

Towards quality Pacific services: the development of a service self-evaluation tool for Pacific addiction services in New Zealand

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Abstract

Objectives To describe the development and use of a quality improvement service self-evaluation tool within Pacific addiction services in New Zealand.

Methods The study involved two phases: (i) a development phase; and (ii) a testing phase. In Phase I, a preliminary tool was developed and piloted with two Pacific addiction drugs services. It was modified to reduce the number of statements, aligning the statements with the National Sector Standards and incorporating Pacific concepts, themes and motifs that underlie the practices of Pacific providers. In Phase II the resulting tool, named Potalanoa, was then tested in four Pacific addiction treatment services. All services provided feedback on the user acceptability and feasibility of the tool, usefulness and adaptability of the tool to specific service settings.

Results The participating services generally found the evaluation tool to be understandable, acceptable and useful. Each service provider demonstrated varied use or implementation strategies for Potalanoa with a general consensus that incorporating the evaluation process within existing team meetings would be ideal. The involvement of all staff within a group setting was also found to be an essential part of the process and a trained facilitator helped with the flow of discussion.

Conclusions The study found that there is a need for an evaluation tool for the provision of quality services. For Pacific services it was important that the tool recognize and capture the Pacific approaches utilized in their service delivery. Overall the tool was found to be acceptable and feasible to use, assisted services to identify areas of achievement and to prioritize areas requiring improvement and was adaptable to 'real world' Pacific addiction treatment settings in New Zealand.

Introduction

Pacific peoples residing in New Zealand are disproportionately represented in poor health statistics [1–5]. With respect to alcohol statistics, while the proportion of Pacific drinkers is less than the general New Zealand population, Pacific people are found to consume greater quantities of alcohol [6]. These drinking patterns are of concern, with greater proportions of Pacific people reporting

adverse outcomes, such as violence and injury from drinking compared with the New Zealand population [6]. To effectively address the poor health statistics of Pacific people, the New Zealand Ministry of Health has prioritized the need for 'responsive services' that 'focus on recovery, reflect relevant cultural models of health, and take into account the clinical and cultural needs of people affected by mental health and addiction' [7]. Accordingly, Pacific-specific alcohol and other drugs (AOD) services have been

established to reduce the health disparities of a population with cultural as well as clinical needs.

Recognition of the global paucity of ethnic specific health research for many indigenous and minority groups, has led to a wave of work in New Zealand to: articulate Pacific cultural values and beliefs; develop cultural competency frameworks; and describe the elements of what makes a Pacific-specific service unique [8–11]. Services catering specifically to this population need to acknowledge the importance of employing competent staff (both at cultural and clinical levels). Competent staff will understand the needs of Pacific consumers and their families; understand service management needs; have access to up-to-date information; and know how to assess and evaluate their service delivery [10,12]. While Pacific cultures are not homogeneous a uniquely Pacific style of service delivery may include the following elements: a holistic ethos of care (e.g. the ‘spiritual’ sits alongside the ‘physical’); recognition of coexisting spiritualities (e.g. indigenous and Christian); and use of Pacific motifs, language and hospitality practices [12]. For example, some Pacific AOD services employ a *Matua* (cultural leader) who can be called upon if required for cultural leadership or cultural supervision. The inclusion of these processes and styles allows both the client, their family and staff to be more at ease by offering ‘a familiar way of doing things’ [13]. The provision of such quality health care services is integral to improving health outcomes for Pacific peoples.

Organizational evaluation programmes and tools contribute to the quality assurance process by assisting providers to evaluate and monitor their service delivery, identifying strengths and areas where improvement is required [14,15]. The value of undertaking a self-assessment process is that it enables staff from all levels to be involved in quality improvement, as well as looking at the organization across its hierarchies [15,16]. It can create common language and systems for managing and improving an organization, integrating improvement initiatives into normal operations and enhancing the development of strategic planning. The process of self-assessment educates staff on quality and improvement and how these are related to their jobs. Using a structured tool allows for the sharing of ‘good practice’ in the organization and, where relevant can facilitate comparisons with other organizations [15]. In the main, these are concepts originating from quality management in the business literature. While a number of self-assessment tools and frameworks have been developed for the health sector [17–23], few accommodate cultural values, and none is specific to Pacific peoples services. A quality improvement tool for the assessment of Pacific-specific health services needs to incorporate a cultural framework that explicitly recognizes Pacific ways of knowing, learning and teaching about quality service delivery; a tool that can sit legitimately alongside the ways of others. The Ministry of Health report, ‘Making a Pacific Difference’, suggested that to measure the quality of a Pacific service, providers and consumers need to work together to identify those quality indicators [24]. The cultural characteristics include: the use of Pacific languages; the use of a variety of communication methods to convey information; recognition and encouragement of full family participation where appropriate; and sensitivity of the influence of the Church on Pacific health behaviours [24].

In this paper we summarize the development of a service self-evaluation tool to be used within Pacific AOD services in New

Zealand. The development of the tool comprised two phases: (i) the development of a preliminary tool; and (ii) testing to explore the acceptability and feasibility of using the tool with four Pacific AOD services across New Zealand.

Method

The study methodology comprised two phases. Phase I focused on the development and design of the preliminary tool, and Phase II was a testing phase using the tool in naturalistic clinical practice. The tool is available from the correspondence author, or at http://www.crrc.co.nz/reports/PADOPT_tool.pdf. Both phases are described in detail below.

Study setting

In the initial development phase, the preliminary tool was piloted by two public Pacific community alcohol and drug counselling services in Auckland. In the second phase the tool was tested with four services spread across New Zealand. At the time of the project all services held a contract with the Ministry of Health to deliver AOD services to Pacific peoples. Three services were non-governmental organizations and one was part of a district health board. All four provided free access to their AOD clinical service. The study was approved by the Ministry of Health Ethics Committees; Northern X (Phase I) (NTX/05/03/32) and Multi-region (Phase II) (MEC/07/11/161), New Zealand.

Phase I: development and design

The development of this evaluation tool was based on the lack of such a quality improvement tool for Pacific services to assess and monitor service outcomes. At the beginning of the project it was recognized that Pacific services were using site-specific tools to assess service and client outcomes, such as questionnaires and surveys. A specific tool for Pacific services, capable of capturing both clinical and cultural practices that would help the service monitor the quality of these practices, was identified as important [25]. Additionally, the tool needed to be able to: assess the practice of health care workers using a self-evaluation approach; draw teams together to understand how the work of each team member fits into the bigger picture of the service; encourage team spirit; assist with delivery issues; and compliment, rather than add to, already existing organizational requirements, such as regular external audits.

The tool’s content followed the format of existing tools, consisting of a list of statements or items describing ‘ideal’ service provision [17,26–30]. Items were selected for the preliminary tool with guidance questions incorporated to help focus participants in the assessment process. These items were drawn from assessment/evaluation tools identified from the literature, and with extensive consultation with the project advisory board and other key stakeholders. Alongside the preliminary tool, a readiness questionnaire was developed to help services evaluate their capacity to undertake a thorough self-evaluation process.

The method adopted to obtain consensus of the items was a triangulation process that involved input via meetings of (i) the researchers; (ii) an advisory board of Pacific experts (including

nurses, doctors, allied health practitioners¹, cultural leaders and service managers); and (iii) a reference group consisting of managers and team leaders of various Pacific services across New Zealand, to provide feedback on the validity of each statement. The expert panel members and reference group members were chosen based on their knowledge, expertise and involvement in the AOD and Pacific health sector.

Ultimately a total of 37 statements were included in the preliminary tool representing the following domains: (i) client and family involvement (statements 1–6); (ii) relationships with community and other agencies (7–12); (iii) responsiveness to staff (13–15); (iv) workforce development (16–22); (v) information utilization (23–26); (vi) service delivery model (27–30); and (vii) quality (31–37).

Participants in each group were asked to critique the suggested statements on the basis of their face validity and usefulness in the context of the Pacific AOD sector. The preliminary tool was piloted with two AOD service providers to explore whether the concept of a self-evaluation quality improvement tool was theoretically and practically sound. Thus, the pilot sought to discover whether the idea of a team orientated self-evaluation tool was attractive to Pacific AOD providers and the reasons why; and whether the structure, format, content and implementation style of the proposed tool was user-friendly enough to gain *prima facie* uptake to assist in service planning exercises.

The preliminary tool was then refined. A triangulation process was again adopted involving: (i) researchers; (ii) advisory board members; and (iii) other lay stakeholders. During the content refinement process, the preliminary pool of 37 statements was reduced to 12 with many of the original statements included in the final 12 as guidance questions (Table 1). The advisory board felt that the preliminary tool reflected a mainstream service approach to quality improvement and advocated it needed to meet the needs of stakeholders and be acceptable to Pacific providers; more specifically, that the tool needed to incorporate a cultural framework that reflected Pacific worldviews. They proposed that the tool has a stronger cultural component, particularly that Pacific values and philosophy, cultural awareness and the concept of relationships (*vā* [31]) needed to be incorporated. These three areas were felt to capture the processes that made organizations and services uniquely Pacific. These concepts are described more fully in the Fonofale health belief model (Fig. 1) [11] and the Seitapu cultural competency framework (Fig. 2) [9]. These Pacific concepts were incorporated into the tool to assist with general principles and languaging of Pacific values and beliefs. Feedback from the pilot sites was incorporated in the statement refinement and, lastly, the final 12 statements were checked for alignment with the 2009 Health and Disability Standards [32].

A training workshop and manual were also developed to provide a core understanding of: (i) the overall objectives of service self-evaluation and the quality improvement tool; (ii) the significance and technicalities of the rating scales; (iii) the importance of recording action points; and (iv) appropriate timing and re-administration. The recommended process for using the tool involved three steps, with an internal facilitator (trained by research team) guiding team members through each statement

providing clarification where required. These steps were: (i) team members rate each statement from an individual perspective using a 5-point Likert scale in preparation for the subsequent group exercise; (ii) as a team, each statement is discussed and a group rating identified which is agreed collectively; and (iii) the group identifies up to three action points to be prioritized for service improvement over the next 6 months.

Phase II: testing

Originally, the tool was proposed to have undergone formal testing to assess the concurrent validity and sensitivity to change. However, there were several issues indicating that this was not possible, including the absence of existing comparison instruments to be used in external validation, the small number of participating services and the desire for a cultural framework embedded in the quality improvement tool. Therefore, the final aims of the testing stage were to examine acceptability, feasibility, construct validity and adaptability of use by Pacific services in a number of 'real world' clinical settings. That is, to examine whether the statements and guidance questions made sense, whether the rating process worked and whether using the tool did in fact assist the team to assess of the quality of service they delivered to Pacific AOD clients and families in their own particular clinical setting. It also aimed to identify if there were additional areas that needed to be included and whether providers would use the tool in practice outside of a research process. The researchers visited the four test sites and observed each facilitator introducing the tool to their team and conducting the self-evaluation exercise.

A revisit to assess sensitivity to change 6 months later was then planned with each site. At both visits the research team collected the responses of each service provider regarding the process of undertaking the evaluation. Audio recordings and hand-written notes were taken during each visit and additional notes made upon its completion. The audiotapes were used against a check of the researchers' observational notes.

Naming of the tool

During the testing stage a Pacific name for the tool, Potalanoa, was proposed by a clinician from one of the services. Potalanoa is a Tongan term and means 'a talk/conversation/dialogue/discussion/sharing'. A Tongan Matua (cultural leader) explained that the term Potalanoa was an old concept:

It involves the unfolding of fine mats on the floor and everyone, young and old, sit on the mat. No one sits on a chair.

This represents that everyone has equal rights to be in the discussion. The discussion or talk is done in a safe way with everyone encouraged to speak. The talk involves a process of discussing the issues and then coming up with solutions.

When the talk is finished, the fine mats are folded back and hung on top of the fale roof or put somewhere in the fale that is special. This action shows everyone that the talk stays with the mats, it is not to go outside, it is like the concept of confidentiality. It's like a family meeting. I believe this is the most suitable concept to name the [preliminary] tool because it represents the process by the team.

At each of the sites, the name Potalanoa was discussed and all accepted it as an appropriate name that was easily recognized and

¹Allied health professionals = psychologists, social workers, occupational therapists, counsellors.

Table 1 Potalanoa outline

Statement	Explanation	Example of guidance question
(1) Client and family rights	Our service recognizes the rights and needs of clients and their families (or significant others) as service users (e.g. right to confidentiality, privacy, informed consent, an advocate or support person and an interpreter).	As a Pacific service, how are your clients and their families informed of their rights (e.g. staff aware of the Code of Health and Disability Services Consumer's Rights, information on client rights displayed in waiting areas and notice boards, clients informed when personal information is collected of them)?
(2) Organizational governance, polices and procedures support best practice	Our service has an environment that promotes and supports best practice.	What is your service's model/s of care (e.g. as a Pacific organization, what beliefs and values guide the way your service is delivered). Is this documented?
(3) Quality systems	Our service is continually developing and improving quality systems for quality service delivery.	What quality and risk management system does your service have?
(4) Staff support	Staff feel acknowledged and valued.	What orientation or induction programme exists for new staff and staff going into a new role?
(5) Pre-entry and entry	Our service has an efficient and effective entry process.	How do people, local communities and referral agencies find out about the service and is the information made available adequate and accurate? (e.g. entry, hours, location, cost, entry criteria, information is easy to understand and is available in different Pacific languages, detail of appropriate contact person/persons displayed)?
(6) Assessment	The assessment tool we use is evidence-based and the process is appropriate for Pacific clients.	How does your service ensure the assessment process is culturally sensitive and appropriate for Pacific clients (e.g. assessment is carried out in a safe and appropriate setting, in a timely manner)?
(7) Treatment	Treatment plans are client-focused.	How does your service recognize cultural difference across the Pacific ethnic groups in its delivery of treatment and support? (e.g. different approaches appropriate to the ethnic group, traditional healers, herbal remedies, spiritual practices)?
(8) Exit, discharge or transfer	The service plans and conducts the safe exit, discharge or transfer of clients.	What policy and systems are in place to support clients' safe exit, discharge or transfer process?
(9) Community participation	Our service actively involves the community in our service.	How are the various Pacific communities involved in the service?
(10) Collaboration and liaison	We work effectively with other services.	How does your service ensure continuity of care for their clients?
(11) Client records	Client information is recorded and stored safely and securely.	What policy exists on collection of data?
(12) Safe and appropriate physical environment	Our service complies with current Health and Safety standards.	How does your service provide an appropriate and safe setting for Pacific clients and their families?

understood across the Pacific communities. In addition, each statement in Potalanoa is accompanied by an image representing Pacific concepts that illustrate the statements (Fig. 3). For example, an image of the council meeting of Matai (chiefs) represents traditional governance and accompanies Statement 2 (organizational governance, polices and procedures supporting best practice). Statement 11 (client records) is accompanied by an image representing the protection of or respect for information: the to'oto'o (middle item) and fu'e (side items), used by tulafale matais (oratory chiefs). Oratory chiefs are believed to be keepers of knowledge; those who are seen to protect sacred knowledge passed down by ancestors.

Results

Testing of Potalanoa was conducted with four Pacific AOD treatment services spread across New Zealand. Similar to the pilot,

each site is unique in how they deliver their AOD treatment. Therefore, to capture the uniqueness of each site, they carried out the self-evaluation process differently, exploring the acceptability, usefulness and feasibility of using the tool in their setting. At one site the statements were discussed in depth by the group using all the guidance questions provided. Using a 5-point Likert scale (rating of 1 = low and 5 = high) the team rated each statement and an action point was identified for each statement. At the end of the session, which lasted for approximately 2 hours, the service had only discussed eight statements and the remaining four statements were discussed by the team at a later date (without the researchers present).

At another site, the facilitator took the team through all 12 statements, focussing on the first two guidance questions. Six areas were identified as action points. Having observed the first site, the researchers suggested that the team prioritize three areas only and the team settled on one area to target for improvement. The third

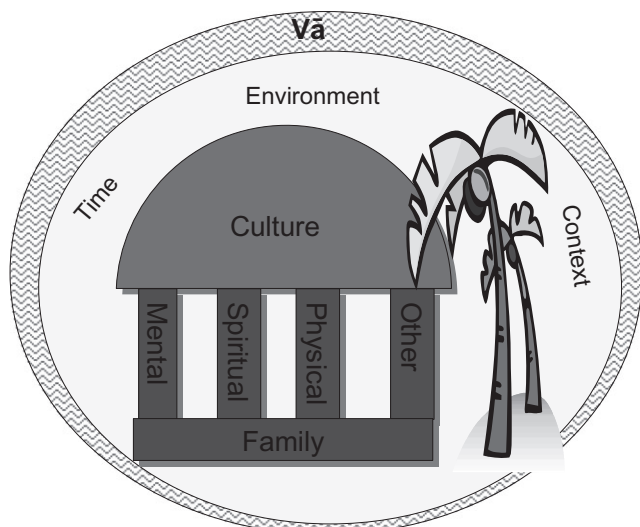


Figure 1 Based on the Fonofale model [11]. This model uses ‘the metaphor of a Samoan meeting house to make the point that in order for the house to stand firm its core structure must exist and hold together – from the posts to the roof’ (p. 27) [12]. It is a key model that captures Pacific values and beliefs and believed to be uniquely Pacific in its promotion of the holistic approach to health care by Pacific services [8]. In this Figure, the concept of vā ‘the space between . . . not space that separates but space that relates’ [39] has been included. Vā is the space that connects people with each other, with all other living things, the cosmos and the gods [40,41]. Pacific peoples come from cultures where the collective has precedence over the individual, so how one relates to others in the family and community is very important. As a member of a collective, a person’s position in the hierarchy will determine their roles, responsibilities and obligations. Being part of a collective is a strength when each member has a clear understanding about their own status, role and obligation and is able to fulfil that. The collective reciprocates by supporting and taking care of its members. As a member of a collective, being able to fulfil one’s responsibilities and obligations impacts on well-being, as when obligations are able to be met there is a sense of fulfilment but when that is not possible there is a feeling of failure and worthlessness. This was considered an important concept to capture within the ‘relationships’ domain of the self-evaluation tool. Pacific AOD services require firm understanding of their cultural value base and this health belief model provides a useful outline in a manner consistent with Pacific provider comments about having tools that reflect Pacific values and things that are familiar to them.

site similarly underwent a facilitated discussion of all the statements. Three areas were selected for action. At the fourth site the facilitator selected three statements to discuss in detail and one action point was agreed upon.

Feedback from the sites about Potalanoa varied. One site reported how the tool ‘identified what we need(ed) to do’ and helped them identify ‘where there was a breakdown in the service and look for ways of getting back on track’. Other sites identified the importance of the team-orientated process to identify areas for improvement and action points required to address this.

There was general consensus across the sites that the tool was acceptable. One AOD clinician commented: ‘There are a few areas

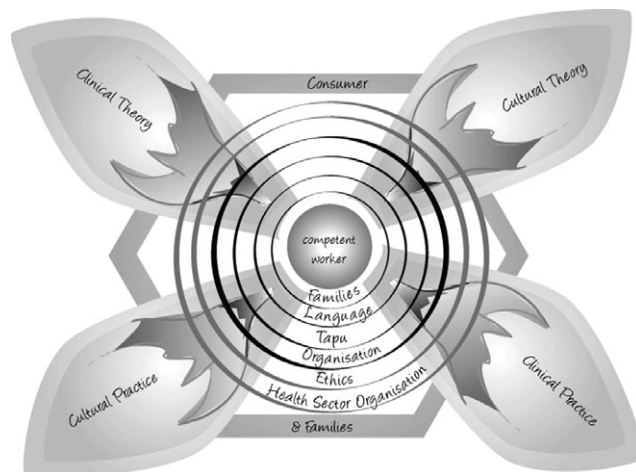


Figure 2 Reproduced from the Seitapu Pacific mental health and addiction cultural and clinical competencies framework [9]. The Seitapu framework ‘describes four key areas in worker competency important to working culturally appropriately with Pacific consumers and their families. These four competency areas involve a three-level stair-casing continuum. This continuum acknowledges that a worker’s knowledge and/or performance in any or all of these areas may differ. The “stair-case” involves three levels: basic, advanced and specialist.’ (page 5) [9]. The value of this framework for organizational self-assessment tool development lies in the detail offered for assessing and monitoring cultural competency among staff.

that need tweaking but generally the tool is user-friendly’. One site, however, reported that the tool had a western flavour and was too wordy. This site believed that Pacific people related more to visual and oral material. They wanted the tool to be uniquely Pacific.

The initial conceptualization of the revisit was to examine Potalanoa’s sensitivity to change resulting from the action points over the previous 6 months and to observe the tool being re-administered. However, observing the re-administration was not possible because three sites had not completed their action points within the 6 months and the fourth site had re-administered the tool again before the return visit.

Reasons provided by the services for not completing the action points varied. One provider noted that they had just gone through organizational restructuring and had a new acting manager and new staff members. A second provider experienced difficulty resolving how to address their action point and a third provider was involved in an external audit process that took place over several weeks. This provider acknowledged that the audit process helped them to recognize that Potalanoa statements were aligned with preparation for audit:

And it is also in line with the auditors’ criteria, the check list of what they’re going through and when I flicked over this I was like ah this has everything like the auditors’ one.

While three providers were not able to complete their action points, they all reported progress at the site revisit. The first provider discussed re-administering the tool during their annual service planning day. The second provider came up with possible ways forward during their revisit group discussion and the third



Statement 2: Organisational governance, polices and procedures supporting best practice. *Image accessed from:*

<http://cache.davlife.com/imageserve/0bxP2kDf4Leeb/610x.jpg>



Statement 11: Client records.

Items are used with permission from Matua Levao Tiava'asu'e.

Photographer: Sherona Mariner.

Figure 3 Examples of images used in Potalanoa.

provider, who had been ambivalent about the tool during the initial site visit, subsequently recognized its usefulness during their external audit process.

The fourth provider had already re-administered the tool during a strategic planning day and the team was working across action points in each of the 12 areas. They reported they had been through three external audits where they had been told the areas that needed to be improved but they had never understood why. They reported that self-evaluation using Potalanoa helped them to understand quality improvement and they were now taking responsibility for how the service was delivered and they were enjoying the process. They were working in pairs on action points and had drafted a service delivery framework with procedures for client intake and intervention. A staff member commented on the Pacificness of the tool:

I guess it is nice that we have got something that is Pacific as well I mean it acknowledges things that we don't, coz I've seen a number of other tools that are out there to assess this kind of service but they don't really encompass everything we do, so it is nice to be able to have that stuff, one to articulate it. We can articulate that when we work with people and our funders and contractors and all that sort of stuff but also having a tool that is capturing our Pacific stuff, that has been very helpful for me.

The researchers noted from staff how the self-evaluation process using Potalanoa had allowed them to assess their service delivery:

... they were quite frustrated for not having anything governing their work or having any sort of standards do you know what I mean we almost had that running around in the dark sort of feeling and probably the [project] has been very timely for us. I am not too sure if we even started working on it if we hadn't taken on the challenge of going with [this project] we could still be sitting there in the same place as we were last year.

The visit with the fourth provider highlighted the importance of the 'readiness factor' when implementing organizational assessment or quality improvement tools. The fourth provider has mostly Pacific Island born staff that may be expected to struggle with the language and concepts of the tool. Instead, they were the group who enthusiastically used the tool and when the researchers re-met with them, they discussed the areas they were focusing on and the reasons for that focus.

A common issue across the sites was determining how to fit the self-evaluation into their time schedule. When the researchers set up the initial sessions they aimed for 2–3 hours as providers were unable to guarantee staff would be available for longer periods of time. The following excerpt shows how self-evaluation was a time-consuming process:

We tried to fit it in with us as much as we can. I mean it is hard right now but because we knew that it was gonna be useful for us so we sort of like in the meetings we bring it up and then sometimes we take the afternoon on Mondays after our meeting to just concentrate on the [tool].

Discussion

Potalanoa is an organizational self-evaluation tool that is designed to be appropriate for use by Pacific AOD treatment services in New Zealand. The tool was developed out of need for a service quality improvement process that could be utilized across different Pacific service settings and that captured the Pacific approaches that they adopted. Potalanoa has been through a lengthy process of development and testing in naturalistic practice settings. The test sites explored the acceptability, usefulness, feasibility and adaptability of using the tool within their clinical services.

The value of a self-evaluation tool as part of continuous quality improvement is to assist services to identify areas of achievement and to prioritize areas requiring improvement. However, unlike external evaluations, self-assessment can place pressure on the organization to find qualified staff to carry out the evaluation or to commit staff to be trained in using the evaluation tool. The time required to undertake the assessment process also adds to this pressure and has resource implications. For a quality improvement tool to be successful it is important for it to be acceptable to the provider services and easily understood by staff. In this study the service providers reported that a tool that was simple and easily recognizable as Pacific was the ideal for a Pacific-specific team-orientated self-evaluation tool. There also has to be buy-in by everyone in the organization, not just management, as part of the process is acceptance that quality is the responsibility of everyone in the organization.

For Pacific services, the interplay of cultural and clinical issues is complex. The idea of recognizing Pacific-specific processes that are integrated with their clinical practices and capturing those

nuances throughout the tool was an important issue for Pacific services. The attractiveness of Potalanoa was that it gives the team members, as a collective, the space and opportunity to address these complexities without the pressure of external scrutiny.

In this study it was found that the successful implementation and action of the self-evaluation tool involved the participation of every staff member in the service. It is recognized that given the complex hierarchical nature (culturally and organizationally) of many Pacific services, there may exist unequal power dynamics that can serve to complicate the potential for open team discussion. Therefore, the role of a facilitator is important because it is the facilitator's skill that draws people into discussion or sets the tone of the session. This allows for open discussion on issues that arise from the assessment process. However, the role of management and their buy-in and ability to engage staff in the process is equally important. Ideally, the team manager would work with the facilitator to plan the session and select the appropriate guidance questions.

The self-evaluation process using Potalanoa is similar to the group-based assessment developed for primary health care organizations using the Maturity Matrix (Oriel, Cardiff, Wales) [23]. Elwyn *et al.* developed the Matrix because they believed it was 'important to separate out the task of quality improvement from organisational accreditation'. The authors also reported that the evaluation could be used 'for priority setting and planning', allowed an organization 'to start at the point of existing competence' and through the group process 'the organisation "learns how to learn" so that concepts of change management become second nature and part of the routine of practice activity'. Elwyn's group found that the assessment provided both a baseline against which they could assess future progress and identified areas of strengths and weaknesses. Participant feedback to the Matrix process was similar to our findings; they appreciated being able to work as a multidisciplinary group on the assessment in their workplace; the discussion for reaching consensus allowed them to gain more insight into 'future developmental priorities'; and importantly they found the exercise useful and enjoyed the experience [23].

In our study staff time at the sites involved in piloting and testing was found to be an issue because it was difficult to organize times when everyone would be on site together. Utilizing existing meetings could be a more effective way of working through parts of the tool so that people become familiar with the tool in shorter, interesting sessions. At both the pilot and testing stages there was a service whose staff were initially reluctant to undertake the self-evaluation process but at subsequent visits with more understanding of the purpose of the tool as part of a quality improvement process, this was no longer evident.

The concept of readiness is important. According to Asiasiga *et al.* 'for an organisation to be ready means the organisation wants to know what is working in service delivery and what is not and to be open to critical reflection and constructive self-assessment' [33]. In a discussion of evaluation readiness in programme evaluation, Clinton refers to the notion of readiness as being 'a critical variable in the change process' [34]. Readiness then is the capacity to evaluate (what resources are available, e.g. time, people, organizational infrastructure) and willingness to evaluate (attitude towards evaluation or level of cooperation) [34]. The research team believed that completing a readiness assessment in addition to testing the self-evaluation tool could have a negative impact on the

small number of services who were willing to participate by increasing their workload further. The fact that Potalanoa was implemented at the outset with all four services in the absence of a readiness evaluation must be acknowledged as a limitation of this study.

This study is important as it has reported the successful development of a Pacific-specific self-evaluation process for addiction services using Potalanoa; the tool face and content validity was informed by extensive consultation with key Pacific and AOD stakeholders and piloting; and the testing process was undertaken in naturalistic clinical settings. This study and the resulting self-evaluation tool respond to the call for culturally specific ethnographic research, frameworks and treatment approaches [35–38]. Additionally, they may usefully assist other ethnic minority groups in the development of quality improvement programmes especially those for whom real disparities in health outcomes exist. However, the research team recognizes that there were limitations in this study. First, the sample size of providers with whom the tool was tested was small, but this reflects the number of Pacific providers contracted to deliver AOD treatment services in New Zealand at the time of the study. Second, as discussed above, the readiness assessment was not used to determine who was ready to participate because of the reduced number of Pacific providers with AOD contracts. Third, sensitivity to change was not measured because 'real world' conditions precluded the sites from completing this. Time and funding constraints together with the complexities that occur in clinical settings that are out of the control of the research team had an impact on the study outcomes. Finally, Potalanoa was developed and tested with Pacific addiction services and needs to be tested more widely if it is to be used within Pacific mental health and other Pacific health or community services.

Conclusions

This study has produced the first Pacific-specific service evaluation tool that was acceptable and feasible to use, assisted services to identify areas of achievement and to prioritize areas requiring improvement and was adaptable to 'real world' clinical settings delivering AOD services in New Zealand. The study highlighted that for a quality improvement tool to be successful with Pacific AOD providers it needs to be easily recognizable as Pacific; capturing the Pacific processes they adopted; and to be simple and brief. The study also highlighted the value of a facilitated team-orientated process for service self-evaluation.

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