

A Preliminary Report on Outcome Measures For Pacific Island Peoples

A Report prepared for MH-SMART
Te Pou Research Programme

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November 2005



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Acknowledgements

We would like to thank all of the participants who have contributed to this project, giving their time and knowledge willingly and supporting the project. In particular we would like to thank our Reference Group for their guiding knowledge and expertise.

We would also like to acknowledge the Te Pou Research Programme and MH-SMART for their responsiveness to Pacific issues by proposing to investigate what work had been done for Pacific people in terms of mental health outcome measurement.

It is important to acknowledge the people involved in the original project investigating the design and implementation of a potential Pacific mental health outcome measure. Thank you for your insight and strategic forethought. It is our hope that their hard work and effort will be recognised in this project and honoured in future projects on Pacific mental health outcome measures.

1. Executive Summary

Background

The purpose of this project is to provide a preliminary report on mental health outcome measures for Pacific people with the dual aims of 1) reviewing existing work, and 2) developing recommendations regarding a mental health outcomes measure for Pacific people. To achieve these aims the objectives of reviewing research and literature and consultation with key stakeholders were carried out.

The literature search included specialist libraries and electronic bibliographic databases. However, due to the nature of the project, a significant amount of information was published and unpublished 'grey literature', gathered from professional and informal networks.

On an international level there is a paucity of literature exploring mental health outcome measurement for ethnic minorities, immigrants or indigenous peoples. Similarly published documents specifically aimed at Pacific peoples mental health outcomes and outcome measurements are sparse. Only one Pacific consumer mental health outcome measure exists to date, The Pacific Mental Health Outcomes Measure from the Lotofale Study, which is reviewed in this document. Overall, there is a lack of research validating the use of any mental health outcome measures for Pacific people, which may potentially result in misleading conclusions.

International and local literatures generally define mental health outcome measurement as the assessment of change in the individual and that this change is attributable to service intervention. The change in the individual may be due not just to 'clinical' but also 'cultural' interventions. However, this definition may differ for Pacific people. Traditional Pacific concepts of health are holistic, where well-being is defined by the equilibrium of mind, body, spirituality, family and environment. Pacific models of health and mental health belief present ethnic-specific philosophical frameworks. Mental health outcomes must be measured in the context in which they occur and thus must include community and cultural norms of mental illness. Given this, it is not unreasonable to suggest that change in wellbeing for Pacific people may reflect more than the impact of service intervention alone and that there may be many facets of holistic wellbeing attributed to an outcome such as spirituality, sense of belonging and connectedness attributable to individual, family and community involvement or intervention. Hence, outcome measurements need to incorporate specific Pacific holistic frameworks of health.

Some of the New Zealand health outcome research includes Pacific components to their projects (e.g., Agnew, et al., 2004; Gordon, Ellis, Haggerty, Pere, Pltaz and McLaren, 2004; Matangi-Karsten et al., cited in Deering et al., 2004; Merry, et al. 2004; Pulotu-Endemann, Annandale & Instone, 2004). In general, the Pacific components recommend that Pacific holistic views of health, Pacific frameworks and culturally relevant issues need to be reflected in mental health outcome measurement in order to accurately measure Pacific mental health outcomes.

Because there are some underlying Polynesian cultural universalities across Māori and Pacific cultures, Hua Oranga, the Māori mental health outcome measure, may assist in providing information for background work on a potential Pacific mental health outcome measurement.

Forty-eight key stakeholder participants were recruited from Christchurch, Wellington, Hamilton and Auckland. Qualitative information was gathered via an individual interview or a focus group/*fono*. Stakeholder demographics reflected a good cross-section of mental health workers, technical expertise and ethnic representation. Participant narratives were audio-taped, transcribed and thematic analysis carried out to form the basis of the results (or key themes).

Lotofale Outcomes Study

The Lotofale study began with an idea in 1998 with Eseta Nonu-Reid, the primary investigator, David Lui, Manager of Lotofale at the time, and Mali Erick, a senior social work practitioner as co-investigators. The initiative came about as result of the need to accurately measure outcomes for Pacific people and to improve service delivery. It was clearly known and accepted by Pacific and non-Pacific people working in mental health and related fields that the mental health outcome tools available at the time did not meet the mental health needs of Pacific consumers and their families. Funding was received and development was underway in 1999.

The primary objectives of the Lotofale Study were to develop a Pacific mental health outcome tool that:

1. Provides an accurate measure of consumer satisfaction of the service they were engaged with (Su'a-Huirua, 2003).
2. Is based on Pacific perspectives, models and frameworks.
3. Is culturally appropriate for Pacific people and reflects the complexity of the Pacific ethnic mix.
4. Can identify areas where a service is doing well or not doing well in meeting the needs of Pacific consumers with the aim of using the information to improve service delivery.

The methodology involved:

1. A literature review of the outcome tools that existed at the time, looking at the strengths and weaknesses of these tools and applicability to a Pacific context.
2. Examination of Pacific perspectives and models to identify the best model to use as the base and founding philosophy of the tool.
3. Use of Lotofale staff and Pacific community and focus groups to develop and design the tool in the four main ethnic languages of Samoan, Tongan, Cook Island and Niuean and also in English.
4. Testing the tool using Lotofale and Manaaki House consumers.

The development right through to testing the tool was completed in early 2001 but the final report was not completed until 2003.

Summary of Key Themes

Most participants had a common understanding that mental health outcome measurement involved measurement of change during and/or after intervention. Over half of the participants were familiar with or had heard of the Pacific Mental Health Outcome Measure (PMHOM) developed in the Lotofale Study. Less than half of the participants had used any formal outcome measures (i.e., the Camberwell and HoNOS).

The two key themes that emerged in regards to participant perceptions and understandings of the PMHOM were that: 1) the PMHOM was more of a consumer satisfaction and/or service or staff evaluation questionnaire than an outcome focussed tool. Whilst evaluation of satisfaction with services may not necessarily be an outcome of treatment, it is an important area to consider in judging appropriateness of care; and 2) the philosophy of the PMHOM, such as the holistic approach it takes based on the *Fonofale* model is the correct approach to take when attempting to measure outcomes for Pacific, and the measure was generally accepted in principle. However, the PMHOM requires a lot more work.

Clinical outcome measures have a role to play in Pacific mental health services. There needs to be a combination of the clinical and the cultural components when measuring mental health outcomes for Pacific people. A Pacific mental health outcome measure could be used in conjunction with a mainstream measure, or a mainstream measure be adapted to include a Pacific dimension. It is beneficial not to duplicate the work already implemented with mainstream measures, not to start from scratch, and refer to any Māori outcome measures for guidance.

There are difficulties articulating what constitutes mental health outcomes for Pacific people and this may be due to the holistic philosophy underpinning Pacific mental health - i.e. when discussing mental health outcomes, Pacific people are often referring to the *intangible* such as spirituality, values and beliefs. Despite these difficulties, it is clear that mental health outcomes are holistic and for Pacific people should not be limited to symptomatology but include the indicators of family, spirituality, community, and the physical, emotional and mental dimensions of well being. Participants generally supported the Hua Oranga model and philosophical approach, and reported that Pacific people could learn from the work Māori had already done.

When discussing what constitutes mental health outcomes and ‘how’ this might be measured, a key theme arising was the overwhelming reference to and emphasis on the importance of the *process* of how to measure outcomes. Participants reported that the essential aspects for accurately measuring outcomes are: 1) Gaining rapport, engaging and connecting with the client; 2) the ethnicity and belief system of the outcome assessor; and 3) the cultural competency of the outcome assessor.

Many participants reported that there would be difficulties in attempting to measure mental health outcomes from a Pacific cultural perspective because they are problematic to quantify - particularly the intangible.

Some participants reported that a lot of Pacific services and/or staff are somewhat removed from the Pacific youth culture in New Zealand. While the components of the *Fonofale* model still applies to Pacific youth as a mental health framework, the model

and also cultural competencies that have been developed need to be revised to ensure they are appropriate for youth.

Five themes emerged regarding the clinical utility of a potential Pacific mental health outcome measure: 1) A measure can be Pan-Pacific; 2) however, it may need to be translated into major Pacific languages; 3) questions need to be Pacific user-friendly, kept simple and to a minimum; 4) points of assessment of outcome could occur at baseline then every three months and 5) it would be appropriate and/or beneficial for mainstream/*palagi* services to use a Pacific measure for Pacific clients but they may require training.

There is a need for further group dialogue around Pacific mental health outcome measures. A suggestion is to also establish a panel of relevant and/or expert key people to further discussions.

Recommendations

1. Development of a Pacific Mental Health Outcome Measure

- ✧ Research and key stakeholder interviews indicated a significantly strong need for a Pacific measure of mental health outcome.
- ✧ The shift to recognising treatment level outcomes that informs future care of consumers should be reflected in an outcome measure for Pacific people. The Pacific Mental Health Outcome Measure developed in the Lotofale Study in its present state does not meet the needs of measuring Pacific mental health outcomes as defined by the objectives of the MH-SMART initiative.
- ✧ It is essential to clearly define firstly what constitutes an outcome from a Pacific perspective and then secondly tackle the issue of how to measure outcome for Pacific people. This includes exploring and identifying Pacific people's holistic perspectives encompassing the spiritual, physical, emotional, and familial aspects of a person's life. For outcome measurement it may include exploring the cultural aspects of intervention utilizing Pacific models and frameworks such as ones used in the Lotofale Study.
- ✧ Research in this area needs to be constant and cumulative so that we are systematically building on previous knowledge. New initiatives involving the conception of a Pacific measure of mental health can draw from the processes, experiences and content of the Lotofale Study. They also need to take into account the research and development of Hua Oranga, the Māori mental health outcome measure. Guidance from Māori and the use of this guidance alongside Pacific cultural frameworks is recommended.
- ✧ A Pacific mental health outcome measure could be designed with the objective of complementing other clinical measures already validated and in use. Given this, the Pacific measure can then focus on capturing essential elements of mental health outcomes that are of cultural significance specifically to Pacific populations.

- ✘ Any project investigating the potential for a Pacific mental health outcome measure needs to be nationally aligned. The issues of integration and compatibility with MH-SMART should be carefully considered when choosing the direction to develop the Pacific Outcome Tool. This will avoid complications in trying to be “all things to all people” and difficulties in trying to integrate two very different paradigms.
- ✘ Access to utilising a Pacific mental health outcome measure should be open to Pacific and non-Pacific staff and services. These services and staff need to be trained in the administration of the measure.

2. Research & Psychometric Properties

- ✘ The reliability and feasibility of a measure are important - requiring acceptability, applicability and practicability. Utility also includes user-friendliness.
- ✘ A validation process of a new measure is required to assess psychometric properties. However, this can be a resource-consuming process. It will be useful to refer to the recent extensive validation framework designed by Māori.
- ✘ A Pacific measure that will be routinely administered and nationally compared needs to take into account the potential need to be compatible and easily integrated with electronic databases already in use, such as the MH-SMART and MHINC databases.
- ✘ A more extensive and international literature review is required to adequately inform and give up-to-date knowledge of cross-cultural outcome measurement.
- ✘ Given the Pacific holistic approach to wellbeing and recovery, it is not necessary to identify that the treatment intervention *causes* the change in the individual because there are too many forces and confounding variables in the wider environment that may not be measurable that may have attributed to change.
- ✘ A process and formative evaluation of the measure would be beneficial.

3. Cultural Competence

- ✘ Core cultural values, beliefs and practices need be reflected within outcome measurement frameworks. Because it is consistent with Pacific worldviews, the *Fonofale* model is considered an appropriate philosophical framework to underpin a Pacific mental health outcome measure.
- ✘ Process and context issues need to be taken into consideration. They may be equally important to the successful use of routine¹ measurement of outcomes

¹ Refers to application of the measurement tool at regular intervals to enable measurement of change

as the instrument itself, e.g. the cultural competency of who is administering the measure.

- ✧ A Working Party should be formed consisting of the required technical expertise and representation to oversee and actively advise on a Pacific mental health outcomes measure project.
- ✧ Consumer representation at all stages and levels is critical.
- ✧ National consultation processes with stakeholder buy-in may increase acceptability of an instrument.
- ✧ A sub-project addressing New Zealand-born Pacific children and youth should be carried out given the Pacific demographic at present and of the future.
- ✧ A Pacific measure should be translated into the major Pacific ethnic languages. The process of translation needs to be systematic and reliable in order to obtain cultural equivalency of the measure across ethnicities.

4. Funding

- ✧ All this requires a comprehensive research strategy as outlined in the recommendations of this report. These recommendations include indicators that constitute mental health outcomes for Pacific peoples, holistic approach across Pacific populations and different ethnicities of Pacific peoples. It is imperative that funding reflects the complexities of this task.

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2. Background

Te Pou's Research Programme previously known as the Mental Health Research and Development Strategy (MHRDS) is funded by the Ministry of Health and aims to support research and development activities to assist in the recovery of people who experience mental illness and/or alcohol and other drug problems. One of the primary initiatives of Te Pou is the Mental Health Standard Measures Assessment and Recovery initiative (MH-SMART). This MH-SMART initiative endeavours to support recovery by promoting and facilitating the development of an outcomes-focussed culture in the mental health sector. A principle means of achieving this is through the implementation of a suite of standard measures of outcome to quantify change in the mental health of consumers using mental health services. This process is required to be responsive to Māori and other cultures within a recovery framework.

Although a mental health outcome measure for Pacific people has not yet been developed, foundation work has been undertaken. The Lotofale Study in Auckland sought to develop a Pacific outcome tool based on the premise that the outcome tools available did not meet the mental health needs of Pacific people. This report includes a review of this work.

2.1 Terms of Reference

Te Pou contracted the research team to provide a preliminary report on mental health outcome measures for Pacific people primarily aimed at reviewing existing work and recommending progress on the development of a mental health outcomes measure for Pacific people.

To achieve these aims four phases of the project were identified. These are detailed below and form the basis of the research design:

Phase 1: Document review and review of existing work

- Include historical and background information from various sources (e.g. documents and reports from the initial Lotofale study)
- Description and review of the Pacific Island Outcome Measurement Tool
- Utilise various government documents
- Include review of Hua Oranga
- Include links to the Child and Youth Outcome Measures and the Consumer Measures project (if available)
- Include various database searches of other potentially relevant information

Phase 2: Consult with key stakeholders

- Form a Reference Group consisting of Pacific mental health workers and other professionals and also representing the various Pacific ethnicities.
- Identify key stakeholders (nationally)
- Contact and interview key stakeholders.

Phase 3: A preliminary written and oral report to the Research Steering Committee

Results analysed and presented (including key stakeholder feedback)

Phase 4: A final written report

The final report will incorporate feedback from the Research Steering Committee and any other invited experts.

3. Methodology

The methodology section outlines firstly how the literature was searched and secondly how information from key stakeholders was collected and collated.

3.1 Literature Search

3.1.1 Grey Literature, Professional & Informal Networks

Unpublished works, otherwise known as ‘grey literature’, were accessed via the research team’s personal collections and also via professional and informal networks.

Because the prior history of the project was not well documented, there has been large reliance on access to information via the research team’s own networks in Pacific mental health. Most relevant were communicating with clinicians, management and mental health workers involved in the original project. Pertinent written documents not widely available to the public were also able to be accessed via these networks.

3.1.2 Specialist Libraries

Appropriate government websites were searched for relevant literature. Any material that appeared pertinent was downloaded and reviewed. The websites accessed included:

- The Health Research Council of New Zealand: www.hrc.govt.nz
- Mental Health Research and Development Strategy: www.mhrds.govt.nz
- The Ministry of Health: www.moh.govt.nz
- The Mental Health Commission: www.mhc.govt.nz
- The Mental Health Foundation of New Zealand: www.mentalhealth.org.nz

3.1.3 Electronic Bibliographic Indexes

A search of relevant online electronic databases accessible through the University of Auckland library system was conducted to locate potentially relevant literature. The following databases were searched:

- ProQuest 5000: more than 7,400 titles of which some 4,000 are in full text.
- EBSCO Publishing: Major components are Academic Search Premier with over 4,600 full-text journals and Business Source Premier with over 8,000 full-text journals. There is an emphasis on peer-reviewed journals.
- CSA Social Services Abstracts: provide bibliographic coverage of current research focused on social work, human services, and related areas including social welfare, social policy, and community development. Covers 1980 to current.

- The Cochrane Library: includes systematic reviews on the effects of health care.
- Academic Search Premier: More than 7,000 journals, with full-text coverage for almost 4,000 titles. Subject areas include social sciences, arts and literature, engineering, general science, multi-cultural studies, and much more.
- PsycINFO: Over 1 million references from the international literature of psychology and the behavioural sciences. Relevant material from the related disciplines of anthropology, linguistics, law, physiology, education, medicine, business, sociology, and psychiatry are also included.
- Expanded Academic: Academic journals, magazines and newspapers. From arts and the humanities to social sciences, science and technology, this database meets research needs across all academic disciplines.
- PsycEXTRA: Focuses on the grey literature produced in the fields of psychology, behavioural science and health, that is material written for professionals, but disseminated outside of peer-reviewed journals. Table of Contents of over 530 biomedical, nursing, and psychology journals.
- PsycARTICLES: 42 journals published by the American Psychological Association.

Keywords used in the search were: (outcome measure) and (mental health). Each database yielded varying numbers of articles with the maximum in the hundreds. However, when the keywords 'culture' or 'ethnicity' were added to the search, the number of articles decreased significantly with some databases yielding no results. Articles deemed relevant to the project were accessed and viewed.

3.2 Research Design

3.2.1 Key Stakeholders

Key stakeholders included clinicians, staff and management employed at DHBs and DHB-related NGOs in Pacific mental health services throughout New Zealand. It also included other key people that had been involved in the original Lotofale Study. The research team identified 45 potential key stakeholders and also utilised the 'snowball effect' whereby key stakeholders identified eleven other potential key stakeholders who may be relevant to the project. Of the 56 potential participants, 50 participants were contactable at the time of fieldwork. Overall, 48 of the 50 agreed to participate.

Participants were recruited from Christchurch, Wellington, Hamilton and Auckland - geographical locations with high concentration of Pacific populations. Three focus groups (or *fono*) were held in total and the sixteen individual interviews were also carried out across the four locations.

3.2.2 Sample Characteristics

Due to the relatively small number of Pacific people working in mental health in New Zealand, it is difficult to maintain anonymity of participants. To protect personal identifiers, only brief details of sample characteristics will be given.

As shown in Figure 1, of the 48 participants, 22 (45%) participants self-identified as being of Samoan descent, 7 (15%) of Tongan descent, 9 (19%) of Cook Island descent, 6 (13%) as 'Other', 2 (4%) as Niuean, 1 (2%) as Tuvaluan and one (2%) as Fijian. The category 'Other' included those that identified as Pakeha/New Zealand European, Māori or Asian (mostly people interviewed for technical expertise and/or had a history of involvement in Pacific mental health outcomes). Of the 48 participants, there were 26 females and 21 males.

Figure 1: Ethnicity of Sample (n = 48)

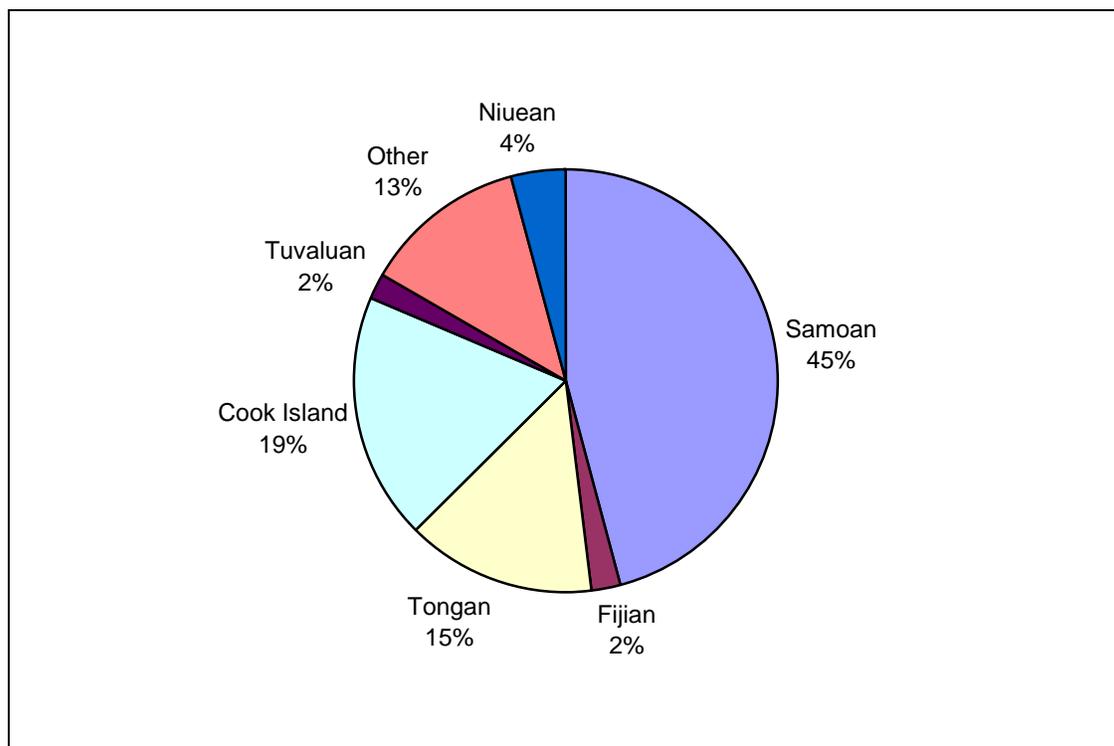
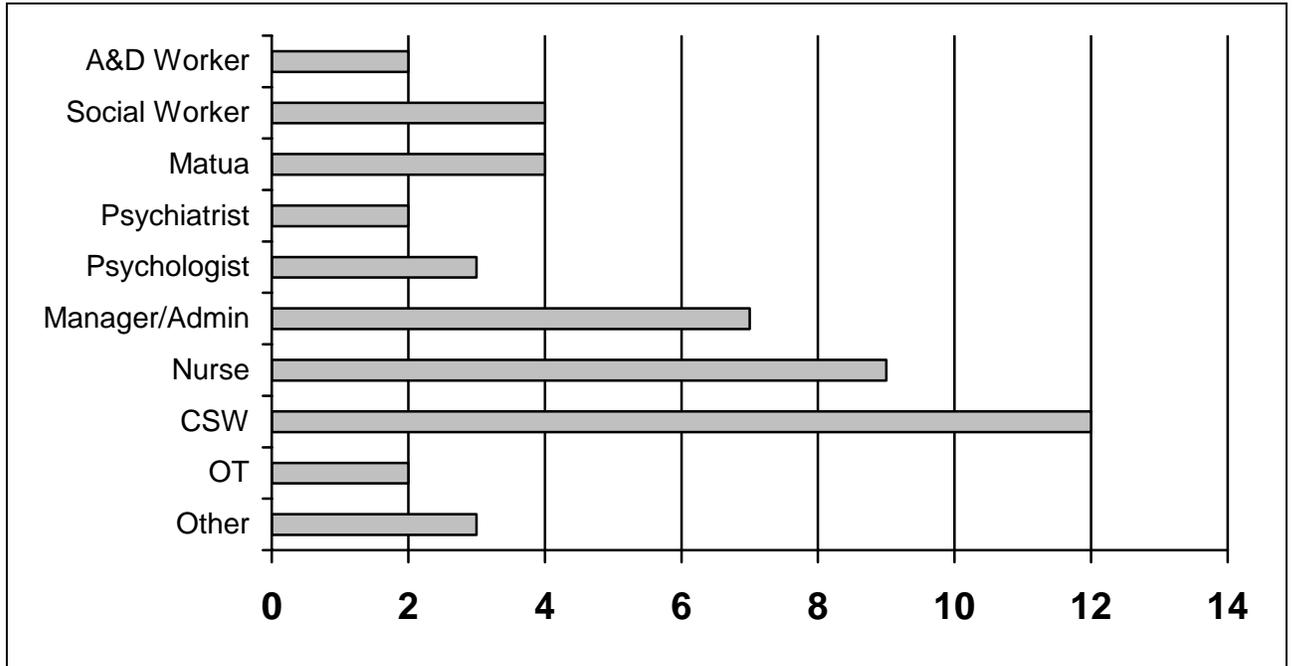


Figure 2 shows the occupations of the participants, the majority of whom were CSWs, nurses and management or administration.

Figure 2. Participants by Occupation (n=48)



3.2.3 Data Collection, Procedure and Analysis

An interview schedule was developed by the research team following a semi-structured interview format, and was utilised as the main data collection tool for the individual interviews. For the focus groups/*fono*, a more ‘unstructured’ approach was taken following a Naturalistic Enquiry mode based on principles consistent with a Grounded Theory approach (see Patton, 2002). Hence, while there were allocated topic areas, questions and theoretical frames emerged from the conversations rather than adhering to a preformed theoretical structure that might pre-empt perspectives.

The main fields of inquiry for discussions were:

- What constitutes mental health outcomes for pacific people?
- How would these outcomes be measured?
- What is your knowledge/experience with mental health outcomes?

Potential participants were contacted by telephone or e-mail, provided with information on the study and requested to take part in an interview. Focus group participants were also contacted via their managers. On agreement the researcher arranged an appointment for an interview. All individual interviews and focus groups took place in the participant’s workplace. Consent forms and information sheets containing written information about the purpose of the research and its ethical details were read prior to the interview and anonymity was assured. If participants were willing to take part, the consent forms were signed. Each qualitative interview was tape-recorded. The individual interviews ranged from 60 to 90 minutes while the focus groups ranged from two to four hours (including ‘Pacific’ protocols).

Participant narratives were audio recorded and notes were taken by pen and paper. Qualitative data was transcribed. The transcript data was then collated and analysed using thematic analysis. Common themes were identified in the data and dominant key themes emerged. These key themes formed the basis of the findings.

Quantitative information was also collected such as number of attendees to *fono*, ethnic make-up of participants, general occupation of participants and other relevant demographic information.

3.2.4 Cultural Methodology

The research methodology utilised a combination of individual face-to-face interviews, focus groups/*fono* and review of documentation. This was conducted by Pacific consultants who have experience in carrying out these data collection techniques with Pacific participants, adding appropriate Pacific protocol to the methodology.

A reference group consisting of Pacific mental health workers and other relevant professionals, and also representing the various Pacific ethnicities was formed to advise the project members. They made themselves available for any ongoing concerns and were also individually consulted for their expertise. Matai were also consulted and were available for consultation throughout the project.

In recognition and acknowledgement of the contribution of knowledge and information shared by each of the participants, a customary provision of a modest contribution (*koha* or *meaalofa*) was made to each participant through the provision of food or vouchers.

To ensure an open and transparent dialogue with the Pacific participants involved, the first draft was presented back to key participants for further feedback, input or clarification prior to a final report being drafted.

4. Document Review

The purpose of the document review was to focus on mental health outcome measurement from a Pacific perspective. Extensive, more in-depth international and local literature reviews on general and mainstream mental health outcome measurement can be found elsewhere (e.g. Deering, Robinson, Adamson, Paton-Simpson, Robertson, Warren & Wheeler, 2004; Gordon, Ellis, Haggerty, Pere, Platz & McLaren, 2004; Mellsoy & O'Brien, 2000; Trauer, Eager, Gaines, Bower, 2004).

4.1 Mental Health Outcome Measurement

In response to the need to facilitate decision-making processes and contribute to best practice in mental health services, there has been a growing interest in, and recognition of, measuring the effectiveness and efficiency of mental health services. Recently, the MH-SMART programme has facilitated a number of initiatives in the area of mental health outcomes including: the Mental Health Classification and Outcomes Study (CAOS) and Outcome Data Analysis, Child and Youth Outcome Measures, Preliminary Work Towards a Self-Assessed Measure of Consumer Outcome, Hua Oranga: a Māori measure of mental health outcome, and Alcohol and Drug Outcomes Project (ADOPT). A Pacific Alcohol and Drug Outcomes Project (PADOPT) is currently underway as a further component of the ADOPT study.

There is yet to be consensus in the literature on an agreed definition of mental health outcome of individuals. A standard definition consistently cited in the literature is:

“The effect on a patient’s health status attributable to an intervention by a health professional or health service” (Andrews, Peters & Teeson, 1994, p12).

Mellsoy and O'Brien's (2000) *Outcomes Summary Report* for the Health Research Council describes in their literature review how consumer outcome measurement involves firstly, the assessment of change within the individual and secondly, that this change must be attributed to the effects of the health intervention (p119). The authors also point out that the attribution of change to treatment effect is not a straightforward process. The MHRDS' preliminary consumer outcome report (Gordon, et al., 2004) further this point, highlighting that change in consumer mental wellbeing can be influenced by a much wider range of influences and reflects more than the impact of service intervention alone:

“Scores from outcome measures can at best tell us that there has been a change, but not what has caused this change” (p2).

There are also problems in the assumption that “no change” in mental wellbeing may not be an improvement in outcome - “no change” may be a positive outcome depending on consumer and clinician perceptions, severity, and also treatment goals.

4.2 A Pacific Perspective

The term 'Pacific peoples' does not refer to a single ethnic group, nationality or culture. It describes a diverse range of peoples living in Aotearoa/New Zealand who migrated from the Pacific, or whom identify with the Pacific Islands due to ancestral linkages and heritage (Ministry of Pacific Island Affairs, 1999). The Pacific population includes representatives from over 22 different communities. Due to migration, 6.5% of New Zealand's current total population is of Pacific ethnicity. New Zealand's most recent Census reports that the Samoan ethnic group makes up almost half the Pacific population (approximately 49.6 %), followed by Cook Islands (22.6 %), Tongan (17.5 %), Niue (8.7 %), Fijian (3 %), and Tokelauan (2.7 %). Pacific people are no longer a solely immigrant population with the majority (60%) of this population born in New Zealand and about two-thirds of the population located in the Auckland region (Statistics NZ, 2003a).

The Pacific population in New Zealand is growing at a rate three times faster than the total New Zealand population - it is projected to reach 414,000 in 2021 - an increase of 58 percent over the estimated resident population of Pacific ethnicity at 30 June 2001. Furthermore, the Pacific share of the total population is projected to rise from the current 6.5% to 12% in 2051 (Statistics NZ, 2003b). The Ministry of Health (2005, p20) estimates that over a six-month period, 23% (including alcohol and drug use disorders) of Pacific people in New Zealand could expect to experience a mental illness. For mental health service providers, the greatest impact of service provision is expected to be in the age range of 10-30 years, because that group is increasing at the fastest rate and those are the years within which first-time mental illness is most likely to occur (Ministry of Health, 2005, p16). Given these rapidly changing demographics it is urgent that existing service providers, current outcome measure projects and future outcome measure initiatives take these into account in their strategic planning, research and development, and service delivery processes.

The Ministry of Health funded *New Zealand Mental Health and Wellbeing Survey - Te Rau Hinengaro* (2003) is of particular significance to Pacific communities because it will be the first time that an attempt has been made to gather epidemiological information on how Pacific people experience problems with their mental health. The survey will provide reliable prevalence information to help plan mental health and other social services.

In response to the significant under-representation of Pacific people working in the mental health sector, a key theme of mental health strategy documents since 1998 has been to develop the Pacific peoples' workforce (Mental Health Commission's, 1998; 2001; 2004). Initiatives aimed at developing the Pacific mental health workforce have recently been employed such as the Health Research Council Pacific Mental Health Workforce Awards, the Clinical Training Agency support packages, and more recently, the Ministry of Health has funded a series of feasibility studies exploring options to increase the Pacific mental health workforce.

4.2.1 Pacific Perspectives of Mental Health

Common values across Pacific nations are ideals such as respect, reciprocity, communalism, collective responsibility, gerontocracy, humility, love, service and spirituality (Anae, Coxon, Mara, Wendt-Samu & Finau, 2002). Pan-Pacific concepts of family emphasise collectivity and encompass the immediate and extended family as well as the wider community. Illnesses can be categorised in strictly biological terms by Western medicine but many Pacific people carry cultural assumptions that may influence the presentation symptoms or the response to diagnosis and treatment (Jansen & Sorrensen, 2002). Traditional Pacific concepts of health are holistic, where well-being is defined by the equilibrium of mind, body, spirituality, family and environment. Pacific models of health and mental health belief present ethnic-specific philosophical frameworks such as the well-known Samoan *Fonofale* model (Pulotu-Endemann, 1995), the Tongan *Kakala* model (Helu-Thurman, 2004, cited in Agnew, et al., 2004) and the Cook Islands *Tivaevae* model (Maua-Hodges, 2004, cited in Agnew, et al., 2004).

There is a paucity of published work on Pacific mental health in New Zealand. A recent Ministry of Health publication *Tupu ola Moui: The Pacific Health Chart Book 2004* provides a stocktake of the health needs of Pacific peoples and includes a comprehensive review of service utilization, health outcomes and determinates of health (Ministry of Health, 2004). Bathgate and Pulotu-Endemann published “*Pacific People in New Zealand*” in *Mental Health in New Zealand from a Public Health Perspective* (MOH 1997). This provides a comprehensive background to Pacific peoples’ understanding of health and needs. They note that Pacific cultures do not have words that translate easily into “*mental illness*” and mental health is considered to be inseparable from the “*overall wellbeing of the body, soul and spirit*” (p.106). Most disturbed behaviour is considered to be a manifestation of an external spiritual force, and the result of breaches of forbidden or sacred relationships (Bathgate and Pulotu-Endemann, 1997; Lui, 2001; Tamasese, Peteru, Waldegarve & Bush, 2005).

In short, there is a common belief across the Pacific cultures that ancestors have a constant spiritual and physical communication with living people (Bathgate and Pulotu-Endemann, 1997, p.106). The traditional approach to treatment is to focus on the whole family rather than solely the individual.

Although Pulotu-Endemann’s *Fonofale* model is based on a Samoan perspective, the model acknowledges that ethnic-specific differences will exist, but there are universal concepts across Pacific ethnicities and the model can be applied in a Pan-Pacific way. Because the *Fonofale* model is integral to the Lotofale Outcomes Study, it is important to describe its components. The *Fonofale* model utilises metaphorical symbols depicted in a visual representation of a *Fonofale* (a traditional Samoan meeting house) with four main posts (*Pou-tu*). The metaphorical house represents the holistic collectivistic approach of Pacific core cultural values. It encompasses six dimensions of health. The foundation (*Fa’avae*) that the *fale* is built upon represents the first dimension of nuclear and extended family (*Aiga*), reflecting the basis for social organisation of Pacific people, and supporting the *Pou-tu*. The *Pou-tu* represent four further dimensions of health:

- *Fa'aleagaga* (the spiritual dimension): the sense of inner well being, encompassing beliefs around Christianity, traditional spirits and nature.
- *Fa'aletino* (the physical dimension): the well being of the body, measured by the absence of illness and pain.
- *Mafaufau* (the mental dimension): the well being of the mind.
- *Isi mea* (the dimension of other): encompasses variables such as finance, gender, age, education, sexual orientation, etc.

Above the *Pou-tu*, the roof (*Falealuga*) represents the sixth dimension of culture (*Aganu'u*), the philosophical drive, attitudes and beliefs of Pacific Islands' culture. Surrounding these six dimensions of health is the environment, context and time relevant to the individual. The dimensions are interwoven and interdependent so that altered states of wellness occur when one or more of the dimensions are out of balance.

The *Fonofale* approach is consistent with the recovery approach, where recovery involves all dimensions of a person's life being in harmony - spiritual, physical, emotional and familial (Malo, 2000; Pulotu-Endemann, Annandale & Instone, 2004).

4.2.2 Pacific Diversity

It is important to recognise and acknowledge the cultural diversity between Pacific cultures - each Nation has its own specific set of cultural beliefs, customs, values and traditions. The status, authority, tradition, obligations and power structures are different for each group. Moreover, the diversity and distinct differences *within* cultures needs to be acknowledged - e.g., between "island-born" and New Zealand-born Pacific people. This is of particular relevance for the future given that the last Census in 2001 reported that 48% of the Pacific population residing in New Zealand were under 20 years of age (Statistics New Zealand, 2003a).

New Zealand-born Pacific youth are in a unique position straddling the two worlds of the *Palagi* and the Pacific (Tiatia, 1998; Tupuola, 1999), where the worldviews are intrinsically different, and where personal identity may include affiliations with both the western and traditional Pacific practices. Culture is dynamic and dependent on context - intergenerational tensions exist between the traditional and the youth cultures (Suaalii-Sauni & Samu, 2005).

Dimensions of mental health for Pacific peoples and implications on outcomes stemming from these may vary depending on the individual's level of acculturation (Faleafa, 2004). Berry, Poortinga, Segall and Dassen (1992) conceptualise acculturation as existing on a continuum with four levels. At one end the individual is solely 'traditional', exclusively holding on to their culture of origin, while at the other end a new cultural identity is developed with the dominant culture completely 'assimilated'. In the middle exists the 'bicultural' or 'integrated', where people maintain interest in the traditions of their own culture while adapting to the dominant culture. Also in the middle are the 'marginalised' where there is little possibility to maintain cultural traditions (often through systematic cultural deprivation), and little possibility of adapting to the dominant culture (often through exclusion or discrimination). A New Zealand study investigating the utilization of the SF-36, a

health quality of life questionnaire, exemplifies Berry's model of acculturation (Scott, Sarfati, Tobias, & Haslett, 2000). The authors found that for Māori and Pacific people 45 years or older, the two-dimensional structure of the questionnaire was not supported, i.e. traditional views of health that did not separate physical and mental health dominated the interpretation of responses. Younger, more acculturated Māori and Pacific participants however rated similar to *Pakeha*.

4.2.3 Pacific Mental Health Outcome Measurement

On an international level there is a paucity of literature exploring mental health outcome measurement for ethnic minorities, immigrants or indigenous peoples. Published documents specifically aimed at Pacific peoples mental health outcomes and outcome measurements are sparse. Only one Pacific consumer mental health outcome measure exists to date, "The Lotofale Study", which is reviewed below.

There is an overarching argument in the international literature for the value and need to make mental health research and measurement culturally sensitive (Guarnaccia & Rogler, 1999; Rogler, 1999). Western experts transferring concepts across cultures uncritically and without adaptation tends to suppress, bias and deflect cultural understanding, giving rise to cultural insensitivity (Rogler, 1999). Simply translating a Western instrument is not sufficient because inadequate translation can lead to a result less reliable than the original version (Berkanovic, 1980). The research purports that mental health outcomes must be measured in the context in which they occur and thus must include community and cultural norms of mental illness, economic and environmental factors, and the consumer's goals and expectations (Hohmann, 1996).

Consistent across the literature is the view that outcome measures need to be psychometrically sound. Andrews, et al. (1994) identified a set of guiding principles that for an outcome measure to be sound it needed to have: applicability, acceptability, practicability, reliability, validity and sensitivity to change. A key characteristic for measures to be applied to ethnic populations is the issue of reliability and validity. That is, the tool measures what it purports to measure (validity), and the test scores are free from errors of measurement (reliability) (Mellsop and O'Brien, 2000, p 122). While valid and reliable mental health outcome measures have been established for consumers of western dominated culture overseas, and are currently being developed for *Pakeha* in New Zealand (e.g. Eager, Trauer and Mellsop, 2005; Trauer, Eager, Gaines & Bower, 2004), there is a lack of research validating mental health outcome measures intended for Pacific people. This probably reflects the relative infancy in the development of general mental health outcome measures worldwide and locally.

The application of standardized outcome measures to populations that the instruments have not been normed or tested on will potentially result in misleading conclusions (Faleafa, 2004). As Gordon and colleagues (2004) point out,

"When a measure is based on the concept of health and recovery prevalent to one culture, it may not measure aspects of health and recovery that are important to people from a different culture" (p 11).

Some of the literature refers to the ‘feasibility’ of mental health outcome measures. Mellsoop and O’Brien (2000) refer to Andrews et al. (1994) set of guiding principles, describing the feasibility of an outcome measure as consisting of the three dimensions of ‘acceptability’, ‘applicability’ and ‘practicability’ - referring to the relevance, effectiveness and practical application of the outcome measure (p 123). In the same vein as validity and reliability, there appears little “feasibility” in applying Western outcome measures to people with non-Western beliefs, values, and paradigms of wellbeing and recovery (e.g. Slade, Thornicroft & Glover, 1999). Anecdotal evidence suggests that the mere definition of a ‘mental health outcome’ may be perceived differently by a Pacific person. Matangi-Karsten et al.’s research on Pacific treatment interventions in the alcohol and drug field identified that, with regard to outcome measures, workers believed the process was as equally important as the actual outcome of intervention (2003; cited in Deering et al., 2004, p38).

As mentioned earlier, when measuring mental health outcomes, attributing changes that occur over the course of treatment to a particular intervention is difficult. Improvement may occur for reasons other than the intervention. Malo (2000) wrote from a Pacific consumer perspective and emphasised the importance of extended family and spiritual beliefs on outcome. A recent publication by the MHRDS, *Pacific Models of Mental Health Service Delivery in New Zealand* (Agnew, et al., 2004) documented in-depth qualitative data on a snapshot of Pacific peoples perceptions of mental health services. One of the authors’ conclusions highlighted the many facets that can be attributed to an outcome:

“...having appropriate family and community networks, appropriate living environments for consumers, meaningful work for consumers and competent mental health staff are what helps towards getting consumers well and towards assisting families” (p xiii).

Matangi-Karsten et al.’s research also reported that *“it is not sufficient simply to measure change by looking at a reduction of AOD use but other areas of the consumers life needs to be equally addressed”* (2003; cited in Deering et al., 2004, p38). A key recommendation was that a consumer outcome measurement system needed to incorporate specific Pacific frameworks that included family and community.

A more recent consumer-led project was carried out with the objective of examining all available self-assessed measures of consumer outcome and as part of this process, included a consultation *fono* with Pacific consumers (Gordon, Ellis, Haggerty, Pere, Pltaz and McLaren, 2004). Pacific consumers in the study also highlighted the holistic approach needed in measuring outcomes, reporting concerns with the lack of items in current measures dealing with relationships with others, family, cultural identity, connectedness and spirituality (p 84). The preliminary report concluded that existing measures are left wanting and recommended that because there was no one measure that was considered useful, that a project be established for a self-assessed measure to be developed and tested by consumers in New Zealand - including Pacific people.

Recent documents refer to Pacific models of care and service delivery and support that these models are informed by Pacific models of health belief (Agnew, et al.,

2004; Matangi-Karsten et al., 2003; cited in Deering et al., 2004). In regards to The Lotofale Study, the outcome measurement was informed by a Pacific model of mental health, which according to the authors appears to be a more valid, reliable and feasible approach to measuring Pacific mental health outcomes. Similarly, the Māori Hua Oranga mental health outcome measure is also informed by the Whare Tapa Wha Māori model of mental health.

The New Zealand Mental Health Casemix Classification & Outcomes Study

The aim of the New Zealand Mental Health Casemix Classification and Outcomes Study (CAOS study) was to foster research and development that will assist in the planning and improved delivery of services for those most in need. The objectives were to “develop the first version of a national casemix classification for specialist mental health services” and to “trial the introduction of an outcome measurement into routine clinical practice” (Gaines, Bower, Buckingham, & Eager, 2003). Eight District Health Boards took part in the pilot study, which included two Pacific teams.

The CAOS Study was the first international casemix classification study that included ethnicity-based classes and exposed some relevant issues for Pacific people. The results published in the final report (Gaines, et al., 2003), stated that there were “statistically significant differences between the three major ethnicity groupings (Māori, Pacific, European/Other) at some points on the classification tree. But at others there were none.” It is important to note that the differences were only between adult episodes but there were no differences in child/youth episodes irrespective of the settings, i.e. community or inpatient. Overall the results showed a consistent pattern that Pacific Island episodes cost the most, followed by Māori then European/Other. Other significant results suggest that Pacific Island and Māori consumers may be entering the mental health services in the latter stages of illness and when admitted are rated as having higher levels of symptom severity and lower levels of functioning than other consumers (Trauer, Eager, Gaines and Bower, 2003).

Pulotu-Endemann, Annandale and Instone (2004) prepared a discussion paper for the Mental Health Commission to summarise Pacific-specific information and to highlight implications of the CAOS report for Pacific people’s mental health. The authors presented a plethora of significant issues for Pacific communities arising from the CAOS report. They identified that the classification was based on *Palagi* paradigms and that outcome measurements that reflect Pacific holistic views of health were not included. Significant issues included:

- *Different perceptions of mental illness*
- *Different preferred treatment models*
- *The need for targeted information or training about mental illness for Pacific communities*
- *Culturally inappropriate mental health services*
- *Inaccessible mental health services*
- *Lack of social service to support consumers and their families*

They concluded that:

“Evidence from New Zealand and overseas demonstrates that culturally specific models of care will be the most cost effective way to improve mental health outcomes for Pacific communities.” (p 4)

Child and Adolescent Mental Health Outcomes

The MHRDS funded a project to address the use and acceptability of child and youth mental health outcome measures in New Zealand (Merry, Stasiak, Parkin, Seymour, Lambie, Crengle, & Pasene-Mizziebo, 2004). The psychometric capabilities of various measures were reviewed, and the views of children, adolescents, clinicians and parents sought. One of the major recommendations was that HoNOSCA and the Strength and Difficulties Questionnaire be introduced into child and adolescent mental health services as routine measures.

Part of this project was to attempt to identify issues for Pacific peoples. Overall, Pacific clinicians generally supported the introduction of routine outcome measures (p 92). Although there were problems recruiting Pacific youth consumers, the youth reported that there is a need for cultural appropriateness and culturally relevant questions to be incorporated into outcome measurement. Other issues reported were:

- That young people may prefer to write things down, particularly if they do not trust their clinician, there is clinician-consumer cultural mismatch, or due to embarrassment and fear of being misunderstood.
- A relevant informant (not necessarily a parent) should also complete the measure, such as extended family.
- Translation and/or interpretation of measures may be needed for older family members

Recommendations also included that future Pacific-led consultation take place regarding the acceptability of outcome measurement and that the process be evaluated and adjusted if necessary. Also, that the training needs of Pacific clinicians be addressed in order to correctly administer the measures.

Hua Oranga: A Māori Measure of Mental Health Outcome

Pacific peoples in New Zealand have ethnic and historical connections with *tangata whenua* as illustrated by a well-known *whakatauki* (Māori proverb) that references the physical and spiritual things which voyaged from central Polynesia to New Zealand with the first Polynesian settlers: “*E kore e ngaro he kakano i ruia mai i Rangiatea*”, “the seeds from Rangiatea shall not be lost” (Ministry of Pacific Island Affairs & Ministry of Justice, 2000, p. 16). Because there are some underlying Polynesian universalities across Māori and Pacific cultures, a more in-depth review of the Hua Oranga may assist in providing information for background work on a potential Pacific mental health outcome measurement.

The past two decades have seen a revived interest in Māori health and wellbeing with a drive for Māori principles and values to be implemented into health policy and

practice (Kingi, 2002). In 1997, Mason Durie and Te Kani Kingi began work on a Māori measure of mental health outcome they called the “Hua Oranga” (literally “fruits of health”), in consultation with Māori stakeholders (Kingi & Durie, 1997). In a report they outlined its’ development up to that point, detailing research processes that had guided them including their adherence to five primary principles; namely: wellness, cultural integrity specificity, relevance and applicability (Kingi & Durie, 2000).

For Kingi and Durie, the concept of “Wellness” provides the framework within which care and interventions for Māori suffering from psychological un-wellness is located and contextualised. This principle underscores the holistic perspective Māori hold in relation to health and wellbeing, and which is more concerned with subjective wellbeing and quality social functioning (Kingi, 2002). This contrasts with traditional western perspectives and modern psychiatric practice which have tended to emphasize the concepts of classification, diagnosis, and recovery from “mental illness” (Kingi & Durie, 2000).

The second principle which Kingi and Durie have stressed is “Cultural Integrity”. They suggest any outcome tool developed for a minority cultural population needs to take into account the norms and perspective of that culture in relation to how outcome is defined (Kingi & Durie, 2000). A third principle, “Specificity”, refers to the need for an outcome measure to be precise in order to measure as effectively as possible the outcomes being targeted. The fourth principle is “Relevance”, which considers the usefulness of an outcome measure highlighting the need for a tool to be appropriate and useful for its’ target population. The final principle is “Applicability” referring to the need for an Outcome measure to be practical and manageable (Kingi & Durie, 2000).

The Hua Oranga consists of three separate questionnaires. One of each is completed by the consumer or *tangata whaiora*, a *whanau* member or significant other (nominated by the *tangata whaiora*) and a clinician. The three questionnaire scores are then combined to form a final total. It is reasoned that the triangulation of the three key stakeholder perspectives will lead to a more accurate assessment of outcome (Kingi, 2002). Each schedule consists of four basic items reflecting the four domains of the *Whare Tapa Wha*, a well-known holistic model of Māori mental health. These four dimensions are the *Taha Wairua* (Spiritual domain), *Taha Hinengaro* (Mental domain), *Taha Tinana* (Physical domain) and *Taha Whanau* (Family domain) (Kingi & Durie, 1997). In addition, Kingi and Durie have suggested five clinical endpoints at which outcome might be measured. These are at assessment, inpatient treatment, outpatient treatment, community care and discharge stages (Kingi & Durie, 2000).

In 2000 the instrument was further tested and revised. Although the authors were confident the first draft was grounded in sound theory (Durie and Kingi, 2000), they recognised the need for clinical testing. It was not a given that the tool would measure what it was supposed to measure and there was the question of generalisability across a wide range of Māori health consumers and treatment/care settings (Durie & Kingi, 2000). Moreover, some apparent limitations needed to be addressed. For example, recommendations and guidelines as to how the tool would be applied and administered needed to be substantiated (Durie & Kingi, 2000).

As a result, two rounds of testing were suggested (Durie & Kingi, 2000). Six separate test sites covering a range of socio-economic, and rural versus urban populations, were selected to trial the Hua Oranga. An integral part of the process also included consultation with key individuals to comment on outcome issues in general and hui with service providers were also organized to obtain feedback. The first round saw the piloting of the Hua Oranga in a range of clinical settings. Feedback was obtained from respondents and then analysed. Relevant modifications to the tool were then made. A second round of testing then occurred within the same settings but with a different range of clinicians and whanau. As with the first round, further feedback was integrated.

Kingi and Durie have emphasized that the Hua Oranga is a Māori Mental Health measure, designed not to replace other existing measures (e.g., HoNOS) but to complement them. Kingi makes the point that a possible criticism of the Hua Oranga is its' lack of quality psychometric properties but reasserts its' intended usage is in combination with other measures. The Hua Oranga is consistent with the Māori global view on mental health, with its' focus on well-being, and not on the measurement of pathology (Kingi, 2002).

Limitations identified by the authors of the tool also include the assumption that the respondents have the capacity to make an informed response to the items of the *tangata whaiora* schedule, indicating that the measure might be less effective with consumers with limited reading skills or impaired cognitive functioning. Likewise some younger consumers might find the schedule challenging on a conceptual level and thus is not recommended for children under the age of fifteen (Kingi & Durie, 2000).

The Hua Oranga appears to have good face validity and adequate content validity. It also appears to be a feasible measure. Because of the wide consultation process undertaken, the Hua Oranga has also acquired a high level of acceptability with *tangata whaiora*, their *whanau* and clinicians. Additional advantages also include its brevity, simple and clear language, and the relative ease of completion and scoring (Gordon, et al., 2004).

At present the researchers are investigating the logistical implications of the measure and designing a validation framework.

The Lotofale Study

In 1998 key Pacific people working in mental health and related fields identified that the mental health outcome tools available did not meet the mental health needs of Pacific consumers and their families. The Lotofale Study based in Auckland was then initiated seeking to develop an outcome tool suitable for Pacific people. The primary goals of the Lotofale Study were to develop a mental health outcome tool for Pacific island consumers, and to provide a measure of consumer satisfaction of the service they were engaged with (Su'a-Huirua, 2003). Initiated in 1999, and in partnership with Manaaki House, principal personnel involved at the beginning of the project included Eseta Nonu-Reid, the primary investigator, David Lui, Manager of Lotofale at

the time, and Mali Erick, a senior social work practitioner at the Lotofale service (Su'a-Huirua, 2003).

As previously mentioned, the *Fonofale* model was selected as the framework for the new outcome measure. Based on the concept of a traditional Samoan meeting house or *fale*, the *Fonofale* model developed by Fuimaono Karl Pulotu-Endemann in the mid-1980's, has come to be utilised as a generic framework for conceptualising Pacific Island mental health and wellbeing (Pacific Island Mental Health Service Auckland Health Care, 2000). In the mid 1990's, the *Fonofale* model became an established paradigm for conceptualising the holistic Pacific perspective on mental health, appearing in several Ministry of Health publications (Pacific Island Mental Health Service Auckland Healthcare, 2000). Around the same time the *Fonofale* model was integrated into service delivery at the Lotofale mental health service by Pulotu-Endemann himself, in a process that involved working closely with Lotofale staff over a three year period (Pacific Island Mental Health Service, 2000).

The *Fonofale* model draws parallels between the facets Pacific people generally perceive as contributing to mental health and the structure of a Samoan *fale*. It is composed of six principal dimensions and illustrates the holistic perspective Pacific cultures have towards mental health. The roof represents the cultural values and beliefs of Pacific peoples. These may evolve and change over time and come to incorporate western elements. The foundation or the platform of the *fale* symbolises the fundamental unit of Pacific social structure and support; the family, both nuclear and extended. Between the roof and the platform, are the four posts which support the roof. One post signifies the spiritual aspect of an individual and this may include Christian beliefs, traditional beliefs or an integration of features from both belief systems. The physical dimension is also represented by another post and refers to a person's bodily functioning and wellbeing. A third post stands for the wellbeing of the mind, and encompasses cognitive and emotional faculties, while the final post represents "other" factors which may impact on a Pacific person's wellbeing including their gender, sexual orientation, age, social and financial status (Pulotu-Endemann, 1995). Additional components have also been incorporated into the *Fonofale* model, and are depicted as rings encircling the *fale*. These are the notions of environment, time, and context and represent and recognise the unique experiences and challenges for Pacific Islanders living within New Zealand (Pacific Island Mental Health Service Auckland Healthcare, 2000).

In 1999, Geoff Bridgman developed a draft Pacific Mental Health Outcome Measure with items that would map on to the six principal components of the *Fonofale* model: cultural, family, spiritual, physical, mental, and other domains (Su'a-Huirua, 2003). Subsequently, editing took place based on feedback received from Lotofale consumers, their families and staff. The draft Pacific Mental Health Outcome Measure (PMHOM) was developed in English and then translated into the Samoan, Tongan, Cook Island Māori and Niuean languages by Lotofale staff. There were differences in the number of items among the different Pacific versions of the PMHOM owing to variation in translation (Su'a-Huirua, 2003). The English, Tongan and Cook Island versions consist of 27 items each, the Samoan version is made up of 22 items, while the Niuean translation contains 39 items. Questions were in a Likert-type scale format with six responses to choose from: excellent, very good, average, needs improvement, not applicable/don't know, no response. There is also the opportunity for written

comments. The following excerpt has been uplifted from Gordon et al.'s (2004) report, describing in more detail what areas the PMHOM covers (pp13-14):

- *Family issues, including the experiences of belonging, love, honesty, respect, trust, safety and forgiveness that clients and families have experienced at the service. This includes how honest they feel staff have been, how informative and respectful, including respecting the status of elders, and how much staff have kept their word;*
- *The respect shown for the family by Lotofale and other mental health services, the degree to which the services was able to work within the family's culture, and the degree to which staff saw things from the family's perspective;*
- *The degree to which the service gave information and support that helped clients and families adapt to New Zealand culture and traditions, including concepts of mental illness, dealing with racism and isolation, pressure from church and family/church donation;*
- *The extent to which resources of the family and extended family have been drawn on;*
- *Cultural outcomes, including developing a better sense of identity as a Pacific Island person, being better able to meet cultural obligations and responsibilities, having increased access to a range of Pacific Island cultural activities and processes (e.g., traditional healing) and giving information and access to culturally appropriate mental health and drug and alcohol services;*
- *Spiritual outcomes, such as better understanding of traditional and Christian beliefs and practices (Christianity is a very prominent part of life in Pacific cultures), and increasing access to spiritual practices and processes, whether traditional or Christian;*
- *Physical outcomes, including fewer physical symptoms and signs of mental illness and of physical illness (e.g., pain, sleep, medication), fewer dysfunctional and aggressive behaviours (e.g., drug and alcohol abuse, anger management, better coping with stress, improved skills for daily living and employment (e.g., budgeting, transport, paid and unpaid work, training), and meeting basic survival needs such as money, housing, transport and child support;*
- *Mental outcomes, both increasing positive experiences (self-control, feeling loved by self and others, independence, motivation) and reducing negative experiences (e.g., depression, suicidal feelings, anxiety; and*
- *Other outcomes, including issues related to being born in New Zealand rather than the Islands, feeling more comfortable with sexual identity, gender and age role, and receiving appropriate support and education regarding sexual issues (e.g., safe sex, contraception, sexual abuse).*

Once ethical approval had been acquired from the Auckland District Health Board, a series of *fono* held in English and Pacific languages were held over the next two years at various locations within the greater Auckland region. Their purposes were to consult and gain feedback from key stakeholders, for staff training purposes in administering the measure, and for the eventual pilot testing of the tool (Su'a-Huirua, 2003).

The final draft of the PMHOM (See Appendix A) was pilot tested by 49 consumers of Lotofale. The sample consisted of 11 Tongans, 17 Samoans, 10 Cook Islanders and 11

Niueans, who were each given a choice of completing the measure in either English or their own Island group language. A little over half chose to complete the tool in their own Pacific language (Su'a-Huirua, 2003).

In November 2002 results from the trial were made available to the Mental Health Commission for statistical analysis. Because of the significant discrepancy between the Niuean version and other versions of the Lotofale tool, it was decided that the Niuean language measure would be excluded from the analysis. In 2003, Su'a-Huirua was contracted to write a report on the processes and findings of the Lotofale Study, however, the report was never completed. The actual results presented in the report focussed on the level of consumer satisfaction in each of the six domains of the *Fonofale* model. They are difficult to interpret and do not give a full picture of the findings because the report was never completed.

In the latter stages of the project, momentum was lost mainly due to a number of key personnel moving on to other positions. Funding for the project became depleted and the entire project appeared to be shelved. It was not until the MHRDS requested this preliminary report in early 2005 that 'lost' information from the Lotofale Study has attempted to have been sought and collated.

Some positives features of the PMHOM have been identified (Gordon et al., 2004, p33). These include the measure's apparent high face validity (the items appear to measure what they set out to measure, i.e. satisfaction with services and change as a result of services), high content validity (good coverage of domains), and high feasibility (acceptability is good with simple wording and applicability is also good as the domains are relevant). Anecdotally, a major strength of the PMHOM was the fact that the project was lead and implemented by Pacific people.

A very apparent limitation of the PMHOM is the lack of information available on the protocols required to use, administer, score or interpret the measure. Gordon et al. (2004, p33) also pointed out the limitations of the PMHOM, such as no information on: construct validity, criterion validity, inter-rater reliability, test-re-test reliability, sensitivity to change over time, practicality, time to administer, cost, availability of the tool, ease of implementation, length of training required, when to assess, how often the measure is meant to be used, time period the measure covers, effects of setting type, or effects of type of mental illness. Other limitations are that the questionnaire is relatively long and appears to be missing key content such as coping with and recovering from mental illness, hope, empowerment and basic needs. A further ambiguity is whether the measure is supposed to be a self-report inventory completed by just the individual, or in consultation with a significant other. However, anecdotal evidence suggests that it is designed to be a consumer self-report measure to be completed by the individual.

The report by Su'a-Huirua (2003) concluded that, "*Several changes are required for the assessment tool to be complete, robust, reliable, objective, comprehensive and accurate in terms of content for evaluating a single, stand alone service provider*" (p81). However, the author failed to suggest the changes necessary or detail suggestions as to what or how these changes should be made. There were a few suggestions or conclusions made:

- That the six elements of the *Fonofale* model adequately address holistic aspects of recovery and are sufficient to meet the needs of the Pacific Islands mental health consumers.
- In the future development of the tool, it may be useful to aim further effort at the spiritual aspect of the tool.
- Questions presented in the tool should focus on only one single concept.
- The Likert scale needs to be more sensitive, suggesting a scale of 1-7.

A final limitation of the PMHOM is the language translation process. The translation of any instrument into different languages is a costly process. Due to budget limitations, the PMHOM was translated into various Pacific languages by Lotofale staff. While translating the instrument into Pacific languages is appropriate and a potential strength of the measure, the processes that were used of carrying out the translations are not sufficient to obtain cultural equivalency of the instrument. As previously mentioned, inadequate translation is a threat to reliability. There are research-based models of translation and adaptation of measures that can help minimise this threat (e.g. Matias-Carrelo, Chavez, Negron, Canino, Aguilar-Gaxiola & Hoppe, 2003).

4.3 Summary of document review

On an international level there is a paucity of literature exploring mental health outcome measurement for ethnic minorities, immigrants or indigenous peoples. Published documents specifically aimed at Pacific peoples mental health outcomes and outcome measurements are sparse. Only one Pacific consumer mental health outcome measure exists to date, *The Lotofale Study*, which is reviewed in this document. Overall, there is a lack of research validating the use of any mental health outcome measures for Pacific people, which may potentially result in misleading conclusions.

International and local literatures generally define mental health outcome measurement as the assessment of change in the individual and that this change is attributable to service intervention. The change in the individual may be due not just to 'clinical' but also 'cultural' interventions. However, this definition may differ for Pacific people. Traditional Pacific concepts of health are holistic, where wellbeing is defined by the equilibrium of mind, body, spirituality, family and environment. Pacific models of health and mental health belief present ethnic-specific philosophical frameworks. Mental health outcomes must be measured in the context in which they occur and thus must include community and cultural norms of mental illness. Given this, it is not unreasonable to suggest that change in wellbeing for Pacific people may reflect more than the impact of service intervention alone and that there may be many facets of holistic wellbeing attributable to an outcome such as spirituality, sense of belonging and connectedness attributable to individual, family and community involvement or intervention. Hence, outcome measurements need to incorporate specific Pacific holistic frameworks of health.

Some of the New Zealand health outcome research includes Pacific components to their projects (e.g., Agnew, et al., 2004; Gordon, Ellis, Haggerty, Pere, Pltaz and McLaren, 2004; Matangi-Karsten et al., cited in Deering et al., 2004; Merry, et al., 2004; Pulotu-Endemann, Annandale & Instone, 2004). In general, the Pacific components recommend that Pacific holistic views of health, Pacific frameworks and culturally relevant issues need to be reflected in mental health outcome measurement in order to accurately measure Pacific mental health outcomes.

Because there are some underlying Polynesian cultural universalities across Māori and Pacific cultures, Hua Oranga, the Māori mental health outcome measure, may assist in providing information for background work on a potential Pacific mental health outcome measurement.

5. Key Stakeholder Input

This section presents and discusses the findings from the key stakeholder interviews.

5.1 Key Themes Arising

Key themes emerging from the narratives of the focus groups/*fono* and individual interviews formed the basis of the findings from stakeholder input. The key themes that emerged were:

1. Experience and knowledge of mental health outcome measures
2. Mainstream versus cultural measures
3. Indicators of a Pacific outcome measure
4. The importance of process
5. Difficulties with outcome measures for Pacific people
6. Pacific youth in New Zealand
7. Clinical Utility
8. Further discussion required

Theme 1: Experience and knowledge of mental health outcome measures

Definition of Mental Health Outcome

Most participants had a common understanding that mental health outcome measurement involved measurement of change during and/or after intervention:

“...It’s about measuring the progress and change that occurs as a result of treatment”.

This is in line with the definition given earlier in the document review:

“The effect on a patient’s health status attributable to an intervention by a health professional or health service” (Andrews, Peters & Teeson, 1994, p12).

However, when asked questions around ‘what constitutes mental health outcomes for Pacific peoples’ various issues arose (see Theme 3: Indicators of Pacific mental health outcome).

This finding appears to negate any anecdotal evidence suggesting that Pacific people may define a mental health outcome differently from western definitions. However, the emerging key theme of 'Pacific mental health outcome indicators below illustrates how the operation or the implementation of outcome measurement may be different for Pacific people.

The Pacific Mental Health Outcome Measure (PMHOM)

Of the 48 participants, over half were familiar with or had heard of the PMHOM. Two overarching key themes emerged in regards to participant perceptions and understandings of the PMHOM:

1) That the PMHOM was more of a consumer satisfaction and/or service or staff evaluation questionnaire than an outcome focussed tool:

"...my impression of the Lotofale outcome measure, it was a whole mixture of things, consumer satisfaction, service evaluation... those things are important and useful...but let's call it what it is... maybe they need to be teased out a bit and not just call it one instrument but several different instruments with different functions".

Many participants agreed that the measure was designed over five years ago and may have suited the climate at the time. However, now there has been a shift to outcomes and the measure required updating to reflect the current climate.

"I think the climate has changed, in 1998 it was about consumer satisfaction, now there is an outcome focus for 2005 and in the future."

2) The philosophy of the PMHOM, such as the holistic approach it takes based on the *Fonofale* model is the correct approach to take when attempting to measure outcomes for Pacific and the measure was generally accepted in principle. However, most participants also reported that the measure required a lot more work if it were to be developed as a standard Pacific mental health outcome measure.

"The measure couldn't be used across agencies in the form that it is in now but I think people are accepting the Fonofale model as a useful kind of philosophical guide on what we should be doing, so we need to go with that."

"The Lotofale measure is consumer rated, there is no rating that is given to the family...it needs to be more than just consumer rated."

There were many improvements that participants reported could be made to the Lotofale measure including:

- To include questions more relevant to mental health rather than service evaluation
- Shortening the amount of questions (see Theme 7, Clinical Utility section)
- The consumer focus leaves no room for family and clinician input, which is an important part of outcomes, particularly given the holistic approach
- Separate out the consumer satisfaction questions and include them in another measure specifically focussing on consumer satisfaction

- In general it is too cumbersome to use in practice

Participants reported that the strengths of the Lotofale measure were:

- The holistic, inclusive approach that included the family and spirituality (see Theme 3, indicators of Pacific mental health outcomes)
- The consumer focus was a necessary part of measuring outcome
- The measure was translated into different ethnic languages
- The entire project of designing the measure was championed by Pacific people from the start

About a third of participants reported their disappointment with the process of the development of the Lotofale measure in that it lost momentum historically and the hard work invested in the project was not furthered:

“It’s just disappointing I guess that Lotofale began this work a number of years ago and then it was shelved and it’s quite frustrating for Pacific consumers and their families who have participated in work like this and then when it’s just chucked...and then the expectation to pick it up years later... so people get a bit annoyed when they’re asked to participate in something and then they don’t have the courtesy of being told what actually happened.”

It is important to note that in general, there was an atmosphere of resistance from some potential participants to take part in this project due to disappointment with the project progress historically, and also due to the feeling of being over-consulted and over-researched of late.

Other Measures

Less than half of the participants had used any other formal outcome measures (i.e. excluding individual therapy goals, global assessment of functioning and discipline-specific measures such as psychometric testing). The two that had been used by participants were the Camberwell and the HoNOS. In general, the HoNOS was considered an acceptable tool by all of those participants that had used it but the major two flaws were that, 1) it was not a complete measure, lacking key indicators of outcome for Pacific people, and 2) the language was not appropriate.

“...It’s a pretty good tool in terms of notes for clients that we can access and the rest of the DHB to use...so it’s easy access to see what’s going on for that client.”

“If you look at [the HoNOS], is that appropriate for Pacific people? - What are the missing things that Pacific people need?...Their family - see there’s a difference between us and palagi: us is more. A family to us doesn’t mean just mum and dad, but it’s extended family, three, four generations - there’s the difference. And some of the language used is not appropriate.”

Participants that had used the Camberwell reported that it had a role in clinical assessment but was not acceptable, had too many questions, and was too cumbersome.

Theme 2: Mainstream versus cultural measures

The Need for a Pacific Mental Health Outcome Measure

Almost all participants reported that clinical outcome measures have a role to play in Pacific mental health services but are not adequate or reliable when attempting to measure outcomes for Pacific people:

“Clinical measures have their role but cultural measures are still needed...the palagi measures miss too much important information out and don’t measure what is a reality to us...if you say that it’s a cultural service then you must have cultural measures in terms of outcomes.”

Merging the Clinical and the Cultural

In regards to dialogue around mainstream and cultural measures the overarching key theme was that there needs to be a combination of the clinical and the cultural components when measuring mental health outcomes for Pacific people. The general perception was that a Pacific mental health outcome measure be used in conjunction with a mainstream measure or a mainstream measure be adapted to include a Pacific dimension:

“...I don’t believe in re-inventing the wheel, we already have outcome measures for symptomatology. Strategically you would want a Pacific outcome measure to measure things that the ones we have don’t measure.”

“I don’t think we should limit ourselves to just a PI measure.... We need to borrow some palagi ideas and implement with our Pacific ways of measuring outcomes.”

Five participants referred to the need to compare Pacific outcomes with the rest of New Zealand:

“The issue for us as a sector is that if we develop an outcome measure specific to us, that’s ok as long as we use it in conjunction with mainstream tools so that we have some comparable results - because what will happen is that our sample sizes seem to be so small that we won’t be able to compare it with anybody else’s data but our own... that the exercise becomes a little bit isolative. What it does is that the results may never be able to be compared with any other groups and therefore we are never going to be able to validate it against anything else and we are going to always question intrinsically how valid our outcome tool is ...without that external comparison.”

Other responses included:

- Not duplicating the work already implemented with mainstream measures, such as the HoNOS

- Referring to any Māori outcome measures for guidance before initiating Pacific research
- Not starting from scratch and ensuring that the previous work done on the Lotofale measure is utilised as a starting point

Theme 3: Indicators of Pacific mental health outcomes

What constitutes pacific mental health outcomes?

The question of defining what constitutes mental health outcomes for Pacific people was seen by the research team as an essential first step required before any suggestions of how to measure outcomes for Pacific people could be unravelled.

It was difficult for participants to articulate what constitutes mental health outcomes for Pacific people - in particular, identifying what differences need to be taken into consideration when dealing with Pacific outcomes as compared with western/palagi outcomes.

A key theme emerging in terms of difficulties articulating what constitutes mental health outcomes was that, because of the holistic philosophy underpinning Pacific mental health, when discussing mental health outcomes, Pacific people are often referring to the *intangible* such as spirituality, values and beliefs. One participant summarised:

“For me I think [what constitutes mental health outcome] is a belief system...It’s about how to look at where culture, where family fit in more than a service delivery... I keep coming back to this health belief stuff because it’s what’s important. There’s no model that says this is how you should do it you know. People come to us and often ask us well what is your service delivery model for pacific and it’s hard to say what we do different... I think it’s about relationships and it’s about beliefs and being able to incorporate those into the whole intervention.”

Another participant reported:

“It’s hard to talk about because it’s almost like we’re putting a scientific framework onto something that’s kind of intangible”.

Other reasons for difficulties in dialogue around what constitutes Pacific mental health outcomes were that:

- The process of the intervention is just as important as the outcome (see Theme 4, The importance of process)
- The “talk of the day” among Pacific mental health service providers is more oriented at a service delivery level (including cultural competencies) rather than at an outcome level
- Although there appeared to be a good understanding of measuring outcomes, mental health outcomes are still a foreign concept to many Pacific mental health workers

- A few participants perceived outcomes in terms of staff evaluation/performance and consumer satisfaction

Holistic Approach to Outcomes Needed

Despite the above difficulties, there was a clear key theme common to all participants that mental health outcomes are holistic and for Pacific people should not be limited to symptomatology but include the indicators of family, spirituality, community, and the physical, emotional and mental dimensions of wellbeing.

“...We prioritise family, culture and spirituality in the assessment, in the management, in the whole process going forward, so it’s honouring all of those things not just focussing on the bio side of thing..... and I think mental health is moving more towards the recovery philosophy so that’s a much more broader base.”

Family

Of all the indicators suggested by participants, the inclusion of family was emphasised the most. Participants reported that family, extended family and genealogical roots were essential to a Pacific person’s identity and that this was missing from the western-based outcome measures. They reported that measurement of the family dimension would include how relationships are functioning and the client’s participation and role in the family.

“...the element that we have to include in our outcome measures is the family’s perspective... and what we have to continue to strive for is to avoid the dilution of our collective sense of being ... and that’s what’s missing from the HoNOS and K-10...they’re all individualistic measures...We need to avoid that and continue to push the collective including our families.”

“The family context is huge because that’s our definition of self, we don’t exist without family...relationships are huge, the relationship dimension comes up in family, and in emotions and in spirituality.”

“...mental illness is one point - but if you’re going to measure, measure things that [identify] ‘what makes these people stay well’ - like families - what are the contributions from families? Does this person have a relationship?...we need to bring it down to ‘in what way are these families supporting this person?’.”

Spirituality

Spirituality was reported by almost all participants as an indicator of mental health outcome. However, when probed further, it was difficult for participants to present how this dimension might be measured as an outcome.

“...spirituality is a vital component of recovery and that needs to be measured, if you can.”

Physical

The physical dimension was perceived as being an important indicator because of the psychosomatic manifestations of mental illness and also because of the common co-morbidity of mental illness with physical illness among Pacific peoples:

“Definitely, definitely the physical dimension, because of the psychosomatic stuff, oh the psychosomatic manifestations of the emotions is heaps!...it’s very common for our people...like being ‘heartbroken’, when it is actually anxiety-related but for them it’s better to frame it as something wrong with their body rather than a panic attack...our people are very psychosomatic.”

“...one of the things that you guys need to go back with is this notion that outcome measures for our community are bigger than just Mental Health Outcome measures - you know the outcomes for us have to be a little bit health related because we’ve such huge co-morbidity now - so we’re finding that if you have a major mental health problem you’re highly likely to have two or three and you’re highly likely to have a major physical condition going on as well - diabetes, obesity, high blood pressure, so do we take into consideration physical outcome measures for people with mental health... So if you were to look at outcome measures, do you look at outcome measures that measure people’s physical health?”

Holistic Approach to Measurement

Given the participant perceptions of the holistic approach to outcomes, it followed that measurement of outcomes was required to be holistic and include the indicators presented above. All participants agreed that measurement of these indicators should be from a consumer, family and clinician perspective.

“When we do an assessment of outcomes, we need to do a complete assessment... to have a good outcome you need consumer rated, family and community and also clinician rated.”

One participant commented on the cultural value of respect and how this may be a barrier to accurate self-reports:

“It can’t just be consumer rated because culturally there is a level of respect and in a clinical situation that often means a level of acquiescence. The client will agree with whatever you say... especially if there’s language barriers or you just don’t have that engagement... so you need other people’s perspectives, people that know the client well.”

Following a brief description of the Māori Hua Oranga outcome measure by the interviewer, participants were given the opportunity to comment. All participants that had discussions around the Hua Oranga supported the model and philosophical approach, and reported that Pacific people could learn from the work Māori had already done:

“...have you had a look at the Māori measure? How they’ve divided into client, service, whanau?...see I’d look at something similar to that to be honest and even if we don’t have to re-invent the wheel and go and meet with them and say how can we modify it?... it’s a start. But that’s the kind of thing to follow rather than start from scratch, taking something like that and adapting it.”

Theme 4: The importance of process

When discussing what constitutes mental health outcomes and ‘how’ might this be measured, a key theme arising was the overwhelming reference to and emphasis on the importance of the *process* of how to measure outcomes. Participants reported that the essential aspects for accurately measuring outcomes are:

1. Gaining rapport, engaging and connecting with the client

“Do you know if you connect deeply with people at a certain level you gain their trust, their respect - their compliance? Yeah, and then you’re far more likely to get positive outcomes. So spirituality from a clinical point of view - can you connect with these individuals in a way that are connecting hearts and minds? You know and you connect with peoples minds if you first engage their hearts - it’s a funny thing to say.”

“I spend a long time on my engagement before I can even go close to what I would call psychological intervention....it has to be a meaningful engagement, we are very good at superficial engagement, they sit there and tell you all sorts of stories...[PT]

2. The ethnicity and belief system of the outcome assessor

“...without Pacific workforce that understand our nuances, we wouldn’t have to spend half our time explaining why or how we feel, because our Pacific clinicians understand that...so the empathy and relationships that our Pacific workforce have with us is, is met more quicker, and we need that... we desperately need that.”

“I think you can connect with people if you have shared experiences aye? [i.e., being Pacific]...its not an argument for saying that European can’t help our people - that’s not true - course they can...but its just a matter of whether...you’ve made enough of an impression, formed enough of a bond, enough of a relationship, trust that they’ll take it you know.”

“...The HoNOS is actually quite a simple thing, it’s not that difficult to use, what I think is more important is how we do the assessment, how you get the information to rate on HoNOS...I think that its having an assessment system that honours Pacific values and beliefs...so its more about the clinician than the instrument.”

3. The cultural competency of the outcome assessor.

“I think it’s more important to focus on the cultural competency of the assessors than the actual instrument in the end.”

“...So to me, it doesn’t matter weather it’s a Samoan, Tongan, Cook Islander; it’s about clinician assessment of you...So therefore what’s more important is getting out what Waitemata DHB have done with cultural competencies...To rate the person who is assessing. Are they culturally competent to do the assessment? Rather than just anybody taking the HoNOS and...rating it without any kind of incorporation of cultural beliefs.”

Theme 5: Difficulties with outcome measures for Pacific people

Many participants reported that there would be difficulties in attempting to measure mental health outcomes from a Pacific cultural perspective because they are problematic to quantify:

“Often it’s difficult to quantify some of the statements that people make in terms of outcomes and what they look like, because we talk a lot about holistic services and being culturally appropriate, but can you really define that in a measurable way. I mean what is culturally appropriate? What are you defining as a good service? And who defines that? You’ve got consumers saying that they want a life worth living. But what does that actually mean and how do you quantify that? How do you evaluate that? How do you measure that?”

A few participants furthered the theme of the difficulties quantifying Pacific concepts by reporting that there are also difficulties in achieving a connection between conceptual ideal Pacific measures of outcome and actual practical implementation of measuring outcomes:

“Somehow outcomes for us has to be more than just making sure their voices go away...Outcomes for us have to bigger than that K-10 and the HoNOS, yeah, but you know, again it’s very airy-fairy, it’s very wishy-washy, some of these concepts we can’t take and put into clinical practice...the problem with intellectuals is that sometimes our intellectual debates and our theorising don’t equal day-to-day practice, on the factory floor, and, and trying to make sure that those two things stay linked and very strong is really hard.”

Theme 6: Pacific youth in New Zealand

Almost all of the participants who worked in DHBs and NGOs had a focus on providing services to adults. However, families were often included in this service. Some participants reported that a lot of Pacific services and/or staff are somewhat removed from the Pacific youth culture in New Zealand:

“...My fear is that, while we say that we have Pacific-specific services, the majority of the clients that are coming through are not Pacific-born, and that’s a trend that’s going to increase. What does cultural competency then mean for those clients and for the practitioners? At the moment we have a lot of staff that are Pacific born and already have the cultural skill, but that’s not a trend that’s gonna help for the future...”

“...there is a huge growing dissatisfaction amongst Pacific youth about current systems of care, about engaging with Pacific services where there are a lot of, um mature to older Pacific Island professionals who are quite disengaged and disconnected from who they are and what they represent, so I don’t know whether or not it will make a difference in terms of outcomes as to whether or not a service helps young people - where the majority of clients are now... the [Pacific] population’s young, so we’re seeing a lot of young people now.”

Almost all participants reported that the components of the *Fonofale* model still apply to Pacific youth as a mental health framework. However, some participants reported that the *Fonofale* model and cultural competencies that have been developed need to be revised to ensure they are appropriate for youth:

“You have the problem of New Zealand-born versus Pacific born and you are just making the assumption that this model you have fits with Pacific therefore fits with New Zealand-born.”

Theme 7: Clinical Utility

When questioned around the clinical utility of a potential Pacific mental health outcome measure, five themes emerged in the majority of participant’s narratives.

1) A measure can be Pan-Pacific:

“There are subtle differences [between ethnicities] but overall I think it’s pretty similar patterns. People talk about ethnic-specific and all of that but I just don’t buy into that, not as a service anyway...we need to attempt to deliver something that’s appropriate to everyone and if you get too specific about things it just becomes too complicated...”

2) However, it may need to be translated into major Pacific languages:

“Language is very important to assess outcomes because they can’t answer questions in English well...culture and language can’t be captured in other models....A lot of consumers will answer questions but don’t know the real meaning of the questions - they have limited English but they try to mask that. They say they understand but really, there’s been no connection whatsoever with the clinician... they don’t want to be shamed...”

3) Questions need to be Pacific user-friendly, kept simple and to a minimum:

“The thing about outcome instruments and things like HoNOS is that we’re planning to use them in every single clinical situation in NZ NGO and DHB so you gotta get something that’s brief, simple, so has all the things like utility, etc. That’s the tough task...We need to get something down to half a dozen questions, key questions that look at what are the best questions that you can have for measuring family wellness or spiritual wellness, anything else is too cumbersome.”

“I think it’s the minimal number of questions that we want. As Pacific people, as a Samoan, we don’t want to be asked a lot of questions...they also need to be user-friendly for our people.”

“...if you want to put onto a busy Pacific service provider a set of 22 questions, I’ll tell you right now, it won’t happen ... And my experiences with the K10 and the HoNOS tell me it’s really hard work getting the staff to do it on a regular basis...”

- 4) Assessment of outcome could occur at baseline then every three months:

“From a service perspective you’d probably want to make sure that there is a baseline done when they first enter the service - mainly because you want to see whether you are making a difference. And then you do them on a regular basis, like every 3 months, and some point before discharge.”

- 5) It would be appropriate and/or beneficial for mainstream/palagi services to use a Pacific measure for Pacific clients but they may require training:

“...the idea is that you want to influence mainstream so that they are taking on the ideas of Pacific people rather than the other way around... it’s just logical, that’s what you want everyone to be doing, influencing the majority to take on some of our thinking rather than the other way around... hence why I talk about the HoNOS perhaps having a Pacific flavour to it rather than we develop something that’s already there. We want to be influencing to better meet the needs of the population... [especially given our workforce], it’s a lot easier and more cost effective...we just need to ensure they have some cultural competency training.”

Theme 8: Further discussion required

An overarching theme in the narratives of most participants was the need for further discussion and dialogue around Pacific mental health outcome measures. It was also suggested by a few participants that these discussions could occur in groups. There were also suggestions to organise a panel of relevant key people to further discussions.

“I haven’t thought through [the Lotofale measure]... the trick is not to do that in isolation, the trick is to do that in a group and sit down and look and to go through the items themselves ... and so my suggestion would be to have a working party to go through each item and just to make some comment on

its'.. psychometric properties...professional opinion as a form of validation and we can all sit around and ask ourselves really closely and have a debate and discussion about each item and really sort of grill that item amongst us... and there is enough experience to get close to getting it right you know... and that would be valuable.”

“...There should be a hi-tech panel...what you need is a biostatistician ...technical advisor...An epidemiologist, you know... and they don't necessarily have to be all Pacific people.”

5.2 Summary of Key Themes

Most participants had a common understanding that mental health outcome measurement involved measurement of change during and/or after intervention. Over half of the participants were familiar with or had heard of the PMHOM. Less than half of the participants had used any formal outcome measures (i.e., the Camberwell and HoNOS).

The two key themes that emerged in regards to participant perceptions and understandings of the PMHOM were that: 1) the PMHOM was more of a consumer satisfaction and/or service or staff evaluation questionnaire than an outcome focussed tool. Whilst evaluation of satisfaction with services may not necessarily be an outcome of treatment, it is an important area to consider in judging appropriateness of care; and 2) the philosophy of the PMHOM, such as the holistic approach it takes based on the *Fonofale* model is the correct approach to take when attempting to measure outcomes for Pacific, and the measure was generally accepted in principle. However, the PMHOM requires a lot more work.

Clinical outcome measures have a role to play in Pacific mental health services. There needs to be a combination of the clinical and the cultural components when measuring mental health outcomes for Pacific people. A Pacific mental health outcome measure could be used in conjunction with a mainstream measure, or a mainstream measure be adapted to include a Pacific dimension. It is beneficial not to duplicate the work already implemented with mainstream measures, not start from scratch, and refer to any Māori outcome measures for guidance.

There are difficulties articulating what constitutes mental health outcomes for Pacific people and this may be due to the holistic philosophy underpinning Pacific mental health - i.e. when discussing mental health outcomes, Pacific people are often referring to the *intangible* such as spirituality, values and beliefs. Despite these difficulties, it is clear that mental health outcomes are holistic and for Pacific people should not be limited to symptomatology but include the indicators of family, spirituality, community, and the physical, emotional and mental dimensions of wellbeing. Participants generally supported the Hua Oranga model and philosophical approach, and reported that Pacific people could learn from the work Māori had already done.

When discussing what constitutes mental health outcomes and ‘how’ might this be measured, a key theme arising was the overwhelming reference to and emphasis on the importance of the *process* of how to measure outcomes. Participants reported that the essential aspects for accurately measuring outcomes are: 1) Gaining rapport, engaging and connecting with the client 2) the ethnicity and belief system of the outcome assessor; and 3) the cultural competency of the outcome assessor.

Many participants reported that there would be difficulties in attempting to measure mental health outcomes from a Pacific cultural perspective because they are problematic to quantify - particularly the intangible.

Some participants reported that a lot of Pacific services and/or staff are somewhat removed from the Pacific youth culture in New Zealand. While the components of the *Fonofale* model still applies to Pacific youth as a mental health framework, the model and also cultural competencies that have been developed need to be revised to ensure they are appropriate for youth.

Five themes emerged regarding the clinical utility of a potential Pacific mental health outcome measure: 1) A measure can be Pan-Pacific; 2) however, it may need to be translated into major Pacific languages; 3) questions need to be Pacific user-friendly, kept simple and to a minimum; 4) points of assessment of outcome could occur at baseline then every three months and 5) it would be appropriate and/or beneficial for mainstream/*palagi* services to use a Pacific measure for Pacific clients but they may require training.

There is a need for further group dialogue around Pacific mental health outcome measures. A suggestion is to also establish a panel of relevant and/or expert key people to further discussions.

6. Recommendations

1. Development of a Pacific Mental Health Outcome Measure

- ✘ Research and key stakeholder interviews indicated a significantly strong need for a Pacific measure of mental health outcome.
- ✘ The shift to recognising treatment level outcomes that informs future care of consumers should be reflected in an outcome measure for Pacific people. The Pacific Mental Health Outcome Measure developed in the Lotofale Study in its present state does not meet the needs of measuring Pacific mental health outcomes as defined by the objectives of the MH-SMART initiative.
- ✘ It is essential to clearly define firstly what constitutes an outcome from a Pacific perspective and then secondly tackle the issue of how to measure outcomes for Pacific people. This includes exploring and identifying Pacific people’s holistic perspectives encompassing the spiritual, physical, emotional, and familial aspects of a person’s life. For outcome measurement it may include exploring the cultural aspects of intervention utilizing Pacific models and frameworks such as ones used in the Lotofale Study.
- ✘ Research in this area needs to be constant and cumulative so that we are systematically building on previous knowledge. New initiatives involving the conception of a Pacific measure of mental health can draw from the processes, experiences and content of the Lotofale Study. They also need to take into account the research and development of Hua Oranga, the Māori mental health outcome measure. Guidance from Māori and the use of this guidance alongside Pacific cultural frameworks is recommended.
- ✘ A Pacific mental health outcome measure could be designed with the objective of complementing other clinical measures already validated and in use. Given this, the Pacific measure can then focus on capturing essential elements of mental health outcome that are of cultural significance specifically to Pacific populations.
- ✘ Any project investigating the potential for a Pacific mental health outcome measure needs to be nationally aligned. The issues of integration and compatibility with MH-SMART should be carefully considered when choosing the direction to develop the Pacific outcome tool and may avoid complications in trying to be “all things to all people” and difficulties in trying to integrate two very different paradigms.
- ✘ Access to utilising a Pacific mental health outcome measure should be open to Pacific and non-Pacific staff and services. These services and staff need to be trained in the administration of the measure.

2. Research & Psychometric Properties

- ✂ The reliability and feasibility of a measure are important - requiring acceptability, applicability and practicability. Utility also includes user-friendliness.
- ✂ A validation process of a new measure is required to assess psychometric properties. However, this can be a resource-consuming process. It will be useful to refer to the recent extensive validation framework designed by Māori.
- ✂ A Pacific measure that will be routinely administered and nationally compared needs to take into account the potential need to be compatible and easily integrated with electronic databases already in use, such as the MH-SMART and MHINC databases.
- ✂ A more extensive and international literature review is required to adequately inform and give up-to-date knowledge of cross-cultural outcome measurement.
- ✂ Given the Pacific holistic approach to wellbeing and recovery, it is not necessary to identify that the treatment intervention *causes* the change in the individual because there are too many forces and confounding variables in the wider environment that may not be measurable that may have attributed to change.
- ✂ A process and formative evaluation of the measure would be beneficial.

3. Cultural Competence

- ✂ Core cultural values, beliefs and practices need be reflected within outcome measurement frameworks. Because it is consistent with Pacific worldviews, the *Fonofale* model is considered an appropriate philosophical framework to underpin a Pacific mental health outcome measure.
- ✂ Process and context issues need to be taken into consideration. They may be as important to the successful use of routine² measurement of outcomes as the instrument itself, e.g. the cultural competency of who is administering the measure.
- ✂ A Working Party should be formed consisting of the required technical expertise and representation to oversee and actively advise on a Pacific mental health outcomes measure project.
- ✂ Consumer representation at all stages and levels is critical.
- ✂ National consultation processes with stakeholder buy-in may increase acceptability of an instrument.
- ✂ A sub-project addressing New Zealand-born Pacific children and youth should be carried out given the Pacific demographic at present and of the future.

² Refers to application of the measurement tool at regular intervals to enable measurement of change

- ✦ A Pacific measure should be translated into the major Pacific ethnic languages. The process of translation needs to be systematic and reliable in order to obtain cultural equivalency of the measure across ethnicities.

4. Funding

- ✦ All this requires a comprehensive research strategy as outlined in the recommendations of this report such as indicators that constitute mental health outcomes for Pacific peoples, holistic approach that can be considered holistic across Pacific populations and different ethnicities of Pacific people. It is imperative that funding reflects the complexities of this task.

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8. Appendices

Appendix A: The Pacific Mental Health Outcome Measure (for the Lotofale Study)

ENCOURAGING CULTURAL WELLNESS

- C1 Did staff help you to understand your culture and family history better?
- C2 Did staff encourage you to take part in Pacific activities as sporting events?
- C3 Have you been told about the services available and the cultural support available by staff?
- C4 Do you believe that the service is able to work in a culturally appropriate way when dealing with your mental wellness or drug and alcohol problems?
- C5 Have the staff assisted you to talk openly with your family and friends about your mental un-wellness?

ENCOURAGING FAMILY WELLNESS

- F1 Do you feel comfortable with the staff that works with you?
- F2 Does the staff show you and your family respect and answered your questions honestly?
- F3 Were you happy with how the staff first met with you and your family?
- F4 Have you or your family been told about ways to deal with living in New Zealand?
- F5 Did the staff help you and your family understand the Palagi [western] way of looking at mental illness?
- F6 Were you and your family helped to work out the best way to care for your health?

ENCOURAGING SPIRITUAL WELLNESS

- S1 Have the staff encouraged you to find your spiritual strength to assist with your recovery?
- S2 Did the staff help you when you wanted to go to a traditional healer?
- S3 Have the staff helped you to learn the importance of spiritual ways?

ENCOURAGING PHYSICAL WELLNESS

- P1 Have the staff helped you with your physical health?
- P2 Has the staff helped you with getting the right type of medication?
- P3 Has the staff helped you control your feelings?
- P4 Has the staff helped you with day to day living?
- P5 Has the staff helped you to get a nice home or get the correct benefit payments?
- P6 Did the staff make sure that our children were properly cared for when you needed them?

ENCOURAGING MENTAL WELLNESS

- M1 Has the help from staff made you feel more positive about yourself?
- M2 Has the staff helped you to get medication adjusted to you feel more in control and comfortable?

ENCOURAGING OTHER ASPECTS of WELLNESS

- O1 Do you think that the staff treat Pacific, New Zealand born, half-caste people the same? Does that make you feel comfortable?
- O2 Sometimes differences between Pacific and Palagi [western] cannot be changed. Has the staff helped you to understand why these differences effect you?
- O3 In you opinion do[es] the staff treat the children, youth, young adults, middle aged and elders with the same respect?
- O4 Has the staff helped you to understand what safe sex means?
- O5 Have the staff helped you to talk about sexual abuse and the effects that is has on your mental awareness?