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Young People’s Experiences of Assessment in a Mental Health Setting.

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Abstract

The high dropout rate of young people in the early stages of engagement with mental health services suggests it is important to better understand how they perceive their initial encounters with the service which usually occur through the assessment process. Given Māori young people are over-represented in mental health statistics, this research explored their experiences of the mental health assessment process, what they learned from this encounter and their views about how cultural aspects dealt with during the assessment. Young people between the ages of 13 and 18 who had undergone an assessment in a child and adolescent mental health centre took part in an hour-long, in-depth narrative-style interview. Sixteen interviews were collected from seven who had been referred via community services and nine who had been referred for a mental health assessment through youth forensic services. Findings reflected young people’s concerns and varied expectations before attending the assessment. Their responses showed how they found ‘opening up’ to an unknown clinician was complex and challenging and how trust was only established gradually, through the clinicians’ personal warmth, consideration, and information sharing. Themes also highlighted aspects of the clinician’s manner that potentially threatened young people’s engagement including formal practices that made clinicians seem they were just doing their jobs, the way questions were framed, and not being informative about the assessment processes. The analysis also suggested that some young people described positive gains from the assessment including better family interaction, increased self-knowledge and feelings of hopefulness.
While some participants appreciated including Māori cultural practices in the assessment, preference for a Māori clinician was varied. The study proposes ways clinicians could enquire about young people’s preferences and fears relating to the assessment process and then make adjustments to meet these needs.

*Keywords:* mental health assessment, young people, Māori, perspectives
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Chapter One

Introduction

Adolescence is recognised as a stressful time of life involving transitions related to autonomy, separation, individuation, and conflicts around identity (Richardson, 2001). These features have been recognised to make adolescents vulnerable to mental health problems (Oetzel & Scherer, 2003). This can be seen in the high prevalence of mental health problems in New Zealand where evidence associates adolescent mental health disorders with serious mental health problems occurring later in adulthood (Fergusson & Woodward, 2002). While increased resources have been devoted to developing mental health services, policies and research (Fergusson & Horwood, 2003), one of the major challenges in providing better support to young people with mental health problems is how to improve their engagement with mental health services (Richardson, 2001) and address the high dropout rates for this population group (Oetzel & Scherer, 2003). It is important to gain clarity from young people’s perspective of what might promote or hinder their initial engagement with services.

While mental health research on adolescent experiences requires more attention in general, the experiences of Māori young people has been a particularly neglected area, despite several factors suggesting it is an area that requires much higher attention. Māori are particularly vulnerable to mental health problems as demonstrated in New Zealand statistical data where an over-representation of mental health problems is apparent (Eaton &
Harrison, 2000). Māori clients may experience challenges during the process of receiving mental health services in mainstream settings, including cultural differences between the Māori health framework and the westernised model of treatment which is the dominant model in these settings. As well, Māori mental health professionals are under-represented to assist with Māori cultural needs (Durie, 1999). It has been recognised that a lack of acknowledgement or balance between clinical and cultural needs can lead to mistrust and disengagement of services and hinder the success of recovery (O'Brien, Boddy, & Hardy, 2007). As a result, the New Zealand health services have implemented strategies, such as: ongoing cultural competence training for professionals of all ethnicities; a review of policies to incorporate Māori models; and efforts to increase availability and accessibility of cultural resources such as Māori specialist teams and cultural advisors in mainstream settings.

However, there remains insufficient knowledge of Māori young people’s worldview and experiences of mental health services, particularly during initial encounters with the service.

While historically there has been less attention paid to children and adolescents’ views in mental health (James & Prout, 1997), in the last decade research has emphasised the importance of collecting young mental health clients’ views to provide services with a clearer picture of young people’s needs and preferences (Claveirole, 2004). In keeping with this trend, a growing number of research studies have explored young people’s experiences in psychotherapy and counselling (Davies & Wright, 2008; Gibson & Cartwright, 2014; Midgley, Holmes, Parkinson, Stapley, Eatough, & Target, 2014). These studies have
provided valuable information on young people’s needs and priorities in relation to psychological support, and more importantly, have shown that young people are capable of expressing their opinions about the services available to them. There is, however, very little research that specifically investigates how young people experience the initial phase of engagement with mental health services, including the assessment process.

The assessment process is quite different from treatment or other psychological interventions in many ways, such as in structure, length, functions and level of engagement (Carr, 1999) and may require independent research exploration. There are, to date, very few studies that explore young people’s experiences of mental health assessment and there is a need for more research in this area (Ellis & France, 2012; Hartzell, Seikkula & von Knorring, 2009). In particular, there is a need for studies that allow young people themselves to give their own accounts of what matters to them and their initial engagements with mental health services. Quantitative research methods such as client satisfactory surveys may provide valuable generalisations about young people’s satisfaction of mental health services (Stüntzer-Gibson, Koren, & De Chillo, 1995), however, such surveys cannot represent the richness of knowledge that can be obtained from clients themselves about their experiences, (Bohart & Tallman, 2010).

I came to this research as a woman doctoral student in clinical psychology and a beginning therapist. I was informed by a perspective that acknowledges service users’ views as very important (Claveirole, 2004), which increased my interest and motivation to
encourage the voices of young people in mental health services to be heard. While I had not initially intended to focus specifically on Māori, my realisation that the young people who came forward to participate were all Māori resonated with my strong interest in culture and my personal experience of being part of a minority cultural group. I come from a Taiwanese cultural background but have integrated with the culture of New Zealand where I have lived for 15 years. While recognising the differences between an indigenous group and an immigrant group, my own experience made me aware of the importance of being heard and the particular importance of giving room for ethnic minorities. As I explored the literature, I realised how little Māori young people’s experiences had been considered in research. As a result, my focus and aim of the study shifted to giving voice to young Māori’s experiences of assessment in mainstream mental health settings. My research addresses three inter-linked questions:

1. What is the process of undergoing a mental health assessment like from the perspective of Māori young people?

2. How does the assessment process influence their understanding of themselves?

3. How does the assessment process influence their engagement with psychological services?

The remainder of this thesis is structured into four chapters. The next chapter explores the literature that informs my research questions. In Chapter Three my
methodological approach is outlined. Chapter Four contains the analysis of the main themes that emerged from the participants’ accounts. Finally, in Chapter Five I discuss the findings, implications and limitations of this research and present suggestions for future research.
Chapter Two

Literature Review

This chapter provides a background and context for this study by firstly reviewing mental health problems in young people to highlight the need for more research on this population. Secondly, I examine the prevalence of mental health issues for Māori in general, and Māori young people in particular. This is followed by a discussion of available mental health services for young people in New Zealand and how the needs and aspirations of Māori culture and young people are addressed and incorporated into clinical practices, including assessment. Next, I present an argument for the importance of involving a client’s experience and point of view in the provision of mental health services and discuss young people’s needs and priorities while using these services. Lastly I outline what I consider to be the advantages of a qualitative research approach to explore client experiences.

Mental Health Problems in Young People

This section considers the unique demands and the challenges young people face during this developmental stage. Common mental health problems and their prevalence and risk factors for young people are presented.

Adolescence is approximated by referring to the second decade of life (Carr, 1999). During early adolescence there are marked biological and developmental changes that
indicate the onset while the end is often understood to be the time when the person lives independently from his/her original family and assumes the responsibilities of adulthood (Kazdin, 1993). However, there remains an ambiguity in defining adolescence since age only approximates these markers and both the onset of puberty and the shift into adulthood can vary widely among cultures. For example, onset of puberty is occurring increasingly earlier in Western society (Gluckman, 2010), while the period of dependence on the family has extended for young people due to the later mean age of marriage and moving out of the family home in the 21st century (Kazdin, 1993). Effectively, adolescence has become a longer and more prominent part of the life-cycle (Gluckman, 2010).

In the field of developmental psychopathology, adolescents have received less attention than children, and such neglect might be attributed to several reasons. First, adolescence has sometimes been viewed as a transitional period between childhood and adulthood rather than a distinct developmental period (Kazdin, 1993). Second, as a transitional period, it was assumed that adjustment issues and emotional or behavioural problems are age and stage specific, and thus less attention was given to adolescent problems as they were assumed to pass with time (Kazdin, 1993). Third, adolescence is a challenging period to understand from both a theoretical and methodological point of view. The dynamic nature of adolescent development may comprise marked changes that can occur within relatively brief periods (Barry & Pickard, 2008; Kazdin, 1993; Schroeder & Gordon, 2002). This development includes biological changes (e.g. height, weight or
reproductive system), maturation of psychological processes (e.g. new attachment relationships or cognitive development) or different sources of influences and opportunities (e.g. peers, new social activities, dating, or work).

Nevertheless, there has been recognition that for many reasons, adolescence needs to be a separate consideration in relation to mental health and wellbeing. First, adolescence is a critical stage in the lifespan, with rapid developmental changes in different domains such as physical, conceptual, social and emotional (Kosky & Hardy, 1992). Young people at this stage also need to deal with issues that are different from those of childhood and adulthood, such as autonomy, separation, individuation and formation of identity, while at the same time engaging in new experiences such as intimate relationships, deeper involvement with peer groups, leaving home, and making educational and occupational decisions (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Conflicts within the self and with the larger society are thus common in this stage, such as with family, friends and school (Richardson, 2001). During this critical period, a mild mental health issues, if not addressed effectively, could seriously impact on young people’s adaptations to changes, and this in turn can adversely impact on their adult life (Feehan, McGee, Raja, & Williams, 1993; Rickwood et al., 2005). Second, mental health problems have some distinct features during adolescence, for instance, young people often present with very different symptomatology to children or adults with the same clinical dysfunction: for instance, symptoms of depression might be masked by anger and acting-out behaviours (Caron & Rutter, 1991). These factors highlight
the fact that special attention is required in developing independent models of practice and research for young people (Oetzel & Scherer, 2003; Powers, Hauser, & Kilner, 1989).

Global statistics indicate a high level of mental health needs in adolescence, suggesting that approximately one-fifth of young people suffer from mild to severe mental health disorders (World Health Organisation, 2005). Common issues in young people include eating disorders, substance abuse, anxiety, depression, self-harm, suicide and conduct disorders (Carr, 1999). In New Zealand, it is estimated that 22-25% of young people meet DSM-IV criteria for one of the major mental health disorders by the age of 15, and around 35 to 45% by the age of 18 (Fergusson & Horwood, 2003; Fergusson, Horwood, & Lynskey, 1993; Mental Health Commission, 2011). Other studies stated up to 25% of young people reported suicidal ideation or committed a suicidal behaviour by the age of 18 (Fergusson, Horwood, Ridder, & Beautrais, 2005). Moreover, a high prevalence of mental health problems can be found in juvenile offenders (Elliott, Huizinga, & Menard, 2012; Ministry of Health, 2011; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). International studies have found high prevalence rates, between 40 to 60 percent, of mental health problems amongst youth offenders (Ministry of Health, 2011). Co-existence of mental health disorders, including conduct disorder and substance abuse is particularly high in this group (Skowyra & Cocozza, 2007).

Many mental health disorders start in adolescence: for instance, the median age of onset for depression and anxiety is 13 to 15 years, and 18 years for substance abuse disorders (Kessler, Berglund, Borges, Nock, & Wang, 2005). The Ministry of Health
suggests that approximately 15% of young people have chronic low-level mental illness problems that continue to impact their lives (Mental Health Commission, 2011). A direct link between early anxiety and increased risks of major depression, anxiety or other adverse psychosocial outcomes in adulthood was also found (Fergusson & Woodward, 2002). This heightens the significance of early intervention, not only to reduce the suffering of adolescents but also to prevent the continuation of mental health problems into adulthood (Feehan et al., 1994; Gluckman, 2010).

To date, a large proportion of mental health research has been conducted on the adult population and young people’s mental health has been relatively neglected (Buston, 2002; Kazdin, 1993; Lambert & Barley, 2001). Researchers have argued that there is insufficient research to effectively understand how to improve young people’s mental health wellbeing (Ellis & France, 2012; France & Homel, 2006; Muncie, 2005). This applies not only to New Zealand, but also globally (Feehan et al., 1994). As research that focuses on childhood and adulthood may not always be appropriate to address the distinct needs of the adolescent population, more research is required to address young people’s high level of mental health needs in the context of New Zealand.

**Mental Health Problems in Māori Young People**

In New Zealand which honours a ‘bi-cultural’ commitment linked to the Treaty of Waitangi, it has been particularly important to develop an understanding of the mental
health of New Zealand’s indigenous population, Māori. In this discussion I firstly consider Māori culture and what health and mental wellbeing means for Māori people. Then the prevalence of mental health problems in Māori will be discussed, situating this in the context of the history of colonisation in New Zealand.

Māori is an indigenous group that migrated and settled in Aotearoa (New Zealand) in 1000 AD. The population was divided into iwi (tribes) and hapu (subtribes). European missionaries began to settle New Zealand in the early 19th century. A treaty, Te Tiriti o Waitangi (Ross, 1958) was signed between the Māori and the British government to establish Aotearoa as a British colony, but also to assure certain rights to Māori (Macfarlane, Blampied, & Macfarlane, 2011). As biculturalism suggests, there are distinct differences between Māori and European cultures, and this can be seen in their perspectives of mental health. Firstly, the Māori concept of wellbeing emphasises a holistic integration of the four aspects of spirit, body, mind and the social environment (Durie, 1985). Secondly, similar to the longitudinal research for young people in general, Māori specific research also found an emphasis suggesting family is central to the wellbeing of Māori young people (Adolescent Health Research Group, 2004). Some discrepancies between Māori and European may lie within the definition of whanau (family) that includes extended family for Māori (Edwards, McCreanor, & Moewaka-Barnes, 2007). For instance, whanau provides more support and nurturing from several generations and relatives such as cousins. Thirdly, cultural identity is considered a key indicator to Māori wellbeing (Duri,
The strength of such identity is seen in family ties, extended family, sub-tribe and tribe, and also the ties with their land, ancestors, language, customs and marae (a sacred place for religious and social purposes). The literature suggests the development of secure cultural identity is a key principle to enhance one’s mental wellbeing and protect against illness (Durie, 1997, 1999; Marie, Fergusson, & Boden, 2008).

Even though a treaty was signed between the Māori and the British government, the years of colonisation have created suffering and adversity for Māori including loss of land, the Māori language and culture. The social and economic repercussions during colonisation, along with ongoing opposition, institutional racism, and rapid urbanisation have placed Māori adults in a position of social disadvantage and adversity (Marie et al., 2008; Reid, Robson, & Jones, 2000). The effects of these negative impacts on Māori people’s wellbeing and socioeconomic status can still be seen today, including their influence on Māori mental health (Herbert, 2002; Macfarlane, Glynn, Grace, Penetito, & Bateman, 2008). Research of ethnic minorities suggests that a disproportionate representation of mental health problems is often attributed to stress factors that are not specific to mental health problems, for example, poverty, environmental stressors, and access to services (Eaton & Harrison, 2000). A pattern of Māori over-representation in New Zealand’s mental health statistics has been a long term issue (Ellis & Collings, 1997). For instance, there are higher rates of re-admission for Māori compared to non-Māori in crisis, acute inpatient and forensic services (Durie, 1999).
The over-representation issue does not exist only in Māori adults. The greatest risk of mental health problems appears to be in the 15 to 29-year-old age group (Blakely, Tobias, Robson, Ajwani, Bonné, & Woodward, 2005). Research found that young Māori may be twice as likely to experience a mental health disorder as young non-Māori (Marie et al., 2008; Ramage et al., 2005; Wille, 2006). Higher prevalence rates for young Māori are found in anxiety, mood disorders, conduct disorders, substance abuse, suicidal contemplation and suicide attempt (Adolescent Health Research Group, 2008; Beautrais, 2001; Beautrais & Fergusson, 2006). Similar to other ethnic minority studies in the world, social disadvantage and childhood adversity were identified as risk factors for mental health disorders in Māori young people (Marie et al., 2008).

Further, Māori young people in particular are overrepresented in the criminal justice sector (Ministry of Health, 2011; Owen & Kokiri, 2001), accounting for about 43 percent of all police apprehensions, with first apprehensions occurring between 12 and 16 years of age (Marie, 2010). Earlier research also related the risk of criminal offending to the change from a rural to an urban environment (O'Malley, 1973) and the restructuring of tribal society (Jackson, 1988). Recent research adds a possible justice system bias (Policy Strategy and Research Group Department of Corrections, 2007) and the impairment to cultural identity resulting from colonisation (Snowball & Weatherburn, 2008). Given that mental health problems are often thought to be associated with youth offending, it is a further concern that there are insufficient programmes and services designed for the mental
Consideration for the disadvantage of Māori in New Zealand was addressed in 1975 legislation where the Treaty of Waitangi was given more significance in national law (Herbert, 2010). This resulted in increased recognition of New Zealand’s obligations to honour a bicultural approach within all sectors of society. This obligation refers to power sharing, bicultural practice and partnership between the two distinctive cultures - Māori and Pakeha (New Zealanders of European origin). The Treaty is now instilled in national life and influences Māori economic, social and health development and has helped to drive the government’s acknowledgement of, and efforts in meeting the mental health needs of the Māori population (Durie, 1996; Herbert, 2010).

Mental Health Services for Young People and Māori Young People in New Zealand

Given the high mental health needs of young people and Māori young people in particular, efforts have been made in research and policy planning aimed at developing mental health services that best fit their needs (Durie, 1996). This section begins by outlining the mental health services available to young people in New Zealand and then discusses how these services have been structured to fit with Māori young people’s needs, health models and priorities.

New Zealand, along with other countries has invested in the development of services and programmes to improve the mental health and wellbeing of young people. These can be
accessed through school, non-governmental organizations for young people, and health and community services (Ramage et al., 2005). Community, Child and Adolescent services are government-provided community based services that aim to increase the accessibility, appropriateness and affordability of these services for young people. Hence, the service is usually free of charge, and a lead worker usually works with the young client throughout the assessment and treatment process. Evidence-based models and approaches specific to children and young people are incorporated to provide services that align with the values and needs of young people (Ramage et al., 2005). A mental health service usually involves a multi-disciplinary team including nurses, social workers, psychiatrists and psychologists who address the different mental health needs of an individual (Ramage et al., 2005).

Family influences are recognised as important to the wellbeing of young people (Fergusson & Horwood, 2003; Silva & Stanton, 1996) and familial factors have been addressed in the design of mental health services delivery. This design includes involving family members in treatment programmes, family therapy, and decisions made around the young clients (McKay & Bannon, 2004).

Alongside community-based child and youth mental health services, there are also youth forensic services that provide specialist mental health and alcohol and other drug services for young people who have offended or are alleged to have offended, and are involved in the New Zealand’s justice system (Ministry of Health, 2011). These services provide early identification of, and intervention for youth offenders who are affected by
mental health problems. While the purpose and health professional involvement of the youth forensic services is similar to community-based child and youth mental health services, the referral system of the youth forensic team, typically through police or courts, tends to be more structured, and is mandatory (Ministry of Health, 2011). This differentiates between the voluntary and involuntary mental health involvement of young people affected by mental health problems in the New Zealand system.

While agencies and policies have been designed to improve the mental health and wellbeing of young people, actual clinical practices with young people and within the system pose several challenges. Firstly, research has shown young people are less likely to access mental health services (Oakley Browne, Wells, Scott, & Mcgee, 2006). New Zealand statistics showed only 1.9% of young people had accessed mental health services during 2007 and 2008, which was well below the 3% target set by the government (Mental Health Commission, 2011). Secondly, international literature suggests that young people seem to be more likely to ‘drop out’ of services (Edlund, Wang, Berglund, Katz, Lin, & Kessler, 2002; Wang, 2007) and miss appointments (Hamilton, Round, & Sharp, 2002). Thirdly, young people are recognised as a challenging age group to engage in mental health services (Edlund et al., 2002; Wang, 2007). Mistrust is often seen in young people towards mental health services, for instance, McGovern and Cope’s (1991) study found young people often carry stereotypes of mental health problems and doubt the usefulness of professional help. They also were more likely to feel less satisfied than older clients about
their mental health treatment (Greenwood, Key, Burns, Bristow, & Sedgwick, 1999). Jorm and colleagues (1997) explained that children and young people tend to have a low literacy and knowledge about mental health with little information being made available to them. It is important for health services to continue to learn effective ways to work with young people to resolve issues of low engagement and access. Rather than attribute the issues to client factors, system and service factors should be considered (Appleby & Phillips, 2013).

The challenges for young people receiving mental health services may be even greater in indigenous culture groups than amongst young people in general (Deane, 1991). Engagement tends to be poorer and there is greater mistrust between clients from ethnic minorities and mainstream mental health services (Singh, Greenwood, White, & Churchill, 2007; Wang, 2007). Some studies found that Māori young people have a low access rate to mental health services (The Werry Centre, 2011) and are likely to experience more severe mental health problems before they seek help (Baxter, 2008; Elder & Tapsell, 2013). They also have a higher rate of premature treatment termination (Wang, 2007; Young, Grusky, Jordan, & Belin, 2000). Factors in mainstream services that can often lead to treatment delays or disengagement included absence of culturally responsive assessment and intervention (Elder, 2013; Pitama, Huria, & Lacey, 2014) or clients’ concern over prescribed medication (Waitoki, 2012). Some studies argue that some contextual factors around clients’ familiarity with mental health services influence their engagement and alliance with health professionals. For instance, one study found that the level of dissatisfaction with the
service for people from ethnic minorities dropped with each hospital admission (Parkman, Davies, Leese, Phelan, & Thornicroft, 1997). In sum, there is a high need to develop mental health services that address the challenges noted above to better engage with young people from ethnic minority groups.

The relevance of developing culturally appropriate health services has gained wide recognition in the last two decades (Durie, 1997), as meeting the cultural needs of an individual is an important step to engagement and recovery (Elder & Tapsell, 2013). When working with young Māori clients, the Treaty of Waitangi provides a framework for safe practices (Manna, 2003). Increasingly service providers are a) forming partnerships with Māori groups in the design and policies of mental health services (Herbert & Morrison, 2007); b) encouraging Māori young people to participate fully and extensively in decision making, choices for treatment, and information sharing (Durie, 1999); c) ensuring Māori priorities have equal consideration in the system without discrimination which can be a barrier to recovery (Fenton & Te Koutua, 2000). This approach includes recognising that western models of mental health are not the only framework for understanding illnesses (Glover & Roberston, 1997). A growing number of agencies, such as Kaupapa Māori services, have adopted such cultural balance through working alongside traditional Māori healers such as Kaumātua (elders) and Tohunga (healers), while not losing sight of western treatment methods and professional standards (Durie, 1999).
In the Mental Health Act of 1992 the importance of respect for a person’s cultural, language, and religious or ethnic identity is emphasised. This has influenced health professionals who have increased their cultural knowledge, and made an effort to provide services that meet people’s cultural values and needs (Elder, 2013). For instance, many services for young people are designed to be less individualised or compartmentalised and rely greatly on whanau support, whanau healing and whanau development in the recovery programme (Durie, 1999; 2004). As well as the social environment of peer groups, school and community that have been identified for young people in general, iwi (tribal) links and access to heritage resources are also recognised as being important to the development of wellbeing in Māori young people (Edwards et al., 2007; Sanders & Munford, 2005).

As the assessment and restoration of cultural identity is a key principle for Māori young people’s mental wellbeing it is often incorporated in mental health services (Durie, 1997). This is implemented by clinicians or clinical advisors by encouraging Māori young people’s participation in their community activities to make connections with their cultural values and beliefs (Durie, 2003). This process has also been incorporated in the management of youth offending, and results showed that criminal offending could be reduced by restoring cultural identity (Snowball & Weatherburn, 2008).

While efforts have been made to make adjustments within health services to accommodate cultural differences (Elder & Tapsell, 2013), a number of challenges remain in the system. Firstly, there has been the issue of matching a clinician with a client, as most
of the clinicians are trained by institutions with a predominantly westernised view of wellbeing. Secondly, there are not enough Māori mental health workers in the service and the European-dominant environment had often restricted Māori workers in being able to practise culturally as opposed to adopting the westernised method in the mainstream services (Fenton & Te Koutua, 2000). In an attempt to deal with the issues aforementioned, policies and standards have been created to deal with system barriers (Levy, 2002). These have included more integration of culturally appropriate practical guidelines (Graham, 1997), additional training in cultural competencies for mental health professionals (Durie, 1999), and recruiting more Māori staff in the mainstream services (Fenton & Te Koutua, 2000). These challenges still remain a concern in the current society and require attention as they continue to result in low levels of client engagement and adherence to treatment plans (Fenton & Te Koutua, 2000). While an awareness of cultural identity and approaches to facilitate the clinician-Māori client process have been emphasised, it is important to recognise that individuals bring various situations and diversities with them and there is no single cultural reality for an ethnic group (Durie, 1995).

Overall, it is important for mental health services to match Māori young people’s realities (Durie, 1999), suggesting that the service should coincide with the cultural expectations of service users in order to maximize its effectiveness. Despite existing guidelines that acknowledge Māori values and bicultural practices, to date there are still gaps in the delivery of those values in the actual work with Māori clients and their families.
(Manna, 2003). Ongoing research is required to better understand how to work with Māori, particularly young people: the age group with the highest risk of mental health problems.

**Mental Health Assessment**

A client’s first interaction with mental health services is recognised to be important in his/her total mental health treatment (McFall, 2005). This initial contact is usually an assessment and it serves many important purposes that influence the quality and success of mental health services. This section firstly outlines the main functions of assessment, explains its importance and describes the general assessment approach used in mental health settings with young people. As well it considers some of the complexities surrounding the assessment of young people.

A comprehensive mental health assessment essentially comprises two main functions: a) to gather relevant information about the client; and b) to develop rapport and increase engagement (McConaughy, 2005). Firstly, collecting information from clients is key to gaining an understanding of the problems they are experiencing. This includes the frequency, severity and duration of specific symptoms and clients’ current functioning (Knight & Ridgeway, 2008). This information allows clinicians to form hypotheses and conceptualise a client’s case. Clinical judgements are also guided by manuals such as the Diagnostic and Statistical Manual of Mental Disorders ([DSM], Carr, 1999). Clinicians usually utilise core theoretical constructs (e.g., models for anxiety, depression, personality
disorder and trauma) to outline the problem, contributing factors, comorbidity, multidimensionality or other complications (McFall, 2005). They also consider a range of other factors, such as strengths that may assist with the client’s recovery (Smith, 2006). The assessment is designed to help the clinician develop a clear conceptualisation of the problem, some possible goals for treatment, and options for case management or interventions. Then these aspects are generally explained and discussed with the client and his/her family (Knight & Ridgeway, 2008). Assigning a diagnosis or treatment recommendation is a major decision that can have long term consequences in a client’s life (McConaughy, 2005).

Secondly, rapport building is important in initial assessments (Sommers-Flanagan & Sommers-Flanagan, 2009). This relational component is considered essential to effective assessment and the outcomes of future treatment (Oetzel & Scherer, 2003). Given the high dropout rate of young people in mental health services, forming an effective relationship in the first meeting can increase the chance that they will return and/or take on recommendations made through the assessment (Bryant 1984; Tomm, 1992). Engagement consists of establishing a mutual understanding and empowering young people to feel assessment has relevance and meaning for them, rather than being just something they “must” undergo (Richardson, 2001). Clarkin and Levy (2004) suggest important factors that contribute to a successful engagement include the clinician showing warmth, empathy, respect, curiosity and genuineness in communication. In addition, clinicians are advised to
form collaborative partnerships that empower clients to find explanations and solutions to their own problems (Carr, 1999). Further, as family involvement is valued in mental health, the clinician also needs to attend to the complex demand of managing relationships with both the family and the young person. Informing family about mental health services and being listening to their concerns (Haley 1980), as well as using uncomplicated language and clarifying reasons for the meeting are examples of key elements in building rapport with the family (Knight & Ridgeway, 2008).

In New Zealand, the general procedure for implementing a mental health assessment for young people usually involves a referral from schools, counsellors, caregivers, or court or medical practitioners. This often occurs when a young client is presenting problematic behaviour, or demonstrating high distress, or risk of suicide, or experiencing difficulties in functioning at home or school. In some cases these young people have come to the attention of authorities including the police or courts. This procedure is similar in other parts of the world (Reich, 2000). The particular context of the referral influences planning for the assessment, and often determines the type of assessment, objectives, and methods to be used and who will be involved. The purpose for the referral may help to define a variety of objectives for each assessment process. For example, an objective might be to establish a clinical diagnosis; to determine the risk of suicide; to assess mental health status in relation to criminal actions (forensic purposes); or to clarify cognitive functioning (Mash & Hunsley, 2005; Ollendick & Hersen, 1993). An assessment is generally conducted by
qualified mental health professionals, but the type of professional can vary depending on the context of the referral. For example, an assessment that requires clarification on a prescribed medication is usually allocated to a psychiatrist; however, when it is important to determine a client’s cognitive ability the assessment would usually be conducted by a psychologist.

Next, an appointment is typically initiated between the mental health staff and the client and/or the client’s caregivers with an agreed meeting time and place. The assessment usually takes place in a mental health clinic, but in New Zealand community services this also sometimes takes place at the client’s home. The two main functions of assessment are often integrated to balance the collection of information relevant to the referral problem or purpose with building rapport to help young people and their family feel comfortable about sharing personal information while engendering hope that problems can be addressed (Sommers-Flanagan & Sommers-Flanagan, 2009).

The formal assessment process usually consists of a multi-method process involving different techniques to enhance the accuracy of information obtained. This often involves an interview, an observation (or mental state examination), psychometric testing and gathering of collateral information.

a) *Interview.* A typical assessment usually consists of a clinical interview of one to two hours between mental health professionals and service users (Carr, 1999). A structured interview procedure is usually guided by a set of standardised questions, for example, using
diagnostic modules designed to gather precise information following DSM criteria for specific diagnoses (Doss, Cook, & McLeod, 2008). In practice, however, most clinicians prefer to use semi-structured interviews covering standard areas of concern but allowing interviewers to use their clinical judgement to modify the interview into a more conversational form. These interviews generally collect information about symptoms, context, family history, personal history and so on. During the interview process the information gathering function needs to be continuously weighed against the other function of rapport building (Miller, 2010).

b) Assessments also usually include some form of clinical observation which is normally described as a mental status examination (MSE) of the client (Polanski & Hinkle, 2000) that provides clinicians with a format for organising objective information obtained through observations. This includes noting: appearance (e.g., physical disabilities, dress, and grooming); cognition (e.g., mood, cognitive functioning, insights, orientation to time, place and people); and attitude (e.g., tone of voice, facial expression). This information can be used to generate hypotheses (Polanski & Hinkle, 2000).

c) Tests and measures. In addition, psychometric testing can be useful in various ways during an assessment, such as to describe personality, or cognitive functioning; diagnose or classify; make decisions or backup hypotheses, or select treatment goals; and evaluate or revise treatment (Barrios & Hartmann, 1986).

d) Collateral information gathering. Information needs to be collected from multiple
people in relevant domains (Mash & Terdal, 1997) to clarify information provided by young clients, who may have limited information about early developmental or educational history, or may be unwilling to report accurately on their present difficulties (Hartzell et al., 2009; Knight & Ridgeway, 2008). It is not unusual to include a family session as part of the assessment process in addition to a one-on-one interview with a young person. A family session can advance understanding of the young person’s problems for both the clinician and parents. It has been argued that this interview enhances the likelihood that parents will follow through on recommendations after an assessment as they were included in the treatment planning (Tharinger et al., 2008). Additionally, a family session allows the clinician to observe the child in the family context, and allows parents to see systemic aspects of their child's problems. This could result in the child feeling less blamed and foster positive experiences among family members (Tharinger et al., 2008). Nevertheless, family assessments are often complex given that multiple information is offered, and parents and young people may not share the same values or understanding of the problem (Hartzell et al., 2009). There may also be particular difficulty for young people in disclosing information or feeling comfortable with their parents present (Ford, English, & Sigman, 2004). Research suggests that concerned young people are less likely to talk openly about sensitive issues such as substance use and mental health (McKee, Rubin, Campos, & O’Sullivan, 2011) and risky sex behaviours (Reddy, Fleming, & Swain, 2002).

Assessment practices for Māori young people. As discussed earlier, New Zealand
health services have developed guidelines to address the mental health needs and challenges of Māori young people. These guidelines also blend cultural approaches into the initial assessment at mainstream mental health settings (Macfarlane et al., 2011). While it may be common for cultural advisors and Kaumatua (Māori elder) to be involved and assist with the assessment process, culturally competent practices are expected of all health practitioners by the guidelines. This section describes how this cultural integration is important to both the rapport building and information gathering aspects of assessment, and provides examples of existing research and guidelines of how to work with young Māori clients.

During the initial engagement, the strength of the rapport is understood to be influenced by the respect clinicians show for the cultural beliefs of their clients (National Health Committee, 1996). Commencing with the greeting phase, rapport can be promoted through practising tikanga (ritual). This may include physical touching such as a hug or hongi (touching noses), a prayer or karakia (blessing), or self-disclosure of some heritage or familial links. While self-disclosure amongst clinicians may be uncommon in western practices, the policy of biculturalism practices recommends that both client and clinician disclose something about their own cultural position (Nairn, 2007). This greeting and introduction process by the clinician and client may take some time before moving on to the concerns of the patient, yet it is considered to be crucial to the process of relationship building (Aklin & Turner, 2006).
Further, as a principle of ‘Culturally Just Practice’ introduced by Nairn (2007), it is important clients have shared understanding of how the system operates and are allowed to express their views and understand their rights in decision making (Manna, 2003). Durie (2005) suggests that these culturally sensitive practices increase clients’ participation and minimise their powerlessness in mainstream mental health services. In addition to establishing a culturally safe relationship with Māori clients it is important to incorporate cultural factors into the information gathering and understanding of the nature of the problem. Durie (1999) has argued that to gain a comprehensive understanding of a Māori client, an assessment should measure cultural and spiritual aspects of the problem rather rely on western diagnostic manuals. It is also highly recommended that during the initial engagement a cultural assessment is completed with the client’s cultural identity as a priority (Manna, 2003). A cultural assessment involves the exploration of a Māori client’s whakapapa (historical route) that gives rise to certain cultural patterns or rituals and shapes his/her beliefs, behaviours, and ways of feeling (Glover & Roberston, 1997). These guidelines on how to acknowledge Māori clients’ worldview and to make sense of their presentation have been included in New Zealand assessment policies (Macfarlane, et al., 2011). A cultural assessment provides important information for intervention planning, and it is vital to engagement and relationship building with young clients and their families (Manna, 2003).
In studies that attempt to address the issue of high dropout rate in Māori young people, it has been pointed out that engagement should begin before the assessment (Durie, 1999). Durie (1999) argues that it is not uncommon for mistrust and disengagement to develop during the crisis management and referral processes, leading to a lost opportunity for early intervention. Therefore, a high level of collaboration and appropriate communication patterns during the crisis stage is recommended including the involvement of individuals and family in planning and negotiation (Drury & Munro, 2008). However, there is insufficient research that specifically focuses on the initial encounter and assessment process for Māori. More research is required regarding how clinicians can engage with Māori clients more effectively at the point of entry into mental health services (Drury & Munro, 2008).

As in research with young people of other ethnicities, it is noticeable that most of the research and literature on Māori mental health has reviewed assessment practices for adults exclusively and considerably fewer studies have examined assessment procedures for children specifically, and fewer still, for young people (Adolescent Health Research Group, 2004; Elder, 2013).

**Challenges meeting young people’s needs in assessment.** It is noteworthy that most of the ideas discussed above have been derived from a professional point of view rather than from those of the client. Some research suggests that clinicians may not be sufficiently aware of the unique ways that young people perceive assessment (Secker,
Armstrong, & Hill, 1999). The following research argues that a) there may be differences in
the priorities of young clients and that of clinicians in mental health services, and b) that
young people may experience these services differently.

In psychotherapy studies it was found that adult clients did not always perceive
therapy in the same way as clinicians (Williams & Levitt, 2008; Bohart & Tallman, 2010).
For example, Levitt and Rennie (2004) asked the therapist and the client to look at video
tapes of their interaction, and the perspectives of the two parties only partially overlapped.
Other qualitative studies of psychotherapy process also noted that clients may be more
concerned about relational and emotional aspects of the therapy while therapists may focus
more on the cognitive aspects (Rennie, 2000; Timulak, 2010). Thus it would appear that
generally clinicians and clients have different priorities in terms of what is important in
mental health interventions.

It is likely that there are even more differences in perceptions of problems and the
process of therapy between clinicians and younger clients. It has, for example, been found
that children may not share the same views or needs for help as their parents or other
authorities (Pekarik & Stephenson, 1988; Shirk & Karver, 2003). From an influential meta-
analysis of 119 studies on cross-informant agreement about child emotional and behavioural
problems (Achenbach, McConaughy, & Howell, 1987), low agreement was found between
children’s self-ratings and those of adult assessors, including mothers, fathers and teachers.
Similar results were revealed in later large-scale studies (Davidson-Arad, Dekel, & Wozner,
and smaller qualitative studies (Freundlich, Avery, Munson, & Gerstenzang, 2006) that suggest there are often different understandings of key concepts or different priorities between children and adults (Holland, 2009). In addition, studies found that parents often do not accurately interpret the views of their children about mental health services (Daley, 2005; Godley, Fiedler, & Funk, 1998; Klein, 1991; Lambert, Salzer, & Bickman, 1998; Loff, Trigg & Cassels, 1987; Shapiro, Welker, & Jacobson, 1997; Stüntzer-Gibson et al., 1995).

While most these studies were focused on younger children, there is most likely some crossover to young people. Altogether this evidence suggests that neither research nor clinical practice should rely only on the interpretation of adults or health professionals. Although they are close to the young people, their views cannot solely represent young people’s point of view (Neill, 2005).

It is clear that mental health assessment for young people represents an important phase in their engagement with mental health services. Assessment involves multiple functions such as clarification and conceptualisation of mental health problems and provides opportunities to build rapport and facilitate engagement. With Māori young people this phase is assisted by incorporating their cultural needs and values in assessment practices. Yet, it is also clear that assessing young people can be a complex process and more research is required to understand this better. As the perceptions of adults close to the young people may not fully reflect their needs and priorities, it is important to ‘hear’ young people’s voices around their mental health experiences.
Young Client’s Experiences of Mental Health Services

This section considers the clients' role in mental health services, and discusses the importance of including young clients’ feedback about their experiences and provides an overview of findings from existing research in this area. This includes findings from the limited research on Māori young people’s views of mental health services.

Customarily, professional discourse and practice have privileged the position and decision making of clinicians within the psychological service (Bohart, 2000; Bohart & Tallman, 2010; Busseri & Tyler, 2004; Kelley, Bickman, & Norwood, 2010), whereas clients have been typically described as the passive recipients of the service (Buston, 2002; Orlinsky, Rønnestad, & Willutzki, 2004). However, considerable evidence has shown clients play an important and crucial role in the outcome of the intervention. Following a comprehensive review of 50 years of literature, Orlinsky and colleagues (2004) concluded that client participation is the most important determinant of a successful psychological encounter, more so than clinician attitudes and behaviours or techniques used. Participation includes the client’s cooperation and experience of the therapeutic bond and his/her contribution to the bond; and the client’s interactive collaboration, expressiveness and openness with the clinician (Orlinsky et al., 2004). Wampold’s (2001) meta-analysis estimated approximately 87% of the variance in any psychological help could be attributed to client or extra-therapeutic factors. These results have shifted attention to the client role in mental health services.
While client factors have been incorporated by many psychotherapy process-outcome researchers, they have been wary as to how client perspectives, which are often subjective and interpersonal, should be included (Macran, Ross, Hardy, & Shapiro, 1999). Rather than simply naming client factors that impact on the usefulness of psychological encounters, a growing number of researchers have argued that client interpretations of experiences are as important as objective client variables (Binder, Moltu, Hummelsund, Sagen, & Holgersen, 2011; Frankel & Levitt, 2009; Gibson & Cartwright, 2013).

In the last two decades, clients have been actively involved in building an evidence base for clinical practice. Governments and other agencies have actively sought to include the views of mental health service clients in their policies and frameworks for clinical management (Bury, Raval, & Lyon, 2007; Department of Health, 1999). Client feedback has been sought over a range of settings to help shape mental health services in many countries including New Zealand (Coffey, 2006; Telford & Faulkner, 2004). These studies aimed to include client feedback in the development to ensure that services were better able to better meet client needs (Secker, Grove, & Seebohm, 2001; Thornicroft & Tansella, 2005; Waldron, 1998). For example, Papworth and Walker’s (2008) study of mental health service users identified important factors influencing their engagement including relationships with service providers; information provision; stigma; choices associated with the psychological help and care pathway, medication and complementary approaches; as well as social support (Green, Hayes, Dickinson, Whittaker, & Gilheany, 2003). Increasingly researchers
are integrating lay views of mental health services into their findings.

In terms of children and adolescents, respect for their views is advocated in ‘The Children’s Act’ (Department of Health, 1989). One article of this act states the need to seek and take into account children’s wishes when making decisions about their welfare (Children’s Rights Development Unit, 1992; Department of Health, 2002, 2004). A similar principle is also recommended for child and adolescent mental health services in the United Kingdom (UK) (Audit Commission, 1999; Health Advisory Service, 1995). However, mental health research consistently reveals that children are not always asked for their views by clinicians (Aubery & Dahl, 2006) and children’s voices are rarely heard in service evaluations (Cavet & Sloper, 2004). A 1999 UK report revealed that only 35 percent of health authorities consulted children, as well as their parents about their needs in mental health services (Audit Commission, 1999). These findings suggest more effort is required in seeking children’s views in mental health services.

While historically there has always been far less research regarding younger clients compared to research focusing on adult clients (Bee, Playle, Lovell, Barnes, Gray, & Keeley, 2008); in more recent times a growing number of research studies have considered child and adolescent views of a range of social and mental health services (Hartzell et al., 2009). These studies include views of outpatient mental health services (Burns et al., 2004; Garland & Besinger, 1996), foster care (Chapman, Wall, & Barth, 2004; Barber & Delfabbro, 2005; Kristinsdóttir, 2004; O’Neill, 2004), residential children’s homes (Barter,
family therapy (Strickland-Clark, Campbell, & Dallos, 2000) and the youth justice system (Ellis & France, 2012). These studies demonstrate that, with sufficient support, child clients are able to provide feedback on the services they receive (Potter, Holmes, & Barton, 2002; Prior, Lynch, & Glaser, 1999).

Some recent studies have explored young clients’ perspectives on different models of psychological help (Davies & Wright; 2008; Gibson & Cartwright, 2013; Gibson, Cartwright, Kerrisk, Campbell, & Seymour, 2015; Kazdin, 2008; Midgley et al., 2014; Stasiak et al., 2013). Using qualitative methods, these studies have begun to accumulate rich contextual understanding of young clients’ experiences, with significant findings emerging such as client expectations, priorities and needs in relation to psychological services. The following provides an overview of findings from these studies of young people’s experiences and their priorities in relation to psychological help.

The relationship between clients and their clinicians has long been recognised as a key element of the engagement process for all age groups, and this is no exception for adolescent clients (Binder et al, 2011; Bury et al., 2007). It has been suggested that this relationship determines the level of engagement and therefore is a strong predictor of the outcome of psychological intervention (Martin, Garske, & Davis, 2000; Roth & Fonagy, 1996; Wilson & Deane, 2001). From interviews across a range of psychological services, young people’s priorities seemed to centre on the need for an understanding and supportive therapeutic relationship (Binder et al., 2001; Bolton, Oetzel, & Scherer, 2003; Everall &
The importance of friendliness, support, empathy and accessibility has been repeatedly emphasised by young people across a range of studies (Buston, 2002; Gibson et al., 2015; Hollidge, 2013). Binder and fellow researchers’ (2011) study further emphasised how young people needed to see the human side of their clinicians; and noticed if they were comfortable in their roles, presented as ‘real people’ who showed a genuine interest in their clients, were attentive and authentic, and did not merely seeing their role as a ‘job’ (Flaskas, 1994; Gibson, et al., 2015). Similarly to adult clients, young people wanted the clinician to provide space to allow them to talk freely about their thoughts and feelings (Gibson et al., 2015; Harper, Dickson, & Bramwell, 2014; Midgley et al., 2014). Additionally, it was important the clinician was non-judgmental so young people felt listened to and accepted (Bury et al., 2007; Harper et al., 2014). Young people also placed value on the establishment of trust that allowed them to feel confident and safe to talk about sensitive issues with consideration of their privacy and confidentiality (Gulliver, Griffiths, & Christensen, 2010). They also relied on the resources given by clinicians to help them problem solve and overcome problems (Dunne, Thompson, & Leitch, 2000).

Psychotherapy research has consistently acknowledged the clients’ need to exercise their own agency (Bohart, 2000; Bohart & Tallman, 1999). The word agency refers to a client’s ability to act on his/her own wishes and objectives (Bandura, 2006). Findings in this area suggest that clients actively exercise their agency on a variety of different levels
throughout their engagement with mental health services (Binder et al., 2011; Everall & Paulson, 2006; Frankel & Levitt, 2008). This is likely to be a particular issue for young people who particularly value their independence and autonomy (Lerner & Steinberg, 2009). Gibson and Cartwright (2013), for example, found their young clients actively sought what they needed throughout the counselling process, and positioned themselves as having a choice about seeing a counsellor, becoming engaged, appraising their counsellors, and taking what they needed to fit with their lives. However, this study was conducted with middle-class, full-time students in counselling settings, which may be slightly different from vulnerable populations in secondary mental health settings in which clients might be experiencing relatively higher levels of distress and feel less empowered to exercise their agency. Other research has suggested that young people need a balance between opportunity for autonomy and maintaining communication and connection that are important elements in therapeutic relationships (Binder et al., 2011).

But while findings recognised that the experience of agency is important to this population, this sense of agency may not always translate as being able to act as an agent for a number of reasons. Young people are subject to institutional and systemic power imbalances, such as those within the referral process, which operate to undermine their choices and limit their ability to speak out about their preferences (Bury et al., 2007; Gibson & Cartwright, 2013). From a social constructivist view, a young person’s ability to construct agency may depend on the extent to which society allows or expects them to exercise
control (Bruner, 1990). The sense of agency clients bring to mental health services may be influenced by their cultural, familial or other life circumstances (Bohart & Tallman, 1999). While these circumstances might be outside of the mental health service, they can become constraints within the therapeutic relationship that prevent clients from verbalising their opinions and needs, for example, due to a fear of being disrespectful, or the need to be a good client. As a result, it has been suggested agency is often reflected internally or non-verbally, and may not always be translated into power over what is happening in the mental health setting. In other words, while clients may have strong views about counselling in the studies, there is little evidence they believed they could or would act upon or deliver their opinions to their adult clinicians during the counselling (Gibson & Cartwright, 2013). This increases the risk that young clients could convey agency through forms of resistance and disengagement, which may result in negative outcomes for psychological interventions (Stringer, Levitt, Berman, & Mathews, 2010). Existing literature recommends clinicians should be cautious about young clients demonstrating their agency through withdrawal from the engagement process (Duncan, et al., 2003; Williams & Levitt, 2007).

Several studies have focused on exploring young people’s experiences of disengagement. Findings in this area of research suggest a number of reasons why young people might disengage from psychological help. Young people reported feeling negative about a clinician using jargon, or being judgemental (Dalrymple, 2002). They were also affronted by lack of feedback or listening by clinicians (Wilson & Deane, 2001). Other
clinician behaviours such as teaching or confronting were also found to relate to client
defensiveness (Patterson & Forgatch, 1985).

Additionally, there are many pre-existing barriers to young clients’ engagement with
psychological help that are not related to characteristics of the clinician or mental health
setting. Young people’s willingness to be involved in psychological help may be related to
their current stage of change (Naar-King, & Suarez, 2011), for instance, their readiness,
motivation and sense of hope. Findings related to this area of research suggested that young
people’s willingness to participate decreases when levels of distress and hopelessness are
high (Frankel & Levitt, 2008). A sense of helplessness may also make clients passive,
and/or together with a low self-esteem may unconsciously elicit defensiveness as a
protection mechanism (Araujo, Ryst, & Steiner, 1999). In addition, clients’ prior
experiences of receiving help may influence their current willingness to seek help (Deane,
Skogstad, & Williams, 1999; Deane, Wilson, & Ciarrochi, 2001). For instance, Wilson and
Deane (2001) found that students’ experience of successful prior support was related to their
openness to seek support from that source again. In summary, there is a need to understand
pre-existing contexts that may increase young people’s resistance towards mental health
services, as well as any factors related to the clinician’s approach that may serve as a barrier
to young people’s engagement.

While research has noted a number of factors that may make it difficult to engage in
psychological services, it has also identified aspects of the encounter which make it easier
for young people to become engaged. In research with adult clients, being able to talk
openly about problems was seen as a valuable component of psychotherapy, even if this was
not often a straightforward process (Farber, Berano, & Capobianco, 2006). Clients often
experienced difficulty when they were first invited to talk about their personal stories
(Frankel & Levitt, 2008). While the same may be true of many younger clients, they have
acknowledged the process of talking and reflecting as valuable in their engagement with
psychological services (Bury et al., 2007; Midgley et al., 2014). While the research of Bury
et al. described how the opportunity to talk in therapy allowed people to develop insight
about their problems, it is possible that the assessment process might also provide
opportunities for the client to develop some initial sense of their difficulties.

Although there has been considerable work done in developing mental health
services that are appropriate for Māori, a gap remains in our understanding of how Māori
clients themselves experience these services. Only one New Zealand study was found that
specifically explored the experience of Māori services users in specialised Māori mental
health services (Pomare, 2015). This study interviewed eight young people and 12 family
members, and found similar features that facilitated engagement, including *aroha* (empathy
and compassion), regular contact and behaviours that reduced the clinician-client power
dynamics. The study also emphasised the importance of culturally integrated interventions,
suggesting how *tikanga* (cultural practices and rituals) and Māori knowledge are key in the
engagement with Māori young people in mental health services (Pomare, 2015). These
findings are valuable in creating understanding about how to work with young Māori but more research is required to hear the voices of young Māori and learn more about how they experience mental health services. Further, there is a particular need for this knowledge in the mainstream mental health settings that have not been studied.

Initial engagement with mental health services. The previous section provided an overview of findings in the area of research that explored young people’s points of view of psychotherapy, counselling and other models of treatment while this section reviews research that is relevant specifically to experiences of the assessment process. A few of the studies described above also noted interesting findings around young people’s experiences in the early phase of entering mental health settings. For instance, Binder and colleagues’ (2001) study, where fourteen young patients were interviewed to explore their experiences of psychotherapy, emphasised feelings of vulnerability and ambivalence towards a potential helper in the early stages of engagement. These feelings included anxiety about seeking help and fear of being judged, which was mixed with a hope of being helped. Trust also appeared to be an issue with young people particularly regarding confidentiality about the disclosure of personal information at the beginning of their engagement with a clinician (Binder et al., 2011). A sense of insecurity and distrust occurs particularly in those who have been told to seek psychological help by social services, school or family rather than in young clients who self-refer (Binder et al., 2011). While many young people found the initial contact stressful, they appreciated the time, encouragement and empowerment given
to help ease them into the situation and allow therapeutic alliance to develop (DiGiuseppe, Linscott, & Jilton, 1996; Shirk & Karver, 2003). Bury and colleagues (2007) found similar results in young people’s initial referral and engagement with psychotherapy, suggesting that participants may carry assumptions influenced by media portrayals of mental health. The study also found that young people found preliminary explanations helpful, such as being reassured about confidentiality and that the clinicians would not judge them (Bury et al., 2007). Creating reciprocity, with the clinician giving encouragement and initial feedback also seems crucial at this stage, as this fosters a therapeutic relationship and allows the clients to begin mental health sessions while containing their fears and ambivalence (Binder et al, 2011; Bury et al., 2007).

As acknowledged previously, there is a need to study pre-existing ideas of what clients bring to mental health sessions. Some studies highlighted a range of expectations young clients might experience before attending a first appointment with a mental health service. Firstly, some studies found feelings such as nervousness or desperation were common before attending sessions (Bury et al., 2007; Carlberg, Thoren, Billstrom, & Odhammer, 2009). Secondly, some studies suggested that young people tended not to trust adult clinicians based on their experiences with other adults (Garland & Besinger, 1996). Bohart (2000) suggests that young people’s negative attitudes or fears of trouble and authority are often associated with coming to the services involuntarily. Thirdly, different levels of hope were found in young people before they attended a mental health service.
Dennison, Stanbrook, Moos-Morris, Yardley and Chalder’s (2010) study found moderate to high levels of hope in young people about the psychological service, although these hopes were not necessarily realistic. For example, some young people thought that the therapist would have all the answers to allow them to make revolutionary changes (Dennison et al., 2010). Then, other studies found distressed clients conveyed feelings of helplessness and hopelessness (Bohart, 2000). These characteristics of young people prior to attending a session can be important as they may predispose defensiveness and then impact on the learning and making shifts in sessions (Bohart, 2000; Cooper, 2008).

While these findings provide a valuable understanding of young people’s feelings and experiences in the early phases of engaging with the services, they only reflect a small part of the overall therapeutic experience. The key components such as trust, relationship, agency and disclosure were mostly described in these studies when considering a course of therapy or other psychological services as an overall experience, and less is known about how these issues play out in the assessment process. The process of engagement can be complex and multifaceted and each phase may require a moment-to-moment, close up, exploration (Frankel & Levitt, 2008). It is emphasized that more research is needed for clinicians working with the delicate early phases of treatment, which are especially challenging given a high level of early drop out in adolescent populations (Midgley et al., 2014; Oetzel & Scherer, 2003; Tuber & Caflisch, 2011).

In summary, this section has considered research that has explored young people’s
experiences of psychological services. Many of these studies highlighted the importance of initial phases of psychological help, especially in relationship building and engagement.

More research is, however, needed to better understand young people’s experiences in the early phases of mental health services, which are most often in the assessment process.

**Young People’s Experiences of Mental Health Assessment**

This section begins by further explaining why a specific research focus is required for young people’s experiences of mental health assessment and then provides an overview of the small number of studies that have explored young people’s experiences of mental health assessments.

As the assessment process serves a significantly different purpose, and entails very different tasks, structures and models compared to therapies, it may pose particular challenges for young clients (Carr, 1999; Knight & Ridgeway, 2008). Firstly, the power imbalance between clinicians and young people may be greater in the assessment phase, compared to the treatment phase as assessment often involve a higher degree of structure with time-constraints on information gathering, psychometric testing, clarifying hypotheses and treatment planning. In contrast, treatment takes place over a longer period and provides more room for flexibility in style and greater responsiveness to the client’s needs (Carr, 1999). Secondly, there can be marked differences in the therapeutic relationship such as clients’ openness or level of rapport and trust towards the clinicians during the first few
sessions in comparison to later in the therapy process (Krupnick et al., 1996). This difference also applies to young people’s knowledge about their problems and the amount of resources they have to help their recovery (Stallard, 2003). These factors lead to questions about whether findings of young people’s experiences in psychological help or other interventions can be applied to their experiences of assessment. Surprisingly, over the past 20 years of research on children’s and adolescents’ views of mental health services, very few studies have specifically focused on mental health assessments. This review of the literature found only two recent studies that shed light on young client’s experiences of mental health assessment (Ellis & France, 2012; Hartzell et al., 2009).

First, Ellis and France (2012) prioritised hearing the voices of 13 young offenders, with an average age of 14, to explore their experiences of psychological assessment within a youth justice setting. Two key aspects emerged from the study: a) young people’s negative experiences of the assessment and b) their lack of understanding about the assessment. Whilst some young people described assessors as supportive, many of these young people related that the assessment was negative, intrusive and blaming, instead of being helpful. Those who had a clear recollection of the assessment process felt they had been treated unfairly and they expressed a sense of powerlessness with concerns about the authority the professionals might have over their lives. The young participants in this study expressed the desire to have their views heard, however, when they tried to communicate with the assessor or challenge the assessment, they feared the risk of further problems. Thus young
people’s attempts to engage were often undermined as they were convinced that further interaction with professionals would lead to new forms of control. Resistance to the assessment process was also explored in this study and this was often expressed passively. A few young people who understood the purpose of assessment had deliberately not attended the assessment session. Ellis and France (2012) suggested that this could be a way to construct their sense of control in a situation that gave little opportunity to exercise this. Strikingly, from the group of young people who had been assessed at least once previously in Ellis and France’s (2012) study, many had little recollection of being assessed. A number of these young people had been involved in a range of agencies before coming to their current assessment setting and expressed uncertainty and confusion about the roles that different professionals played. They also reported being unsure about the assessment process, and were unaware that their referral information such as school behaviour might determine their treatment plans. As a result, they felt it was unjust when they were excluded from their present school, or moved to a special school as a result of an assessment. The authors highlighted these phenomena could be attributed to several factors: a) the control and regulation which is built into everyday interactions between professionals and young people, b) the unequal distribution of power where adult professionals were the ones setting the agenda and taking control of the outcome, and c) insufficient information and explanations being given to young people about the procedure and purpose of the assessment (Ellis & France, 2012). In sum, the rather negative experiences found in this
study provide some cautions regarding psychological assessments, particularly in a forensic setting.

Whereas Ellis and France’s (2012) sample targeted young offenders in a forensic setting, Hartzell and colleagues’ (2009) study included 14 younger people (from ages 10 to 18 years) who were accompanied by family members at their first meeting in a mental health setting. The study explored what young people felt about this first family meeting which was in fact their first encounter with child and adolescent psychiatry. Young people in this study focused more on what they liked about the clinicians’ behaviours, such as how clinicians facilitated communication by listening, asking questions, simplifying questions and words, suggesting answers, correcting themselves and making adjustments in an active dialogue with the young person. They also valued therapists who were not only neutral and accepting of their stories, but also alert and ready to deal with serious matters such as risks of self-harm or being harmed by others. These young people also reflected about some things they did not like during the session, such as the session being too long, and wishing the difficult areas could be dealt with more delicately, for example, not changing topic from a difficult subject too soon.

Similarly, to studies that discussed young people’s sense of agency, young people in Hartzell and colleagues’ (2009) study expressed a desire to be active and included in the session (Stith, Rosen, McCollum, Coleman, & Herman, 1996). They reported they liked being allowed to express their feelings and also appreciated how the clinician managed to
adjust to each person in the room and allow space for various perspectives (Hartzell et al., 2009). Young people were found to appreciate having family members in the session, as they felt they had someone to depend on, and that not all adults in the room were strangers. However, the young people in this study also felt challenged and powerless when more than one adult in the room reacted differently to their viewpoint. They valued equal opportunities to contribute their views in the room (Hartzell et al., 2009).

One limitation to Hartzell and colleagues’ (2009) study may be that the interviews were conducted in a group session in the presence of parents. The researcher asked the parents the question first, before inviting the young people to add their perspectives. This approach may have influenced how the young people told their stories. Moreover, the researchers noted the interview focused more on young people’s likes and dislikes about the session, rather than providing opportunities for young people to share how they later made sense of the session or how they related the session to their life experiences. Hartzell and colleagues (2009) recognised the tentative nature of their findings, particularly as a lack of relevant research findings made comparisons difficult.

A significant gap also lies in the inclusions of cultural minorities groups in studies of young people’s perspectives. There has been no research specifically focused on the experiences of Māori young people undergoing mental health assessment. However, Pomare’s (2015) study did ask young people to comment on the referral process and the initial contact with the Māori specialised mental health service. The findings highlighted
the concerns and uncertainty before engaging and during the initial contact, including fears of being judged, concerns about the stigma associated with having a mental health problem, uncertainty about the assessment process, along with mistrust associated with previous experiences with health services. Further, young people and their families appreciated the warmth and sense of connection displayed by the staff, and the integration of Māori rituals in the process that made them feel at ease. Although this study provided some valuable information about the initial engagement, as the study was conducted in the Māori specialised service, it is uncertain whether the cultural recognition they reported would be experienced in the mainstream services. Further, the study enquired about the initial engagement post intervention and longer terms of engagement, and many participants had difficulties recalling and separating specific information about initial encounters from the overall experience. Consequently, more research that specifically focuses on the way that Māori young people assessment is needed.

The structure of assessment suggests obvious differences between assessments and psychological help such as psychotherapy and counselling, which suggest possible and potential discrepancies in clients’ experiences of these. Unfortunately, very few studies have focused entirely on the assessment phase, as separate to the treatment phase. The studies by Ellis and France (2001) and Hartzell and associates (2009) both contributed valuable information to our understanding of how young people might experience the assessment situation. However, there is an urgent need to expand the existing limited
literature through a more specific, in-depth focus of young people’s experiences of mental health assessments, including the pre-assessment, during assessment and post assessment processes. In particular research should consider young Māori clients in New Zealand mainstream services.

Methods employed to understand client experiences. When considering clients’ views about services, it is important to consider how these views were obtained. Many studies aimed at gaining feedback from young people about their experiences of mental health services have been conducted using quantitative methods which allowed little scope for young people’s individual constructs of their experiences to emerge (Holland, 2009). Quantitative studies that utilise pre-defined rating scales to measure certain aspects of the field do provide useful indications of broad trends, for example in relation to treatment preference or trends in outcomes (e.g., Clark et al, 2014). Such methods with specific constructs are useful in evaluating interventions and services because they only focus on specific aspects of the services (Kazdin, 2008). However, when it comes to understanding clients’ worldviews, certain methods (for example a survey using reliably organised categories) may be insufficient to engage with the complexity of human experience (Gordon, 2000). The factors or aspects that the researcher, as an observer finds helpful may not necessarily correspond to the client’s opinion of what is personally helpful (Orlinsky et al., 2004). Many studies do not consider that clients themselves could identify aspects they would find helpful or important (Hartzell et al., 2009). Thus research has rarely given young
people an opportunity to identify freely ‘what the important aspects were’ and ‘what they meant to them’. As well, such research has not explored the nuances in individual cases (Asay & Lamber, 1999; Holland, 2009). Greig and Taylor (1999) also noted professional disagreement about the desirability of obtaining information directly from children, and doing research ‘with’ them rather than ‘on’ them. Quantitative researchers using youth satisfaction questionnaires, (e.g., Stüntzer-Gibson et al., 1995) may have contributed to a professional view of patterns of young people in the service, but the reason they have been categorised this way or the subjective reasoning behind the ratings is unknown. On the contrary, studies using participants’ narratives instead of questionnaires in evaluations have revealed new perspectives on mental illness and recovery, as the methodology effectively focuses on individuals’ recollection of what they felt was important, instead of making assumptions about their needs (Elliot, 2005; Vaughan & Roberts, 2007).

Therefore a qualitative, explorative methodology is widely recommended in the literature as a way to access not only clients’ overall experiences, but also potential changes in experience that occur through the process of assessment. (Binder et al., 2011; Elliot & James, 1989). Valuable and effective learning information for clinicians and policy-makers can be obtained through real feedback from clients about services they have received and these users’ priorities and preferences in mental health services (Bohart & Tallman, 2010).
Conclusion

This review has highlighted the mental health needs of young people, and particularly Māori young people, and the challenges involved in engaging them with mental health services. While health services have attempted to develop mental health facilities that fit with the needs of young people and Māori, relying on the knowledge and perspectives of adult researchers, caregivers and professionals in this area may not be sufficient to understand what works for these clients.

Existing research that foregrounds the voices of young clients, suggests that young people are capable of expressing their views and preferences in relation to mental health services and related forms of psychological help. Several of these studies mentioned initial encounters with the mental health service as being particularly important and suggest that the early assessment phase requires independent research given the many differences between assessment and intervention. To date, very few studies on young clients’ experience of assessment exist. Two studies and one Māori study discussed in this review provide some valuable knowledge in this area, although many questions around young people’s experiences of assessment remain unanswered. In this research I explore young people’s own accounts of a mental health experience with the aim of helping clinicians understand how young people may experience mental health assessments and to facilitate knowledge of how this might influence young people’s engagement with the service and result in a better sense of themselves. Research suggests that in-depth exploration using a
qualitative approach would appear to be particularly useful in capturing young people’s worldviews. Last but not least, there is clearly considerable need for more cultural knowledge on how to facilitate engagement with Māori young people. Exploring this subject in the context of New Zealand would be particularly useful for understanding the needs of Māori young people to allow adjustments to be made for this age and cultural group in New Zealand’s mental health system.
Chapter Three

Methodology

This study explores how young people, particularly those of Māori descent make meaning of their experiences of undergoing an assessment in a mental health service setting. The need for such a study to gain more understanding has been highlighted in previous chapters and a review of relevant literature. This chapter firstly presents the aim of the study, then sets out the case for the use of a qualitative research approach. I then describe the methods I used in this study including ethical considerations and my attempts to ensure the quality of the research.

Research Aims

As has been discussed in the previous chapter, there is limited empirical evidence illuminating young clients’ views of their experiences in mental health settings. This study aimed to explore young people’s experiences and gain an understanding of the meanings they gave to their experiences of assessment in a mental health setting. Specifically, the focus of this research was to examine how young people perceived and made sense of their experiences of assessment, to explore how these interpretations were constructed in their accounts, and then to understand how they integrated these experiences into their lives post assessment. In conjunction with these, the study was interested in the cultural context and/or values that informed their experiences or perceptions. The purpose of the study was
to inform mental health practice when working with Māori young people.

**Methodological Approach**

It is important to consider the epistemological position of the study, that is, the views of what can be known and how it can be known. This study adopts a critical realist epistemological approach that focuses on the way people make meanings of their experiences, recognising that this is influenced by both material realities as well as social and cultural constructions (Willig, 2001). In this sense, the accounts that the young people gave of their experiences revealed some level of objective reality but also captured their subjective ‘takes’ or commentaries of the reality shaped by socially constructed perceptions, beliefs and expectations (Bunge, 1993; Frosh & Young, 2008).

I was also aware of the importance of engaging safely with my Māori participants. In order to do this I needed to be aware of and draw on the frameworks that inform principles and aspirations of Māori culture and worldviews (McClintock, Mellsop, Moeke-Maxwell, & Merry, 2012). In using this methodology, I aimed to produce knowledge of Māori young people’s perspective of assessment in mental health settings through their own voices (Macfarlane et al., 2011). This research prioritised listening to participants’ voices with face-to-face discussion and active participation which fits with the values of Māori culture. Nevertheless, the influence of any western theoretical conceptualisation within biculturalism was not to be dismissed, but considered as an accompaniment to cultural
reasoning in order to create a fuller picture (Macfarlane et al., 2011). Being a non-Māori researcher and an immigrant in New Zealand with a passion for studying cultures, I brought my own cultural perspective to bear on the way that I interpreted the accounts of my participants.

**Qualitative Methodology**

Despite differences in methodology, all qualitative approaches aim to expand our understanding of shared and individual features of the experiential lives of human beings (Holloway & Todres, 2007). Qualitative research investigates how individuals make sense of the world, how they experience events or manage certain situations (Willig, 2001). Rather than identifying cause-effect relationships, variables, or testing a specific hypothesis, the focus is on the exploration of the quality and texture of people’s experiences of a phenomenon. Holloway and Todres (2007) suggested that qualitative research sits on the continuum between art and science in its process. Like art, qualitative research is characterised by imagination, and creativity; it is fluid, dynamic and flexible. At the same time, qualitative research transforms understanding through authentic and coherent views of participants that actively integrate scientific knowledge into its practices (Holloway & Todres, 2007).

Likewise, this particular study is concerned with making meaning of how young people make sense their experiences before, during, and after participating in a mental
health assessment (Willig, 2001). In addition to adding to existing knowledge, this approach to research also allowed me to contribute to the empowerment of clients; and provide knowledge that allows readers to relate emotionally, or identify with the themes (Holloway & Todres, 2007). This is because qualitative research uses accountable, non-reductionist and transparent ways to approach the complexity and uniqueness of a social human being (Willig, 2001).

As this study focused on a newer and less researched area, qualitative research enabled me to adopt an exploratory attitude to the data (Willig, 2001). In other words, analyses were concluded from the data itself, with the potential to discover ideas not yet present in the research literature (Braun & Clarke, 2006). However, I also acknowledge that as an individual and a researcher, I did bring already formed preconceptions and theoretical knowledge to this study. In sum, my study engaged attempted to grasp the experiences of the young people, both from their original accounts of their experiences as well as with theoretical and contextual interpretations of these accounts (Braun & Clarke, 2006).

**Method**

This section includes a description of the participants, the recruitment setting, and the means of data collection for this study. This is followed by a discussion of how cultural and ethical matters were addressed.
Participants

Participants were young people living in Auckland, New Zealand, who had undergone an assessment at the Child and Adolescent Mental Health Service (CAMHS) or the Youth Forensic Service (YFS) within a year prior to the interview. Of the 16 young people who took part in this study, five were young women and 11 young men. Their ages ranged from 13 to 18, with an average age of 15.6 years. It was not our attention to limit our recruitment to a particular ethnicity, however the participants who agreed to be interviewed all had a Māori heritage. Many of them also identified themselves as having another ethnicity alongside Māori. See Table 1 for more participant demographic information.

Qualitative methodologies do not require a large number of respondents, because the construction of rich, detailed narratives within the research context is the key for such a study (Frost, 2011). As such, only a relatively small number of participants were required for this study. The final number of participants was set according to the saturation of the data that occurs when further data collection no longer adds anything new to the findings (Guest, Bunce, & Johnson, 2006).

Recruitment Setting

The CAMHS where this research was conducted provides assessment and intervention for children and adolescents between the ages of 13 and 18, typically referred
by other community agencies (i.e., school, hospital, counsellors, sports group) or family members. The YFS in this study provides similar mental health assessment and treatment for young people who have offended or are alleged to have offended. These young people’s needs for referral are typically identified when they undergo a screening for mental health and/or alcohol and drug problems during their transition through the justice system. Therefore, the referrers can be a) police at the point of apprehension, b) health professionals during health checks before court, c) court judges during the court process, or d) staff members when the young person is detained or in custodial care (Ministry of Health, 2011). Both CAMHS and YFS provide assessments for young people at their initial appointments. Both services are made up of experienced mental health professionals including specialist psychiatrists, psychologists, social workers, child psychotherapists, nurses and occupational therapists who all participate in mental health assessments. Cultural advisors appeared to participate in many, but not all of the assessment sessions. Their role was aimed at facilitating the assessment with participants from the same culture as themselves in order to assist client engagement. In this study, nine participants were referred to the forensic team (YFS) following their criminal offending. Some of these young people had suspected mental health problems or required an assessment of their cognitive functioning. The remaining seven participants were referred to the community team (CAMHS) and required support for family conflict, or suicidal behaviour, or mood, anxiety and other mental health problems.
Table 1

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Service/ Reason for referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awa</td>
<td>Female</td>
<td>16</td>
<td>Māori</td>
<td>Community/ suicide attempt</td>
</tr>
<tr>
<td>Ben</td>
<td>Male</td>
<td>18</td>
<td>Māori</td>
<td>Forensic/ mental health</td>
</tr>
<tr>
<td>George</td>
<td>Male</td>
<td>16</td>
<td>Māori</td>
<td>Community/ parent being mentally ill</td>
</tr>
<tr>
<td>Hohepa</td>
<td>Male</td>
<td>16</td>
<td>Māori</td>
<td>Forensic/ mental health</td>
</tr>
<tr>
<td>Huhana</td>
<td>Female</td>
<td>14</td>
<td>Māori</td>
<td>Community/ difficulties at school</td>
</tr>
<tr>
<td>Kakariki</td>
<td>Female</td>
<td>14</td>
<td>Māori</td>
<td>Community/ family conflict</td>
</tr>
<tr>
<td>Kiri</td>
<td>Female</td>
<td>16</td>
<td>Māori</td>
<td>Community/ mental health</td>
</tr>
<tr>
<td>Marian</td>
<td>Female</td>
<td>17</td>
<td>Māori/ Pakeha</td>
<td>Community/ mental health</td>
</tr>
<tr>
<td>Matiu</td>
<td>Male</td>
<td>15</td>
<td>Māori</td>
<td>Forensic/ cognitive testing</td>
</tr>
<tr>
<td>Peter</td>
<td>Male</td>
<td>14</td>
<td>Māori</td>
<td>Forensic/ criminal offending</td>
</tr>
<tr>
<td>Rongo</td>
<td>Male</td>
<td>16</td>
<td>Māori</td>
<td>Community/ suicide attempt</td>
</tr>
<tr>
<td>Sam</td>
<td>Male</td>
<td>15</td>
<td>Māori/ Europe</td>
<td>Forensic/ mental health</td>
</tr>
<tr>
<td>Tehaki</td>
<td>Male</td>
<td>16</td>
<td>Māori/ Cook Island</td>
<td>Forensic/ cognitive testing</td>
</tr>
<tr>
<td>Te Pahi</td>
<td>Male</td>
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<td>Māori</td>
<td>Forensic/ mental health</td>
</tr>
<tr>
<td>Tui</td>
<td>Male</td>
<td>16</td>
<td>Māori/ Pacific Island</td>
<td>Forensic/ mental health</td>
</tr>
<tr>
<td>Zac</td>
<td>Male</td>
<td>14</td>
<td>Māori/ Pakeha</td>
<td>Forensic/ mental health</td>
</tr>
</tbody>
</table>

*Note.* The names of the participants have been changed to maintain their anonymity.

Most assessments took place at the clinic, but sometimes an exception was made.

For instance, one participant saw the clinician at his home for the first session, and then attended the second session in the clinic. Another client saw her clinician at her home then at a café. Also, there were variations in the number of sessions participants attended during
the assessment process. Some attended only one session whereas several others had two or three depending on the purpose and progress of assessment.

During the research recruitment phase I was unaware of a) the participants’ background and referral pathway prior to entering the clinic; b) which team or professionals they had engaged with; or c) their length of engagement with the service. This information was obtained from the participants’ own disclosures during the research interviews.

**Recruitment Process**

Prior to the recruitment the cultural advisor of the CAMHS and YFS assisted with arranging a *powhiri* (formal welcoming ceremony) as an ‘opening’ at a *marae* with a *kaumātua* (chief) present. Three potential recruitment paths were developed to maximise potential participation in the study. First, potential participants who had completed an assessment session were identified by clinicians or administrators. They were then invited to take part in the study by clinicians who were working with them. Clinicians were asked to provide brief information about the study to potential participants and give them an invitation pack, which included the researcher’s contact phone number. Second, an approach was made to cultural advisors who were willing to contact interested young people who had undergone assessments during the past year, explain the project and its benefits to these potential participants, and assist them in how to contact the researcher. Lastly, I placed several posters in the clinic that provided brief information on the study,
participation criteria, my contact details and incentives for participation. Those who were interested could take a research card attached to the poster or enquire at the service counter for a more detailed participant information pack. The response rate from two of the recruitment options (through posters in the clinic or through clinicians’ invitations) was much lower than through the cultural advisor’s contact, which goes some way to explaining the high Māori representation in the sample.

All recruitment routes required that individuals who were interested in participating or wished to know about the study should contact the researcher directly by phone, text message or email. This process was established to ensure the participants’ confidentiality and anonymity in the research. The researcher then provided further information about the study through the Participant Information Sheet (Appendix A). Participants were provided with *koha* (a gift) in the form of a $20 mobile phone voucher or movie voucher to thank them for their time in taking part. They were also to be reimbursed for travel and parking costs where these were incurred.

Given the context of this study, many participants were still waiting for court results, waiting to begin therapy, or dealing with family issues or other issues that had led to their referral to mental health services in the first place. This made the data collection for this study relatively slow and in the end the data was collected over a period of two years.

When it was discovered that there were likely to be participants of Māori descent in this research project I sought cultural advice and adopted culturally appropriate practices
through the course of the data collection and analysis. Firstly, advice was sought from the Māori cultural advisor based at CAMHS and YFS and also Erana Cooper, a clinical psychologist and lecturer in Kaupapa Māori Psychology in the Department of Psychology, at The University of Auckland. Erana had been consulted earlier in the designing of the project and ethics application, while, as mentioned previously the cultural advisor had provided assistance in recruitment by encouraging Māori young people’s participation.

Secondly, Dr. Margaret Dudley, a Māori clinical neuropsychologist, and a lecturer in the Department of Psychology at The University of Auckland read the final draft of this thesis to check for cultural appropriateness of my interpretations.

Data Collection

During the data collection, open-ended, narrative interviews were used in order to give participants an opportunity to describe their experiences in their own words. This was carried out in the manner of a conversation with the researcher using prompts to encourage participants to tell their stories. Such method is recognised to be particularly useful in allowing participants an opportunity to reflect on important experiences in their lives (Frost, 2011). I hoped to facilitate young people to convey their thoughts and feelings, empowering them to have a voice in telling stories of their experiences (Langellier, 1989). Interviews with the young people lasted approximately 45 minutes to one hour. All interviews were tape recorded and later transcribed, with the permission of the participants (Easton,
McComish, & Greenberg, 2000). The interview usually began with an open invitation: “Tell me about what happened…” or “What brought you to the centre?” Simple and straightforward questions were asked to open up the lines of communication (McConaughy, 2005), such as “Tell me more about that”, or “How was that for you?” Participants were also asked to expand on or explain certain words or phrases to clarify their meanings and to initiate more details of their accounts. Minimal encouragers were used as listening to participants’ responses was key to elicit further narratives. While there was no formal “interview guide”, there were open ended questions which the interviewer used to help participants think about their experiences. Examples of kinds of questions and prompts can be seen in a tentative interview schedule (Appendix C). While these questions aimed to encourage a richer content, overt commentary that might disturb or direct participants’ narratives needed to be avoided (Murray, 2008). I was also mindful of several ways I might suppress an account, for example, by interruption. It was useful to listen to the first few interviews and then reflect on these factors. Such processes helped me make improvements in my interviewing skills and thus in the quality of emerging narratives from participants. In respect of the participants’ storytelling I occasionally used non-judgemental validation but not to approve or reinforce any part of the story (Frost, 2011).

Before the interview began, efforts were made to engage with participants and to help them feel more at ease. I was particularly aware of the potential for young people to be disempowered in the process of research and I was keen to ensure that they felt able to
present their views (Song & Parker, 1995). I therefore spent time introducing myself and getting to know the participants prior to interviews. Confidentiality was also discussed. I explained to participants a) that only my supervisor and I had access to the interview data, b) how long and where the data would be kept and c) that their identity would not be revealed when the report was written up. They were also informed of their rights to access and modify their transcripts. All participants were given information about their rights regarding participation, and that their choice to participate would not affect their standard of treatment at the clinic.

The cultural advisor was also available to be consulted to ensure interviews were culturally suitable for participants; for example, selecting interview locations that were familiar to the participants, such as the Māori clinic centre, or local community centre. Tikanga was applied throughout the data collection to help engage with Māori participants. These protocols included offering a karakia (prayer) and providing kai (food) at the beginning of all interviews. Participants were also told they were welcome to bring a support person to attend the interview with them, and only one participant brought his Māori social worker to the research interview (Marie et al., 2008).

It is important to point out, that while a narrative interviewing style was followed, participants’ elaboration skills varied significantly. While some participants were active in creating their own narrative, others gave short answers and little elaboration on their experiences. For these participants I provided more prompts and reflections in an attempt to
get them to elaborate. On some occasions open questions about general events were asked
to help the participants open up, such as “What was the closing like?” or “What was special
about that experience?” These questions were asked cautiously by the interviewer who did
not want to direct the participants with their own perspectives. The diversity shown in
participants’ various communication styles was respected.

Narrative interviewing techniques can be creative in constructing shared
understandings and in collaborating with participants in the interview. I used drawing and
timelines to facilitate the co-construction process with the participants and to explore the
rich content of different timeframes of events. For example, one participant revealed
several events that happened between the onset of mental health problems and the actual
assessment, such as breaking the law, police interview, court attendance and other contacts.
It was helpful to draw a timeline of these events on a piece of paper with the participant to
ensure I understood them clearly and to enable him/her to expand on his/her experiences of
these events. While I carried my own agenda to the interview, I recognised that all
interviewees had their own agendas and understandings of the interview interaction, and I
could not control this interaction (Frost, 2011). It was important to keep in mind that the
aim was to invite participants to express their own views, which might be different from
those of others, including the interviewer.
Ethical Considerations

Ethical approval was given by the Northern Y Regional Health and Disability Ethics Committee to conduct this study and approval was also obtained from the relevant District Health Board. Efforts were made to ensure my practices were guided by the ethical protocols and guidelines of the university and the mental health settings.

A number of potential ethical issues were taken into consideration throughout the study. When conducting research enabling participants’ voices to be heard, a consideration of ethics is important. This is particularly so when the participant group is vulnerable and private and confidential topics are discussed, mental health problems (Smith, 2006). It was important to be mindful of the participants’ well-being throughout the interview, be transparent about the interview procedures, and ensure these young people’s comfort in participating. Participants could find discussing a sensitive psychological experience might evoke distress. This was minimised by providing participants with clear information about the study before the interview. Participants were to be given information about available psychological support plans with referral to support agencies where necessary. I was required to be attentive to the conversation as well as non-verbal cues to identify distress in participants. I also asked the participants to inform me if they needed a break or were becoming in any way distressed.

Clients who participated in the research interviews had different levels of understanding, preparation, expectation and previous experiences and these may have
affected how open they were in discussing their mental health experiences. It would be unrealistic to assume that I would be able to understand everything participants tried to convey and I used reflection and paraphrasing frequently during the interview to clarify their meanings. To foster a sense of ownership in their participation, a summary of the final report was made available to them.

Furthermore, as the qualitative study involved a small pool of participants who gave detailed accounts of themselves and their lives, it was even more important than usual to protect participant confidentiality and anonymity. Personal identifiers were removed or changed when writing the thesis and presenting the analysis to ensure that individual participants could not be identified. This included leaving out some identifying demographic details and collapsing individual narrative data into themes. The data was treated with sensitivity and respect, for instance, the audio tapes were deleted after transcription had been completed and the transcripts and any other data will be stored securely for ten years in the Department of Psychology at the university and destroyed ten years after the eighteenth birthday of the youngest participant.

As 16 is the age when young people are legally and morally responsible for decisions about their wellbeing, those participants under this age required parental consent to participate (Powell & Smith, 2009). Those who were over the age of 16 were allowed to give their own consent to participate in the study, although they were encouraged to discuss the study with their parents. This was particularly important if the interview was to take
place in their home. Many of the participants consulted their parents about the study and a few caregivers contacted me to seek further information.

Data Analysis

This section introduces the principles of thematic analysis and how it was applied to the data to inform findings of this study. The actions taken to ensure the quality of the analysis are also discussed.

Thematic Analysis

A thematic analysis was chosen for this study as it is capable of capturing patterns of meaning in interview data. (Braun & Clarke, 2006). For my research purpose a theme was defined as a repeated pattern within the data set that had important meaning to my research questions (Braun & Clarke, 2006). These themes could be derived from patterns such as conversation lines, vocabulary, actions, feelings, proverbs, and so on (Taylor & Loewenthal, 2001).

In this study, all the interviews were transcribed prior to the analysis. One could say that the analysis and idea generation begins during the data collection and transcription (Ryan & Bernard, 2000). Transcription included a literal account of all verbal utterances (Braun & Clarke, 2006). I did spend a few hours on transcribing some audio-taped interviews, but then I paid to have the majority of the interviews transcribed by a transcriber, who was better experienced with using audio equipment and listening-typing
multi-task skills. However, once the recordings were transcribed, I spent some time
listening to the entire audios at least twice and checking the transcriptions against them.
This allowed for increased accuracy of data (particularly around punctuation that could
influence the nature of content) but also gave me an opportunity to familiarise myself with
the interview data (Easton et al., 2000).

Following the transcription, my analysis continued, guided by the thematic analysis
procedure of Braun and Clarke (2006). Throughout the analysis I repeatedly familiarised
myself with the data, sometimes by reading the entire data set and sometimes by reading the
content around the specific research question associated with the data. As I became more
familiar with the data, ideas and patterns emerged that would later develop into themes. I
maintained an active, analyst role as I mined for meanings, and thought about how data was
associated with specific areas of research (Taylor & Loewenthal, 2001). In reading the data
I carefully noted each data item and wrote down interesting ideas that generally came from
them. Coding began once I had my initial list of ideas. This was done by drawing out
interesting features in a more systematic way. Coding represented the basic elements from
the raw data, referred to as ‘extracts’, which could be segments or sentences revealing some
aspects of young people’s views towards assessment. Relevant extracts were assigned to
codes while the relevance and coherence of these extracts of data were constantly and
consistently reviewed. The number of times participants expressed the same idea across a
data set was recorded to note its frequency. I had no rigid rules about how much repetition
would count as a theme or whether it had to exceed a certain proportion of my data set before it generated sufficient evidence for a theme. As I started to add meanings and interpretation to each code, a number of codes were gradually integrated together to create potential themes in the way that Braun and Clarke (2006) describe.

Each theme comprised a clear description, and themes were kept distinct from each other and each was linked back to the research question. To assist the generation of themes I was guided by the research question (Braun & Clarke, 2006). I divided my overarching research question of “how do young people make sense of their experiences undergoing assessment” into a series of narrower research questions as follows:

- What was it like for them to find out about the appointment?
- What was it like for them before they attended the appointment?
- What was it like for them to attend the assessment session?
- What did they like or dislike about the session?
- What stood out during the assessment?
- How did they perceive the clinicians?
- How did they feel at the end of the session?
- Did attending the assessment result in any changes in the way they saw themselves?
- How did they fit this experience into their life as a whole?

To create a convincing story overall, I ensured the analytic narratives for each theme
were strong and clear and also balanced with vivid and convincing extracts. I looked both for data that supported themes as well as data that might suggest greater diversity in the data set. In the final stage of writing up the report for this study, I had my last opportunity to refine all my analyses and data, together with my summation in relation to the research question and literature. Overall, these processes highlighted how active and repeated reviewing, reflecting and refining were essential for a study using thematic analysis. In the end there were 24 themes under four main categories.

**The Quality of the Research**

The study aimed to meet the overarching criteria for assuring the quality of qualitative research suggested by Parker (2004). These criteria include reflexivity, grounding in existing research and developing coherence in analysis and arguments.

Reflexivity refers to the researcher’s influence on the construction of meanings throughout the process of research, and this factor is emphasised in all qualitative research (Frost, 2011). I acknowledged the importance of examining my decisions and practices in the study, from theoretical assumptions, selection of participants, interview schedules and interviews, to the process of analysis and its presentation. I aimed to provide transparency in relation to my own position and openly consider the impact this might have on my research (Parker, 2004).

My position as a researcher was as an Asian, middle-class, mid-age, single, woman
student. I was born in Taiwan and moved to New Zealand when I was 13. Coming from a multi-cultural background I have the privilege to speak two languages and am aware of cultural differences and the various perspectives of individuals. I had some awareness of how norms and expectations of mental health services could be quite different due to either different systems in different countries or the different cultural background of the receiver of the service. I was aware that my background made me particularly interested in, and sensitive towards cultural differences and this may have meant that potentially I paid more attention to cultural context when I was conducting interviews and analysing data.

Having been trained in the field of clinical psychology for the last six years, I acknowledged that I have developed preconceptions about what a mental health assessment should be from the professional’s perspective. It was helpful to learn from the literature about the potential for different perceptions between patient and clinicians, and also differences between the views of young people and adults. I tried to remain aware of the potential for my training to blind me to some of these differences. As Holland (2009) notes it is important to be sensitive to the possibility of categorising my participants as pathologised “others” which might undermine the validity of their accounts of their experiences of mental health assessment (Holland, 2009).

Furthermore, I recognised that there is always an asymmetrical power relation between the interviewer and interviewee (Kvale, 2006). This would have been especially so given the age difference between the participants and me. It was possible that the
interviewees saw me as connected with the clinic or cultural advisor and that this may have influenced what they chose to disclose.

I was privileged to receive support from a cultural advisor. He was passionate about his role in the mental health services and was always active in maintaining ongoing relationships with Māori clients through sport and their caregivers. I felt grateful to see his input into the lives of many troubled young people, and he invited them to participate in the study to give them some opportunities to ‘help others’, “express their views” and also contribute knowledge to this field, particularly for their cultural group. While this was helpful, I was conscious that the relationship between the participants and this cultural advisor were more informal than the usual relationship between professionals and clients within mental health settings. While this relationship seemed to provide comfort for those young people whose participation in the research he facilitated, I was also aware he may have had an influence in the way that they engaged in the research interview with me. Not all participants had this introduction and it may be that this shaped their responses too.

I found it helpful to document my thoughts and concerns about the research on a notepad throughout the process of the study, and to be open to discussing issues or dilemmas that might have influenced this study with my supervisor and colleagues during the course of the research.

I also attempted to ensure the quality of the research through the process of analysis, by checking the validity and coherence of my analysis and organisation of data (Parker,
2004). For instance, tape recording of the interview allowed the content to be correctly transcribed and analysed, which in a way increased validity of the study (Easton et al., 2000). Reliability is not considered a legitimate marker of quality in this kind of qualitative research, but I discussed the extent to which the themes honestly reflected the data and were internally coherent with my supervisor to achieve some consensus perspective (Morrow, 2005). I also considered my findings in the context of existing literature and used this to help me identify strengths and weaknesses in my analysis.

When writing up the report it was also important to be mindful of the language I used. My presentation needed to consider how accessible my study would be for those with little or no experience in research or related areas, as well as the more knowledgeable public (Parker, 2004). In particular, it was important that this research would be accessible not only to professionals but also to mental health service users.
Chapter Four

Findings

This section presents the findings of a thematic analysis, which highlighted themes that assisted in answering the research question, namely how participants make meaning of their experiences of an assessment in a mental health setting. The themes described here are presented in a way that follows participants’ accounts of their journey through the assessment process including: the early phase when they first found out about the appointment for the assessment and the period prior to attending the session; the initial engagement with the clinicians at the service; the experience of the assessment as it continued; and finally the termination of the assessment and the post-assessment phase.

These were organised into seven categories that highlight participants’ experiences through these phases: 1) Before the assessment; 2) The initial engagement; 3) The process of opening up; 4) What helped participants feel comfortable in the assessment; 5) What did not work in the assessment; 6) Reflections on Māori culture; and 7) What participants took away from the assessment. Each of these categories was comprised of themes reflecting key aspects of participants’ experiences. A summary of categories and themes is presented in the table below.
Table 2

*Categories and Themes in Participants’ Experiences of a Mental Health Assessment*

<table>
<thead>
<tr>
<th>Categories</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Before the Assessment</td>
<td>‘I imagined what it would be like’</td>
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<td></td>
<td>‘I worried about more trouble’</td>
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<tr>
<td></td>
<td>‘I had no choice but to go’</td>
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<tr>
<td></td>
<td>‘It was easier when I knew what to expect’</td>
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<tr>
<td>The Initial Engagement</td>
<td>‘It’s not what I expected it to be’</td>
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<td></td>
<td>‘It wasn’t easy to open up’</td>
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<td></td>
<td>‘I started to talk more and more’</td>
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<td></td>
<td>‘Learning to open up with family’</td>
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<tr>
<td>What Helped Participants Feel</td>
<td>‘They came down to my age’</td>
</tr>
<tr>
<td>Comfortable in the Assessment</td>
<td>‘They showed consideration for my needs’</td>
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<td></td>
<td>‘They understood what I was going through’</td>
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<td>‘They were cool’</td>
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<td></td>
<td>‘They let me talk about positive things in my life’</td>
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<tr>
<td>What Did Not Work in the Assessment?</td>
<td>‘They were just doing a job’</td>
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<tr>
<td></td>
<td>‘The talking and questions were uninteresting’</td>
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<tr>
<td></td>
<td>‘They didn’t prepare me for what would happen’</td>
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<tr>
<td>Reflection on Māori Culture</td>
<td>‘Doing things the Māori way’</td>
</tr>
<tr>
<td></td>
<td>‘I felt more comfortable with a Māori clinician/advisor’</td>
</tr>
<tr>
<td></td>
<td>‘Talking to a Māori did not work for me’</td>
</tr>
<tr>
<td>What Participants Took Away from</td>
<td>‘I was relieved to open up’</td>
</tr>
<tr>
<td>the Assessment?</td>
<td>‘It helped me understand things differently’</td>
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<tr>
<td></td>
<td>‘It gave me hope that I could get help’</td>
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<td></td>
<td>‘It changed things for the better’</td>
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<tr>
<td></td>
<td>‘It gave me what I needed at the time’</td>
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<td></td>
<td>‘It made no difference to me’</td>
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</tbody>
</table>

**Before the Assessment**

Every participant described how, prior to the assessment he/she had thought to some extent about what the session might be like. While most participants were notified about the appointments they were to attend, they gave different accounts of the amount of information given to them, how this was delivered to them, and how much they understood.
about what the appointment would include.

They spoke of their assumptions and expectations before their encounters with the mental health service. The themes that were identified under this heading were ‘I imagined what it would be like’, ‘I worried about more trouble’, ‘I had no choice but to go’, ‘It was easier when I knew what to expect’.

‘I imagined what it would be like’

It seemed that many participants had limited information about the assessment process before they attended the session. The mental health service made appointments by sending out an introductory letter, but most participants said they had not seen this or were unaware of its existence. With limited information prior to their first appointment, most participants spoke about how they formed advance impressions about what the session would entail. Some of these impressions were imagined on the basis of media representations of mental health services or previous experiences with other authorities or agencies. For some participants like Huhana, the imagined view was initially positive. She said when she first heard about it, “I think it was like, like a school playground. It reminded me of a playground”. Others had a more daunting image based on their knowledge of popular media. Even for Huhana, the more she thought about it, the more she imagined a more negative scenario:

I thought it was like, you know how you have police interviews, I thought it
was going to be like that…. Like, on TV when they like, it’s a dark room and like there’s the criminal fella and then the police officer and the police officer is like … scary.

Similarly, Awa imagined a highly negative image of a locked psychiatric facility that the clinic would be similar to. She said, “Oh yes, I thought it would be like, like one of those mental hospitals, like the prisoners live there”.

Peter had been notified by his caregiver about the session, but had little knowledge of what it would be about. Given the assessment took place at a hospital he used his previous knowledge of this environment to imagine what might be in store for him:

They, my um caregiver told me… And they just took me. I didn’t know what it was. And I thought it was some medical thing 'cause we went to the hospital…. I thought I was getting a check-up or something, but yeah it was that. I thought it was a check-up like a medical check-up thing.

Nevertheless, a few participants seem to imagine something that more closely approximated the reality of an assessment process, although sometimes with rather negative connotations. Ben for example, spoke about how he associated to the word ‘assessment’, “I thought I was getting my head read. Like checking if I’m going to commit suicide or anything bad going on. Yeah like psychologically checking someone’s head”. When he was asked to elaborate more, he said that he thought that the ‘reading’ would be done through questions and analysis of what he said:
Asking you ‘do I have thoughts of killing myself or do I have any scars on my wrists’. Anything suicidal thoughts…I didn’t do that. Just like saying, it’s just a smart way of saying I’m getting shrinked. I’m getting I don’t know eh.

Just checking if your head is alright, in the right space.

Overall, it seemed that most participants had drawn on various ideas from either past experiences, media, or imagination to provide them with some idea about what the assessment would be like. This occurred with the absence of clear information about what would happen. Only a few participants had some previous experience of assessment and thus had some idea of what to expect from the session, although this did not always result in more positive expectations.

‘I worried about more trouble’

Those young people who were referred by the courts or who had been to other agencies like police prior to the assessment associated the mental health assessment with their criminal acts, and thought that attending the assessment might get them into more “trouble”. For example, Hohepa felt uncomfortable before the assessment, as he felt the assessment information would be used by court judges and would be likely to bring more trouble for him:

I didn’t feel comfortable talking to, to other people in [YFS], and yeah. Oh 'cause’ um that was like, it was part of court, so I was sort of worried about
putting myself, put myself at risk, from more trouble. And um 'cause that assessment was for court, and um the judge would have seen it, yeah. The assessment, the whole assessment, yeah 'cause they one day told me that the judge was going to get a hold of it and then it wasn’t confidential, then they’re like yeah, so it worried me a little.

For participants who were not legally required to attend the assessment, they still seemed to assume they had something wrong. For example, Awa said “Oh 'cause I thought [CAMHS] would be like one of those places like, like oh like they would growl at you. Oh no like, people who get like mad at you, oh for the stuff you do”. Similarly, Kiri who had been referred by a social worker to CAMHS, talked about how she immediately felt something was “wrong” with her when she heard the word “psychologist”, “When they said psychologist I said what’s psychologist. They are like oh it’s like a therapy session. I’m like why do I need therapy, there’s nothing wrong with me”.

It seems that many of the young people had concerns about negativity or consequences when coming to the clinic for assessment. Those who were referred for forensic reasons appeared to show concern about getting into more trouble while other participants expressed discomfort and fear of perhaps being judged or treated in a hostile manner.
‘I had no choice but to go’

In addition to speaking of largely negative expectations of the assessment, almost all participants gave an account of how they had ‘no choice’ but to show up to the assessment. Sam, like many of those who had been referred by a court order to attend the assessment, talked about how he had to go although he had been “asked” by his lawyer if he was willing to do this. He said, “Yeah, oh they just said it was an assessment that the court wanted. ’Cause my lawyer asked if I wanted to go do it. I didn’t really have a choice”. Kiri also explained that she had little choice about attending the session. She was told to do this without knowing why she had to go. Her confusion about why she was there seemed to remain throughout the first session:

I actually don’t know what happened because like my social worker said that like I had a meeting there. I was like eh what for. I didn’t know what it was. Like a psychologist or something. It was like um why. And then yeah, but I still don’t know why we had to go. I was thinking like what happened, why, why do I have to go, yeah.

Interestingly, most of the participants, like Kiri, did not reveal their uncertainty or reluctance about attending the assessment to the adults around them. They seemed to believe they had no choice but to fit in with adult decisions. When the interviewer asked if Kiri told the clinician about this, she said, “No, ’cause they said I didn’t have a choice, I had to”.
This belief around having no choice was present even for some of those for whom the assessment took place in their own homes. Tehaki, for example, recalled being given a clear message by the clinicians that the court required them to come, and remarked, “Oh they said that, the Court said they would come to my house. Oh, the Court asked them to come. They said they were involved in the Court thing”.

However, it was not only formal requirements to attend the assessment that made participants feel they had no choice. Huhana, who was not legally required to attend the assessment, spoke about how her mother just insisted Huhana needed to turn up to the assessment following advice from a school counsellor:

Um [counsellor] asked first by then um me and my mum had a talk about it
and then she told me that I have to do counselling, so then I just go along
with other people. Can’t be bothered arguing.

She elaborated on some of the pressures that she felt had made her submit to the assessment in spite of her reluctance to do so:

Um, if I didn’t do it mum would like be angry at me, like 'cause she wanted me to do it. Like my aunty, and my aunties and uncles, some of them, like they want me to get help 'cause sometimes I just have those worse feelings you know…Well I just kept telling my mum ‘I didn’t want to go’. ‘I don’t want to go’. ‘Get out there, go’. ‘Okay’.

A sense of lack of choice or power over their decision to come to assessment was
expressed by majority of young people in this study. This seemed to apply most obviously, to the young people who were legally required to attend the assessment. However, some of those referred from the community also spoke about being forced to attend the session without being given sufficient explanation of the reason for assessment.

‘It was easier when I knew what to expect’

Some participants suggested that anticipating the assessment was easier when they had been given some advance knowledge of what to expect. In some instances, the counsellor and mental health worker had some discussion with participants prior to the session. This gave them some general ideas about the mental health service. For example, George said a cultural advisor contacted him before the appointment and explained what would be involved in the assessment sessions. George observed, “Yeah, he explained it pretty well. Like his issue, oh my dad’s issue and yeah, I thought on yeah, I guess he’s here to help me”. He explained about the detailed information he had received prior to the session, and how he had been comforted by this knowledge. Perhaps as a result of being better prepared than other participants, his expectations of the session seemed to be more positive:

I’m thinking what’s going to happen, what are they going to talk about, and yeah. I don’t know, talk about my dad. Talk about his feelings and mine.

Yeah. About what I experienced living with him. ... Yeah. I felt comfortable.
I’m ready to talk about anything. Well I know, all I knew was that they were
going to help me and that, yeah. So I thought that would be a good idea,
’cause I actually quite needed the help, yeah.

For some of the other participants it also seemed that the worker who had referred
the participant was perceived as taking an active role in facilitating the participant’s
openness to the mental health service. In Kakariki’s case it was the nurse from the
emergency hospital who provided some explanations and encouragement:

Um, at first I didn’t really want to go. I just wanted to stay home and all that.
I just wanted to be on my own. But she persuaded me, said it was a really
good place and that it was good for me and all that. So yeah. So really she
changed my mind.

Marian was the only participant who initiated an appointment herself after she
discussed it with her boyfriend who had been to the clinic previously. She had experience
with using other counselling services before. These factors seemed to have given her a good
knowledge of what to expect coming to the CAMHS and an expectation that the clinic
would be able to help with her problems. She described how she had an opportunity to
discuss coming to the clinic with staff member from a domestic violence agency that
assisted her with the referral process:

This year, um well I’ve known them for like quite a while and heard about
them through other people as well like my boyfriend at the moment and
they’re like really good people. And then I was working with the lady from [a domestic violence agency] and she like helped me, well I told her about [CAMHS], I said that they’ve got like some really good counselling. My boyfriend told [me] that it would be a good idea to go like go see them, talk to them because they’re really helpful, really lovely people.

She elaborated on having experienced counselling before and having some understanding of mental health problems and this seemed to increase her expectation that the assessment would have some benefit for her:

I’ve been through heaps of stuff in my life. Well… as I grow up like now I understand what [Child Protection Agency] and the police are kind of thing, like I didn’t know what they were back then and it’s cool like having the [CAMHS] because it’s free. Yeah I’ve had a lot of counselling in my life, over those three years.

It seemed from participants’ observations that knowing more about the service created potential for more positive expectations of how it could help them.

Overall, a few patterns were evident in this pre-assessment phase. First, it seemed that the amount of information that was given to the young people influenced their knowledge about what the assessment was for and what would happen in the assessment. However, the data suggested that most of the participants in this study had not been given information about the service and so were left to imagine what the assessment session might
be like. Their expectations were usually negative, drawn from past experiences or unrealistic media portrayals. Those participants, who had an opportunity to talk about the assessment with health workers seemed to have formed more realistic ideas about what to expect in the assessment and had positive expectations that they could be helped.

**The Initial Engagement**

Regardless of the level of preparedness and uncertainty, most young people spoke about a process of slowly adjusting to the assessment context. This process is described under the theme ‘It’s not what I thought it was’. Following this most participants described the process of disclosing personal information during the initial engagement, with and without their family in the room. This is described under the themes of ‘It’s not what I expected it to be’, ‘It wasn’t easy to open up’, ‘I started to talk more and more’ and I was ‘learning to open up with family’.

‘**It’s not what I expected it to be**’

Some participants spoke about their realisation of how different the setting was compared to their prior expectations and how, in many cases, they were reassured to find that their prior negative perceptions did not match the reality. For example, Huhana said she had imagined the scene would be much more frightening than the actual reality was: “Um, [I thought] there was going to be millions of people staring at me. But I got in there and there was only like two people in there. Yes! [laughs]”. Awa also commented positively
that the setting was quite different from the images she had formed, by remarking “Oh yes, I thought it would be like, like one of those mental hospitals, like the prisoners live there and I got to see the place I was like this is pretty cool”. Tehaki who had associated the assessment with a hospital and had imagined the assessment would be a medical one, was pleased to discover that the assessment involved talking rather than the physical examination he had been expecting. He said “I just asked them what is this place? Oh I thought it was a hospital eh, the doctor and nurses, but they come out and it was just like we were talking”.

Awa spoke of feeling positive as soon as people in the room introduced each other, she said, “When we were introducing each other I was like oh okay. And I was actually quite happy that I did go”.

It seemed that confronting the reality of the assessment setting was less frightening than some participants had anticipated. Some seemed reassured by this and their uncertainty and worries about the assessment were diminished.

‘It wasn’t easy to open up’

Many participants said talking openly was not something they usually did in their lives, whether to a stranger or to others in general. They talked about feelings of anxiety and discomfort during the early phase of the assessment. Lack of familiarity with the clinician seemed to be an issue that made some young people feel “shy” in the room and hesitant
about opening up. Some participants, like George, for example, talked about feeling nervous about speaking to strangers: “Yeah, before I came I was a bit nervous. Getting ready to speak to some random person”. Awa explained how it was difficult to open up to strangers, she said, “Because I used to be really shy. I didn’t like talking to people I didn’t know”. Te Pahi also spoke about how he felt ‘shy’ and hesitated to open up with someone he could not yet relate to. This was especially important for him as he was feeling vulnerable at the time:

The first time I went there I was yeah I was shy and felt quite down at the time. ... she [the clinician] was trying to make me open up like yeah she was being really kind but the first time I went there I wasn’t quite opening up to her sort of thing ...

Te Pahi offered reasons that made opening up to the clinicians difficult, including that he often does not know how to explain his feelings. He also spoke about the importance of trust when it comes to talking about personal things:

I don’t usually speak about my personal things too much to people at all. Well it was quite hard [talking about feelings] really because I didn’t really know how to explain it at the time. Well things I was going through at the time like really sad for me because it was like I didn’t really want to speak about it at the time. I don’t usually talk about those things to people. I’m like, well yeah I am quite a shy person. I only talk to people that I really know and that I can really trust sort of thing.
Matiu mentioned talking was ‘alright’ but implied that talking openly about his feelings was not a part of his normal routine. He explained that his normal life did not often involve talking in this way: “Oh yeah like I’m pretty humble, just eat, sleep, eat, sleep yeah”.

The issue with trusting an unfamiliar person was presented as being part of the difficulty that some participants had in speaking openly in the assessment. According to Peter, having to engage in personal conversation immediately the session started was what made him draw back. He explained that he felt uncomfortable about clinicians acting like they understood him when they knew little about him or his background:

'Cause I just met them there, but like about two minutes later they want to talk to me. It’s like they tried to act like they knew me, but they don’t even know me. I reckon it’s bad when like they feel sorry for you, whatever, it’s weird. Like have a first session but like a short one and just have a talk about, not like personal stuff but just like normal stuff, about life, and then do all the other stuff later on. So you can meet them too. [Interviewer: what would have helped?] If I knew them probably [and people who] we just had the same kind of background thing. Just like, no not try hard, just take people to connect. Like ones I know most of the time. Not some random guy.

Ben spoke about how he initially mistrusted the clinicians and felt his words might be misinterpreted. This made him cautious about saying too much in the initial phase of the
assessment:

[In the session I was thinking] Yeah, here we go again. I’m getting my head read again, like a vegetable. Just wouldn’t talk because [they] twist my words. Yeah like I say something and then they enhance what I just said and make it sound real bad. I just said the one word and you’ve gone and elaborated on it. [Interviewer: can you give an example?] Say if I said I feel normal, they will take that as oh he’s going to kill himself, oh I just said I don’t feel normal because it doesn’t mean I want to kill myself. I can’t just say I feel normal, I’ve got to say something to clarify the right answer. So I don’t get the wrong words.

Ben’s mistrust appeared to be based on his previous experiences with other psychologists in which he felt he was judged:

…sometimes, but not the assessor but just some people are judgmental, like people will think something and it’s not even true. … Like some psychologist. … Yeah and think they know it all and stuff, even if they don’t know anything when you say to them. Mm. I know a few.

One young person, Hohepa, felt he would only be able to overcome his reluctance to talk if he were drunk:

Oh ’cause I don’t really open up to much people. Like um like what I told them I don’t open up when I’m sober but when I’m drunk I open up a lot.
And like I have mixed emotions, like I cry when I drink and I bring up like past stuff, like this car crash and that, just yeah.

Some participants like Te Pahi explained that it was even harder to open up because of the cultural difference between him and the clinician:

Yeah I was like being so shy and her not being a Māori sort of thing she didn’t really like, I suppose I don’t know I suppose I just needed a Māori person to talk to I suppose. Someone who can actually relate to me sort of thing.

Although most participants seem to have experienced some initial difficulty talking with the clinician, a small number felt they had no issues with opening up straight away in the session. They attributed this to being either the sort of person who trusted easily or the fact they usually talked about their issues with other adults. For instance, George said he was happy to open up and answer the clinician’s questions:

I can open up to pretty much anyone. Yeah, if I know something I would talk. I just have a sense about people. Yeah. I’m very trusting. Yeah, I trust her. …Yeah, I’ll open up if they ask about it yeah. If they want to talk about it I’ll talk about it.

When asked what helped him open up, George explained that he was used to talking to his family, “yeah, we used to always talk. 'Cause I was raised with just my mum, and my sisters”.
Sam also said he felt he had opened up and told the ‘truth’ from the beginning. He said “Just I’m always open, an open person. And ah just tell the truth”. His reference to ‘truth’ in this extract, however, needs to be understood in the context of the court ordered referral and it may be that Sam felt under some pressure to display his honesty.

Marian, was an exception among the participants. She had a clear idea of what kind of help she could get from the clinic and was ready to disclose personal issues straight away:

It was pretty good counselling because I really needed someone to talk to, yeah definitely. Yeah I have to have that hope and faith that things are going to get better otherwise you kind of stay in that kind of space and I guess that’s what happens when you kind of don’t ask anyone for help, like you stay in that space…that’s why I brought them because I was just like I don’t know what to do, I’m going nuts, I feel like I’m going to explode and just lose it at somebody and end up in prison, something like that, probably not end up in prison. I was just really insecure, like not feeling so secure, just wanting to lose it.

Most participants spoke about how it was not easy for them to initially open up about themselves or disclose personal information. Some related this to being shy while others spoke about mistrusting an unfamiliar clinician. However, a small number of young people described their ability talk openly from the start of the assessment. This, however,
appeared to be the exception rather than the rule.

‘I started to talk more and more’

While most participants talked about what made them feel uneasy about opening up immediately in the session, most described how they experienced a gradual change as the assessment progressed. Many participants like Rongo talked about a process of shifting from feeling nervous to feeling more and more comfortable about opening up:

At first I felt a bit nervous because I’m not really used to talking to people about emotions, but then as the session went on it got really comfortable. I was only letting out a little bit at a time. And then as the time just kept ticking I was opening up more and more. So every session they had was, I was just opening up more and more.

Rongo was asked to elaborate further about what helped him open up increasingly through the assessment. He explained that not only did he feel the environment and the staff made it easy to talk, but he also received some encouragement to ‘let it out’ so he could receive the help he needed. He described how this helped him realise the importance of talking:

So yeah it’s a good environment. It really helps you to let out all our emotions and everything you have to. So they made it really easy to just talk, and especially with [cultural worker and clinician] explaining, you know, just let it out now so that we can cover everything in this one session so we know
how to help you for, in the future. So that was really good. I think it’s because they actually opened my eyes to realising that it’s really important to get that stuff out and not to hold it in.

Hohepa who believed that he could only open up when he was drunk, explained that as his session continued the clinician commented on how open he had been. This surprised Hohepa as it countered his previous experiences where he had not been able to speak to professionals:

Yeah, well I liked it because um I talked a lot in that and um yeah it kind of made me happy in a way 'cause like everybody, oh I have done a lot of counselling, [alcohol and drug service] and all that and [trauma counselling] and um I never really opened up to them.

Awa explained that for her it was a matter of having no choice but to speak which ended up giving her more confidence to put her point of view in the session:

Um, I think I just got a bit more confidence in myself, I can relate to them. Sometimes I had to get up and speak where I knew I had no choice but to. Well the first time, I had to stand up and introduce myself, and I was like oh. And then I just started getting sort of [used to it] because we always had to get up and say something. [In the end] I know I got a bit more confident in myself.

One participant, Kiri, had been to school guidance counsellors previously and expected that
the process would be repetitive. This appeared to make her slightly unwilling to talk:

In the room I put on a smiley face and I nodded. I was nervous but I didn’t want to show it. And when I got in the room I was like, do I have to talk about our past and stuff. I didn’t really want to because then I’m going to have to repeat myself over and over. It felt okay, but it’s 'cause I had to repeat myself. And I don’t like repeating myself. 'Cause it gets annoying.

However, she explained that as she began talking more and more she felt relieved and happier. This gradual change in the way she felt was a surprise to her:

I wanted to get things off my chest too. And I felt a bit like release, now that I got it off me. Mm, I repeated it, but I added on some more bits… No but it’s 'cause that’s what they’re there for, to help. And I told him. It was a bit shocking at first, but now that I got it off my back it’s like yes, high five. 'Cause like I’m not that kind of person, what I hate doing it like talking about my feelings, that’s what I hate. But yeah, um I was telling him I felt like, I was getting happier and happier and happier now that I was finally getting it off my back. I was quite shocked but in a way happy, yeah. Like it wasn’t immediately, but it was like a few minutes after I said it, sat down and like yes, oh got it off me. And like none of that, like um I got it off me, I can walk around and not be worried.

Te Pahi reported that after he observed what others were doing in the room he
decided to open up. Two things happened that changed his ‘attitude’. The first was when
the cultural worker began by opening up about herself:

 Me going there and being really shy at the start … Yeah well as soon as [the
cultural worker] came into the room he started telling me things about him
that he had never told anybody about. I sort of like, as soon as he started
mentioning those sorts of things that got me to open up about my personal
things I suppose.

The second factor was related to the clinician’s questioning that gradually guided Te Pahi to
share more information about himself with her:

 [Clinician] she was like well let’s just say doing an assessment on me about
like how I was when I first started; to how I was when I finished there; to see
like how my feelings were and how I was sort of thing. Yeah at the start she
like, well she knew something was wrong with me and well as I started
going along and started getting used to that place, as I started opening up to
her she was like, she started to notice like a change in my attitude sort of
thing.

Huhana was another participant who experienced a change in her ‘attitude’. She explained
that in the first session, although she did some talking she was just ‘going along with it’. In
her mind she did not want to be there and did not respond well to the clinician’s attempts to
make her feel comfortable:
And like oh she was trying to make me feel comfortable. But I don’t like it when people try too hard. Yeah 'cause it makes me feel stink. So I was just like, went along with it. Just at the start. And then I just got bored. 'Cause I had to sit there. I’m not used to like just sitting in one spot all the time. …then I start playing with my clothes.

Then prior to the second session, she described not wanting to go back and was still unsure about whether she was prepared to engage with the service. Nevertheless, she found herself feeling more comfortable in the second session. She attributed this partly to feeling more physically at ease after being given the option of sitting on a bean bag:

But um, but I went back with a better attitude sort of, yeah, way better attitude. [The first time] I was really moody and I didn’t want to go. The second time I didn’t care 'cause I knew it was going to be boring. [Inside me] I was oh I don’t want to go. [The second time] I got to sit on the bean bag this time. Um, I felt more comfortable talking to the lady, like if I’m not comfortable then I won’t say as much as I usually would. 'Cause I’ve met her before, that first time. It just felt normal. Oh, no 'cause the first time I wasn’t even listening. I just kept saying yeah, 'cause I was bored. Yeah it’s just like it [the second session] felt faster. We were talking more.

However, as Huhana explained, it was unusual for her to talk about herself, as often she had coped with different situations without need of help. Thus it was not an easy feeling when
she opened up in the session. It felt ‘weird’ to her and made her feel like a “loser”. She explained how talking openly to the clinician continued to be an ambivalent experience for her:

Oh well when I was like talking to the lady about what was happening, I felt like a loser. I was like, oh I’ve been through so much and like I don’t need all the help and like they were giving me help and I was like, like it was weird.

Yeah. It’s like, ‘cause all that time when I was going through bad stuff, I didn’t want any help at all. I just thought oh nah I’ll do it by myself. And like they were giving me help and I didn’t even want it. I was like, I knew that I needed it, and then I just took it.

Not all participants shifted their attitude and behaviour in the room as the assessment continued. Peter continued to feel sceptical about the clinician’s attempts to establish a relationship with, and show empathy for his problems:

No, but like if someone was, had a bad as life and that and they feel sorry for them. I don’t know, some people might like it. I don’t. Yeah, it was like um what they thought about me. It’s like they tried to act like they knew me, but they don’t even know me. I only had a two-hour talk, oh no like four hour talk and then they know my whole life, that’s what it looked like.

Overall, it appeared that most participants gradually opened up as the assessment progressed. For some this appeared to be a natural process after realising they had ‘let out’
things about themselves. In other cases this was a matter of seeing some benefit from talking, being encouraged to talk or growing more familiar with the surroundings. Later sections of these findings discuss further what clinicians may have done to facilitate this process. There were a few participants however, that retained their sense of discomfort after the initial phase of the assessment.

‘Learning to open up with family’

Some participants described similar experiences of being quiet initially to gradually speaking more openly in the session, but in slightly different contexts. Their initial hesitation was attributed to having family members in the session. Huhana, for example, explained about how it was hard for her to speak openly with her mother in the assessment session. Her mother’s reactions when Huhana talked about her issues seemed to hinder her from sharing:

I don’t mind [mum] coming, I just don’t like her staying with me, because she always butts into my conversations, and then she will like change the story and she doesn’t even know. And cause like, I only just moved back with my mum and I don’t talk to her. I don’t talk to her about my problems, ‘cause she just makes such a big deal out of it.

Similarly to Huhana, Awa said she had been hesitant about opening up in the assessment session while her parents were in the room:
At first I was, I think I was holding back a bit on information, because I didn’t want my parents knowing what I had done. It was a bit awkward, 'cause I don’t really like saying like stuff in front of my mum and dad.

'Cause I never tell my problems to my mum and dad.

However, she explained that realised it was important for her family to know about her issues. Sharing appeared to get easier for her as she realised her parents were more supportive than she had expected. Finally being able to talk in front of her family became a positive experience:

And then as it went on I figured it’s important that my family should know what’s happening, what’s going on. And then I opened up. …Oh [in the beginning] I felt shy, I was just worried that they might say something, but they didn’t. … When I was telling them I really didn’t want to say it, but I knew if I got it off my chest I would feel a bit better. Yeah, I was okay.

'Cause they’ve been supportive as well. [Interviewer: How was that for you?] It was new. It was a good experience.

Rongo similarly described how talking in the session with his parents present was very difficult in the beginning. Initially he held back some information out of fear of distressing them but eventually he shared further details:

The first session it was really emotional for my parents. [Interviewer: how about you?] Yeah, but I tried to hold that. ... Yeah, but eventually I got it all
out during the first session. [My step mum] Oh well she was emotional because I’ve known her since I was nine. I look at her as another mum. She loves me heaps, so she really got emotional when she heard about my suicide attempt from drinking.

Some never came to see the benefit of talking in front of their family members. Kakariki, for example, commented on how being separated from her parents and taken to another room actually made her feel comfortable talking about her issues:

[Interviewer: How did you feel when they said you are going to be in a different room from them?] I felt, I thought it was actually quite good, 'cause you know how you don’t really feel confident telling your parents, oh I did this and this and this. Yeah. Instead of telling them in front of everyone. Yeah it was way better. And I thought that that was actually quite a good, what do you call it, a good way to do it, yeah.

Te Pahi, a 17-year-old young man referred to the forensic team, was a notable exception amongst participants as he appeared comfortable having his mother in the session right from the beginning because he felt shy about being alone with the clinicians. For him opening up seemed easier when his mother was present in the room:

Oh yeah, lucky [mum] she was there because like some things I just don’t want to say sometimes just shy and yeah just lucky she was there.

[Interviewer: what would be different if she weren’t there?] Well I would
have been different for starters. I wouldn’t have been how I was if she wasn’t there, I probably would have been like more quiet. Yeah didn’t talk much.

It appears that while a small number of the young people talked about wanting to open up because of the presence of their family members, most young people expressed reluctance to talk about their problems in front of their family members, at least at the start of the assessment process. There seemed to be a variety of reasons for this including that they feared their parents would not respond helpfully and would disapprove of things they had done, or that they were concerned about upsetting their parents. This seemed to be a temporary process and most of these participants gradually opened up and found it was a positive experience.

The analysis of themes that related to the initial engagement with the assessment showed a pattern of young people feeling ‘shy’ or ‘uncomfortable’ initially about sharing their personal information in their initial encounters with clinicians. Most of them described how talking about their issues or emotions was ‘unusual’ in their lives. Some young people highlighted the importance of the trust and familiarity needed before they were willing to make disclosures about themselves. Some attributed their difficulties opening up to their families being present. Many participants described the gradual process they needed to open up more and more, while some others pointed out some factors that facilitated their being able to open up. For a small number of participants, ‘time’ did not help them grow the confidence or trust in talking to the clinicians. The next analyses will draw out specific
components of the clinicians’ behaviour and various cultural aspects that facilitated young people’s engagement in the assessment process.

What Helped Participants Feel Comfortable in the Assessment?

This section describes participants’ accounts of what facilitated them to settle in, and what invited them to become a participant in the room with the clinicians. The section focuses on the way that participants understood the clinicians’ interaction with them and how this influenced their engagement and experiences in the room and their relationships with the clinicians. The themes identified included: ‘They came down to my age’, ‘They showed consideration for my needs’, ‘They understood what I was going through’, ‘They were cool’, and ‘They let me talk about positive things in my life’.

‘They came down to my age’

Many participants valued the way that clinicians attempted to engage with them as young people, for example in the way they explained information, or when they used age-appropriate language. For instance, Rongo commented he could readily relate to information given to him by a clinician:

Oh they were good. [Clinician] was really interesting. He was actually quite cool. He knows how to talk to us young people. The way he explains things really makes sense to me. He’s really good. He just focuses on what is hurting and stuff. So he knows how to talk to young people ’cause he’s a
young guy himself.

Similarly, Kakariki discussed how the clinician explained things in great detail in a way that seemed appropriate for someone of her age:

What stood out for me in the meetings, um, I think what kind of stood out was that they kind of explained quite everything in quite good details, which is quite a good thing. Like with me I am just like ohh, so, like kind of quite confused usually. I’m kind of confused with certain things and yeah, which is usually me, but [laughs] …Yeah, how they explained it a bit more, yeah. Thought that was very helpful. It’s like the way they explain things was quite useful, especially to me at my age. I’m just like sitting there like I don’t quite understand, but I kind of picked it up, yeah. Yeah, was real useful for me.

Sam described how the clinician had simplified the purpose of the assessment for him with explanations about large words that were difficult to understand. He said, “Yeah they were cool. Using big words but still telling me like, it was just all an assessment about court”.

Marian enthusiastically pointed out how the clinician in this mental health centre had made an effort to try and find a way to explain things in a way that she could understand:

Um oh she was just really nice, like she just came down to my level kind of
thing, came down to my level yeah. She was pretty straight up…. She’s very intelligent. Very. It was really like not like a brainiac’s language. But like came down to my level to try and explain it to me.

Marian elaborated further when the interviewer asked how CAMHS was different from other counselling services she had been to previously:

[This CAMHS] are more like, they deal more with kids, so they understand a whole lot of different things that, like how a kid feels more than how an adult does. Like they come down to that level, like they remember what it was like when they were kids. But like for other counsellors they’re kind of just like you have to see it from an adult point of view.

It seemed that the participants appreciated the outcome of this behaviour and also valued that the clinicians had tried to understand how things might be understood from the young client’s point of view.

‘They showed consideration for my needs’

Participants spoke about moments in the session where they felt respected and their feelings were considered by the clinicians as particularly important to their engagement. They particularly noticed these attempts by the clinician to consider their needs in the early stages of the session when they had arrived usually with some level of caution and shyness. They talked about different approaches the clinicians took that showed them their needs
were considered and respected.

For instance, George admitted he was nervous initially, but this feeling gradually disappeared when the clinician began by introducing herself to help him feel more at ease:

Yeah, before I came I was a bit nervous. Getting ready to speak to some random person… Yeah, it was disappearing, just at the start, it was disappearing. [Interview: What made it disappear?] Um, ‘cause’ she was opening up herself to me, talking about her. Um, she went into her background, like how she was raised, yeah, that she wanted to support people, like people to talk to, yeah. She did like a bit of a background about herself, yeah, and then I talk about myself.

Hohepa noted how he was concerned about what the clinicians were like and what he should talk about when he first arrived at the session. However, the non-judgemental attitude of the clinician helped Hohepa to ease himself into the session:

Oh it was kind of cool because at first I was sort of like worried about talking to her and all that. I thought she would like, written heaps of stuff down and then just to get me in trouble. But she was alright. She never done any of that. She was um, oh I don’t know how to explain it but like she was cool. Yeah. Like they made me feel comfortable after the first session. They didn’t judge me or anything. So to me that was cool, like I don’t like people who judge me, which makes me like not open up. Yeah.
Then Hohepa explained further that as soon as he was relieved of his fear of being judged in the situation he felt able to engage more fully in the session:

But they did make me feel comfortable, so that was all good. And from there I just, I felt, I felt right about doing it. …Even the like, they were saying that it’s part of court, like the court’s going to get it and then they’re going to see what they can do. Like even that worried me at the start, it didn’t concern me like after I started talking to them. That’s how comfortable I was around them. I didn’t really care. So if they did tell the courts then I don’t mind. …Yeah. But they were cool like about everything.

As well as the clinician’s non-judgemental attitude, rather than hurrying clients into self-disclosure, Hohepa appreciated how the clinician allowed time at the beginning of the session for them both to warm up:

Yeah, like she didn’t straight away just ask me personal questions, like she asked me like how I was feeling today and if I was feeling good to talk about like this or good to talk about that and um yeah. She was cool.

Another participant, Awa reflected how early in the session she experienced the clinician’s attempt to normalise the situation making her feel more at ease:

Um, just 'cause he’s told me he’s been through the same situation with other kids. That made me feel a bit better. [Interviewer: What were they trying to do?] Um, well I thought they were just trying to make me feel like, like it’s
okay, everyone else has problems, and, yeah.

Helping participants to warm up was not just limited to normalisation, giving participants time and showing a non-judgemental attitude. Awa mentioned how it was helpful to have some humour distributed as intervals between serious topics as this seemed to improve her mood:

I just remember it being like fun. Oh 'cause first it would be serious and then we would just joke around a bit and then we would go back to being serious again. Like being serious. Yeah like trying to make my mood happy. They would have to be the most coolest people.

The participants tended to notice even the subtlest moments of kindness, respect and/or consideration from the clinicians at this early phase of engagement. They described different ways that helped them feel more at ease and these seemed to focus around being treated non-judgmentally, and being given adequate time and space to get to know one another, rather than going straight into talking about problems. From a participant’s perspective this seemed to indicate that the clinician was being respectful of his/her needs and helped him/her to feel more at ease about engaging with the assessment.

'**They understood what I was going through**'

Many participants spoke about how they appreciated the effort clinicians took to connect with their stories. These young people felt pleased about the sense that the
clinicians understood what they were going through.

Some people like Ben spoke about how he appreciated the way his clinician seemed to understand him as well as the empathy she showed towards him. He said the clinician “was understanding” and “she knew exactly what I was talking about. She was softer, she knew what I was feeling about”. Matiu spoke about how he felt his clinician understood him even when he was speaking about difficult issues:

She was alright. She was cool. Um oh because she understood me like when um, when I’d talk to her about what I was doing here, like about my stealing and the car and stuff, like I was telling you yeah.

While note-taking can be perceived as something that distances the clinician from the client, Rongo spoke about how he appreciated that the clinician used note-taking as an opportunity to reflect on their conversations and then sought to make sure she had understood him correctly:

They had diaries and yeah they were just taking down notes. Yeah they would give us feedback at the end of the session to see if everything was right. Just so that their information is correct. So if there was any errors they can just fix it up. I reckon that’s pretty good.

Kakariki also appeared impressed with how quickly the clinician was generally able to grasp what she wanted to say:

I was like, we all got to talk and it was kind of interesting and yeah. Like
how they explained things and like how like everything about it, they kind of got it on the dot. Yeah, it was like quite good. Maybe they might like have missed a few details or something, yeah. But they actually quite got it quite quickly. It’s more about me and my understandings and they quite got it, which I was kind of amazed.

Further, Kakariki reflected that she had not often felt understood in this way:

> You know how they kind of got it and then yeah. I was like, 'cause usually people were like um well mmm, but they kind of actually got it. They got quite a bit of details, so, which was good.

She went on to describe how the clinicians had even recognised the difficulties between her and her mother, something people outside of her family were not always aware of:

> Well actually well besides they are quite actually good, like the activities and that. 'Cause I know me and my mum, our bonding is kind of poor, was quite poor, and they were trying to get me and my mum together and like string, like get a better bond out of it yeah, so…. I think they found out by the second, second meeting that me and my mum’s thing’s quite poor. Yeah, it was just like yeah, they kind of knew, I kind of told them that our bond was like quite off and, yeah. I actually thought that it was quite good. 'Cause it’s like no one really gets that mine and my mum’s bond is kind of poor. But my family knows it, they always see it, but yeah. So people who don’t know
me actually knows, yeah.

In this case, the participant’s appreciation of the clinicians’ understanding seemed to go beyond ‘seeing it’ like her family had always done, but also understanding the importance of helping her and her mother have a better bond.

It appeared that the participants appreciated the understanding the clinicians conveyed through their tone, their noting things down accurately and then reflecting their understanding back to the client, and by sympathising about the difficulties participants were experiencing.

‘They were cool’

Many of the participants reflected on the personal qualities of the clinician as being important in their engagement during the assessment. Several participants used the word “cool” to describe the clinicians and some reflected on the characteristics that seemed to belong to this description. In many cases this appeared to relate to the perceived genuineness of the clinician’s style. For example, Marian talked about her positive impression of the “real” and relaxed style of the clinician that seemed to be the primary factor in helping her engage:

She’s really cool. She’s a really lovely lady…Lovely lady, beautiful person. … Like she was herself. Acted like herself, like she didn’t try to act like anyone else, like crack a joke and at least like normal like not too
professional and stuff like that. [Interviewer: Not too professional means?]

Trying to be somebody, like trying to be what they tell you to be. Yeah she
didn’t act like she was better than me kind of thing, like some people do that.

Similarly, Huhana reflected on how she was able to relate to the clinician, following an
occasion when the clinician unexpectedly showed her less professional side. For her, this
lightened the mood of the session and helped her to feel that the clinician was someone she
could relate to rather than just someone doing her job:

[Interviewer: What was she like?] She’s cool. Um… like ‘cause I usually
swear a lot and then like I swore once. I’m used to people swearing around
me and she said suddenly, kind of just laughed, because she doesn’t look like
the person to say something like that. [She said] Bitch. And then I started
laughing and she was like what’s so funny, and I was like, nothing.

Huhana also elaborated that this more relaxed way of communicating was closer to what
she was familiar with and also closer to a Māori style of relating:

Like it means like, like, like sort of like, not so much gangster, but like, like
Māori gangster. She was pakeha. Like the way she talked, I’m used to, like
that’s, I’m not used to people talking to me like, like, like, oh I don’t know
how to say it. Like the way she was talking was, like the way I’m used to
being talked to, like how I’ve been brought up…. And you think that was
quite cool.
Other participants seemed to have slightly different ideas about what made a clinician ‘cool’. With Te Pahi, for example, it was the kindness he sensed in the clinician that made her “cool”:

She was really cool, she was like so cool to me, she was like just the way she was. She was like really cool. Just how she was, she was like a really kind person. Kind hearted yeah. I suppose the way she made me feel, like yeah I’m going to open up to her. Oh just the way she like, it was sort of like the way [clinician] done. She was cool about everything, yeah.

Similarly, Kakariki also focused on the warmth and kindness she sensed in the clinicians. She described her experience with the clinicians as being like visiting family members at their house:

Once I actually came in and how I met them and that, it was actually quite, they were quite good. They were like welcoming and that. It was like real good. It’s like the vibe I got off them straight away was like, I’m going to a family member’s house, yeah a close family member’s house yeah. So that’s what I kind of got off them. [Interviewer: Right from the start?] Yeah, they were like good and that. They came off like um loving and warm, or warm and all that. It’s like oh yeah, you know how you get that fuzzy feeling where you curl up to something real soft, yeah. So that’s how I kind of felt.

Participants’ reflections of clinicians’ personal qualities included a real, kind, and
relaxing style that seemed to assist participants in relating more easily to the clinicians.

‘They let me talk about positive things in my life’

Some participants noticed there were two aspects of the assessment, one of which was around their problems or their “bad” stuff while the other was related to positive aspects which were often about their interests, career and future. A number of participants noted that rather than only focusing on the “bad” points, talking about good things in their lives had left them feeling more positive about themselves and their future.

Tehaki, for example, referred to the two contrasting topics several times by naming them “good” and “bad”. While he did not explain his reasoning he said he did not like the clinicians and his family talking about his bad side:

Um yeah they say just stay on the right track, good things. Try to stay out of trouble a little bit. Yeah, all my family, dad and that, yeah they were just talking about my good side and my bad side. Oh there was a lot, they were like talking about my bad side. I just don’t like it.

Tui similarly explained that there were two clinicians during his session, each focusing on a different area of interest. One seemed to discuss the crimes he had committed, while the other talked about what he would like to do in the future. In Tui’s experience the discussion around the future stood out more and left him feeling more positive about himself:

The session that I had with the lady was I think, I think I’m not sure. But um
discussing what I wanted to do, like good things I wanted to do. Um, what
um, gonna do once I’ve finished the talk or what I feel like after I’ve finished
the talk, um, ah, what my goals were or what I was looking forward to,
looking forward to doing um, yeah. …Um, it felt good that, good things were
coming out of my mouth. Um I could just picture myself being there, but at
the same time I was just realising that I can’t get there doing the stuff that
I’m doing now, like getting in trouble with police officers and all of that.

Um yeah so I needed a shape up I guess.

For Tui, it seemed when the clinician provided a space in which he could talk about positive
aspects of himself this seemed to balance out the impact of talking about his difficulties.

Another participant, Rongo, also highlighted his appreciation of a clinician who
acknowledged the potential for positive changes in his life rather than just highlighting his
problems:

He’s real cool. He’s real cool to get along with. He looks at the positive side
of things and what’s good in life, what I can do, and he sort of opens up my
choices and opens up my eyes to new stuff.

It seemed that participants appreciated being given the opportunities to talk about
the positive aspects of their life, including their interests and their future, rather than just
talking about problems and difficulties.

Overall, it appeared that participants appreciated clinicians coming down to their
level, being considerate of their needs and attempting to understand where they were coming from. They also valued positive qualities of the clinicians including kindness and genuineness. In addition, they felt more comfortable when clinicians acknowledged and talked about positive aspects of their lives and their future.

**What Did Not Work in the Assessment?**

As the young people made sense of what helped them engage in the session, they were also able to reflect on what happened in the session that was less effective in engaging them. These young people sought these components during the session, and the absence of them seemed to impact negatively on their impression of the assessment experience. The key themes that emerged in this area were ‘They were just doing a job’, ‘The talking and questions were uninteresting’, and ‘They didn’t prepare me for what would happen’.

‘**They were just doing a job**’

Some participants felt that the interaction was too professional and formal. This seemed to impact on the sense of a genuine human connection that the previous themes suggested had helped the participants to engage.

For example, Sam felt the language used by the clinicians set the distance between them and for him this was not the same experience as talking to a friend:

Yeah. It’s all good like talking to your friends or something 'cause it’s more exciting. [Interviewer: was it like talking to your friends?] No, oh yeah, oh
how is it like talking to friends? [Interviewer: what was the difference?] Just like they were talking in massive words. They were like complicated. 'Cause it’s like all business kind of stuff. Yeah, very formal. Yeah just, I don’t know, oh yeah they were big words. Yeah that I didn’t understand.

Rongo shared a similar experience where the clinician used big, long words that were confusing to him:

Yeah I think sometimes with [clinician] she would talk, I would call it in brainy words, I didn’t properly understand her and then [cultural advisors] would explain it in a way that I would understand. …Really big words that mean little things. [Interviewer: example?] No, but there were some, I got confused. … Yeah, they make it really long. That gets me confused. Yeah. They had them a few times in the first session and I got stuck and lucky my step-mum was there. 'Cause she answered for me. [The cultural advisor] would be saying oh what do you think that your family thinks of you, and I would be like oh, so she couldn’t say that instead of saying a lot of big words.

While the cultural advisor helped Rongo’s understanding in the session, he felt the clinician’s lack of concern for his needs was reflected in her focus of just getting the information she needed. Tui also perceived the clinician as someone who was only doing ‘a job’. He experienced the clinician as being less warm and personally engaging than some
other participants had suggested:

I think it was like ah, like any other job that he does. Oh every other thing that he does with other kids I guess, people. Ah yeah I reckon it was just um oh he wasn’t … Um let’s just say he was like a robot. Oh yeah like, oh not saying that he was like a robot, but um, he was … not oh emotionless. Not like he didn’t care or anything, but um just like he’s sussing things out in his head and acting like it’s not a bad thing or a good thing. Yeah so he had kind of alright to talk to, yeah. Yeah um, I didn’t really feel anything. It was, yeah I didn’t really care. The feeling was like, the monotone, it’s a metaphor for the feeling that I had at the time that I was talking to him.

Ben and Peter who had both had experience with a child protection agency and thought the clinic would get them into trouble, seemed to engage particularly cautiously with the clinicians. For example, Tui felt the assessment relationship was rather like a one-way interaction in which the clinician was gathering information. When the interviewer asked, “What do you think he was doing, when you first saw him?” Ben replied “assessing” and “they were investigating my life”.

A few young people spoke about finding note-taking off-putting in the session. For example, Sam noticed while one clinician did the talking the other clinician spent most of the session writing notes. He said, “Yeah, that lady didn’t really talk that much, she was just… just writing notes down and that. They were just writing notes and that. Oh yeah,
writing notes, just yeah”.

For Peter, the note-taking was a source of concern in the session. He believed the excessive note-taking disrupted the conversation:

It was like dodgy, but 'cause they’re like just sitting there and writing down stuff, like cops. Yeah, they might tell the world. I don’t know, they could have told anyone 'cause they were writing it down. Didn’t want to open up because of that. They didn’t really relate to any of it. Like they just wrote it down. Yeah, 'cause it’s like, I don’t want them to write down 'cause it’s like an interview thing. You have to talk and then stop and write it down.

Similarly, Huhana talked about how the note-taking interrupted the natural flow of the conversation, as she often had to wait for the clinician to write things down:

In [CAMHS] she would ask me a question, I would sort of answer it and she would start writing it down. And then I would have to wait until she stopped writing. [Interviewer: How is that for you?] I don’t know, less talking for me.

It seemed that many participants felt uncomfortable with the clinician taking on a more formal and professional role. They observed behaviours such as note-taking and using big words as indicating that the clinicians were ‘just doing a job’ or just wanting to get information, rather than genuinely trying to engage with young people.
‘The talking and questions were uninteresting’

A number of participants spoke about feeling “bored” in the assessment. Some participants said the talking was “too long” and that the questions were “repetitive”. For instance, Sam said, “Yeah, way more talking. Talking forever. Oh it was just heaps. But oh yeah we talked quite a bit”. Then when the interviewer asked what that was like, he replied “Ah boring”. The length of the session also made participants like Tehaki tired. He said, “They were asking me the same questions again and again. I was just getting tired. … That was supposed to be for one hour but when they looked at the time it was two hours there”.

Peter who also felt the session was too long, offered his opinion that making the session shorter would have made him feel less bored:

'Cause it was pretty long, the first one. I think it was the longest I had ever had with those things. It was like two hours or something. Well we had like two breaks in that. [Interviewer: What could they have done differently?] Shorter. Not two hours. Like an hour or something. 'Cause like when it’s long it gets boring. But if it was short it would be alright. But just short because when it’s long you get bored. I got bored. It’s like a waste of time talking because you forget half, like it just goes.

It seemed that in addition to the length of the session, some participants spoke about the clinicians’ repetitive questions as being tiresome. Matiu, for example, discussed how this made the session long and annoying to her, “It went on a bit too long. I was thinking oh
and we did a lot of talking, okay… It was alright. It was just, just like annoying because she kept on repeating yeah”.

Peter also disliked the questioning process which he saw as being unnecessarily disorganised:

It was boring, 'cause it was for ages and we were talking about the same thing. So yeah it was pretty boring. Just talking. But they are asking like the same questions and that. It was just um, where I am staying, like where I’ve stayed, which schools and that, all that. Like when I got in trouble, yeah. They were talking about the same thing. [Interviewer: how did that make you feel?] Just dumb. … They were going backwards and forwards, like we were talking about school, this, that and then go back to school.

Some participants offered speculation about the way questions were asked. Peter, who was referred to the forensic team, described his suspicion that some of the repetitive questions asked by the clinicians were a test to see whether he would give the same answer. He explained how this made him feel angry and reluctant to cooperate:

Yeah, I think I did just because they already knew what I told them so I didn’t really tell them that much. So yeah I think I lied a bit just because I was annoyed. But I know I daydream a bit. 'Cause I always daydream when it’s boring. I just sit there. They’ll be talking and I’ll just sit there and look somewhere.
Peter elaborated on how he would have preferred the questions to be asked. He believed that more time should be spent on one topic before the clinician moved to the next rather than coming back to earlier questions later:

It gets through to them, but it comes back to you like. Yeah. Like you give it to them, and they ask something else. But like yeah… They ask you what school do you go to, how old are you, like they just change it. They should stay on A for a bit and then go to B. Not go like around in circles. …They go from A then they go to Z and then they go back to some other thing and then go back to A. They should just stay on A.

Tehaki, who was also referred to the forensic team, offered a similar comment to Peter’s. To him, the questioning seemed like what “cops” do. He gave advice that there could be more pauses between questions:

Oh no, it’s that I don’t like, they asked too many questions and I just didn’t like it. Wasn’t angry with them. Just like the cops, ask too much questions…. When they talk, [should be] not straight away, not stop, they can talk like um not talk too much just yeah. Try not to ask too much questions, just talk and stop, not talk, talk, talk all the time. Like talk and then kind of stop and then talk.

Huhana described having moments of feeling she was engaged in the assessment, and moments when she found herself feeling bored. She provided some advice about how
questions could be framed differently, such as through open questions:

I guess questions. Like um, instead of asking so much questions, like just one question that you get a lot of answers out of. 'Cause too much questions, it gets too boring. Um, like a rose or something, um like….Yeah, just like an example. Like um like how many bees does it take to pollinate a rose, like how many roses are in the bush? How many different ways can you make a rose? Instead of asking so much questions, just like firstly say what’s your favourite flower. And if they say rose, say why do you like it. Instead of asking so much questions, boring questions. […].And like ‘what happened’…Yeah, “what happened”. It’s like an easy question, it’s not, kind of like say so much stuff. Instead of too much answer questions.

In spite of several of the participants describing boredom and frustration with the questioning process, it seemed that no participants had spoken about this to their clinicians.

Participants related their boredom to the length of the sessions, repetition, too many questions or the way questions were framed. Some participants appeared to be sceptical about the purpose of the questioning and some seemed to associate the questioning with other negative experiences of authorities such as the police.

‘They didn’t prepare me for what would happen’

Several participants spoke about feeling frustrated when there was less transparency
in relation to the process of the assessment, such as what would happen next and who would be involved. Hohepa talked about feeling shocked when he only found out, at the first assessment session that his parents would be there:

   It was like a shock because I didn’t know my parents were in there too.

   [Interviewer: You didn’t know they were coming?] No, ’cause um they said they were going to talk to my parents but that didn’t know, they didn’t tell me when, yeah, and I see my parent there…

Furthermore, Hohepa also talked about how the ending of the second session was unexpected for him. He spoke about how he had gradually built up rapport with one of the clinicians and the cultural advisor from the first session and how it then came as a shock for him to see them leaving the session, leaving him in the room with another clinician that he knew less well:

   I didn’t expect [closing of session] to be like that. ’Cause um [Clinician One] and [cultural advisor] they just left and they said all the best and all that.

   They said their byes and I was alright and then I still had to talk to [Clinician Two] …Oh it was like, I sort of was shocked ’cause like I didn’t expect that, until um, until half way through the session they said oh we’ve got to leave at this time, me and [clinician One] will leave at this time ’cause we’ve got another like another meeting or something and then I was like oh yeah, but I didn’t know if we were still going to continue, me and [Clinician Two].
Hohepa then elaborated on how it was awkward for him to talk to another clinician with whom he did not yet feel a connection:

And then um when they left yeah I was, I was just shocked. I didn’t know what to say to [clinician Two], like I had never really talked to her before, I never really, connected with her. … Yeah. I was more with [Clinician One] and [cultural advisor] that I was than her. [Interviewer: Anything you felt you wish they could do differently?] Oh yeah um closing it properly instead of just them leaving and saying bye. It was just the first session and the second they opened with a karakia. And then um in the first session they closed with a karakia but not with the second session.

From this extract it was clear that the participant had hoped for a proper closure to the session, rather than the abrupt departure of his clinician without warning.

Tehaki similarly described being taken by surprise with a lack of information about an assessment which occurred in his own home. He explained how the clinicians had spoken only to his aunt about the appointment, but his aunt did not inform him about it or when it would occur. Tehaki described he was surprised to see the clinicians coming to his house, and the fact he was not informed they were coming earlier contributed to his unwillingness to engage in the session:

Oh, I was just, I didn’t know they were coming and that. They were talking to my aunty on the phone but my aunty didn’t tell me. But the next day she
told me they were coming. That day they came. Ah I was just shocked. I didn’t know they were there. So I just opened up the door. Oh just I wasn’t ready to talk.

It seemed that participants felt particularly uncomfortable about the assessment when they were not given clear information about how it would work and an opportunity to prepare themselves for any changes through the assessment process.

Overall, when participants articulated aspects of the assessment they did not like this was because they felt that the clinicians had not attempted to develop a real relationship with them and appeared just to be doing their job. Some found the process of assessment boring and the questioning tedious, while others felt frustrated about not being properly informed about what would happen in the assessment and how it would progress.

**Reflections on Māori Culture**

Given that all the participants were Māori or had some Māori heritage in their family, it is not surprising many young people reflected on the significance of culture in the assessment process. This was identified in several themes such as ‘Doing things the Māori way’, ‘I felt more comfortable with a Māori clinician/advisor’, and ‘Talking to a Māori did not work for me’. The themes in this section highlight the way that clients reflected on the presence or absence of Māori cultural practices in the assessment process.
‘Doing things the Māori way’

A number of participants spoke about how doing things ‘the Māori way’ helped them feel more comfortable during the assessment process. Most of these mentioned that a *karakia* was helpful at the beginning and end of the assessment sessions. Some explained that including a prayer in the session felt like a familiar and comfortable way of doing things. For example, Rongo talked about praying at the beginning of the session, “It’s just a normal process of life, ‘cause’ we just stand up, say our prayer to bless the occasion to make sure that things run smoothly”. Similarly, a number of others spoke about how it felt normal to have *karakia* at both the beginning and end of the session. As Te Pahi said, “Well first I have to sit down and have our little *karakia* first, have a *karakia* to start off and then get straight into it. [Closing of the session] we just ended with a *karakia*”.

While some young people seemed to see this just as part of their normal way of life, other participants like Tehaki commented on the particular value of having a prayer as a way of showing kindness to his family. He described the clinician as “kind”, and said “Like a good thing, like a, yeah talking to me and that. So polite. Saying good stuff to my family also oh just say the closing prayer”.

One participant, Kakariki, explained that she had not expected a *karakia* at both the beginning and the closing of the session, although she reported, as did others enjoying this cultural aspect:

Um, they just kind of summed everything up and like did a *karakia* and all
that, yeah. … did it at the start, at the beginning and the end. Yeah, so which was a good thing 'cause you don’t really go to meetings and it happens like that. So it’s like quite amazing to have people like that, so yeah. Yeah the karakia and that. [Interviewer: How was that for you?] Quite good yeah 'cause it’s like when you turn up to a meeting you don’t expect that. But once they started doing it I was like oh my gosh.

Including this cultural practice into the assessment session appeared to make some participants feel more at ease. For example, Ben who had described feeling cautious at the beginning of the session said that the karakia was helpful in making him feel that there was a shared sense of culture with the clinicians:

[Interviewer: Anything else he did that you think helped?] Him saying the karakia and he said everything. Mm. We’re the same culture. [Interview: How was it helpful?] Because I know what he’s saying and just got that vibe. All Māoris have it. From [the area], oh I’m from [the area] too, oh cousins.

It appeared while some participants had experienced karakia in their assessment sessions, other had not. Some of these participants felt that without this, the session did not feel ‘right’. As mentioned before, Hohepa experienced an abrupt ending of the assessment session with the main clinician and cultural advisor leaving the room first:

And yeah after my parents, after my parents meeting they went and waited in
the car the whole time for me, an hour and a half and then um [clinician two] said oh yeah we should close it because um I don’t want to keep your parents waiting, and yeah we just said our goodbyes from there. [Interviewer: you mentioned before the closing could have been different] Yeah like a proper *karakia* and then, then yeah… but it was more like a normal bye, I guess you see someone and you just go oh bye I’ll see you later. And yeah. Oh that didn’t really affect me big. But I reckon that’s the only thing out of everything that they did, they did everything, I would make, no dramas or nothing but like that was the only thing that I think that they like could be worked on, yeah.

In addition to noticing the presence or absence of a *karakia*, some participants spoke about wishing there had been food provided during or before the session, as is typical in Māori culture. For example, Kiri talked about feeling hungry when they arrived at the session. He said, “In my head I was like I’m hungry”. Others expressed their hope to have some food. For example, Hohepa, talked about the need for food in order to feel energetic enough to engage in the session:

[Things the YFS could have done differently] The foods. Oh ’cause I, in the session it depends how long it is, and sometimes you get, you get tired and you need energy or you start feeling hungry or something. ’Cause when I was in the session I took heaps of bubble gum and I just kept chewing the bubble
gum yeah. …'Cause like when I had the most of them were mainly like
before lunch, like early in the morning and I missed breakfast for that and…
I just kept chewing bubble gum. Yeah they offered (a drink), but I didn’t
(take it), I was mainly hungry.

Most of the participants were not offered food during the assessment with the
exception of two who were given food at the instigation of the cultural advisor. George was
one of the few who had been given something to eat and said “food” when he was asked
what he liked about the assessment. This helped to make the experience of the assessment
enjoyable for him:

Food. It was [cultural worker] He brings some lunch in, some sandwiches
and fruit. Yeah. Before the session. Yeah, we had some lunch, and then went
to the meeting. Um, oh that was it. It was just good. Good to talk. Nice
food.

Marian described how she went out with the clinicians and cultural worker to have some
food after they had conducted the assessment at her home:

I think it was [cultural worker’s] idea and [clinician] came a bit late and
don’t really know where to go like for a coffee but then we found somewhere
to go have something to eat, have a coffee and drink. …We went go for
coffee but they were closed, [so] we went [fast food] and he was having a
feed and we were eating our vegetarian food and having a full on talk about
like where I am at now and what’s going on in my life and a few big issues that are going on in my life.

She spoke about feeling appreciative of the food and kindness, and this appeared to have motivated her to respond positively to the assessment:

Yeah and that made me feel quite special then. In a way it makes you feel like you want to make them feel the same way, like you want to give back what you’ve taken, like they come and see you, put effort into you, buy some food and stuff and you want to put love and effort into, as much love and effort as they put into you, you want to put into doing better for yourself so that they can see you succeed. So they can see that what they’ve done has actually made a difference, yeah. Yeah they feed you, you drink coffee, spoil you pretty much like seriously spoil me. It’s kind of like it’s lovely knowing that it’s almost like take you out and listen to you for an hour or two and get you a coffee and buy you some food.

Marian suggested that instead of holding assessments inside, it would be a good idea if clinicians took clients out to have a picnic in the outdoors:

Maybe take you out to somewhere like more, like representing New Zealand, like the bush and nature, the scenery that we have in New Zealand is real beautiful. Like maybe taking the kids out there and stuff and seeing the world, like appreciating the world and maybe having a picnic outside instead
of like going to a café where it’s kind of like enclosed and not really being with nature anymore.

Māori cultural practices seemed to help some participants feel more comfortable during the assessment. These accounts suggested a positive connection between food and talking. To some of the participants it also felt right to have cultural components such as *karakia* to start and close the assessment, particularly when they were carried out by the cultural advisors.

‘*I felt more comfortable with a Māori clinician/advisor*’

No participants mentioned they were offered a choice for the ethnic preference of their clinicians during their assessment. However, several participants suggested that they preferred to have a Māori staff member involved with the assessment and said they felt less willing to open up to a person who did not share their culture.

Tui, for example, explained how he felt the cultural difference between himself and a *pakeha* clinician made him feel uncomfortable: He believed that someone from his culture would be more able understand his culture.

[Interviewer: So what made it not so comfortable?] Oh that I didn’t know him at all. Yeah, he’s a stranger to me and no offence but he’s *pakeha* and um yeah. Oh because he was *pakeha*, I didn’t feel comfortable talking with him. Mmm, I reckon it would have been better for me to talk to a Pacific Islander
or Māori. It would have been more comfortable. It would have been good.

'Cause they’re from your culture. They know more about your culture and yeah, more understanding of the culture and how the culture thinks and all that.

A few other participants also pointed out the advantages of having a Māori clinician or cultural advisor present during the assessment. Rongo spoke of how he felt the Māori cultural advisors were able to facilitate the information gathering process better than someone from another culture:

Yeah, 'cause with [Cultural advisor one] and [Cultural advisor two], since I’m Māori and my parents being Māori, they understood the situation a bit better than [a European clinician] did. And yeah so they know how to really talk to Māori people, just to get that information out, what they try to do, what their goals are.

Sharing knowledge of cultural backgrounds appeared not only to facilitate information gathering, but also allowed the clinicians to make connections to the same community or even to the extended family. For instance, one participant, Tehaki was pleased when the cultural advisor in the session introduced himself through his cultural background and Tehaki found some connections to his own family. He said that the cultural advisor was “talking about oh his family” and “oh yeah talking about the Cook Island side and that”. Then he said, “Oh yeah, hey. I was just shocked. Oh like he’s my uncle...Yeah,
just something in common”.

While several participants said they preferred or saw the advantages of having a Māori clinician, none of them reported a highly negative experience with non-Māori clinicians, except for one participant, Zac, who was part Māori and part pakeha. He described how he stopped the assessment session half way as he became agitated with what he saw as culturally insensitive questions from the clinicians. He ascribed this to not only the cultural differences, but also to the power difference between him and the clinicians, which made it hard for him to engage with them:

The attitude, that was just dreadful. I didn’t like them, I saw them as stubborn white people, rich [swear word]. Sorry my language but I’m just going to speak the truth here. Yeah. Oh I’m pakeha myself, what I call them, have you seen um Pirates of the Carribean? Have you seen how they got those rich white people and then they’ve got the pirates, they’re the rich white people. Yeah. I was the pirates. Um it was just like the tone of their voice.

When Zac was asked about how the non-Māori clinicians could have been more culturally appropriate for him, he noted some Māori specific customs, such as pepeha (self-introduction), that were absent in the session but are important ones when getting to know a Māori client:

Most probably, um well what iwi are you or hapu are you or
asking...Interview like that to a Māori kid you’ll go what’s your iwi do you
know your pepeha, are you able to tell us about your pepeha, see that’s
something else culturally. That helps you understand a lot more about a
person. My name is, I am from, this is. The other person oh my name is, this
is...

One participant was able to recount a difference in his level of engagement between
a Māori and a non-Māori clinician during the assessment. Te Pahi provided an account of
his disengagement with a non-Māori clinician at the start and his wish to speak to someone
from his own culture:

First I met [clinican], well the first time I went there and I met [clinican] she
was trying to make me open up like yeah she was being really kind but the
first time I went there I wasn’t quite opening up to her sort of thing and well
so what she done she went to go and get [cultural advisor] to come in. Well
since she was not a Māori so I could like relate to [cultural advisor] sort of
thing. Yeah I was like being so shy or her not being a Māori sort of thing
yeah. I didn’t like… she didn’t really like…. oh I suppose I don’t know I
suppose I just needed a Māori person to talk to I suppose. Someone who can
actually relate to me sort of thing, yeah.

Te Pahi then described how when this Māori staff member joined the session his level of
engagement increased straight away:
Interviewer: How did the cultural advisor who came in make any change?

Well a lot really because like him being Māori we could talk about Māori things. About like family and all that. So that was quite good. I started opening up to him instead of [clinician] and well she was quite surprised herself. Like I said when she walked in the room and I can talk to this dude because of the way he was talking to me and I could relate to him… like straight away like I started like talking to him and she was quite surprised at how much I was talking to him really… Well that was like I suppose like, well after that it was like him getting to know my family tree and all of this.

Yeah that was quite good…

Some participants talked about their cultural preferences for the assessment, preferring a Māori clinician that they could connect with more easily. These participants felt that relating to a Māori professional was beneficial and appeared to facilitate some of them with engaging and talking openly.

‘Talking to a Māori did not work for me’

While clearly some participants found the culture of clinicians mattered other participants did not perceive this as an issue for them at all, or preferred non-Māori clinicians. George who self-identified as Māori, explained that it was good to talk to someone regardless of their culture or ethnicity. He elaborated this was also his mother’s
way of relating to others. He said, “It just feels good to talk to someone about it. No. I
don’t really care about culture. I don’t know. I was just raised to treat everyone the same”.

When the interviewer asked what had influenced him to be that way, he said, “Probably my
mum, ’cause I was raised around her more. Yeah, she’s Māori”.

Peter did not specifically bring up anything about culture. However, when the
interviewer prompted him, it seemed although he self-identified as Māori, he did not think
culture mattered much. He explained that being polite and acting normal was enough for
him. He said, “That was alright, I guess, yeah alright. Like they weren’t rude. They were
just normal”.

Interestingly, Rongo, after mentioning in an earlier section about his preference for
Māori clinicians also recognised and appreciated how most professionals, regardless of their
cultural background, were able to show appropriate and genuine consideration for Māori
clients:

It’s cool, ’cause everybody is friendly and they seem to get along really well.

I think just knowing people as well and they know, if you are Māori, then
they really know how to connect with each other by explaining where they
are from and stuff. And yeah that helps. [Interviewer: Is it just the Māori
staff or everyone?] It’s everyone.

A couple of participants spoke about their experience with a Māori worker, and
pointed out that it could be unhelpful when a Māori worker thought he/she knew the culture
too well and missed out some important aspects in the engagement process. Marian who
identified herself ‘completely as a Māori except a little bit of pakeha’, shared her
experience with a Māori staff member. She perceived him making assumptions about his
cultural link with her family that were not warranted. Marian explained why she disagreed
with his attitude towards culture:

The Māori guy kind of came inside… so he came over and um my mum
invited him in and stuff and they had a bit of a chat, he kind of walked in like
personal, like started talking about how, what it’s like to be a Māori and how
he’s like a teacher and [made comments about other ethnicity], like you can’t
just walk into a Māori house and be like say the same kind of things that he
would be able to say and I thought like that was kind of like a bit racist of
him, like honestly, like people are people and um I’d give them respect no
matter what culture they were but yeah and he kind of came across quite
rude, like arrogant and that.

She elaborated on what she saw as the arrogance of this staff member who she
implied also took for granted his gender dominance as a function of Māori culture:

Yeah and he kind of like came and he sat on the chair and then he like chilled
out on the chair like comfortable as…like it was his home and it was like
okay yeah I just thought he kind of didn’t have much respect but like most
males don’t, honestly. Most males don’t. They’re a little bit disrespectful and
lazy. Um they think in a different way to what a female would. …Um like he can walk in and be like hey bro so how’s it going at home kind of stuff and like how’s the kids and can I have a coffee kind of thing, I don’t know what he meant, he meant it in a way that he can like put himself in there like just as over-confident, egotistical male. I didn’t like it. Like… like I guess young Māori, being a Māori like walking into another Māori person’s house you can tend to be like a bit cocky because you’re their culture and you think that you have some kind of right to do stuff. Culturally, probably using his culture to his advantage. Saying to me I’m a Māori I can do this and that because I’m Māori and it’s like you’re human, do you realise you’re just a normal male like every other male, just because this is your country it doesn’t mean you can act like that. For him he made for a little bit more Māori by talking about his background, as a Māori.

Marian continued by giving other reasons for why she would prefer to open up with a clinician from a different culture to her Māori culture. It seemed that Marian was concerned that she might be overly familiar with her clinician and perhaps enact some of her negative feelings about her own family members in this relationship:

I think it actually makes it a little bit more difficult to talk to a Māori, as seen as like my parents are Māori and like I have my own dramas at home, you don’t feel comfortable towards your parents about certain things. And as a
counsellor if you go to a Māori girl, if I had a Māori counsellor woman, it
would um, I would feel a little bit more like I could be a little bit more
disrespectful towards her because my past like being disrespectful towards
my parents and stuff, because they’ve hurt me and I feel like I’ve got the
right to be disrespectful towards them if I feel like I have to defend myself.

She talked further about the value of seeing a professional outside of her circle, as she
believed her previous experiences had taught her this:

That’s what a counsellor is for. Like someone outside of your circle that you
can just blurt to and you know that it’s safe with them the information. … I’d
be like no or I’d be like hiding it and then I’d be hiding things from her
because I feel embarrassed and like I’m disappointing my family. Well you
don’t trust them. I don’t really trust many people inside my circle, like my
family and stuff I can’t just tell them anything, like now I’ve learnt from my
mistakes I can’t just talk to them about anything because it will just go
around the circle, like it will stay inside the circle like safe inside the circle
but you’re in the circle as well and then you feel like all this pressure of
everybody talking about you is really pulling you down.

Marian explained further that her views could sometimes be seen as unacceptable to her
own culture, therefore she prefers seeing a non-Māori that does not have to understand her
culture but would listen to her and validate her experience:
In a way for my culture a child is meant to listen, there’s no questions asked. You listen. If you don’t listen, you get a whack around the ears, like it’s just seriously what happens and it’s probably a better thing that she understands, that she’s not my culture and she doesn’t understand so much. I mean she’s heard about it but it’s not the same as actually experiencing that. Yeah talk to them a lot more and she listens because it’s her job to listen. Yeah, not many Māori people listen to a Māori girl talking about her family the way I do. I told a pakeha lady she’d be like oh I understand, I feel sympathetic for you, you feel like you you’re being ignored, you feel like you haven’t got enough attention and you end up seeking it from somewhere else like I do.

The young people’s cultural preference of clinicians seemed to vary among different participants. For a couple of participants, culture did not matter but for some like Marian, there were particular reasons behind why it was easier to talk to a non-Māori clinician.

Overall, many participants noticed the presence or absence of cultural practices in the assessment, mostly regarding the karakia. This was discussed in a way that felt ‘normal’ and ‘right’ for the young people, and a couple of participants felt special to receive this cultural input. Some participants also seemed to feel the lack of the ritual of having food together in the engagement process. Only a couple of participants were given kai before or during the meeting, and some participants believed having kai would have facilitated the engagement or opening up. Lastly, not all participants spoke about their preference for a
Māori clinician. This seemed to vary among individuals with some pointing out the value of this, while others seemed less concerned; one participant was actively negative about having a Māori staff member involved in their assessment.

**What Participants Took Away from the Assessment?**

A few participants felt nothing but happiness the assessments had been completed and they could go back to their normal life. However, it was interesting to note how the majority of participants felt that they took something away from the assessment experience including support, increased understanding of themselves and hope for the future. The key themes emerging from this heading were ‘I was relieved to open up’, ‘It helped me understand things differently’, ‘It gave me hope that I could get help’, ‘It changed things for the better’, ‘It gave me what I needed at the time’, and ‘It made no difference to me’.

**‘I was relieved to open up’**

Most participants shared a sense of relief after the session about opening up to someone about their stories and a sense of accomplishment in being able to do so. Some participants elaborated little about this experience but conveyed a positive feeling after attending the session. George, like many participants, expressed a sense of relief about having been able to release feelings he had been holding inside previously:

I felt pretty good. I felt pretty good to open up to someone. Um oh I just felt happy. It’s a release, some of that stuff. Yeah, I thought about it when I was
home. I was thinking, god it was good. Finally spoke to someone about it.

Yeah.

As mentioned in earlier sections, it was unusual for some participants to open up at home. This context appeared to make opening up a particularly significant experience for some participants. For example, in Te Pahi’s case, being able to open up during the session was more than a relief. It also seemed to have elicited a significant sense of pleasure and accomplishment:

Well it made me feel quite relieved really, like you know getting out of my chest sort of thing, just telling them those stuff was quite good, well after that like when I went home I was quite happy in myself for like telling him these things. Things that I had never told anybody, not even my own family, I never used to talk about those things. I wouldn’t tell my brothers or anybody. That was quite good for me. … [Interviewer: What was important for you in that session?] Getting to open up I suppose about my own personal life. Yeah it was something, well we wouldn’t usually do that sort of thing.

The experience of being able to open up gave some participants a new awareness of their own strengths and increased confidence. Hohepa was pleased to find out he could do something (opening up) that he normally did not think he could do without alcohol:

Oh yeah 'cause like when they first told me that like, um I opened up to them, well I didn’t notice it, 'cause they said, they asked me, I don’t know it
was a question that they asked me and I answered it and then they were like

oh see you don’t need alcohol to open up, you just did it right then. And

yeah that sort of made me happy and I was like oh yeah true, I don’t need

alcohol to open up, but yeah. So all good.

In a few cases participants not only felt relief at opening up themselves but also

having been able to share information with family that they had not previously been able to
do. Kakariki, for example, felt pleased that this process has increased her family’s

knowledge about what she was going through:

Um, I actually felt quite good, once I walked out of that room I felt quite

good because my family knew what I was going through and what happened

and that. There was like no secrets. It was just like a plaster pulled off and

everything exposed. Yeah.

Many participants felt a sense of relief at opening up in the assessment session.

Those who were not used to opening up to others described a sense of pride in their

accomplishment. Some were also relieved that their families now knew what they had been

secretly struggling with.

‘It helped me understand things differently’

Some participants explained that the assessment led them to start thinking about

their decisions and behaviours as well as their futures. For example, Rongo talked about
how the assessment made him think differently about his decision to attempt suicide. He said, “I think there was a bit of thought about myself though, just a little bit, on my decisions that I made, and my suicide attempts were pretty stupid.

Some participants spoke about how the assessment had helped them think about moving forward in a different way. For instance, Tui conveyed how the assessment shifted his mind set and focus onto what he actually wanted to do in his life. He said, “Um looking towards what I wanted to do that was good. Um instead of carrying on doing what I was doing”. Hohepa talked about how the assessment had made him think about how his current behaviour was limiting his future options. He said, “Oh, that was alright ’cause they, just um, made me like think about my actions and um about like what I really want to do and if I really want to stop drinking and um my drug usage”.

Te Pahi suggested the assessment had helped him think deeply about different aspects of his life and the importance of making the most of it:

I suppose it got me thinking about my life and what I’d been hearing and all of this stuff and where I might be heading in a couple of years’ time or so. Round about this time. Yeah makes me think about the past, present and future I suppose. Yeah it made me think about things I’ve done in the past good and bad and well I don’t know things I could maybe do and still well it got me thinking about things I used to do in the past but I don’t do any more now sort of thing. … Like get out there and do something I suppose yeah.
Me being the youngest out of my brothers and seeing my older brothers grow up and end up nowhere it’s sort of like not really a positive thing on my life sort of thing. Like watching them to grow up to be nothing, it’s like well it got me thinking like well am I going to grow up and be exactly like my brothers, be a nothing, be a bum sort of thing or should I just you know do what my koro (grandfather) said and get out there and make something of my life.

A couple of participants also mentioned that the assessment had helped them discover increased support, realising that there were people who cared and worried about them. For instance, Rongo talked about how the session prompted an awareness of the support he had from his family and relatives, and this made him think differently about his suicide attempt:

Yeah, and they just explained that I had a lot of support from family, on mum and dad’s side, and they went through on who is your closest cousins and the ones you are close with, and those you are not so close with and just aunties and uncles. So they were just pretty much going through all the support you had. My thoughts were a bit, thinking to myself I was a bit stupid for trying, yeah. It just opened my eyes to how much support I had.

Gaining new understanding through the assessment was not as easy for all participants. Kiri, as an example appeared uncertain about whether she would be able to use
what she had learned through the assessment to make changes in her life:

Even though we talk about our feelings, how do you feel, what’s going on at home, it still makes no difference. Yeah, it still makes things who you are and things the way it is. 'Cause like one thing for sure you can’t change your past and you can’t change who you are, you’ve just got to live with it. Yeah that’s what I reckon.

However, Kiri then spoke about how she had indeed taken some new learning from the assessment process:

But in a way like it helps you, like it makes it like, what do you call it, how do you call those um it relaxes you more knowing that you’ve got this big like, like the big cloud over you and you make, like you get rid of it bit by bit, but it’s got to take time, yeah. It feels good knowing that it’s out. But sometimes when, it’s like when you kick a door open, it’s good knowing that you kick a door open and like knowing what’s behind it, but sometimes when you kick a door open you can’t close it again, yeah. Yeah, yeah, you just going to have to face it, you’re going to have to face what you started and until the end. You started it, now you’ve got to finish it. Even though it takes time, or may take a long time, sort it in the end, you’ve got to finish it yourself. Yeah, even though you close it, but knowing that it’s still open.

This participant conveyed her mixed feelings of relief at having opened up, and gaining an
understanding of her difficulties but also some concern at having to now live with this new understanding of herself.

It appeared that some participants found the assessment useful in terms of helping them to think about their decisions and behaviours differently, as well as giving them a clearer picture of themselves and the support available to them.

‘It gave me hope that I could get help’

In some cases the assessment seemed to have left participants with a sense of hope that they could be helped. This hope appeared to be based on having developed a more positive expectation of what professional assistance could offer. Some participants who were returning to the clinic for therapy following their assessment, conveyed a sense of excitement about going back. For example, when Rongo was asked what it was like thinking about going back for the next session, he said “I can’t wait”. Hohepa also described his wish to return to the clinic for more sessions, after the relief and pride he had felt in opening up. He said, “Oh yeah I didn’t have enough. Well I liked it because um I talked a lot in that and um yeah it kind of made me happy in a way”. It seems what Hohepa experienced at YFS was different from what he had experienced in other agencies. He emphasised the relationship he had developed with the clinicians in this particular setting:

Oh I have done a lot of counselling, [Alcohol and drug support service] and
all that and trauma counselling and um I never really opened up to them, sort
of all those other counsellors, so I did at the [YFS]. Yeah, like um I wanted
to go back.

Those participants who bonded with the clinicians quite quickly seemed to have a
particularly positive outlook on how they could be helped following the assessment
sessions. For example, Kakariki said that after she attended the assessment with the
community team she experienced increased hope that she could be helped to manage issues
in her life:

    Um, I actually thought that they would be able to help me quite a bit and that
    I could go quite far, and um, yeah. And that they, they will be able to help
    me and make me feel better and all that, like all the simple stuff and that.
Thinking about the possibility of how she could be helped seemed to have allowed her to
imagine positive changes continuing into the future. She elaborated, “Like I couldn’t like, I
couldn’t stop thinking how they would help me in the future and how the future was going
to be and all that and how I would be much happier and all that”.

Some other participants seemed to have a positive expectation that the assessment
would provide sufficient information to enable them to get access to the help they needed.
This was certainly what Hohepa conveyed when he talked about how he was waiting for the
assessment results and recommendations about his mental health:

    Oh yeah, um to see if I got like anything wrong with my brain ’cause um. …
So me and my parents were like sort of oh, like confused about what, what really happened and that. … I just really want to find out. I do. Yeah, ’cause if I do then I need help with that, because I don’t want to end up killing someone or anything. Yeah. Oh yeah because they, even with my criminal like activities, I’m trying to change that too. And that’s why I’m trying to get help and all that.

Participants seemed to have discovered hope through the assessment. In some cases this seemed to be because they had a more positive expectation of what help professionals could offer and because they believed the assessment could provide helpful insights into their problems.

‘It changed things for the better’

More than half of the participants seemed to feel that the assessment had changed things for the better in their lives, although not necessarily always with the knowledge of why or how this had happened.

For those who spoke about personal changes, being able to talk more openly to people about the things that worried them seemed to be a common feeling. Rongo for example acknowledged how the assessment had helped him to learn to verbalise his emotions:

I found that talking actually helps really well and they really helped me to
open up to just talking, which I had never done. I didn’t like talking about
my emotions. It felt weird. But it feels normal now, to talk about emotions
now.

A number of participants suggested the experience of talking about their feelings in
the session also seemed to have brought changes to their mood. For example, when the
interviewer explored the benefit of talking about his emotions with Rongo, he said, “Yeah it
has, because before I used to have a real temper, short tempered and I find it easier not
getting angry anymore”.

In some cases, participants noticed a shift in mood right after they had attended the
assessment session. Hohepa explained that he had opened up in the session, then noticed
his mood had changed and stabilised in the week immediately after the session:

[Interviewer: How was the week like?] Oh it was, I normally have mood
swings, like I get angry over little things. Nah, that’s what I told them too
and they said that’s like they are going to check about that for my head
injuries. But yeah like our course that I went to, like if someone drew on my
piece of work I would get angry about that, but like our course, for that
week, I had a good week, I helped, oh we moved into a new building and we
had to rip our old carpet and um sand the walls down and then um yeah did a
little bit of renovating, and I did that with a full smile and non-stop work,
just … Oh I don’t know, like I feel like it related to the [YFS], but yeah then
again I don’t know.

Kakariki came to the session with a background of family problems that had caused a lot of stress. She also talked about how the assessment lifted her mood and made her feel better:

Um, yeah sort of like really made me feel more positive, yeah, which is a good thing. Like they kind of uplifted my life, yeah so to say if I was like, one of the reasons, it’s like a drug addict getting clean, like feeling way better, yeah. Something like that yeah.

There were a couple of participants like Awa who noticed some small changes in her confidence as the assessment progressed over the two sessions. She seemed to attribute this to having to speak up during the assessment process:

It’s like every time I visit them I just think about the stuff they told me, and then it just changes my mood and then yeah. I know I got a bit more confident in myself. 'Cause I used to be really shy. I didn’t like talking to people I didn’t know. Um, sometimes I had to get up and speak where I knew I had no choice but to. Um well the first time, I had to stand up and introduce myself, and I was like oh. And then I just started getting sort of [fine with it] because we always had to get up and say something.

Some other young people talked about inter-personal changes such as in family interaction following the assessment. Rongo explained that the assessment process helped
him to talk more freely to his parents. During the session he worried about what his parents would think of him, but soon he found support and a sense of understanding from them. It appeared that beyond the assessment sessions this experience had continued:

I was trying to get my mind off everything just so it makes it easier for me to talk to my mum and so we were trying to bring up problems and her getting emotional again. But yeah I just learnt to talk to her now. It helps a lot. Because before the [CAMHS] I didn’t talk to my parents at all about what I was going through and my emotions and everything and what was wrong. They would sort of try and click on then I would just tell them that I’m fine. But yeah the [CAMHS] just helped me past that point of my parents getting disappointed at me for stuff. Oh ’cause my perspective is the things I was thinking of they would have just been disappointed and angry, and I didn’t really want that to happen. But then once I did tell them they were just upset, not really disappointed, they understood the situation really well, and yeah once I talked to them it made it easier. So [CAMHS] helped me open up to my parents as well…. Just learning how to talk to people is my main focus. And it worked.

Rongo also talked about how this had helped his family by teaching them how to support and help him through difficult times:

[Interviewer: how?] I don’t know. Just talking to [the clinician] and
discussing it with my parents made it easier I guess. Mum was just surprised, yeah. How well I was doing. Yeah. I talk more. Me and my mum talk way more than before. Yep. Mum finds it real helpful, and it gets her help as well. And my dad, he got a bit of, getting a bit of help from this. I think it’s just helping them to think of solutions. What to do when I’m in a downer, down buzz, in a negative place. So yeah it helps them to sort of know what to do in personal times. He gives my mum solutions to when I am angry. Get me to do press-ups.

While some participants articulated changes they had initiated as a result of what they had learnt during the assessment process, some other participants said that changes just ‘happened’ to them after the session without fully understanding why or how this had occurred. Awa, for example, spoke about some significant changes that the assessment process had made to her family and especially her relationship with her mother. She had not expected this as before the assessment their relationship was poor:

Yeah, 'cause we all had a family meeting and [the clinicians] came and I thought they like helped us, make the family get along with each other.

'Cause when I finished we had been getting along good. [Interviewer: What happened in that session?] Um… I forgot. Yeah, to talk to all of us and to ask how we were doing, how we were getting along. Pretty good. Yeah, we still haven’t argued or anything. Oh [before] it was hectic, it was like at each
other’s throats and me and my mum never got along until the [CAMHS] came in, I started like respecting my mum a bit more. Oh 'cause me and my mum, we never got along, we always have fights.

Awa offered her own speculations about how the assessment might have contributed to the positive changes in her family:

But then I told them about my problems and stuff and then it made me think and then that’s when I just started giving up on her and started being a daughter that she actually wanted, and then, yeah. Oh they talked…they talked to my mum, then they talked to me, then my dad, and yeah we just all kind of got along after that. Yeah, I’m actually surprised myself that it actually did help.

While the changes to Awa’s family were sudden and unexpected, the changes seen by some other participants were more subtle and gradual.

Huhana was someone who previously described the assessment as “boring”.

However, she still saw some positive changes in her interactions with her mother after the assessment:

In a way it felt more, because I had done it before, just not the [CAMHS], and it was boring and scary at the same time. I didn’t really care. But it was, in a way but … It made a change in my family. I haven’t had an argument with my mum in ages though, so …Yeah. It’s pretty cool. Um just a better
attitude [laughs]. I listen more. I listen more. And, like I know how to say

stuff without my mum getting angry.

Marian was another participant who talked about subtle changes in her life. She was aware of her own agency in creating this change. She explained how after the assessment she began to learn to trust her family and initiated changes in her behaviour:

I don’t really trust many people inside my circle, like my family and stuff I can’t just tell them anything, like now I’ve learnt from my mistakes I can’t just talk to them about anything because it will just go around the circle … and then you feel like all this pressure of everybody talking about you is really pulling you down. I’m trying to learn how to though, I’m trying to learn how to trust my family because recently, it’s just kind of like counselling really. … because the last four years every single night, every time I go home, I close my door, go into my bedroom, close my door, go into my room…and just in the last week I’ve left my door open and they can feel that change.

Marian elaborated on the gradual trust and respect she was hoping to build by altering her attitude and openness towards her family. At the same time she expressed her awareness that this might take time:

Yeah, my granddad felt a bit more, I think he feels a little bit more uncomfortable I think, but a little more comfortable as well, like you know
we don’t really talk very much. Yeah it’s showing him a little bit more respect I guess. A little bit more love. I trust you, I hope you can trust me too.

It’s actually making a difference slowly, slowly.

Changes were also perceived on other intrapersonal levels, such as in school or in the community by a couple of participants. Huhana, for example, talked about noticing some changes that happened to her behaviour with her friends at school:

And I don’t ditch school just because I am in a bad mood anymore. Yeah, um at home it’s sort of better. Yeah but um I don’t know. Well like I talk to my mates more about it than my family, 'cause my family’s just weird to talk to.

[Interviewer: To mates?] Yeah, just more of what happened.

Many participants elaborated or conveyed a sense of improvement in different areas of their lives after attending the assessment, including shifts in mood, growing confidence in self-expression, and in their interaction with others.

‘It gave me what I needed at the time’

Some participants shared how the experiences of undergoing the mental health assessment served as the right support for them at a particular time of their journey.

Huhana, for example, was used to dealing with her issues on her own and therefore stayed ambivalent about engaging in the session. However, she talked about how this support was offered to her at a time when she needed it and how she opted, in the end, to
take what she needed:

It’s like, 'cause all that time when I was going through bad stuff, I didn’t want any help at all. I just thought oh nah I’ll do it by myself. And like they were giving me help and I didn’t even want it. I was like, I knew that I needed it, and then I just took it. [Interviewer: Took it?] Yeah, advice. And like, um like strategies sort of.

Marian was a participant who was undergoing difficult times and approached CAMHS for help. She commented that the kind of support she needed from the clinician was not to hear the problems she already knew she had, but to receive reassurances that she was okay:

I did need quite a bit of help back then because like when you think you’re crazy like it’s not really cool, actually thinking you’re crazy. You need somebody to tell you. You need a professional to tell you, you’re not crazy, there’s nothing wrong with you, you’re normal, yeah that’s what I kind of needed. …Yeah he told me there was nothing wrong with me and didn’t tell me I was depressed which I already know.

Receiving the right help at the right time in someone’s life appeared to be a meaningful and powerful experience. Kakariki’s metaphoric account is a good example of this:

I think it um I think it fits quite well, 'cause before it was just like, a brick
wall that is missing a few bricks here and there, and they actually kind of completed the wall, yeah so far, like on my journey, yeah. [Interviewer: In what way?] Um like support, because before I didn’t really have much support from really anyone, beside family and that, well I knew that, but like, it’s like I needed kind of more support and they were there to fulfil it.

It appears from these participants’ reflection of what they received during the assessment, for example advice, reassurance, and support, fitted with what they needed at the particular time when they were in difficulties, and because of this, turned the assessment into a meaningful experience for them.

‘It made no difference to me’

Although about half of the participants spoke about taking away something positive from the assessment experience, not all participants saw the assessment as having significance in their lives. Several participants felt they had gained little from the experiences, particularly those that had been referred by the police or courts to the forensic team. Some participants like Sam and Ben said “I forgot about it” when asked about their thoughts after the session. They emphasised that the assessment had not had any particular meaning in their lives.

Some other participants expressed ambivalence about the significance of assessment to their lives. Tehaki, for example, who was referred for an assessment through the courts
said, “Oh I just don’t like it. Oh it was alright. I don’t know”. Tui, who only had one session with the forensic team, explained that when he completed his assessment he simply resumed his way of life just as it had been before he attended the session:

    Um, I reckon most people my age or people like me, people who have been through what I’ve been through, after a talk like that, I think it will all just go back to normal, see what happens. Oh just as if the talk had never happened.

    That’s what I reckon.

    Some others were aware of the help and support the service was intending to provide, but they did not believe this had made a difference to them. George, for example, talked about the help that came with the service, but implied that in his life, it made no real difference:

    It’s just another piece fitting in. Trying to help out. Yeah, doing their job right, yeah. Yeah, they’re helpful. They helped me and my dad. Um, I didn’t think it would make a difference. I would still live my life normally. I just felt normal. Just like another average day. Just talking, talking about a different subject.

    For some participants, the idea that they had been forced to attend the assessment in the first place still tainted their expectations of the service. This seemed to apply mostly to participants from the forensic team. Tehaki, for example, talked about the requirement to go back to the YFS again even when he did not feel like doing this:
Oh going back again, they want me back, so I said oh yeah. It was alright. I just didn’t feel like going but I have to. Um oh social workers said I had to go so they can finish off the [task].

Zac appeared to be an exceptional case. He described how he became agitated and angry during his assessment and terminated the assessment session early. He believed his experiences at the session were bad and caused more harm than good. He perceived the assessment as damaging and his mood was worse for a week afterwards:

I saw that as not so good. Um I’m giving a shit because like you know it was crap. I’ve been asked all these questions it was crap. It just adds bad things yeah. As in like it just made my day bad that’s all. That meeting was like, because it just gave me a bad experience. I reckon it was a waste of time, like you know that 10 to 15 minutes it was a waste of time in my life. I could have been doing something even better like going for a walk, going getting drunk or something, you know have fun but I didn’t drink but you know like as an example. Well it affected that whole week really because from that day, like once I was in a good week until that day, okay I think it was the next day or the next day after, I ended up chasing my auntie with an axe. Doesn’t sound too nice.

The earlier analysis provided some context to Zac’s situation, who wished he had a Māori clinician and who became angry when triggered by a sensitive question about a family
member.

Overall, all participants talked about what happened to them after the assessment in various ways. Their observations included: they were relieved to open up, they were helped to see themselves or their problems in a new way, and some things changed in themselves and in their relationships with others. For several participants the assessment seemed to fit with a particular need they had had at that time. However, for some participants the assessment had made no difference to their lives. This was particularly so for those who saw the assessment as being associated with courts and their criminal offences.
Chapter Five

Discussion

The aim of this study was to understand young people’s experience of a mental health assessment, how it influenced their understanding of themselves and their engagement with the service. The rationale for this study developed from a recognition of the paucity of literature on young people’s perspectives of mental health services. The focus of this research was young people’s first encounter with a mental health service through the assessment process. In this way this study is different from the limited existing research which largely explores young people’s experiences of the overall course of therapy (Davies & Wright, 2008; Gibson & Cartwright, 2013; Gibson et al., 2015; Kazdin, 2008; Midgley et al., 2014; Rennie, 2004). The cultural context shared by the participants of this study also introduced a novel perspective into the research on young people’s experiences of psychological services. There are few studies that focus on the experiences of young Māori in either therapy or the assessment process.

This chapter provides an acknowledgement of the context which framed participants’ accounts of their experiences of mental health assessment as well as a discussion of the themes that emerged out of the analysis. This will be followed by a discussion of the implications of these findings for clinical practice and research. The discussion will conclude with a consideration of the limitations of the study and recommendations for future research.
The context of participants’ accounts. The key findings need to be understood against the context in which participants experienced and offered their accounts of a mental health assessment.

Firstly, there was considerable variety across the different accounts provided by the young people who took part in this study. It was noticeable that participants differed significantly with regard to their articulation, expression and willingness to elaborate on their experiences. For instance, some participants gave short answers when prompted by questions whereas others provided detailed descriptions of their experiences and also noted the context that influenced their perspectives. During the interviews it was also evident that participants took different amounts of time to warm up to talking to me and to begin to express their views rather than simply describing ‘what happened’. The differences in the depth of their accounts could have been associated to differences in age, verbal ability, sociability or their ability to express themselves (Grotevant & Cooper, 1985). As Binder and colleagues (2000) note, it was important not to assume that those young people providing more detailed and extensive explanations were not necessarily representative of those who gave shorter, less extensive accounts.

Secondly, as Buston (2002) notes, differences in the accounts that young people give of their experiences of mental health services may be driven by factors such as previous experiences with help and support. Certainly, some of the people in my study had different levels of experience across a range of services. In my study it was also clear that the young
people had entered mental health services for quite different reasons and via different pathways. Some participants had come through a referral from the community for family and/or school problems, depression or some other emotional difficulty, while some came following suicide attempts. Others had experienced serious accidents that required assessment for their mental health or cognitive functioning. However, the largest number of participants (nine) had been specifically required to attend a mental health assessment after some involvement with the police or the courts. These different pathways to referral, and reasons for assessment did seem to have some influence on participants’ accounts. This was most obvious in relation to the group with forensic referrals. These young people seemed more preoccupied with possible ‘trouble’ arising from responses. Not surprisingly, this group seemed to view the purpose of the assessment as complying with an order by the court rather than a source of help to them personally. Consequently these participants often seemed to find less that was helpful in the assessment than did participants who had come for other reasons. This finding is consistent with studies that show that those who entered therapy driven by ‘should’ or ‘must do’ received less benefit than those who had been self-motivated to go (Bohart, 2000). Similar guardedness and lack of trust were also commonly seen in the young people who had experienced assessment at forensic settings in Ellis’ and France’s (2012) study.

Lastly, as all the participants recruited in this study were Māori, or had at least one Māori parent, it was important to include a cultural context to participants’ accounts in this
study. The analysis shows that for some participants, cultural values informed their preferences for particular approaches in the assessment and their perceptions of its value. Nevertheless, as noted by Durie’s (2005) literature, not all Māori participants preferred the same service or health approaches. Therefore it was important to recognise the diverse cultural preferences participants brought with them to the mental health settings.

It is important to recognise this diversity in the participants and the way that this provided contexts to their specific perceptions during the assessment or during the interview.

**Key Findings**

The main findings of this research are organised around the three phases of the assessment process, namely before the assessment, during the assessment, and after the assessment.

**Before the Assessment**

**Concerns and expectations.** The thematic analysis suggests that the young people might have experienced a range of negative or unrealistic expectations about the assessment process prior to engaging. Common feelings included nervousness, and worries around getting into trouble or being judged. Some uncertainty was expressed by most of the young people before attending the assessment. Many described having little knowledge about mental health services and had difficulty picturing what the initial assessment session would
be like. However, regardless of whether they had previous knowledge of mental health services or not, most of the young people seemed to have formed some preconception of the assessment. Some of the young people seemed to base their perceptions on popular images. For example, they expressed ideas that the clinic was a place where people got locked up or where doctors would carry out examinations of them to see ‘what was wrong with them’, rather than envisaging a more collaborative process. This was consistent with what was found in other psychotherapy studies which suggested that young people often use media portrayals to shape their expectations of mental health services (e.g. Bury et al., 2007; Midgley et al., 2014). These expectations may exacerbate young people’s fears about the assessment (Bury et al., 2007).

Participants also brought their fears and anxieties from previous encounters with adults in authority. This was particularly common amongst those referred for forensic reasons and who related the assessment appointment to previous experiences of engaging with police and justice services. These participants had the expectation they were likely to get into further trouble.

Bury and colleagues (2007) have described a range of other factors that might feed young people’s concerns about engaging with a mental health service including life stress and mental health difficulties. From a developmental perspective, the common feature of self-doubt and concerns about self-image in adolescence may heighten the fear of being judged or examined (Richardson, 2001). These may contribute to young people’s concerns
prior to coming to the assessment and it is important clinicians are aware of young people’s pre-assessment concerns. Clinicians who fail to identify these expectations could increase the risk of a breakdown early in the process of engagement (Midgley et al., 2014). As noted in the literature, the more negative the preconceptions that clients bring to their initial engagement, the more likely they are to terminate their involvement prematurely (Philips, Wennberg, & Werbart, 2007).

Nevertheless, in this study there were a small number of young people who talked about their hopes and positive expectations they would be given a space to talk and to be heard. They seemed to have more realistic expectations around receiving advice and strategies to help them get through their difficulties, while recognising that talking might not be easy. This small number of participants had previous experiences of receiving help, including successful counselling. This is consistent with Bury and colleagues’ (2007) finding, suggesting those with previous and successful experience of receiving help, are more likely to have positive expectations of current help-seeking.

**Powerlessness.** This analysis suggested that young people experienced limited agency and relative powerlessness in the referral process. Many believed that they had no choice but to attend the appointment and were not in a position to control or challenge the referral process. While for the young people who had been referred to the forensic service this lack of choice may have been an inevitable part of the process, those referred by different routes also seemed to experience similar levels of powerlessness. The lack of
power that young people felt in this study was shown most clearly in the way they talked about not being informed about the arrangement of the appointment, not being told about the meeting time and feeling confused about the purpose of the assessment, but being afraid to ask. As Binder and colleagues’ (2011) study suggested, young people experienced more ambivalence about mental health services when the service had not initiated direct contact with them or fully informed them about the process. Young people’s experience of this powerlessness in the initial engagement with mental health services needs to be understood in the context of being a patient and a young person facing the authority of health professionals, court judges, parents and other adults who often make decisions on their behalf. The lack of power that clients might experience is also reflected in the literature on adult Māori clients, who often experience disempowerment about their choices in mental health services (Durie, 1999). The social disadvantage of Māori can also increase their sensitivity towards a power imbalance and the lack of opportunity to participate or influence the assessment process.

The need for active client involvement in therapeutic encounters is consistently emphasised in literature focused on adult clients (Bohart, 2000; Bohart & Tallman, 1999). This may be an important issue for young people who are recognised to be particularly concerned about their independence and autonomy (Lerner & Steinberg, 2009). According to the literature on client agency, when young people felt there was a power imbalance, they were seldom able to challenge the clinician directly. Instead they
used covert resistance and disengagement as a way to express their feelings (Bury et al., 2007; Gibson & Cartwright, 2013). Māori young people might feel particularly powerless to challenge the authority of adult clinicians as the importance of respecting older people is emphasised in Māori cultural collectivist norms (Durie, 1997). While young people may appear compliant during the process of assessment this may reflect in guarded responses. This may have been the case for participants in this study who appeared to assert their agency covertly through ‘boredom’, impatience, and withholding personal disclosure.

Attention should therefore be paid to the relative powerlessness experienced by the young person in the early stages of the assessment process as this can hinder the engagement through the assessment (Stinger et al., 2010).

The importance of information sharing. The importance of information sharing was repeatedly mentioned by the young people throughout different phases of the assessment but was seen to be particularly important in the pre-assessment phase. When comparisons were made between the young people who seemed to have more positive expectations of the assessment and those who felt more negative, the quality and quantity of information they had prior to the assessment, and from which information provider it was received, seemed to be important factors. In this study some of the young people noted they had been given information from health professionals such as nurses from an emergency department or a cultural advisor prior to the appointment. Where this occurred the participants appeared to be better prepared with somewhat with more realistic expectations.
and a positive view of what would take place at the first meeting and how the service could benefit them. Unfortunately, not all young people in this study received this support or introduction prior to their appointment, and many referred from the community who had heard about the appointment from their family members, described receiving little information about what the service would entail. This desire to be given accurate information about how the assessment would be conducted, continued into the assessment itself. Participants expressed their preferences for having things explained to them earlier in order to be prepared for what would happen such as changes in their clinicians or not being notified about family members joining the session.

This finding is consistent with research that identified information provision as an important factor in service users’ engagement (Papworth & Walker, 2008). This is a particular concern to Māori service users whose participation in health services depends on effective information sharing with those running the service (Durie, 1999). Involvement from cultural advisors as early as possible has also been repeatedly emphasised as a positive introduction to mental health services in Māori literature (Durie, 1996).

In this study families were not always effective in conveying information to the young person about the assessment. This is consistent with the literature that suggests family may not function as an effective agent to deliver information about mental health problems and services. The general public, including families differ from experts in their beliefs about mental health disorders, and these attitudes can often hinder appropriate help-
seeking (Jorm, 2000). The service should recognise that leaving the task of notifying the young person to family members may not be enough to prepare young people to attend a mental health assessment. A lack of information may increase young people’s anticipatory anxieties about the nature of the mental health assessment.

**During the Assessment**

**Revising preconceptions.** The thematic analysis suggested that the initial experience of the assessment process might be dominated by young people’s anxieties and concerns to protect their own autonomy. In their initial encounter with the clinic, the participants described themselves as actively making sense of the situation in which they found themselves, observing the new environment and being highly attentive to how their clinician acted towards them, both verbally and non-verbally. In an unfamiliar situation and with little opportunity to exercise agency, the participants seemed to adopt a cautious and watchful position in relation to the assessment process. Once they were physically present in the clinic, participants seemed to go through a process of revising their preconceptions in the light of the reality. In most cases they explained how the actual experiences through interaction or observation, helped to disconfirm their concerns. For example, the experience of ‘talking to someone’ in a comfortable space replaced more frightening thoughts about hospitals or police. It seemed that confronting the reality of the assessment setting was less frightening than some participants had anticipated. Some seemed reassured
by this and their uncertainty and worries were gradually diminished.

However, given the challenges to the young person’s power in the referral process, it is not surprising that many appeared to continue to feel somewhat wary of what it might mean to subject themselves to an unfamiliar environment with a new service. Westra, Aviram, Barnes and Angus (2010) stressed the important role of disconfirming negative expectations in psychological services. Their study suggests that successful engagement for clients frequently involved a process of disconfirmation, such as being surprised to find out psychological services were collaborative, or that they had the right to make decisions during the process (Westra et al, 2010). It may be that the unexpected discovery that something was better than expected made this experience more powerful and memorable for the participants in this study.

**Developing a relationship.** Many participants described how they felt shy and awkward about meeting the clinician, an adult stranger, in the first session. Most seemed to take some time to develop a relationship with the clinician. The initial difficulty in establishing trust in the clinician is well recognised for young people undergoing psychological services but increasing rapport can be assisted by clinicians’ responses to this challenge (Binder et al., 2011). Participants in this study identified aspects of the clinicians’ behaviour that had facilitated their gradual engagement.

One of the aspects that facilitated clients’ comfort appeared to be when the clinician responded in ways that were contrary to stereotypes of professionals as formal, authoritarian
and task oriented. The young people spoke about valuing that clinicians had ‘come down’ to their age level, had felt more like a friend, used words that were easy to understand and used humour. This is similar to Gibson and colleagues’ (2015) study that found young people valued a ‘friendly’ rather than professional relationship with the clinician.

The findings of this study also suggest that young people appreciated the lack of hierarchy in their relationship with adult clinicians and the efforts the clinicians made to help the young people feel more at ease. This seemed to help balance the unequal power relationship between the young person and the clinician. This is consistent with literature that emphasised young people’s need of an equal relationship with a clinician before they are prepared to participate in any psychological engagement that requires deeper processing (Binder et al., 2011; Bury et al., 2007; Gibson & Cartwright, 2014).

Some young people also spoke about the importance of being understood. This was not only limited to clinicians’ ability to register the detail of their stories, but also their ability to grasp how the young person was feeling even when this was not openly expressed. Further, they appreciated the empathy shown by the clinician, shown through their softened tone of voice to match with young people’s distress. Even those young people, who could not quite pin down the aspects that facilitated a positive experience during the session, alluded to the kindness and genuineness of the clinicians. Young people also seemed to value the patience of the clinicians that gave them time to warm up in the session. To the young people this seemed to indicate that the clinician understood their anxieties and
insecurities about coming to the assessment. The need to feel heard and to feel understood concurs with other findings in the literature that suggest adolescents desire a deeper connection with their clinician (Buston, 2002; Gibson & Cartwright, 2014). This allows them to feel important, less alone, and hopeful (Jonas-Simpson, 2001; Larsen & Stege, 2010; Shattell, McAllister, Hogan, & Thomas, 2006). Research also suggests that engagement is more likely to increase when adolescents feel their clinicians are empathic (Buston, 2002).

The findings in this study indicated that young people value the relationships formed with the clinicians. Graham (1997) suggested that young people typically focus more on a good relationship with the clinician as being most helpful to their engagement, and comparatively less on techniques or specific tasks during the session. This fits with the young people’s developmental stage, in which establishing and maintaining relationships is particularly important (La Guardia & Ryan, 2002). Research has noted that a person-to-person level of interaction, with greater reciprocity, may be more likely to preserve young people’s sense of autonomy, help them contain their concerns and anxieties, and form positive therapeutic alliances (Buston, 2002; Hartzell et al., 2000). Relationship building is also particularly crucial in working with Māori clients and family particularly during initial assessment as it builds a platform for ongoing engagement (Pomare, 2015).

Not surprisingly, young people’s accounts in this study suggested that where the relationship with the clinician felt unequal or less ‘real’, this impacted negatively on
participants’ experiences of the assessment. The young people talked about their dislike of clinicians being like a ‘doctor’ or ‘police’, using jargon, and rushing through multiple questions. Participants also seemed less positive about clinicians who they saw as just ‘doing a job’ rather than wanting to relate genuinely with the young people. Other researchers have noted that where the clinician fails to respond to the client’s needs as a person this can impact negatively on the outcome of the engagement (Bury et al., 2007).

The process of opening up. The young people’s accounts in this study also revealed that ‘opening up’ to someone in a mental health setting, during the first visit can be a complicated process. Most of the young people in this study spoke about finding it difficult to talk openly about their problems with clinicians to start with. Some referred to their limited experiences of ‘opening up’ to other adults in their lives. Some spoke about needing time before they felt able to disclose more about themselves to the clinician. It seems that once the young people began to open up, their clinicians responded helpfully with acknowledgement, reflection and affirmation which encouraged clients to continue to open up. Overall, most of the young people were able to talk and reported positive experiences of ‘releasing’ feelings and thoughts they had not previously shared. There are recognised benefits to being able to talk openly in an assessment. Research suggests that young people in particular appreciate being given room to talk and reflect on their issues (Hartzell et al., 2000); Oetzel & Scherer, 2003). In addition, Kelly, Klusas and von-Weiss (2001) suggest that revealing secrets can be beneficial experiences. While the process can
help people gain new insight this finding suggested people feel better for simply attempting catharsis by releasing the secret.

In Māori culture one of the base values of forming or restoring a secure identity lies in providing space for people to talk about themselves (Durie, 1999). Māori literature also recognises that the ability to express oneself freely is key to mental health recovery (Lapsley, Nikora, & Black, 2002). This appears to be the case for many in this study, where the process of ‘opening up’ was a positive experience for many of the participants.

There appeared to be particular challenges for young clients in talking openly in front of their parents. They explained that it was uncommon for them to talk to their parents about their issues, and also they worried how their parents would respond emotionally knowing about their difficulties. The mixed views on family involvement in therapy with young people have been shown in other research in this field. For instance, while some research highlights the importance of family involvement in therapy for young people (Adolescent Health Research Group, 2004; Hartzell et al., 2009), other research has reflected young people’s concerns about confidentiality and their discomfort in relation to parents being involved in the process (Collins & Knowles, 1995; Gibson & Cartwright, 2014).

Nevertheless, in spite of experiencing some initial difficulty with talking in front of their parents, some of the participants in this study described benefits of having their families involved in the assessment, such as discovering support and care from family members.
members. This disconfirmation of their concerns appeared to have facilitated further family discussion to develop collaborative ways to support the young person. This is consistent with Pomare’s (2015) study suggesting the benefit of active whānau (family) involvement as one of the key aspects of health for Māori as it recognises the cultural importance of a sense of belonging and collective wellbeing.

**Integration of Māori culture.** Young people in this study reflected on the significance of Māori culture in relation to all phases of the assessment process. The majority of young people had a cultural support person joining the assessment session(s) and, in most cases, introducing Māori cultural practices into the session including a prayer, karakia as an opening and at the end. These practices were experienced as familiar and comforting to many of the participants in this group. The young people in this study also seemed to notice when a cultural practice was not consistently followed through, for example, having a karakia at the beginning but not at the end of the session. While few participants experienced sharing food, some thought that this would have made them feel more comfortable sharing food with clients during the assessment. This is consistent with Māori practices where people eat together before discussing serious issues. These correspond with Māori literature that emphasises cultural integration in clinical practices (Durie, 1999), and the importance of clinicians respecting the cultural values of the clients (National Health Committee, 1996). The tikanga incorporated into the mental health assessment was seen as a valuable component by at least some of the young people, and
supported the notion of cultural integration in clinical practices (Durie, 2005; Manna, 2003; Nairn, 2007).

There was some variation in the preferences of the ethnicity of the clinician, with inconsistent preferences between Māori and non-Māori clinicians. Some young people preferred a Māori clinician, while others were not concerned about the clinician’s ethnicity. One participant gave a detailed explanation of how some features common in Māori people may be what made her less comfortable with sharing information with a Māori clinician. Although this view was an exception in broader sample, this participant’s perception did underline the importance of not making assumptions that young Māori clients would prefer a Māori clinician. It is noteworthy that no clients in this study talked about been given a choice in relation to the ethnicity of the clinicians they were assigned. Much of the existing, relevant literature suggests client preferences for a cultural match with clinicians (e.g., Chen, Fryer, Phillips, Wilson, & Pathman, 2005; Malat & Hamilton; 2006; Turner & Maothei, 1986). However, one should not assume or impose stereotypes as there should be a balance between cultural grouping and personal preferences. Durie (1995) pointed out the risk of assuming that individuals move in “particular ethnic or cultural directions when in fact they may have quite different inclinations” (p. 465). Individuals should be given a space to articulate their own positions with the recognition that Māori people may have different preferences and priorities depending on their developmental stage, situation, experiences, attitudes and values.
The findings in this study suggest that while Māori young people respected Māori values around health and recovery, these values were often perceived as being unmet in their mental health services’ experiences. The significance of the Treaty of Waitangi has been repeatedly emphasised in the literature and guidelines, including the obligation of participation, informed decision-making, power sharing, and partnership between the Māori young person and the health professional or service who may be of a different culture (Herbert, 2010). However, the participants in this study reflected on gaps in information and a lack of control and opportunities to negotiate or to voice their preferences. This highlighted that what has been advocated in the health system for bicultural practice, may not always be transferred to clinical practices with young people in mental health settings.

After the Assessment

Some previous studies have explored what young people might take away from a therapy process (Bury et al., 2007), but very little is known about what they may take away from an assessment. This study suggests a range of possibilities for what a client might gain from an assessment. In some cases participants took away a sense of hope and comfort from their experience. There were also some who described experiencing substantial changes in their lives following the assessment and some who felt largely indifferent from the experience.

Hope and a sense of accomplishment. The feelings that were described by some
young people in the study included a sense of accomplishment once their assessment was completed. These young people talked about feelings of pride at having been able to participate effectively in the assessment. They also expressed a sense of relief and gratitude that they had been able to find the courage to talk about their problems in sessions, especially as this was not a usual experience for most of them.

Further, many young people in this study experienced the cessation of their assessment with a sense of being at the start of something promising, or at the beginning of something new. They talked about having appreciated the assessment sessions and their hope that this might lead towards more positive changes in the future, even with the acknowledgement that it might take time. Those who were about to enter a treatment programme also expressed hope and trust about how the treatment might be able to help them. The findings suggest that this initial contact with a mental health service can help to set up positive expectations of services that might last into the future.

In earlier psychotherapy studies, young people were typically found to experience sadness, loss or ambivalence after completing therapy (e.g. Bury et al., 2007). These emotional responses were not found in this study, suggesting that the process of ending assessment is less complicated than ending therapy. This may be because of the relatively short duration and limited opportunity to form a relationship with clinician.

Mental health recovery can often be a long term journey, and does not end with the assessment phase. However, the hope and trust established in this phase may be extremely
beneficial to young people’s motivation to engage with recommendations that may include some sort of intervention. Research on mental health treatment emphasises that a willingness and openness to therapy is an important indicator of a client’s probable engagement in the actual treatment and its subsequent outcomes (Bury et al., 2007). Therefore completing an assessment with a positive expectation of help may be a valuable starting point for other therapeutic engagements. This is especially pertinent with adolescents’ relatively high ‘drop out’ rate in treatment compared with other age groups (Philips et al., 2007). Increasing adolescents’ willingness to come back to the service is a high priority.

**Therapeutic changes.** Several young people in this study talked about the changes they observed in themselves and aspects of their lives following completion of the assessment process. They talked about gaining more understanding of themselves and a new perspective on their lives, behaviour and the future. This suggests that even in a small number of assessment sessions, clinicians can facilitate clients’ reflection on their lives. This is consistent with literature pertaining to adults that suggests such reflexivity allows clients to explore reasons behind their behaviours and often leads to positive changes (Rennie, 1992). In adolescence, where the developmental emphasis is on self-understanding, this experience of self-knowledge and transformation may be particularly valuable (Oetzel & Scherer, 2003). This study highlights the potential for an assessment session to activate reflexive processes that lead to changes in the lives of young clients.
In addition to self-knowledge, many young people in this study also highlighted some interpersonal changes they noticed after the assessment, including better communication and expression of emotion in their interactions with family and peers. They also noted reduced conflict and greater support within their families. While not all participants could explain how these changes occurred, they attributed these changes to attending the assessment. Quantitative research has suggested a different type of assessment, with specific structure or design (e.g., therapeutic assessment, Ougrin, Ng, & Low, 2008), can provide significant increases of hopefulness and a decline in symptomatic distress post assessment for young people. While this type of assessment may be different from the usual assessment, the results indicate recovery could start in initial phases. However, no previous qualitative research in the field of young people’s experiences had explored perceived changes for young people post assessment. With no existing data to make comparisons it is slightly difficult to draw conclusions about this finding. Nevertheless, this study showed young people made connections of the positive changes in their lives to the experiences at the assessment. This finding suggests the initial phases of receiving support from a mental health service may be an important, unacknowledged part of recovery.

**Feeling indifferent.** Not all the participants in this study found the assessment process helpful. A couple of participants seemed to have continued feeling mistrust towards the clinicians and maintained their guardedness throughout the assessment. These young
people found the process boring and tiring and seemed to try and answer questions in such a way to not disclose their private worlds. While most young people in this study seemed to have taken something away from the assessment sessions, this small number of people said they could not see any purpose or benefit from the assessment process. They talked about simply returning to their normal life.

Only one participant described a negative reaction to the assessment. He became very angry during the assessment and thus the session was stopped partway through. This incident made the participant unhappy for the rest of the week. This exception suggests how a difficult mental health assessment experience could also significantly impact on a young person – in this case negatively. However, this participant’s view was unusual in this study. Nevertheless, this single experience suggests the need for further research that explores the potential for negative experiences to occur in mental health assessment, especially as these are likely to be under-represented in a sample who volunteered to talk about their experiences.

Implications

Service users’ viewpoints and experiences provide a valuable source of evidence on which to base clinical practices (Bury et al., 2007). Given that young people can provide useful information of the processes of clinical practices, in regard to areas of satisfaction or dissatisfaction, mental health services should provide more opportunities and space for
young people to express their views. This could occur in more visible mental health service feedback procedures such as client-based reflective sessions or outcome questionnaires. Given the difficulty young people have in expressing their views directly to clinicians, it may be that these views can also be gathered through focus groups run by people outside of the mental health service. These views could then be taken into account in the design of programmes and services.

As disempowerment may begin before the assessment starts, more attention should be directed towards the period between referral and the appointment date. The current procedures of the participating service in this study and other similar services are to send a formal letter notifying the family of the appointment. It may, however, be useful for clinicians or cultural advisors to contact the young adult directly, to introduce their roles and explain what to expect in the appointment. Opportunities could also be given for young people to voice their concerns openly. In this way their fears could be normalised, their questions could be answered, and young people could be given more accurate information about the assessment session. While power imbalances between young clients and adult clinicians will always be present, access to more information prior to their assessment may allow young clients to feel a greater sense of control over a potentially frightening experience. This practice could also help to address issues such as unrealistic expectations early in the process.

Involving family members at this stage may be important as they can be the people
who deliver messages to young people about the appointment, and sometimes young people may express their fears and concerns to their family rather than to the clinicians. Educating adults on the purposes of assessment and how they could assist young people to prepare for the session in a supportive manner might also facilitate the provision of more accurate and helpful information to the young person. The cultural advisor’s role is potentially a very valuable one for young Māori; facilitating an accurate understanding of the assessment and providing support and encouragement prior to the assessment.

From the beginning of the assessment process, clinicians should prioritise building trust and alliance and make attempts to actively address young people’s concerns or fears. Busy clinicians should be aware that if they rush too quickly into information gathering due to time or work pressure, this may increase the risk of disengagement if young people’s concerns and disempowerment remains unaddressed (Wilson & Deane, 2001). To ensure effective engagement clinicians also need to acknowledge the developmental priorities of young people that influence their engagement with adults (Bury et al., 2007). From young people’s accounts in this study, patience is crucial in the initial stage, giving them time to warm up; with recognition that opening up is a gradual process.

Clinicians also need to bear in mind that developing a genuine relationship with the young person in the assessment process is important. This involves being friendly, informal and engaging in ways that are appropriate to young people’s age and level of understanding. Clinicians should avoid jargon and asking too many questions. They also need to be aware
that young people may feel bored, as there are not many occasions where they are required
to concentrate in an intense emotional experience for one or two hours. Breaks could be
given without necessarily waiting for young people to initiate these.

Services could also consider providing refreshments at the beginning or during
breaks, as this gesture can provide young people, particularly Māori who associate the ritual
of kai, with a sense of being respected and considered.

Respect can also be shown by being transparent about the process of the assessment,
informing young people about what will happen and involving them in decisions which
affect them. Treating young people as equal participants in the assessment process has
important implications for their sense of trust and experience of agency within the
assessment process.

While there were some common themes emerging from young people’s accounts of
their experience of mental health assessment, it was clear that there was also considerable
diversity in their views, reflecting their unique contexts and priorities. Clinicians should
take time to understand their individual preferences and values and avoid making
assumptions about what any young person might prefer.

Clinicians are encouraged to seek feedback throughout the session, as this promotes
collaboration and helps clinicians adjust to meeting young people’s unique needs (Williams
& Levitt, 2007). However, they need to recognise that young people may experience
difficulties in conveying their views within the assessment session because of the power
differential between them and the clinician. Furthermore, clinicians need to be aware of the contexts that may constrain young people’s engagement or openness to assessment. This includes being aware of the systems or other agencies that were involved before the referrals. These may have left young people feeling they have lost their rights to voice their views. It is important for clinicians to remain alert to their young clients’ less direct ways of expressing dissatisfaction. For those clients that are cautious about voicing their views, clinicians could explore barriers to agency and reasons for resistance in a transparent and open way.

While for the clinician the focus of assessment is information gathering and treatment planning, they may be less aware of the meaning that this experience carries for young clients. From the accounts of young people in this study, it is possible that assessment may be seen more as a form of intervention in itself. The assessment can provide them with a sense of hope which will affect their willingness to engage with mental health services in the future. It also may be seen as a source of improved self-understanding and positive change in their relationships. Services that recognise this fact will be likely to put more effort into the relational aspects of the assessment, aiming to provide a supportive and respectful environment for young people, rather than simply focusing on obtaining information on young people’s symptoms and problems.

Lastly, this study delivers research implications. There is insufficient Māori research available and one of the challenges is the difficulty of recruiting and engaging with Māori
participants. This study applied a great amount of effort to facilitate a culturally appropriate recruitment and data collection process, including a close collaboration with cultural advisors through the entire research, participation in cultural events, and utilisation of tikanga such as karakia and kai, or locations such as the Māori clinic centre and marae. With these important aspects, this study run by a non- Māori, successfully recruited and interviewed 16 Māori young people. This study encourages researchers from any ethnic group to emphasise cultural practice when working with Māori participants in order to effectively generate more Māori literature that is significantly needed.

**Limitations**

The findings of small scale qualitative research, as in this study are not intended to be generalised to broader populations. The aim instead was to deepen our understanding of how the assessment process was experienced by a small group of Māori participants who were mostly recruited by the cultural advisor at the CAMHS or YFS. Therefore to be meaningful, this data needs to be interpreted in that particular context. While the findings from this study may have some relevance to other similar contexts, if theoretical generalisations are taken from this study and applied elsewhere, consideration needs to be given to whether cultural settings, expectations of young people and the forms of assessment are similar.

The sample size was relatively small, partly because the recruitment process of
participants was highly challenging. The recruitment relied on clinicians, cultural advisors and advertising the project, as direct access to participants was limited due to the sensitivity of the setting and confidentiality issues. Nonetheless the sample size was consistent with most qualitative studies (Morrow, 2005), and the fact that the participants offered many similar responses suggested that saturation may have been reached (Guest et al., 2006).

A recruitment process that relied heavily on other personnel also meant the findings may have been affected by this selection method. Although clinicians invited all clients who fitted the criteria to participate in this study, it is possible that they tended to give information to those with whom they had a good relationship and also that those who volunteered had experienced a better relationship with the service. In the case of those who were recruited by cultural advisors (the majority of participants), there may have been an established cultural tie. Thus, the findings cannot be taken to represent the perceptions of all young people undergoing assessments at mental health settings as it is likely that this sampling method may have attracted those more likely to be positive about their assessment process than those who felt disengaged from it.

Nonetheless, a number of factors do strengthen confidence in these findings, including a balanced number in the gender of participants and the inclusion of participants from both forensic and community based settings. As well, this study included one participant who had ‘dropped out’ halfway through the assessment. This interview provided information about what contributed his disengagement. While including participants from
different settings may have introduced contextual differences into the research, this reflects

the diversity of mental health clients that often come with different purposes and referral

sources. In spite of these differences, the commonalities in the accounts of participants also

suggest some features of their experience were similar.

It is important to be mindful that the interviews were a communication of experience

in a specific timeframe and interview context between the adolescent and an adult with a

background in psychology. There were also other potential power imbalances such as those

between research interviewer and interviewee, or between Māori and non-Māori that

influenced this interaction. Despite on-going efforts to reduce power imbalances, it is likely

that these shaped participants’ accounts in particular ways. Other researchers may have

elicted different stories from participants, or given different interpretations to the

transcriptions. As I myself belong to a cultural minority in New Zealand, I may have

introduced my own preconceptions about young Māori clients’ preferences and experiences.

My interpretation could have also been influenced by clinical judgment or theoretical

knowledge given my background in psychology and as an adult. Thus throughout the

research process I made use of self-reflection and discussions with my supervisor and

cultural consultants, to ensure any preconceived and personal interpretations were reduced.

Such forms of reflexivity are important in qualitative research (Parker, 2004).
Suggestions for Future Research

This study explored the experiences of a group of young people undergoing assessment at mental health settings. As this has been a rarely studied topic, further research in this area would be useful. Given the rich and broad range of themes found in this study, further research could benefit from focusing on a smaller number of ideas and exploring these in greater depth. For example, it might be valuable to explore the powerlessness at pre-assessment phase, or the sense of hope young people experienced at the end of assessment. It would be useful to study the experiences and perceptions of young people who have undergone a mental health assessment in different referral and service contexts and cultures. Future study could also involve parents’ perspectives and experiences of their children’s assessment process, in order to better understand how clinicians could better involve family members in this process.

Similar research to this study could be conducted by collecting data at the time of the assessment rather than retrospectively, as this could provide a deeper exploration of particular phases during the initial assessment.

More research on Māori people’s experiences of mental health, especially during adolescence, requires on-going attention. Future studies could consider in more details of the range of ways that Māori culture could be more appropriately included within the assessment process and how best to work with the diversity of cultural preferences in this group.
Lastly, it is important to note that not all the participants in this study found the process of assessment helpful and almost all of them found it stressful at times. This reinforces the need for research about the more negative as well as positive experiences of young people in mental health services. The experiences of young people who dropped out from services or felt negative towards the clinicians, needs to be better understood, as they could provide insight as to what disrupted trust or engagement during their sessions.

**Conclusion**

This research has shown that young people can provide thoughtful accounts of their experiences of psychological help. From the interviews, it was clear that the young people in this study were capable of articulating their views on the assessment process. They were able to offer a range of thoughtful insights, and sometimes rich accounts of their experiences. This finding is consistent with existing research on young people’s perspectives (Binder et al., 2011), suggesting that young people are actively engaged with reflecting on their experiences during their encounter with service providers.

This study has pointed young people bring a range of hopes and concerns to the initial assessment, influenced in some cases by their relative lack of power in the referral process. Providing realistic expectations and accurate information before the assessment and throughout the sessions may be particularly important. With initial feelings of insecurity and fear, young people were particularly sensitive and attentive to their
environment and the clinicians and attempted to retain their agency in indirect ways. While some remained guarded throughout the assessment many young people tended to go through a process of preconception revision where their concerns were reduced.

Clearly, the quality of the relationship with the clinician was one of the most important issues in facilitating young people’s engagement and trust in the assessment process. Young people appreciated having an equal relationship with clinicians, through being respected, given time and space to warm up, or being communicated with in language appropriate to their age. They also appreciated feelings of understanding and kindness conveyed by the clinicians. While talking openly with a stranger about themselves might have been challenging and uncommon, these young people were able to gradually do so when given appropriate space and affirmation by the clinician. Similarly, the gradual discomfort and worries for young people about disclosing their difficulties in front of their parents appeared to change to a beneficial experience for the young people.

These young Māori were aware of Māori practices incorporated into the assessment and many appreciated this. While cultural integration was seen as valuable, it is important not to assume that all Māori would share the same preferences for a Māori clinician or for Māori practices. Finally, a supportive assessment can allow young people to feel hopeful about seeing positive changes in the future. Findings from this study indicated that assessment sessions may be able to provide some therapeutic benefit for young people in areas such as self-knowledge, mood, and other interpersonal changes, including family and
peer interaction. These young people attributed these positive aspects to the assessment process.
References


*Work, 23, 21–39.*


Bohart, A. C. (2000). The client is the most important common factor: Clients' self-healing capacities and psychotherapy. *Journal of Psychotherapy Integration, 10*(2), 127-149.


Ellis, P. M., & Collings, S. C. D. (1997). Mental health in New Zealand from a public health...

Dropping out of mental health treatment: Patterns and predictors among 
epidemiological survey respondents in the United States and Ontario. *American 

of Social Work* 3, 321–337.


Feehan, M., McGee, R., & Williams, S. M. (1993). Mental health disorders from age 15 to 
age 18 years. *Journal of the American Academy of Child & Adolescent Psychiatry*, 
32(6), 1118-1126.


21-year study. In S. S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the*
context of childhood adversities (pp. 130–155). Cambridge: Cambridge University Press.


Health Advisory Service. (1995). *Together We Stand. The Commissioning, Role and*
Management of Child and Adolescent Mental Health Services. London: HMSO.


Kristinsdóttir, G. (2004). I have been very pleased being in foster care, but ... Young people’s experience of long-term foster care. *Journal of Child and Youth Care Work, 19*, 148–158.


Children, permanent parents, and other supportive adults talk about the experience of moving from one family to another. *Journal of Family Studies, 10*, 205–219.


Patterson, G. R., & Forgatch, M. S. (1985). Therapist behavior as a determinant for client


Potter, R., Holmes, P., & Barton, H. (2002). Do we listen or do we assume? What teenagers


Sage.


the Juvenile Justice System. Delmar, New York: The National Center for Mental
Health and Juvenile Justice.


empirical assessment. *Australian & New Zealand Journal of Criminology, 41*(2),
216-235.


in-depth interviewing. *Sociology, 29*(2), 241-256.


Wellington, NZ: Ministry of Justice.

Children and Young people*. Chichester: John Wiley & Sons.

Stasiak, K., Parkin, A., Seymour, F., Lambie, I., Crengle, S., Pasene-Mizziebo, E., & Merry,
S. (2013). Measuring outcome in child and adolescent mental health services:
Consumers’ views of measures. *Clinical child psychology and psychiatry, 18*(4),
519-535.


Goals, techniques, clinical utility, and therapeutic value. *Journal of Personality Assessment, 90*(6), 547-558.


Appendix A
Participant Information Sheet

Project title: Young people talk about their experiences of sessions at the [CAMHS].

Principal Investigator: Name: Dr Kerry Gibson
Role: Senior Lecturer / Clinical Psychologist
Address: Tamaki Campus, University of Auckland, Private Bag 92019, Auckland 1142
Contact Phone No: (09) 373 7599 (ext: 88556)
Email: kl.gibson@auckland.ac.nz

You are invited to take part in a research study about young people’s experiences of sessions at the [CAMHS].

Please take your time to think about it and decide whether you wish to take part. Taking part is completely voluntary (your choice) and if you decide you do not wish to take part, it will not affect your continuing healthcare in any way.

What is it all about?

- We are doing some research on how young people (aged 13 – 18) find the experience of having sessions at the [CAMHS]. We are interested in hearing your stories about what this was like from your perspective. We believe that having more information on how young people experience sessions and gain support would help counsellors to meet young people’s needs better.
- If you have had one or more sessions at the [CAMHS] in the last year and are between the ages of 13 and 18 you would be eligible to take part in the study. We need about 40 people to take part.
- The study will be conducted over a period of three years.

What happens during the study?

- If you are eligible to take part in the study we would like to interview you for about one hour about your experience of having sessions at the [CAMHS]. Interviews will be held at the [CAMHS], the University of Auckland clinic, your home, or another location that we have agreed together. We will contact you to arrange a good time for you to do the interview, and make sure that it does not conflict with other commitments you may have.
- If you are under 16 you will need your parents’ consent to take part in the study, otherwise if you are over 16 you can make the decision on your own. You (and your parents where applicable) will need to sign a consent form to say that you agree to take part in the study.
- During the interview we will ask you to tell us about your experience of having
sessions at the [CAMHS] in your own words. We will audio-record this.

- We would also like to conduct a follow-up interview with you approximately one month after the first interview to check whether there is anything else you would like to add about what your experience of sessions at the [CAMHS] was like. This would be conducted in person or over the phone. It would take about 30 minutes depending on how much you want to tell us.
- Later a written version of the interviews (a transcription) will be made. You will have a chance to look at the written copies of your interviews and make any changes that you feel are necessary.

What are the risks & benefits to you?

- The study is not a treatment, but rather a chance to talk about your experience.
- You will have the chance to talk about your own experience of having sessions at the [CAMHS]. We hope that this will be useful and interesting for you. You will also be helping professionals to get a better understanding of how to help other young people like you.
- Sometimes talking about personal things like counselling can make you feel upset as you think back to difficult times. If this happens we can help you to get some support if you need it. You can also stop the interview at any time if you are feeling distressed and/or do not want to continue.
- The researcher will make sure to check in with you throughout the study to see if you need a break or are feeling distressed. If needed they will put you in touch with agencies that can provide support. You will also be provided with some information to take home about where you can seek support if you are feeling distressed after the study.
- The study will involve about 2-3 hours of your time, and if not conducted in your home may require you to travel to the [CAMHS], the University of Auckland clinic or another mutually agreed location.
- Where applicable we will reimburse your travel and parking costs.
- We will give you a $20 mobile phone top-up as a way of thanking you for the time you have given to help us with this research.

Compensation

In the unlikely event of a physical injury as a result of your participation in this study, you may be covered by ACC under the Injury Prevention, Rehabilitation and Compensation Act. ACC cover is not automatic and your case will need to be assessed by ACC according to the provisions of the 2002 Injury Prevention Rehabilitation and Compensation Act. If your claim is accepted by ACC, you still might not get any compensation. This depends on a number of factors such as whether you are an earner or non-earner. ACC usually provides only partial reimbursement of costs and expenses and there may be no lump sum
compensation payable. There is no cover for mental injury unless it is a result of physical injury. If you have ACC cover, generally this will affect your right to sue the investigators. If you have any questions about ACC, contact your nearest ACC office or the investigator.

**Participation**

- It is up to you to decide whether or not you want to participate in the study. If you decide not to take part in the study this will not have any effect on future care or whether you can use the service again. Even if you do agree to be interviewed, you do not have to answer all the questions, and you can change your mind during the interview and decide to stop. If you decide you do not want your interview to be used in the research you have up to two weeks after the interview to let us know if you have decided to withdraw from the study.
- Participation in this study will be stopped if the researcher feels it is not in the participant’s best interests to continue.

**General Information**

- You may have a friend, family or whanau support to help you understand the risks and/or benefits of this study and any other explanation you may require.
- Once you express interest in participating in the study, you will be contacted by the researcher to organise a time and place for the interview. This will also be an opportunity for you to ask any questions about the study.
- An interpreter can be requested in the following languages if needed: Māori, Cook Island, Fijian, Niuean, Samoan, Tokelauan and Tongan.
- Depending on your preference, the interview may take place at your home, at a community centre, at the [CAMH] or at the Psychology Clinic at the University of Auckland’s Tamaki campus.

**Confidentiality**

- Your participation in this study is totally confidential and no material raised during the interview will be shared outside the research group. Some of the clinicians from the [CAMH] are advising us on this project, but they will not know that you are participating or get to hear anything you have said in your interview.
- We would like to write up the research findings so that people can learn more about young people’s experiences using the support services. When we write this up we will use quotes and examples from your interview but we make sure no material which could personally identify you will be used in reports on this study.
- All researchers are obliged to keep the transcribed interviews as well as the forms in which you have given your consent to take part in this research. We will keep these documents in a locked cabinet in the Department of Psychology for 10 years after your 18th Birthday and will then destroy them. The forms you have signed will be kept separately from the interview material so that nobody can identify you from the
Results

- The results of the study will be made available to you in a report that summarises the findings on young people’s experiences of sessions at the [CAMH]. These will be sent to you if you indicate that you would like to receive them. A full copy of the published results can also be made available upon request.
- The study will be published as part of a doctoral thesis and may also be published as academic journal articles.
- There will be a delay between the interview you take part in and the publication of the results.
- If you wish to know more about or discuss the outcomes of the study you can do this with the researcher.

Who should I contact if I have further questions?

If you have any questions about the study or would like to hear more about it, do not hesitate to contact the Principal Investigator, Kerry Gibson ph: (09) 373 7599 (ext: 88556). You can also text Kerry at [redacted] or email her at kl.gibson@auckland.ac.nz

If you have any questions or concerns about your rights as a participant in a research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone: (NZ wide) 0800 555 050
Free Fax (NZ wide):
0800 2787 7678 (0800 2 SUPPORT)
Email (NZ wide): advocacy@hdc.org.nz

For Māori health support at the ADHB, or to discuss any concerns or issues regarding this study, please contact Mata Forbes RGON, Māori Health Services Co-ordinator / Advisor, 5th Level, GM Suite, Auckland City Hospital. Tel 307 4949 extn. 23939 or Mobile 021 348 432

This study has received ethical approval from the Northern Y Regional Ethics Committee.

Please feel free to contact the researcher if you have any questions about this study.

Thank you for making the time to read about, and consider taking part in this study.
# Appendix B
## Participant Consent Form

**Project title:** Young people talk about their experiences of sessions at

### REQUEST FOR INTERPRETER

<table>
<thead>
<tr>
<th>Circle one</th>
<th>English</th>
<th>Māori</th>
<th>Fijian</th>
<th>Niuean</th>
<th>Samoan</th>
<th>Tokelauan</th>
<th>Tongan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes: I wish to have an interpreter.</td>
<td>E hiahia ana ahau ki tetahi kaivahakaMāori/kaivahaka pakeha korero.</td>
<td>Ka inangaro au i tetai tangata uri reo.</td>
<td>Au gadreva me dua e vakadewa vosa vei au</td>
<td>Fia manako au ke fakaaoaga e taha tagata fakahokohoko kupu.</td>
<td>Ou te mana’omia se tasi e auai e fa’amatalaina upu i le gagana Samoa</td>
<td>Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na gagana o na motu o te Pahefika</td>
<td>Oku ou fiema’u ha fakatonulea.</td>
</tr>
<tr>
<td>No:</td>
<td>Ae Kao</td>
<td>Ae Kare</td>
<td>Io Sega</td>
<td>E Nakai</td>
<td>Ioe Leai</td>
<td>Io Leai</td>
<td>Io Ikai</td>
</tr>
</tbody>
</table>

- I have read and I understand the information sheet dated ________________ for volunteers taking part in the study designed to understand young people’s experiences using the services in the CAMHS. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.
- I have had the opportunity to use family/whanau support or a friend to help me ask questions and understand the study.
- I have had ample time to discuss with whanau/family and friends when a decision is required or when making a decision.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my treatment at the CAMHS.
- I have had this project explained to me by the researcher of the study.
- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
- I understand that the compensation provisions for this study.
- I know who to contact if I have any questions about the study.
- I know who to contact if I have any distress after the interview.
- I understand that I will need to obtain consent from my parent/caregiver if I am under the age of 16.
- I understand that the interview will be tape recorded and I will be given a chance to look at the written form of the conversation and make any changes.

I consent to my interview being audio-taped. YES/NO
I wish to receive a summary of the results. YES/NO
I would like the researcher to discuss the outcomes of the study with me. YES/NO

I, __________________________ hereby consent to take part in this study.

Signature __________________________ Date ________________

Project explained by __________________________

Project role __________________________

Signature __________________________ Date ________________

Interpreter (if needed)

I __________________________ translated the project to the participant

Signature __________________________ Date ________________

If the participant is under 16:

I, Parent/ Caregiver (print name) __________________________ hereby

consent for my child (print name), __________________ to take part in this study.

Signature __________________________ Date ________________
Appendix C

Interview Guidelines

The participants will be asked to participate in a semi-structured interview where a number of questions will be asked based upon the responses they provide. The interview will be conducted in the form of a conversation using prompts to assist participants to tell their own story in their own words. The researcher may ask questions to facilitate the participants account but will not direct the course of the interview as in this methodology the structure needs to be decided by the participant him or herself. The following open ended questions are anticipated to be used:

To start the interview participants may be asked questions such as:
- What brought you to the [CAMHS/YFS]?
- Tell me about your experience with counselling/assessment at the [CAMHS/YFS]?
- Tell me about the sessions that you had there?

As the interview progresses participants may be asked questions such as:
- What stood out for you as important about that experience?
- What was it like for you?
- What was your understanding of the session?
- What was the clinician like?
- What was helpful? What was not helpful?
- What is it you remember most about the experience?
- How did the process fit with your cultural views, practices or values?
- How did you make sense of that experience?
- What do you think was happening there?
- What did you like? What didn’t you like?
- What happened after the session?

Participants may be prompted to elaborate their accounts as well as to provide examples:
- Can you tell me a bit more about that?
- Can you tell me what happened in a bit more detail?
- Can you give me an example of that?
- What happened when you…
- What did you think of that?
- What was it like?

Provide minimal encouragement such as: Mmm… Hmm…; Ok; Yeah; etc.