

**Walking in Two Worlds:**  
**A Kaupapa Maori Research Project Examining the Experiences of Maori**  
**Nurses Working in District Health Boards, Maori Mental Health Services**

by

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## **Abstract**

Maori mental health nurses undertake alternative ways to practice which are informed by Maori philosophies and principles. This includes a view of health that is holistic and incorporates ideas of the entire rather than the part. This research project investigates the experiences of Maori nurses working in District Health Board (DHB) Maori Mental Health (MMH) services in order to illuminate the practices, skills and knowledge bases that Maori nurses utilise to work with Maori people.

This study was undertaken using a Kaupapa Maori research framework. This particular approach permits the validation of nursing practice and knowledge that MMH nurses acquire, develop and use to “walk in two worlds”, te ao Maori (the Maori world) and te ao Pakeha (the Western world). The underlying philosophy and principles of a Kaupapa Maori approach provided the cultural framework that was familiar to the participants as Maori nurses. The five participants were MMH nurses who had previously worked or were currently working in services for a period of at least six months. Two semi-structured focus group interviews were used to gather the nurse’s discussions of their experiences. Their stories were analysed using an integrated Kaupapa Maori (Maori philosophy) and interpretive-narrative approach. Dissemination of the findings resulted in the development of four dimensions of Maori nursing practice. These were Whanaungatanga (Affiliation); Manamotuhake (Affirmation); Nga whawhai kia haere nga tahi ana (Alignment); and Te kai o te Rangatira, ko te whaikorero (Articulation). These dimensions are broad concepts that capture the unique practice and knowledge necessary to work effectively as a MMH nurse. Understanding these

dimensions will assist other nurses in preparing to work within MMH services. They will also help services to identify and implement strategies to support nurses to work more effectively and safely, ultimately enhancing the provision of care and treatment for Maori people.

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## **Glossary\***

Aotearoa	Maori name for New Zealand
aroha	to love, empathise with
awa	river
awhi	to embrace
hapu	sub tribe
he kanohi kitea	seeing people face to face, being present
he nui aroha kia korua	love to you two
hinengaro	emotions, mental well-being
hui	gathering/s
ingoa	name
iwi	tribe, tribal area
kai	food
kai manaaki	carer
kanohi	face
karakia	prayer
Kaumatua	elder expert in tikanga Maori
kaupapa	philosophy/ies
kaupapa Maori	Maori philosophy
Kawa Whakaruruhau	Cultural safety between Maori and non-Maori
kawa	protocols
koha	gift
korero	speak/s

koro	older man
kotahitanga	togetherness
Ko wai ahau?	Who am I?
kupu	word/s
kuia	female elder
mahi	work
mana	respect, pride
manaakitanga	to be cared for, protecting
mana whenua	local to an area
Maori	indigenous people of New Zealand
maramatanga	understanding/thoughtfulness
marae	gathering place of the iwi, or hapu
Mate Maori	Maori illness
matua	parents
maunga	mountain
mihimihi	a greeting
mihi whakatau	greetings, introductions
nga mihi aroha kia koe	greetings and love to you
noa	to move from special to normal state
nui aroha kia korua	great affection to you two
Pakeha	of European descent, non-Maori
poroporoake	Maori farewell ceremony
powhiri	welcoming ceremony
rangatahi	youth
rangimarie	peace, forgiveness

rongoa	Maori herbal medicines
takahia	to fall, trample
(nga) tamahine	daughters
tama	son
tangata	people
tane hoa	husband, man
tapu	special state, sacred
tamariki (ma)	children
tangata whaiora	clients in health services (Maori)
tangata whenua	people indigenous to the land, local tribes
taonga	precious gift
tautoko	to support
te ao Maori	the Maori world
te ao Pakeha	the Pakeha world
te reo Maori	the Maori language
tikanga Maori	correct Maori practice
tinana	body
Te Tiriti o Waitangi	The Treaty of Waitangi (TTWO)
tino rangatiratanga	self determining, autonomous, to have control over
waiata	song, singing
wairuatanga	spirituality
waka	canoe
whakarongo	to listen
whanaungatanga	familial relationships
whakapapa	family connections, tree



Whakatauki

Maori proverb, saying

wairua

spirit

whanau

family

whare

house, building

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\*Translations used are those of my family and reflect those shared by most Maori people

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## Chapter One: Introduction to the Research

*I came across to Maori Mental Health (MMH) as a student nurse, I can remember sitting at the table with all these Maori professionals, and they were intelligent Maori. That's what really captured me; it was an opportunity to learn more about who I was. I could be working with like minded people.*

*(A Research Participant, 2006)*

These words are a glimpse into the reflections of a MMH nurse, inspired by an opportunity to work with others who shared a passion for working with Maori people. The enthusiasm expressed by this participant was similar to that voiced by all the participants in this study, in that they had a desire to learn and develop themselves and understand the impact of their Maori identity on their nursing practice. According to the Ministerial Taskforce on Nursing (1998) Maori nurses undertake alternative ways of practicing which achieve positive health outcomes for Maori, however little is known or documented on what these practices are or the reasons why Maori nurses practice differently.

This thesis addresses the question: What are the experiences of MMH nurses working in District Health Board (DHB), MMH services, in order to assist them to reveal, clarify and articulate the ways in which they practice. Although this project is about Maori nurses and mental health, to a large extent it is about being Maori in the world as it is known today, and the consequence of living in two worlds, te ao Maori and the world at large. In Aotearoa/New Zealand the world at large is mainly the Pakeha world.

The title "Walking in Two Worlds" was decided midway through the research. What became apparent in the focus group interviews was how nurses referred to Maori and mainstream in mental health as being different, and Maori ways of knowing as being important. The writing of this thesis has been intentionally written to articulate aspects of the two worlds. It is aimed at positioning MMH nurses within the different cultural contexts that they work. The concept infers acknowledgement of the skills that are required to integrate different and at times conflicting knowledge bases. Although walking in two worlds seems ideal and straight forward, it alludes to historical events such as colonisation, oppression of culture and institutional racism and the ongoing effects of these on the current Maori health status and delivery of health care. For those MMH nurses who artfully integrate a Maori cultural perspective with their clinical nurse education, the notion of walking in two worlds is likely to be familiar.

As part of walking in two worlds for this thesis, when Maori terms are first introduced an English translation is provided. An example of the difficulties related to walking in two worlds for this document is the limitations of technology to displaying macrons for the Maori terms that are used.

Despite there being an abundance of research literature on Maori, Maori health and nursing, literature on Maori nursing practice developed from a research base is severely lacking. This project then had two intentions, to investigate the experiences of Maori nurses, and also to add to the already limited Maori nursing research knowledge base. It was also thought that from

this research other Maori nurses would be encouraged to take up the research challenge.

The investigation required an approach that was consistent with information gathering through the expressing of experiences, and that centralised Maori philosophies, principles and ways of knowing. As a result a Kaupapa Maori research approach was not only deemed appropriate but necessary. The recruited participants were Maori nurses who worked in MMH services that strived to maintain a Kaupapa Maori philosophy.

Kaupapa Maori is a general term and in its broadest sense refers to “Maori desires to be fully Maori” (Pihama, Cram, & Walker, 2002, p. 30). It is described as the philosophy and practice of being and acting Maori (Smith, G., 1992, cited in Bishop, 1999) and assumes the social, political, historical, intellectual and cultural position of Maori people as legitimate. “It is a position where Maori language, culture, knowledge and values are accepted in their own right” (Smith, G, 1992, p. 13).

As the methodology for this study, Kaupapa Maori principles and practices determined and guided the research process. These included the practice of tikanga Maori in the use of focus group interviews for collection of experiences and the integration of Kaupapa Maori principles with an interpretive-narrative approach for the analysis process.

The remainder of this chapter presents an overview of the research topic and description of how the thesis document is laid out. A positioning of ‘self’ is



provided as a way of locating the researcher in the study. It also serves as a prelude to the reasons why and how this project was undertaken.

### **Positioning 'Self' in the Research**

*Tena Koutou Katoa. Ko tenei te mihi ki a koutou katoa, ko nga Koroua, ko nga Kuia, ko nga kaimahi o nga roopu Te Oranga Hinengaro, ko nga kaitiaki o to tatou tangata Maori. Nga mihi, nga mihi.*

*To you all, this greeting is to you the older men and older women, to the guardians of mental health services, to those who are carers of the Maori people. Greetings, greetings.*

### **Ko wai ahau? (Who am I?)**

**Whakapapa** is more than one's family tree; it is genealogy and the spiritual and ancestral links which connects people back to their family, iwi (tribe), and the whenua (land) from which they come.

Ko Whakapunake te Maunga  
*Whakapunake is the mountain*

Ko Hopupu honengenenge matangirau I te Wairoa te awa.  
*Hopupu Honengenenge matangirau I te Wairoa is the river*

Ko Takitimu te waka  
*Takitimu is my canoe*

Ko Te Rauhina te Marae.  
*Te Tauhina is the Marae*

Ko Ngati Kahungunu te Iwi.  
*Ngati Kahungunu is the tribe*

Ko Ngati Kahu te hapu.  
*Ngati Kahu is the sub-tribe*

Ko Wakaiti Taite raua ko Huia (nee Christie) oku matua.  
*Wakaiti Taite is my father, Huia (nee Christie) Taite is my mother*

Ko Steven Saba toku tane hoa.  
*Steven Saba is my husband*

Ko Cory taku tama.  
*Cory is my son*

Ko Holly raua ko Deni aku tamahine.  
*Holly and Deni are my daughters*

Ko Wakaiti Saba toku ingoa.  
*My name is Wakaiti Saba*

Tena koutou, tena koutou, tena koutou katoa.

I am a Registered Comprehensive Nurse, and currently enrolled in an advanced nursing programme with the Graduate School of Nursing, Midwifery and Health at Victoria University of Wellington. This thesis marks the completion of a Masters of Nursing (Applied) Degree. Presently, I am working with a Crisis Assessment and Treatment Team and a Home Based Treatment Team. Prior to this, I worked in a community MMH Team as a case manager and for a short time filled the position of Acting Team Leader. I have also worked in a number of mainstream in-patient psychiatric wards. Though I am not with a MMH service, since the outset, my passion has been toward working with Maori colleagues, in the context of a Maori health framework, and for the betterment of Maori people. It is this desire that has driven the present research project.

## **Reflecting Back**

The question that initially inspired me to undertake this research project goes back to a time three years ago when I was asked by a Pakeha (non-Maori) friend and colleague, why is it, that Maori nurses are leaving MMH services in droves? Unfortunately, this reality is one that I, and other Maori nurses have witnessed and become increasingly concerned over. The high incidence of burnout and staff turnover in these services is well known amongst MMH nurses. Reasons for levels of burnout and staff turnover in MMH services are unclear; however the numbers of Registered Maori nurses is likely to be a contributing factor. Maori nurses make up only 7.5% of the total nursing workforce including midwives (Ministry of Health, 2004), while the Maori population is estimated to be 14 percent.

The question asked by my colleague raised my concerns for those nurses who were still there, and reminded me of the support that I had received while working in a MMH service myself. Although I remember this time with great admiration for those who were able to artfully use their skills and knowledge to work with Maori tangata whaiora (MMH consumers), it is only recently that I have been able to reflect on and consider the many challenges that MMH nurses faced and continue to face today.

For me, working in a MMH service was a good experience. The service operated from the principles of whanaungatanga which meant that all members had the responsibility of supporting each other toward the common Kaupapa (philosophy) of health. I particularly enjoyed the karakia (prayer),

and waiata (songs) that the whole team participated in during the morning meetings, and learned much about myself in terms of Maori culture and my Maori cultural identity and heritage.

I enjoyed the mentorship of Kaumatua and relied on the support and teachings of other nurses who were more knowledgeable than me, to work effectively with Maori tangata whaiora and their whanau. However, it is also within this experience that I became most aware of the realities of mental health or poor mental health of Maori, barriers for MMH teams to the delivery of appropriate services and, the difficulties Maori nurses faced when providing effective and appropriate nursing care to tangata whaiora.

Although I had successfully completed the cultural component of my nursing education, read literature on the statistics and determinants of health for Maori, and also lived a relatively culturally informed life, these did little to prepare me for the realities that Maori people contend with when experiencing mental illness.

There are significant disparities in whanau health status. As a population group, Maori have on average the poorest health status of any group in New Zealand (Ministry of Health, 2001, p. 1). In 1998 a report to the Minister of Maori Affairs; Progress Toward Closing the Social and Economic Gaps Between Maori and Non-Maori was completed. It provided the benchmark against which to measure progress toward achieving the government's objective for Maori development. The findings showed that Maori were experiencing poorer educational outcomes, higher unemployment, lower

income levels, lower rates of home ownership and, poorer health status than non-Maori (Love, 1998). As a Maori nurse working in a community environment, when working with tangata whaiora, these findings were apparent. A high proportion of the tangata whaiora Maori that I worked with were unemployed and relied on Unemployment, Sickness or an Invalids Benefit as their main source of income. Many lived in large Housing Corporation complexes (state owned and subsidised housing) with their families often exceeding the number of occupants approved for the dwelling. Few had completed formal tertiary education or gained qualifications, and many were struggling to pay bills and buy kai (food). Along with these circumstances, I witnessed a high incidence of tangata whaiora accessing services through the criminal justice system or presenting in such acute psychiatric states that an admission to the psychiatric in-patient ward was deemed necessary. Many tangata whaiora (clients in health services) had very little support because they had been separated from their whanau (families), and were struggling to even establish a sense of identity. Research by Te Puni Kokiri, Ministry of Maori Development (1996) highlighted many of these trends. For example, between 1984 to 1993, noted as a period of deinstitutionalisation and a transitioning a psychiatric patients into the community, Maori rates of referral from welfare and law agencies were almost double Pakeha rates, in 1993 the readmission rates showed that Maori males had escalated to nearly twice as high as Pakeha males for severe mental illnesses and drug and alcohol disorders (Te Puni Kokiri, 1996, p. 27). Perhaps as a consequence of these and other such concerns, it was difficult to help tangata whaiora meet the psycho-social and cultural needs within the limitations of my job. Practices such as buying kai, working after hours, and

driving tangata whaiora long distances to be with their whanau, was not condoned, however was common place for me and amongst the nurses I worked with. Such behaviours were kept quiet to avoid being deemed inappropriate or unprofessional as they were not listed or expected as part of my job description or responsibility. While it was not the intention of this study to validate such practices, it was hoped that the meanings and reasons why Maori nurses sometimes go beyond the role expected of them, would be better understood as a result of this research. Further, this understanding may assist in the designing of orientation packages for new Maori nurses, help to inform nurse education programmes of the needs of MMH nurses, assist MMH services to better support their Maori nursing staff, and ultimately improve the delivery of health care to tangata whaiora.

### **Overview of the Research Method**

As mentioned above, this project was undertaken using a Kaupapa Maori methodological approach. This involved an integration of Kaupapa Maori principles adapted from the framework, Kaupapa Maori Research Principles for Researching Maori developed by Te Awekotuku (1991) and further outlined by Smith (1999) and Pipi et al. (2004).

The framework describes seven principles that are recommended as a guide for conducting research for the purposes of developing Maori knowledge that benefits Maori people. They are not prescribed methods or procedures that should be followed, but instead provide a conceptual framework that sets out basic guidelines to assist researchers to work in ways that are consistent with

Maori cultural beliefs, values and practices. The framework also allows room for researchers to include other concepts that support and are consistent with a Kaupapa Maori philosophical approach.

The principles are:

- Aroha ki te tangata – to have a respect for people
- Kanohi kitea – the seen face; to present yourself to people face to face
- Titiro, whakaronga ... korero – to look, listen ... speak
- Manaaki ki te tangata – to share and host people; to be generous
- Kia tupato – to be cautious
- Kaua e takahia te mana o te tangata – to not trample over the mana of the people
- Kaua e mahaki – a warning not to flaunt your knowledge.

The concepts of tapu and noa (special/unsafe state to safe state), wairuatanga (spirituality), whanaungatanga (relationships; familial relationships) kotahitanga (togetherness), maramatanga (understanding and thoughtfulness) and rangimarie (peace and forgiveness) were also included, applied and integrated throughout the research.

The above principles and concepts were applied in the processes of collecting data through the use of focus group interviews within a setting that promoted tikanga (right Maori practice) consistent with that of a marae (Maori gathering place) and the analysis of participant's experiences (in the case of this project, discussions) with focus on Maori concepts and practices. Kaupapa Maori methodology determined the process prior to and during the selection of

participants, which involved consultation with kaumatua and Maori team leaders in MMH services and from the mana whenua (local tribe/area).

Participants recruited were mental health nurses who identified as Maori from two DHBs, and who had worked or were working in MMH services for a period of at least six months or more. Two focus group interviews were held. The first focus group interview consisted of four participants and the second with three from the first interview with the addition of two new participants. Both focus group sessions were audio-taped and these recordings were transcribed verbatim. An integration of the Kaupapa Maori principles with an interpretive-narrative approach was used to analyse participant's narratives. This involved analysing participant's discussions to identify nursing behaviours and practices with particular focus on those that centralised Maori knowledge and beliefs.

### **Laying Out the Thesis Document**

This section sets out the journey of investigation for this research project.

Chapter Two – *Gathering and Presenting the Literature* presents a literature review; a backgrounding of MMH nurses outlining historical and present issues which have affected and continue to affect them today. A description of how literature was collected opens this chapter.

Chapter Three – *A Kaupapa Research Methodology* presents an outline of the Kaupapa Maori methodology used for this project. It provides discussion on



how and why its underlying principles were applied. Documents related to the methodology such as the Approval from the Human Ethics Committee, Victoria University of Wellington (Appendix 1) and, the Panui (notices, Appendix 2), Information Sheet (Appendix 3) and Consent Forms (Appendix 4, 5) are located as Appendices. This chapter also outlines the process of analysis and the integration of a Kaupapa Maori and an interpretive-narrative approach, and the processes used to formulate and structure presentation of the research findings.

Chapter Four – *Presenting the Findings*, is a presentation and discussion of the main concepts that emerged from the findings. Participant's quotations are used with narration from the researcher throughout this chapter.

Chapter Five – *Conclusions and Making Recommendations* concludes the thesis report. This chapter outlines the conclusions and recommendations as a result of the findings. This chapter closes the thesis document with a final closing statement.

Each chapter begins with a brief introduction. Whakatauki (Maori proverbs, sayings) are used throughout to illuminate Maori concepts and serve as a reminder of the cultural context that position this research project.

## **Chapter Two: Gathering and Presenting the Literature**

*Ka kahi te toi, ka whai te maramatanga*

*If knowledge is gathered enlightenment will follow*

*(The Maori Health Committee, Te Kaunihera Rangahau o Aotearoa, 1998)*

The history for Maori mental health nursing prior to the 1980s is vague and largely unknown, and can really only be considered or theorised about in terms of what was happening with mental health services and nurses in general in New Zealand at the time. Even from this perspective it would be mostly speculative.

This chapter presents a review of the literature. Although all concerns and issues for MMH nurses deserve attention, due to the limitations of this project only those issues considered consistent with this research study are examined and discussed. The chapter begins with a description of the process undertaken to gather relevant information and is followed by a review of the issues that affect and continue to affect MMH nurses working in MMH services today.

### **Gathering the Literature**

An initial search for literature was made using a combination of the key words and phrases, research for Maori Nurses, Maori psychiatric nursing and MMH services in New Zealand. The search involved investigation of the Proquest,

Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, Cochrane and Psychinfo databases. This proved to be too wide in terms of finding studies similar to the planned project, however there were many articles that focused on health and illness for Maori, health inequalities and disparities between Maori, non-Maori, and Maori and mental health. Most discussed the appropriate delivery of care for Maori patients, but none focused on the experiences of Maori health professionals, or the experience of Maori nurses working in MMH services.

A further wider search was conducted in an attempt to find international studies that might be similar and play a role in shaping and guiding the project. Using the key words and phrases: indigenous nursing research, aboriginal nursing, native nurses and research, colonisation and nursing, and cross-cultural nursing, many articles and discussion documents from New Zealand, Canada, North America and Australia were found. Two studies similar to the present project were found on this search. One of these studies investigated the lived experience of Ojibwa and Cree Woman healers (Struthers, 1999) and the other looked at the phenomena of nursing in the Native American culture (Lowe & Struthers, 2001). Both studies proved to be very helpful in understanding the issues for indigenous nurses. From this search, I was also able to gather information on key themes and ideas such as indigenous definitions of health, inclusion of indigenous cultural activities in the delivery of nursing care and other ideas similar to this projects topic. Two articles by New Zealand writers referred to 'walking in two worlds' and the experience of indigenous health professionals delivering health while balancing two cultural perspectives, the dominant pakeha culture with their

Maori cultural perspective (Bosmann-Watene & Webster, 2003; Close, 2005). Both were discussion documents and provided accounts of the individual health professionals own experience of working with people from their own ethnic group. Toward the latter stages of the present study, two further articles were discovered. The first investigated how Maori conceptualise health (Cram, Smith & Johnson, 2003) and the other investigated the characteristics of Maori nursing practice (Simon, 2006). Both were of significant value and as will be evident in the discussion chapter, their findings were similar to the key findings of this study. A further, even wider search was undertaken to include studies from other health disciplines. The key word nursing was changed to health carer or clinician. As the search progressed, I also investigated electronic libraries with Capital and Coast Health Medical Library, the Ministry of Health Website, Te Puni Kokiri Website and used the search engine Google for internet searches.

I was able to find an abundance of information on cultural safety, Kawa Whakaruruhau, colonisation of Maori in New Zealand, and the history of Maori people. Articles and books were used to discuss The Treaty of Waitangi, recruitment and retention of the Maori health workforce, the development of MMH services, and other key ideas which had some relevance to the overall research topic. Of much help was the document Report of the Ministerial Taskforce on Nursing, Releasing the Potential of Nursing (1998), which documented the findings of a survey of nurses in New Zealand. It was most useful because it identified concerns raised by Maori nurses in the delivery of health care to Maori similar to this project.

Despite the vast amount of information and discussion documents available on the health and illness of Maori, socio-economic deprivation of Maori, the provision of adequate and appropriate health care to and for Maori, there was a significant lack of research information about Maori health professionals, including Maori nurses and their experience of working with Maori or non-Maori tangata whaiora. Considering that an increase in Maori health professionals including Maori nurses is continuously recommended in governmental documents toward addressing socio-economic and health disparities for Maori in New Zealand, this lack of information is very surprising. It is hoped that this project will help in some way to illuminate and address this information gap.

Additionally, although information on cross-cultural nursing care was readily available, it presented little significance to this project. Cross-cultural nursing assumes that the nurse, from the dominant culture (usually non-Maori) is working with a client (Maori) from the minority group. The intention of this study is to understand the experiences of Maori nurses who work with Maori tangata whaiora and Maori colleagues in Maori services.

### **Reviewing the Literature**

When reviewing existing literature it became apparent that issues relevant to the topic of this study were vast, and a detailed examination and critique of this would warrant investigation beyond the scope and timeframe provided for this project. The literature review that is presented is therefore not comprehensive. The issues that are identified highlight past and present

concerns, and are discussed to position the need for this research and why understanding Maori nurses experiences are important.

The literature is divided into those issues that affect or have affected the current provision of nursing care from DHB based, MMH services today.

### **Colonisation and Health Professionals**

In order to acquire a secure and meaningful identity and to enjoy good health and a sense of well-being, Durie (2003, p.3) claims that "Maori people must be able to live comfortably as Maori and as citizens of the world." Durie (1997) states that "Maori cultural identity has been seriously eroded by military might, the law, loss of land, exclusion from power, and economic deprivation. The effects remain evident and are related to a variety of socio-cultural problems and conditions which undermine a positive Maori identity" (p. 51). Cultural identity comprises of a cultural history and a cultural present. For Maori, the effects of colonisation continue to have a far reaching effect particularly in terms of their cultural identity.

Colonisation and in affect, assimilation are historical processes that have been experienced by many if not all the indigenous cultures of the world. In its broadest sense colonisation entails the migration, control and the settlement of people from one country to another. Pearson (1990) argues that "it is about a shift of domination in colonial situations" (p. 225).

Lawson-Te Aho (1998) describes colonisation as a political act that assumes cultural superiority and the right to dominate. As a process it has to render indigenous perspectives and experiences as irrelevant, inferior and second class, in order to impose a new cultural belief system and political order. These are the necessary conditions without which, colonisation could not work according to Lawson-Te Aho. Since the arrival of the first British settlers in New Zealand and through the process of colonisation and assimilation, Maori people have not fared well in both health outcomes and socio-economic status. Argument of the consequence of colonisation on the ill-health of indigenous people is vast. Durie (2003) argues that in New Zealand “the results of colonisation were consistently cataclysmic... A common pattern emerged: loss of culture, loss of land, loss of voice, loss of population, loss of dignity, loss of health, and wellbeing” (p. 225).

Colonisation has resulted in the disadvantaged position of Maori today, as a group compared with Pakeha because of the destruction of their (Maori) “economic and cultural base” (Polaschek, 1998, p. 453). According to Voyle and Simmons (1999, p. 1035) “Indigenous people who have been dispossessed of their lands and resources bear a disproportionate burden of health problems”. Woodward and Kawachi (2000, p. 924) also argue that “the far reaching causes of ill health included the alienation of land and suppression of Maori culture and language”. Further, they state that the present health gap between Maori and non-Maori is an “equity issue because these powerful, historical predisposing factors lie outside the control of the people who now experience an excess of disease and injury.”

For Maori nurses, colonisation continues to affect them in at least two ways.

Firstly, as Maori citizens they are subjected to the same negative consequences as are other Maori, and secondly, as nurses they must deal with the needs of at risk tangata whaiora who continue to suffer consequences such as poor mental health and poverty. Identified in the document *Reducing Inequalities in Health* (Ministry of Health, 2002) Maori in New Zealand suffer worse health than other New Zealanders. In effect this has created a health gap that has led to a demand for more Maori health professionals toward addressing health inequalities and disparities (Ministry of Health, 2001). Maori Mental Health nurses along with other Maori health professionals have been identified as part of a solution toward resolving these health issues.

The demand for more Maori health workers in all areas of health is clear and resonates in contemporary literature and governmental documents. However, despite this, there is a serious lack of argument and/or information on how the increase of Maori health workers will reduce the existing health inequalities and disparities, or of the specific skills and knowledge that will address this goal.

Intellectuals, who have been trained in western technologies, have been regarded at times as very problematic. Smith (1999) argues that their (intellectuals) importance in nationalist movements is related to their abilities to reclaim, rehabilitate and articulate indigenous cultures. Smith further states that at the same time, "these same producers and 'legitimizers' of culture are the group most closely aligned to the colonizers in terms of class interests,



their values and their ways of thinking" (p. 69). According to Awatere (1984) "colonial Maori are noticeable because they have succeeded as white in some section of white culture, economically, through the arts, at sport, through religion, the universities, the professions" (p. 83). This argument would suppose that Maori nurses who have successfully completed degree level qualifications as required by nurse education institutions, have been assimilated to the dominant Pakeha culture. This means, in order to succeed in the western culture, nurses must accept and allow the pakeha culture to become a part of their own identity.

Sir Apirana Ngata, a Maori leader, politician and scholar, in 1949 encouraged Maori youth to seek out knowledge derived from science and technology and to blend it with Maori customary knowledge, retaining in the process a wider spiritual context (Ngata, 1949, cited in Durie 2003, p. 3). In this regard, culture must continuously evolve and adapt in order for Maori people to live healthily in a constantly changing environment. The notion that Maori culture is static, and rooted in traditions and beliefs that are hundreds of years old, and that Maori people should behave in accordance with these traditions in order to maintain a Maori cultural identity is unrealistic. Ngata (1949) proposed that blending cultures is not only possible, it is inevitable and should be encouraged. Miraglia, Law and Collins (1999, p. 1) argue that: ...people learn culture. Culture is a body of learned behaviours common to a given human society, and acts like a template (i.e. it has predictable form and content), shaping behaviour and consciousness within a human society from generation to generation. So culture resides in all learned behaviour.

Indeed, though the success of Maori nurses can be interpreted as a sign of assimilation, it may also constitute a dynamic, ever changing and evolving culture that is more familiar to Maori than any other. Never-the-less, there exists literature to assist intellectuals who are trained and acculturated into western institutions to be assisted back to there own cultural identity. Fanon (1990) identifies three levels through which native intellectuals can progress in their journey back over the line. First there is a phase of proving that intellectuals have been assimilated into the culture of the occupying power. Second, comes a period of disturbance and the need for the intellectuals to remember who they actually are, a time for remembering the past. In the third phase the intellectuals seek to awaken the people, to realign themselves with the people and to produce a revolutionary and national literature. Fanon states that in this phase the writer takes on the habit of addressing his own people. It could be argued that Maori nurses who are seeking to learn more about their cultural identity are already in the process that Fanon has described. In this case the experience of balancing two cultural perspectives is consistent with a period of disturbance and a process of realignment back to Maori people.

### **The Contribution of the Te Tiriti o Waitangi (The Treaty of Waitangi)**

Te Tiriti o Waitangi (TTOW) was signed in 1840, and its intention was to forge an alliance and partnership between Maori and Pakeha in Aotearoa, New Zealand (McCluskey, 2005; Sharp, 1997). It is the founding document and legitimate source of constitutional government in New Zealand today and for Maori people the Treaty articulates their status as tangata whenua, the

indigenous people of Aotearoa. Over the past decade, through TTOW, Maori people have become more strident to have their demands, aspirations, values and structures incorporated into New Zealand's social and political processes.

In health, The Treaty of Waitangi has special relevance. Article two of TTOW guarantees tino rangatiratanga which provides for tribes to exercise authority in respect of their own affairs (Durie, 1994; Webby, 2001). Article three guarantees equality and equity between Maori and other New Zealanders with an overall aim of protecting Maori well-being. These Articles guaranteed the right of Maori to the same level of health as other New Zealanders and the New Zealand government has a responsibility to ensure that this right is upheld. However, after consideration of the current health status of Maori, Webby argues that “due to the still needed autonomy in health policy and care delivery, and the disparity between Maori and non-Maori status, obligations under these Articles are yet to be fulfilled” (p. 18).

In an attempt to address Maori health disparities, the Ministry of Health documents, *He Korowai Oranga; Maori Health Strategy* (Ministry of Health, 2001); *Te Puwaitanga, Maori Mental Health National Strategic Framework* (Ministry of Health 2002b); *Reducing Inequalities in Health* (Ministry of Health, 2002) and; *The Blueprint for Mental Health Services in New Zealand* (Mental Health Commission, 1998) outlined strategies that were aimed at addressing Maori health issues as an obligation to TTOW.

The *He Korowai Oranga; Maori Health Strategy* (Ministry of Health, 2001) document identified service delivery goals around Maori taking control over

their own health structures, increasing and developing Maori health providers and development of the Maori health workforce. The purpose of *Te Puawaitanga; Maori Mental Health National Strategic Framework* (Ministry of Health, 2002b) was to provide DHBs with a nationally consistent framework for planning and delivery of services for tangata whaiora, and their whanau. It was also intended that this document would direct DHBs to meet the Ministry's mental health policy objectives for Maori over the next five years, and ensure that all MMH services retained a discrete and prominent identity within the government's national health strategy (Wilson & Peretini, 2002 cited in Ministry of Health, 2002b).

In these documents, the need for Maori participation at all levels of the health sector was recommended. This included increasing the number of Maori actively being involved in policy-making decisions to increasing the number of Maori as health professionals at the coal face (Ministry of Health, 2001). Further, government health policies, documents and services are highlighting the need for Maori aspirations and philosophically informed ideas into the provision of mainstream as well as Maori specific services.

### **The Journey for Maori Mental Health Services – From Whaiora to Kaupapa Maori**

During the 1970s and 1980s with the introduction of new anti-psychotic medications, the number of long stay inpatient beds in mental health hospitals in New Zealand was drastically reduced resulting in a massive discharge of patients into the community (Durie, 2003; Te Puni Kokiri, 1996). Durie states

that “there was a deliberate effort to separate treatment from care and in that process, some shift in responsibility from hospitals to local communities occurred” (p. 223). However, at a time when large mental hospitals were adopting policies of early discharge, and return to the community for longer-term patients, there was an increase in admission and re-admission rates for Maori to inpatient wards. As a result, in 1983, the first Maori cultural treatment unit Whaiora was set up at Tokanui hospital. It was an initiative developed and run in part, by MMH nurses designed to give Maori tangata whaiora an alternative approach to mental health care that recognised the contribution of cultural awareness on tangata whaiora's well-being and mental health. The management approach involved consideration of Maori cultural beliefs, values, and practices while maintaining the use of modern treatments. Durie argues that the need and purpose of such a service was recognition that existing mainstream services were failing to address the needs of Maori patients, particularly those needs that were culturally bound.

Durie (2003, p. 225) purports that in 1984, “over fifty percent of Maori whanau had their relative placed in hospital against their will, and many felt excluded from institutionalised practice and decision making.” He explains that cultural beliefs in health practice are important because this approach recognises the needs of Maori whanau and allows for whanau to participate in the treatment and care of their family members. The importance for change was because the “services at the time were mono-cultural and overlooked the input of whanau”, and “Maori did not conform to the typical presentation whether physically or psychologically” (Durie, p. 4).

The concept and approach that Whaiora embodied, largely influenced the development of modern Kaupapa MMH services that are operating today. Pipi et al. (2003) report that in the past, health interventions for Maori that have been supported by governments have almost always been ad-hoc, additions to existing services. Early examples include James Pope's intervention for Native Schools, the Division of Native Hygiene and the Maori Nursing Scheme (Reid & Cram, 2005). Another type of intervention was generated from within Maori communities. Contemporary examples are seen in 'by Maori for Maori' initiatives and central to these initiatives are mechanisms now called Kaupapa Maori.

Keelan (1997) acknowledges that while there are some similarities, there are differences that exist between Maori and non-Maori services. The main focus for a Maori service is that it is managed by "Maori for Maori; incorporates tikanga Maori; that whanau, hapu and iwi are involved; it provides traditional Maori rongoa and healing practices, cultural assessment and emphasises whakawhanaungatanga" (p. 5).

In 1999 a set of specifications for Kaupapa Maori services, were developed by the Health Funding Authority not only for use in hospital environments but also residential homes. These were based on five groups of values including the use of the four cornerstones of health (Te whare Tapa Wha), taha wairua (spiritual), taha whanau (familial), taha hinengaro (emotional, mental), taha tinana (physical); whanaungatanga/kotahitanga (relationships/togetherness); Wairuatanga (spiritual wellbeing); Manaakitanga (to be cared for, protecting);

and Rangatiratanga (to have autonomy or self control over ones own health and well-being).

Services were also expected to demonstrate commitment to TTOW. The increase in services has also meant an increase in demand for Maori health professionals. These requirements largely come out of concern for the disproportionate numbers of Maori tangata whaiora diagnosed with severe mental illness and a greater number of admissions to acute psychiatric in patient wards (Durie, 2003, p. 227)..

Increases in MMH services that are both clinically and culturally driven assume there will be a positive impact on the health outcomes for Maori people. Due to the extensive positive affirmations in existing literature of by 'Maori for Maori' services, it is easy to see how negative effects or implications can be overlooked or ignored. For example, MMH services for some, continue to be viewed as aligned with in-patient wards, and those who work within them enforcers of these institutions who are conformed to hospital policies and regulations developed by managers who are often non-Maori and unfamiliar of Maori culture. For some tangata whaiora, these services are a reminder of, and represent past services responsible for the negative experience of previous admissions to long stay wards (Durie, 2003).

Perhaps, because it may be too early to estimate yet, the true impact that MMH services have had on mental health outcomes for Maori is unclear. Even more difficult is trying to understand or estimate the effects of Non-government organisations (NGOs) in comparison to DHB services on mental

health disparities. Despite this, anecdotal evidence from Maori nurses suggests that the effect of increased services, particularly Kaupapa Maori services on Maori health outcomes has been positive. English (1997), the Minister of Health at the time, supported the notion that services located in Maori friendly environments like marae or local Maori communities has meant that mental health and other health services have indeed become more accessible. However, Durie (2003, p. 227) warns of services that window dress or induce Maori people into thinking they are accessing services that are Kaupapa Maori, with traditional cultural interventions or ideas of self-determination when they are not. For Maori health professionals this is important if they are to fully understand their roles and responsibilities within the services they represent.

### **Education and Kawa Whakaruruhau for Nurses in Aotearoa/New Zealand**

The exact numbers of nursing students who identify their ethnicity as Maori is unclear, and it is therefore difficult to estimate the rates of final passes of graduates leaving nursing programmes. Despite this lack of evidence, it is accepted that Maori who successfully complete and pass their nursing education is significantly fewer than that of non-Maori (Nursing Council of New Zealand, 2000). Maori are demanding that indigenous systems of teaching and learning be positioned within nursing programmes or that Maori be given the resources to develop their own system outside mainstream (de Carlo Ahuarangi, 1996). Other initiatives on workforce planning have also taken place.



In 1996 a joint working party on the mental health workforce development was established. Its main purpose was to review the relationships between providers of mental health services and education providers. A final report resulted in the development of Terms of Reference for establishing national standards for mental health education programmes (Mental Health Commission, 1998). This included recognition of prior learning, the establishment of career pathways and a national curriculum for the mental health workforce.

One of the terms of reference looked at priority areas of the mental health workforce and skill development. A key finding was that programmes would need to monitor risk reduction and evaluate cultural safety. It was recommended that programmes be whanau-centred, have a priority on tamariki and rangatahi (youth), and should be surrounded by Maori models of health covering specific Maori knowledge and processes such as: the holistic approach to maintain an environment consistent with Kaupapa Maori principles and philosophy.

An example of such an environment is the Tihei Mauri Ora (TMO) nursing programme in the Waikato Institute of Technology. It was developed because of the difficulties experienced in attracting and retaining Maori nursing students in mainstream nursing programmes. It was introduced in the Diploma of Nursing programme for three years specifically for students who identified as Maori. The programme integrated health and nursing-related knowledge from both the Western and Maori worlds, and was delivered in a framework and environment familiar to Maori. Maori mentors were available

to help students with specific papers as they were usually recent graduates themselves (Simon, 2006). The involvement of whanau, smaller class sizes, and significant leadership from Maori tutors was encouraged as part of the programme. The Treaty of Waitangi was the tool for negotiating the TMO programme.

Apart from the Tihei Mauri Ora programme, other programmes specialising on Maori cultural or spiritual education for nurses and other health professionals though increasing are scarce. To date there remains a serious lack of appropriate education programmes designed for Maori nurses to be educated in and learn to work within contexts consistent to the Maori people they work with. Maori nurses have contributed to the development of nursing theory and practice in New Zealand. For example, Kawa Whakaruruhau (Cultural Safety between Maori and non-Maori) was developed as a framework in order to analyse nursing practice in New Zealand from Maori nurses' perspectives as Maori.

A study by Manchester (2000) showed that Maori nursing students continue to experience struggles in nurse education institutions. Maori students described feeling isolated in nursing schools that have no Maori tutors, and because of the small number of Maori students attending, they also described having to put their own cultural beliefs on hold because of their tutors' trans-cultural rather than bicultural views on nursing. They expressed that any Maori input into their studies was really a token gesture and even the little there was, was met with resistance from them and most of the non-Maori student body (Manchester, 2000). A similar study by Weaver (2001) explored

the educational experience of forty Native American nurses. Weaver's findings showed some correlations of the concerns and struggles of Native American nurses with those expressed in literature by Maori nurses. Native American nurses indicated that the cultural content from their nursing programme was quite limited, and support for their cultural identity was poor. Further, most of the respondents experienced struggles with cultural shock, cultural differences, stereotypes and racist attitudes, isolation and assumptions about their cultural identity.

The concept of cultural safety or Kawa Whakaruruhau in the Maori context, originated in New Zealand in the 1980s, and since 1990 has been integrated as a formal and compulsory component of the nursing curriculum and a requirement for subsequent registration (Nursing Council of New Zealand, 1996, 2002; Richardson, 2004). Polaschek (1998) states that cultural safety in New Zealand has focused on the attitudes which individual nurses bring to their practice, attempting to change the effects of their social conditioning on their approach to nursing. This approach gives recognition not only to Maori as the indigenous people of New Zealand but also to the uniqueness of Maori experiences in relation to biculturalism and colonisation.

Culturally safe nursing practice is defined as practice involving "actions which recognise, respect and nurture the unique cultural identity of the Tangata Whenua and safely meet their needs, expectations and rights" (Wood & Schwass, 1993, p. 5). Cultural safety involves recognition of negative attitudes and stereotyping of individuals because of the ethnic group to which

they belong. It requires acknowledgement of the situation that all Maori face as a result of a colonial experience.

Cultural safety and Kawa Whakaruruhau, provides for the formal recognition of power relations within health care interactions (Ramsden, 2002). Such a concept can be easily aligned with Kaupapa Maori services because of the power relations and consequential struggles associated with such an approach. Both approaches assert that in order to provide care that is effective and respectful of the cultural identity of tangata whaiora, the health professional must be aware of their own baggage and cultural biases on the health and safety on the recipient of health care (Richardson, 2004).

Biculturalism represents the meeting of two cultures, the culture of the indigenous people of New Zealand, with the culture of all other groups that are not Maori. This concept in relation to cultural safety within nursing emphasises the dual dynamics of the nurse-patient relationship. Thus the culture of the nurse is positioned in relation to the unique, individual culture of the tangata whaiora (ibid).

### **The Experience of Maori Nurses and other Health Professionals**

Mental Health Nursing as described by Te ao Maramatanga - College of Mental Health Nurses Inc (2003, p. 1), is considered a “specialised expression of nursing which focuses on the mental health needs of the consumer, in partnership with family/whanau and the community in any setting.” The mental health nurse is “registered with the Nursing Council of New Zealand under the

Registered Nurse or Practitioner scope of practice, and is authorised to practice in the area of mental health" (Te ao Maramatanga - College of Mental Health Nurses Inc, 2003, p. 1). These definitions apply to all nurses, Maori and non-Maori alike. Standards for Mental Health Nursing were outlined in this document. The purpose was to advise the public and to guide the professional nurse about the expected level of competence in the context of mental health. The standards are generic and detail the rationale, attributes, skills, attitudes and performance criteria. While there is recognition of Maori as the tangata whenua of Aotearoa, little consideration is given to the cultural implications of Maori nursing practice, or to the Maori cultural definitions of health and well-being, which greatly influences how Maori nurses work. Further, there are no references to the careful balancing act that takes place for Maori nurses who juggle their Western nursing education with their Maori belief systems. According to Webby (2001) safe Maori nursing practice must include Maori ways of knowing. Webby states that "Maori nurses must be given the ability to create their own practice to best meet their tangata whaiora needs." Webby argues further that MMH nursing is complex and challenging. "It is a process that involves constantly making parallels between Maori ways of knowing and Western notions and models of care" (p. 18).

The challenge of finding the balance between Te Ao Maori and Te Ao Pakeha is further discussed by Close (2005, p. 22) who states:

Historically, Pakeha viewed health with a sickness focus. All health care was directed at the causes of disease. Pakeha systems developed on models of power and control, and the desire to fix problems. The Maori perspective focuses on a balance of all components within the Maori

worldview. Statistics for all areas of social and economic areas demonstrate that Pakeha systems do not successfully address issues for Maori. Trying to fit a Maori into a Pakeha system is like trying to put a star into a square hole. It doesn't fit.

Reid and Cram (2005) argue, "there are two worldviews operating in Aotearoa, New Zealand, one is where Maori are tangata whenua (people indigenous to the land, local tribe) and the ways of being, doing and knowing are normal and accepted, the other is the pakeha culture" (p. 34). This reality or concept is familiar to many Maori nurses; it emerged as the appropriate title of this study and is referred to in the literature as "walking in two worlds" (Bosmann-Watene & Webster, 2003; Close, 2005). Two world views as this chapter demonstrates affects education, and, practice outcomes for Maori in nursing and should be considered at all level of policy and decision making. Studies that have investigated Maori nurses' experience of working in a DHB, MMH service are almost non-existent. As a consequence, there is little appreciation of the unique and complex work that Maori nurses do, or of the specialised knowledge and nursing skills that they offer. According to the Ministerial Taskforce on Nursing (1998) the alternative ways of practicing which achieve positive health outcomes by Maori nurses for Maori are often not recognised as they have not as yet been validated.

While this lack of research limits understanding of the value of MMH Nursing practice, much can be learned from those studies by Maori nurses in other areas of health, MMH professionals of other disciplines, and international

studies that seek understanding and meaning of the experiences and practice of indigenous nurses.

A study that specifically looked at experiences of Maori nurses was conducted by Simon (2006). The study investigated Maori nursing practice following education in an undergraduate nursing programme. The undergraduate programme attempts to integrate nursing related knowledge from both the Western and Maori worlds. Simon found that by understanding the current experiences of Maori registered nurses, their reflections on their preparation for practice, the present and future education and practice needs of Maori nurses could be identified. It was found that Maori nursing practice differed from western medically driven health models of care. Maori nursing practice could be characterised as having five features, these were; promotion of cultural affirmation including cultural awareness and identity; the support of, and access to Maori networks; the adoption of Maori models of health; the enabling of visibility and pro-activity as Maori nurses; and the validation of Maori nurses as effective health professionals (Simon, 2006, p. 203). Cultural affirmation including cultural awareness and identity was considered by participants as very important to Maori nursing education and practice. Simon explains:

Identity is further enhanced when Maori practices are accepted as a recognised approach to the learning, and if facilitated in the workplace, provides opportunities for the nurses to retain their identity as Maori.

In a similar study by Lowe and Struthers (2001) where data was collected from 203 native American nurses, students and caregivers in 1997 with a

follow up study in 1998, they attempted to depict the phenomena of Native American nursing. This resulted in the development of a conceptual framework of the following seven dimensions, caring, traditions, respect, connection, holism, trust, and spirituality (p. 280). Similarly, it has been my experience that Maori nurses seek to acknowledge and validate practice that relates to their cultural identity and the cultural identity of their tangata whaiora. This involves the inclusion of respect and trust and acknowledgement of traditional ways of knowing.

Lowe and Struthers argue that although some of these dimensions exist in both Native American and mainstream nursing, Native American nurses often defined their practice differently, because they “perceive life through a world view that is different and that guides them in making sense of their own world and health matters” (2001, p. 282).

From the literature, it is apparent that indigenous health professionals share similar ideas about their health practices world wide. There is an emphasis on the need to validate health practice that is culturally bound (Close 2005; Lowe & Struthers 2003; Simon, 2006; Struthers, 1999; Webby, 2001), for example, connectedness, spirituality, respect, tradition, and cultural holistic definitions of health (Bosmann-Watene & Webster, 2003; Cram et al. 2003; Durie, 1994; Lowe & Struthers, 2001; Struthers, 1999). Cram et al. for example, examined the way that Maori talk about health, Maori health, and Maori experiences of interacting with both mainstream and Maori providers of healthcare. They found that:

Participant's conceptions of Maori health and their explanations for poor



Maori health demonstrated holistic ideas, along with an understanding of the various personal, whanau, and societal influences on health and wellbeing. (p. 5)

Their findings affirmed the ongoing strength of Maori health concepts, as well as highlight the depth of analysis by Maori of the causes of current Maori ill health.

The findings by Cram et al. (2003) would not I believe, be surprising to Maori nurses who operate from a Kaupapa Maori knowledge base. The findings strengthen and validate the use of Maori models and definitions of health that are already used and understood by many Maori nurses. For example in Kaupapa MMH services, there is an emphasis on working with, and understanding the role of whanaungatanga (extended whanau including members over three or four generations). Webby (2001, p. 18) argues that “Maori nurses commonly work with whanau, enabling the mobilisation and interrelations to best aid the recovery of tangata whaiora” Allowing Maori nurses space to articulate issues that influence and develop their nursing knowledge, skills and practice is paramount if the aim is improve health outcomes for all Maori people.

### **The Maori Nursing Workforce**

Ramsden (2002) argues that efforts have been made to investigate increasing the Maori nursing workforce on the premise that more Maori nurses could give better service to Maori however, this may not succeed for various reasons.

Ramsden argued:

The political will to create a funded campaign to attract Maori to nursing is not evident at the local or national levels... series of undergraduate preparatory programmes followed by nursing degree programmes which are based on outreach learning located where Maori people live. Currently there is no national policy to encourage recruitment of Maori into the nursing service and therefore little funding to encourage creative recruiting (pp. 4, 5).

It was not until 1994 that nurses and midwives were first asked to identify their ethnic group by the New Zealand Nursing Council when applying for their practising certificates. In 1996 the question was revised and identifying ethnicity was brought into line with the census classification of the same year. The number of nurses identifying as Maori in 1994 was estimated at 780 (2.8% of the nursing workforce). By 1998 this number increased to 955, a mere three percent (New Zealand Nursing Council, 2000). The number of nurses identifying as Maori by 2004 was 2883, an increase of almost 300 percent since 1998. Even with this increase, statistics showed that Maori Registered nurses made up only 7.5 percent (includes registered nurses, enrolled nurses and midwives) of the total nursing workforce (New Zealand Workforce Statistics, 2004), while the Maori population is estimated to be 14 percent. When considering the range of health services and areas that Maori nurses are employed, the numbers who choose to work in the area of mental health is significantly reduced. This number is further reduced when taking into account the variety of governmental and non-governmental, Maori and non-Maori health providers and services that MMH nurses choose to work in (Tassell, 2004).

Ramsden (2002, pp. 4, 5) argued:

There is an assumption that Maori nurses and health workers, will choose to work in areas of health that have the greatest need and that they will automatically know how to culturally and clinically interact with tangata whaiora, whanau, hapu and iwi. However nurses should not be expected to work among Maori people if that is not their choice. And, it is naive to assume that all Maori are subject to a form of socialisation which is homogeneous and enables them to nurse other Maori in a culturally safe manner. Further, there is still major debate about the definition of Maori let alone what might comprise Maori nursing practice.

Despite the increases over the past two decades, the pool of MMH nurses remains relatively limited and comparatively much smaller than non-Maori. Lack of Maori nurses directly affects staffing, staff turnover and the incidence of burnout for nurses already working in MMH services. In order to better understand this occurrence it is necessary to investigate the experience of Maori nurses who are more likely to understand these concerns.

In summary there are a number of issues, past and present that affect and continue to affect MMH nurses today. Historical events such as colonisation, the signing of Te Tiriti o Waitangi, the emergence of Maori health services, and the development of new technologies affects the way that Maori people view themselves in New Zealand society today. For Maori nurses who work in MMH services, having an awareness of ones own cultural behaviours, knowledge and practices, and knowing how they have been shaped, is important, particularly if there is to be understanding of how clinicians affect and care for Maori tangata whaiora. As a consequence it is necessary to explore Maori nurse's experience

of their work and their understanding and awareness of the issues that affect their nursing practice. Chapter Three outlines Kaupapa Maori as the methodology for this research investigation.

### Chapter Three: A Kaupapa Maori Research

*He waka eke noa*

*A canoe on which everyone can embark.*

*( Karetu, Brougham, Reed, 1999 p.24)*

The above whakatauki refers to the ownership of common property. A canoe constructed by one person working alone, was deemed as common property of the whanau. Practically everything in a traditional Maori village was owned by the whanau (Karetu et al.).

The notion of individuals working toward a common goal for the betterment of the whanau is consistent with a Kaupapa Maori research approach. Maori researchers have the responsibility of upholding the mana (respect/pride) of Maori people and should set out to make a positive difference for the collective (Bishop, 1997; Smith, 1999). According to Bishop, Kaupapa Maori research is collectivistic, and is orientated toward benefiting all research participants and their collectively determined agendas.

This chapter outlines Kaupapa Maori Research methodology and provides explanations on how its underlying philosophies and its related principles were applied and operationalised in this research. In addition, the methods used to recruit participants, and conduct focus groups as well as explanations outlining the roles of the researcher and co-facilitator and process of analysis are discussed.

The present study was undertaken within the context of a Kaupapa Maori research framework. This particular approach not only permits the validation of nursing practice and knowledge that is culturally determined, but also provides room and acceptance for the notion, of “walking in two worlds”, te ao Maori and te ao Pakeha. As a metaphoric term, walking in two worlds depicts the idea of individuals striving to find cohesion between multiple cultural paradigms. This is the reality for MMH nurses who need to demonstrate a degree of confidence and competence in clinical and cultural knowledge and nursing practice.

Maori nurses must contend with a variety of cultural paradigms including the culture of nursing, the culture of mental health, Maori culture and Pakeha culture, in order to assist Maori tangata whaiora through a process of recovery. This project investigated MMH nurses experiences with a focus on understanding their nursing practice and how being Maori shaped this.

### **Kaupapa Maori Methodology**

Investigating the experiences of MMH nurses required a research approach that centralised Maori philosophies and ways of knowing within mental health nursing. In the case of this research study, Kaupapa Maori research methodology was most appropriate. According to Cunningham (1998), the Kaupapa Maori approach centralises Maori, seeks to assist the process of identifying Maori issues in ways that employ Maori methods of investigation and analysis. The final decision to use this particular research approach was influenced by a number of factors. Firstly, the participants were experienced

MMH nurses who worked or were working in services that upheld a Kaupapa Maori philosophy. It was therefore assumed that participants would have some understanding of the underlying principles and Maori concepts of this project and feel more comfortable sharing their experiences from within a study environment that strived to maintain a whanau oriented context.

Secondly, Kaupapa Maori research involves investigations that benefit Maori people and the intent of this investigation was to give opportunity to Maori nurses to voice their concerns and identify issues that were relevant to them.

Thirdly, as a Maori researcher I am interested in continually understanding and learning about Maori culture, and this approach makes room for issues that pertain to both nursing and contemporary and traditional Maori cultural knowledge.

Although this thesis does not seek to provide a definition of Kaupapa Maori research, it is useful to consider how other Maori writers have addressed this issue. Pihama, Cram and Walker (2002) define Kaupapa Maori research; as “Maori desires to affirm Maori cultural philosophies and practices”. In short “Kaupapa Maori is about being fully Maori” (p. 30). Irwin (1994) on the other hand identifies specific criteria. Kaupapa Maori research is

research that is culturally safe, which involves the mentorship of elders, which is culturally relevant and appropriate while satisfying the rigour of research and, which is undertaken by a Maori researcher, not a researcher who happens to be Maori. (p. 24)

According to Cram, Phillips, Tipene-matua, Parsons and Taupo (2004)

Kaupapa Maori research “is set within a historical context and addresses the

oppression of Maori in their own land and breaches of the Treaty of Waitangi guarantees of tino rangatiratanga (self determining, autonomy)" (p. 17). They further state that Kaupapa Maori research is an attempt to retrieve space for Maori voices and perspectives, whereby Maori realities are seen as legitimate. Kaupapa Maori research methodology is the collection of assumptions about research that informs the process of inquiry and hence determines the methods used. It is the philosophical basis used by the researcher to guide research (Cram et al., 2004). According to Smith (1999) Kaupapa Maori research typically involves Maori as participants and/or researchers and operates out of a philosophical base that is guided by practices that reflect a Maori code of conduct. Smith argues further that Kaupapa Maori research is "an approach that has to seriously address the cultural ground rules of respect, of working with communities, of sharing processes and knowledge" (p.191). This means it must incorporate processes such as networking, community consultations and whanau research groups, which assist in bringing into focus the research problems, which are significant for Maori. Smith discusses that in the past, research approaches have been more interested in taking and using data without any concern of the consequences for the people being studied. Kaupapa Maori research challenges the dominance of the pakeha world view of research.

Bishop (1999) argues that there are a number of aspects to Kaupapa Maori research that sets it apart from traditional western research, one being the "operationalisation of tino rangatiratanga" to Maori people (p. 2). Such an approach challenges the "locus of power and control over the research issues of initiation, benefits, representation, legitimisation and accountability, being



located in another cultural frame of reference/world view" (Bishop, p. 1). It is the "discursive practice that is Kaupapa Maori that positions researchers in such a way to operationalise self determination" (agentic positioning and behaviour) for research participants. This is because the cultural understandings and practices of Maori people implement and organise the research process (Bishop, 1999, p. 1). Further, Bishop (1996) identifies a number of questions which need to be considered in relation to Kaupapa Maori research: Who determines the research and why? What are the goals? Who will benefit? Is the research for the betterment of Maori? Who is going to design the work? What rewards will there be? Who is going to have access to the research findings? Who is the researcher accountable to? And, who has control over the distribution of knowledge?

Although there appears to be little consensus, there are a number of emerging themes that contribute to a definition of what constitutes a Kaupapa Maori research approach, for example, the legitimising and affirming of Maori philosophies in research, the operationalisation of tino rangatiratanga and the idea of the collective. For this research project no previously described specific approach has been adopted, instead there was a combining of principles and concepts drawn from the various writings on Kaupapa Maori research. For example the concept of the collective and the facilitation of whanau (family) like relationships are considered of significant importance and are main concepts that thread through this project. It could be argued in fact, that without understanding, recognition and inclusion of the whanaungatanga (familial relationships), Kaupapa Maori research could not proceed. Smith

(1999) suggests that whanau within the research context provides in-built obligations and responsibilities that keep the research safe.

In this project whanaungatanga constituted the relationships that existed before this project as well as those that were forged as a result of it. Unlike the relationship formed as a consequence of being research participant in that it ceases once the interview has finished, whanaungatanga implies an ongoing and long lasting relationship. Whanaungatanga in this project was the concept that underpinned the bases of relationships between the research participants, kaumatua, academic supervisors, my own whanau, and me as the researcher. It was also one of the underlying concepts that determined the use of focus group interviews for the collection of participants' experiences. Focus group participants were viewed as a whanau unit, as a consequence, there were responsibilities and obligations applied that would be expected of any whanau. This meant a responsibility by each whanau member, particularly the researcher, to maintain the integrity and safety of other members in order to achieve an outcome that was positive and rewarding for all those who participated or had a vested interest. An example where responsibilities and obligations were outlined and maintained in this research was in the participation of participant's in development of ground rules (see Table 1, later in this chapter) for focus group interviews.

Kaupapa Maori research, according to Cunningham (1998) is also a formative process. It has its own methodologies and researchers may employ a range of research methods appropriate for Maori. For this research project methods consistent with traditional and contemporary Maori culture were used. This

involved hui (gatherings), he kanohi kitea (meeting people face to face, being present), karakia, mihihihi (greetings), whakapapa, waiata, powhiri (Maori welcoming ceremony), poroporoake (Maori closing, farewell) and consultation and participation of Kaumatua.

Ngahuia Te Awakotuku a leading Maori academic and Professor of Research and Development with the Waikato University, developed a framework outlining a set of ethical principles, and responsibilities, which researchers can utilise when conducting research with Maori people. The framework was developed as a code of conduct for the New Zealand Association of Social Anthropological Association. It sets out basic rules aimed at respect for the protection of rights, interests and sensitivities of the people being studied. It is this framework consisting of seven Kaupapa Maori research principles (see Table 1), along with the concepts ***tapu and noa, wairuatanga, whanaungatanga, maramatanga and rangimarie***, that underpin this research project.

Table 1, identifies and provides examples to illustrate how the principles and concepts were operationalised in some areas of the research

Table 1 \* Application of Kaupapa Maori Principles and Concepts to Research Methods

Kaupapa Maori Principles	Application of Principles/Concepts
<p><b>Aroha Ki te tangata:</b> A respect for people</p> <p>This principle refers to the ability for people to define the terms in which they participate.</p>	<ul style="list-style-type: none"> <li>• The researcher was known to the participant's</li> <li>• The research was driven by a desire to affirm and validate the existing practice of Maori nurses, and also add to the existing Maori nursing knowledge base.</li> <li>• The study strived to enhance health outcomes for Maori accessing MMH services</li> <li>• The researcher has skills in communication and experience in facilitating groups</li> </ul>
<p><b>He Kanohi kitea:</b> The seen face; present yourself to people face to face</p> <p>This principle encompasses the concepts of trust gained and relationship building, when meeting people face to face.</p>	<ul style="list-style-type: none"> <li>• Face to face consultation occurred between MMH services and the researcher</li> <li>• Face to face contact with participant's occurred through the use of focus groups interviews to gather information and data</li> </ul>
<p><b>Ti tiro, whakaronga ... korero:</b> Look, listen ... speak</p> <p>This principle encompasses the art of stopping to look and listen, and knowing when it is appropriate to speak. It is about demonstrating respect for the opinions, ideas and knowledge of others.</p>	<ul style="list-style-type: none"> <li>• The researcher facilitated the focus groups in a way that allowed participant's time to describe their experiences</li> <li>• In the focus group interviews the participant's were encouraged to voice their concerns, express their feelings and give meaning to their experiences</li> <li>• The researcher did not offer any experiences or opinions during the focus group interviews in an attempt to refrain from influencing participant's</li> </ul>
<p><b>Manaaki ki te tangata:</b> Share and host people; be generous</p> <p>This principle refers to maintaining a collaborative approach. It is about reciprocity and giving back to the community involved in the research.</p>	<ul style="list-style-type: none"> <li>• The information gained from this research will be shared with the indigenous nursing community</li> <li>• Ensuring that all involved in the research, including the participant's, the Kaumatua and co-facilitator were supported</li> </ul>
<p><b>Kia Ngakau Mahaki:</b> Do not flaunt your knowledge</p> <p>This refers to being humble in your approach, and using your knowledge and qualifications to benefit the community.</p>	<ul style="list-style-type: none"> <li>• Acknowledgement of the knowledge that each participant brought</li> <li>• And that this knowledge forms the basis of this research project</li> <li>• Participant's trusted that their experiences would be used in a respectful and meaningful way</li> </ul>

<p><b>Kaua te takahia o te mana o te tangata:</b> Do not trample over the mana of the people</p> <p>This principle refers to upholding the dignity and integrity of people. It is about sounding out ideas, disseminating research and providing feedback that keeps people informed.</p>	<ul style="list-style-type: none"> <li>• Kaumatua were consulted about the tikanga and kawa of the local area</li> <li>• Participant's work schedules, comfortability in the focus groups, and level of experience were pivotal factors in how the research was determined and conducted</li> </ul>
<p><b>Tapu and Noa:</b> Movement from formal to informal</p>	<ul style="list-style-type: none"> <li>• Food was offered at the opening of focus group sessions as a way of moving from the formal process of Powhiri (welcome) to a more relaxed position considered conducive to open discussion.</li> </ul>
<p><b>Wairuatanga:</b> In the context of this project wairuatanga refers to Spirituality, hope and life force</p>	<ul style="list-style-type: none"> <li>• Acknowledgement and acceptance of cultural diversity, spiritual understanding and difference.</li> <li>• Traditional and contemporary karakia (prayers) were used throughout focus group sessions</li> </ul>
<p><b>Maramatanga:</b> Understanding and Enlightenment</p>	<ul style="list-style-type: none"> <li>• The aim of this project was to develop an understanding of issues that effect the practice of Maori nurses. From the outset it was hoped that having this understanding would enlighten all nurses and add to the existing nursing knowledge base.</li> </ul>
<p><b>Rangimarie:</b> Peace and Harmony</p>	<ul style="list-style-type: none"> <li>• Rangimarie is concept that underpins this research project. In order to achieve Rangimarie, a process of maramatanga must first take place.</li> </ul>

\*Source: Maori Principles Adapted from Smith, L. (1999). Decolonising methodologies, research and indigenous peoples. Dunedin, University of Otago Press and Pipi, K., Cram, F., Hawke, R., et al., (2004). A research ethic for studying Maori and Iwi provider success. Social Policy Journal of New Zealand 23 (December): 141-153.

## **The Method of Focus Groups**

The concept whanaungatanga helped determine the use of focus group interviews as the method of information collection. For Maori the concept of whanau has always been central to ideas of health and well-being.

Whanaungatanga refers to the relationships that are based on kin and the responsibility which existed between these kin (Bishop, 1996; Ministry of Health, 1998). This concept traditionally was concerned with the culturally bound connections established between family members who had a common descendant (Wihongi, 2005). However, it has developed to encompass the connections and diversity of wider groups in communities who share common interests or practices, for example sports teams, groups of friends, work colleagues and/or even groups of patients accessing the same services. Bishop (1999) argues that research groups constituted as whanau attempt to develop relationships and organisations based on similar principles to those which order a traditional or literal whanau. The whanau is a location for communication, for sharing outcomes and for constructing shared common understandings and meanings. Like any whanau group, individual members carry the responsibilities and obligations associated with maintaining and supporting the integrity and safety of the collective.

Whanaungatanga is considered integral to the provision of health care in MMH services. For this project, responsibilities and obligations extended to others who were not present in the focus group process but who had a vested interest in the research findings. In this case consideration was given to the greater collective who included MMH nurses in general, Maori health services,

tangata whaiora whose experiences formed the basis of Maori nurses' experiences and the Maori community.

Principles of a Kaupapa Maori research can be easily applied to focus group interviews. He kanohi kitea or meeting people face-to-face is considered important in Maori communities, as being present with people aids in building trustworthy relationships. Titiro, whakarongo ... korero (look, listen ... speak) is a process whereby the roles of researcher and participant's are of watching, listening, learning and waiting until it is appropriate to speak. Manaaki ki te tangata incorporates notions of sharing and hosting people and being generous with the knowledge that is gained. It also refers to a collaborative process, reciprocity, sharing and giving back to the community that is at the centre of the research.

Krueger (1994) argues that focus group interviews are a method of obtaining information from special audiences such as ethnic groups and in this process are able to "produce meaningful information in a manner that shows respect for traditions and uses language barriers and culture as an advantage" (p. 217). Further, Krueger defines a focus group as "a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment" (p. 6).

Participants' ideas can be swayed by comments of others and sometimes make decisions after listening to the advice and counsel of others in the group. Focus group interviews were selected because traditionally Maori culture was an oral culture (Cox, 1993; Taurima & Cash, 1999) in that

information was passed down through generations by the telling of stories.

The Kaupapa Maori research approach in this project enables the participants through their voices to include, incorporate and uphold oral and cultural traditions.

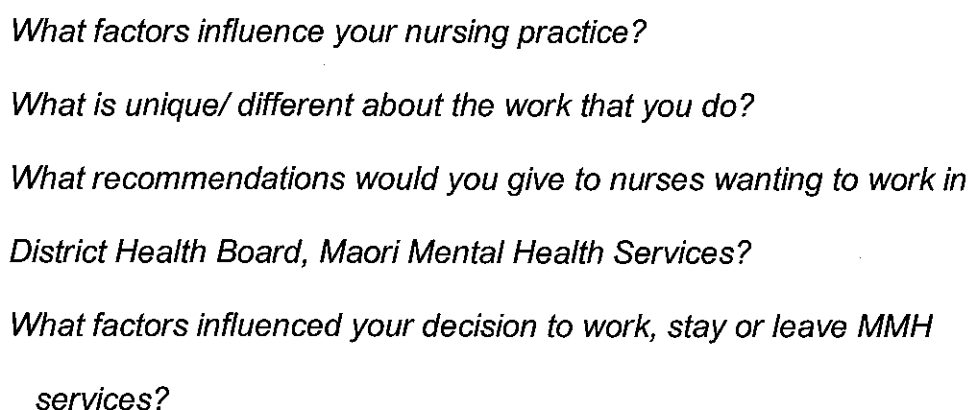
An environment that assists the process for natural interactions is also consistent within the context of whanaungatanga. Whanau like connections assumes that relationships are built on trustworthiness and familiarity. A whanau driven environment that relies on trust and the strength of bonds between individuals can therefore provide a safe venue for open and honest communication. According to Krueger focus groups place people in a natural real-life situation as opposed to controlled experimental situations. "Inhibitions often are relaxed in groups, and the more natural environment prompts increased candor by respondents" (1994, p. 34). And further, focus group discussions have flexibility, which allows the moderator to probe issues as they arise, not possible in more structured questioning sequences such as mail-out surveys; results are not presented in complicated statistical charts.

Before any part of this research project could be started an application seeking ethical approval was obtained from the Victoria University of Wellington Human Ethics Committee (Appendix 1). The application included all Panui (Appendix 2), Information Sheets (Appendix 3) Participant Consent Forms (Appendix 4) and the Co-facilitator Consent Form (Appendix 5) that were used in the actual research project and, an outline of the procedures that would be used to gather and store data and information.



As this study was interested in investigating and giving meaning to the experiences of MMH nurses working in DHB MMH, a set of open ended questions were developed (see Figure 1), aimed at stimulating Maori nurses to think and talk openly about their experiences as Maori and as Maori nurses

**Figure 1.**



*What factors influence your nursing practice?*

*What is unique/ different about the work that you do?*

*What recommendations would you give to nurses wanting to work in District Health Board, Maori Mental Health Services?*

*What factors influenced your decision to work, stay or leave MMH services?*

### **Lead Questions for the Focus Group Interviews**

### **Recruiting Participants**

Prior to presenting the research aims to MMH service teams or recruiting participants, a Kaumatua was consulted for advice about the tikanga and kawa (protocols), or right way to proceed. The inclusion of Kaumatua or people who are expert in tikanga Maori is pivotal to Kaupapa Maori research. Cram (2001) argues that Kaumatua should be involved throughout the research process because they are repositories of health and local knowledge as well as matauranga Maori.

Consultation with the Kaumatua involved a discussion about the research question and purpose, a request for guidance and advice about maintaining

cultural, spiritual integrity and safety of the participants, the researcher and the research process. It was also an opportunity to discuss possible benefits of the research for local hapu, iwi and Maori people in general. Following this consultation it was agreed that he (Kaumatua) would facilitate the opening of the project at the first focus group session, however he would not be available to close the meeting at the second session. Further, it was agreed that the researcher or any of the participants capable of formally closing the session could do so.

It was fortunate that the Kaumatua who agreed to participate, was not only knowledgeable in Maori spiritual and cultural beliefs, values and practices, he was also familiar with the operations of MMH services. He was able to identify potential issues and problems that might occur for the research process and already had an understanding of the issues relevant to Maori nurses in MMH services. The Kaumatua was held in high regard by mana whenua (local to an area) and Kaumatua in the local and surrounding areas.

Team Leaders of two local MMH services were contacted by phone and given a brief outline of the research project, and then dates and times for hui were made for the project to be presented in more detail and in person to nurses in two MMH services in DHBs. Hui were organised for the same time as regular nursing forums, as this was considered more likely to get a good attendance and nurses would be able plan to come in advance. However, it was understood that due to the nature of case management and tangata whaiora acuity, an audience was not guaranteed and, therefore the possibility of re-scheduling or re-organising further visits was factored into the project

timeframe. In these hui, nurses were given an outline of the research project, information sheets that outlined issues of confidentiality, the right to withdraw from the project, and an explanation of the use of Kaupapa Maori principles as the framework underpinning the research project. Potential participants were given an opportunity to ask questions directly to the researcher, and were encouraged to contact the researcher if further queries arose after the meetings had finished. Copies of the information sheets, confidentiality forms and panui were displayed on nurse's information desks, for those interested but were unable to attend the presentations.

From the services approached, a total of nine consent forms were received. Of the nine nurses consenting only one was male. From these nine, six possible participants completed the consent form at the initial hui held at their place of employment. The other three consent forms were received through the mail after reading panui and information sheets left at their services.

Following receipt of the first six Consent Forms (estimated number of participants to conduct a focus group); each participant was sent a letter detailing the date, time and venue for the first focus group (approximately four weeks following initial visits to the services). Telephone calls were made to confirm details outlined in the letter, however only two of the prospective participants could be contacted by the telephone numbers they had given on their consent forms. A further attempt to contact nurses was made by e-mailing those who were sent letters. However, this returned a response of less than half the nurses who consented. Over a period of one month all potential participants who completed a consent form were sent a letter, e-mail

and were telephoned to ensure sufficient numbers of participants in the research, to answer any questions and to establish availability.

### **Characteristics of Participants**

MMH services, up until recently have sought to employ Maori nurses exclusively, however more recently, with the limited pool of Maori nurses, some services have employed non-Maori nurses in an effort to alleviate pressures associated with high case loads. Never-the-less, criteria was specific in that nurses wishing to participate would need to identify as Maori. Having this criteria supposed that participants would be knowledgeable about the implications and consequences of what it means to be Maori in New Zealand society, of being a Maori nurse, and of working in mental health. Further, it supposed that all participants understood what it meant to live and work as part of a minority group in New Zealand society, and were more likely to have had some experience of environments might undervalue theirs and/or their tangata whaiora (Maori) cultural, values, beliefs and practices. Other criteria outlined in the information sheets were: nurses must have worked or be working in a DHB, MMH service for no fewer than six months; nurses must have current nursing registration in New Zealand; and nurses must have been registered for two years. The purpose of these limits and timeframes were to ensure that nurses had gained enough experience to differentiate between usual and unusual practice and service situations.

## **Conducting the Focus Group Interviews**

It was intended that two focus groups with the same participant's would be conducted. An interval of two weeks between focus group sessions was planned to allow a period for participants to reflect on their discussions and to give them an opportunity to consolidate ideas or issues that emerged for them in preparation for the following session. Two or more focus group sessions with the same participants is considered necessary for information saturation (Krueger, 1994). This means that issues poignant to the research aims are discussed to completion and until there is no more information to give.

Actual numbers of nurses attending focus groups were fewer than the number of those consenting. A factor that may have influenced the number of participants attending the first focus group was the time that recruitment occurred. The first focus group session was initially organised for late January. However, this was problematic as three of the participants had planned annual leave over this period and as a result this initial date was changed.

The first focus group session consisted of four participants with the second session consisting of three participants from the first session and two new participants. Although the intent of the second focus group session was to reflect and add to information already gathered, it was necessary in this group to also provide a more in-depth summary of the main themes that emerged. This was to ensure that the two new participants were focused toward the aims of the study and could contribute their opinions and ideas without

replicating information already gathered. Despite this possibility, the interview process was open to any input that participants offered and they were encouraged to talk freely.

Though focus groups are considered to typically consist of six to ten people, the group sizes can range anywhere from four to twelve (Krueger, 1994). According to Krueger, the size is conditioned by two factors; it must be small enough for everyone to have opportunity to share insights and yet large enough to provide diversity of perceptions. A disadvantage for smaller groups of four to five participants affords more opportunity to share ideas; however this can result in a smaller pool of total ideas. Focus groups are usually composed of people who do not know each other and caution is advised with groups consisting of close friends, family members or work mates, because they may be responding more on past experiences, events, or discussions than on the immediate topic of concern. Further, familiarity tends to inhibit disclosure (Krueger, 1994). However the concept *whanaungatanga* encompasses ideas of the collective and a willingness to share and contribute to the whole.

The small number of participants in this project may be reflective of the limited numbers of Maori nurses working in mental health services. Maori nurses in mental health also tend to know each other.

The advantages of using focus group interviews for this project was firstly, that focus groups are considered socially oriented procedures and this can be easily applied to Kaupapa Maori research which encourages a *whanau*

oriented environment which relies on familial relationships to foster a feeling of safety in the collective and collegial tautoko (support). And secondly, if a small number of participants consented to the research this would not present a major issue with the rigour of the research findings. Rather a small number would mean there would be more opportunity for each individual to speak and to give more meaning to their experiences. For this study, the quality of information was more important than the quantity of information received.

Initially it was intended that focus groups be held at a marae or marae-like setting, however after further consideration and discussion with Kaumatua, the groups were both held at a facility that was central to the location of most participants. Though this location was within the general hospital grounds, it was sufficiently removed from mental health services to avoid recognition by other mental health workers (to maintain confidentiality) or interruption. Marae protocols in this setting were easily applied. For example, the first focus group session opened with karakia by the Kaumatua. This was followed by mihi whakatau (introduction by each of the participants). Kai was provided by the researcher and followed these introductions.

The powhiri marked the beginning of the information collection process and also the development of a whanau group. It was considered a time of caution and getting a feel for how each individual fitted into the group as a whole. As part of the tikanga of powhiri, kai is shared. The idea that kai or breaking bread as a way of initiating and building trust is an inevitable part in the practice of tapu (e.g., sharing your knowledge and experiences that are scared or precious to you) and noa (e.g., making discussions okay, workable

and safe) (Barlow & Cleve, 1991). Furthermore, kai can be utilised as a process of koha (gift), a form of reciprocity for participation. In this project kai was used to move the tapu (special) state of the group into a noa (less special) state. It signified the movement of a formal process into a more casual relaxed position. It was hoped that the act of sharing kai would not only facilitate whakawhanaungatanga and the sharing of opinions and ideas but also create an atmosphere that would allow participants to feel safe when describing their nursing experiences.

The procedure for each focus-group session, outlined in the initial information sheets, adhered to a strict timeframe. This was to ensure that adequate time was given to group discussions and participant's were able to finish at the agreed times. When the half hour allocated for introductions and food was over, explanations outlining the purpose of the research study, issues relating to confidentiality, and participant's right to withdraw were given.

Ground rules were established. Initially draft rules were shared with the group, and participants were offered an opportunity to add any rules they deemed appropriate. The final agreed rules included those rules necessary to maintain participant confidentiality, the expected timeframe of the sessions, the right of each participant to leave and any rules in accordance with the research process. The agreed ground rules are displayed in Figure 2.



- The Co-facilitator would be the time keeper and notify the group ten minutes to the end of the session
- Each participant would be allowed to speak without interruption
- Participants could request to have the audio tape recorder turned off if they did not wish any particular comments to be included or if they required time to compose themselves
- No information in discussions, or the identity of any participant would be discussed outside the focus group sessions
- Participants would be able to eat kai during the discussions
- I as the researcher would facilitate the focus group interviews but would not be providing experiences or opinions in order to avoid influencing the group
- Participants would be respectful of each others input
- The participants could leave the group if feeling uncomfortable and would be able to return if they chose to do so
- If any unsafe, dangerous practice or if reflections that caused distress as a result of the research occurred, then participant's would be approached or could approach the facilitator or co-facilitator after the sessions and offered referral to a nominated clinical or cultural supervisor
- Research questions would be used only if participants were unable to generate new ideas or if discussions required re-focusing

Figure 2. **Ground Rules for Focus Group Sessions**

Participants were also given an opportunity to ask any questions before discussions began. The group was informed that both sessions would be facilitated by the researcher, with assistance from a co-facilitator who was Maori and was familiar with the processes of Kaupapa Maori research.

Following the development of the ground rules, a brief introduction of the research aims was presented to the participants at the first focus group interview. This included an outline of the Kaupapa Maori principles and philosophy. The participants were invited to ask questions and were then asked to describe their experiences. To begin discussions participants were encouraged to talk about reasons that led them to work in MMH services. Communication and facilitation techniques such as reflective communication, clarifying, summarising of main ideas and refocusing were used to maintain discussions. Prompts such as: what do others think? have others had the same experience? And, what does ... mean to others? were used in an attempt to bring all participants into the conversations.

A white board to document main ideas raised in discussions was used to help participants to keep focused toward the overall research aims. Humour was encouraged and played an important part in ensuring an enjoyable experience.

At times during the interview sessions participants appeared stuck for ideas. On these occasions a prepared research question from those listed in Figure 1 was introduced. Participants were given the opportunity to reflect on the questions and then invited to discuss their understandings, opinions and

experiences. Both the co-facilitator and I as the facilitator asked questions like what did that mean to you, can you give us an example?, and how did that make you feel? in an effort to again stimulate discussions, capture the richness of participant's experiences, and clarify their ideas.

At the second focus group interview following the introduction of two new participants, a summary of previous discussions, highlighted points that arose, and revision of the research aims and questions were re-presented. This was in order to ensure that the research topic was fully discussed and to allow any new ideas or information that may have surfaced for participants, during the two week interval between interviews to be captured. Participants were advised of the timeframes for the completion of research report, and advised of a date that they would likely receive a copy. Participants were again informed of their right to withdraw their information at any point before analysis of the information. Karakia at the end of the second focus group also marked the end of the collection of information process.

Audiotape recordings commenced from the initial introduction of the research aims presented at the first focus group interview, to the closing Karakia at the second interview. At no time did any participant request that the recorder be turned off.

### **Ethical Considerations**

There were a number of ethical considerations that needed to be addressed in this research project and they are discussed separately in the following

sections. These included the roles of the researcher and co-facilitator, the relationships already established between the participants and the researcher, informed consent, confidentiality, potential harm, and use of data.

### **The Role of the Researcher**

As a Maori nurse well known to other Maori nurses in the local area, there was a potential that participants may have felt obliged to participate in the project because of the existing relationship and familiarity. Furthermore, I was aware that I already held very strong views about the research topic, and knew that I would have to put aside my views during the group discussions to avoid influencing participants. As the facilitator my role was limited to introducing the predetermined questions to assist participants in generating their own conversations and keeping them focused toward answering the overall research goals. I purposefully, did not participate in focus group discussions to ensure that the participant's took control of the interview process. To address the issue of participants feeling obliged to take part in the project, I consistently explained that there would be no repercussions if they chose to pull out or declined to take part. This was explained at various stages of the research process including in information sheets (Appendix 1), at the commencement of, and during focus group sessions.

During the course of the focus groups, participants were able to share a lot of personal and professional information about themselves as Maori people, as Maori nurses and of their understanding of their experiences from both Pakeha and Maori world views.

## **The Co-facilitator**

The purpose of the co-facilitator was to assist in preparing equipment for each session, for preparation of kai, to facilitate the focus group interviews in the event that the researcher was called away to manage a health emergency, and to support any of the participants away from the group situation should the need arise. In this research project, though the co-facilitator was well versed and knowledgeable in research and in Kaupapa Maori, she had no experience or knowledge of nursing, or of working in mental health services. Although it was unintended it proved to be advantageous. Participants were more inclined to give explanations and descriptions of their experiences in detail in order for the co-facilitator to understand.

A debriefing session immediately following each of the focus group interviews was held between the researcher as moderator and the co-facilitator to review for any important themes or ideas that were expressed, any noteworthy quotes, any unexpected findings, and general discussion about how effective the focus group interview was in answering the research question. The co-facilitator was required to complete a separate consent form (Appendix, 4) before the commencement of the focus group sessions.

## **Confidentiality**

Participant consent forms (Appendix 3) were checked, and issues relating to confidentiality were discussed at the beginning of both focus group interviews.

Participants were advised that efforts would be taken to prevent them from being identified in the research report and any potential identifying characteristics would be altered so that the participants' identity would remain confidential. This was done by removing all names from the raw data, and all reasonable care was taken to ensure that the data collected was stored in a safe and secure, locked cupboard. It was also outlined that transcriptions and audio-recordings would be destroyed five years after completion of this thesis.

### **Reducing Potential Harm**

The assessment of harm was considered from the beginning to the end of the research project. This involved thought toward how the research could be used to disadvantage the participant's or the Maori community in general. Although the intention was to identify ways of improving nursing practice for Maori nurses and bettering services for Maori tangata whaiora, it is difficult to totally eliminate any potential harm in research. For example, the numbers of Maori nurses are very few in mental health and this means that it is likely that they know and are familiar with each other and in some cases, their experiences. In some circumstances revealing an experience that may be criticized by another participant who holds a more senior or management position in the same service may affect the relationship after the research project is completed. Additionally, this situation may affect the amount and quality of information the participant is willing to share in the focus group interviews.

There was a potential for participants to bring up negative experiences that might cause distress to themselves or to others, and so it was emphasised that as the facilitator, I would make every effort to ensure that they would be supported by either me as the researcher, the co-facilitator or a nominated independent clinical supervisor. Also, Kaumatua participation and guidance was essential in ensuring that cultural and spiritual safety was maintained.

### **Security of Information**

All data collected is kept in a secure place with the researcher and will be held there for a period of two years after which it will be destroyed. The only people who will have access to raw data including audiotapes will be the researcher, the co-facilitator prior to the second focus group and the research supervisors. Once this thesis is successfully completed, a report of the findings will be presented to the two MMH services, from where participants were recruited. Those participants who ticked yes on the consent forms will be sent a copy of the final thesis.

### **Analysing the Focus Group Interviews: An integrated Kaupapa Maori and Interpretive- Narrative Approach**

As this research was concerned with gathering data in the form of group interviews, about the experiences for Maori nurses through discussions of their work and life stories, analysis required an integration of two forms of analysis that were not only compatible but would be consistent with the Kaupapa Maori methodology and its underlying philosophy and principles.

In this research project an integrated Kaupapa Maori with narrative analysis combining thematic analysis and a systematic interpretive approach was used. Combining these analyses meant that the richness and depth of participants' experiences and discussions could be captured, with particular focus on issues relevant to them because of their Maori identity. Data is gathered through listening to people's experiences. Through the telling of their experiences people can express their identity, relationships and emotions (Casey, 1995). Further, they can orientate life events, in some cases gaining a sense of perspective which can often lead to problem solving (McLeod 1997). The function of narrative analysis is to consider the potential of stories to give meaning to peoples lives (Emden, 1998). For narrative analysis researchers look for patterns in transcribed texts, comparing and contrasting patterns with other texts. These may be texts of other narratives or literature written on the same or similar research problems (McQueen & Zimmerman, 2006). This kind of analysis is not aimed at preconceived answers about a topic, but opens the way for any opinions or ideas by participants, even if these ideas contradict existing research. McQueen and Zimmerman argue that from this context researchers should be willing to reassess their own views and speculate on the ideas and evidence presented in the interviews to support existing theories and be willing to create new ones.

A Kaupapa Maori analysis offers an alternative view. There is always a high degree of Maori involvement at all levels and when applied, Maori knowledge results. "Maori analysis places Maori experiences at the centre of the



theoretical base" (Cunningham, 1998, p. 400). It wholeheartedly accepts Maori and Maori processes as the reality (Cunningham, 1998; Reid, 1998).

Cunningham argues further that;

Maori analyses by Maori may have specific biases based on the subjectivity of the researcher, yet this may yield particular meaning; mainstream analyses may offer theoretical objectivity which, in Maori terms implies other biases. Their application to the same data can yield substantively different results. Ultimately recommendations from a Maori analysis have greater potential to meet the needs and expectations of those who have the subject of the analysis.

Although the combining of two analyses may seem difficult and complex, for this project it was relatively easy. This was because the analyses were compatible shared similar principles and processes and could be applied to the process of data analysis simultaneously. Although narrative or Kaupapa Maori analyses do not conform to any one specific procedure of analysis, suggestions from other authors of how meaning can be derived from narratives were considered. There is a view that formal *how to do it* manuals are unhelpful because researchers should come up with their own method. While this may sound like a good idea, novice researchers may prefer to be guided by a set of predetermined procedures. An example is provided by Emden (1998) who describes a process where interview text-based data is read, and then the interviewer's questions and comments are deleted. The remaining text is read for sense. The process of detracting words or phrases is repeated until only fragments of core plots and themes remain. Alternatively McLeod and Bolomoutsou (2000) suggest a step-by-step

procedure in which the entire transcriptions are reviewed for the presence of stories, before segments of text are micro-analysed and converted into stanzas. The text then reads like a poem and the final story can be analysed for its elements (cited in Priest, Roberts, & Woods, 2002). In this project the process used was guided by those of other qualitative researchers such as Emdens and, McLeod and Bolomoutsou.

### **The Processes for Analysing the Focus Group Interviews**

Analysis for the present study involved content-analysis of transcriptions (transcribed verbatim) and field notes gathered from the two focus group interviews. This type of analysis is argued to be most robust compared with memory or note based only collected data analysis because researchers are more likely to accurately describe and interpret the participant's language, tone and context of what is being said (Krueger, 1994). For example, misinterpretations of participant's responses can occur if the analyst does not recognise when participant's are being sarcastic or using humour to describe their experiences.

In the first stage of analysis a reading of all transcriptions and field notes was done to check for sensibility. Throughout this initial reading, editing was done and notes were added for purposes of clarification. Following this, a further reading in conjunction with audio tape recordings was completed. This was again for clarification, but it was also to check for the presence of ambiguity in any sentences or words and to accurately interpret the tone, language and

context of what was being said. At this point the text was reviewed for any common themes that emerged.

Because the aim of this study (investigating the experiences of Maori nurses) was broad and did not seek to answer any specific questions about the topic, analysis was open to all ideas and opinions. This meant that every narrative or comment by the participants was coded and then sorted into sections according to one of the identified themes. Those comments that could not be located were sorted under the heading extra comments. Although there was a risk of diminishing or changing the context of what a participant said when narratives are being separated, or when researchers categorise according to their own interpretations, particular care was taken to sort narratives in their completeness. For example, in instances where a participant described an experience relevant to one theme to illustrate an issue relevant to another, the narrative would not be broken down to fit into a theme, but instead it would be sorted into a theme in its entirety. In some instances, narratives that aligned to more than one theme were repeated under those themes. Once this initial sorting process was complete, a more focused analysis of the narratives for each of the themes was conducted. They were screened for frequency, extensiveness, intensity, and specificity of participant's responses (Krueger 1998). Participant's responses, comments and opinions were further coded in order to arrange responses, where possible, according to similarity and difference, and agreement and disagreement. Frequency of ideas or responses did not necessarily represent significance or importance. For example, in some instances it may have been an indication that all participants agreed or shared consensus on a point of interest only. In other

instances participant's themselves ordered their ideas in order of importance and in these cases this is how they have been reported.

The final stage of analysis concentrated more specifically on the dynamics of the discussion, noting particular narrative linkages between concepts, and themes. A narrative linkage can be viewed as a process whereby elements of a story are combined to produce meaning (Gubrium & Holstein, 1997 cited in Ansay, Perkins, & Nelson, 2004).

### **Rigour and Trustworthiness**

Ensuring that the research generated rigorous findings was managed in several ways. These included kaumatua involvement in the designing of the study and in the interpretation of Maori words and concepts. In the recruitment phase participants were given plenty of time to make an informed choice which was important as many had a collegial relationship with me. In the focus group interviews ground rules related to confidentiality, the rights of each person to be heard and the like were used to provide a means of ensuring that all voices could be heard. Confirming the contents of what people said in the focus groups was undertaken through the use of a whiteboard. A co-facilitator was used to ensure that the discussions were recorded in considerable detail. Finally, field notes were taken by both the researcher and co-facilitator to ensure accuracy of data collection.

Ensuring a rigorous analysis process involved working with both the Maori and English language. This involved for example making decisions when to use

Maori terms and how best to translate and interpret the meaning of terms such as whanaungatanga and whanau which have numerous meanings in Maori society. These decisions were not made alone, however advice from whanau and kaumatua was sought. The advice received was to claim their use and to utilise a definition that facilitated understanding of the ways that Maori nurses practice.

In Chapter Four the findings are presented. Participants' quotations are used to highlight the main themes that emerged and they form the basis of development for the four dimensions of Maori nursing practice.

## Chapter Four: Presenting the Findings

*Ko Te Wairoa hopupu honengenenge matangirau*

*The people are like the river*

*The beginning is turbulent and as it travels along*

*it twists and turns over the rapids*

*As it reaches the end of its journey it smoothes with the fast current and flows  
strongly and swiftly out to sea.*

The above whakatauki is the name of the river from where I was born.

Though it pertains to the people of Wairoa, it reflects a metaphoric description of the journeys that people take toward their mental, physical, and spiritual growth. In this instance it represents journeys of development for Maori Mental Health nurses.

Maori Nurses are aware that they undertake alternative ways to practice nursing that are often driven by Maori cultural philosophies and principles when working with Maori tangata whaiora. They are also aware of the variety of historical and current issues and the implications of these events on the delivery and quality of their work.

This chapter presents the main findings gleaned from the focus group interviews on Maori nurses experiences of working in MMH services. Chapter five presents a further analysis and discussion of the findings to ascertain the underlying meanings that participants gave to their experiences. Quotations are used to support participants' assertions and illustrate the key ideas and

concepts that emerged. Individual participants are not identified as often when one spoke, others agreed. The selection of quotations therefore reflects the main ideas arising from the group as a whole as often the words of one participant often captured the sentiment of the group. Analysing the data was not an analysis of the separate stories of individuals.

### **The Main Issues Affecting Recruitment and Retention for Maori Nurses in Maori Mental Health Services**

Participants were asked to discuss their reasons and their experiences of getting jobs and working in District Health Board, Maori Mental Health services. This produced a range of responses on their understanding of the main issues affecting recruitment and retention of Maori nurses coming into, staying or leaving, these services. Participants viewed working for Maori tangata whaiora important. For example, a participant explained their motivation to work with Maori people originated from before she commenced nursing. This motivation continued because of the experience of working with Maori. The participant stated:

*Well I knew when I went through my nursing training I wanted to be a nurse to work for Maori people. I knew that even before I started, so I thought, oh yeah, we need Maori nurses in nursing...The thing about working in, MMH; it was the tangata whaiora that taught me more than what the Manager did. Actually sitting there with them, listening to their stories, knowing where they came from and being able to share that both ways that was probably the most beneficial thing that I got out of working with MMH.*

Equally important was working in an environment that supported self development, particularly toward a Maori cultural identity. One participant who first entered a MMH service as a nursing student noted:

*I know I came across to MMH as a student nurse and I can remember sitting in the kitchen at the table with all these Maori [professionals], and they were intelligent Maori. And that's what really captured me; it was an opportunity to learn more about who I was, and work with like minded people, that was a big plus for me, so I certainly acknowledge the opportunity of going there as a student nurse, and being well supported by those ones.*

The role of more experienced nurses was important to all participants' decisions to work in a Maori service toward mentoring and guiding nursing practice. A participant stated:

*I think the experienced clinicians have a calming effect on people who perhaps haven't had that much experience, because they get to a point where they don't stress, because they take it in their stride. I think the main thing is that they know how to prioritise. What you can do, what you can't do. What to hold onto and what to hand over, it's having that knowledge. When we first started we thought we had to do everything, but you learn that you don't have to do everything.*

All participants expressed a desire to work with Maori because of their concern for the over-representation of Maori in the mental health system; the lack of Maori nurses in the area of mental health; and a passion to make a



difference for the Maori community. Another participant explains the reasons for decision to work in a Maori service:

*For me, working in MMH was really because of the great need for Maori people, and the Maori community...I have a strong desire to see things happening for our tangata whaiora, and that they have the right to become well...it was actually my passion to work with Maori and make a difference.*

Participants clearly stated that financial gain was not an influencing factor in their decision to work in MMH-DHB. Two participants said that they had given up more lucrative job opportunities in favour of working with Maori, and that a DHB, MMH environment was consistent with their overall career goals.

Participants discussed the challenges of working in MMH services and for some, the reasons for why they eventually left. Constant pressure of staff shortages, the lack of human resources including experienced Maori nurses and unrealistic expectations from management, tangata whaiora and the community featured prominently and were listed as reasons why participants chose to leave the services.

Participants expressed a desire to work with the assistance of Kaumatua to support Maori culturally determined practice. A participant noted:

*The fact that you're working within this Kaupapa Maori team, it does give you a sense that this is okay. I can go to Koro [Kaumatua/older man] and say to him, Koro, a tangata whaiora has had someone die in their family, can you come with me, and it feels good. And it feels good to say*

*to Koro, a tangata whaiora ran out of food and I had to give them twenty dollars, and Koro would say, oh yeah, and no having to be told it was a boundary. I do it because that's what we do. If you were in another team, it would be classed, as a boundary, you can't cross this boundary line. But you know that it's okay.*

## **A Maori Cultural Identity and Nursing**

Establishing and developing a cultural identity was highlighted as a strong factor influencing participant's decisions to work in MMH services and on the way that they worked with their tangata whaiora. Participants were asked to identify what Maori cultural values, practices or concepts were important or integrated into their nursing practice. Participants described working in a Kaupapa Maori services provided opportunity to learn more about their own cultural awareness and competence as Maori. Assisting tangata whaiora to develop their cultural identity was viewed as a part of the Maori nurse's role. A participant talked about their work in helping Maori rangatahi (youth) to develop a cultural identity:

*From having worked alongside tangata whaiora and having had dealings with rangatahi mauriora, the young ones, they have a big learning kerb. For them it is a sense of belonging, that marae focus and being part of a team, actually getting to know who they are and why as Maori they do the things that they do. A lot of them have lost that understanding or their parents have lost it; those connections of who they are. It was really awesome to see that blossoming...I love it when I drive down the main road heading home, and see the young boys going out, their*

*running down the road to go out on a waka (car, canoe). But with our older tangata whaiora because of that history of hospitalisation, they've lost that connection. A big part of my mahi [work] was trying to establish that when I was a kai manaaki [carer]. Trying to rebuild that bridge which had been destroyed because of how they had been, when they'd been unwell and in hospital away from their whanau for so long. I mean that was always so challenging I certainly support a marae focus.*

Participants discussed their experience of nursing education and cultural competency and were asked to describe where they had gained their cultural knowledge. Three participants said that life skills learned from their whanau and their upbringing contributed positively to their competence in working from a Maori perspective. One participant said:

*I could use the skills of being Maori going into my nursing. You know you could use the skills you already had as a Maori...you could use those Maori models but it's already instilled in you. From the day you were born, to where you come from, and if you knew all that kind of stuff, you were able to help others...In my experience of working with tangata whaiora it was almost like a journey that you both got on, and it was for me, knowing where they came from, who they were at the time and where they were going. It wasn't until you knew where they came from, and their history that you knew where they were, now, today. And be able to heal what ever happened to them in the past to let them move forward. I mean, I don't know what therapy or what theory or what word you use for that, but it is almost like, this is what it is to be Maori, this is how I grew up, knowing through my elders and people, so it was*

*something in me, it wasn't something I read off a piece of paper to say this is what you do?*

Participants referred to an understanding or knowledge that was innate, and that influenced and directed their nursing practice with Maori tangata whaiora. For example one participant explained:

*I think it's innate in Maori but it's also an expectation. Because if you worked in a Kaupapa Maori service and you went back the next day and said I left the Whaia in her flat, on her own with no kai, there's that expectation from the rest of the service of why didn't you do something about it. So we are actually being monitored by each other.*

There was discussion on the variation of understanding on cultural awareness and competency between clinicians. A participant stated:

*I just know that in terms of everyone's confidence in their cultural understanding of tikanga, that we're all different as clinicians and that we also work with tangata whaiora who are have different levels and understandings of their own cultural heritage...this affects your role as a nurse.*

The previous comment was considered and remarked upon by another participant who said:

*I don't really think it matters, I mean, it doesn't matter what [cultural] level you're at. I mean, I was the youngest Maori in the team and you know we had Hui and some of them [us] were fluent and I wasn't fluent, but I knew I was Maori and I knew my tikanga, and I knew where I was from,*

*and that's all I needed to know. But I wanted to learn other aspects, so everyone supported everyone in that kind of respect....*

Participants consistently referred to working as whanau or with whanau in a whanau based service as integral to their nursing care and practice. The idea of whanau or whanaungatanga is a concept that all participants felt was important in maintaining well-being for themselves as individual clinicians, the service as a whole and the basis for building relationships with tangata whaiora accessing the services. One participant stated:

*It was about the whanaungatanga about making sure each clinician feels safe. They [tangata whaiora] may not have that whanau connection because of raruraru [disagreement], but they see me as part of the whanau and I can go around and have shared kai, because to them it's better to have some whanau than no whanau. We forget to think Maori, and tend to look at the family problems and issues and whanau dynamics and we forget about those awesome things about them like their an awesome card player, or pool shark, stuff like that...that's the main thing for our whanau, the dynamics and relationship issues, and financial problems, we tend to overlook the wonderful things about them.*

Participants identified that working closely with colleagues was not only about whanaungatanga but also about safe clinical practice. A discussion between participants refers to working in pairs. One participant stated:

*The safety, the ability to debrief coming back home was a big thing. When I think, we would be driving back home and you've had something really horrible happen, you go back to an empty whare [building] you've*

*no one to talk to be cause they've all gone home, because they've all finished.*

Another participant responded:

*That was the risk, you were knocking on people's doors and you didn't know how they were...*

A third participant showed agreement and expanded on the previous comments about working alone when uncertain about the environments participants were entering:

*Yes...I didn't know how they were, even the dodgy areas that they lived. So working together was really important. You may not be able to build a rapport with Tangata Whaiora, but your colleague might. It's just that simple...One could be on the cell phone while the other ones driving. They can do the administration while you're driving.*

Some participants described an obligation as 'Maori' to work beyond the generic role of the nurse in order to meet tangata whaiora's psycho-social needs. As one participant stated:

*As Maori MH nurses we don't work within the boundaries and restrictions like non-Maori nurses, because we're always pushing the boundaries. We don't leave people without kai, a lot times we've forked out for kai for people. I don't see this as boundaries or restrictions but just how I treat people. And I think, just speaking generally, that's how Maori nurses see it. You wouldn't want yourself or any of your whanau to be left in that kind of predicament. So that's why you do those things, that's why you stay late, to try and settle people, to make sure the paper works done, because we don't work in those boundaries of time, even though*

*sometimes its to the detriment of our own whanau and to our own self cares.*

Some participants expressed a belief that Maori nurses were better at understanding and working with Maori tangata whaiora, because they had lived and experienced their lives as Maori and therefore had a better understanding of the lives of the Maori tangata whaiora. However, Maori nurses experienced difficulty in articulating the differences between nursing practices that were specifically Maori driven. This is illustrated in a discussion by the research participant's. A participant stated:

*My decision to come away from working within a Maori service, was the fact that they were allowing non-Maori to come in, you know off the cold face pretty much. I found that really disheartening. I didn't find it threatening in any form, but I didn't feel they [non-Maori nurses] had the same sort of understanding, you know about being Maori ...there's not just knowledge that comes with you into the area.*

Another participant continued:

*You know my non-Maori friend and I have these ongoing disagreements, she is a strong believer that you don't need to be Maori to be able to do a good job. That can be true yes, but you need to have that some sort of bond with the Tangata Whaiora, you need that, that's really important. I mean there are lots of things about being Maori that you can't be taught.*

## **Achieving Justice and Equity for Tangata Whaiora and their Carers**

The idea of justice and equity for Maori was of particular importance and concern to participants because it encompassed factors of social need and fairness, discrimination and marginalisation for Maori tangata whaiora and the effects that these factors have on nursing care. Participants were asked to comment on the main concerns based on their observations and experiences about their practice when working with tangata whaiora and their whanau.

All participants expressed a belief that the socio-economic position of tangata whaiora significantly influenced an individual's health status and consequently their nursing interventions. Most nurses agreed on issues particularly in relation to levels of poverty, housing and unemployment and the associated difficulties for follow-up of tangata whaiora in community-based care. The most commonly mentioned activity and concern that participant's talked about was helping Maori tangata whaiora get their basic needs met. One participant stated:

*Well the fact is that you're picking up on people who are coming into your service whether it be through the in-patient unit, whether it's in the community or the Alcohol and Drug Service, it's their psycho-social stuff. They've got no money, no home, no food, and as Maori working, or just as Maori you knew that someone who didn't have food needed it, even if it's out of your own pocket. So, we would, and that's just what you did, you know, I could give it all sorts of names, but that's what you do. To help them out you work really hard doing letters to housing New Zealand*



*to get them accommodation. Get them money to get food or go with them to food banks. We put a lot of effort into that.*

Despite the majority of participants agreeing with assisting tangata whaiora with food parcels and in some instances giving money, not all participants agreed with this practice, noting a difference between assisting tangata whaiora and empowering them to assist themselves. A participant explained:

*We as clinicians are trying to provide the best management plan for our tangata whaiora, and I'm saying that because we have to become more rigid in the context of giving out food parcels. I know that the Maori heartaches... you can't keep supplying food or handouts all the time; you've got to use that tough love concept regardless. You're not establishing their sense of belonging, their pride or dignity toward being self-sufficient. They know that their clinicians will go down and get that food parcel for them, and you're not actually helping them grow. People become more dependent because they know that's going to happen. Even ourselves, if we were unemployed, we'd have to manage at that level. It's about choices and I always establish with my tangata whaiora that it's about choices. You choose to buy the 'dack' [cannabis] every day, so then you have to choose in relation to how much you're going to provide for your own food.*

Another participant's response showed disagreement:

*Unfortunately for some of our pakeke (older Maori people) who have been institutionalised for such a long time, it's difficult to turn that around. It feels like its past that point of return, and we have to do something to*

*begin to address these needs.*

Tangata whaiora who were under financial pressure were less likely to attend doctor's appointments, get blood tests done or collect medications from pharmacies. A participant described their observation and experience:

*Disparities between Maori and non Maori I think...there's more non-Maori and you know, you get real poor ones and real rich ones and there's a wide income range for them, but for Maori most Maori are at the lower end of the scale, beneficiaries either living with whanau or living on their own in supported accommodation.*

Another participant provided their understanding of socio-economic position on tangata whaiora's well-being:

*Tangata whaiora are in the lower socio-economic bracket. It definitely impacts on their health. Their psycho-socio needs increase and there isn't that balance. Most of the people that I see are in housing Corp flats called the ghetto. People that I know in the mainstream team, you know, they have flash homes. They don't have to have baked beans for tea, they've got gardens, and the people that we work with, they don't...they seem to be doing all right, but generally they just don't have any money. Were always forever arranging food parcels for them, because they're just making ends meet.*

## Using Maori Models of Health to Work with Tangata Whaiora

Participants were asked to identify nursing practices that assisted them to work in MMH services. The use of Maori models of health was viewed as important in working effectively with Maori tangata whaiora and their whanau. Participants said working in MMH services allowed them a freedom to work with these models and that for some Maori tangata whaiora, Maori models of care was most appropriate. A participant described an experience:

*Talking about the model Te Pounamu, we use Whare Tapa Wha. Those tools are really good, they're assessment tools that help us understand what happens to people, and draw out their tangata, which is about identity. It's the one I tend to use as part of therapy, which helps the person with their identity.*

*I had a woman I started working with last year. I did all the right things all the clinical things that you are supposed to do as a nurse. And then I started thinking; she would korero [speak] Maori, she reads and writes Maori every day. She teaches Maori, and then she comes to see me at the end of the day. She's speaking Maori. It was only until I was able to use Te Tuakiri with her and use the Maori kupu [words] that we worked through the process right to the end. And by the time we got to the end, she was happy with what was happening within herself, and this actually worked. This doesn't mean to say that this is going to work with all Maori. It's just that she spoke Maori and for some of the older people who think Maori and speak Maori maybe this is something, you know, their identity's something that needs to be acknowledged.*

Despite the ability to use Maori models of health some participants identified difficulty in finding balance between their western nursing education and Maori cultural approaches to health and well-being. They expressed a difficulty working in services that promoted themselves as Kaupapa Maori particularly while located within the rules, regulations and policies of a DHB. Participants thought that a Kaupapa Maori service was one that advocated the use of traditional Maori ways of healing such as rongoa or mirimiri. One participant stated:

*It's quite interesting, our service was right there, and the rongoa [Maori medicine] whare [house] was right there [gesturing with hands, close proximity]. There were some Kuia that did rongoa that I looked after but it wasn't something that came through our service and that's what I got really frustrated with. It didn't quite fit the western models of health that our service upheld.*

As Maori nurses who work within Maori or Kaupapa Maori services, assumptions are often made that clinicians working in this area are expert in Maori culture, and should know how to practice nursing in a culturally appropriate way. There is also an assumption that because you are Maori you will understand and know how to implement care from Maori models of health.

A participant stated:

*There are a lot of assumptions that are being made because you work in a Kaupapa Maori service. That it's innate. But that's an assumption. In the NGO [non-governmental organisation] sector it's the same thing. People have a passion to work in that area. But I think, they do things*

*but they don't know what or why they do it. I'm not saying that I understand everything, but sometimes its easy to go with the flow rather than put your hand up and say 'kaore au I mohio', I don't know. Because there's an assumption that if you are within that service then you should know.*

### **Maori Mental Health Service, a Kaupapa Maori Approach**

Participants were asked to share their understanding of what it meant to work in a Kaupapa Maori service. Participants understood these services to be ones that were underpinned by principles consistent with Maori beliefs, values and practices, such as whanaungatanga, whakapapa, te reo Maori (the Maori language) and tikanga Maori. They also believed that they should encompass the idea of by Maori for Maori, that were self-determined, and that incorporated traditional Maori healing practices alongside contemporary health interventions.

Most participants said that working in a service that was Kaupapa Maori driven was a major reason for taking up jobs in these services. Its philosophies were consistent with the ways in which they understood health and well-being from a Maori cultural perspective. One participant described disappointment of not being able to work in a way that purports to be a Kaupapa Maori service. The participant stated:

*I've always thought, ooh cool, I'm going into MMH, choice, rongoa, you know, traditional Maori ways of healing, ways of being, and I thought choice and that was what I wanted to learn, how to do Maori rongoa and*

*I thought that would be great but I still haven't seen it...I do feel strongly that, having worked in a Maori service within a DHB, it doesn't really fit. It's feels tokenistic, you've got restrictions and you are accountable to a lot of things that are put upon you, from a Pakeha perspective.*

The practice and application of whanaungatanga was considered a way of upholding a Kaupapa Maori service responsibility. For example one participant said:

*When you see a tangata whaiora and he's got no food in his house, you actually don't go away and say here's your pills and here's your jab, see you later and walk out the door, you would say here's some kai...it's called whanaungatanga, it's because they're a part of the whanau. You wouldn't leave your whanau without food, if you knew they didn't have any food, you wouldn't feel right knowing that you're going home and you've got food and they haven't. I think we learnt it from our own whanau circles.*

Another participant talked of flexibility as an advantage to working in a Kaupapa Maori service:

*It doesn't matter which DHB you're in, I suppose you do have that flexibility. You know you can take tangata whaiora out for a walk in the bush or walk down the beach, or share a kai with them. All those things are very important and it's nice to know that your team actually supports that. Tikanga that you have within the work place, it's like the icing of what you're doing. You don't have to justify what you doing...you can*

*stand up and korero Maori and do a karakia or even waiata and feel comfortable about it. This environment is really important.*

Some participants expressed that there was an unrealistic expectation put upon them from their managers to provide cultural input for the entire mental health service within their DHB. They felt obliged to perform cultural duties outside of their clinical obligations, for example organising and attending all powhiri and poroporoake. Participants found that attending to their clinical work as well as meeting the cultural service obligations was sometimes demanding. A participant explained:

*We have to actually justify why we do things the way we do. It just doesn't work in a DHB, they [managers] have no understanding, and yet you have to be there to support them when they decide they want to have a powhiri, or something, like when important visitors come through and they need you. There was no time to do our mahi; I guess that was the thing I noticed when I was at MMH, that there were a lot of hui and powhiri and after time it became a negative part of being there. The time would have been better spent with tangata whaiora. Two of three days in a hui, that didn't feel right.*

This view was supported by another participant who explained their experience. The participant noted:

*For those of us who worked there, we sometimes found that we were all hui'd out. All we wanted to do was our clinical work; because we were falling behind...sometimes being there for an 8:30 a.m. hui was unrealistic for us, because we needed to be in town, especially on a*

*depot day, to capture those, so we didn't spend the rest of the week chasing them. They [managers] even tried to make it compulsory, everybody had to attend.*

Another participant described an experience of trying to balance clinical practice with service expectations:

*There were powhiri and powhiri openings, it's a cultural part of working in MMH services, but there was also the clinical part of us being nurses. We had our own nursing ethics and code of conduct, which we had to attend and adhere to as well. So there needed to be a balance all the time... You had to go along with whatever management said; I felt you were just there to please.*

All participants agreed that the comprehensive nurse education and the Registered Nurse, Level One Programme for Mental Health (RN1) available in 2006, do not adequately prepare Maori nurses to work with Maori tangata whaiora in MMH services. Due to the limitations of the focus group interviews, there was not enough time for in-depth discussions on the concerns relating to the provision of current or past nursing education programmes.

The experiences that participants discussed illustrated a wide range of concerns and views. In the interviews they sometimes experienced difficulty in articulating the underlying beliefs that drove their practice or practice decisions when working with Maori tangata whaiora. At times they referred to being Maori or having an innate sense of Maori culture that determined the interactions with their tangata whaiora, and felt a responsibility not only to their employers, but also to the people they worked with, Kaumatua and Kuia in the



services, the Maori community, and other Maori colleagues. In order to draw meaning from the participant's experiences a further synthesis of the findings was undertaken and this is presented in the following chapter.

## Chapter Five: Synthesis and Discussion of the Findings

*Ma te kanohi miromiro*

*If I had the eye of the miromiro*

*(Karetu, 1999, p. 126)*

The above quotation refers to the miromiro, a small bird, which searches for insects in the bark of the trees. It is meant to encourage anyone who is searching for an object. For this research study, the researcher seeks to understand the meanings that MMH nurses give to their experiences.

The views of the participants are wide ranging and a further synthesis of the findings was necessary to draw and develop meaning for the concerns and issues raised by participants. Further analysis with a Kaupapa Maori lens lead to a synthesis of the data and provided a mechanism to give Maori meanings to the issues, ideas and themes arising from the experiences of the participants.

This chapter presents discussion of the findings according to four dimensions of Maori nursing practice that became apparent as a result of this research. Participants use of words and concepts such as whanau, kai, tautoko, aroha and mana and with further discussion with kaumatua the dimensions ***Whanaungatanga***, Affiliation (Familial relationships; family); ***Manamotuhake***, Affirmation (The right to stand alone); ***Nga whawhai kia haere nga tahi ana***, Alignment (The struggle to progress in unison); and ***Te kai o te Rangatira, ko***

*te whaikorero*, Articulation (Talk is the food of the chiefs) arose. This chapter also provides recommendations and closure of the research project.

The four dimensions of Maori nursing practice are not static, they are evolving and overlapping. They attempt to capture the dynamic processes, and complexities associated with being Maori, being a Maori nurse, working with Maori tangata whaiora; the Maori community; and Maori colleagues working in MMH services situated in a western orientated health institutions as described by the participants.

### **Whanaungatanga, Affiliation (Familial Relationships; Family)**

This dimension encompasses the concepts of whanau and whakapapa. It is recognition of the interconnectedness between people. It reflects the obligation of individuals, and associated behaviours (nursing practices) toward the collective and a responsibility of maintaining these relationships in order to achieve well-being.

The concepts whanau and whanaungatanga were frequently referred to by participants. For example one participant acknowledged that whanaungatanga was important because it was “about making sure each clinician was safe” while another referred to the significance of whanau in creating “a sense of belonging.” The concepts were considered important in maintaining well-being for individual clinicians, the service as a whole and the tangata whaiora accessing the services.

Participants identified that sharing workload and the clinical risks by working in pairs was not only a way of maintaining clinician's safety but also a way of facilitating whanaungatanga. Participants valued having someone to challenge them on nursing rationale and treatment decisions. They also felt reassured that colleagues could pick up their work loads if they were absent. In regard to resources participants found that having another nurse work with them actually saved time because decisions were made faster, responsibility for filling out documentation was shared and urgent phone calls could be done while on route.

Self disclosure in the process of reciting whakapapa (ancestral connections to the land) and clarifying ancestral ties and making familial connections was identified as an activity that Maori nurses undertook when working with Maori tangata whaiora in order to create a meaningful therapeutic relationship. Maori cultural activities such as karakia, waiata, attending hui, powhiri and poroporoake in service delivery was important in presenting workers in Maori services as unified.

Kai and the meaning of kai were mentioned frequently in the findings. For participant's kai played an important part in the development of relationships based on whanaungatanga. The meaning of kai was viewed from two perspectives. Firstly as way of facilitating and maintaining relationships, participants identified that at times sitting and sharing kai with tangata whaiora during home visits was important. Secondly participants assessed tangata whaiora health and well-being on the amount, access and availability of kai.

In cases where kai was inadequate participants sometimes felt compelled to provide kai or in some cases provide a way of getting kai (giving money).

Participants identified that working beyond the role expected of a mental health nurse, was a common activity. One participant noted that Maori nurses commonly pushed the boundaries of their employment in order to meet the needs of their Maori tangata whaiora. For example, time was important in terms of completing work between the specified hours of employment; however this became less important when dealing with Maori tangata whaiora requiring input from participants after hours. Participants discussed a responsibility to remain, or be present with tangata whaiora until a job was complete despite disapproval by managers.

### **Manamotuhake, Affirmation (The right to stand alone)**

This dimension is about the validation and acceptance of Maori cultural philosophies, behaviours, and practices and also recognition of a Maori cultural identity as legitimate. It is also about acknowledgment of the knowledge and skills Maori nurses bring to their practice, and the right of Maori nurses to participate in the delivery of nursing care as Maori.

From the findings integrating clinical and cultural knowledge was a process that participants believed necessary to work with Maori tangata whaiora and in Maori services. This involved the combining of traditional and contemporary Maori cultural values, practices and beliefs with their nursing education. Participants shared their experiences of attending powhiri,

poroporoake and participating in hui as representatives of their service. They also described initiating and maintaining nursing relationships with tikanga Maori.

Participants considered that nursing programmes did not adequately provide them with education on Maori cultural knowledge or practices or offer advice on the potential difficulties associated with integrating cultural knowledge with nursing practice. Strategies on integrating were drawn mostly from participant's own life experiences and upbringing. One participant claimed that the process of integrating knowledge was innate because it was a way of life. Some participants described frustration at having to continually justify their actions and expressed concern that their practices would be viewed by others unfamiliar with Maori ways of knowing, as crossing professional boundaries. As a result they experienced an observed an increase in work stress when trying to adhere to cultural and clinical expectations and views, particularly when they were at times incompatible.

Participants identified developing awareness of one's own cultural identity as an influencing factor in their decisions to work in MMH services. An environment that supported cultural awareness and self development was considered important to increasing competence and confidence to work with Maori people. Participants believed that working in MMH services provided opportunity to learn more about themselves, their cultural heritage, Maori tikanga and kawa.

A Maori cultural identity was viewed by participants as a way of locating themselves in terms of their ability to work from within a Maori cultural context.

Participants recognised a variation in levels of understanding of contemporary and traditional Maori cultural beliefs and practices between themselves as clinicians and also between them and tangata whaiora. As a result, participants evaluated their own capabilities and limitations in the delivery of appropriate cultural nursing care and assessed the impact these levels had on their tangata whaiora. One participant described having to change their nursing approach to a Maori focused approach because a tangata whaiora spoke te reo Maori. Participants considered that a strong cultural identity for their tangata whaiora toward building self confidence, self esteem, mana and independence helped them to live healthily. This view is supported in the literature by Durie (2003) who claims that having a secure and meaningful identity assists in good health and well-being.

Participants indicated that the use of Maori models of health were important in assisting tangata whaiora to develop cultural identity because they are holistic and inclusive of all dimensions of health. They encompassed both participants and tangata whaiora understandings of health and well-being and also centralised traditional Maori healing practices such as mirimiri (massage) and rongoa into nursing practice. Bosmann-Watene and Webster (2003) argue that unlike modern Western conceptions of health, the Maori worldview makes no distinction between, religion science and medicine. Maori view the mental, physical and spiritual as a whole. There is no separating these dimensions as they are woven together and interconnected (Durie, 1994). Maori models of health were consistent with the underlying Kaupapa Maori philosophies of the services participants worked in and more appropriate when working with tangata whaiora Maori.

Kaumatua, Kuia and others capable of teaching Maori nurses and tangata whaiora, Maori ways of knowing was identified as important toward developing nursing competence and confidence. Considered reservoirs of Maori knowledge, participant's indicated a high level of respect and a cultural accountability to Kaumatua and Kuia. Participants viewed the position of Kaumatua and Kuia in services as equal to, or in some cases more important than those positions held by service managers. However, there was disappointment and participant's identified ongoing difficulties when managers considered to be holding the purse strings and outside the immediate working environment, did not recognise or understand this view. Exclusion of Kaumatua or Kuia from participation at these levels was considered an example of differing world views and cultural misunderstandings.

### **Nga whawhai kia haere nga tahi ana, Alignment (The struggle to progress in unison)**

This dimension refers to processes that need to occur so that Maori nurses are prepared, able and supported to work in a way that is effective and safe, and for the betterment of Maori people. Participants strongly viewed the needs of Maori tangata whaiora, demanded a high level of nursing input. They described working with tangata whaiora who were often poor, unemployed, lived in poor housing conditions, were heavy alcohol and drug users, often came to their services through the criminal justice system, and who more often presented to mental health services acutely unwell. Participants described a difficulty in keeping tangata whaiora engaged in services and accepting of treatment. They described having to follow up and



monitor tangata whaiora more intensively than when they had worked in other services. This involved, transporting tangata whaiora to and from medical appointments, assisting tangata whaiora to get accommodation, sorting out benefits and other similar tasks which they would usually be expected to address themselves. In some instances participants described having to be creative because some tangata whaiora needed to be tracked down in order to administer interventions.

Participants identified an obligation to work in ways that incorporated everyone's expectations despite knowing this was unrealistic. This was illustrated in one participant's experience of trying to make time to attend service hui when the demands of clinical work were high. Participants described a necessity to prioritise expectations according to their own understanding of what was important to them and their tangata whaiora often resulting in non-attendance of culturally driven service hui, in favour of meeting the clinical needs of tangata whaiora.

Participants described frustration at the lack of recognition and consideration of issues that Maori nurses faced reflected in the unrealistic expectations from services. They explained that they were expected to manage despite short staffing, high case loads, tangata whaiora acuity, meeting cultural service obligations, and integrating practices from differing world views without provision of adequate education or preparation. As a consequence, recruiting and retaining Maori nurses without consideration of these issues was difficult. This difficulty was further increased because of the small pool of MMH nurses in the services.

Participants identified that they were interested in learning about Maori culture, and services that purport a Kaupapa Maori approach were attractive. They expected Kaupapa Maori services to be underpinned by principles consistent with Maori beliefs, values and practices. They would encompass ideas of “by Maori for Maori” services, that were self-determined, and that advocated the use of traditional Maori ways of healing such as rongoa or mirimiri, however within their services these types of interventions were non-existent, with little to no service planning toward inclusion of Maori therapies in the future. Further, participants were disappointed that despite community-based services providing traditional Maori healing interventions being relatively close to their own service, no formal service-to-service relationship had been established. It was left to the individual clinicians to establish any working relationships or connections.

For participants, the philosophies of Kaupapa Maori services were consistent with the ways in which they understood health and well-being, however, once employed participants many were disappointed by the exclusion of Maori healing therapies from these services associated with being located in a DHB.

**Te Kai o te Rangatira, ko te Whaikorero, Articulation (Talk is the food of the chiefs)**

On the paetapu (the marae forecourt) issues are debated, and differences are resolved. It is here that the Rangatira (the chief), imparts his knowledge.

Under Article Two o Te Tiriti o Waitangi (1940), tino rangatiratanga asserts the Right of Maori people to have ownership or sovereignty over all things Maori.

Tino Rangatiratanga refers to the ability of Maori people to determine and have control of their own destinies including issues relating to their health. This concept refers to the authority to speak and be heard. For this study, articulation is about Maori nurses and their ability to articulate their work identifying the ways that they overcome challenges. It is also about sharing or imparting knowledge as taonga.

From the findings it is apparent that participant's valued an opportunity to articulate their concerns, and they expressed a strong desire for their concerns to be heard and considered in the provision of appropriate training and education in nursing programmes and in the delivery of services and service planning.

Participants considered that MMH services were specialty services that required clinicians to have special training and education. There was an expectation from all participants that MMH services would not only support cultural development of clinicians, but would also provide in service training, or assist in accessing appropriate educational institutions in learning Maori health therapies and the cultural training they believed they needed.

Participants identified this was important to being able to develop competent nursing practice and knowledge.

None of the participants had received any formal cultural training because it was not provided in their nursing programmes when they first entered the services. Participant's believed, there was and continues to be a reliance on clinicians already in the service, to assist new staff in becoming competent Maori health professionals. They believed new nurses needed assistance

and guidance in understanding the impact of historical events, and political and socio-economic factors on the health and well being of the people they care should be prioritised and included in the curricula of nurse education institutions. Currently the responsibility of orientating, teaching and supporting new staff into MMH services is largely left to the more experienced nurse clinicians who already had their own work and case loads to manage.

Participants identified that a comprehensive orientation was necessary in transitioning staff into MMH services. They described their own experiences of being caught up in the busy ness of services and feeling pressured to pick up case loads without any formal service induction and potentially increasing the risk of work stress at having to learn on the job. The importance of orientation was consistently highlighted in workforce development literature (e.g., Meyer & Meyer, 2000). Specifically, an orientation should be well-presented, relaxing and informative, whilst acknowledging and valuing the importance of an individual's employment commencement. Tassell (2004) argues that ensuring the orientation process is characterised by such aspects increases the likelihood that the employee will feel well supported, increasing the likelihood of job satisfaction and retention.

Participants identified clinical and cultural supervision as essential to the retention of Maori nurses in MMH services. Discussion about ensuring opportunity for nurses to debrief about stressful situations with more experienced staff was essential to reducing burnout. For some participant's, the idea of supervision was not broached with them when they started their

employment. In other cases they were informed to find their own supervisors, without knowing how important it was, or how to enlist one.

Finally participants recognised a serious lack of information or evidenced based research that addressed the concerns of all Maori health professionals aimed at improving the care for tangata whaiora.

## **Conclusions and Recommendations**

There were a number of limitations relating to this research project. The focus groups were small and this is likely to have affected the pool of total ideas gathered. Also, participants were recruited from only two DHBs and their experiences are reflective and are limited by these services. Currently there is considerable variation between DHBs in terms of the provision of Maori and Kaupapa Maori services, and the philosophies that underpin the provision and delivery of health care. As a result the experiences of the participants are limited to them and it would be difficult to generalise these experiences to all nurses in MMH services.

Findings from this study were similar to other studies on indigenous nurses. Lowe and Struthers (2001) for example, in their study of the phenomena of Native American nurses identified dimensions of nursing such as caring, traditions, respect, holism, trust and spirituality. Further they identified respect for traditions and for elders as the repositories of knowledge. Similar to the findings of this study, Lowe and Struthers discussed the importance of interconnectedness, spiritual connections to the land, and cultural identity.

They identified that Native American nurses draw from cultural traditions, knowledge and concepts when working with their own people. This would suggest that the concerns and underlying concepts and principles that drive nursing practice for indigenous nurses have wider implications for indigenous nurses globally.

### **Summarising the Findings and Applying them to Maori Nursing Practice**

There is no doubt that Maori tangata whaiora benefit from services that emphasise a Maori cultural approach; however, the same benefits or positive aspects of such services on those health professionals working within them may not be so obvious. The aim of this research was to investigate the experience of Maori nurses who work or who have worked in MMH services within DHBs and it was hoped that through sharing experiences the research would identify factors that influence the recruitment and retention of staff.

Participants chose to enter MMH services based on a belief that they will be able to positively affect the health outcomes for Maori tangata whaiora, that they would be able to learn and practice in a Maori culturally appropriate way, that they would learn about their own cultural heritage, that they would be able to develop understanding on Maori illnesses and Maori healing practices and treatments and, that they would work in environments with other like minded Maori people.

There was an expectation from participants that Maori services that purported to be Kaupapa Maori would deliver care and treatment consistent with the

cultural needs of themselves and the tangata whaiora who accessed them. For Maori nurses, services that support the practice of tikanga Maori, including education in te reo Maori, and facilitation of powhiri and poroporoake and other Maori cultural activities are likely to positively influence recruiting and retaining of staff. The development of an environment that encourages cultural self awareness for its staff differs vastly from one that demands high levels of cultural participation. Services that expect nurses to balance tangata whaiora case loads and clinical work and also participate in service driven Maori cultural activities without consideration of the consequences of this added expectation are more likely to increase work stress, perpetuate feelings of dissatisfaction and increase the risk of staff burnout. Alternatively, services that support nurses to develop understanding and knowledge around Maori healing therapies are more attractive because they suggest an encompassing and holistic approach.

Participants expected that services would encourage the development of relationships at management level or at least facilitate connections between tangata whaiora and providers of traditional Maori interventions such as rongoa and mirimiri, or consider funding for the provision of some of this treatment themselves. The provision of such treatments was considered by participants to be some of the specialist interventions that separate MMH services from mainstream teams and other non Maori specific services operating under DHBs. A barrier to this idea and possible reluctance for DHBs to invest or incorporate services that provide these therapies may be the lack of scientific evidence and research around the effectiveness of many of these interventions because they are considered alternative.

Services that claim to be Kaupapa Maori but whom primarily provide western treatments and interventions, are likely to be misleading or confusing to tangata whaiora, and particularly disappointing to nurses who accept employment based on this belief. Kaumatua were valued by participants as instrumental in maintaining a culturally and spiritually safe environment and pivotal in assisting nurses in balancing the western world of medicine with te ao Maori. It is therefore important that services clearly outline and recognise the context and level of expertise that Kaumatua bring to the work environment in order to preserve and safeguard their 'mana' or status from being minimised.

Learning to work from both clinical and cultural perspectives was considered important and difficult by participants, firstly because finding and maintaining cultural balance reflects the reality for some Maori who struggle to make sense of their experiences in New Zealand society from a Maori cultural point of view. And secondly, in order to provide holistic care, nurses must have competence in assessment and treatment from both perspectives. While this may seem straight forward, currently there are few current education programmes that address cultural competence for nurses and for the most part they have had to learn on the job. Further, there is no evaluation tool or marker to measure competence, or whether being competent in a Maori cultural perspective is even possible given the complexities and diversity of what constitutes Maori or being Maori today.

A conclusion drawn from the research findings refers to the provision of comprehensive and structured orientation induction packages. These



packages for newly employed nurses are important in the retention of staff and prevention of burnout. The development of packages should be prioritised to ensure that new nurses are given adequate time to complete the induction procedure, and an allocated supervisor or 'buddy' should be assigned to facilitate the process. Services that try to fast track nurses through this process or miss this process all together because of their work demands, run the risk of staff feeling that they have been "thrown into the deep end", overwhelmed and ultimately wanting to leave.

According to participants, services that allow nurses to work in pairs are more likely to retain nursing staff. With the difficulties associated with recruiting, for example the limited pool of Maori nurses in mental health, nurses working in pairs may seem unrealistic. However, argument from participants for the advantages of working with another clinician is strong. For example, the responsibility of clinical decision making at the time of assessment is shared between both clinicians and decisions may be reached sooner when both nurses' knowledge bases are pooled. Further, many MMH nurses cover huge geographical areas and travel large distances away from their work spaces. In pairs they are able to attend to administrative tasks such as phone calls, writing notes, organising an admission while on route, or while their colleague is attending to the tangata whaiora. This may allow clinicians to work more effectively with their tangata whaiora in a more time efficient manner and is consistent with the concept whanaungatanga and the philosophies of Kaupapa Maori services. Although there are no specific policies preventing nurses in MMH services from working in pairs, the general consensus from this study is that allocation of case loads and work is assigned according to

the individual clinician and that those nurses who have decided to combine their case loads and work together have done so at their own volition and without the support of their managers.

Participants described constantly going beyond the bounds of duty. This type of behaviour was kept quiet for fear of being deemed inappropriate or crossing professional boundaries. To some of the participants, within the context of a Maori Whakaaro, or a Maori way of thinking, this was not only considered culturally acceptable but expected. Such practices considered common for participants included working well past work hours, giving kai for tangata whaiora, and in some cases giving money. These behaviours in themselves created dilemmas for participants particularly when cultural and clinical philosophies or principles clashed. Participants found themselves weighing up which line of thinking was more important. In cases such as these, participants viewed Kaumatua as the best source of support and were valued in helping staff rationalise, justify, validate and give meaning to their actions. Managers however may not condone such behaviours creating to some extent an 'us and them' mentality which has a potential to create conflict.

Apart from Kaumatua support, other forms of supervision were deemed necessary by participants. Clinical and cultural supervision were identified by participants as essential to the provision of effective safe nursing practice. Services that support nurses in undertaking both types of supervision are more likely to maintain and retain a healthy workforce. Ensuring the provision of supervision to new employees should be prioritised not only by the clinicians accessing it, but also by the services by ensuring that staff members

have the time to attend. A list of supervisors and an explanation outlining how services can support nurses to carry out supervision should be included in the initial induction programme. Currently the onus is on the clinician to obtain a supervisor, however work demands often associated with staffing pressures and recruitment and a need to get new staff working can easily lead to minimising the need for it. For MMH services both cultural and clinical supervision should be prioritised.

Although it was not intended as an outcome of this research, it can be concluded that MMH nurses value opportunity to get together, away from their work environments to discuss the issues that are relevant to their work, practice and the tangata whaiora they work with. It was seen as a chance to learn from each others experiences, build relationships and gain support from those who understand the difficulties as well as the advantages of working in MMH services.

As a result of the research findings, a number of implications for further research, for MMH services and for future provision for Maori nurse education emerged. These are listed below:

1. Maori nurse researchers consider undertaking further research on;
  - Understanding the links between cultural identity for the nurse and competent cultural and clinical nursing practice
  - Identifying the factors that will support the recruiting and retaining of nurses in MMH services
  - Comparative studies on indigenous nursing practice

- Development of the characteristics and dimensions of Maori nursing practice
2. MMH services should re-evaluate workload and cultural expectations placed on case managers with consideration toward;
    - Clinicians case loads and participation in service cultural activities
    - Current regulations on working with clients, i.e., supporting clinicians to work in pairs
    - providing and ensuring comprehensive supervised orientation and induction programmes for new employees
    - supporting the provision of both clinical and cultural supervision
    - supporting regular Maori nursing forums
  3. Services that assert a Kaupapa Maori stance or approach should articulate to new employees the expectations and limitations of service delivery particularly the provision or lack of provision of Maori healing therapies and interventions. Including those constraints associated with being part of a hospital DHB.
  4. Services should consider getting more structured in-service cultural competence education, apart from that given by Kaumatua, or the generic cultural competency already provided, for example;
    - Education on Maori illnesses and healing interventions
    - Te Reo Maori
    - Instruction on Maori Tikanga and te reo Maori
    - Cultural Safety and Kawa Whakaruruhau
    - Training on the development of cultural identity

- Provide or support education on Tino Rangatiratanga, Whanaungatanga, and operationalising principles of Te Tiriti o Waitangi in nursing practice

### **Closing Statement**

Through the six nurses in this research project who generously shared their experiences, four dimensions of MMH nursing practice were identified. These were, Whanaungatanga, Manamotuhake, Nga whawhai kia haere nga tahi ana and, Te kai o te Rangatira, ko te whaikorero. It is hoped that these dimensions will serve as a foundation for further development and research of Maori nursing knowledge and, also serve as acknowledgement of the taonga that Maori nurses already bring to their nursing practice. Further, it is hoped that the findings arising from this research will be used by MMH services, and providers of nursing education programmes, as a guide to assist Maori nurses to work safely and effectively, and in a way that honours and respects the work that they do.

Tena Koutou, tena koutou, tena tatou katoa.

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## Information Sheet

*Tena Koe,*

*Ko Whakapunake te maunga  
Ko Te Wairoa hopupu honengenenge matangirau te awa*

### **Ko Ngati Kahungunu ki Wairoa te Iwi**

*Ko Ngati Kahu te hapu  
Ko Takitimu te waka  
Ko Wakaiti Saba toku ingoa*

I am currently undertaking a Master of Arts (Applied) Degree in Nursing at the Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington. As part of this degree I am undertaking a research project leading to a thesis. The university requires that ethics approval be obtained for research involving human participants.

**The Experience of Maori nurses working in District Health Board, Maori Mental Health Services**

The objectives of this research study are to;

- Explore the meaning that Maori Nurses give to their experience of working within Maori Mental Health Services.
- Identify the role of the nurse working in Maori Mental Health – District Health Boards.

If you;

- Identify as Maori,
- Are a New Zealand registered nurse,
- Have worked as a registered nurse for two or more years,
- Have worked or are working in Maori Mental Health Services in the DHB for 6 months or more, then

I would like to invite you to participate in this research study.

As a participant you will be expected to attend focus group sessions (maximum of three), which will be conducted using the principles of a Kaupapa Maori research framework.

Focus groups will be audiotape recorded and each session will last for 90-120 minutes. Thirty minutes will be allocated for mihimihi (introduction) at the first session. As the researcher, I will facilitate all sessions, and open-ended questions pertaining to the topic will be used to stimulate and generate discussions.

I am interested in participants, feelings, thoughts, opinions and experiences of working in Maori Mental Health Services. Discussions will allow an exploration of the factors that influence nursing practice in this particular environment, and investigate why Maori nurses choose to enter or leave this service. Exploration of political, philosophical, and theoretical positions from you as a Maori Mental Health nurse is anticipated.

The sessions will be held at a negotiated time and place and kai (food) will be provided.

Because the nature of this research explores your personal experiences and the meanings that you give to explain these experiences while in a group environment, there will be potential risks.

Some of these risks might include:

- Surfacing of uncomfortable or painful memories
- Exposing yourself and your ideas to others who may not agree
- Being involved in a project that may challenge the delivery health services

Should any participant feel the need to withdraw from the project, then they may do so at any time (refer to consent form).

The research project will be put into a written report and no identifying information about participants will be included in the report. Both individual and group responses will be presented in the report. All material collected will be kept confidential. No other people besides my supervisor, Dr Rose McEldowney, the Co-facilitator, the transcriber and me, will have access to the audiotape recordings of the sessions. The thesis will be submitted for examination to the Graduate School of Nursing and Midwifery, and placed in the University Library. It is intended that articles will be submitted for publication in scholarly journals, and that the research project and findings will be presented back to Maori Mental Health Service Teams on completion. Participants will also be offered a copy of the final report. Audiotape recordings and transcripts will be destroyed five years following completion of the research.

If you have any questions or would like to receive further information about the project, please contact me on (Cell) 027 2309196 or (wk) 04 9182274

You can also contact my supervisor Dr Rose McEldowney in the Graduate School of Nursing and Midwifery, Victoria University, Wellington, on phone 04 463-6651.

*Ka kahi te toi, ka whai te maramatanga*

**If knowledge is gathered, enlightenment will follow**  
(Te Kaunihera Rangahau Hauora o Aotearoa 1998)



He Panui He Panui He Panui He Panui

**Maori Nurses' Experience of working in Maori Mental Health Services within  
a District Health Board**

**A Kaupapa Maori Research Project**

*If you*

Identify as Maori;  
Are a New Zealand registered nurse;  
Have worked as a registered nurse for two or more years; and  
Are working, or have worked in a Maori Mental Health, District Health Board  
for more than 6 months

Then become a participant in this study  
Share your views and opinions about what it means to work in  
a Maori Mental Health Service

You can register your interest by contacting me directly on the numbers below  
and I will send you an information pack and consent form

I will also be visiting Maori Mental Health Services in your region to explain  
the research objectives, give details of what is involved, answer questions and  
recruit participants  
(Date and times yet to be confirmed)

*Tena koutou, Tena Koutou, Tena Koutou Katoa  
Waka Saba*

Contact me on 027 2309196 or (wk) 04 9182274  
You can also contact my supervisor Dr Rose McEldowney at  
Victoria University of Wellington, PO Box 600, Wellington,  
telephone 04 463-6651

*Ka kahi te toi, ka whai te maramatanga*

**If knowledge is gathered, enlightenment will follow**  
(Te Kaunihera Rangahau Hauora o Aotearoa, 1998)



## CO-FACILITATOR CONFIDENTIALITY FORM

I agree to maintain confidentiality when assisting facilitation of focus group sessions.

I will not disclose any information related to the participants in the research project.

I also understand that the only communication I have related to the research project will be with the researcher Waka Saba.

I also understand that my role will be to assist in preparing equipment for the sessions and I may be asked to facilitate the sessions if the researcher is not able to do so

Signed \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_





## CONSENT FORM TO PARTICIPATE IN THE RESEARCH PROJECT

### **Maori Nurses' Experiences of Working in Maori Mental Health Services within a**

### **District Health Board**

I have read the attached information sheet and understand the explanation given to me about this research project. I understand that I am able to contact the researcher to ask questions and have them answered to my satisfaction. I also understand that I may withdraw myself (or any information I have provided) from this project (before data collection and/or analysis is complete) without having to give a reason.

I also understand that:

- Kaupapa Maori will be the guiding framework for the research study;
- Any information I provide will be kept confidential to the researcher, her supervisor, the co-assistant and the person who will be transcribing the audiotapes;
- The researcher will keep the audio taped conversations in a locked filing cabinet at her home;
- I may be expected to attend up to three focus group sessions that may last up to 120 minutes;
- The researcher may give a copy of the research summary to other participants and Maori Mental Health Services
- The completed thesis will be submitted to the University Library;
- The researcher may use the data in presentations at conferences or in articles for national or international refereed journals;
- The tape recordings of the focus group sessions will be destroyed five years after the end of the project; and,
- I understand that any data I provide will not be used for any other purpose other than that stipulated in this form without my consent.

I would like a copy of the research report when it is completed. Y ☐ N ☐

I have read the consent form and attached information sheet and I am willing to take part in this research project.

\_\_\_\_\_(Date)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Daytime Phone No.)

