a tacit assumption in most Western psychiatry settings that assessment and treatment is a secular undertaking. Even outside psychiatry there is an assumption from a non-Pacific worldview that it is rude to impose your own spirituality on others and therefore the right thing to do when meeting new guests (or clients, let alone patients!) would be to

abstain from assuming they would like a prayer at the beginning of a meeting or interview, in order to avoid offence. The concept of *'itu lua'* would suggest that the opposite may be true for Samoan and other Pacific families. Not attending to spiritual wellbeing could cause offence or may lead families to feel uneasy about the lack of care taken over spiritual aspects of care. When we meet with families for the first time, and at subsequent meetings we take care to offer the family the choice of whether we start the session with a prayer. This frequently makes a positive difference to engagement with the family and families for whom spirituality is less important don't seem to be offended by the offer.

'Itu lua' and assessment of possible culture mediated spiritual experiences

Sometimes young people presenting to our service, describe experiences that are not 'typical' psychiatric symptoms but may be distressing to them. For example, a 15 year old NZ born Samoan girl described looking in the mirror and after a few moments one side of her face began to take on a skull-like appearance. She associated this with old stories she had heard in her aiga of a spirit woman who falls in love with men, seduces them, then ends their lives. While from a clinician's point of view, it may have been possible to interpret this young person's experience as dissociative, her New Zealand born Samoan case manager recognised elements of the story as resembling cultural descriptions she had heard in her family of origin of some kinds of traditional illness. She was also familiar with the cultural story the young person was referring to. She therefore sought advice from Samoan colleagues who advised her to monitor this experience with the young person and if it persisted or became distressing for her, to suggest that the young person and her family could seek advice from a traditional healer (*Taulasea*), most appropriately one known to the family and trusted by them.

The Ole Taea Afua study participants called for dedicated Pacific mental health services to recognise and remunerate traditional healers from Samoan and other Pacific cultures to allow these services to comprehensively address mental health problems from both a cultural and clinical viewpoint^{1,9}. At this stage we are unable to offer this service directly, but on occasions where there are clear indications, Pacific clinicians endeavour to support families in making contact with traditional healers in their own communities, with ongoing monitoring of symptoms and any safety concerns.

Itu lua and 'other pressures'

The proverb quoted at the beginning of this paper could be taken to refer to mental illhealth that may be precipitated by social and economic pressures faced by Pacific families, especially in Aotearoa/

New Zealand. The Ole Taea Afua study referred to the many financial pressures that Samoan families face providing financially for their extended family as well as church obligations, and responsibilities and financial contributions to their families, villages and districts of belonging back in Samoa^{1,9}. Poverty places many stressors on a family. As Pacific CAMHS clinicians, we lose credibility with families if we don't attend to this. If a family has no food in the fridge or cupboard then therapy for other problems is likely to seem irrelevant for them. Sometimes addressing personal needs can lead to a break through in engagement with a young person. A clinician noted a marked improvement in rapport with a 12 year old boy after she arranged for care and protection services to fund his rugby team fees and found a second hand pair of rugby boots for him. This made it possible to work with him on clinical issues such as anger and defiant behaviour that had been threatening his school placement and disrupting home life.

In Ole Taea Afua, conflicts of cultural identity between Pacific values and the dominant culture were emphasized as a big pressure on teenagers in particular. Racial stereotypes and prejudices held by non-Samoan peers and teachers as well as pressure to achieve academically in a palagi environment were also noted. Further factors identified included drug and alcohol abuse, unresolved grief, physical and sexual abuse and isolation due to the breakdown of traditional collective support systems. In our clinical work we attempt to create space for families to reflect on the many pressures in their lives and incorporate these factors into our clinical formulation.

Fostering a spirit of collaboration

"In Samoan Culture there are three perspectives. The perspective of the person at the top of the mountain, the perspective of the person at the top of the tree, and the perspective of the person in the canoe who is close to the school of fish. In any big problem the three perspectives are equally necessary. The person fishing in the canoe may not have the long view of the person on the mountain or the person at the top of the tree, but they are closer to the school of fish." Tui Atua Tupua Tamasese Efi.¹

In Ole Taea Afua, this metaphor as well as the Samoan concept of fa'afeletui were used to describe the research process which attempted to interweave the different voices and views of participants in the study to create the final research findings¹. Similarly, towards the end of an assessment process with a family, we feed back to the young person and their family our understanding of what brought them to see us, and the context of this. We commonly use a

white board to visually represent this, and we have been exploring Pacific metaphors to help make these discussions easier for Pacific families to relate to. While clinical themes are presented in language used by the family, we also strive to present them in a way that helps explain a psychiatric diagnosis when that is relevant, alongside holistic aspects of family, culture, physical wellbeing and spirituality including all relevant aspects of a conventional CAMHS assessment.

Such a joint formulation and resulting discussion naturally flows into the next step of treatment options or "what will we do next?" (if anything). What do the family want our assistance with?

In making it clear that the family and young person have choices about what we do next and that our role is to offer advice and guidance, there is an increased likelihood that they will be motivated to participate further in any treatment that is agreed upon.¹²

Relational self and Western theories of psychological development

Reflecting on the Samoan relational self has led us to question tacit assumptions in Western theories of emotional and psychological development taught to us in clinical training programmes. These theories commonly privilege individuation as a key developmental task or developmental pathway to emotional maturity. Such theories contain implicit assumptions that point to western individual notions of self as universally applicable.¹⁰ In contrast, the Samoan relational concept of self leads us to consider an expanded view of psychological development in which interdependence is valued as a mature state and a Pacific young person's roles and responsibilities towards their aiga and community are important to consider in any clinical exploration of their sense of identity.

In our Pacific CAMHS setting, these ideas would become relevant when we are considering the situation of, for example, an 18 year old Pacific young person, who, having moved out of home, later moves back to his parents' home to help care for his elderly grandparents. From a Palagi psychological viewpoint this could be viewed as a retrograde step that renders him more dependent on his parents, and might meet with covert or overt disapproval from his therapist. However, we would be open to the possibility that this move might represent a step towards emotional maturity and may strengthen his interdependence and sense of identity.

Conclusions

“E poto le tautai ae sesē le atu i ama”
(Even experienced fishermen can make mistakes
while fishing)
 - Samoan proverb

Although we are experienced and qualified in some ways, we don't see ourselves as experts. We offer these perspectives in the hope that they will contribute to further development of child and adolescent mental health services in different parts of the Pacific. The early development of our Pacific child adolescent and family mental health service has focused on accessibility and engagement with Pacific families. Samoan research has strongly informed our reflection on our clinical practice.

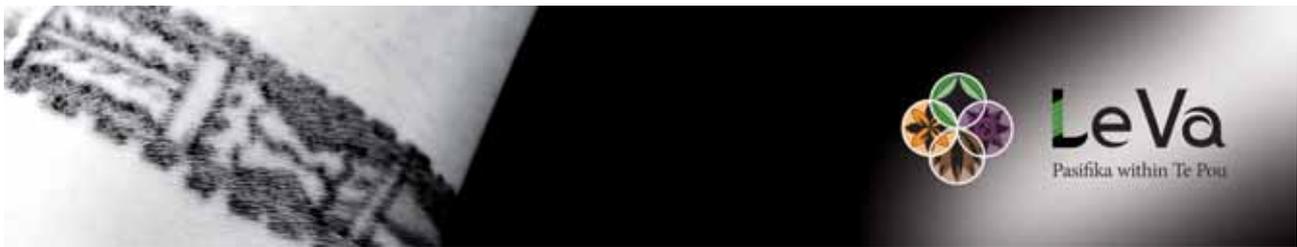
Similar qualitative research focused on cultural concepts of mental health and wellbeing with other Pacific nations groups is necessary to support the development of Pacific CAMHS services, as well as outcome studies to show which mental health treatments work for Pacific young people and their families. Dedicated Pacific CAMHS in Aotearoa/NZ have a responsibility to foster the development of qualified CAMHS practitioners from all Pacific nations and support the development of child and adolescent mental health services in less well resourced communities across the Pacific.

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