

**Pacific community mental health nurses'  
experiences of working for a District Health  
Board in New Zealand**

**by**

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## **ABSTRACT**

As meeting the mental health needs of the Pacific people living in New Zealand has become a major focus for providers and District Health Boards since deinstitutionalisation, so is the significance of mental health care delivery for the Pacific minority. Pacific community mental health (PCMH) nursing as a means of healthcare delivery is a fairly new and unknown practice domain. The fact that no studies have been carried out to explore nursing in this field makes this an area that requires an understanding. This understanding will, in turn, enhance knowledge embedded in PCMH nursing and helps reduce practice constraints. This study explored the perspectives of Pacific nurses on what it is like for them to work in a PCMH service within a District Health Board. Five Pacific Island nurses who worked in the three Pacific Community Mental Health services based in the Auckland region participated in the project. The study employed narrative inquiry to gather data through focused storytelling method.

The results of the study have indicated that PCMH nursing is a unique nursing field as well as highlight significant practice issues for nurses. Complex service infrastructure and language have been found to be the major contributing practice constraints. The findings suggest the need for District Health Board authorities, Pacific Mental Health service management, professional nursing education and development programs to consider addressing these practice issues to prevent further increase in the problem of PCMH nurses shortage and enhance recruitment and retention of these nurses.

**Keywords:** Pacific people, Pacific culture, mental health nursing, professional nursing development,

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## **Glossary**

<b>Alofa</b>	A word that means love, loving or caring
<b>Aitu</b>	A term used by the Samoan people for Ghost or Supernatural spirit
<b>Atua</b>	Samoan name for God
<b>Fa’aaloalo</b>	The Samoan term for respect
<b>Fa’amagalo</b>	To forgive
<b>Fa’aSamoa</b>	Phrase that describes the traditional Samoan way of life
<b>Fagogo</b>	Samoan term for storytelling
<b>Fak’ilonga tevolo</b>	Tongan term to describe a person possessed by evil spirits
<b>Fanau</b>	Samoan term for children or descendants
<b>Fonua</b>	Tongan word for land
<b>Laufanua / fanua</b>	Samoan translation for land
<b>Ma’i aitu</b>	A word use by Samoan people to describe a person possessed by a spiritual being
<b>Matua</b>	A word that means elderly or parent
<b>Pacific people</b>	The phrase that describes people from the Pacific
<b>Palagi</b>	The term that refers to a European person
<b>Talofa</b>	A word used to say hello
<b>Tagata</b>	Given Samoan term for people
<b>Tapu</b>	A term that similarly means sacred or forbidden in Pacific Islands and in Maori language
<b>Tofa soifua</b>	A phrase used to say goodbye
<b>Tohunga</b>	A term for traditional healer in the Maori language
<b>Vanua</b>	Fijian term for land

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## **Chapter 1: Introduction to the thesis**

The establishment of Pacific Community Mental Health (PCMH) services in response to the needs of Pacific people living in New Zealand has created opportunities for Pacific nurses to utilise their clinical and cultural knowledge and subsequently gain new experiences. 'Pacific' is a generic term that is predominantly ascribed to those people of South Pacific ethnic origin, who share a broad array of cultural affinities (District Health Board, 2004). The phrase 'Pacific people' describes a diversity of ethnic communities living in New Zealand who migrated from numerous Pacific Islands for example Samoa, Tonga, Cook Islands and Niue (MHR & DS, 2004).

As a New Zealand Registered Nurse with a Pacific heritage, I have had the opportunity to work in two different PCMH services under separate District Health Boards (DHBs). In this project I was interested to find out about other Pacific nurses' perspectives of their experiences of working in these specific PCMH settings. A desire to seek an understanding of other Pacific Island (PI) nurses' practice encounters primarily originated from my own intriguing experience of working in PCMH services for many years. I have discovered that PCMH nursing is a complex practice that involves providing care to a community of Pacific people which reflects their traditional ethnic and cultural philosophies.

Since mental health services for Pacific people and associated PCMH nursing practice have mainly developed over the past decade, no previous studies were found in the research literature to explore nursing practice for this specific ethnic minority. Studies by O'Brien (1999) and Benner (1984) have indicated that nurses have been deprived of the ability to articulate from a theoretical perspective, the uniqueness and richness of knowledge embedded in their clinical practice because of the lack of systemic study and research. Hence, this research sought to gain knowledge from Pacific Island nurses about



what it is like for them to work in a PCMH service within a DHB. It is anticipated that the storytelling method utilised to gather data in this research project will generate a greater understanding and clarity of PCMH nursing practice.

A Pacific Island nurse is a health professional who identifies with a Pacific heritage. They are also qualified registered nurse currently practicing in New Zealand. Their nursing experience together with their Pacific cultural background knowledge is seen an essential requirement that would enable PCMH nurses to mediate and respond effectively to Pacific Island peoples' mental health needs. PCMH nursing emerged as a product of the *Mental Health Commission Blueprint* (1998) proposal for the recruitment of appropriately skilled Pacific workforce that includes nurses with languages, cultures, and customs to provide better services to Pacific people living in New Zealand.

The PCMH services are situated in the Auckland region under the umbrella of different DHBs and each service take on a Pacific name based on the team preference, cultural connection and significance. These services include: Faleola, Lotofale and Isa Lei services. The Faleola Service is located in the South of Auckland, the Lotofale Service is based in the Central Auckland area and the Isa Lei Service is situated in the West Auckland region. Each service has developed differently because of Pacific population density in their area of service and also the type of service organisation and staffing differences. The *Northern Regional Mental Health Sector* (NRMHS, 2003/05) document have indicated that the Lotofale services was first established in 1995 as a Community Support Services and later integrated the clinical component in 2003 with the addition of medical staff and nurses. Lotofale provides consultation and liaison services to the Auckland District Health Board mainstream services as well as fanau (family) support and advocacy for the Pacific communities. Isa Lei service was developed in 1999 to provide cultural and clinical services for the Pacific people living in the North of Auckland area. The team consists of

cultural workers who provide cultural perspectives in addition to nurses who deal with the clinical aspects. The Faleola service which was established in 1999 as a clinical service caters for the larger Pacific population in the Auckland region. The staff comprises of Pacific mental health professionals that includes psychiatrists, nurses, social workers, occupational therapist and psychologist who provide consultation and liaison services as well as crisis coverage services for the youth and older adult group residing in the South Auckland area.

This research project begins to uncover the knowledge base in PCMH nursing through Pacific nurses' stories. Nurse researchers such as Benner (1984), and Porter-O'Grady (2001), to name a few, have been influential in the development of this research project. Porter-O'Grady for example urged nurses to define the realm of expertise embedded in their practice and embrace the issues existing around practice foundation in order to initiate change and find a meaningful place in the current health system. It is expected that any practice issues identified in this study will help develop strategies to address any difficulties in the PCMH nurses' work.

The following sections of this chapter will focus on the driving forces largely responsible for developing this project. They provide background information drawn from my experience and perspectives of working in Pacific mental health services. This chapter offers a discussion on the significant issues of concern for Pacific community mental health nurses that emerged from this background standpoint. The aim and significance of the study that transpired from this backdrop is also presented in the final section of this chapter.

## **1.1 Background to the study**

An aspiration to pursue this research topic was based on my experience as a Pacific Island nurse working in PCMH service within a DHB. PCMH services were purposely established as part of the Blueprint Mental Health Commission (MHC, 1998) proposal which initiated an appropriate approach to meet the needs of the Pacific Islands population living in New Zealand. Pacific people philosophically believe that mental well-being is dependent on all aspects of a person's life being in harmony. Spiritual, physical, emotional, and family well-being together represent the holistic way in which mental health needs are addressed (Bathgate & Pulotu-Endemann, 1997). The Blueprint proposition supported this holistic perspective as an ideal underpinning and thus proposed a 'by Pacific for Pacific' service delivery model. Nursing practice was to acknowledge this approach as the best means of achieving improvement in the quality of life for Pacific mental health clients. Hence recruitment of culturally appropriate health workers that includes nurses with skills in Pacific languages, cultures and customs were endorsed.

My career in the field of PCMH embarked on ten years ago has been invigorating and rewarding. I had the privilege of working in the two separate PCMH services under different DHBs which provided an inside view of nursing in these settings. Becoming a member of a Pacific multiethnic team is reminiscent of discovering my roots and sense of family connection. As a Samoan person who is not usually keen on the Fa'aSamoa (a Samoan way of life) and preferring to live the simple Palagi (European) way, I envisaged my career at PCMH service would be challenging. On reflection during my first days in the PCMH service, I experienced apprehension and was unsure of what to expect or what was expected of me. I found myself constantly struggling to maintain a balance between the clinical and cultural aspects of clients' care and simultaneously feeling isolated at the lack of appropriate support and supervision.

Currently my role encompasses a variety of tasks and activities. The most significant aspect is conversing and interacting with Samoan clients and their families in their native language which is a huge advantage particularly for those with language barriers. My ability to speak a Pacific language has also occasionally drawn invitations from internal and external community and mental health establishments to participate in a number of Community Mental Health promotions and education via radio talkback programs. In addition were requests for mental health education from community church groups, as well as involvement in the Samoan PMH cultural competency workshops as a group facilitator.

Over the years, it has been my observation and belief that nursing in PCMH is considerably distinctive. My belief in commencing this research is that PCMH nurses' experiences would be different for those who are Pacific Island born compared to those who are New Zealand born with Pacific heritage. For example, at a workshop, a Pacific Island-born nurse continues to attribute mental health disorders to the malevolence of ancestral spirits (ma'iaitu) and believe in traditional treatments. In contrast, a New Zealand-born Pacific nurse has a less traditional understanding of mental health and aetiology of mental health disorders and treatment (Cultural Competency Report, 2004). As no previous research has explored this specific nursing domain, the impetus for this research study is to uncover Pacific nurses' perspectives of their encounters in PCMH settings. The following section presents some of the issues that I have identified in PCMH practice.

## **1.2 Issues for Pacific Community Mental Health nurses**

The opportunity to work in two different PCMH services have provided me with an inside view of the distinct nature of the service delivery models they implement. At the same time I was able to identify the persisting gaps and barriers existing in PCMH services. Each service delivery model has its challenges, advantages and disadvantages. For example,

models of service delivery that espouse separate clinical and cultural components pose duplication of role activity and contradict the culture of holistic nursing care. This has implications for the multidisciplinary team, clients and their families instigating confusion as well as unnecessary misuse of service delivery expenditure.

Over the years, changes have gradually emerged specifically in the nature of particular PCMH services. For example, due to the persistent problem of a shortage of Pacific mental health nurses, staff who are identified as non-Pacific are employed to fill the gaps which contradicts the 'by Pacific for Pacific' philosophical approach espoused by the Blueprint (MHC, 1998) strategy. These non-Pacific staff have openly commented and expressed their frustration in our team discussions that they constantly experience apprehension upon approaching or visiting clients and their families due to the lack of understanding of the culturally appropriate Pacific ways. This can have an impact on how these nurses perceive and respond to clients' needs or situations arising in their practice setting and thereby hinders their ability to contribute effectively to Pacific clients' and their families' needs. Furthermore, non-Pacific staff has also been employed by particular PCMH services often in leadership and management positions instead of Pacific personnel. These situations undermine and underestimate the value and expertise of PCMH nurses and consequently impact on their self esteem. Such circumstances can also convey a negative impression for Pacific nurses or other Pacific staff who may be perceived as incapable or incompetent of performing such leadership roles in PCMH services.

Additionally, with the recent changes in professional practice competency under the Health Practitioner Competence Assurance Act 2003, Pacific mental health nurses are expected to demonstrate both clinical and cultural competence. My concern is how PCMH nurses' practice competency is assessed and evaluated considering the Professional Development Recognition document (National Nursing Organisation, 2004) for nurses mainly arises

from a Western mainstream perspective. PCMH nursing is a specialised field of practice that requires an explicit professional development framework that reflects their scope of practice. I anticipate that the stories of other PI nurses' practice experiences obtain in this study will uncover the knowledge embedded in PCMH nursing and subsequently help identify any practice issues. This may help facilitate a more suitable framework that caters for PCMH nurses' needs and professional development.

The next section presents the aim of this research project. The remaining section discusses the rationale for why this research study is significant based on my background knowledge and observation of the PCMH.

### **1.3 Aim of study**

The purpose of this research project was to investigate the varying perspectives of individual nurses in terms of their practice experiences while working in the PCMH services of a DHB. As no previous studies were found in the research literature exploring nursing practice in this particular field, this project is exploratory and aims to identify the knowledge embedded in the PCMH domain.

### **1.4 Significance of the study**

As a Pacific nurse working in a PCMH services, I was interested to find out from other nurses their perspectives of working in these PI services. Anecdotally, colleagues have shared that they would like to be able to tell their stories about their practice. I consider that it is timely to gather the stories about what it means to be a PCMH nurse so that Pacific Island nurses can identify the key knowledge and development required to further advance PCMH nursing practice.

With the current climate of evidence-based nursing, research has always been a valuable source of knowledge. This research project provides a tool for PCMH nurses to articulate from a research basis their practice encounter and simultaneously create visibility and recognition for this nursing phenomenon. Buresh and Gordon (2000) point out that unless nursing is visible and vocal, it cannot be seen as a significant health care profession. Data generated through this inquiry will contribute towards building this information base and foundation for future research and pave the way for other Pacific nurses that may wish to pursue research in the field of PCMH nursing.

It is anticipated that voicing any practice concerns through this study will have positive impact on health provider organisations and nursing authorities in that by listening to these nurses, appropriate measures to address any practice concerns maybe facilitated. Any practice issues or satisfaction identified in this study will contribute to the professional and Pacific workforce development processes and hopefully strengthen the prospect of recruitment and retention. Ultimately this venture can be seen as a role model to inspire other Pacific nurses to consider pursuing an ambition in the field of nursing research. In the next section, I present a view of my position in this study.

### **1.5 Locating my position in the research**

Originally, I am a Pacific person, born, raised and educated in Samoa. My nursing qualifications were attained in New Zealand where I have lived the most part of my life. I have been privileged with an upbringing that has nurtured me with the experience of being a Samoan. Migrating to New Zealand is a blessing in that I have been exposed to a world of cultural diversity and people from all walks of life. Furthermore, having children with New Zealand-born identity has also presented me with a view of their personal and cultural existence in relation to New Zealand-born Pacific nurses.

The shared mutual cultural understanding and nursing experiences with PCMH nurses who chose to participate in this study have provided me with an inside view of both worlds thus the ability as a Pacific nurse researcher to move from ‘insider-to-outsider’ and ‘outsider-within’ position (Southwick, 2001). However, undertaking this research has its complexities and challenges as I constantly needed to remind myself to be clear about my position particularly in the data collection and interview process. The challenge was finding myself shifting location at times from outside view as a researcher to inside view where participants expected me to be. This helped developed my awareness of maintaining boundaries and recognises the essence of good communication skills, specifically listening, and simultaneously retain some sense of coherence. The remaining section of this chapter presents an overview of this study.

## **1.6 Overview of the study**

In this Chapter 1, I have set the scene beginning with an introduction of the overview and background of the study. The chapter indicates some of the issues identified in the field of PCMH nursing. The aim and significance of this project has been outlined and concludes with a view of my position as a researcher in the project.

Chapter 2 begins with a view of the scope of the literature search undertaken in this project. My understanding of the study topic is elaborated utilising a range of literature and research studies to construct a framework for general critique and discussion.

In Chapter 3, I present the theoretical and philosophical positions and assumptions underpinning this framework and include the rationale for the preferred choice of methodology. Following is a discussion of the method and design used to collect the data and outlines the relevance of storytelling method in gathering the data for this project. This chapter familiarises the reader of the journey and processes undertaken to obtain and



analyse the data and taking into account the fundamental aspects of ethical considerations, accountability and responsibilities involve.

In Chapter 4, I present the stories of the five participants; Mika, Peta, Semi, Tepora, and Sara. It includes interpretations, commentaries and observations of the text obtained from the interviews undertaken between the researcher and each individual participant. This process sets the foundation to identify emerging themes from each participant's stories.

Chapter 5 creates a space for the reader to gain insight into the findings and specific outstanding key core themes and subordinate themes that generally originated from the participants' stories. In addition, this chapter acquaints the reader with those particular features that distinguish Pacific-born and New Zealand-born nurses' practice.

The final Chapter (Chapter 6) presents an overall discussion about the project and the outcome of the study. The aim of the study is revisited with reflections on the significance of this study to PCMH nurses. The discussion focuses on the knowledge and insight gained from this project about the significant issues and the implications for PCMH nursing practice. This chapter concludes with recommendations of the way in which this project may contribute to addressing PCMH nursing practice issues and encouraging further studies to expand knowledge about this nursing domain.

In the following chapter, I present a discussion on the review and critique of literature in relation to PCMH nursing. It begins with an overview of the process undertaken to obtain relevant literature to this research project followed by discussions on a wide range of the research studies in relation to PCMH nursing.

## **Chapter 2: Literature Review and Critique**

This chapter presents a review of the literature undertaken to develop familiarity and comprehensive understanding of information related to the research topic. The purpose of this research project was to explore Pacific nurses' perspectives about their experiences of working in Pacific Community Mental Health (PCMH) services within a District Health Board (DHB). In the first section, I present an overview of the search process undertaken to identify relevant literature to the topic of study. The following sections discuss key areas relating to the study that include: identifying the Pacific population in New Zealand (NZ); Pacific perspectives on health, mental illness and treatment; Pacific community mental health services; the nurses' role in PCMH services; and developing competencies and professional expert practice in PCMH nursing.

### **2.1 Scope of the literature search**

A search of the literature used terms related to the experiences of Pacific nurses working in Pacific community mental health services to search nationally and internationally. Relevant journals, articles and texts were gathered from University libraries and DHB libraries. Database searches included Internet Google, and the website. The keyword 'Mental Health Nursing' was used which revealed a broad category of articles. Words 'community' and 'experiences' were added which produced a number of articles. However, when the term 'Pacific nurses' or 'Pacific' was added, no articles were produced which proved quite frustrating. The lack of existing relevant studies suggested to me that research in this specific nursing field is limited.

However, Southwick's (2001) PhD study on the experiences of Pacific womens' stories of becoming registered nurses in the New Zealand context, and Logovae's (2002) and Esera's (2001) theses on exploring the experiences of Pacific Island nurses practising in the

mainstream mental health services were found. These studies have contributed to the establishment of literature associated with the PI Nurses' practice in New Zealand.

Strategic documents on *Pacific Island Mental Health Services and Workforce* (MHC, 2001), *Blueprint for Mental Health Services in New Zealand* (MHC, 1998), and the *Mental Health Research and Development Strategy* (HRC of NZ, 2004) documents are also reviewed. These documents are included in this study as they have been instrumental in supporting my discussions in relation to the establishment of PCMH services, and Pacific workforce development issues.

Currently, Logovae's (2002) study has been found in relation to Pacific mental health nurses' experiences of working in the inpatient mainstream services. While there is some research involving perspectives of Pacific Island nurses, there was none located about Pacific Island nurses working in PCMH services. Studies were found relating to the experiences in nursing generally for example; Kipping and Hickey's (1998) study carried out in London explored mental health nurses expectations and experiences of working in the community; Lea's (1994) research looked into nursing in today's multicultural society; and Polaschek's (1998) study conducted in New Zealand that explored cultural safety in relation to nursing people of different ethnicities.

The following section presents a discussion about Pacific people living in New Zealand supported by relevant demographic literature. The chapter incorporates policy documents and relating research literature.

## **2.2 Pacific people residing in New Zealand**

'Pacific people' is a phrase that describes a diversity of ethnic communities living in New Zealand who migrated from the Pacific Islands or identified as Pacific people due to their

ancestry or heritage (Mental Health Research & Development Strategies, 2004). The term 'Pacific' primarily refers to the population with South Pacific ethnic origin from Samoa, Cook Islands, Tonga, Niue, Tokelau, Fiji, Papua New Guinea, Tuvalu, Vanuatu, Kiribati and the Solomon Islands (Pacific Cultural Competencies, 2004). According to the Statistics New Zealand Census (2001), Pacific people living in New Zealand comprise a total of 231,798 which is approximately 6 percent of the total New Zealand population, with the largest number of Pacific people residing in the Auckland region.

The Pacific population is predominantly made up of four island groups specifically Samoan (50%), Cook Island (23%), Tongan (16%) and Niuean (9%) (Mental Health Commission, 2001). Each Pacific ethnic group possesses their own distinct culture, language, history of settlement in New Zealand and health status. Almost 90 percent of the Pacific population in New Zealand speaks English and about half the population recorded in the Census 2001 have the ability to speak two languages (Mental Health Research & Development Strategy, 2004). Samoan and the Tongan people are reported to have the largest population of non-English speaking persons. These findings on language confirm the need to facilitate appropriate Pacific mental health care resources to support non-speaking Pacific families and to prevent misdiagnosis of mental illness.

Given that Pacific people inhabit different social locations and encompass a variety of backgrounds and experiences, there is inevitably a range of viewpoints about what it is to be a Pacific person and how mental illness is perceived. The *Mental Health Research and Development Strategy* (2004) document illuminates that Pacific people can align themselves differently in relation to ethnicity, geography, family, school, church, age, gender, New Zealand born or Island-born, occupation, or a combination of these. 'New Zealand-born' is an expression that acknowledges both Pacific and local upbringing and a

shared identity with other young Pacific peoples who have significant variation in the ways they perceive themselves and the equal importance placed upon their identity.

The rapid growth in the Pacific population in New Zealand is predicted to reach 414,000 by 2021 which is an increase of 152,000 or 58 percent over the estimated resident population of Pacific ethnicity of 262,000 as at 30 June 2001 (DHB, 2004). Cook et al. (cited in MHR&DS, 2004) predicts that the Pacific population will have doubled in the next 50 years due to the high fertility rate and high population growth. Cook et al.'s prediction resembles the projected growth rates of minority populations in America as indicated in Coffman's (2004) study where Hispanics have the largest group at 35.3 million (12.5%) people, slightly higher than African American at 34.6 million (12.3%), Asian American 10 million (3.6%) and American Indian 2.4 million (0.9%) of the American population. From a health workforce perspective, Coffman declare that while the American population has become increasingly diverse, nurses have remained a homogenous group with 90 percent of nurses being Caucasian. In comparison, the Pacific population in New Zealand continues to increase rapidly while the number of PMH nurses is not increasing or at the same rate and there is underrepresentation due to the short supply. I will discuss this further in section 2.4. However, before discussing the delivery of Pacific mental health services, in the next section I consider how Pacific people perceive mental illness and their treatment, and how this impact on their wellbeing.

### **2.3 Pacific peoples' perspectives of health: the causes and treatment of mental illness**

Central to more effectively meeting the mental health needs of Pacific people is to fully understand their perspectives on health (MHC, 2001). Pacific peoples' beliefs of health and treatment are noticeably analogous. Certain dimensions contribute to the Pacific peoples' perception of well-being. For example, Lui (PMHA&DS, 2004) affirm that health

and wellness from a Samoan perspective depends on a balanced relationship between the three elements; the Atua (God), tagata (people) and laufanua (land/environment) which is defined and guarded by tapu. Violation of the tapu means a person may risk being punished by the guardians of the tapu resulting in deranged relationships, leading to illness or worse. The breach of the tapu if serious can bring upon a curse.

The universal belief across Pacific cultures is that mental illness is considered a manifestation of external or supernatural forces or ancestral spirits who have taken possession of the person because the person or their family have broken a particular custom or tapu. Samoan people for example perceive the person identified as having a mental illness as being possessed by the spirits or 'ma'i aitu', manifesting in out-of-character behaviour and offensive language (Esera, 2001). Similarly, Tongan people described this notion as 'Fak'ilonga tevolo', also manifested in bizarre demeanour with overtones of mental illness (PMHA&DS, 2004).

Bathgate and Pulotu-Endemann (1997) maintain that Pacific people generally do not regard mental illness as resulting from a condition originated within, and totally confined to a person exhibiting certain types of disturbed behaviour. Furthermore Kleinman (Shin, 2002) is adamant that cultural and social factors may not influence the aetiology and causes of disease. Kleinman believes that local cultural orientation organise peoples' conventional common sense about how to understand and treat their illnesses. There is an element of truth in Kleinman's comment in relation to Pacific people living in New Zealand who have adapted and embraced their new way of life and have become more understanding and receptive to the western view of illness and treatment.

The common beliefs about mental illness and traditional healing are held by Pacific people as well as other non-western indigenous people (MHR&DS, 2004). Maori people of

Aotearoa New Zealand for example consider the use of traditional healing as an option of treatment before or after seeing their family doctor. Like the Pacific people, therapy treatment for Maori people practiced by the *tohunga* (traditional healers), concentrates on all aspects of health; the body, mind, soul and spirit. The role of the healer usually involves diagnosing and providing treatment which includes a combination of medicine prepared out of different plants and elements, or activities such as massage (Macpherson, 1990). This process sometimes involves questioning the person perceived as possessed using appropriate skills which may identify a circumstance when the 'aitu' (spirit) makes known its presence. Macpherson elaborates that the healer informs the family that such an activity can be offending and that the process includes asking the person to admit to deviances which when revealed may cause social tension or embarrassment to the client and their family. Traditional healers are perceived as having the essential mystical powers to restore the spiritual upset aspect experienced by the possessed person. Maori people consider that the healing power of the *tohunga* is a gift bestowed from above (MHR&D Strategy, 2004). Pacific traditional healers are scarce in New Zealand and not easily identified or accessible. They can sometimes be discovered by word of mouth by asking other Pacific people living in the community.

I identified two studies which focused on the use of traditional healers in health care (Sinclair, 2005; Struthers, 2004). Sinclair's study which focused on six Pacific Island clients accessing mental health services in the South Auckland region indicates that half the participants in the study made contact with a traditional healer before seeking secondary mental health care. Outcome of the clients' connection with the traditional healer were not identified in the study. Although this study has relevance to PCMH services, the findings have indicated a number of limitations which hinders the possibility of generalisability of the findings to the population of PMH clients. For example the participants recruited were ethnic specific and does not represent a wide range of ethnic

cultures. In contrast, Struthers's study using a phenomenological approach explores the perspectives of four indigenous American Indian people diagnosed with cancer who used traditional healers in their healing journey. The results suggest that all four participants provided powerful accounts of traditional healing highlighting the nature of holistic healing which the participants referred to as the mental, spiritual and physical elements of their being. Limitation of the study due to the small number (6) people interviewed suggests that a larger study that includes more individuals from other tribes is essential to ascertain whether the findings are replicated. The study has relevance as it advances scientific knowledge through vital data about indigenous traditional healing and can be useful to the PCMH care. Nonetheless, there is lack of research evidence to explore the therapeutic effect of Pacific traditional healing method on treating Pacific people with mental disorders. However, traditional healing remains as an alternative method of cure and treatment for Pacific people and can be complementary to western health care practices (Esera, 2002). The following section discusses the PCMH services establishment in relation to the 'by Pacific for Pacific' approach to service delivery.

## **2.4 Pacific Community Mental Health services**

PCMH services development emerged following deinstitutionalisation of mental health services during the 1990s and greater advocacy by Maori in the last 10 years that began to acknowledge the significance of culture in mental health. Consequently, the *Health Research Council and Development Strategy* (2004) document perceived this movement as creating an awareness of the impact of culture in the presentation, assessment and treatment of mental illness that led to recognition of the need for culturally appropriate mental health services. The PCMH service development is seen by the *Mental Health Commission* (2001) as a positive step in the delivery of better mental health services to Pacific people.



The three PCMH services located within each DHB in the Auckland region provide an integrated clinical and cultural service for Pacific people. Each service takes on a Pacific name based on its cultural significance. The Pacific multidisciplinary teams consisted of staff from diverse Pacific ethnic background and mainly include a consultant psychiatrist, registrar, social worker, nurses, occupational therapist, psychologist, administrators, team leader, a matua, specific cultural support workers (a separate component in other services), community support workers (non-existent in other services), and service manager (in other services). The PCMH team creates a warm respectful working environment where staff learns from each individual's unique Pacific culture.

PCMH services endorse the *Blueprint for Mental Health Services in New Zealand* (MHC, 1998) objectives to improve the quality of life for Pacific consumers. It has been anticipated that this development reflects the Pacific peoples' philosophy and holistic approach to mental wellness with increase ownership and provision of services designed by Pacific people for Pacific people and delivered by Pacific people (MHC, 1998). However, the 'Pacific for Pacific by Pacific' approach has been strongly criticised by the *Mental Health Research and Development Strategy* (2004) as more of a strategic tool for political leverage than an ideological objective. I support this perspective based on my view of the current changes occurring in PCMH services. For example, non-Pacific staff has been employed to work in the Pacific services which maybe due to the lack of Pacific mental health nurses. Obviously, this is indicative of unresolved issues existing in the PCMH establishments such as Pacific workforce development particularly recruitment and retention.

The quandary as indicated by the *Mental Health Commission* (2001) is Pacific mental health providers' uncertainty in relation to the lack of Pacific expertise at the management, accounting, contracting and organisational level in developing and maintaining a PCMH

services infrastructure. This is a concern for the growing population of Pacific people in New Zealand limiting their choice of mental health services responsive to their needs. Polaschek (1998) argues that we cannot ensure that the needs of people from minority cultures will be met until the effects on the health care system of inequalities in power between groups in society are addressed.

Durie (1998) in his review of Maori mental health development presented issues that correspond with Pacific mental health services. Durie stipulates that if the current trends in Maori mental health are to be reversed, active participation by Maori in the process and the retention of a cultural base is critical. This statement endorses Crawley, Pulotu-Endemann et al.'s (1995) suggestion that in order to provide culturally appropriate and effective services, Pacific people need to be involved in formulating mental health policies. Moreover the 'Pacific for Pacific by Pacific' approach can work given the right resources and skilled Pacific people to drive and manage these facilities. This optimism also reflects my observation of one PCMH service in the Auckland region that is striving to maintain the Pacific for Pacific philosophy since its establishment.

One wonders whether nurses in PCMH services are meeting the needs of Pacific clients and their families. Crowe, O'Malley and Gordan (2001) present a relevant study which used a qualitative method to evaluate whether community mental health services are meeting the needs of clients in New Zealand. The results suggest that nursing care provided was valued greatly by consumers. It was indicated in this study that nurses demonstrated relevant key skills, knowledge and understanding of mental disorder and also building of relationship within the contexts of the consumer's live. Furthermore, because of the nurses' willingness to be flexible to the demands of the organisation and the service users, nurses remain critical to the success of community-based care. No mention of limitation in the study. However, the significance of the study for consumers was

indicated. This study has relevance as it mirror those attributes held by PCMH nurses. Even so, research is needed to explore feedback and clarification from Pacific clients and their families in relation to the services provided for them by PCMH nurses. The next section presents a discussion on the perspectives of the nurse's role in PCMH services.

## **2.5 The nurse's role in Pacific Community Mental Health service**

Pacific nurses perform a significant designated role of 'keyworker' in the PCMH multidisciplinary setting that requires professional responsibilities and commitment. The tasks involve coordinating the clients' care plan utilising a range of knowledge and skills that encompass clinical and cultural aspects to establish relationships with everyone involved in the process. It includes organising family meetings with clients and their families and arranging their medical reviews as required, which maybe held at their homes or in the workplace. The nurse liaises and consults with relevant internal and external health services that includes mainstream and Pacific Island Non-Government Organisations (NGOs) services in an attempt to access appropriate resources to meet the client's needs. The nurse also initially visits clients in their homes on a regular basis and responds to crisis by consulting with the crisis team as required. Access to appropriate resources to ensure clients' safety is paramount. Constant interaction and consultation with the multidisciplinary team on a daily basis regarding clients' progress is a continuous activity of the nurse. Facilitating clients' clinical review and maintain ongoing assessment, monitoring and evaluation of their recovery progress is a major responsibility. Mental health education for clients and their families is also an important activity, and includes fundamental cultural activities such as translation for clients and their families and other health providers when required.

Like any health care environment, PCMH nurses constantly encounter difficulties in practice. Kipping and Hickey's (1998) study conducted in the United Kingdom (UK),

interviewed 12 mental health nurses about their expectations and experiences of working in the community. While the study was carried out within a different cultural context, it highlighted similar issues experienced by PCMH nurses such as blurred roles. The concept of separate clinical and cultural components creates blurred roles and also confusion particularly for Pacific nurses who find it difficult to separate the clinical from their cultural affiliation. This study has good qualities and can be useful in other community health settings despite the limitations based on the small number of participants. The use of multiple sources may have provided data triangulation to increase validity and reliability of this study. However the lack of specific element in the context to capture the essence of Pacific Mental Health care such as cultural aspects makes it difficult to come to some conclusion whether transferability can be contemplated as a possibility for PCMH nursing (Pollit & Hungler, 1993).

I carry a case load with a designated cultural adviser of the same Pacific ethnic identity and we both speak the language (Samoan) fluently. Occasionally a Pacific language interpreter who has no knowledge of mental illness assists with a mental health assessment which may subsequently result in misunderstanding and misdiagnosis. Lea (1994) claims that using interpreters may complicate rather than simplify the communication process. Lea suggests that this may be due to variation in the level of literacy between the interpreter and client, or relatives may filter information sought which they may see as sensitive or personal. This is evident from my own experience for example, at an inpatient meeting held for a client, the interpreter asked me to intervene as she could not explain what the term Schizophrenia is in Samoan language. One would argue that staff identified as cultural advisors or community support worker or clients' family members should be used to respond to clients' cultural needs. This maybe an ideal option, but occasionally a Pacific nurse who speaks the language spontaneously translates due to unavailability of these cultural resources.

The nurse's role in the PCMH multidisciplinary setting entails numerous activities that require professional skills such as those indicated in Bugge, Smith and Shanley's (1999) study. This descriptive survey study that was conducted in the UK explored the aspect of professional skills in a multidisciplinary health setting. Twenty participants from a multidisciplinary group employed in a Scottish Health Board were asked to identify the perceived skills required for mental health staff in the community. The study found that despite role complications, nurses are looked upon as major key role players in the team as they possess distinguishing specialist skills in addition to the common core skills that are central in multidisciplinary community practice. The researcher suggests that the overall questionnaire response of 36 percent adversely affects the representation and generalisability of the findings which may have indicated flaws in this study. This type of research has flexibility with broad scope focusing on a range of topics with extensive analytical approach which would be useful for Pacific multidisciplinary team.

The following section presents a discussion on Pacific cultural values and beliefs and their impact on nursing Pacific clients with mental health issues.

## **2.5 (i) Relationship of Pacific cultural values and beliefs to nursing practice**

Cultural values and beliefs dynamically influence Pacific peoples' experiences of mental illness and treatment. In the context of culture, Bauwens and Anderson (1992, as cited in Lea, 1994, p.307) states that 'all belief systems are culture-bound because they are based on cultural factors and the meaning that individuals ascribe to these factors'. Bauwens and Anderson describe 'values' as standards by which people judge their own and other peoples' actions, whilst 'beliefs' are statements which people consider being true and may or may not be based on actual evidence. Ma'ia'i (1994), and Tamasese Peteru et al. (1997) highlight the importance of understanding Pacific peoples' cultural values and beliefs in

order to provide appropriate and effective responses to their mental health needs. Yet one must be mindful that values and beliefs are uniquely diverse within each Pacific Islands group.

The common Pacific cultural values encompass trust, reciprocity, creativity, restraint and compassion and are embedded in human relationships and their environment. In most Pacific languages, similar words used to describe the concept of environment or land is 'fonua' (Tongan), 'fanua' (Samoan), and 'vanua' (Fijian) (Samoan Pacific Cultural Competency, 2004). Within this concept is what surrounds and permeates all that Pacific people do. In the Fa'asamoa (Samoan way of life) for example, the fundamental basic values are; alofa (love), fa'aaloalo (respect), and fa'amagalo (to forgive). Alofa is a reciprocating process that underpins the receiving and giving that is initially transferred through activities such as traditional healing processes. Pacific peoples' humanity is defined by their obligation to fulfil their role and responsibilities of care that is central not only to their health practice and religious beliefs but to Pacific peoples' expectations of fulfilment to one's family. This is characteristic of Pacific nurses who at times carry out extra tasks outside of work hours or their practice. For example they facilitate family meetings or provide mental health education in their native language as part of their intervention to support clients who maybe experiencing a crisis or family dilemma.

The DHB (2004) Pacific Cultural Competency Framework stipulates that Pacific cultural values must underpin the development of initiatives and innovations determined by Pacific people if it is to have any positive impact. Nevertheless, deep-seated cultural beliefs are criticised by Razali and Najib (2000) as a major barrier to psychiatric treatment. Due to contrasting beliefs held by the Pacific peoples, the Western psychiatric context and medical clinicians about the causes of mental illness and the way in which it is addressed, this is perceived by psychiatry as problematic. I support this comment based on my

experience of dealing with Pacific clients with persisting non-adherence complications due to the impact of the cultural beliefs attached to their mental disorder and treatment. For example, a 20 year old woman with a diagnosis of schizophrenia who was recently referred to the PCMH service has a history of non-adherence to medication treatment. This Pacific born woman with a strict Pacific cultural upbringing informed me and the psychiatrist upon our home visit that she had stopped taking her medication. Her father who is a devout church minister stated, 'My daughter does not need medication because she is not mental. God will make her better'. Apparently her father has a huge impact on decision making in his daughter's life.

The Mental Health Commission (2001) strategic development document suggests that an understanding of Pacific cultural values and principles serves to influence planning and implementation of appropriate mental health service delivery to Pacific people. These cultural values and principles according to Bhugra and Bhui (1997) provide determinants such as social support, socially acceptable emotional conduit, cathartic strategies and synchronisation of individual differences which amalgamates to provide a consistent and meaningful world view. In the following section I discuss the nature of nursing in Pacific community mental health services.

## **2.5 (ii) Nursing in a Pacific community mental health services**

Nursing in a Pacific multicultural service is a complex dynamic due to the cultural emphasis attached to mental health care service delivery. Nurses are expected to have knowledge and understanding of Pacific cultures in order to respond to clients' needs appropriately. Spence (2003) describes nursing as a cultural phenomenon and encountering differences, working with prejudice, paradox and possibility due to the contradictory nature of this phenomenon as a whole. Pacific people expect acknowledgement and genuine commitment from health providers including nurses that

reflects the holistic approach to mental wellness that is inherent in their cultural belief system. Nevertheless, in a multi-ethnic Pacific society, there can be a temptation to try and catalogue different customs and beliefs for various groups.

The notion of 'holism' is explored in Cortis' (2004) study that involves a Pakistan community living in England. The findings in the study highlighted how culture which was considered a key component of 'holistic care' was poorly understood and applied by professional health workers that include nurses. There was no mention of limitation in this study. This study has relevance as it reflects the similar problem in PCMH in regards to holistic healthcare service and can be transferable to PCM healthcare.

Parfitt's (1998) presents some practical solution to the problem indicated in Cortis' and Spence's studies. Parfitt view 'crossing bridges' and 'doing the cultural thing' as a way of walking in people's shoes and sharing different cultures than that of their own. This notion appears pragmatic for PCMH nurses' practice considering their effort to learn the different Pacific ethnic cultures and languages. However, I am not convinced this would be a straightforward adaptation for nurses working in PCMH services. From my experience of working with a case load of clients that consists of approximately six different Pacific ethnic clients, I found it very difficult to try and speak or understand many of these ethnic languages. Considering the large case load and the unpredictable nature of mental disorder and care in the community, times spent with clients and their families to learn these cultural characteristics are limited.

Studies by Narayanasamy (2003) and Lea (1994) have suggested that transcultural nursing is the ideal model for nursing in multicultural societies. For example, Narayanasamy who conducted an empirical study in Britain used a questionnaire to explore how nurses from a region with a multi-ethnic and culturally diverse population respond to clients' cultural



needs. The purpose of his/her study was to gain insight about nurses' experiences and beliefs about transcultural nursing. The study results indicated that from a sample of 126 participants, only 12% of nurses responded to the cultural aspects of clients' care. Furthermore, research was recommended in the study to confirm if this practice is widespread and has indicated caution when making generalisations of the findings. Interesting findings provided in regards to the small number of nurses responding to cultural aspects of client's care which maybe due to the lack of cultural knowledge. The researcher elaborated in great detail the steps taken to confirm validity and reliability of data collected. Despite the limitations of the study based on the small number of mental health participants, this method proves reliable and trustworthy and can be applied to PCMH setting.

Leininger (1997, cited in Narayanasamy, 2003, p. 185) describes transcultural nursing as a formal area of study and practice that focuses on aspects of comparative holistic culture care, health, and illness patterns of people with regards to their cultural values, beliefs, differences and similarities and with the aspiration to provide care that is culturally congruent, competent and compassionate. This transcultural perspective is supported by Davidhizar, Bechtel and McEwan (1999) who claim that there is a need to incorporate transcultural health perspectives in clinical practice as it is considered essential to the provision of holistic care. However, Leighton (2005) objects to a transcultural nursing framework saying that it is culturally biased and politically instrumental. Quite the opposite, Lea is optimistic that the transcultural approach enables the nurse and patient to improve or sustain their health and contradicts racism, oppression and caring that co-exist in a multicultural society. Cooney (1994) claims that transcultural nursing is essentially based on nurses' scientific knowledge of a range of different cultures to enable therapeutic responses to clients' health needs. I would argue that PCMH nurses would not require scientific base knowledge of different Pacific Island cultures as they naturally share a

variety of common values and beliefs that help create therapeutic intervention in response to clients' needs. Pacific people also have differences in their traditional customs and languages that sometimes create communication difficulties.

Polaschek (1998) indicates that the transcultural view is inadequate as it mainly focuses on individual interactions without recognition of the influential social structures within which all these interactions occur. From this viewpoint, Ramsden (Polaschek, 1998) emphasises the value of cultural safety in multicultural nursing based on the biculturalism view. The concept of cultural safety was developed by a group of Maori nurses in the late 1980s to analyse nursing practice from their standpoint as the indigenous minority in New Zealand. Teaching and learning about this concept has been implemented in undergraduate nursing since 1992. Culturally safe nursing practice involves actions which recognise, respect and nurtures the unique cultural identity of the Tangata Whenua (indigenous people of the land) in New Zealand, and meets their needs, expectations and rights in a safe manner. The cultural safety conception is without a doubt fundamental in the delivery of mental health care to Pacific people and Pacific nurses naturally apply this philosophy to their nursing practice. The following section presents a discussion on competency and professional expertise in a Pacific nursing domain.

## **2.6 Competency and professional practice in Pacific community mental health nursing**

Competency has become the major objective for nursing practice in New Zealand since the introduction of the Health Practitioner Competence Assurance (HPCA) Act (2003). This legislation has provided the impetus for the Professional Development and Recognition Programmes (PDRP) for nurses by the National Nursing Organisations (2004) to reflect the nature of nursing in Aotearoa/New Zealand. Subsequently Pacific registered nurses are required to provide evidence of their competence relating to their scope of practice. My

concern is to what this professional development means for me as a Pacific nurse working in a PCMH setting considering that this framework arises mainly from the Western mainstream view.

PCMH nursing is a specific matrix of nursing care that requires not only clinical knowledge but Pacific cultural background knowledge and understanding that underpins Pacific peoples' cultural philosophy to ensure their holistic needs are met in a culturally appropriate manner. Due to the significance of culture in the care of Pacific people, the PCMH services in line with DHB have created their own Cultural Competency practice guidelines. The 'Pacific Cultural Competency' is described as the ability to understand and appropriately apply the cultural values and practices which underpin Pacific peoples' worldviews and perspectives on health (DHB, 2004)

The HPCA Act has emphasised the issue of cultural safety in the provision of care to people of different ethnicity. Coup (1996) in her analysis of cultural safety and culturally congruent care has highlighted the importance of understanding cultural factors in nursing practice to be able to provide culturally safe practice. Culture is a world of knowing that permeates other dimensions of knowing that informs nursing practice like an invisible pattern (Gavriel, 1996). It is this cultural knowing that enhances other ways of knowing and increases the nurses' sensitivity to the issues of being in the world of another. Being Pacific born and raised, my view of the world is primarily through the eyes of a Samoan despite the fact that I have spent most of my life living in New Zealand. This legacy and exposure to both worlds and the culture of nursing, shapes and influences my understanding of being in the world of others. Schreiber (cited in DHB, 2004, p.14) explained that a deep multifaceted understanding of culture cannot be developed by standing at the top of a distant mountain because cultural knowledge originates from a culture's centre world view.

Benner's (1984) theory of nursing experience indicates that knowledge embedded in clinical expertise is central to the advancement of nursing practice and the development of nursing science. However, Benner and Benner (cited in Benner, 1984, p.4) states that "not all knowledge embedded in expertise can be captured in theoretical propositions or with analytical strategies that depends on identifying all the elements that go into decision making". I support this statement in reference to my experience as a PCMH nurse. As I have mentioned previously, PCMH nurses usually go the extra mile to do things for their Pacific clients outside their practice hours. Additionally their spontaneous fa'aalalo (respectful) manners according to Pacific protocols and beliefs are portrayed through interactions that occur when they meet with the Pacific clients and their families. These fa'aaloalo responses and activities are recognised as important to the Pacific people as it acknowledges their ancestral cultural beliefs and values. The shared inherent Pacific cultural understanding mainly influences the nurse's response and unexplainable activities towards Pacific clients' mental health needs that only a Pacific nurse would understand.

I have worked in mainstream healthcare services and in other areas of health before taking up my current position in PCMH service and know the difference in terms of cultural emphasis in practice. Hence, I believe that the Professional Development Programme framework lacks the elements that determine the competency level of PCMH nurses. I would argue that PCMH nurses are experts in their own specialised domain as they have the 'know that' and 'know how' knowledge as pointed out by philosophers of science Khun (1970), and Polanyi (1958, cited in Benner, 1984). Both Khun and Polanyi described 'know how' as skills acquired through clinical experience in the practice of a specific discipline and 'know that' as knowledge acquired through theory and scientific formulation. Additionally, a considerable number of PCMH nurses have had years of life experience and extensive mental health nursing background and have also gained academic qualifications at a postgraduate nursing level.

## **2.7 Summary**

The review of the literature provides a broad spectrum of perspectives in relation to mental health nursing in the community using various methodologies to obtain research data. However, while there is some research involving perspectives of PI nurses, there was none located about PI nurses experiences of working in PCMH services? Although numerous studies present analogous practice perspectives in many different health community settings, these do not provide conclusive account of the elements that capture the essence of the PCMH nursing phenomenon. Obviously, research is needed to explore this field of nursing practice. The various methods and design employed by different research studies provided me with some insight into a more suitable appropriate method to utilise in this project. The review of the literature has helped me consider the narrative form of inquiry as most appropriate method to gather data of PI nurses' practice account. According to Benner (1984), accounts of practice situation with context intact is best presented in the narrative form. Benner indicates that the narrative research methodology will uncover the unexamined area of practical knowledge that can then be systematically studied and refuted or extended. The following chapter provides a discussion on the methodology, method and design utilised for this research project.

## **Chapter 3: Methodology, method and design**

This chapter discusses the rationale for my choice of qualitative methodology to answer the research question: “What is it like to be a Pacific community mental health nurse within a District Health Board?” This research project will focus specifically on the narrative inquiry approach. The study design comprises specific features relating to the narrative inquiry research method in the process of gathering participants’ stories.

### **3.1 Rationale for the theoretical framework**

For many years prior to undertaking this research project, I have pondered the question, ‘What is it like for other Pacific nurses working in PCMH services?’ But to be presented with an exceptional opportunity to fulfil my vision through this research project is a privilege beyond my imagination. In the early stages of this project, I began to visualise how PCMH nurses could share their experiences and which might be the appropriate qualitative theoretical and methodological framework that would allow me to carry out this inquiry the best way possible. Instantly, I was particularly captivated with the term phenomenology which then became the focus as I gathered literature relating to this specific methodology. However, I needed a framework that would allow me to explore and articulate the complexities fundamental in this research question.

Narrative inquiry became apparent as more suitable to answer the research question as it encompass a range of approaches that would enable the depth and richness of PCMH nurses’ life experiences to emerge within an interpretive paradigm. Barton (2004) explains that narrative inquiry is about eliciting from life stories the insight, essence and resonance that accompanies the philosophical and cultural expressions and desire for the stories to be recognised. Barton maintained that the interpretive activities of both the researcher and the participants reveals a circular way of understanding experience through the process of co-participating and co-constructing stories inherent in narrative inquiry.

Historically, narrative inquiry has been theoretically and philosophically developed as a qualitative research methodology in nursing over the past two decades. In the early 1900s, Freud in his psychoanalytical case studies together with other sociologist researchers, used life narratives gathered from clients' experiences for academic studies (Reissman, 1993). Since then, life story narratives have become a part of human inquiry as quantitative inquiry was considered too narrow and limited to understand human action and experience. Narrative inquiry is about the study of ritual, routines, metaphors, epiphanies and everyday life experiences (Barton, 2002). It involves structuring time as a continuing past, present and future (Lindsay & Smith, 2003) in relation to the three critical dimensions of human experience; significance, value and intention. It is an interpretive process and in turn requires interpretation (Reismann, 1993) and given meaning subjectively by the researcher and the participant as co-researcher. Narrative inquiry is also contextually bounded which means stories elicited are told about peoples' lives and are situated within a particular historical, cultural, social or political context. Overall, Narrative inquiry is about reconstructing life experience by making backward and forward connections between what researchers do to things and what they enjoy or suffer from these things as a consequence (Lindsay, 2006).

Nurse researchers such as Benner (1984) and McEldowney's (2005) have contributed to my choice of narrative as a form of qualitative inquiry to pursue with this project. For example, Benner proposed that the narrative mode presents practice situations laden with assumptions and expectations that can generate new questions for further refinement, development and testing. Benner further suggests that uncovering these assumptions and expectations can reveal unexamined practice knowledge that can then be extended and studied systemically. Alternatively McEldowney's conception of life-story narratives has helped me gained a better understanding of this methodology. She describes narrative inquiry as like an umbrella that arches over different strands or methods that include

autobiography, life history, biography, oral history and life story. All these methodologies work with stories generated, conducted and interpreted by the researcher through conversation with the participants to form a narrative framework.

The central focus of this study is to understand the Pacific nurses' experiences of working in PCMH services in a DHB. I wanted to know precisely what this experience is like for them and how it has shaped their nursing practice. From this view point I have chosen the storytelling approach within a narrative inquiry framework to focus on PCMH nurses' practice. Storytelling and narrative are alternative modes of inquiry with different meanings that have been used interchangeably and synonymously. Bruner (1986, as cited in Mello, 2001) points out that storytelling is considered the oldest method of communication and is defined as a linguistic activity that creates negotiated transactions that humans translate their individual private experiences of understanding into a public culturally collaborated form. The next section focuses on a discussion of storytelling as a method and how this process is influenced by a Samoan perspective.

### **3.2 Storytelling as method**

Storytelling (fagogo) was the principal method for data collection in this thesis. It is a way of connecting, exchanging and consolidating knowledge, and facilitating the nursing research process (Giarre & Jaccheri, 2006). Storytelling is a process of reflection and action that requires researchers and participants to think together as co-participants and co-construction in the retelling process (Barton, 2004). Clandinin and Connelly (cited in Richmond, 2002) indicated that stories allow individuals to reflect upon life and explain themselves to others in order to study life narratives as a context for making meaning. Plummer (2001, p. 395) states:

to tell the story of a life may be one of the cores of culture, those fine webs of meaning that help organise our ways of life. These stories...connect the inner world to the outer



world, speak to the subjective and the objective, and establish the boundaries of identities.

The art of storytelling in connection to its ancient roots remains an activity where a tale is told aloud to an audience without the use of memorised scripts or other literary texts, and is the closest thing in modern contexts to the orality of our preliterate ancestors (Mello, 2001). Fagogo (storytelling) in the Pacific Islands is usually of legends and myths and is a fundamental way in which ethnic culture and tradition has been passed from one generation to the next (MHR&D, 2004). Tools as such personified distinctively Pacific philosophical frameworks that underpin uniquely Pacific perception and interpretations of concepts such as the self, time, mental health and the like.

Albert Wendt is an example of a skilled storyteller of Samoan heritage and an inspiring award winning author and novelist. Wendt's novels locate both the world within the Pacific and the Pacific within the world. He offers complex insights and profound understanding into the culture and lives of Pacific people. His novel the '*Flying-fox in a freedom tree*'(1974) for example is one of his collection of stories written from a contemporary Samoan viewpoint that presents an exceptional traditional Pacific island community caught up in the rapid changes of the twentieth century.

As a Samoan nurse researcher, my intention was to inform this research process from a Pacific perspective which includes: respecting the differences of the individual participants (fa'aaloalo mo tagata taitoatasi), meeting face-to-face (va fealoaloa'i), a collaborative approach (feso'otaiga aloaia), being careful and cautious (fa'aiteete ma fa'apalepale), protecting one's identity and dignity (puipuia le mamalu ole tagata), and knowing when to speak (iloa le taimi e tautala ai). This culturally sensitive research approach (Tillman, 2002) both acknowledges and recognises Pacific ethnicity and situates culture as central to

this research process. The following section presents a discussion regarding the ethical deliberation of the study.

### **3.3 Ethical consideration**

The principles of ethical practice in narrative inquiry are significant in terms of what is right to do (deontological ethics), of achieving what is good (consequentiality ethics) and of exemplifying the necessary qualities of character to live well (virtue ethics) (Barton, 2004). From these principles transpired ‘goodness’ standards in relation to this study which means that participants were considered first and foremost taking into consideration protecting their privacy, safeguarding their rights, interests, sensitivity, and making written information accessible to participants.

Ethical approval to undertake this study was obtained from the Victoria University of Wellington Human Ethics Committee (refer Appendix 1). Prior to the recruitment process, a presentation and verbal briefing about the nature and demeanour of the research and issues of voluntary participation, privacy and confidentiality and their right to withdraw were discussed with the targeted PCMH nurses’ group. An information sheet (refer Appendix 3) that explained and emphasised these issues was also provided and distributed to the group. I was aware of the possibility of the likelihood that I will know the participants. Permission was then sought and acquired from the PCMH services (refer Appendix 2) where Pacific nurses are employed. Once the organisation manager agreed and signed a form of permission for the nurses to be involved, I consulted with the participants about the agreement that they could attend an interview in their work time. Potential participants who volunteered and agreed to participate were again provided additional verbal explanation and written information through face to face contact during the recruitment process. Through this contact, a suitable date and time was arranged to

conduct the interview. A written consent form (refer Appendix 4) was provided for participants to sign prior to commencing the interview process.

The ethics of narrative inquiry involves learning how to listen and receive stories followed by interactions of authenticity and respect (Barton, 2004). Respect (fa'aaloalo) in Pacific culture is the foundation of good relationships that binds everything together. I introduced what this study was about in our PCMH group discussion and took into account suggestions and feedback from the group. Narrative inquiry largely involves being in relationship with human beings which also requires accountability and responsibility (Barton, 2004). Acquiring the participant's trust is imperative. Before obtaining their consent, I emphasised to the group that their identity would be kept confidential. In the Fa'a Samoa (Samoan culture) for example, every relationship is sacred (tapu or sa) and is sealed by feagaiga (a covenant) with boundaries defined by tapu or sa and breaching the tapu can result in a curse being brought upon the person (Lui, 2004). This cultural affiliation reinforced my belief about the essence of respect in my personal encounter with participants that includes the people that I care for and work with. I was aware that if the confidentiality of any of these people that includes the participants in this study was dishonoured then the trust would be broken. The following section discusses the concept of the Treaty of Waitangi in relation to the research process.

### **3.4 The Treaty of Waitangi**

To acknowledge the Treaty of Waitangi as the founding document that underpins provision of health care for all New Zealanders is to determine the relevance of this research project in relation to the tangata whenua (original people of the land). Currently within the New Zealand context of a multi-ethnic and multi-cultural society, there is a tendency to overlook the significance of this document. The Treaty is equally beneficial for Pacific

people who despite dissimilarities share traditional analogous complex issues with Maori people in regards to health and culture.

This thesis explores the perspectives of Pacific nurses working in PCMH services to gain a better understanding of what it is like for them to work in a multi-ethnic multi-cultural health setting. Article Two of the Treaty (Maori Health Framework Seminar, 1995) for example assured Maori people their rights and full participation in health decisions and autonomy over their cultural, social and economic interests. Participants in this study are entitled the right of self determination, the choice to participate and fair treatment, and to safeguard their privacy and confidentiality.

As indicated in Article Three of the Treaty, Maori and Pakeha people were guaranteed partnership and equality in health and decision making at every level. This research project is consistent of the Treaty of Waitangi principles which encompass partnership, protection, participation and Tino Rangatiratanga (self determination) that shape the practice of Mental Health Nursing in New Zealand (Te Ao Maramatanga, 2004). Because of the shared interests in the topic under inquiry, I consider this venture a partnership negotiated between myself as the researcher and Pacific nurse participants which involves working together through collaboration to accomplish an outcome beneficial for both parties. Without the contribution and dedication of participants, this project would not be possible. The following section of this chapter presents the recruitment process undertaken in this study.

### **3.5 Recruitment of participants**

Towards the end of 2005, I made a presentation to the PCMH nurses group in the Auckland region about the research project that I intended to undertake. An open invitation was put out to nurses for anyone who would be interested in participating in this project. Clear explanations of the intention and purpose of the project had generated interest in the

group who gave their support for this project. Consequently, a number of nurses subsequently expressed that they were willing to participate in this research.

The following prerequisite inclusion and exclusion criteria were determined for the selection of potential participants to the study. These included: preferably Registered nurses who self-identify as a person of Pacific ethnicity; nurses who responded to the letter of participation; those who consented to participate in the research; and those who have worked in PCMH services in a DHB for at least 12 months or more. The rationale for the time frame of one year or more was that I believed that these nurses would have gained sufficient insight and understanding of the work involved in their practice setting. The criteria for exclusion included: Pacific mental health nurses who had not worked in a PCMH setting; and, those nurses that did not identify with a Pacific ethnicity. Information sheets were distributed to participants at a number of Pacific mental health nurses forums and also through their work email with an outline of the project and contact information for potential participants.

Due to the restricted timeframe and the lack of response to recruitment advertisement, a final selection of five people was made from those nurses who volunteered to participate in the research. Taking into account the ethics committee's suggestion, a decision was made not to interview those Pacific nurses whom I worked with directly. Hence a nurse who had previously left a Pacific service was recruited to the study. Individuals were asked if they were still willing to participate and were given the choice to decline to withdraw if they wished. This was to ensure participants did not feel coerced or put in a position where they might feel obliged to take part in the study. An arrangement was made to meet with each individual participant to go through details of the project to ensure they understood the purpose of the project and the process involved and if they had any questions to ask and if they wished to continue or withdraw. A follow up meeting was arranged for an appropriate date, time and venue for individual interviews to be conducted.

### **3.6 Study participants**

Registered Nurses were recruited from three PCMH services located in the Auckland region. The nursing staff arises from diverse Pacific Islands includes Tonga, Samoa, Cook Islands, Niue and Fiji. Initially, five nurses volunteered to participate which reflects a balance between the three PCMH services. Due to the restricted timeframe and potentially large amount of data to be gathered and analysed, I considered the small sample of five sufficient to represent the small population of PCMH nurses. All participants were identified as registered nurses with a Pacific Island ethnicity and have worked in the PCMH setting for a period of a year or more.

As I mentioned earlier, the impetus of this study was to confirm an aspect of New Zealand and Pacific-born nurses' practice in PCMH settings. Hence, of the five selected, two were Pacific born; one male and one female. Of those that were New Zealand-born one was male and two female. All participants spoke fluent English, and those with a Pacific first language did not require the use of an interpreter. Given the reasonably small sample of potential participants, there was a risk of breaching participants' identity and confidentiality. To prevent this from happening, a decision was made to refer to participants as being a Pacific nurse rather than identifying them by their specific ethnicity. Pseudonyms are used to disguise or alter any details that would expose participants' identities.

### **3.7 The research process**

Data collection is the distinctive systemic collection of information pertinent to the research purpose or the specific objectives, questions or premise of a study (Burns & Grove, 1997). The primary goal for the data collection in this research project was to illicit stories of the experiences of PCMH nurses to discern the participants' standpoint. Collection of data for this project was through face to face, audio taped interviews. Due to

time constraints and participants' work commitments; I negotiated with each participant to arrange an appropriate time and private meeting location. An interview date and time was scheduled with a minimum of a week's notice in advance.

Prior to commencing the interviews, participants were given the opportunity if they wanted to ask any questions about the research project. A consent form was then given to participants to sign. A list of interview questions (refer Appendix 4) that include open ended questions and probing was used to facilitate the interview process. Content of the interview focused on the issues central to the research question. The participants were encouraged to share stories about their practice within a PCMH context and to take as much time as they needed.

The first question usually began with a single probe such as 'tell me how you first got into Pacific mental health services.' Each participant was interviewed for a period of 60-90 minutes. The interviews were audio-taped and in case of a malfunction, a backup tape-recorder was kept as a reserve. Tape-recorded interviews, handwritten field notes and memos were transcribed onto a word processor following each episode of fieldwork. My reflections of each encounter were documented in my field journal which was maintained throughout the time of data generation to record how the interview gathering process was progressing at the end of each interview. The journal helped me reflect on various aspects of the process and how I established my role and position as a researcher. Stories as texts were collated and indexed for easy access to data and a hard copy of the data was produced as original and kept as reference in the case of computer system breakdown.

The second follow-up interviews were conducted at a mutually agreed place with pre-arranged convenient times to both the participant and researcher. A copy of each participant's interviews was either forwarded through their email address or face to face

contact prior to the follow-up interview. Due to time constraints, the follow-up interview was via telephone conversation as preferred by most participants. This second interview was to reflect and clarify any unclear information from the first initial interview transcript. Every attempt was made throughout the data collection procedure (with ethical considerations permeating the entire research process) to ensure any potential bias or inconsistencies were prevented or eliminated and to create credibility of this project. For example, although interview questions were geared to obtain responses in relation to the research topic, I was aware of the tendency to ask questions to obtain a response that I might want to hear. Every effort was made to prevent this. The following chapter discusses the issue of rigour in regards to validity of this research.

### **3.8 Rigour**

Rigour in this project is established through the concept of trustworthiness to convince the reader of the important findings. Trustworthiness in this qualitative inquiry appeals through the notion of credibility and transferability. To ensure trustworthiness, Robson (Badger 2000) claims that information must be presented in a logical unbiased reasoning to demonstrate thoroughness and academic rigour in the study.

Riesman (1993) highlighted four ways to develop rigour in a research project which are; persuasiveness, correspondence, coherence and pragmatics. Persuasiveness for example is eminent when theoretical claims are supported with testimony of informant's accounts and an alternative interpretation of the data is considered. Correspondence as indicated by Lincoln and Guba (Reissman, 1993) involves taking the result back to the participants for a member check to ensure that any quoted material and informant's consent has been adequately disguised and secured.

In the second face to face meeting held with individual participants, a copy of their interview transcripts was handed to them with the opportunity to view their stories. I asked whether this reflected their experience and to incorporate any changes required.



Transcripts were sent to those participants who were unable to attend a second meeting with the same information. Lincoln and Guba (Reissman, 1993) explain that this allows the reader joint responsibility in judging the evidence claimed. A follow-up contact was arranged within one week with participants, to obtain feedback regarding view of their transcripts and whether there were any changes that needed to be made. Koch and Harrington (1998) claim that research derived from this member check approach, authenticates data and contributes to the rigour of the research process.

In terms of credibility, Lincoln and Guba (cited in Reissman, 1993) maintain that credibility of a study is increased if the investigator's reconstructions are recognisable as adequate representation. My intention in this thesis was to ensure logic and transparent presentation of the entire process undertaken that is understandable for the reader and thereby increase the credibility of this study. Then again, Koch and Harrington (1998) argue that credibility should be judged on the usefulness of the research project.

In regards to transferability, Tuckett (2005) explains that a research study can be transferred for the knowledge to be generalisable and must include thick description that encompasses the research setting, participants' details, in-context data, credible interpretation, information and description of recordings and data storage. Transferability of this study is advanced through the process of thick description of the whole research development. Thorne (2000) points out that the quality of the study is considered successful if the findings 'ring true' to the audience. The next section discusses the process undertaken to transcribe the research data obtain from the participants' interviews.

### **3.9 Transcribing the participants' stories**

Transcribing is essential to analysis of narratives or stories. The first interview was transcribed completely and verbatim by me. However, due to the limited time-frame and the large amount of data to be transcribed, the remaining four interviews were forwarded to an experienced transcriber contracted specifically for this project who signed a

confidentiality form (refer Appendix 6). The problem that I discovered with using a transcriber who is not familiar with the specific profession or the researched topic is incorrect spelling of peoples' names and other technical terms.

I found transcribing a gradual, lengthy and interesting process as I got to analyse and interpret particular content of the interview data simultaneously. Occasionally, the tape needed to be re-rewinded and re-listened to several times in order to produce a more detailed accurate representation of key moments in the conversation. Transcribing the interviews was completed within a period of approximately eight weeks. The transcripts were stored in an indexed file electronically and hard copies were also kept in a file. Interview transcripts were forwarded to participants to check for accuracy and to see if they wished to add, delete or change anything prior to the second interview. Participants were also given the opportunity to keep a copy if they wished. The transcripts were then analysed and interpreted for key themes that emerged from the data. The following section presents a discussion on the analysis and interpretation of the data process.

### **3.10 Data analysis and interpretation**

The purpose of data analysis is to classify the interviews and present a narrative that confirmed what happened or why and to provide a description of the norms and values that instigate a topic or cultural activities (Rubin & Rubin, 1995). I found analysing the interview data to be a most complex, time-consuming and scrupulous process. It required concentration and attention to subtlety, nuances of speech, organisation of a response, confined contexts of production and social discourses that outline what is alleged and what cannot be spoken (Reissman, 1993). Considerable time was spent scrutinising the drafts of transcripts across a number of interviews, trying to establish a sense of logic and how I would analyse, weave together ideas and concepts presented in this ocean of interview material. Reissman illuminates that the interview analysis is difficult to distinguish from

transcription. It requires close and repeated listening together with methodical transcribing that normally leads to insights and consecutively influences the preferred means of representing an interview narrative in a research text.

Narrative or story analysis does not have a single heritage or methodology. In spite of this, I needed an analytical process that was easy for me to understand and follow. Rubin and Rubin's (1995) analytical approach provided me with a particular less complicated guide to assist through this process. Analyses of the data began while the interviewing was still in progress and continued following the completion of each interview, and then again after all the five interviews were transcribed. Reflection and recollection upon each interview were documented in my journal and stored electronically in the computer data base at home following each interview.

The final data analysis involved reading and rereading the larger group of transcripts separately to pull out core ideas, concepts and emotive stories to find themes that described the participants' experiences. I then searched for explanatory concepts and picked out the words used frequently by the participant. Rubin and Rubin refer to this as recognising concepts using a specialised vocabulary or offering a particular inclination to a more common word or phrase. I found that asking questions such as 'what does this mean?' or 'what is this person talking about?' or 'is this word or phrase significant?' often helped provide a meaning or an idea and consequently opened up an underlying concept. I shall elaborate more on this with examples from interviews in the next chapter.

Rubin and Rubin (1995) emphasise the importance of paying attention to stories which are refined, condensed or altered versions of events, as very often they communicate significant themes that explain a topical or cultural arena. The purpose of this research project was to discover any underlying themes that are regarded as significant to PCMH

nursing practice. Themes provide an explanation of how or why things happen. Individual participant stories were firstly categorised in stages and coded according to time and sequence of events. For example, what happened as participants embarked on their journey in the PCMH service to arrive at this point and concluded with what their future intentions are. A list of specific concepts and phrases were then emphasised with a brief summary that suggests or indicate a theme relating to what the participant said. Finally, materials from all interviews were placed into one category to be compared and to identify variations and nuances in meaning to determine the connections between themes.

As I mentioned in the early stage of this project, one of the rationale for this study was to confirm my belief that Pacific-born and New Zealand-born Pacific nurses' experiences would be different. Subsequently, interview transcripts were separated and categories under these two Pacific entities to establish the concepts that describes this phenomenon. This helped refined and linked together notions that formulate the themes and sub-themes, thus provide a clear description and interpretation of the participants' stories in terms of the literature and theories related to PCMH nursing. In the following chapter, I present the five participants' stories about the 'what' and 'how' of working for Pacific community mental health services within a DHB.

## **Chapter 4: The participants' experiences of working as a in the PCMH nurse**

This chapter presents interpretations and discussions of participants' responses regarding their experiences of working in Pacific Community Mental Health (PCMH) services. The purpose of this research was to discover how each participant perceives their encounter within PCMH services. As mentioned in Chapter 3, the findings were obtained through face-to-face interview with five participants. A list of questions was modified as appropriate throughout the course of the dialogue to allow participants to articulate their viewpoints. The participants' names are pseudonyms to protect their identity and maintain confidentiality. They are: Peta and Mika who are both Pacific Island born while the other three participants Semi, Tepora and Sera are all New Zealand born.

Walking into the midst of stories (Lindsay, 2006) as the data collection unfolded, I shifted from the transcripts of the participants' stories to formulate themes that reveal nurses' experiences of the PCMH domain. The individual stories were organised in meaningful concepts under each participant's name and categorised in terms of past, present and future orientations and in order for me to establish cross case comparison and to identify emerging themes.

This chapter comprises interpretations of each individual interview as focused storytelling and the analysis presented reflect this focus. Each hour long interview was held once at different dates and time and were conducted at each participant's workplace in a private locked room. The interview began by asking the participants to tell me what inspired them to work in PCMH service. Participants were encouraged to take as much time as they needed. It was obvious that each person had a story that preceded their stories about entry into PCMH practice. Although English was not always the nurse's first language, the

interviews are sometimes not grammatically perfect. Hence, I have chosen not to change them as they are reflective of how various Pacific nurses speak.

## 4.1 Key to Transcriptions

In presenting the research findings, the abbreviations and conventions that have been used in the transcriptions are outlined in the following context.

Italics	Identifies the interview data provided by the nurses participating.
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Names	With the consent of the participants, the nurses' voices are identified through the use of pseudonyms.
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(Name, 4:1 - 4:5)	References the participant's name, interview and page number.
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[ ]	Indicates alterations made by the researcher to enhance clarity and grammatical flow
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.....	Denotes material deleted from the original text.
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In the following sections I present the transcriptions of each individual participant's stories about their experiences in PCMH services.

## 4.2 Peta's experiences

Peta is a Pacific born who spoke Pacific as first language and is fluent in English. When asked what influence her to work at PCMH services, she explained:

*I was asked to consider working in [specified PCMH service]. Another reason why I chose to work in Pacific mental health service was because when I was working in a mental health hospital in the past, there was a lot of our people who had been admitted because they were misdiagnosed and didn't have anybody trained to translate for them and their English wasn't that good. I was sent to translate for them and I felt that I need to work in mental health to support Pacific people that got admitted there because sometimes just knowing that you're Pacific Island (PI), it calmed them down. So when the position came up at the PMH service, I applied for it and I got the job and that's why I'm here.*

Upon joining the PCMH team, Peta had experienced mixed feelings and wondered whether she chose the right place to work as she thought her designated Pacific service was in a chaotic state. However, she felt that perseverance prevailed as service resources improved which made her felt better.

Peta carries a client load that consisted mainly of clients with whom she shared similar ethnic background. Her role involved initial assessment upon client's referral to the service, coordinating an intervention plan that includes organising client's clinical appointments, liaising and consolidating with appropriate services and resources to meet their needs. This also included the cultural aspects with which she utilises her Pacific language skills and understanding of their culture. Peta commented:

*We provide cultural support. I mean we go to clients' homes, because I speak the language they welcome you with open arms but most of the young ones they speak English which I don't have any difficulty relating to them but with the parents and*

*grandparents, I have better rapport with them and I explain to them in the language about mental illness.*

In dealing with these difficult practice issues, Peta utilises separate cultural and clinical supervision which she sometimes found complicated.

*At times it's difficult talking to the non peer about nursing, that's why I have a clinical and a cultural supervisor.*

Peta was adamant that the PCMH services have senior nurses with academic qualifications such as a Masters degrees who have also done supervision courses whom she believed are capable of providing supervision that encompass both the cultural and clinical aspects for those requiring supervision in the PCMH field.

Peta noted that working in the PCMH service made an enormous impact on her nursing practice and at times she felt overwhelmed with the amount of responsibility and commitment involved in her role. She elaborated:

*Well as a PI, because you have that nurture, you know empathy for your people. I find it really hard you know. You have to wear two hats, you're translating. You think in English and you translate and then you have to translate back into your own words to write it down and that's double action. And at times when I really have a hard day, I think maybe I should go back to mainstream and I can just think one way. I can only go there [mainstream] and work eight hours then I go home. But working with PI in the community you go the extra mile because you want the best for your people and you work long hours and you don't get remunerated for that, you know you don't get paid.*



Working with her own people and making a difference in their lives was considered by Peta as an advantage.

*I have a better relationship with them because they understand me as a Pacific Islander working with them.*

Nevertheless a disadvantage of working in the PCMH service was detected in her response as she pointed out:

*The disadvantage for me is that you are expected to do everything. You do your work inside but also do the social issues and more or less taking them to WINZ (Work and Income New Zealand) to do their benefit.....you advocate for them. You advise them to go do their benefit or see their family doctor and sometimes they can't afford to pay the doctor.*

Peta spoke of the barriers existing in the PCMH service that prevented her from moving forward and expanding her role. One of the major challenges that she identified was conveying her practice objectives due to the lack of communication and consideration from the PCMH services and DHB management.

*If there are things that you want to put in place but can't because you have to go through the management, and having a manager who is not a nurse or [does not have] nursing background or understanding is a real barrier. I suppose they're there to manage the resources and save the money. But for me, I see the need to have PMH nurses to fill the gap between primary health and mental health because I feel that our people that have gone to the GP for instance with depression or anxiety are not managed properly there. Our hands are tied because we have to go through layers of management to try and talk to them [management] to look into this. Also the limited resources they put in place for conferences and workshops means that you can't go*

*and its part of the requirement of the Nursing Council that you have the hours to go. I find that a bit frustrating.*

Despite the challenges, Peta said that the PCMH service had made a significant contribution to her professional practice development. Furthermore, she discovered that working with Pacific people and seeing clients stabilised and moved on generates immense satisfaction. She declared:

*Coming into a PCMH service, I have been able to go back to university. The support I was given was tremendous. Even though I have this caseload, I've been able to juggle it around and of course I wanted to give the best I could because of the support that I get. That makes me want to stay in the service and this is the uniqueness of the Pacific service that I work for. They are very supportive towards me, not only academically but also the cultural aspect of my practice. The staff and the doctors are very supportive towards us doing all this.*

In terms of future prospects, Peta talked about her aspiration of returning to the Pacific Islands and utilising her knowledge in the mental health establishment there. She recognised the substantial need in the mental health area in her homeland for people with mental disorders who maybe reluctant to leave their native land in search of mental health treatment in other countries.

### **4.3 Semi's experiences**

Semi is a New Zealand born young Pacific male nurse whose first language is English and speaks limited Pacific ethnic language. For Semi, it was through his positive experience gained during his nursing training placement at the PCMH service that influenced him to seek employment in this service. He explained:

*When I got that experience of working within Pacific Health, I think that sort of put it in the back of my mind that maybe that's where I might want to work. So then afterwards I had a taste of other places like mainstream and inpatient and community and I think it showed up that this is where my heart lies and where I fit in best. Getting the experience when you're a student I think help[s] out a lot and I also got a positive experience while I was at [specified] PCMH service. That sort of pushed me towards Pacific mental health.*

Semi noticed that being in a familiar environment and being around people of the same background and culture made him feel at ease within the team when he started at the PCMH service.

Semi's caseload mainly consisted of Pacific clients with whom he shared a similar ethnic background. His role involved coordinating client's care plan to ensure their mental health needs are met holistically. This included consultation and consolidating with all personnel involved (both internal and external) to access appropriate resources to address their mental health as well as social issues. Upon exploring some of the difficulties encountered in his practice, Semi noted that the predominant impediment in his undertaking was his lack of confidence. He recognised this attitude as characteristic of a typical Pacific student.

*When you're a Pacific student, for example when you're studying, you're always taking the back seat, sometimes you're always observing and you're more taking a quiet stance in the background, in the class, just sitting back and absorbing it as much. I think that trickled on to when I first started work, so I was quieter and took the back seat.*

Consequently, Semi expressed his gratitude for the robust support received from his senior colleagues who steered him in the right direction.

*They pulled me aside and had a pep talk and that helped. Having that*

*encouragement and support, really pushed me forward.*

One of the difficulties he sometimes encountered in performing his key worker role at times is the language barrier. This was mainly a difficulty during intensive family meetings for clients. To address this, the assistance of senior colleagues who speak the requires language fluently are utilised. Nevertheless, Semi stated:

*I don't see it all as language being the main thing. I think a lot of how you present yourself, how you act, just a lot of tradition.*

In dealing with difficult issues arising in his practice, Semi acknowledges the benefit of peer supervision as well as cultural supervision with a supervisor from his own ethnic background. Alternatively, Semi felt that it is imperative to make use of senior nursing colleagues for supervision. He elaborated:

*Our nurses who have gone on to postgraduate study and have years of experience, they are more than capable of providing supervision to not only junior nurses but student nurses. I think it's essential that we get our own sort of people with our own background giving supervision. I think it has to be done. Like I know from experience with talking to those nurses and its like supervision, it's helped me a lot in my practice. I feel that a lot of the nurses that I've worked with will be able to give expert supervision in a competent way.*

Semi felt that working in the PCMH service has had a noteworthy impact on his nursing practice that consequently enhanced his awareness of the essence of diversity in nursing.

*I think it sort of like if you're a Pacific you know you've got your own role to play as a nurse. And I think my skills that I have learned through University and through life experiences and towards Pacific people is a big bonus for us.*

As a New Zealand born and raised Pacific person, Semi regarded working in the PCMH environment as a huge advantage personally and professionally.

*One of the best advantages I've found is I've learned more about my own culture, of who I am, of where I've come from and where my parents have come from. I think I've sort of got a better appreciation of being different. Like before I used to think I'm Pacific but I want to be a Palagi (European). Coming here to a PCMH service, I thought now I've missed out on a lot that like when I was young I should have kept speaking my Pacific language at home. The biggest benefit would be learning more about mental health and that, but for me it has been learning more about my culture and my own background, so it's good.*

The disadvantage indicated by Semi was not being able to see the bigger picture. He felt that he maybe missing out on opportunities to explore what other practices have to offer and different processes such as advocacy with his own people.

*I guess, in a way I'm missing out on a little bit but for myself I am quite happy where I am and still enjoying the learning experience.*

The dominant barrier that Semi aimed to overcome is his inability to speak his native language fluently. He has distinguished this as an essential element and intends to keep practicing and aims to speak the language fluently in the next couple of years. The rationale for this objective was viewed as vital to his professional practice.

*Like a crisis comes up and I can't access our senior staff and I will be stuck. Like, especially if I'm working in a specialist area and that is one of the skills that you need as a speciality. Y...ah, so I want that speciality role of being a speciality nurse by being able to actually fluently speak my language.*

The lack of assertiveness in his dealing with clients was also considered a barrier in his practice and says he is always trying to please people and to make them happy. Semi comprehended the need to accommodate a more self-confident attitude.

Semi felt strongly that working in the PCMH service has made a considerable contribution to his personal and professional practice development. He elaborated:

*Oh yes I think it's made me more aware of different options of care. Like while I was studying at University we were taught a certain way of care plans and certain way of presenting yourself when you approach or converse with a client. But when you come into PCMH those ways don't work with the clients. So now that I've been in PMH I've learned and appreciate that there is always different ways of doing things and especially with Pacific people some approaches don't work so we have to come up with our own cultures Pacific and appropriate sort of practice, way of doing things. That's what I've learned being in here. I've also learnt that I've got to open up my way of thinking and not just straight learning out of a book, there's a lot of grey areas.*

In terms of future aspiration, Semi was adamant that he wishes to continue working in a PCMH service for the next two years to broaden his experience as a Pacific nurse. Moreover he envisaged establishing his career in the future in the Pacific health sector maybe at a distinct echelon.

*I want to maybe in the future work in policy making that will further impact on nurses' practice and have a bigger range of impact on our people. But I know definitely that I will still be working in the Pacific health area and maybe on that different level, working for our people.*

In his final words, Semi expressed that he never contemplated a career in PCMH services but believed it was a blessing. He said that coming to a team where he was accepted feels right and he is privileged to have had the opportunity to work in a PCMH service.

#### 4.4 Mika's experiences

Mika who is a Pacific born male nurse whose first language is Pacific and fluent in English as second language. He attributed his decision to seek employment in the PCMH service primarily to the influence of his past experience of working mainstream mental health services. He spoke of the detrimental consequence of cultural needs deprivation on clients' mental state he had identified while working with an ethnic minority group particularly the Afro Caribbean people. He declared:

*That really gave me the passion to work for the Pacific people. I could see the great big gaps in meeting the needs of those people, and of course misdiagnosis purely because of not understanding the cultural aspects. So I was excited when I came back to New Zealand and found that there are services for the Pacific people. I was keen and enthusiastic to work for them because I know that they needed people to support them in their own culture, in their own environment so yes that's how I decided to work for the Pacific service.*

Prior to commencing his career at a PCMH service Mika worked at the inpatient mental health unit for a few months which he felt was a privilege that introduced him to how the New Zealand system works and also his first encounter with the Pacific clients. He claimed:

*I was glad to be one of the Pacific nurses whom when people from our Pasifika (Pacific) were admitted to the inpatient, when they see somebody of their own culture they feel comfortable. You don't need to establish any rapport or any of that relationship type of thing that nurses need to do. That happens automatically because they are glad, so from there I played the role of being a true advocate for Pacific people because we understand their needs and understand what they want and some of the things, the language barrier and some of the cultural issues were just there.*

From the inpatient unit, he moved onto the PCMH service and took up the position of Community Mental Health Nurse. Mika described the difficulties encountered in his role as Care coordinator where he actually tried to work his way around getting used to having a clinical team with a cultural component attached to the service delivery model. He elaborated:

*It was quite difficult to establish yourself as purely as a clinical person, as a clinician to take care of the medical aspects and to take care of any other physical aspects that you might want to intervene because if we look at the clients holistically, you know that encompass all of us and to become a clinical person from a specific Pacific Island background. I grew up in a Pacific Island and I completed my education predominantly here in New Zealand and in [overseas country], still you can't separate the two and that's one thing that took me some time to get used to.*

Mika noted that the difficulties encountered in his role were due to the complex nature of the Pacific service delivery model. For example, a staff member of the same ethnicity employed as cultural worker to work alongside him to provide the cultural aspects of a client's care. He felt that this often resulted in a conflict of opinion in the cultural arena.

*I mean sure enough we are more experienced as a nurse from a clinical viewpoint but we do know about the cultural aspects as well so sometimes it is quite interesting to discuss about the cultural aspects when it comes to addressing some of the needs for Pacific consumers. So it took me some time to establish myself as a clinician and also [learn to] dialogue with the cultural worker.*

His understanding of the rationality behind this PCMH service model was for the clinical and cultural component to complement each other and find true balance. Mika indicated that determining what that point of balance is has been one of the difficulties in nursing. He claimed:



*Of course we are educated in western institutions and our mentality of thinking revolves around mainstream western culture and of course it will take some kind of effort to change that mentality and incorporate our clinical [knowledge] and look at it from our Pacific perspective. I look at medication as a trivial vital part of intervention for people because we no longer look from a medical model but consider other aspects that affect a person holistically.*

A prominent barrier that Mika had identified was the restraints in terms of flexibility. He pointed out that a PCMH service is still very much under the influence of the mainstream organisation hierarchy.

*Although the service I worked at is a Pacific service, to me it's still just like a mainstream service and very much influenced by a DHB so very much of the policies and everything that's covered is very much mainstream, it gives me the feeling that we are just a puppet of a big organisation. We can operate so much within that confined space of that arena. So I think that one of the barriers to me was that we're doing our best to work with our clients but still the organisation or the hierarchy of things are still, we are still under the umbrella of a bigger mainstream organisation. So there's a feeling of being restricted with what we are able to do.*

Upon exploring how barriers or difficulties encountered are dealt with, Mika said that it was his enthusiasm and keenness in his personal endeavour and passion to work with Pacific Island people to make a difference in their lives that motivated him to adjust and deal with any emerging challenges in his practice.

*When I started at the Pacific service, I straight away..... noticed the difference that it makes. I kind of slotted into my role without much difficulty knowing that I have to learn rather quickly and secondly, I have to be very effective in my role in helping support Pacific consumers. Additionally, the staff have been wonderful support and there's a feeling of family atmosphere and relationship within the team. Despite our*

*differences, the Pacific concept of working relationship gives us the kind of collective brothers and sisters working for a common cause and in that sense I was supported in a lot of ways. And also, I guess there was opportunity to further my education through various organisations that started with Pacific Island workers in which through them I was able to get supervision indirectly.*

On the subject of supervision, Mika's prospect of utilising PCMH nurses for supervision with the use of a framework modified and tailor-made to suit PCMH nurses' needs will be more effective. He stated:

*There's more to supervision than just sitting face to face and talks about it and unloading. There are other aspects within our Pacific way of life that enriches and add value to that relationship you know. I mean if you sit down with a palagi supervisor you kind of move from the Pacific way and try to be in line with what they have, their way of life and we try and bring them out into our own cultural arena which can be hard for some people. I think it makes life easier when we do our own supervision and more effectively.*

Mika felt that working in PCMH has made enormous impact on his nursing practice professionally and personally. He said that it has transformed his mainstream westernised perception and has become more comfortable as a Pacific Island worker and relate well to whoever he works with or helped.

The opportunity to truly make a difference in Pacific consumers and their families' lives was seen as an advantage of working in the PCMH service. Mika claimed that the advantage of having both instinctive knowledge of the Pacific cultural way and an understanding of the mainstream western way of thinking enables PCMH nurses to inform clients and their families holistically. Moreover, Mika is optimistic that working in the PCMH service has helped him pave a leadership pathway into management to fulfil his

vision and future goals primarily to influence decision making targeted to benefit Pacific consumers and their families' lives. On the other hand, the disadvantage of PCMH services which Mika identified was that because the Pacific service is within the mainstream umbrella, he felt that there are more restrictions on what nurses can do.

A barrier that Mika identified was the need to improve the relationship between the cultural workers and the nurses in the PCMH service. Although Mika was reluctant that the two components would ever truly integrate due to considerable differences, he proposed that these two staff groups require ongoing discussions to get them to work together effectively. Another barrier that he felt needed transformation is DHB management restrictions on Pacific services. Mika commented:

*The DHB management should give more freedom for the Pacific services to pursue their own plan because there's a feeling that they are not given that opportunity. You know, the DHB can let Pacific services venture out on their own as far as the length of the lead.....but that has been restricted.*

Mika noted that the PCMH service has made immense contribution to his nursing practice development both professionally and personally.

*I've done two years at a PCMH service and it's given me a lot of incentive, renewed my passion, given me some goals for my future direction. So that's certainly reaffirmed my passion and pathway into a management position where I truly believe that I can make the right decision for the right reason to make a difference.*

With his enduring relentless passion to help Pacific people with mental health problems, Mika believed that his faith played a major part in his worldview, passion and vision for the future. He concluded:

*My vision is that I want to be involved in an organisation for the Pacific community that will become a service that our Pacific people can be proud of. Coming back to New Zealand, there are things such as people stereotyping Pacific people that they can't manage or mismanaged finance, all the negative stuff. I'd like to be a part of an organisation to change that for Pacific Island people and leave us to be involved in a service where people can be proud of. My hope is to be a part of that journey and to leave a legacy for someone to build on in the future.*

#### **4.5 Sera's experiences**

Sera is a young New Zealand born Pacific nurse whose first language is English and speaks a limited Pacific ethnic language. She described her first encounter with a diversity of Pacific Islands people as a 'cultural shock'. Despite this Sera decided to work the PCMH service because of its convenient locality to her new residence.

*I thought it would be good for me to work in a PCMH service and be able to work with Pacific Island people. So I actually rang a PCMH service and they were really keen to employ me because they were looking for nurses. So that's how I came to be working in PCMH services.*

Upon commencing her career in the PCMH service, she soon discovered impediments that hindered her expectations of working in the service and developed ways to address these. Sera explained:

*I was actually looking forward to it because I thought I had a lot to offer in my skills and knowledge where I had come from previously. But as time went on, I felt that the infrastructure of the service was really quite chaotic and disorganised and I felt that there needed to be a lot of improvement and a plan put in place. I have started at the right time to help out in the service improvement and quality as it was in the*

*development stage. So it's a really good journey and I guess and there have really been great improvements.*

Her role as key worker involves coordinating clients' care from a holistic approach that includes organising clients' clinical appointments, providing education about their mental illness and medication, administering medication, liaising with the multidisciplinary team and external agencies and also advocating for clients. Sera claimed:

*My philosophy is being able to make a difference and bring some quality of life or improvement in the client's life. You know, it's not only looking at the mental illness and treatment with medication but also having a holistic approach looking at the whole life, spiritual and physical and looking at the person as a whole.*

Sera indicated that one of the challenges encountered in her practice is conflict in communicating with other disciplines. Furthermore, the language barrier has been identified as another complicating aspect. Because her client load consists of diverse Pacific ethnicities, she has to rely on the support of the matua or the support worker to overcome these barriers. She commented:

*It can be quite difficult because I'm trying to build a rapport with the clients but the language barrier can be a problem but at the same time I have to get along with the staff a lot more and work collaboratively with the team. However, if it's a client of the same ethnicities, then I tend to speak in my language but my Pacific language; I can only speak the basics. It's not fluent. But when I am working with the family then I will have to try and get on board a community support worker that speaks the other language and especially when working with the family and trying to be respectful and fa'aaloalo. We don't really rely on interpreters. If I'm stuck, I would also talk with a nurse of the same ethnicity to get their idea or perspective on an appropriate way to deal with the immediate situation.*

The benefit of supervision with a senior nursing staff member and also with her peers which she utilises to deal with difficult issues was acknowledged.

Sera felt that working in PCMH has had a significant impact on her nursing practice as it has increased her awareness of the importance of working collaboratively with all people involved in clients' care. In addition, it also helped her recognise the fundamental aspects of effective communication. In her own words:

*Sometimes I feel a bit inadequate you know it can be a bit awkward if I go in on my own to see the client and the family and especially if I can't speak the language or they find it hard to understand English and I'm not getting all the information from the family you know what I mean, and if I get the matua with me I find that they are not holding back and they are a lot more open and receptive because I'm just a young Pacific Island girl coming in and they probably think well 'who are you' and probably just say 'yes yes' to everything just to please me. But when I got people that we can go out together for example in the case of a woman whom I went to see with the matua and discussed some issues that she wanted to know about and she was quite tearful about it but was able to voice it out and speak in her own language to the matua and it was good in that way.*

Sera described the advantage of working in PCMH services as analogous to a family environment and connectedness. She felt supported by the staff and enjoys working with Pacific clients and their families. She continued:

*I have that connection because you know when they see that I'm a Pacific Islander or I'm (ethnic) or a young person or I'm a woman I mean that's a real bonus for them. And seeing that I am of the same then they feel a bit relaxed especially my (ethnic) clients. Yeah they are a lot more receptive and they can talk to me in the language. That's really quite unique.*

She felt that the nurses do what they can for the clients but they tend to become dependent on the health professional which she considers a disadvantage in PCMH nursing. Sera pointed out:

*As a Pacific Island or cultural service you kind of go that extra mile to really try and help clients although we try and teach them to be independent. Cause even though the PI motto is family orientated where it's a 'we' not an 'I', where we're not individualist, you know when someone in the family gets sick they just give them that special treatment and treat them as sick for the rest of their lives. And it becomes difficult when they become reliant upon you.*

One of the barriers Sera spoke of was the pressure from management for PI nurses to increase their case load. She felt that there was a lack of consideration from the management to hear their concerns and point of view. Sera remarked:

*The hierarchy are trying to push the numbers up. In a Pacific Island service, we should be looking at a manageable case load because we're doing a lot more work using the holistic model approach. We should be looking at the quality not the quantity and being able to do the job thoroughly and effectively. Rather than maintain them with medication and medication, I mean there is a place for medication but medication is not the end all. If you've got a high case load, you know, I feel like I'm running around like a loose chicken and am not really making a difference other than jabbing them with their injection and [saying] see you later I've got no time to talk to you. I've got to go and see this other client you know and that's not good. We're meant to be unique and different as a Pacific Island service. Why try and bring in how they do things in mainstream for us to take on board. I think it's very rude to just go in and out of their house without sitting with the client, give them their injection and spent time to talk with the family.*

Sera noted the importance of ongoing training in enhancing her nursing knowledge to enable her to deliver best practice. She said that at this point she feels bogged down with paper work which she perceived as another barrier that she intends to eliminate so she can pursue further education studies.

Upon exploring whether working in this service contributed to her professional development, Sera took a lengthy pause before responding briefly:

*Just being able to work collaboratively with those involved in the care of clients and I've learnt more about holistic.*

In terms of future aspirations, Sera emphasised that she wants to continue working with not only Pacific Island people but people from other ethnicities as she believes that there are commonalities or similarities generally. What's more she contemplates moving into mainstream with the intention of making an impact in educating or encouraging Palagis (Europeans) about how to work specifically with Pacific Island people and their families.

#### **4.6 Tepora's experiences**

Tepora is also a young New Zealand born Pacific nurse. English is her first language and speak limited Pacific ethnic language. Her decision to work in the PCMH service was mainly instigated by her desire to work with her own people and also due to the service locality convenience to her new residence. She described an ecstatic and satisfying experience of joining the Pacific team.

*I felt good because I was coming back from mainstream into Pacific Island mental health and felt happy with the fanau at home and I can relate to my people and felt a real bonus was that I was going to work in the Pacific Islands team so I felt a lot of you know relevance there. Working for the Pacific people and that was a good*



*feeling that I could identify with the culture even though I don't speak my Pacific language.*

Her key worker role involves coordinating the clients' care plan. The tasks includes home visits, assessment of clients, administering medication, monitoring clients' mental state and their treatment and supporting clients and their families.

One of the difficulties that she identified in performing her role is the language barrier with which she utilises her work colleague who speaks the language to support her with this cultural aspect. Tepora stated:

*My Pacific language speaking is a big barrier for me that I feel needs to be worked on, yes not being able to communicate effectively in (ethnic) language to the patients, especially if they don't understand English. So that's a barrier for me as a New Zealand born person.*

Tepora also viewed politics as another stumbling block in her practice that sometimes hindered her attempt to seek approval from management to acquire opportunities to further enhance her professional development. She declared:

*Well if you don't get along with your team leader, things are going to be a bit hard especially when you want to improve your professional development and you want to go to courses but you have to go through the team leader to get approval to attend these courses and up skill yourself.*

With regard to professional development, Tepora argued that the current professional development portfolio framework does not necessarily reflect PCMH nurses' practice. She explained:

*We had to compact years maybe 15 or 16 years of nursing practicing in mental health into four or five months of that portfolio and all the work within the portfolio doesn't necessarily reflect on PCMH practice.*

In exploring how she dealt with or overcame any difficulties arising in her practice, she said that communication is paramount in dealing with obstacles and to maintain good working relationships with other people that include management. Yet Tepora attributed communication to a detrimental circumstance that occurred in her practice setting where a disagreement with her team leader occurred. Tepora took advantage of external supervision to deal with challenging situations in her practice. She supports the idea of supervision that encompasses both the clinical and cultural aspects as it would be easier to relate to that supervisor.

It was noted that her vocation in a PCMH service has had an exceptional impact on her practice as a nurse. She claimed:

*It has helped me a lot you know with my identity, who I am as a (ethnic) Pacific nurse. I can relate to the patients and their families and the communication is better whereas in mainstream there's a bit of unbalance.*

From her point of view, working in PCMH services has presented her with a variety of advantages. Tepora talked of the privileges she had been exposed to in PCMH service in comparison to past employment.

*I have gained a lot from working here compared to other services I've been in. I've worked in [an] NGO and that doesn't provide enough clinical practice for my own practice. I worked in mainstream but it's too limited whereas in this area, Pacific Island, it opens a lot of avenues and takes you places like if you want to attend courses or conferences, you can apply because it's relevant to your own practice.*

In terms of disadvantages, Tepora comprehended her shortcoming as lack of access to funding to pursue further studies or attend conferences. She seemed ambivalent as she perceived herself as a neophyte in the system and lacked acquaintance of appropriate resources to attain the funding. Tepora considers this a barrier that she intends surmounting to advance her options of accessibility to relevant information that facilitate her professional expansion in PCMH practice. She believed an imbalance exists in staff accessibility and restriction in terms of resources such as the internet, forum and conferences.

On the contrary, Tepora is convinced that the PCMH service has made an exceptional contribution towards her professional practice development. She elaborated:

*I attended the (ethnic) Pacific Competency course which contributed towards my practice because it helped me understand the (ethnic) way and how to relate to our patients and our families and how they think and the stigma of mental health has an impact on their wellbeing. I'm also starting to go to these courses and have attended three professional development presentations and nurses' forum and all these courses have helped with my professional development.*

Tepora is optimistic that her passion to work with Pacific Island patients and their families has inspired her to continue her career in PCMH service in the future. She anticipates continuing her education studies and professional development and to become an advocate for young New Zealand born nurses to consider working in mental health. Her closing comment was:

*It is a privilege to work in the Pacific Island clinical service and especially when your people are involved. Politics will be there in different services but you have to overcome them and be strong and not pander out to other people.*

The next chapter constitutes an overall discussion of the findings and classification of the core themes and contributing themes that emerged from the participants' encounter within PCMH services. The analysis and interpretation that focused on participants' storytelling proved a lengthy time consuming process. However, the structured questionnaire helped provide a guideline to determine exactly what I needed to look for which made the process smooth and easy to follow.

## **Chapter 5: Findings and interpretation**

This chapter presents a general discussion on the findings that have emerged from analysis and interpretation of the participants' stories about their experiences in PCMH services. The aim of this research was to investigate the varying perspectives of Pacific nurses on what it is like for them to work in PCMH services.

Being a researcher in this project and as a nurse working in PCMH services, I was confronted with the challenges that could affect the data gathering and interpretations. For example, the conspicuous recurrent expression “you know” presented in their stories indicated that the participants spontaneously anticipated my understanding of their practice context. Hence, I have mentioned earlier that every effort was made to prevent bias in this study by bracketing my own preconception of PCMH practice but focusing on the participants' stories.

The following sections of this chapter creates a space for the reader to gain insight into the world of PCMH nursing and engage in the interpretations and the themes that have emerged from across the participants' stories. As part of the integration, I will also expand on the findings as necessary. All five interviews were amalgamated and scrutinised to ascertain the overall core themes and contributing sub themes. The core themes include: a Pacific identity and sense of belonging; making a difference; complex service infrastructure; a specific Pacific nursing context and practice variation. The sub themes include: Pacific for Pacific mental health advocate; going the extra mile; the Pacific care approach; role conflict; puppets of an organisation; disempowerment; professional practice development, and professional supervision; communication barriers and role constraints. These themes are outlined in the table below. The final section in this chapter acquaints the reader with those particular features that discerns Pacific-born and New Zealand-born practice experiences in PCMH practice.

**Table 1: Themes and sub-themes**

<b>Themes</b>	<b>Sub Themes</b>
1. A Pacific identity and sense of belonging	Pacific for Pacific mental health advocate
2. Making a difference	- Going the extra mile - The Pacific care approach
3. Complex service infrastructure	- Role conflict - Puppets of an organisation - Disempowerment
4. A unique nursing context	- Professional supervision - Professional practice development
5. Practice variation	Communication barrier and role constraints

In Table 1, the first column contains the main core themes of the study. The second column encompasses the contributing sub-themes.

## **5.1 Significant themes**

### **Theme One: A Pacific identity and sense of belonging**

In response to how they felt upon entry into PCMH services all five participants articulated feelings of excitement and gratification to be associated with people whom they share common traditional Pacific backgrounds. Tepora for example described a sense of connection and at home in familiar grounds within the PCMH setting. For Sela, she described experiencing cultural shock upon observing a diverse Pacific community. Despite her bewilderment Sela actually felt at home in the PCMH setting.

Mika on the other hand became fascinated by the team spirit and unique family unity that exudes within the PCMH setting. He claimed that despite the ethnic dissimilarities, the

Pacific concept of working relationship creates the kind of collective brothers and sisters working towards a common cause and supporting each other in various ways. Peta proclaimed that the uniqueness of the PCMH services had inspired her to remain working in her designated PCMH service.

All participants (particularly those nurses who identified as New Zealand-born) felt that their vocation in PCMH services had a profound impact on their personal identity. Tepora indicated that it had helped established her identity as a Pacific Island nurse. Similarly, Semi claimed that the PCMH service had helped enhance his knowledge of his Pacific cultural heritage and personal identity and genealogy. Additionally, Semi declared that he has gained a greater appreciation of being Pacific and of being different.

## **Sub Theme:**

### **Pacific for Pacific mental health advocates**

The concept “true advocate” for Pacific people was specifically emphasised by Mika who believed that the Pacific nurses natural identity and background inheritance have allowed them to fulfil their obligation to PCMH services and to the Pacific clients and thus become true advocates for them. Peta declared that because Pacific nurses have an innate Pacific upbringing, they know empathy for their own people. Consequently the rapport and relationship with clients and their families materialised instantly.

Despite minor difficulties in relation to language, those nurses identified as New Zealand-born are just as indispensable as those nurses born in the Pacific Islands. In numerous ways language difficulties had not prevented them from creating a healing environment manifested in the receptive therapeutic relationships with the clients under their care. Semi, for example perceived language as not being the main attribute but just being identified as a Pacific and how one acts and present traditionally as a Pacific person makes a difference.

Essentially, it became clear that the nurses' strong sense of Pacific identity manufactured a genuine commitment to help those Pacific people they care for within their role.

Mika felt that because Pacific nurses are experienced clinically and culturally, they are in a better position to address Pacific people's mental health issues holistically. All participants have indicated that because Pacific nurses have the inherent cultural knowledge and clinical experiences, they are able to demonstrate the 'by Pacific for Pacific' initiative indicated by the Mental Health Commission Blueprint (1998) and ultimately become true Pacific for Pacific Mental Health advocates for Pacific people.

## **Theme Two: Making a difference**

Initially, the predominant inspirational rationale identified in each participant's dialogue in response to the question 'what motivated them to work in the PCMH service' was their passion to support their own Pacific people. This enthusiasm led to the aspiration widely held by all intentionally to make a difference in Pacific peoples' lives. Sela for example declared that her philosophy is being able to make a difference and bring some contribution in the client's quality of life. Likewise Mika perceived that his undertaking in PCMH has reaffirmed his passion and objectives purposely to help Pacific people and where he believed could make difference.

Making a difference was demonstrated by all participants in various demeanours primarily through reciprocating interactions with clients and their families. Generally the impression that I detected from each participant's story was that just being identified as a Pacific person generates positive effect on their liaison with Pacific clients and their families. Mika indicated that the clients feel comfortable when they noticed that the nurse is of their own culture. In the same way, Peta asserted that being a nurse of PI descent has a calming affect on the clients. Moreover, Sela explained that when the clients recognised that the



nurse is a Pacific Islander and of the same ethnic background, they felt relaxed and were a lot more receptive as they could converse in the Pacific language. Sela perceived this as a real ‘unique’ experience.

Additionally, participants have indicated that the ability to speak a Pacific language is a valuable attribute that makes a difference in establishing working relationships particularly with those clients and families with language difficulties. Peta noted that speaking the language helps create a therapeutic environment for the nurse and the family. All participants have indicated that their Pacific affiliation generates positive impact on relationship establishment with Pacific clients and their families. Peta commented that she has a better relationship with them because they understand her as a Pacific person.

## **Sub themes:**

### **Going the extra mile**

The idiom “going the extra mile” illustrates the tasks nurses carried out for clients that fall outside the designated PCMH service contract conditions. This slogan was uttered by Sela who perceived, going the extra mile as being attentive and client focused on what is best for the clients to support them through their journey to recovery. Peta indicated that when working with Pacific Island people in the community, nurses go the extra mile because they want the best for the Pacific people.

Going the extra mile was demonstrated by participants for example as activities that involve spending time after working hours when required to meet with the clients and their families. According to Peta, time is not of the essence, and is not restricted or limited when working with Pacific people. Furthermore, spending time with the clients and their families sometimes results in working long hours. She describes that giving time to the people involves asking how their families are. Peta’s conviction synchronises with Sela’s

philosophy of a Pacific Island family unit that the individual becomes a “we” not “I” hence the significance of family involvement. However, Sela commented that going the extra mile is an undertaking that Pacific nurses don’t get remunerated for or get paid.

### **The Pacific care approach**

Each individual imparted corresponding perception of the complications encountered within their keyworker role and thus established a more effective approach that works with Pacific clients and their families. Semi for example felt that working in PCMH service has made him aware of the different options of care and different ways of doing things that complement Pacific people’s mental health care needs. He discovered that certain methods taught in his university studies such as particular ways of care planning and how to present oneself and converse with clients and their families does not always work with Pacific clients. Semi emphasised that doing things the Pacific way is not representative of what people learn out of a book. Semi claimed that Pacific nurses have their own culturally appropriate sort of practice and ways of doing things with Pacific people.

To be fa’aloalo or respectful is identified by Sela as imperative when working with Pacific people. From Semi’s perspective, a Pacific nurse would know their own role to play and know how act and present themselves traditionally which influences the way clients and their families’ respond towards them. Practically, working closely with the Pacific families was considered traditionally fundamental. As Sela pointed out, the Pacific Island motto is family orientated which means that the client is always considered part of an aiga (family unity) and cannot be seen as a stand alone individual.

In regards to Pacific clients’ mental health assessment, both Sela and Mika claimed that PCMH nurses no longer view care only from a western medical model as medication was considered only one component of care intervention. They commented that intervention for

Pacific people requires a holistic view of life as a whole, spiritual and physical in addition to the medical view of mental illness and medication treatment. Mika explained that an integration of the clinical and cultural knowledge together with the use of the Pacific Islands Fonofale model (Pulotu-Endemann et al., 1995) utilised in the clients' assessment provides that holistic Pacific perspective of the whole person.

Both Peta and Mika divulged parallel perspectives pertaining to the detrimental effect of unmet needs and misdiagnosis (by non-Pacific health workers) due to misunderstanding Pacific clients' traditional cultural health concepts. Language translation is seen as a relevant enterprise embarked on by Pacific nurses to counteract these language difficulties simultaneously in clients' care intervention. Peta for example recognised the need for language translation about mental illness for those Pacific people with poor English. Generally, all five participants disclosed mutual beliefs that the shared Pacific legacy and cultural understanding facilitates the reciprocal relationship with clients and their families that helps foster quality care that is specifically culturally appropriate for them.

### **Theme Three: Complex service infrastructure**

Although the prospect of working in PCMH services appeared promising, most participants talked of feeling ambivalent wondering whether they had made the right decision when they first started working in a Pacific services. Others expressed disappointment upon commencing in their designated PCMH setting. Sela for example was optimistic that her skills and knowledge would be beneficial for the service. However, she felt that the service infrastructure needed improvement.

In exploring their role in the PCMH services, all nursing participants were designated as keyworkers and performed tasks according to their specific PCMH service delivery model infrastructure. The nurses worked in different models in how they integrated the clinical

and Pacific cultural components. Obviously, several service models emerged. In one PCMH service model, the clinical and cultural components are implemented separately. This means the nurse perform the nursing and clinical aspects of clients care while those employed as cultural workers conduct the cultural perspectives that includes cultural assessments and the like. Another PCMH service instigates a similar model that incorporates separate clinical and community support constituents. The third PCMH service denotes an integrated clinical cultural model with which staff that includes nurses who are identified as keyworkers provides both clinical and cultural aspects to meet clients' holistic needs.

The participants who worked in the two PCMH services that employ discreet service delivery models have talked about the difficulties such as communication barrier and conflict of opinion predominantly in regards to the cultural aspects. In Mika's view, there seemed to be a persistent problem between the cultural workers and the nurses. Mika elaborated on his frustration in trying to adapt to a PCMH service delivery model with separate clinical and cultural components. From his viewpoint, establishing his position entirely as a clinical person was problematic taking into account his own natural Pacific cultural affiliation. He declared that Pacific nurses who were born and raised in a Pacific Island environment found it is difficult to operate purely from a clinical arena and not be influenced by their cultural viewpoint.

## **Sub Themes:**

### **Role conflict**

Mika articulated on the Pacific service structure and anticipated ongoing challenges of working alongside a cultural worker due to conflict of opinion in the cultural arena. He argued that Pacific nurses are experienced from a clinical perspective as well as knowledgeable about the Pacific cultural aspects. Mika further elaborated that trying to

merge the clinical and cultural component to determine a point of balance involved a great effort and requires changing the westernised mainstream culture mentality to incorporate the Pacific cultural perspectives.

Similar concerns were also indicated by Sela who worked in a similar service structure but in another PCMH setting. She commented on the transparent conflicts that occur between various disciplines, the management, and with non-Pacific Island staff and the challenges with co-ordinating and informing the community support worker (CSW) and everyone involved including clients and their families about meetings and appointments specifically due to language barrier. However, Sela commented on the value of utilising the community support worker input in her role and endorsed working collaboratively in regards to language difficulties.

In contrast, Peta who is Pacific born works under an integrated PCMH service delivery model claimed that the amount of responsibility involved in her role is quite overwhelming as nurses are expected to do everything. Then again, Tepora and Semi who are both New Zealand born Pacific and also working in the same service said that they utilised other non-nursing colleagues who speak the language fluently to assist them. Despite these challenges, all three participants conveyed comments indicating that they enjoyed their work in this PCMH service and were inspired to continue working in the service.

### **Puppets of a big organisation**

The term “puppets of a bigger organisation” was the catchphrase initiated by a participant to describe the characteristics of PCMH system. Mika for example attributed the service infrastructure to the influence of a DHB provider. He felt that the policies and everything that covers PCMH services epitomises the mainstream service model. Furthermore, Mika believed that PCMH services are restricted and have not been allowed the flexibility to

operate outside the hierarchy or mainstream organisation. Mika suggested that the DHB management should give freedom to the PMH services to venture out on their own so that they can operate from a Pacific standpoint how health care ought to be in a real Pacific Islands' way. By the same token, Sela felt that the pressure from management to increase the nurses' caseload is distressing as it seems like she was running around administering clients' injections and not spending time talking with them. Sela argued that PCMH services are meant to be unique, and adopting mainstream way of doing things is rude and inappropriate.

Sela elaborated that the holistic model approach requires great effort and time to ensure the job is done thoroughly and effectively rather than looking at the quantity and maintaining clients on medication. Peta expressed a similar view due to the persistent increased number of referrals entering her designated PCMH service that primarily necessitate stabilising clients and referring them onto the general practitioner (GP) to allow room for the next referrals to enter the service. In her observation, clients referred to GP for management of their mental health disorders such as depression and anxiety have not been managed properly.

## **Disempowerment**

It became apparent that all participants have experienced a sense of disempowerment in their individual endeavour. Some felt "restricted" in their attempts to advance their professional practice to their full potential while others felt deprived of the opportunity to expand their role generally. The concept of disempowerment articulates the frustration experienced by those particular participants who work under the PCMH services that implement separate cultural and clinical service delivery models. Mika for example felt that the inability to utilise both cultural and clinical aspects in his keyworker role

prevented him operating from a holistic perspective in addressing his client's needs. Mika pointed out that nurses are experienced from a clinical and cultural viewpoint.

Sela and Peta who both worked in different PCMH settings felt disempowered at the constant negative response that they received from their services management in their attempt to convey practice concerns across. The majority of participants have expressed similar disappointment at their failed attempts to gain approval from their designated service management to attend professional pursuit such as conferences and relevant forums. Peta seemed adamant that if nurses were not authorised to attend such professional activities, a consequence would be that they are denied the opportunity to enhance their professional development. Furthermore participants commented that PCMH services have got experienced nurses with essential skills and qualifications such as a masters degree in nursing that will also help expand their role to the primary health arena. Peta felt that having PMH nurses employed in the primary health area will help bridge the gap with GP client referrals coming into the PCMH services if management consider endorsing this option.

It became clear that the participants' predicament synchronise with Mika's "puppets of an organisation" notion where the management hierarchy holds the power over decision making processes regardless. As Peta stated:

*Our hands are tied as we have to go through layers of management who are not nurses and when you finally got there they say that you have to consolidate with this or work on that before you can go further which is quite frustrating.*

#### **Theme Four: A unique nursing context**

In exploring how working in PCMH has contributed to their professional practice, all participants impart corresponding responses claiming that the PCMH services have

provided them with an exceptional opportunity that subsequently presented them with a unique experience both personally and professionally. Each participant divulged various specific aspects that contributed to their nursing practice and simultaneously identified the discrepancies in their practice setting. Although most were intrigued with the unique experience, some were overwhelmed with the responsibility involved in their role specifically those identified as Pacific-born nurses. Peta for example affirmed that she wears two hats which suggest that when language translation is involved, it requires thinking both ways which she perceived takes double action. Both Peta and Mika for example attributed this experience to their inherited Pacific cultural knowledge together with their clinical experience.

The noteworthy impact upon working in PCMH services as indicated by Semi was his increased awareness of the essence of diverse cultural nursing. Consequently, he believed this has helped ascertain his role as a Pacific nurse. Semi felt that his skills gained through university studies, his life experience and liaison with Pacific people has made a huge contribution to his professional practice and development in PCMH. Then again Mika believed that working in a PCMH has transformed his mainstream westernised perception and enhanced his confidence of his own Pacific identity thus facilitating his ability to communicate with any individual regardless of ethnicity. Moreover, Sela implied that working in a PCMH had increased her awareness of working collaboratively with other disciplines and also her knowledge regarding holistic nursing. For Tepora, confidence of her own Pacific identity has been intensified thereby enhancing her communication and relationships with Pacific clients and their families. The various practice experiences and perspectives illustrated by the Pacific nurse participants have revealed numerous interesting features that encompass the PCMH nursing context. For example, having a Pacific identity is a fundamental characteristic for a nurse working in PCMH services. In essence being identified as a Pacific nurse helps facilitate a spontaneous performance



thereby ‘making a difference’ by initiating and implementing a culturally appropriate ‘Pacific care approach’ and hence become ‘true advocates’ for Pacific people.

## **Sub themes:**

### **Professional Supervision**

An essential method that PCMH nurses predominantly utilised which they regard as valuable in their professional practice development was supervision. In spite of this the majority of participants have disclosed complications with having separate cultural and clinical supervisors. Mika for example noted that the challenge of having a Palagi (European) supervisor was trying to move away from the Pacific way and align with their way of life. Likewise, Peta felt that talking to a non nursing cultural supervisor about nursing issues was difficult.

Participants have recommended the use of competent PCMH nurses to provide supervision as they felt that there are aspects of the Pacific way of life that enriches and adds value to the supervision relationship. Essentially, Tepora expressed that a supervisor with both the clinical and cultural understanding would make the nurses’ job easier because they can relate to that supervisor. Similarly Mika contends that supervision with a PCMH nurse would be straightforward, simple, and more effective because nurses know their Pacific standards, values and ways of doing things. Semi who has had supervision with senior nursing colleagues claimed that PCMH nurses are more than capable to give expert supervision in a competent way.

### **Professional practice development**

All participants commented on the numerous avenues made accessible to them such as attending courses and conferences that were equally relevant to their professional practice.

Peta for example proclaimed that she has been able to attend university and obtain a diploma and masters degree. Mika who previously left the PCMH service to pursue a career in management was adamant that working in PCMH has provided him with a myriad of incentives to renew his passion and paved his pathway into management position where he anticipated making a difference in Pacific people's lives.

With respect to participants' view of their practice development in PCMH, all participants had expressed satisfaction with the support they received from the PCMH services. However, the Professional Portfolio development that the PCMH nurses adhere to was perceived as inappropriate and does not represent PCMH nursing practice. Tepora for example claimed that Pacific nurses put together 15 or 16 years of nursing practicing in mental health into four to five months of the current portfolio and all the work within the portfolio doesn't necessarily reflect PCMH nursing practice. Tepora felt that the Professional Portfolio Development epitomises the mainstream practice model which harmonised Mika's criticism that the PCMH services policies and procedures mirror the westernised mainstream model and way of doing things.

### **Theme Five: Practice variation**

In exploring the context of two separate entities, participants' stories brought to light the inevitable differences in both the Pacific-born and New Zealand-born Pacific nurses' practice. The lack of language was similarly identified by all participants as an obstacle. In scrutinising each individual context, Pacific-born nurses Peta and Mika exudes confidence of their Pacific cultural affiliation than their non-Pacific born peers Semi, Sera and Tepora. However, these Pacific-born nurses' stories indicated that this inherent connection sometimes creates complications in their role. Speaking the language for example is described by one participant as "double action" and extended responsibility. Alternatively language was perceived by the all participants as a source of disempowerment and practice

constraint. Additionally, these nurses felt that they have not been remunerated or recognised for the extra work that they do. Although New-Zealand born nurses possess relatively sound knowledge of their own Pacific backgrounds, a lack of fluency in language was determined by Semi, Sera and Tepora as a disadvantage in their practice. The inability to speak a Pacific language is perceived by these New Zealand-born nurses as a huge barrier in their communication, specifically with clients and their families.

### **Sub Theme Five:**

#### **Communication barrier and role constraints**

The three New Zealand-born Pacific nurses indicated that their inability to speak their Pacific language fluently hindered their capability to communicate effectively especially with those clients and families that do not speak or understand English. Consequently, they were sometimes unable to obtain all the necessary information required. All three participants were able to identify the relevance of speaking their own Pacific language and recognised this as an essential skill that nurses need to have especially when working in a PCMH specialised area. In addition, all three recognised the need to improve this aspect of their practice and anticipated development in language skills as a future objective.

Pacific-born Peta and Mika who practice in different PCMH settings divulged dissimilar experiences. Their role encompasses distinctive magnitude due to divergence in their designated PCMH service model structure. Peta for example felt that the ability to speak a Pacific language engenders extra responsibility which she says requires wearing two hats. Peta explained that translating require thinking in English and then interpretation into writing which takes time and effort. In contrast, Mika felt that this natural skill was reclusive at times due to segregation of the cultural aspect from his role.

In the next chapter, I discuss the main aspects that contributed to the establishment of the research topic. The recommendations in relation to this discussion are presented and followed by the conclusion.

## **Chapter 6: Discussion**

This thesis has sought to establish an understanding of the experiences of Pacific nurses working in the PCMH services within a DHB. The study topic is specifically significant to me as I was particularly interested in other Pacific nurses' perception of working in PCMH services in contrast to my own experiences. The Pacific nurses' stories have made known the profound impact the PCMH services had made on both their personal and professional growth. The findings have reinforced my perspective of the practice issues for PCMH nurses that I have indicated in the early stage of this thesis. The experiences of Pacific nurses have offered an inside view of their practice domain that sits with the literature and adds to the body of knowledge about what it is to be a community mental health nurse in a DHB. This chapter reflects on the Pacific nurses' stories and testimonies and expands the research milieu by incorporating my own experiences and perspectives of nursing practice in PCMH services.

In the following sections of this chapter I present the three outstanding key features that are the major contribution to this study. The key findings will be briefly discussed in relation to what has been written by others about the topic. The first section discusses the philosophical notion the 'by Pacific for Pacific services' in relation to PCMH nursing. In the second section, the discussion focuses on the subject of practice constraints in PCMH services. The discussion in the third and final section concentrates on those specific aspects that encompass PCMH nursing practice and the prospect of supervision and professional development.

### **6.1 By Pacific for Pacific services**

The 'by Pacific for Pacific' catchphrase has monumental significance in the establishment of PCMH services. It marks an epoch of change in the mental health system that acknowledges the impact of culture to the well-being of Pacific minority living in New

Zealand. Essentially the notion ‘by Pacific for Pacific’ is about having a Pacific identity and cultural background knowledge to meet Pacific peoples’ mental health needs in a culturally appropriate way. The stories shared by the PCMH nurses in the study affirm that they are ‘true advocates for Pacific people’.

The concept of ‘true advocate’ describes the Pacific nurses’ commitment to Pacific people and the PCMH services that they work for. The participants claimed that because they have an understanding of the Western mainstream and Pacific cultural ways of thinking, they are able to inform clients and their families the best ways possible to support them. Benner and Wrubel (1989) describes this understanding as “embodied intelligence” where people acquire a culturally skilled “habitual body” that allows them to perceive contexts organised according to human purposes complete with their significances and past concrete experiences.

This raises the question for non-PI nurses who work at a PCMH services. How does this position these nurses who neither have a Pacific identity nor background knowledge of PI people and their cultures? Cultural knowledge is much more than just learning to say ‘talofa’ (hello) or ‘tofa soifua’ (goodbye) when you meet with Pacific people. While the policy statement suggests that the PCMH services is ‘by Pacific for Pacific’, is it really? Will it ever be as long as its situated within what we might consider to be mainstream healthcare delivery system?

The ‘by Pacific for Pacific’ proposition is about making a difference to the lives of Pacific people who experience mental health problems. ‘Going the extra mile’ for example denotes extra activities that fall outside PCMH nurses’ designated role. Going the extra mile’ is perceived by PI nurses as being attentive and client focused on what is the best way to support clients through their recovery journey. Participants in the study have argued

that 'going the extra mile' requires spending time to have a proper conversation with the client and their family. From a PI perspective, when an important meeting occurs; Pacific people usually consider time as not of the essence but the issue at hand. Consequently, there is the tendency for people to lose track of the time. Going the extra mile may create confusion as it demonstrates that Pacific services are comfortable with this situation but it is unclear whether the DHB policy promotes this type of intervention. This type of intervention has implication for nurses as it creates tension with time management and stress with work overload.

The findings suggest that PCMH nurses are in a better position to fulfil their obligation to Pacific services and become 'true advocates' for the Pacific people. Again, what does this mean for non-Pacific nurses working in the Pacific services who also do their best to provide quality care for the PI people? One wonders whether these nurses are at ease in an environment that is culturally orientated. Or does it matter really how they feel? The following section discusses the challenges experienced by the nurses in their practice in PCMH services.

## **6.2 Pacific community mental health nursing practice constraints**

While their vocation in PCMH services may be gratifying and reassuring, the Pacific nurses' stories direct our attention to the significant issues that impact of PCMH services on their practice. For example the issue of separate culture and clinical components other nurses have in their role while others do not. It became apparent that those nurses that work under segregated clinical and cultural model encountered ongoing difficulties in their attempt to ensure holistic care intervention. As Cortis (2004) points out, 'holistic care' is problematic if it is poorly understood and applied and will consequently result in clients having their needs unmet. Several participants spoke of medication as only a part of the care package that nurses provide in a separate clinical component. This type of model has

implication for Pacific nurses which means they would be deprived of their ability to carry out holistic Pacific perspectives of client's care and simultaneously contradict the culture of nursing practice. Essentially, Pacific people's holistic care requires an integration of their spiritual, physical, emotional, and family well-being in order to in order to meet their mental health needs. It is my belief that not only are PI nurses naturally in a better position to provide holistic mental health care, they will contribute saving time and costs to the PCMH services and DHB organisations.

Quite the opposite, those participants who work under an integrated clinical cultural model have not indicated any concerns about the PCMH service infrastructure or model. These individuals appeared to be content and comfortable in their designated practice setting despite the enormous amounts of work involve in their role. The findings brought to light the disparities and inconsistencies in the three PCMH services. The question is, how embedded are the Pacific services models in the current system and are they sustainable. The study suggests the need for research to seriously examine which service delivery model works well for both Pacific clients and Pacific workers. The implication for nurses is that if they continuously experience difficulties and discontentment within the PCMH services, this will result in nurses leaving the service and of course increase the problem of PMH nurses shortage.

Language has been shown to be a fundamental attribute and activity that Pacific nurses spontaneously carry out. However, language translation was indicated by some of the participants as an activity that falls outside of their designated role while others claimed that PCMH nurses are underpaid and have not been remunerated for the extra work that they do. Then again, what about those nurses that cannot speak the language. Furthermore, do those nurses that speak the language have a choice to refuse translation when the need arises? The implication for nurses in terms of overworked and underpaid would be stress,



dissatisfaction and might eventually look elsewhere for better pay and less stressful employment. Yet again, this will contribute to the problem of PCMH nurses shortage.

On the contrary a number of participants in the study perceived that political ideology and DHB organisations influences are allegedly responsible for the PCMH 'services infrastructure' complexities and how they operate. This led to the notion 'puppets of a bigger organisation' by one of the participants who felt that the PCMH services are under the control of the DHB management authorities. There is a perception that Pacific services could only operate in a confined space and have been restricted flexibility to operate outside that boundary. Hence I draw the reader's attention to Southwick's (2001) perspective on Pacific women's stories of becoming nurses in New Zealand where she talks about boundaries and what happens to people when boundaries are created and who has the power to create these boundaries. The implication for nurses is isolation and disempowerment and decreased self esteem. PCMH nurses have a wealth of skills and knowledge and much to offer. The findings suggest the need for opportunities to demonstrate PCMH nurses' expertise in the community. Benner (1984) indicates that expertise operate from a deep understanding of the total situation and make judgement or manage complex situations in a truly remarkable way.

The common problem that came across amongst all the participants is the sense of disempowerment that transpired through their expressions. It has been indicated that the efforts made by a number of nurses to voice their practice concerns have been overlooked by service management authorities. In this circumstance I refer to Southwick's (2001) argument on whose voices are privileged and whose voices are sheltered when boundaries create demarcation within the social order? Thus the impact of disempowerment elicits considerable bearing and contingencies for PCMH nurses' practice. Once again this can

have a detrimental effect on PCMH nurses' self-esteem and professional practice development.

In this next section, I discuss the PCMH nurses' perspectives on those aspects that encompass PCMH nursing. This is followed by discussion on the aspect of professional supervision and professional development in relation to PCMH nursing.

### **6.3 Pacific community mental health nursing education and professional development**

My foreground perception in the development of this research was that PCMH nursing is a unique nursing context hence my endeavour to clarify this nursing phenomenon through Pacific nurses' practice experiences. Benner (1984) hypothesised that not all knowledge embedded in nursing practice can be captured in theoretical propositions or with analytical studies but by interpretive description of nurses' actual practice.

The PCMH nurses spoke of the difficulties encountered in their practice and how they as nurses developed more effective 'culturally appropriate ways' that reflect Pacific peoples' mental health care which they believe makes a difference. The findings have revealed that university nursing education does not reflect what PCMH nurses do. This begs the question, what is it that nurses learn from their nursing education and in their practice and what needs to happen here. According to the *National Nursing Organisations* (2004) document, nurses in the education roles are responsible for promoting, facilitating and providing clinical education to maximise health care delivery. How can this be possible for PI students who anticipate a career in PCMH if they are not getting adequate knowledge in relation to this specific field of nursing? Consequently, inappropriate information can be misleading. PCMH nursing is a unique healthcare context that encompasses an understanding of Pacific peoples' cultures. I reiterate Schreiber's (cited in PCCF, 2004,

p.14) statement that, “a deep multifaceted understanding of culture cannot be developed by standing at the top of a distant mountain because cultural knowledge originates from a culture’s centre world view”. This can have implication for Pacific nursing students who maybe misinformed about what PCMH nursing ought to be and subsequently deprived them of the true knowledge.

Supervision has been signified as an essential method that assists PCMH nurses in dealing with practice impediments. However it appears that a number of nurses have experienced complications with this process. This raises the question, is supervision really significant and does it matter? The finding suggests the need for a more constructive framework to accommodate PCMH nurses needs. The issue of time and cost is also attached to supervision activities. If PCMH nurses are capable of providing supervision as indicated in the study, then this might be considered an ideal option. The implication for nurse is that the lack of appropriate supervision will affect their competency status in terms of the professional nursing development requirements.

It had been outlined in the findings that the professional portfolio development does not reflect PCMH nursing practice. It indicates that this framework lacks the elements to neither define the nursing experience embedded in PCMH practice nor reflect these nurses’ competency echelon. The implication for PCMH nurses is that the lack of appropriate framework to reflect nursing in PCMH would mean that nursing knowledge embedded in this field will go unnoticed and unaccounted for. Benner (1984) argues that not all nurses become expertise and recognition of expertise in practice can only be made visible through essential link in theory development. Benner continues that this multifaceted knowledge with its concrete referents cannot be put into abstract principles or explicit guidelines. The findings suggest the need for an appropriate framework that reflects PCMH nursing as it is.

The study has also identified distinctive differences in Pacific-born and New Zealand-born practice experiences. Primarily language appears to be common practice constraint experienced by both sides. For those participants who identified as New Zealand-born, they have noted that not being able to speak a Pacific language fluently is a disadvantage as it creates tremendous communication barriers. This raises the question, how can this problem be addressed? What about those non-Pacific nurses who are unable to speak the language and does speaking a Pacific language really matter? The study suggests the need to explore the options specifically for non-Pacific speaking nurses who may require specific education to support them with language difficulties.

The discussion that I have presented in this chapter provided an overall view of the main aspects that have been the contributing factors in the establishment of this thesis. I anticipated at the beginning of this project that any practice concerns identified through this study would hopefully have a positive impact on the DHB health provider organisations and nursing authorities to help address these issues. In the next section I present some of the recommendation in regards to the practice issues that has been identified as a result of the findings.

## **6.4 Recommendations**

This study has confirmed some of the practice issues that I have highlighted in the beginning of this thesis. These significant practice constraints warrant consideration by the DHB and professional nursing authorities to address these practice impediments. The concern regarding the PCMH services infrastructure and its complications for example that instigate negative impact on PCMH nursing practice, yet professional bodies and DHB organisation and nursing profession authorities expect PCMH nurses to be culturally competent.

It appears that a number of PCMH services do not reflect appropriate holistic healthcare model and thus portray false impression and system failure. This suggests the need for nursing education programmes to ensure appropriate knowledge that define and reflect PCMH nursing as it is. There appears to be the need in university Postgraduate nursing programme for PCMH nurse educators who have relevant experience in this field of nursing.

The study has also identified the need for an appropriate Professional Development framework tailor-made to accommodate PCMH nursing knowledge as it is and to discern competence in this field of nursing. Again an alternative would be to consider involving a PCMH nurse representative in professional development competencies and evaluation processes within the DHB. This study indicates that Pacific nurses' can make a huge impact in the field of policy and procedure making processes given the opportunity.

The problem of shortage of Pacific mental health nurses is well documented (MHC, 2001). Unfortunately, highly skilled PCMH nurses including two nurses who participated in this study have recently left the PCMH services while others anticipate leaving these Pacific services in the future. This indicates the need look into why nurses are leaving the PCMH services. There appears to be the need to investigate the nature of the PCMH services infrastructure and models of service delivery to explore whether they are workable and beneficial for both the PI clients and the PI service provider.

The study has indicated the need for opportunity for PCMH nurses' allowing them to expand their professional potential into other areas that includes primary health care and management positions. This will simultaneously create visibility for PCMH nurses and contribute to improving recruitment and retention. Finally there seems to be the issue of overworked and underpaid that warrants attention. PCMH services and DHB management

authorises will seriously need to look at addressing these practice concerns and most of all consider listening to the voices of PCMH nurses.

## **6.5 Conclusion**

Arriving at this point of the research, I reflect on the challenges that I have encountered along the journey as I moved between my own experiences and that of the participants. In essence my pre-understanding of the research topic provided me with a vision and pathway to accomplish this project. I feel blessed with this unique opportunity to fulfil a long held ambition about PCMH nursing. With respect to Pacific nurse researchers Southwick (2001), Logovae (2003) and Esera (2001), I acknowledge their passion and contribution towards research into the Pacific Islands nurses' realm. To those inspiring researchers such as Benner (1984) and O'Grady (2001) who have encouraged myself and other nurses to define the realm of expertise embedded in their nursing practice in order to embrace any existing issues around practice foundation and subsequently initiate any necessary changes.

This study offers insight into the perspectives of Pacific nurses about their experiences of working in PCMH services. In particular it has used the focused storytelling method to gather this information that were then analysed and interpreted to serve the purpose of this thesis. Through participants personal stories emerged a wide range of aspects that encompass nursing practice embedded in the PCMH field. The results of this study have validated my own perception of PCMH nursing as well as confirm some of the issues that I have indicated in the beginning of the project. The study findings indicate that PCMH nursing is the essence of diverse cultural nursing. PCMH nursing, as understood in this study, can be regarded as an ability to use multiple forms of knowledge, skills and the 'self' in ways beyond measure. The use of PCMH nursing, as a product of the 'by Pacific for Pacific' initiative, aims at providing care that is tailor-made to effectively meet the mental health needs of Pacific people living in New Zealand. In many ways PCMH nurses

can be regarded as unique healthcare professionals and can be seen as instruments equipped with comprehensive knowledge and skills to convey mental healthcare services for Pacific people that they care for. It would be fitting then to say that PCMH nurses are truly mental health advocates for Pacific people. I would argue that 'specialist nursing' is an appropriate concept to define the PCMH nursing discipline; nevertheless this requires consultation with nursing authorities to gain acknowledgement and achieve consensus.

This study has ascertain PCMH nursing as it is as well as highlight significant issues and challenges for PCMH nurses' practice. These practice constraints, if not addressed may consequently result in decreased job satisfaction and ultimately attrition of the PCMH nursing profession. This thesis is the starting point in an attempt to understand the PCMH nurses' experience in their practice field. Obviously, the scarcity of research in the field of PCMH nursing indicates that this topic warrants further study. This thesis contributes to building this information base.

## Appendix 1

VICTORIA UNIVERSITY OF WELLINGTON  
*Te Whare Wananga o te Upoko o te Ika a Maui*



TO	Jacinta Apelu
COPY TO	Dr Kathy Nelson, Janeen Batchelor
FROM	Dr Jenny Neale, Acting Convener, Human Ethics Committee
DATE	25 September 2006
PAGES	1
SUBJECT	<b>Ethics Approval: No 70/2006, What does it mean to be a Pacific community mental health nurse in a DHB</b>

Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved and this approval continues until 28 February 2007. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

A handwritten signature in blue ink that reads "Jenny Neale".

Jenny Neale  
pp Allison Kirkman  
Convener



## Appendix 2

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*Te Whare Wananga o te Upoko o te Ika a Maui*



### Participant Information Sheet

#### **Project Title:**

**Pacific community mental health nurses' experiences of working in a District Health Board in New Zealand**

#### **Brief description of the study**

The purpose of this project is to explore the varying perspectives of participants in terms of their practice experiences while working in a Pacific community mental health service under a District Health Board. As no previous research was done in this specific area, this study aims to identify the themes Pacific community mental health nurses regard as significant to their practice. This project intends to provide a format for participants to talk about their experiences and what it is like for them to work in this Pacific cultural mental health care setting. It is hoped that the result of this study will identify the underlying Pacific knowledge that informs Pacific mental health nursing practice in the community and also increase knowledge and understanding about how Pacific community mental health nursing can be further developed.

#### **You are invited to participate in this study**

I would like to talk with you as a Pacific person about your experiences of working as a nurse in the Pacific community mental health service. I would like to meet with you at least two times for an hour to two hours at a time. The meetings will be held at a place that is convenient for you. The discussions will be audio taped and if you have any questions or concerns in regards to this meeting, I will be happy to discuss this with you.

#### **Ethics and confidentiality**

All information released from this study will be presented clearly and in a way that the identity of participants will not be determined. If at anytime the participant discloses information that could dispose their identification, this information will be kept confidential. All audio tapes will be kept secure during the project, and at the end of the research will be destroyed or returned to you if you prefer. Any identifying information will be excluded from any report or discussion relating to this research to maintain confidentiality and protect your identity.

## **Participation**

Your participation in this research is voluntary. You may decline to participate. If you agree to participate you can withdraw at any point until the first interview is held. If participating in this research causes you any discomfort or distress, the interview can be stopped, and you can decide whether to withdraw from the study.

## **Project results**

I can send you a copy of the research report or discuss the findings with you, whichever you prefer. This report will be developed by March 2007. Please indicate in the tick box in the consent form if you wish to receive a copy of the report. If you have any concerns or further queries about the project, please feel free to contact the project investigator or my supervisor at the Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington.

**Jacinta Apelu** at Isa Lei Service

Waitemata District Health Board (09) 838 2800 extn 4906

## **Supervisors**

**Dr Kathy Nelson**, Lecturer, Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington Ph: 04 463-6138

**Associate Professor Rose McEldowney**, Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington Ph: 04 463-6651

## Appendix 3

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*Te Whare Wananga o te Upoko o te Ika a Maui*



### Consent form for recruitment of nursing staff in a research project

I, \_\_\_\_\_ (print name) give permission for our nursing staff to participate in a research project carried out by Jacinta Apelu for the purpose of her Masters in nursing thesis.

Signature\_\_\_\_\_ Date\_\_\_\_\_

Designation\_\_\_\_\_

DHB\_\_\_\_\_

## Appendix 4

VICTORIA UNIVERSITY OF WELLINGTON  
*Te Whare Wananga o te Upoko o te Ika a Maui*



### Participant Consent Form

#### Project Title

#### **Pacific community mental health nurses' experiences of working in a District Health Board in New Zealand**

I have read and understand the information explained to me about the study. I have had the opportunity to ask questions and am satisfied with the answers provided.

I understand that taking part in this study is entirely my choice and that I have the right to withdraw from the study prior to the first interview date.

I understand that my participation in the study is confidential and that no material which could identify me will be used in any reports or findings in this study.

I have had time to consider whether to partake in this study. I know whom to contact if I need to ask any questions about the study.

I voluntarily agree to participate in this research project and thereby give my written consent to partake in this study under the conditions set out in the participant sheet.

#### **Participant:**

Name\_\_\_\_\_

Signature\_\_\_\_\_

Date\_\_\_\_\_

#### **Researcher:**

Name\_\_\_\_\_

Signature\_\_\_\_\_

Date\_\_\_\_\_

<b>Participants information:</b>	Yes	No
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I wish to receive an executive summary or the research report  
(Postal address)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Contact:** Jacinta Apelu at Isa Lei Service (09) 838-2800 extn 4906

Please contact me on the above phone number if you require any further information about the study.

## Appendix 5

VICTORIA UNIVERSITY OF WELLINGTON  
*Te Whare Wananga o te Upoko o te Ika a Maui*



### Confidentiality agreement for transcriber

#### Research title:

**Pacific community mental health nurses' experiences of working in a District Health Board in New Zealand**

**Researcher: Jacinta Apelu**

I, \_\_\_\_\_ (print name) have read the information sheet outlining this study. I have discussed with the researcher the nature of the research and have had any questions that I have had answered to my satisfaction. My role as the research transcriber has been outlined to me by the researcher.

- I understand and agree to keep the information I hear and type in the course of transcribing confidential to the researcher and myself.
- I agree to ensure that all the research information (Tapes and Transcripts) will be securely stored and will be inaccessible to other persons.

I have read and understand my responsibility.

Full name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix 6

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*Te Whare Wananga o te Upoko o te Ika a Maui*



### Participants Questionnaire Guide

Interview date: \_\_\_\_\_

Before we begin I would like to advise you that you can take as much time as you wish to talk about your experience.

1. Tell about how you first became employed by the Pacific Mental Health Services.
2. Tell me what your thoughts and feelings were when you first started working in this service.
3. What is your role in this Pacific multidisciplinary team and what is it involve?
4. What are some of the difficulties that you may have encountered in your role if any?
5. How have you dealt with any difficulties or issues in your practice and were there any support available for you?
6. What do you consider as advantages or disadvantages for you and for your practice in this cultural setting?
7. How has working in the Pacific mental health service impact on your practice?
8. What if any are the barriers or aspects that you would like to improve or work on in your practice?
9. Tell me how this experience has contributed to your professional practice development and future goals.

Thank you so much for sharing your experience. Your contribution to this study is greatly appreciated.

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