

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

Te Arawhata o Aorua
Bridging two worlds:
A grounded theory study

A thesis presented in partial fulfillment of the requirements for the degree

of

Masters of Philosophy

in

Nursing

at Massey University [Albany], New Zealand.

Maria Baker

2008

Abstract

Te Arawhata o Aorua – Bridge of two worlds is a theory about Maori mental health nurses. The aim of this study was to explore what was occurring amongst Maori mental health nurses and dual competencies. A grounded theory informed by a Maori centred research approach was adopted and conducted with three focus groups of ten Maori mental health nurses situated in one metropolitan and two provincial cities. The research design was informed by Mason Durie's Maori centred concepts of whakapiki tangata (enablement), whakatuia (integration) mana Maori (control) and integrated with grounded theory to guide the collection and analysis of the data. Audio taping and field notes were used to collect the data and the processes of constant comparative analysis, theoretical sampling and saturation were used to generate a middle range substantive Maori centred grounded theory. One core category was identified as *two worlds* which describes the main issue that they are grappling with. The basic social psychological process of *bridging of tension* explains how the two worlds are managed through two subcategories of *going beyond* and *practising differently*. *Going beyond* consists of two components, *being Maori* and *enduring constant challenge* that set the philosophical foundation to practice. *Practising differently* describes three key components as *kaitiaki of wairua*, *it's about whanau* and *connecting* each are blended into each other and fused into nursing practice. The impressions of the Maori mental health nurses have been interpreted and explained by this theory. The substantive grounded theory provides a model to guide health services appreciation of Maori mental health nurses, for professional development of Maori mental health nurses and to policy writers.

Acknowledgements

I want to extend my gratitude to the Maori Mental Health Nurses for their participation in this study and of Te Ao Maramatanga (College of Mental Health Nurses) for their support during the recruitment phase.

A special acknowledgement to Dr Denise Wilson for her support and guidance as Supervisor for my Master's studies from which this thesis has been made possible.

I wish to thank the whanau with Te Rau Puawai (Massey University) for their relentless aroha and tautoko throughout this academic journey. To, Te Rau Matatini for their leadership and strength in the strive toward excellence in Maori workforce development, to Te Rau Designz for the awesome tohu. To, Sue and the PHO whanau in Northland.

More importantly to my whanau, for their sacrifice's and continual support of me with this mahi and the things that I do. Nga mihi aroha ki a Frank me Francee.

Ko tenei te mihi aroha kia koutou katoa.

*Turuturu taku manu ki te taha uta
Turuturu taku manu ki te taha wairua
Koia atu Rutua
Koia atu Rehua
Turuturu taku manu*

*Let my bird settle
May it bridge the gulf between earth and heaven
There at the horizon stands Rutua
There at the horizon stands Rehua
Let my bird settle at the place of joining.*

(This Muriwhenua karakia acknowledges the joining of people, utilised in koha)

Glossary

The following descriptions have been formulated to provide further clarity about their meanings within this thesis.

Aorua or Ao e rua	Two worlds
Arawhata	Bridge
Atua	Higher being, god
Awhi	Embrace, help, aid
Hapu	Sub-tribe
Hinengaro	Often viewed as the psychological or mental dimension. In traditional Maori korero Hinengaro is the deep mind or consciousness.
Hoha	Annoy, nuisance
Hongi	Greeting between people where the pressing of noses represents the sharing of breathe.
Hui	Meeting, gathering
Iwi	Tribe, tribal affiliation through whakapapa
Kaitiaki	Guardian, protector
Kanohi ki te kanohi	Face to face [preferred method of meeting]
Karakia	Prayer, incantation, blessing.
Kaumatua	Elder
Kaupapa	Ground rules; general principles
Korero	Talk, discussion
Maemae	Pain, sore
Mahi	Work
Mana	Often defined as status and standing. Mana is the spiritual power that maybe accorded a person or group through ancestral descent or because the person or group has certain gifts and or achieved something. Mana is not always about power. Personal Mana can be enhanced through the collective opinion of the people.
Mana whenua	People that belong to the area, location.
Mana tane	Power or status of the man
Mana tangata	Power or status of the person
Mana wahine	Power or status of the woman
Maoritanga	Maori culture, Maori knowledge
Matauranga	Knowledge
Matua	Parent or elder
Maunga	Mountain, landmark of significance
Mihi whakatau	Welcome, greeting
Momo	Characteristics, attributes
Pakeha	Non Maori, European or westernised
Pepe	Baby

Pito	Belly button. Planting of new born baby's pito into whenua acknowledges connection between baby, whanau to the whenua.
Poutama	staircase
Porangi	Maori explanation of mental unwellness. Can mean mentally unwell or silly.
Pou	A post placed to note its position or standing
Rangahau	Research
Raupatu	Alienation of Maori land
Reo	Language; Maori language. Traditionally language to Maori was the life blood and sustenance of the culture – a gift from the gods.
Rereke	Difficult
Ta	Sir
Tai Tokerau	Northland
Tangata	Person
Tangata Whaiora	Person seeking wellness or health
Tane	Man, male
Tangihanga	Funeral, grieving process
Taonga	Prized possession
Tapu	Often defined as restricted or sacred. Tapu provides the link between the mana of the gods and the spiritual powers of all things derived from the gods. Everything has inherent tapu; because of this they can become tapu through dedication to remain under the influence and protection of the gods. In modern times Tapu has been reframed in a protective sense to encompass secular things (e.g. confidentiality; trespass). Restrictions and prohibitions that protect tapu (<i>wellbeing, dignity & sacredness</i>) from violation.
Tauwi	Non Maori, or non Iwi
Te Rau Puawai	National Maori Mental Health Workforce Development program (Massey University)
Te Rau Matatini	National Maori Mental Health Workforce Development Organisation.
Tika	The right way (of doing things)
Tiaki	Care for
Tikanga	Code of conduct; method; plan; custom – the right way of doing things.
Tinana	Physical dimension; the body
Tohu	A sign or a symbol
Tupuna	ancestor
Wahine	Woman, female
Wairua	Spiritual dimension. For many the spiritual or inner force affect how people feel and how they respond. Wairuatanga must be nourished through events and inter relationships with others.
Whaea	Elder woman, mother

Whakapapa	Genealogy, family history
Whakapiki	To raise, to uplift, to enhance
Whakatauki	Proverb, saying
Whakatuia	Integration
Whakawaatea	Blessing or cleansing ritual
Whanau	Often defined as family and birth. Whanau has been proposed as a key component of Maori identity and the healing process. Whanau describes groups interconnected by kinship ties. In modern times; groups use whanau to encompass their common purpose and have adopted whanau values.
Whanaungatanga	Recognises wider relationships. Whanaungatanga is kinship in its broadest sense and concerns itself with the process of establishing and maintaining links and relationships.
Whanau pani	Grieving whanau
Whenua	Land; placenta Land provides security, warmth, nourishment to the people.

Table of Contents

Te Arawhata o Aorua.....	1
Bridging two worlds:.....	1
<i>A grounded theory study</i>	1
Abstract	2
Acknowledgements	3
Glossary	4
Table of Contents	7
List of Figures.....	9
List of Tables.....	10
Chapter 1: Introduction	11
<i>Nursing Competencies</i>	13
<i>Cultural Safety</i>	15
<i>Cultural Competency</i>	15
<i>Dual Competencies</i>	17
<i>Research Aims</i>	18
<i>Thesis Overview</i>	18
Chapter 2: He Rangahau Research	21
Background.....	21
<i>Ethics</i>	24
<i>Grounded Theory</i>	26
<i>Participant selection and recruitment</i>	29
<i>Overview of Focus Group Process</i>	30
<i>Literature review</i>	32
<i>Grounded Theory Techniques</i>	32
Section Two	45
<i>An Overview of Te Arawhata o Aorua</i>	45
Chapter 3: Ao e Rua - Two Worlds	46
<i>Te Ao Maori – The Maori World</i>	47
<i>Te Ao Pakeha - The Pakeha World</i>	49
<i>Overview of Dual Competencies</i>	52
<i>Tension</i>	54
<i>Summary</i>	56

Chapter 4: Going Beyond.....	58
<i>Being Maori</i>	58
<i>Enduring Constant Challenge</i>	62
<i>Summary</i>	66
Chapter 5: Nga Mahi Rereke - Practising Differently.....	67
<i>Kaitiaki of Wairua</i>	67
<i>It's about Whanau</i>	71
<i>Connecting</i>	74
<i>Summary</i>	80
Chapter 6: He Korero - Discussion.....	82
<i>Strategies to support Maori mental health nursing</i>	87
<i>Recommendations for Maori nursing professional development</i>	88
<i>Further Research</i>	89
<i>Limitations of the Study</i>	90
<i>Conclusion</i>	90
References.....	92
Appendix I.....	104
<i>Ethical Approval</i>	104
Appendix II.....	105
<i>Participant Information Sheet</i>	105
Appendix III.....	107
<i>Participant Consent Form</i>	107

List of Figures

Figure 1. Poutama model	28
Figure 2. Preliminary theoretical sampling example.....	34
Figure 3. Subsequent theoretical sampling example	35
Figure 4. Mind map of tension of two worlds.....	38
Figure 5. Questions to encourage theoretical sensitivity	38
Figure 6. A reflexive memo.....	40
Figure 7. Example of early modeling diagram.....	41
Figure 8. Sir Apirana Ngata’s whakatauki – E tipu e rea	47

List of Tables

Table 1.	
An Example of Invivo Coding	36
Table 2.	
An Example of Invivo Codes Grouped in a Common Cluster.....	37
Table 3.	
Condensing Codes from Data into Properties and the Concept Being Maori ..	39
Table 4.	
Bridging the Tension	57
Table 5.	
Recommendations of Te Arawhata o Aorua (Bridging the Tension)	87

Chapter 1: Introduction

The aim of this chapter is to set the scene for this thesis, so it explores the reasons for the compelling need of dual competencies in New Zealand in relation to the Maori mental health field with a specific focus upon registered nurses. The focus will consider a New Zealand and international perspective of cultural competency and dual competency which lead to justifying the purpose for conducting this study.

In the first instance, it is important to briefly reflect upon the Maori mental health need which sets the schema (context) of this thesis. The mental health issues amongst Maori have been burgeoning since the 1970's (Mason, et al., 1988; Te Puni Kokiri, 1993) and are not relenting according to the findings of Te Rau Hinengaro (a national survey), that was conducted with over twelve thousand households, twenty percent of whom were Maori in 2003 and 2004 (Baxter et al., 2006). Of this group, over fifty percent of Maori adults experienced mental illness sometime in their lives, with anxiety, substance use and mood disorders as the most common lifetime disorders. Acute hospitalisation rates for mental disorder were eighty percent higher than non Maori and it is predicted that three in five Maori will acquire a mental illness sometime in their lives (Baxter et al., 2006; Baxter J., 2007). Co-morbidities and the severity of mental health conditions stress the significant burden and negative impact upon Maori. Moreover, the differing patterns of access and service use of Maori tangata whaiora (Baxter, J., 2008) highlight concerns about the ability of mental health services and health professionals to respond adequately to Maori health need.

The role of policy is integral to consider as one approach to improving the mental health of Maori through the purchase and delivery of health services. That is, the influence of health policy is from hence how practice and services for Maori health can be improved.

There is a sense of cohesion amongst New Zealand's national policies in the field of mental health over the last decade, that reflect objectives and principles

aimed at improving Maori mental health. These consist of involving Maori in planning, development and delivery of mental health services (Ministry of Health, 1994, 1997), the development of Kaupapa Maori mental health services and a skilled Maori mental health workforce (Mental Health Commission, 1998; Te Rau Matatini, 2006).

Upon examination of the policies developed between 1994 and 2008, it is evident that social and cultural principles have immersed into these to influence health service delivery and health professional practice. Such as, Kia Tu Kia Puawai (Health Funding Authority, 1999) a purchasing guide, emphasized the need for Maori mental health models in addition, to linking social, cultural and economic determinants to Maori mental health. With this wider emphasis upon health, policies incorporated principles that also extended to the importance of Te Reo Maori (Maori language), whenua (land), Marae, primary health care, education, housing and employment opportunities as vital to improving Maori mental health. As well, the recognition of cultural identity and knowledge is essential for Maori wellbeing (Ministry of Health, 2002). Generally, the measures and objectives developed focus on key areas for the improvement of health and to assert the fundamental purpose of policy, in this instance to improve the mental health of Maori (as well as of New Zealanders) (Ministry of Health, 1994,1997,1999, 2002, 2005a, 2005b, 2008). The inclusion of the workforce and their development posed by policy and the clear need of Maori warrant particular attention in this chapter.

In the late nineties, concerns about the unsatisfactory delivery of mental health services in New Zealand continued to be echoed by tangata whaiora, prompting a number of changes. In terms of practice one contribution was the development of the National Mental Health Sector standards (Ministry of Health, 1997). Its purpose, to ensure consistent and quality mental health service provision and practice across New Zealand that in turn influenced contracts and the quality monitoring of these.

At the same time, mental health workforce development received considerable attention and investment to increase numbers and to enhance existing health professionals (Mental Health Commission, 1998) with a substantial focus toward Maori mental health workforce development. The under-representation of Maori across health disciplines highlighted the disadvantages for Maori

tangata whaiora who could not access Maori health professionals (with an appreciation of their culture) for assessment, treatment, support and recovery (Mental Health Commission, 1998). Progressively, significant and various initiatives have been established to increase, enhance and develop the Maori mental health workforce situation (such as Te Rau Puawai and Te Rau Matatini).

Set against this theme, are strategies that support the notion that the health needs of Maori will be met by increasing and enhancing the competency of non Maori and Maori health professionals (Ponga et al., 2004; Ministry of Health, 2005; Te Rau Matatini, 2006).

Responsiveness, the idiom utilised to emphasize the response to clinical and cultural needs of tangata whaiora (Ministry of Health, 2005). Has an underlying philosophy that supports a responsive mental health workforce that ensures access to full information, is collaborative, is encouraging of feedback about the service and ensures easy access to it. In addition to these qualities, the responsiveness to Maori require an understanding about Maori models of health and the access to culturally relevant support and treatment for the holistic care of Maori tangata whaiora. In order, to provide these, the workforce is expected to be culturally and clinically competent or dually competent (Ministry of Health, 2005; Te Rau Matatini, 2006). Strategies to build such a responsive workforce are in progress, aimed at strengthening the cultural capability of workers in mainstream mental health services to work effectively with Maori and to continue the development of the Maori mental health workforce, to enhance the cultural and clinical needs of Maori (Ministry of Health, 2005; Te Rau Matatini, 2006; Robertson et al., 2006).

Nursing Competencies

To appreciate cultural and clinical competencies further, an examination of competency with Registered Nurses in New Zealand is explored. The registered nurse is a health professional that utilises nursing knowledge and judgment to comprehensively assess health needs, provide care, advice and support tangata whaiora in a range of settings (Nursing Council of New Zealand, 2005). A practising registered nurse in New Zealand is legally and

professionally accountable to the regulatory body, (the Nursing Council of New Zealand) which set standards to ensure a safe and effective service to the public (Nursing Council of New Zealand, 2005).

Within four domains of standards, indicators are established for the registered nurses' practice, these cover themes of professional responsibility, management of nursing care, interpersonal relationships, as well as interprofessional health care and quality improvement. Two competencies that warrant further examination are 1.2 "*Demonstrates the ability to apply the principles of the Treaty of Waitangi to nursing practice*", and 1.5 "*Practises nursing in a manner that the client determines as being culturally safe*" (Nursing Council of New Zealand, 2005). These specifically have implications for nursing practice with the incorporation of culture and the contribution toward Maori health.

Competency 1.2 requires a registered nurse to understand Te Tiriti o Waitangi (Treaty of Waitangi) before one can apply its principles to nursing practice. The Royal Commission on Social Policy (Durie, 2001) defined three principles, now simply known as partnership, protection and participation as being inherent within the Te Tiriti o Waitangi. This expects nurses to recognise the rights of Maori having control over their own decision making, knowledge and determination of health needs and solutions. This is achieved by working with Maori toward an agreed purpose of improved health, also by recognising the Maori view of health as a taonga (prized possession) with acts taken to protect health. Appreciating the diversities amongst Maori require the acknowledgement of various beliefs and practices integral to health. Along with recognising Maori equal rights and access to services with the justification to participate in health service delivery at all levels (Nursing Council, 2005). Competency 1.5 expects the nurse to understand cultural safety as defined in New Zealand (Ramsden, 2002), and demonstrate nursing practice fit to be judged by the tangata whaiora as being culturally safe to them (Nursing Council of New Zealand, 2005).

Cultural Safety

The development of cultural safety was significantly influenced by the negative experiences amongst Maori with the western healthcare system, which impeded their culture and wellbeing (Ramsden, 2002). Cultural safety deems culture to belong to a group of people, supported by a set of elements that make up a way of life or mores aided by an accepted worldview, belief and value (Ramsden, 2002, Nursing Council, 2005). Culture is considered to be more than ethnicity and recommends the nurse to contemplate aspects of gender, age, religion, sexual orientation and location that a person may associate with (Ramsden, 2002). More importantly, cultural safety is about the transfer of power from the nurse to the tangata whaiora (Ramsden, 2002; Richardson & Carryer, 2005), enabling them to feed back (to the nurse) about their health care experience and a preservation of their culture (Nursing Council of New Zealand, 2005).

In the New Zealand mental health field, Mental Health Nursing Standards (Te Ao Maramatanga, 2005) and Recovery Competencies (Mental Health Commission) provide additional guidelines for competent practice in mental health nursing. Each has embedded components of cultural safety and Te Tiriti o Waitangi also.

By examining these competencies, there is an expectation that nurses practising in New Zealand will optimally work with Maori and others in a culturally safe way. Ideally, for nurses to fully understand and to implement these requires theory, knowledge and practice related experience within New Zealand to appreciate and comprehend Te Tiriti o Waitangi, Maori Health and cultural safety as the motives to these competencies (Nursing Council of New Zealand, 2005; Richardson & Carryer, 2005).

Cultural Competency

The parallels with overseas nursing competencies exist in so far, as promoting cultural sensitivity, an awareness of cultural difference and culturally congruent nursing care across a range of cultures (Manderson & Allotey, 2003, Australian Nursing and Midwifery Council, 2005; Chenowethm et al., 2006; Ballantyne, 2008). Of particular note, are the influences from nursing models that have

conceptualised culture into nursing (Leininger, 2007; Campinha –Bacote, 2002) with theories that contribute toward the nurse’s cultural competency.

Either way, the incorporation of a person’s culture into nursing practice is important, overall, the principles that underpin these nursing competencies position nursing practice as a form of social and individual responsibility to improve the health and wellbeing of people of all cultures. In New Zealand, these competencies significantly promote strong references for the improvement of Maori health.

Then again, emerging evidence (O’Brien et al., 2004; Mental Health Commission, 2004) purport that Maori cultural issues are not being addressed in practice and the paradigm shift required to engender culturally competent nursing practice is complex (Richardson & Carryer, 2005; Robertson et al., 2006). Nevertheless, there is no research or evaluative evidence to prove the cultural appropriateness and responsiveness of nurses (Johnstone & Kanitsaki, 2007) or if as a result of the previously mentioned nursing competencies, there is an improvement in nursing care to Maori or to Maori (mental) health.

Becoming culturally competent is an ongoing process (Campinha –Bacote, 2008), its importance is elevated since the establishment of the Health Practitioner Competency Assurance Act (2003), thus inflating the need for registered health professionals to be culturally competent (Bacal et al., 2006; Ratima et al., 2006). Cultural competency is the acquisition of skills to achieve a better understanding of members of other cultures (Durie, 2001).

The international approach to cultural competency consists of a range of methods and techniques, such as the development of cultural competencies and models of practice (Leininger, 2002, 2007; Campinha-Bacote, 2008), the promotion of interpreter services, the recruitment and retention of an indigenous workforce, provision of cultural competency education (Leininger, 2002; Leishman, 2004; Mahoney et al., 2006; Campinha –Bacote, 2008), the promotion of traditional healing, working with indigenous communities (Woodroffe & Spencer, 2003). Along with, the inclusion of family and communities in nursing practice, an immersion into culture (St Clair & McKendry, 1999, Canales et al., n.d) and administrative structures facilitative

of support for the cultural values of tangata whaiora (Brach & Fraser 2000; Anderson, Scrimshaw, Fullilove, Fielding & Normand, 2003). These are similar parallels to New Zealand's merging approach to cultural competency also. Cultural competency goes beyond an awareness and sensitivity of culture, which include not only knowledge and respect for different cultural perspectives but there is a need to possess the skills and ability to use these cross culturally (Brach & Fraser, 2000).

In the mental health field (in New Zealand), culture is specifically used in its context to reduce Maori health disparities (Durie, 1997). There is support for mental health nursing competencies (in New Zealand) that ensure practice is culturally appropriate and valid for Maori tangata whaiora and their whanau (O'Brien et al., 2004; Te Ao Maramatanga, 2004). Nevertheless, the development and validation of cultural and dual competencies in mental health are in a pioneering stage (Te Rau Matatini, 2006). Led by Maori health professionals, a specific focus are dual competencies that recognise the importance of clinical and cultural expertise by synthesizing indigenous values with clinical standards (Te Rau Matatini, 2006). On the other hand, the term dual competency within national policy suggest a second definition about two sets of competencies, that are clinical and (cross) cultural elements for non Maori health professionals (Ministry of Health, 2005). These, provide a contrast to the current context of dual competencies, suggesting that competency development is influenced by philosophical, contextual and experiential domains.

Dual Competencies

There is no research yet available about dual competencies amongst Maori mental health nurses although there is evidence to highlight the need to support the dual accountabilities (requiring both Maori cultural and clinical expertise) of Maori health professionals (Ponga et al., 2004; Ratima et al., 2007). At the same time, the profiling of competency development in national policy, workforce development strategies and the influence of legislation (HPCA, 2003) are prompting the importance of clinical and cultural competencies (Ministry of Health, 2005; Te Rau Matatini, 2006; Robertson et al., 2006).

No international literature was available to compare with similar indigenous workforce developments or approaches using competencies that blended with indigenous methods of practice (that is, dual competency). As the development of competencies broadly assist health professionals to contribute toward improving health (inclusive of Maori health), an inquiry about dual competencies and its impact upon Maori mental health nurses thus shaped the rationale to conduct this study.

Research Aims

The broad question that this thesis set out to answer is: What's occurring amongst Maori mental health nurses and dual competencies? The research uses a framework devised specifically for this study to explore this amongst Maori mental health nurses which is described in the next chapter.

Thesis Overview

The theoretical framework upon which this thesis is built upon involves a Maori centred approach to grounded theory, used to explore amongst Maori mental health nurses, what was occurring amongst them and dual competencies. This thesis divides into two sections; the first section consists of two chapters that set the foundation for this thesis. The second section presents the Maori centred substantive theory of Te Arawhata o Aorua, which is explained over three chapters. In the theme of a Maori centred approach, whakatauki (proverbs) mainly from Tai Tokerau (Northland) are dispersed throughout the thesis to offer further reflections to the themes of the discussion.

Section One

The first chapter provides an argument for the justification of this study with Maori mental health nurses. It sets the scene with the acknowledgement of Maori mental health need and the cohesive policy directions that over the last decade, have aimed to improve Maori mental health. The need for improved

practice and workforce development are presented, followed by an examination of competencies expected of registered nurses in (New Zealand) mental health. The concept of responsiveness is introduced, then with a discussion about cultural safety and cultural competency. This chapter concludes with the statement that there is no research completed upon the cultural appropriateness or cultural safety of nursing practice or if any of the expected nursing competencies are assisting practice to improve Maori mental health. In spite of this, the focus leads into the development of dual competencies with an inquiry about the relationship to Maori mental health nursing.

The second chapter *He Rangahau* describes the research framework and processes that were undertaken in this study to explore the question of: What is occurring amongst Maori mental health nurses and dual competencies? The theoretical framework of a Maori centred approach to grounded theory is described, inclusive of an explanation about the necessary research components of the ethics process, the overall participant selection method and means of gathering information. Furthermore, examples of data analyses are integrated into the discussion about the techniques used in a grounded theory study.

Section Two. This section presents the Maori centred substantive theory of Te Arawhata o Aorua which is explained in three chapters. The third chapter Ao e rua presents the main issue of Maori mental health nurses as two worlds, the Maori and the Pakeha worlds which signify specific areas of knowledge, philosophy and culture as their main concern. A brief overview of dual competencies is presented in addition to the grounded theory. The chapter highlights the antecedent to tension that occurs between the two worlds and identifies the need of the Maori mental health nurse to bridge.

The fourth chapter describes one of the key components of Te Arawhata o Aorua as *going beyond* and presents its two concepts, of *being Maori* and *enduring constant challenge* as key attributes of the Maori mental health nurse. Whose focus is to extend beyond and to overcome challenges to pursue favourable outcomes for tangata whaiora and their whanau.

The fifth chapter details *practising differently* by its three concepts of *kaitiaki of wairua, it's about whanau and connecting*. This discussion impresses upon the importance of wairua, whanau and connecting in the care of Maori and each principle is integrated to each other with links to the previous chapter of going beyond. Overall, completing the deliberate blending of the Maori world into nursing practice. The last section includes a discussion of the theory and provides recommendations for strategies to improve Maori mental health nursing, these are proposed in three categories for health services, for Maori mental health professional development and for policy. This is concluded with suggestions for further research and an explanation of this study's limitations.

Chapter 2: He Rangahau Research

“Reframing occurs within the way indigenous people write or engage with theories and accounts of what it means to be indigenous” (Smith 1999).

This chapter presents the theoretical framework that was utilised in a study with Maori mental health nurses to explore the question of what’s occurring amongst Maori mental health nurses and dual competencies. This will commence with a background discussion and rationale for establishing a Maori philosophical approach to this study and in keeping with a Maori centric approach, will provide details of the Maori participants within this study. Following on, the reader will appreciate through the conception of this chapter, that the components entailed have supported the interactional nature of a grounded theory by including examples of data within the discussion.

Background

It is important to recognise that the history of „research“ and Maori has not been an equitable association; it has had overtones of colonisation and an abuse of power with subsequent offences to Maori (Smith, 1999; Cram, 1997). This has been perpetuated by the contrast in belief system and practices of Maori and that of non Maori researchers in the acquirement and eventual utilisation of knowledge connected to Maori (Smith, 1999; Cunningham, 2000; Henry & Pene, 2001; Mead, 2003; Sporle & Koea, 2004). Also, constructs used in research have not been favourable to Maori, together raising distinctions between Maori and non Maori in regard to the approaches to knowledge (Bishop, 1998). Additionally, Maori perspectives about some sets of knowledge are meant for certain people, this aligns with cultural mores about the sacredness of this information, thus will shape an attitude about how best to protect it (Cram, 2001; Cram & Smith, 2003; Sporle & Koea, 2004).

Impressions held by Maori of knowledge, its domain and to who rightfully are permitted access to it, will rightfully place limits upon it and will conjure the choice to participate within a research or not. Whilst the reasons for Maori being uneasy about research are valid, Maori scholars have transformed research to involve Maori at all levels of research to assertively address and counteract the power issues associated with initiation, benefit, representation, legitimacy and accountability in research (Bishop, 1998; Sporle & Koea, 2004). Along with this, Maori researchers are focusing toward making change, improving social justice, promoting self determination for Maori and reconciling Maori knowledge (Durie, 1995; Smith, 2005).

Te Tiriti o Waitangi (The Treaty of Waitangi) is regarded as one of the key influences to assisting with Maori being more empowered in research, especially across non Maori institutions where the responsibilities to Te Tiriti o Waitangi are two fold (i.e. there are two partners – Maori and non Maori) (Massey University, 2008; Health Research Council, 2008). This is evident; by ensuring researchers have an equal partnership with Maori that demonstrate respect for the individual and collective rights, by involving Maori participation at all levels of the research (i.e preconsultation, ethics application, research preparation, study, evaluation, feedback), and actively protecting Maori rights, culture, tikanga (customs) and Te reo (language) (Health Research Council, 2008). The shift for Maori has facilitated a yearning by Maori to tell and document their own stories in their own way and by doing so shifting and consolidating their place of power within the research world (Smith, 1999).

Ko Maori ahau

I am Maori and as a Masters student it was important to consider a study that would produce a thesis that was influenced by Maori and the choice was to conduct a study with Maori. In respect of this, it was important to consider prior to the study an approach that would locate Maori, our individual as well as collective knowledge and processes central to us (Spoonley, 1999). As a budding Maori researcher with an insider and outsider perspective there were reflections about bias and the need to reconcile the requirements of research with Maori that required constant reflexivity (Bishop, 1998; Smith, 1999). Supported by Maori and academic structures, with relationships built into the study, and enhanced my critical reflection during the tenure of the study and

the analysis of the data. The choice of approach to support Maori in this research is called a Maori centred approach which will be discussed.

Maori Centred Research

Maori centred research was coined at the Hui Whakapiripiri (research hui) held in 1996 (Durie, 1996) in an effort to promote change to western research methods. It is mainly a philosophical approach (Wilson, 2004) that centres research primarily on Maori people as Maori and the methods employed are responsive to Maori culture, Maori knowledge and contemporary realities (Durie, 1998). Such an approach deliberately locates the experience and philosophy of Maori at the centre of a situation. In this study, a Maori centred approach to research was conducted so that Maori mental health nurses would be the central focus, integral to this is their knowledge and the study being of benefit for Maori (Durie, 2001a; Cunningham, 2000). Retrospectively, the developments that supported the development of Maori centred research consisted of international shifts amongst Indigenous peoples toward self determination and greater autonomy of their knowledge.

At home, the New Zealand government's commitment to the Te Tiriti o Waitangi distinguished Maori as the country's indigenous people and recognised that Maori worldviews and knowledge were unique (Durie, 2001a). The three principles salient to a Maori centred research are: Whakapiki Tangata (*enablement or empowerment*), Whakatuia (*integration*) and Mana Maori (*Maori control*) (Durie, 1996).

- Whakapiki tangata applies to the principles of enablement and benefit of Maori. Underpinning this concept upholds the dignity of individuals through processes that ensure confidentiality and consent and of the collective by ensuring accountability to a community through all phases of the research.
- Whakatuia refers to the integration of a research approach with a Maori worldview and its links to culture. Underpinning whakatuia incorporates a holistic approach and the importance of relationships.
- Mana Maori encourages tino rangatiratanga or self determination, control and tiaki (care) of the data and research. Underpinning this concept ensures that Maori have control over the participation, process and protection of information in research. Evident in this thesis of a Maori researcher with the support of a Maori supervisor and whanau tautoko

being involved in the design and conduct of the study. This principle supports Maori involvement at all levels of the research as participants, researchers and analysts (Durie, 1996; Cunningham, 2000).

To advance Maori knowledge and development, a Maori centred approach to research supports the use of mainstream research tools and methods, provided that Maori remain as lead drivers across all levels of the research and are involved in the data analysis. Maori data analysis ensures that the meanings yielded from Maori are closely associated with the reality of Maori (Cunningham, 2000).

At the same time, recognising that tension can occur for a Maori researcher who may need to meet the converse expectations of Maori and in this case of academia (Cunningham, 2000). Extending on from this discussion demonstrates the binding of Maori ethical principles with those of the university supporting this academic study.

Ethics

*He Tika He Pono
That is right and what is true*

Ensuring that research is ethical considers the protection of participant's rights and their safeguard against potential harm. Ethical processes in research involve key requirements such as informed consent, the maintenance of privacy and confidentiality of information, the lessening of risk to participants, the identification of benefits and or alternatives to participants (Minichiello, 2003). Moreover, the principles that are pertinent for Maori need to consider the influence of Maori history, the respect of Maori values, tikanga (customary practices) and te reo (language) (Mead, 2003; Sporle & Koea, 2004).

As mentioned the Maori centred approach provided a philosophical perspective to the study but as a Maori researcher, further guidance was offered by the principle of tika, the basis of tikanga. These ensure that processes and procedures are correct and at the end of the research all those connected to the research are enriched (Mead, 2003). The ethical framework

that guided this study is presented as seven Maori practices provided by Smith (1999) and Cram (2001), essentially contributing to a Maori specific code of conduct. These are:

- Aroha ki te tangata (*a respect for people*) enables people to define their own space and to meet on their own terms. This requires a mediation of power differences between researcher and research participants.
- Kanohi kitea (*the seen face, to present yourself to people, face to face*) stresses the importance of meeting people face to face so that trust and relationships can be enhanced.
- Titiro, whakarongo, korero (*look, listen, speak*) emphasizes that the researcher should be observant through all human senses and to be open to shared thoughts. In addition, the aim is to develop an understanding of the research participants, their information and to locate a respectful place in which to speak.
- Manaaki ki te tangata (*to share and host people, be generous*) promotes a collaborative approach to research supportive of reciprocity. It acknowledges that learning and expertise are present between researcher and research participant, and that there are expectations of caring for people.
- Kia tupato (*be cautious*) is about being politically astute, culturally safe and reflective as an insider researcher. The notion of caution is alerted to researchers to ensure they are aware of the influence of Maori and non Maori processes with Maori.
- Kaua e takahia te mana o te tangata (*do not trample over the mana of the people*) asserts to the researcher the importance to sound out ideas to people before disseminating research findings and about keeping people informed about the research.
- Kaua e mahaki (*do not flaunt your knowledge*) promotes researcher humility through the sharing of knowledge and the utilisation of their status to benefit the community (Smith 1999, Cram 2001, Pipi et al., 2004).

These seven Maori practices further enhanced the philosophical Maori centred approach to this study, further ethical guidelines that were adhered to were provided by Massey University (Massey University Human Ethics Northern Committee (Appendix 1).

Grounded Theory

Grounded Theory is a qualitative inductive method to research that was developed by two sociologists, Barney Glaser and Anselm Strauss (1967) who discovered it as a way of helping to reveal how people manage the problems within their lives (Schreiber & Stern, 2001; Strauss & Corbin, 1998). Grounded theory is a method that is based upon the conduct of social research to generate theory through the careful observation of people, of their behaviour and speech practices (Glaser & Strauss, 1978). Grounded theory is supported by the philosophical perspective of symbolic interaction which provides the theoretical foundation to social action in this theory (Blumer, 1968; Charon, 1998). It makes the assumption that people make order and sense of their lives. So its core ideas involve the researcher considering the social activity that takes place amongst people, their subsequent actions and responses, their definitions and decisions that influence these, as well as the influence of time and their active participation involved in behaviour (Charon, 1998).

The term „grounded“ emphasises that theory should be constructed from within the data that is gathered, so that a true picture or a reality of the people that the data belongs to can be easily created. From this, an eventual theory emerges from a method of coding and constant comparison of data „grounding“ which duly provides insights into what is occurring amongst people or a phenomena. A grounded theory can generate two types of theory these are known as substantive and formal theories. The substantive theory is developed for an empirical area of inquiry whereas formal theory is developed for a conceptual area of inquiry (Glaser & Strauss, 1967; Minichiello, 2003). Substantive and formal theories can blend to each other but it is preferable if a grounded theory focus upon either one as subsequent strategies will differ (Glaser & Strauss, 1967).

The grounded theory approach encourages the researcher to stay close to their study through its methods of simultaneous, integrated data collection and comparative analyses, of which each build upon each other throughout the study (Glaser, 1978).

As data is obtained from interviews, notes and observations the aim of the researcher is to define what is occurring by defining the action in the gathered data from these observations, through an ongoing coding and comparative

process. The process is assisted through memos and theoretical sampling techniques which assist with the emergence of codes or categories. The data is subjected to constant comparison until the codes, concepts and categories generated have been saturated (Glaser & Strauss, 1967, 1978).

Basic social processes are theoretical reflections and summarizations of patterned organisations of social behaviour. These conceptually capture what people go through, these are not universally standardised but can uncover what conditions or variables give rise or account for a certain situation or problem to occur amongst a group of people (Glaser, 1978). There are two types; these are basic social psychological processes (BSPP) and basic social structural processes (BSSP). A basic social psychological process (BSPP) is a process that helps to understand the behaviours within a group. These processes help to tie stages and phases of the theory together and explain most of the variation amongst the data (Schreiber & Stern, 2001).

Developing a Substantive Grounded Theory

A model that assisted to analyse the data is best described by Wilson (2004) as the poutama model (Figure 1). The model provided a process to develop a substantive grounded theory informed by a Maori centred approach. The poutama is symbolic of a stair case and traditionally represents the journey of Tane nui a Rangi, who scaled the heavens in the pursuit for higher knowledge.

Today, the poutama is used in recognition of Tanenui a rangi's pursuit of knowledge by representing a specifically Maori centred learning and developmental approach that incorporates tikanga and Te Ao Maori (Maori world) (Tangaere, 1997). In Wilson's poutama there are six steps that incorporate a Maori centred perspective and demonstrate the coding and comparative analysis typical of grounded theory. These steps commence with data collection ascending upward to open coding, then selective coding, theoretical coding, substantive coding until the top step is reached with the eventual emergence of a substantive Maori centred grounded theory (2004).

The poutama portrays the continual observation and performance of key activities that are associated with the researcher analyzing the data. Upon

each step, one can imagine the data's continual transformation undergone by the coding and sorting during each phase.

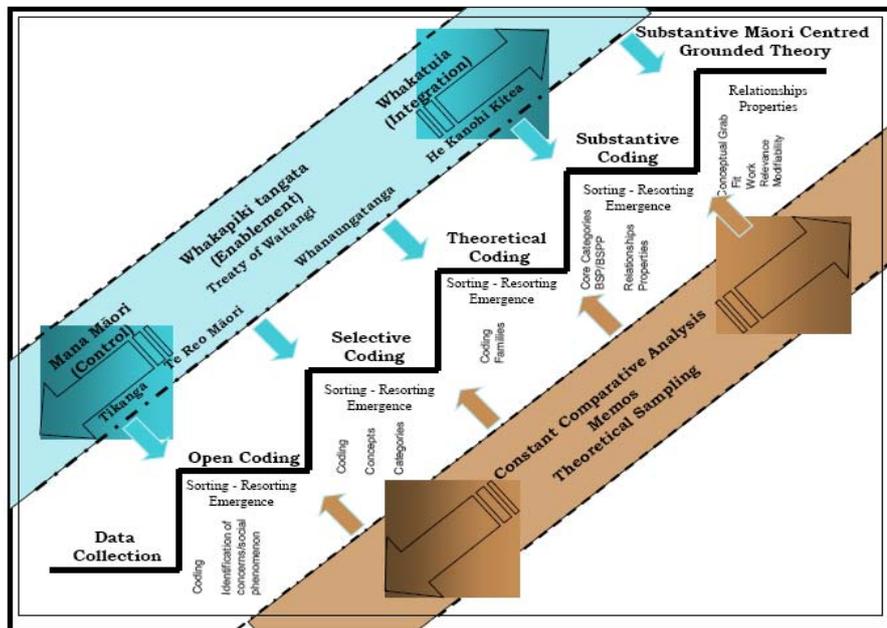


Figure 1. Poutama model

Note. Source Wilson, D. (2004). *Nga kairaranga oranga - the weavers of health and wellbeing: A grounded theory study*. Unpublished doctoral thesis, Massey University, Wellington, New Zealand.

Upon the horizon guiding the poutama are the pertinent principles associated with a Maori centred approach to research, whakapiki tangata (*enablement or empowerment*), whakatuia (*integration*) and Mana Maori (*Maori control*). In addition, Wilson (2004) has included the Maori principles of tikanga, te reo, whanaungatanga and he kanohi kitea to appreciate the important practices and processes that are important to Maori. These further align with the seven Maori ethical principles previously described (Smith, 1999; Cram, 2001). The accord with this poutama encourages a Maori centred dogma that accepts the researcher returning to prior achieved steps to revisit and revise data by descending and then re-ascending the steps until the emergence of a substantive grounded theory.

Participant selection and recruitment

A consultation process occurred with the Maori caucus of Te Ao Maramatanga (College of Mental Health Nurses) and Maori mental health professionals to introduce the idea of this study. Purposive sampling was used to decide that the potential research participants could be through Te Ao Maramatanga. There are objectivity limitations in this method with a high risk of bias however the advantage of purposive sampling is the decision to select a specific group who would meet the required criteria to participate within a research (Minichiello, 2003).

The selection criteria for this study was registered nurses who identified as Maori, worked in mental health services and were current members of Te Ao Maramatanga (College of Mental Health Nurses). The exclusion criteria was Maori mental health nurses who were participating in the Te Rau Matatini dual competency based professional development and recognition programme pilot. The reasons for this exclusion were due to my involvement in the pilot as well as to seek a neutral group of Maori mental health nurses for participation.

The recruitment procedure commenced with phone and email discussions with Te Ao Maramatanga (College of Mental Health Nurses) Executive Board, requesting permission to access their member data-base, for the purpose of inviting Maori nurses to participate in this study. The discussion was followed by a formal letter to the research board reiterating the request to access the Maori membership within the College and its purpose. Te Ao Maramatanga granted permission with the condition that the board solely manage the process of my access to their database. This required, the submission to Te Ao Maramatanga, a copy of the study's ethical approval, the participant invitation and information sheets in stamped envelopes which in turn were sent by the College registrar onto Maori nurses (Appendix 1 & 2).

Within the subsequent month, email and phone contacts were received from Maori mental health nurses indicating an interest to participate in the research. As each nurse made contact, I responded with a reply indicating potential dates for hui (meeting). Once numbers of nurses began to increase, I coordinated hui so as not to lose motivation of these nurses to participate and to ensure accessibility to a group. The negotiation of dates, venue and times

occurred amongst the nurses to ensure availability and access to hui in their locations. The principles of aroha ki te tangata enabling people to define their own space and kia tupato an awareness of processes being conducive to Maori were applied. This resulted in three focus groups of ten Maori mental health nurses being held in one metropolitan and two provincial cities.

The participants identified with a range of Iwi – Te Aupouri, Ngai Takoto, Ngati Kahu, Ngapuhi, Ngati Hine, Ngati Whatua, Tainui, Ngati Porou, Te Arawa, Ngati Kahungungu, Tuwharetoa and Whakatohea. They had a range of nursing experiences from inpatient mental health units, Kaupapa Maori mental health services and mainstream community mental health services. At the time of the study seven of the nurses were employed in clinical roles within District Health Board Kaupapa Maori mental health services, one nurse was employed in a mainstream mental health service and two nurses were in teaching roles with undergraduate and new graduate nurses. Each participant identified as Maori, their differences reflected in their Iwi affiliation and life experiences.

Overview of Focus Group Process

Focus groups provide opportunities to determine perceptions, thoughts and feelings of people about a range of issues (Krueger & Casey, 2000). For Maori the ability to hui (meet) in groups is an effective and culturally conducive method to promote the sharing of korero (discussion) and whakaaro (thoughts) in order to acquire information or an understanding about a common area of interest (Mead, 2003). In this study, hui with Maori provided a specific space where Maori were at the centre of the korero, sharing whakaaro and matauranga (knowledge). Hui provided opportunities for the specific principles of kanohi ki te kanohi (meeting face to face); titiro, whakarongo, korero (to be observant and to share within the group) and manaaki ki te tangata (facilitating the hosting and collaboration of people) to be operationalised. As previously, mentioned three groups were conducted in one metropolitan and two provincial cities.

Prior to the commencement of each hui, the mana (status) of the people and the place was honoured through appropriate tikanga such as karakia (prayer), mihimihi (greeting) and whakanoa (making common) in the sharing of kai (food). Then, whakawhanaungatanga (relationship building) and the kaupapa (purpose) were established with the group. This approach set the context for the focus group and overtly respected Maori and assisted to mediate the roles between Maori researcher and participants. Although, most of this part of the process was orally based, additional participant information sheets were available to each participant whilst the study was explained. This ensured each nurse was clear about the purpose of the research and focus group, the importance of confidentiality and how the findings would be utilised. Informed consent from each participant was acquired once the nurse was satisfied with the aim of the research and its processes. Each nurse completed a participant consent form (Appendix 3), in addition to being informed that at anytime, they could withdraw from the group without issue.

Participants were encouraged to be respectful of the korero that would emerge within the groups and that at any time the korero consisted of third party information that this information would be filtered for its appropriateness. At the same time, respect for the korero that occurred in the group was encouraged to remain within the confines of the korero and not to be extended externally to the group. Participants were informed that their information would be audio-taped and gathered but unidentifiable, plus the storage of data would be locked in a filing cabinet accessible only to me and my academic supervisor for the tenure of the study.

Once the data had been analysed and the report written, the data would be stored for five years by Massey University. Access to the final thesis report would be made available to them.

As one focus group was completed, theoretical sampling assisted to inform the questioning and considerations for the subsequent focus group discussions. Each focus group commenced with the same prompter question to warm up the participants to the context of the pending discussion. This prompt was: What is the meaning of Maori mental health nursing? And a range of questions and prompts followed to incite further discussion about what was

occurring amongst Maori mental health nurses and dual competencies. Each group was audio-taped; transcripts were subsequently compiled contributing to a mass of data for analysis. I also took field notes during the discussions.

Literature review

A review of literature generally provides ideas for a research and this was conducted to justify the topic to this study (see Chapter 1). The principles of grounded theory discourage this as there are concerns that the researcher will wrongly fit their data according to their preconceived biases and theories prior to the generation of the grounded theory (Glaser, 1978). However, it is unlikely that a researcher can act passively with the data, as past experiences and knowledge will influence thinking (Charmaz, 2005). But to remain aligned to a grounded theory study, when the theory emerged and was sufficiently grounded, it is then that the researcher is supported to review the literature and to relate this to the theory.

In this instance, a review of literature occurred in the early stages of preparation for this study to justify the topic for exploration and then another review of literature at the conclusion of the developed theory. The limitations with this were two fold, one that the literature review conducted at the commencement of the study focused upon an area that had little literature written about it which was partly the reason for its interest. Secondly, when the theory emerged, this required a search of other literature which rarely focused upon the issues that were identified by the nurses (Schreiber & Stern, 2001). Although, this is typical of a grounded theory, there was encouragement to read outside of the area that one is used to so it extended one's theoretical sensitivity (Glaser, 1978).

Grounded Theory Techniques

In keeping with the interactive theme of a grounded theory study against the poutama utilised in this study, this section will present data examples immersed with the discussion associated with the grounded theoretical techniques.

Data Collection

Data collection is the first step of the poutama; the data from the groups were transcribed from the audio tapes and printed off. A learning curve conquered quickly in this research was the impact of data over-whelm caused by audio recording the groups. Audio recording is not generally supported by Glaser (1978) due to this subsequent issue of data overwhelm, however Minichiello (2003) acknowledges the benefit of being able to listen and re-listen to interview tapes in grounded theory when obtaining an overall picture of a group, which I too valued from doing. It is recommended that if audio recording is going to be incorporated that the researcher commences coding immediately so as to prevent coding delays (Glaser, 2003). Amongst the data collection and the commencement of data analysis, I found myself reading the data continuously and re-listening to the tapes to gauge an impression of what was occurring in the data. The field notes that I took were minimal in comparison to the audiotape data yet provided some useful observations, viewed as important by Glaser (1996).

Theoretical sampling

As the data collection takes place, its analysis is occurring simultaneously (Glaser & Strauss, 1967). There is a conscious deductive aspect of inductive coding which is achieved through theoretical sampling. That is, the constant comparison of data with data will inform its meaning and the process used is to explore, confirm or provide converse cases of the emerging codes, concepts and categories (Glaser & Strauss, 1967). Theoretical sampling can occur at any stage, the researcher will target certain groups of data to compare its findings against other data to test developing hypotheses and to refine possible meanings. This is conducted until saturation of the data is reached meaning that the concept, category or process can be fully explained and there is no new information or meanings discovered from the ongoing analytical process (Glaser & Strauss, 1967, 1978). In Figure 2 is one example of theoretical sampling, in this instance similar nursing experiences amongst Maori mental health nurse's highlighted issues associated with the acute mental health care of Maori and raised a hunch about Maori working with Maori, stimulating a query about whether Maori working with Maori could reduce the likelihood of aggressive incidents from occurring. No specific

literature about this hunch was available, although there was some local literature about the issues associated with Maori in acute mental health units and the high likelihood of their involvement in challenging incidents, restraints and seclusion (El Badri & Mellsop, 2002, 2006; Abas et al., 2003; McKenna et al., 2003).

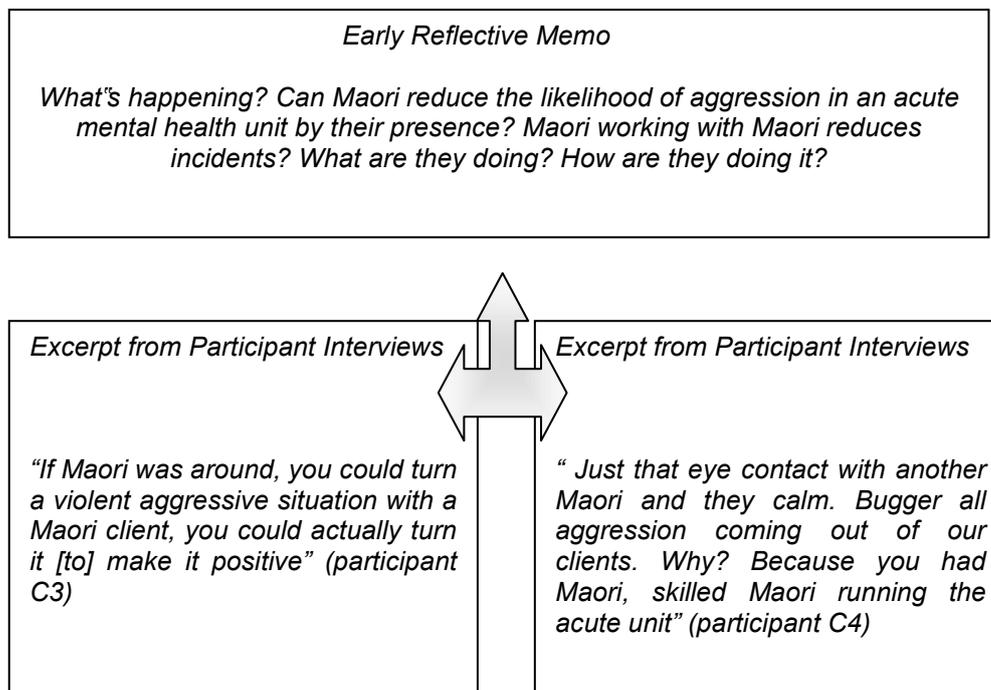
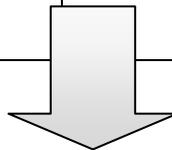


Figure 2. Preliminary theoretical sampling example
Note: Source. Excerpts from participant interviews and memo bank.

As the comparative analysis upon this hunch continued, a further exploration of what was occurring in these situations and how Maori mental health nurses were managing these situations provided the realization that these nurses were *connecting* with Maori from a Maori perspective. In addition, the ongoing comparative analyses generated a view that connecting and relationships were occurring at a deeper level amongst Maori.

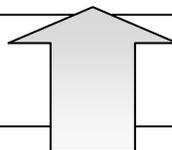
Selection of Data Group 1	
Focus Group 1- (participant C3)	
At that time I was the only Maori mental health nurse, because a Maori Nursing colleague had just moved down and left me on my own. Second Maori Nursing colleague had gone, so I just stuck it out for another three years and waited till more Maori nurses came along. But I actually stayed there for Maori. It was for Maori clients, because I could see a difference, if a Maori was around you could turn a violent aggressive situation with a Maori client, you could actually turn it the opposite, make it more positive and you wouldn't even have that.	<p>Only Maori Mental Health Nurse. Maori Nursing colleague left. Alone Persisted working Awaiting for Maori Nurse recruitment, Remained for Maori clients. Difference in care for Maori clients. Maori staff presence:</p> <ul style="list-style-type: none"> - Comforting to Maori clients - Reduced aggression - Restore to positive outcome



LAST MEMO

There are a minimal amount of Maori nurses in acute inpatient mental health units
It does raise issues for Maori nurses:

Maori nurses talk and relate with Maori tangata whaiora and their whanau,
Maori nurses make themselves available to care for Maori tangata whaiora,
Maori nurses recommend Maori staff best meet the needs of Maori tangata whaiora in inpatient mental health unit,
Maori nurses talk to Maori
Maori nurses calm and comfort Maori
Maori nurses improve communication.



Selection of Data Group 2	
Focus Group 2 –(participant B1)	
That was my frustration with working in the Inpatient mental health unit, often there were no Maori on a shift or if there was there would probably be one of the Maori Psychiatric Aides on. Frequently I would be asked to go up and speak to some Maori that was playing up in Inpatient Unit. Could you come up and help us, can you talk to the whanau can you talk to the client, because there was nobody else that could talk to them or wanted to talk to them. And again it was that thing of as soon as I opened my mouth things were away.	<p>Frustration Minimal Maori staff Maori playing up on inpatient unit Frequently asked to help staff Asked to speak to Maori and their whanau Nobody available to talk to Maori client No problem when discussion initiated.</p>

Figure 3. Subsequent theoretical sampling example
Note: Source. Excerpts from data analysis and memo bank.

Coding

Step two through to step five on the poutama (Figure 1) represent the grounded theory techniques of coding and comparative activities. These require creativity and openness to the data, so that the researcher can enquire about the data through questioning, abstraction and conceptualisation. This is achieved by an intricate process of coding steps that are used to label, separate and organize the collected data (Charmaz, 2005).

Open coding was conducted by interview texts being coded word by word, this involved a line by line *invivo* process whereby the underlining of key words of the participant's discussions in the study occurred. Table 1 demonstrates one example of the generation of codes that were taken from an excerpt of one of the interviews. The text is underlined from the discussion then shifted into a list of open codes.

Table 1.
An Example of *Invivo* Coding

Example of Excerpt	Open Codes
Ref: (participant C1)	
Actually I've been <u>asking myself that</u>	Asking myself that
question for days. It's <u>working with Maori,</u>	Working with Maori
<u>working with whanau</u> and I think that's <u>why I</u>	Working with whanau
<u>first came into nursing, not so much mental</u>	[whanau] why I first came into nursing
<u>health at the time, because I felt we needed</u>	Not [so much] mental health
to work with our whanau. That's my	Need
thoughts at the moment.	

Note: Source: data analysis.

The process of open coding includes sorting and resorting which contributes to an assembly of data broken into various texts, and then categorized into lists of codes to emphasize the participant's meanings. Open coding is confined to the substantive area under study to promote relevance, fit and work of emerging categories (Glaser, 1978; Wilson, 2004). This is followed by a purposeful

separation and linking of codes with other emerging codes which eventually inform the establishment of concepts and categories. This process reveals the meanings in the text and identifies relevant patterns amongst the data. Table 2 demonstrates an example of a selection of codes that were taken from the open coding exercise to represent commonalities, in this example the commonalities began to reveal the emerging idea about Maori and Pakeha worlds.

Table 2.

An Example of Invivo Codes Grouped in a Common Cluster

A selection of the grouped codes
Two worlds
Combining together
Clinical side as well as tikanga side
Being competent
Both Maori and western Pakeha world view
See it as both worlds
I look at both worlds
To eliminate clinical side
Maori side is always there
I embrace western concepts and taha Maori
Taha Maori is clinical
Clinical, cultural , taha Maori
Under a Maori paradigm make it work in a westernised paradigm
Need westernised knowledge

Note: Source: data analysis

Selective and theoretical coding

The symbolic representation that is constructed in grounded theory is demonstrated by the way the concepts relate to each other, highlighting the actions and interactions of the participants (Schreiber & Stern, 2001). Concepts are supported by the participant's words that are collated from the data, which adds meaning for the participants. To facilitate the development of concepts is to appreciate the interrelationships in the data, of which „coding families“ assist the process. One coding family is the *six C's* which prompt the researcher to look for cause, context, contingency, consequence, covariance and condition within the data. Another is the interactive coding family which

was utilised in this study, which facilitates a focus upon the interaction of effects and patterns of variables within the data (Glaser, 1978). This interactive process was especially crucial in the identification of the Maori mental health nurse's two worlds and subsequently of the tension involved.

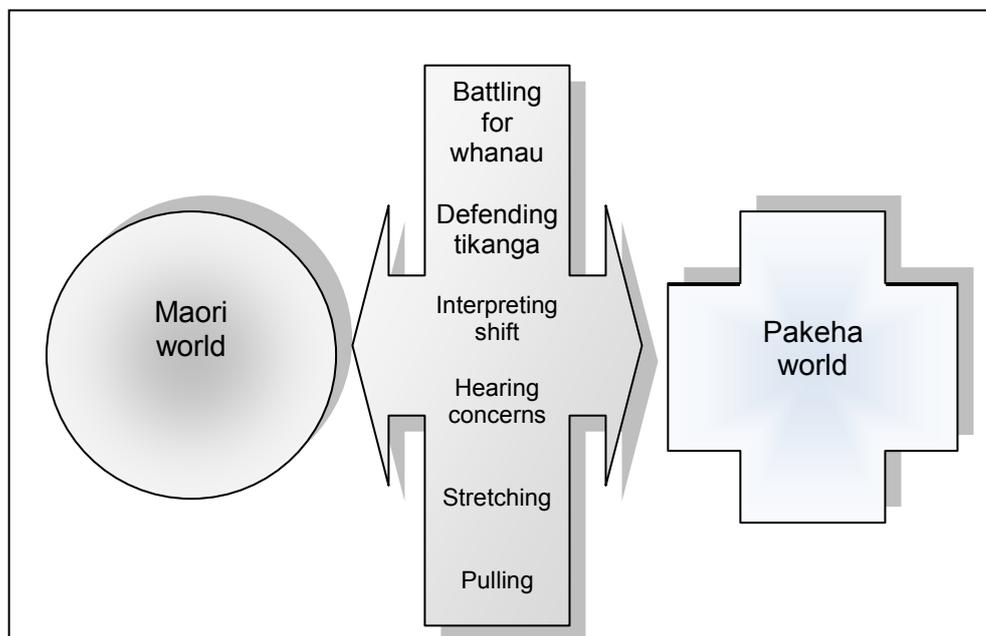


Figure 4. Mind map of tension of two worlds.

Note: Source: Memo bank.

As the data undergoes a reshaping process, it alters and changes its perspectives through the coding and categorisation processes, as mentioned this involves a breaking down of the data and reconstruction of it once regrouped or categorized. There can be multiple texts that emerge a range of concepts to provide and summarise meanings that are representative of the data's meaning. The process of theoretical sensitivity encourages the researcher to challenge potential biases against the data. This is achieved by taking a step back from the data and acquiring an abstract perspective of it (Schrieber & Stern, 2001). To determine what is important and what isn't in the data, the theoretical sensitivity process provides three levels of questions for reflection which assist with the conceptualization of data (Glaser, 1967, 1978; Corbin & Strauss, 1998). These are presented in Figure 5.

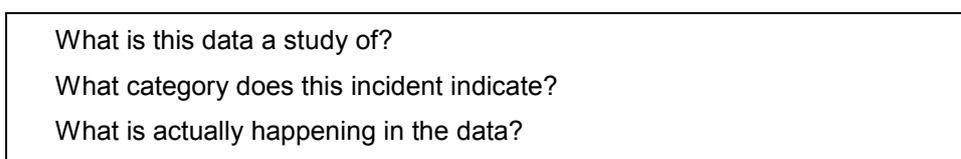


Figure 5. Questions to encourage theoretical sensitivity

Note: Source Glaser (1967,1978).

As the codes emerge from the data, a sense of meaning is acquired. Table 3 demonstrates one example of related codes that emerged from the data, these entailed codes that focused on subjective and social meanings of Maori, these were then condensed into properties to generate one concept called *being Maori*.

Table 3.

Condensing Codes from Data into Properties and the Concept Being Maori

Codes	Properties	Concept
Being Maori is important Maori is a key focus Maori world drawn from Cultural world is Maori Tangata Whenua I am Maori first I came with all things Maori There are processes from a Maori perspective Common thing is Maori Maori have genuine communication Maori know everyone For Maori she was gifted Contemporary Maori Knowing only Maori know Maori at the end Its natural for Maori Things only taught to Maori to recognise I stayed there for Maori Maori eye contact with Maori and they calm Love being a Maori Nurse Skill of the Maori Nurse Hapu & iwi aren't contemporary Maori are the same Differences come from maunga, hapu & iwi I like being Maori These make a Maori mental health nurse: You have to be Maori You have to have whakapapa, I'm a Maori who happens to be a Nurse; not a Nurse who happens to be Maori.	<div style="border-bottom: 1px solid black; padding-bottom: 5px;"> <p style="text-align: center;"><i>Proud to be Maori</i></p> </div> Importance of acknowledging a Maori identity, It is determined by whakapapa. Supported by the exclamation of „I am Maori“. <div style="border-bottom: 1px solid black; padding-bottom: 5px;"> <p style="text-align: center;"><i>Committed to Maori</i></p> </div> Accountability and desire to improve the health and situation of Maori <div style="border-bottom: 1px solid black; padding-bottom: 5px;"> <p style="text-align: center;"><i>Maori relate with Maori</i></p> </div> Form of knowledge and communication understood between Maori.	<p style="font-size: 2em; margin: 0;">↓</p> <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: 0 auto;"> <p style="text-align: center;">Being Maori</p> <p style="text-align: center;">Properties</p> <p style="text-align: center;">Proud to be Maori, Committed to Maori, Maori relate with Maori.</p> </div>

Note: Source data analysis.

Memos

Data analysis can be tedious and time consuming, the utilisation of memos is recommended as an activity throughout the coding process so that reflective thinking, conceptualisation and the creation of ideas are possible. Memo's assist the researcher to reflect upon the possible meanings and perceptions emerging from the data, and engenders a further depth of understanding about them. Other benefits include the uncovering of latent patterns, the testing of

possible hypotheses, the clarification of possible connections between categories and properties and the confirmation of core categories thus assisting with the emergence of theory (Glaser, 1978,1992).

As a novice researcher, I had a need to stay reflective and objective to the data, of which memo's served well in providing. An example of a reflexive memo is presented which notes some insights into the impact of tension upon a Maori mental health nurse. Memo's also providing for a vehicle to identify biases and to place these aside so that the data is not forced to fit into any preconceived ideas.

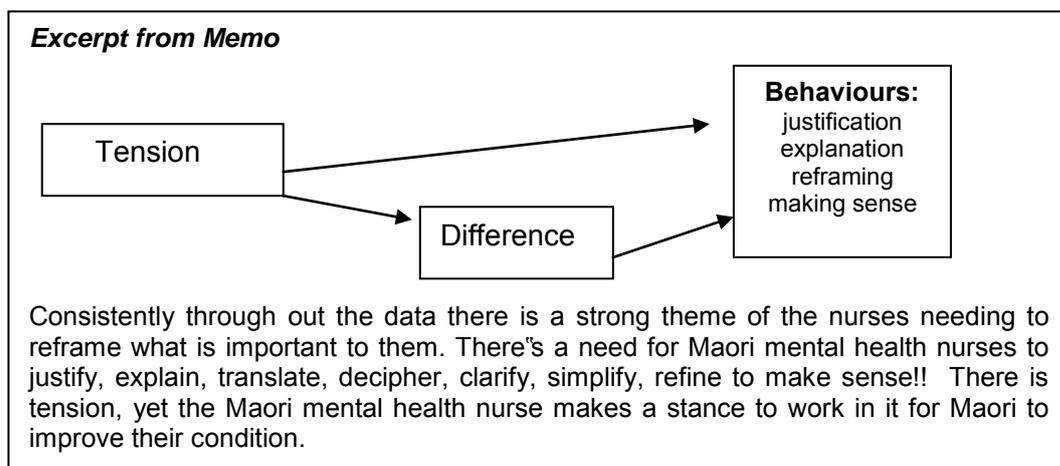


Figure 6. A reflexive memo

Note: Source memo bank.

There is no formula for memo writing, it is an activity that encourages a pause in the midst of data coding and encourages reflection, spontaneity, creativity and criticism about the data. Memos consist of sentences, paragraphs and drawings or modeling (such as mind maps, flowcharts or diagrams).

The reflective expression is left to the freedom of the researcher provided it supports the grasp of the immediate or transpiring thoughts. These are performed throughout the data analysis at a distance from the writing up of the final draft of the study, so memo presentation is not an issue. However, when the data process concludes it is expected that there will be a diverse bank of memo's that will require revisiting so as to coordinate and then to incorporate into the final writing of the theory (Glaser, 1978). The use of modeling and mind mapping assisted me greatly, this was a method that supported data analysis and conceptualisation of the data (Glaser, 1978). Together, these

provided various methods of expression as well as assisting to reveal how the patterns within the data were connected and how interactions were interplayed between concepts, contexts and situations. In Figure 7, this early modeling example was an attempt to link how Maori learning about Maori health inequalities early as nursing students, this was tied to the realization that there are differences for Maori and in mental health. Additionally, many were fearful of the mental health setting but still chose to enter mental health nursing as a career option. Together these commenced the conceptualisation that Maori endured difference and challenge to get to where they are today.

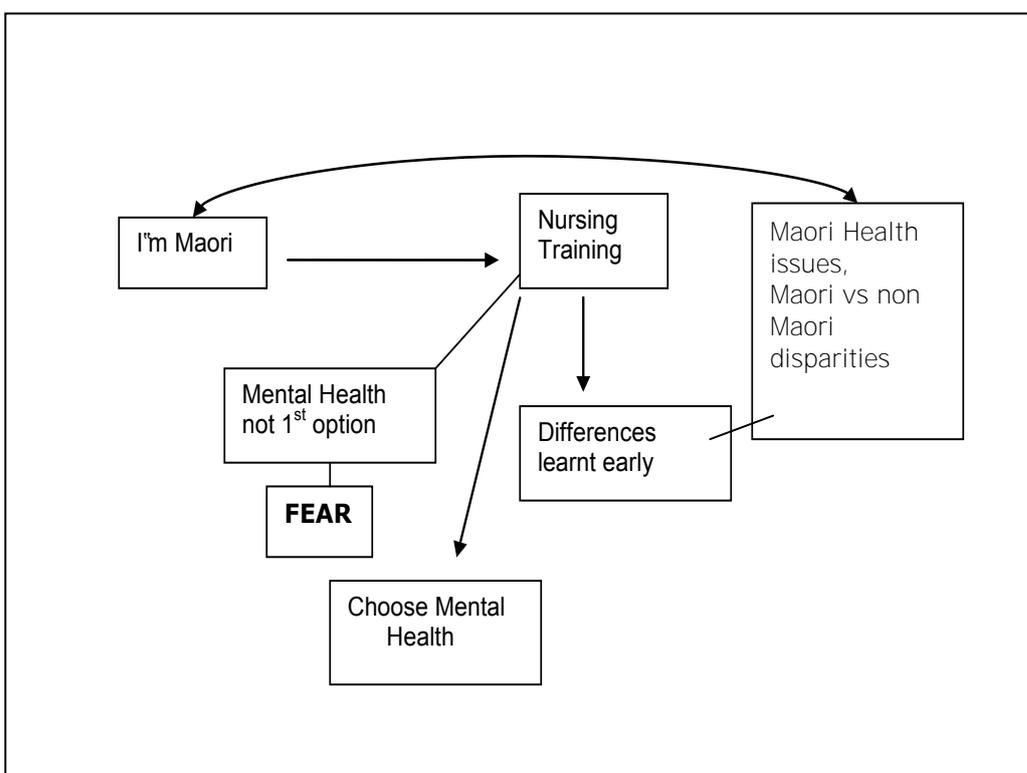


Figure 7. Example of early modeling diagram

Note: Source memo bank

Ideally, a grounded theory results in the identification of categories that are grouped as they emerge from the data and are modifiable to ensure fit and relevancy to the data. Categories will have a name, a concept about what the category segments of data are and a set of criteria to demarcate it from other categories (Minichiello, 2003). As mentioned, the participant's words are recommended for the naming of concepts and categories to ensure that the participants intended meanings are close to the theory.

The identification of a central or a core category emphasises consistent meaning that is threaded throughout the data but may be expressed in various ways. This will appear frequently in the data and hold logical and consistent relations with all or almost all components (Strauss & Corbin, 1978). A basic social process is a type of core category or variable that emerges providing explanation for the process or behaviour within an area of concern for the participants (Glaser, 1978). These embody what people will do or use to resolve their main problem or concern. These are not always easily recognizable to the participants due to their immersion within their experiences, but once identified, they do recognise the process (Glaser, 1978; Wilson, 2004).

As the coding and comparative analyses of the data concluded, one core category and two subcategories were identified. The core category is called „*two worlds*“; the two subcategories are called *going beyond* and *practises differently*. The basic social process that demonstrates how the problem of *two worlds* is resolved by Maori mental health nurses was identified as *bridging the tension*. Whilst the nurses did not utilise the term of bridging the tension, it appeared to be the process that was happening amongst Maori mental health nurses to work in their two worlds and that bridging the tension was accomplished through the two subcategories of *going beyond* and *practices differently*. This formed a Maori centred substantive theory called Te Arawhata o Aorua that will be described further in section two.

Te Arawhata o Aorua



Te Waka Arawhata o Aorua is a symbol of the Māori mental health nurses journey. It's name translates as the waka that is the bridge of two worlds: that are Te Ao Maori me Te Ao Pākehā.

The brown side panels of the waka are based on traditional takarangi (spiral) designs which depict agility, holism and symbolize ora (wellbeing), portions of the takarangi reduce to an occasional bridge mindful of the need to practice differently to achieve ora. The panels are complimented by Kawakawa (Māori rongoā) and a nursing badge representing the blending of Māori and Pākehā worlds into nursing practice.

The red colour is reminiscent of the blood loss that occurred during the separation between papatūānuku (earth mother) and Ranginui (sky father). It reflects upon the source of living things and the elements of duality, such as : tāne - wahine (man and woman) and ira atua - ira tangata (immortal and mortal).

The seaspray from the hoe (paddle) represents the turbulence that occurs in the two worlds. The kaihoe (paddler) carries the essence of being Maori and manoeuvre's the waka swiftly through the moana to achieve the needs of Māori.



Section Two

An Overview of Te Arawhata o Aorua

This theory has emerged from the perspectives of Maori mental health nurses who participated in a research to explore what was occurring amongst them and dual competencies. Typical of a grounded theory, is that the initial subject of this study did not sustain its focus, as it was not of vital importance to the participants (Glaser & Strauss, 1978). But the topic of dual competencies did facilitate the identification and appreciation of two worlds as the main concern (category) of Maori mental health nurses. The (basic social) process of bridging was discovered as a way of solving the tension of two worlds. Within this theory, invivo codes have been used as much as possible to name the categories, concepts and properties to reflect the perspectives of Maori mental health nurses and to connect the conceptualization of the data to them.

Briefly, the theoretical explanation of Maori mental health nurses is called Te Arawhata o Aorua or bridging the tension of two worlds, it describes:

- the two worlds as Maori and Pakeha worlds,
- the tension that is provoked by the two worlds,
- the reasons that appeal to the Maori mental health nurse to go beyond the call of duty to make a difference,
- and what Maori mental health nurses must do in practice to bridge the tension.

The further description about this theory will be offered in the following three chapters commencing with the two worlds. In keeping, with the pictorial of Te Arawhata o Aorua, the whakatauki (proverbs) that are offered throughout this section of the thesis aim to enhance the reflections associated with the theme in the discussion.

Chapter 3: Ao e Rua - Two Worlds

The term two worlds acknowledge the main issue that Maori mental health nurses are grappling with. This chapter will explain the *two worlds* separately, and will pause to highlight impressions about dual competencies that led to the emergence of the two worlds. This will lead onto the recognition of tension that is subject to the phenomenon of Ao e rua (two worlds).

According to Koltko-Rivera (2004) a worldview considers an individual's fundamental beliefs about a variety of situations and subjects including views about relationships between people and the world. Individuals and groups use their beliefs to guide their actions which are mediated by a person's culture (Koltko-Rivera, 2004). A worldview is fundamental and implicit that a person will rarely question it or want it to change (Olsen, Lodwick, & Dunlap, 1992). The worldview of Maori mental health nurses consist of two worlds, this term has been used to signify two separate areas of spatial, knowledge, philosophical or cultural contrasts (Salmond, 1991; Ashton 1992; Mealing & Sawicka, 1996; Salmond, 1997; Morris, 1998). Also, as an idiom *two worlds* has described the adjustment of the world of indigenous people to that of colonialism (Smith, 1999; Durie, 2001a) thus revealing the indigenous experience of two different facets that exist within one world (King, 1992; Morris, 1998). For Maori mental health nurses, two worlds is the place that they intermingle and practice in, the two worlds are a Maori world and a Pakeha world, each promoting divergent worldviews to each other.

"It's about the two worlds combining them together, the clinical side as well as the tikanga side" (participant A02).

"The ability to function in both worlds" (participant C4).

"I see it as both worlds" (participant A01).

Maori have recognised the presence of two worlds, an example reiterated in the whakatauki (proverb) *E Tipu E Rea* (Figure 8). Ngata acknowledged the presence of Maori and Pakeha worlds, with the encouragement to participate in both.

That is, for Maori to acquire the skills of the Pakeha to enable participation in that world but not foregoing the importance and preservation of the customary knowledge and spiritual aspects that belong to the Maori world (Durie, 2001a).

*E tipu e rea mo nga ra o tou ao
Ko to ringa ki nga rakau a te Pakeha
Hei ara mo to tinana
Ko to ngakau ki nga taonga a o tupuna Maori
Hei tikitiki mo to mahuna
Ko to wairua ki to Atua, nana nei nga mea katoa.*

Grow up and thrive for the days destined to you
Your hands to the tools of the Pakeha to provide physical sustenance,
Your heart to the treasures of your Maori ancestors as a diadem for your brow,
Your soul to your God, to whom all things belong.

Figure 8. Sir Apirana Ngata's whakatauki – E tipu e rea
Note: Source Durie (2001a)

Also, a contemporary model shares similar features to Ngata in the recognition of two worlds for Maori by suggesting that a Maori whare (house) is a place of Maori residence and foundation, whereas the Pakeha house that sits next to the Maori whare provides a place of participation and employment for Maori (Jackson & Poananga, 2001). Together this model and Ta Apirana Ngata's whakatauki suggest that Maori have accepted that there are two worlds for Maori to function across and that each bear dissimilar contexts and expectations of Maori within life, work and relationships. A further insight to the foundation of two worlds in which Maori mental health nursing practice rests will provide further explanation.

Te Ao Maori – The Maori World

The Maori world is the world that Maori belong to; it provides the cultural context for Maori and regards Maori identity and whakapapa (genealogy) as integral to it. As an insider to this world, the Maori world promotes much bearing upon the determination of what is important to Maori and to their practice.

“The key things that make a Maori mental health nurse, number one is you have to be Maori and you have to have whakapapa. Being Maori and having whakapapa is important to me” (participant B1).

The Maori world is underpinned by processes and procedures, a Maori value and belief system that is socially and culturally integrative. The Maori world facilitates the Maori way of doing things according to Maori custom and is viewed as tika (correct) way of doing things (Barlow, 2001; Mead, 2003).

“From a Maori perspective we all know that there are processes, procedures that have to happen.” (participant C2).

“If we’re doing right, if we’re being right, then I think our practices and that will be right, we will be tika” (participant C1).

In addition to customary knowledge, tradition and history provide Maori with insights about what is common understanding about how other Maori may exist and relate to each other, and such knowledge is transferred into practice with other Maori.

“Looking at our culture as our history because that’s common among all of us is our history.” (participant C4).

Matauranga Maori (Maori knowledge) and tikanga provide ways for Maori to approach and to interpret Maori presentations. In addition the Maori world has a strong spiritual realm that will inform how to respond to a Maori tangata whaiora presentation (Royal, 2003). This means seeing what is important to Maori and being one in wairua with them.

“What we’ll see is something pertinent to our culture, spirituality wise could be deemed as a delusion in a westernized one, so you need Maori nursing, that’s why I came into it to represent those people and those belief systems ” (participant C2).

The Maori world is distinct to Maori, it provides a value and foundational basis for Maori that interweaves cultural mores, beliefs and customary knowledge into practice.

Te Ao Pakeha - The Pakeha World

The Pakeha world represents approaches to health that focus on illness, disease, diagnosis, medication, western health contexts and practice. It involves skills and knowledge about pathological approaches and technical views to a particular condition or person (Durie, 2001a). Understanding the knowledge and skills of the Pakeha world is vital to add into nursing practice and to be able to incorporate an alternative perspective to health. Knowing the clinical skills within the Pakeha world is important to place alongside of the Maori world.

I also believe that you need clinical skills to go alongside [Maori] so that you can walk in both worlds” (participant A04).

“I like to look at both of the [clinical and Maori] models because we can’t eliminate the clinical side of our whanau” (participant A01).

Pakeha methods of health have been included by Maori in the past to enhance the health of Maori (Lange, 1999; Durie, 2001a). The participation in the Pakeha world is a decision made with much responsibility and cause, the Maori nurse is required to attain the skills and knowledge that belong to this world in order to bring in components of the Pakeha world for the wellbeing of Maori.

Furthermore, the participation in the Pakeha world aids the status of the Maori mental health nurse, not only is there an understanding of the Pakeha world but there is acknowledgement and acceptance of the Maori mental health nurse by its terms.

“We need the westernized knowledge, firstly so they will acknowledge us and we know what they’re talking about.” (participant C4).

“It’s knowing your work, knowing your medications, knowing your patho-physiology.” (participant C3).

“You need to be trained to be employed in your positions in the Pakeha environment. And for District Health Board Mental Health we are in a Pakeha environment, we have to have a tohu (qualification) the tohu allow me to be employed.” (participant A02).

Accepted entry into the Pakeha world brings power and supports the utilisation of a body of knowledge and common language to advocate for tangata whaiora. Such ability provides for informed discussion and debate with health professionals whom function within the Pakeha world. Using the same language as the Pakeha provides for a better deal for tangata whaiora.

“We have to master as much as we can to enter their (Pakeha) world, to have that discussion and that debate otherwise we can't advocate” (participant C4).

“I think that the western models that we have to learn are there just to enable us to be able to argue with Pakeha, use the same language and that as what Pakeha use so that we can get a better deal for tangata whaiora” (participant A03).

Working hard to be thought of a clinician is important in the Pakeha world. Striving to achieve in the Pakeha world for the benefit of their roles and in responsibility to their people is not a new concept for Maori. Carroll one of the first Maori doctors encouraged Maori to compete with Pakeha on their own terms and where possible to surpass them in similar ventures (Lange, 1999). Maori pursue Pakeha knowledge and education with underlying aspirations of wanting to excel in the Pakeha world

“I worked really hard to be thought of kind of a clinician, really worked hard at it “ (participant A03).

“We've got to be more smarter clinically as well as hold onto our culture” (participant C3.)

Asking the doctor about the reason for giving medication to a tangata whaiora and negotiating a better course of treatment for them is supported by having

the skills of the Pakeha world to critically debate with clinicians. This is important for an informed clinical dialogue for optimum treatment decisions and positive outcomes for tangata whaiora. This means being informed about and comprehending pathophysiology, symptoms, medication and treatment responses to enable the ability to filter subjective differences and to maintain the needs of the tangata whaiora at the centre of practice.

“(I) said, (to the Doctor) Why are you giving Clonazepam (anti-anxiolytic medication)? He says oh that’ll settle him. And I say his voices are so extreme the patient himself is screaming, so you’re just going to make him a sleepy psychotic person. You know. But if you don’t know your (clinical knowledge) stuff you couldn’t bring that into the discussion. So you know, ten minutes later you walk out with no Clonazepam. And then he sort of takes you back, because sometimes we’re playing with someone’s ego, not playing, we’ve got someone’s ego sitting in there with the doctor. So he’s gonna protect his wonderful ego and then you have to go back into the pharmacokinetics of it. You know damn well you’ve got it, but you keep going for your patient.” (participant C4).

Employment in the Pakeha world is always possible, as the body of knowledge and skills associated with the Pakeha world are imperative to it and to the Maori mental health nurse’s role. But its significance is viewed as a pragmatic one. As the foundation and style of Maori mental health nursing practise is engendered by the Maori world, with expectations to maintain the Maori world in practice. The content in the Pakeha world provides a way to interact with that world when required. But, if the Pakeha world threatens to overcome the status of the Maori world, this would be viewed as failure to the Maori mental health nurse.

“If the clinical skills become bigger than the kind of tikanga then I think we’ve lost it, but we can all of us can work in mainstream because mainstream want us, all of us [Maori mental health nurses] can work there but to keep that tikanga alive I think is the thing that Maori Mental Health Nurses can do” (participant A03).

E titiro, e whakarongo ana ki nga Ao e rua, Ko te tai tama tane e papaki mai nei ki Hokianga, Ko te tai tama wahine e papaki mai na ki Taumarere.

I look, I listen to the two worlds. The tide of the male aspect which beats at Hokianga and the tide of female aspect which laps at Taumarere.

(An adapted Ngapuhi whakatauki, the two tides from differing shorelines has parallels with the presence of two worlds.)

Overview of Dual Competencies

This part will provide insights about dual competencies, although these were not of great importance to the Maori mental health nurses and should not detract from the theory of Te Arawhata o Aorua, the topic did lead to a discussion about what *dual competencies* might mean or imply for them, consequently assisting with the emergence of the two worlds. The term *dual competency* is a contemporary descriptor for the identification of skills and knowledge of the two worlds, but it is not a term commonly understood or used to usually express the inherent requirements of the two worlds.

“You know its (dual competencies) there, but we don’t talk about it on a day to day basis, we actually do the mahi (work) in it. We do that (dual competencies) on a day to day basis we do that, not just with each other, we do it with whanau and tangata whaiora. So you don’t think about it until it has been termed to you and you think but we do it (work dually competently).” (participant A02).

There is an appreciation that the concept of dual competency aims to acknowledge two sets of skill and knowledge. Doing so recognises that there are two differing approaches to nursing practice, reinforcing the practice experiences of two worlds and the need for two skill sets.

“I first started thinking about dual competence and thinking about how I could work with a team who had varying levels of competence, both clinically and culturally or clinically and from a taha Maori perspective.” (participant B1).

*“There are two different ways of nursing and two different skill sets.”
(participant B2).*

“I worked with a Whaea, she had enrolled in a course and they were developing dual competencies. She was doing it and my understanding was that dual competencies is about actual learning and building towards being able to use both western models of care and Maori models of care while working with tangata whaiora with mental illness. Its (dual competency) about being competent in both Maori world view and the western Pakeha worldview.” (participant A03)

Still, the word *competency* provokes ambivalent feelings and meanings as comparisons are made against Pakeha forms of competency measurements and the additional expectation to prove oneself in some way. There were suggestions for an alternative term but no replacement for the word *competency* was offered.

“Competency’s not a nice word, cause for me it felt like Oh! No! now I’m gonna have to prove in two different ways something that I haven’t got my head around proving in one way.” (participant B1).

*“I would like to see a different word but I don’t know what.”
(participant C4).*

“I wouldn’t have called it dual competency, I don’t know what I would’ve called it.” (participant B2).

In any case, the discussion about dual competencies highlighted an appreciation for the binary approach in the Maori mental health nurses practice, and thus the emergence of the two worlds. One reflection extended to a questioning of the validity of dual competencies for non Maori and the meaning for Maori especially if one skill set (required of dual competencies) belonged to the Maori world. This aspect, reiterated that Maori are the best to move across the two paradigms that are present within the Maori and Pakeha worlds.

“Maori nurses can go across, we can work across there (Maori) and in here (Pakeha). They (Pakeha) can’t work across, they are not Maori, and they cannot know our tikanga, our values and our beliefs. I believe dual competency basically means two paradigms, the cultural concepts that you bring, Maori I mean, and their concepts, that’s why I said they can’t move across. We can cross their line, they can’t come across because they don’t have it, and we’re the only ones that can. There’s my half Maori and my other western concepts. They can only stay there, they can’t come across. That’s how I see and understand why we are the way we are.” (participant C3).

Tension

Highlighting the tension in the two worlds is important to provide a perspective of the issues and to name some of the occurrences. The words that come to the naïve mind when the term *tension* is proposed are features of stress, pressure, pulling and stretching and conflict, thus unavoidable elements of this phenomena. Subjectively, tension is noted by the verbal and emotional reactions prompted by verbal criticism, some health settings and by the actions of others that contest aspects of practice that are informed by the Maori world. The tension is being made to place tikanga aside to the clinical, and being challenged for meeting and greeting tangata whaiora.

“In the past it’s always been the clinical and our tikanga is always left on the side and when we try to bring or incorporate tikanga into clinical we have been challenged. I remember that day when a Pakeha nurse challenged me she said that I crossed the boundaries when I hongied (pressing of noses) one of my tangata whaiora. I said to her that it is our way of greeting it is not about boundaries, in fact it is more ignorant of me if I didn’t do that”(participant A02).

Being asked to break down and explain Maori aspects to Pakeha can be frustrating especially if there is limited understanding or minimal tolerance toward Maori. Nonetheless, it does require the deciphering and mediation of information to shift the message from Maori across to the Pakeha world to

ensure that the needs of Maori tangata whaiora are met. For example, negotiating with and for a whanau, when the medication regime of their loved one is not optimum and then battling for that whanau with the Doctors to get their needs met adequately.

“When I go to Tauivi (Pakeha) I find it, I get a bit hoha [annoyed] with the way they think because I really have to explain or I have to break things down and why should I have to water down something that is ours?” (participant A04).

“(talking with mother of a tangata whaiora) How long has she had eczema? (Mother says) Oh! Since such and such. When did the medication start? (mother says) Around about the same time. Because it’s your people, you’re battling for a whole family, I’m gonna go in and look at that (it took the Doctor) ten years! It was an allergy secondary to antipsychotic medication. So you know!” (participant C4).

As the two worlds are contrast there is an overt collision of values and beliefs that manifest a realization that the world that one practises from evokes difference of worldview, of purpose and of practice. Hearing the concerns of tangata whaiora and interpreting their shift in wairua is even more difficult when Pakeha colleagues do not acknowledge wairua or heed to the concerns expressed by Maori. Thus, decisions made about diagnoses and treatment are misinterpreted with dire consequences to tangata whaiora wellbeing (Durie, 2005b)

“ (tangata whaiora) came to us and said there are old people around [me]. We say, they’re trying to help you. The (mental health) service wanted to let (the tangata whaiora) go but a Maori Nurse goes to the Doctor and says you can’t put (tangata whaiora) on leave, because (their) tupuna are crying, because (the tangata whaiora) is going to leave this world. You get laughed at, they put (tangata whaiora) on leave, (the tangata whaiora) killed herself. Our culture knew (tangata whaiora) was in trouble because there’s that shift in spirituality. We weren’t there to challenge whether (tangata whaiora) could see them or not, what we saw as Depression, they

(non Maori health professionals) saw as a Delusion.(the tangata whaiora) was mamae (in pain) inside.” (participant C4).

Summary

In summary, the two worlds consist of two separate entities, each have distinctive signifying areas of knowledge, philosophy and culture. Together the two worlds provide the main platform of the Maori mental health nurse but they are not mutually congruent. The effect of the two worlds is one of tension, that prompt reactions that conjure energies and forces of pulling and stretching with the Maori world from the Pakeha world. This includes defending tikanga and the Maori world, negotiating and battling for whanau to get needs met, hearing the concerns of tangata whaiora and interpreting their shift in wairua as bridging strategies in practice.

The bridging of this tension is achieved by two subcategories which are discussed next and further illustrated in Table 4. This describes two subcategories as *Going Beyond* and *Practising Differently*. *Going beyond* consists of two concepts, these are being Maori and enduring constant challenge which focus upon extending beyond and overcoming challenges to pursue favourable outcomes for tangata whaiora and their whanau. *Practising differently* consist of three concepts of kaitiaki of wairua, it's about whanau and connecting. These represent the blending of the Maori world in nursing practice.

Table 4.

Bridging the Tension

Sub categories	Focus	Concepts	Properties	Theoretical Propositions and outcomes
<p>Going Beyond</p>	<p>Extending beyond and overcoming challenges to pursue favourable outcomes.</p>	<p>Being Maori</p> <p>Enduring constant challenge.</p>	<p>Proud to be Maori Commitment to Maori Maori relate with Maori.</p> <p>Learn early about challenge and indifference Removing the barriers</p>	<p>Going the extra mile to meet the needs of tangata whaiora and whanau.</p>
<p>Practising Differently</p>	<p>What is important for Maori mental health and Maori Nurses</p>	<p>Kaitiaki of Wairua</p> <p>It's about whanau</p> <p>Connecting</p>	<p>Preserving spirituality Ensuring tikanga Enhances wellbeing Extends to others.</p> <p>Whanau are priority Whanau shape Maori nursing Early experiences of need</p> <p>Connecting Forming deep bonds Knowing and understanding.</p>	<p>The blend of Maori with nursing enables the bridging of two worlds.</p>

Chapter 4: Going Beyond

This chapter will describe the first of the subcategories *going beyond* in the Maori centred substantive theory *Te Arawhata o Aorua*. *Going Beyond* consist of two concepts, the first that will be discussed is *being Maori* followed by the second concept of *enduring constant challenge*.

Being Maori integrates the proud identification as Maori and a commitment toward improving Maori health. Enduring constant challenge describe attributes that influence the behaviours to bridge the tension of two worlds. Together these are conceptualized as the philosophical and intellectual basis to this theory.

Being Maori

Identifying Maori identity, is an area that has received various perspectives over the years. Including a range of measures such as the quantification of a Maori identity based upon the amount of Maori blood a person might have and thus being classified as half or full caste Maori. Another has included being judged upon whether one is living a Pakeha or Maori lifestyle (Durie, 2005a). Either way, most of this type of criteria was established to classify Maori and to assimilate Maori into a homogenous group. These methods of classification have since been overshadowed by more valid forms of measurement such as ethnic and self identification amongst Maori (Durie, 2005a).

Through a longitudinal Maori household project called Te Hoe Nuku Roa (Durie, 1997; Forster, 2003) an exploration of realities amongst Maori is underway utilising a range of social, economic and cultural indicators. Evident from the responses of Maori thus far, is that Maori cultural identity is conceived by personal perception, cultural knowledge and participation in Maori society (Durie, 1997). Nevertheless, there is no single set of constructs which make up a typical Maori identity and today Maori are linked to contemporary realities as well to traditional arrangements (Durie, 2001a). In this study, Maori mental health nurses identified as *Being Maori*, and in alignment to this identity a

range of cultural attributes associated with this as important to them, thus the importance of naming this concept as they called it (Glaser & Strauss, 1967).

Being Maori is based on Maori whakapapa (genealogy), informed by upbringing and is a choice to be called such. Supported by the declaration of *I'm Maori*, a stamping of one's identity and an announcement of pride to be Maori in a manner that says there is distinguishing differences and a uniqueness about being Maori. This is sanctioned by being tangata whenua (people of the land) and having a turangawaewae (a place of standing), consolidating ones cultural significance by pou mana (a stance of power).

"I've stood up in front of the tauwiwi (non Maori) nurses and said "kia ora I'm X I'm a Maori mental health nurse", in reaction they stand up and say "kia ora, I'm an English mental health nurse and (they) say what's the difference? So I point out to them, I am tangata whenua, we hold the poupou. They sort of took that, Oh! , but that's what you get when you stand up and say "I'm a Maori mental health nurse". "I am Maori first", "A Maori Registered Nurse". You have a reaction like that and it's (not) until you explain it and then they realise there is a difference." (participant C3).

Identity is acknowledged when others belonging to the same grouping reinforce the same terms or title associated with identity, the same way that a person proclaiming such might do (Charon, 1998). Being Maori highlights the importance of Maori cultural heritage and is the most vital distinction above most other characteristics.

"I'm a Maori who happens to be a nurse, not a nurse who happens to be a Maori. And for me that's what it's all about, the way that I was brought up, the way that I see the world. I'm a Maori who happens to be a nurse." (participant B1).

Physical presentation of inanimate elements or the observation of events represents intrinsic meaning and reminders of being Maori and a cultural heritage (Mead, 2003). Recognised as symbols, signs or landmarks philosophical and traditional meaning from the Maori world are appended to such sightings to link with the Maori world for definition and guidance.

*“We come with our own hapu, iwi, our own awa, our own maunga.”
(participant C3).*

“You’ve got to be open and you’ve got to be able to live within the environment and you’ve got to be very open to that, respect for why the fantails there, whether we like it or not, a lot of that are our guides. The sea. You’ve got to be at peace with nature and what you see and what you don’t see. We accept as people that they’re all around us.” (participant C4).

A worldview promotes a cloaking effect or perspective across most facets in practice, recognition that ones core ideas are central to informing how care can be provided and advanced. In this situation, there is belief that care will be enhanced by deliberately including values, customs and ways of the Maori world into practice.

“We are focused on Maori and the way and lives of how Maori live and trying to implement that into our care using our cultural concepts.” (participant A01).

“Put the things that were important to me into my nursing practice about whanau and about tikanga and the way you treat people and the things that are really important and the wairuatanga.” (participant B2).

Tikanga (customs) are integral to the Maori world and to being Maori, two principles of tika (correct) and pono (truth) provide an ethical basis for behaviour and practice that ensure cultural integrity (Barlow, 2001; Mead, 2003). Being responsible and accountable are true to these principles that also encompass the persons purpose to take on a role and in this situation a reason for practice.

“What drives me is responsibility and that responsibility is about being responsible and accountable to my whanau and making sure that the skills that I can translate into I guess have descent outcomes for

whanau, tangata whaiora, the people that I work with.” (participant A03).

Knowing that one's past informs the present is a common colloquial amongst Maori that reiterates a critical process of learning and knowledge retention that has occurred across generations of Maori (Barlow, 2001; Mead, 2003). History has been a story about power and marginalization of Maori and indigenous peoples due to colonization (Smith, 1999), of which the effects of land loss and cultural alienation are still stagnant reminders of. This requires the acquirement of attributes that demonstrate a political staunchness, informed by history and equipped with the motivation to counteract the impact of history in practice with Maori.

“Being Maori you have to take a stance, you have to be aware of what I guess has happened to us as a people through colonization, being a Nurse is political, you have to take a certain stance in the way that you perform your duties” (participant A03).

“Having an understanding of the history is really helpful. From my perspective, many of our people are still wearing the effects of raupatu (land confiscations). Many of our people are poor. A lot of it goes back to raupatu and understanding the effects of raupatu” (participant B1).

Being Maori distinguishes cultural meaning in Maori korero (discussion) and behaviours, with these, barriers are eliminated in a world where misunderstandings of a Maori presentation are possible. By getting the message of tangata whaiora across to health professionals is important to meet their needs especially if cultural mores are not understood by non Maori health professionals (Cram & Smith, 2003).

“The young girl, three sisters, three different versions, but the common thing was Maori, we acknowledge that. So you're sitting there and you're still analyzing from a cultural point of view, What's common amongst this? all of them. And there was like, all the way through, one of them would mention the Grandmother. You know with

the so called westernized training, Nana was sick, unwell. From a Maori (perspective) she was special and gifted.” (participant C4).

Being Maori is met with challenge especially when working in two worlds, it is proposed that Maori surmount the struggle and challenge in order to fulfill the role of a Maori mental health nurse or to practice well. The following section presents a discussion upon enduring constant struggle.

Enduring Constant Challenge

Enduring constant challenge acknowledges that issues generate from the two worlds, but that the presence of certain abilities will assist with bridging the tension of the two worlds. This section discusses these abilities and identifies that Maori learn about challenge and difference early in the preparation of their nursing role. And that this commences a journey of constant adaptations to struggles throughout practice in the two worlds.

Two candid terms are proposed as being integral to being Maori and enduring constant challenge, these are Maori endurance and resiliency. It is proposed that during the discussion of this study that there is Maori endurance which is signified as a cluster representative of innate strength, resiliency, access to resources, environmental synergies and the impact of societal and global change. Maori endurance is a dynamic journey that extends over time, interacting with spiritual, physical and social systems and encountering barriers as well as opportunities (Durie, 2005). This gives the impression of what has occurred with this group of Maori mental health nurses.

At the introduction of two worlds, the journey of Maori endurance commences with the immediate insights that challenges are imminent. This is supported by the recognition that there are two worlds and that within each are differing value bases and different ways to practice nursing. There is no choice but to learn to rise above or to cope with challenges in the early phases of role development. As the participation is mainly within a Pakeha world construct, survival and conformity are somewhat required to achieve the desired skills that are sought from the Pakeha world. In addition, feelings of conflict are conjured by variable observations that raise concerns about the impact of the

system upon Maori and the presence of cultural apathy about Maori health. This is responded to by the triggering of an interpersonal defense line as a means of coping with the conflict that then feeds into the shaping of a stance to stay strong for the purpose of Maori.

“In my training, they (tutors) talked about Maori and their teenage pregnancies and I would look down at my notes and think they’re talking about my mother .I’m just going to finish and I just kept my head down and passed. And since then I’ve read a whole lot of stuff about people who pass in the dominant culture, so I was kind of aware then that there was two different ways of nursing and two different skills sets about nursing ” (participant B2).

“While I was training, I actually felt there was a need, I saw there was a need there for Maori. I thought this was not fair so I felt that I wanted to come and make a difference” (participant C1).

Mental health is a sector in health that is recognised as exposing health professionals to negative experiences and distressing behaviours that trigger considerable personal and professional conflict (Fisher, 2002). Being scared and being frightened of mental health as a student is also what makes mental health nursing a least desirable career option for many nursing students (Kempthorne, 2006). Fear amongst nursing students of tangata whaiora and the perceived inability to cope with the health conditions and the mental health settings are all features that promote negative views about mental health nursing (Happell, 1999).

“I was scared of mental health when I first, I didn’t want to come here. I didn’t want to do my clinical placement, and even when I did my clinical placement, we were a month or three weeks in the inpatient unit, two and half of those weeks I was sitting in the office cause I was terrified” (participant C1).

“I think I was a bit frightened about going into mental health and it was because I did not think I had the skills to go in to make change from what I already knew” (participant A04).

However, in regard for the conditions of Maori tangata whaiora, Maori will endure and adapt to situations so that they can deliberately present themselves in potentially stressful places to care for and to show presence to Maori tangata whaiora. Transcending the reality of a situation, suggests that there is strength of purpose and a commitment to Maori that emotionally moves Maori to be physically close to Maori. This is commonly expressed as being due to a passion and desire, thus to make a positive difference for Maori.

“It wasn’t until my placement at a mental health unit and I saw how many of our people were out there and that really took me and made me more passionate and more strong about making a difference for our people”(participant A02).

The feeling that gives rise to the active desire to alleviate suffering by purposefully entering into a place of despair or suffering is viewed as compassion (Le Noue, 2000). This is a profound emotion that is prompted by the suffering of others and triggers the desire to care for tangata whaiora. In practice, this encourages the fronting of people on behalf of tangata whaiora. Advocating through an interpretation of tangata whaiora needs to others requires mediation in the two worlds and knowledge of what to express, when and how to deliver it in a way that adequately advocates for their needs.

“Because you’d be advocates, you got to be able to front people at different levels to get our needs met but met appropriately not for tokenistic reasons, or for dependency (participant A02).

Maori working with Maori provide seamless mediation and interpreting approaches through shared values and an understanding of what’s going on for tangata whaiora (Ramsden, 2002). Throughout the professional journey, there is continual exposure to situations that require change of thought and action to counteract conflict. Although, compassion compels purpose, there are times where it is difficult to get the needs of tangata whaiora across when there are contrary views of need. Especially in times of wrong doing and injustice, the attempts to advocate can go without being heard.

“I’ve been on the ward there’s about twenty of these people sitting in the kitchen and we are all sitting outside and its quite rude and I say

to the charge nurse why don't you, why don't you ask those fella 's if they would like to go to the whare and yet that kind of stuff is still going on, you start feeling stink as a Maori because you know that's wrong, you know but no ones listening sort of thing. I felt when I found I was working in the unit. There were a few things I didn't like, I tried to say something but who cares, you just see things that you know are not culturally appropriate .How do you cope with that ? You just cope with it, you just cope with it.” (participant A01).

Resiliency is the ability to moderate or adapt when up against negative effects of stress (Jacelon, 1997). Factors that strengthen personal resiliency consist of positive relationships, emotional insight, spirituality, achieving a life balance and reflective practice (Jackson et al., 2007). Being Maori provides a cultural construct for at least three of these elements; of relationships, emotional insight and wairua, the other two features are professional and personal aspects, that would require further research to ascertain their presence amongst Maori mental health nurses. Knowing what is occurring for Maori and that it is not right, will draw the Maori nurse to work with Maori to facilitate their needs being met.

“One of the reasons why I was drawn to this area of mental health, because of, it's a knowing again, that's what happening for our people is not conducive or therapeutic for our people and we're practicing in it.” (participant C2)

Summary

In summary *Being Maori* provides an explanation of the cultural strength that is embedded within the Maori world, reiterated by a declaration of I'm Maori as a proud identifier, this is supported by pou mana (stance of power) and symbols and tikanga that consolidate its links. *Enduring constant challenge* describe the underlying resiliency and endurance required to shift paradigms of the two worlds. Along with adaptations to challenging situations that show strength and coping strategies.

Together *being Maori* and *enduring constant challenge* conceptualize philosophical and intellectual properties that provide reason to going the extra mile to meet the needs of tangata whaiora. This subcategory provides underlying principles that link into *practising differently* which will be presented next.

Chapter 5: Nga Mahi Rereke - Practising Differently

He toka tumoana he akinga na nga tai.
A standing rock in the sea, lashed by the tides.

(An adapted Ngapuhi whakatauki represents the Nurse as the rock, withstanding the buffeting of the conditions).

This chapter will describe the second of the subcategories *practising differently* in *Te Arawhata o Aorua*. *Practising differently* considers three concepts of *kaitiaki of wairua*, *it's about whanau* and *connecting*. These are described in individual sections to highlight each elements qualities of difference yet there will be synergies to each other.

Kaitiaki of Wairua

The role of wairua (spirituality) in health is recognised (Pere, 1984; Durie, 2001a) as a vital component to the wellbeing of Maori and is therefore integral in *practising differently*. Explaining wairua is no easy fete, some view it as spirituality, yet spirituality is difficult to describe, wairua is not synonymous with religion, yet both influence people. As complex wairua might be to define, it represents a sense of spiritual peace and understanding by and for people that is definable by them in their interpersonal way (Shirres, 1997; Royal, 2003; Ruwhiu, 2005).

“For me it’s definitely about considering those things that are unseen and unspoken.” (participant B1).

To understand wairua requires a willingness to reflect upon what wairua may mean interpersonally, thus exploring and developing ones own perception about wairua. By doing this, assists with the identification and appreciation of wairua and strengthens the attitude required of the nurse to acknowledge and respect wairua.

“I don’t think you can be an effective (Maori) mental health nurse without your own self awareness and personal growth, reflection and you add the importance of wairua and the importance of whakapapa” (participant B2).

Maori mental health can be revitalized through the attention to and care of wairua (Royal, 2003; Ruwhiu, 2005). Practice based upon the belief that everyone has wairua centres it as the focal point of care. This requires emotions and feelings that care for wairua, and supportive behaviours that look at, extend and reach out to tangata whaiora an appreciation of their wairua.

“Acknowledging wairua as a significant part of that person not just the psychological and bio-psychosocial kind of aspects of the person, which are predominantly part of the mental health [nursing] kind of focus” (participant B1).

“Maori mental health nursing for me is a part of holistic care because you are looking at the wairua” (participant A04).

Wairua is vital in the healing process of tangata whaiora (Royal, 2003). In order to facilitate appropriate remedies or approaches with tangata whaiora, needs to commence with an overt attention to wairua in the assessment of their health issues. This will assist to determine what relationship their experiences are to their wairua. If wairua is neglected there is risk for misunderstanding and misdiagnoses especially if cultural mores are not considered to be of importance to a health presentation (Durie, 2005b).

“(tangata whaiora) might come to us and say I saw my tupuna last night!, and the (non Maori) clinicians are going by side effects, (saying) Are they shuffling? Are their eyes blurry? Whereas we’d (Maori mental health nurses) go back for the tupuna and (ask) are they still coming to you? and If there’s a change there? We look at that consistency and that phenomenon.” (participant C4).

There is a responsibility to ensure that wairua of tangata whaiora, their whanau and colleagues are safe and that wairua is maintained for healing, wellbeing

and strength. This responsibility employs the kaitiaki role (a guardian, protector or keeper) to be enacted (Barlow, 2001; Royal, 2003).

“We’ll see something pertinent to our culture, spirituality wise could be deemed as a delusion in a westernised one, so you need Maori nursing,[to] represent those people [Maori] and those [Maori] belief systems.” (participant B1).

“Working with your own people and working with other [Maori] professionals like yourselves. What I mean is you feel safe. If I see something and I say to somebody Gee! that other person will understand. So you feel safe.” (participant C3).

Being a guardian of wairua, supports the components within going beyond such as mediation and interpreter roles and extends to actions of monitoring and negotiation of the two worlds for the safe care of wairua. Tikanga (Maori customs) and rituals that are handed down through generations are accepted as reliable and appropriate ways of achieving and fulfilling certain goals that attend to and care for wairua (Royal, 2003). The application of tikanga support the release of negative spirits and impediments that maybe damaging and facilitate the binding of beneficial wairua (Shirres, 1997). At times, this requires the anticipation of tangata whaiora wairua needs and stepping in on their behalf to facilitate processes that enact rituals and tikanga to preserve their wairua and enhance their wellbeing.

“This family where a baby had died and the clothes (were) still in the linen cupboard. (tangata whaiora) was distressed (and) depressed. (prior) they had dressed the baby in these clothes, and the mother took the clothes off the baby, gave it to her and put [other] clothes on, so in the meantime(tangata whaiora) had these clothes you see and didn’t know what to do with them. (tangata whaiora)] knew there had to be a process or procedure that needed to happen to whakawatea (cleanse, blessing) the clothes and bless all that stuff but she didn’t know how to do it. And it was just through korero that we (provided) a simple little karakia, whakawatea and she was happy with that.” (participant C3).

Death and dying are intricately connected to the preservation of wairua which underpin a belief about the importance of a safe transition of wairua from this world onto the next (Mead, 2003). There will be organised actions in response to a person's pending or recent death which will be carried out in line with the principles of tika (correct) and the application of tikanga. Support to tangata whaiora and whanau will require being physically present to Maori, to show ones face to the aggrieved and to be present in thought and understanding.

"As Maori, you help (the tangata whaiora) over, to cross. You do all that and you do all the awhi awhi [caring] sending (the tangata whaiora) on her way" (participant C3).

"Life and death is your path. They (non Maori) don't realise that you need to be there. That is the clinic" (participant C2).

The ritual aspects of tikanga are important to adhere to as there is belief that if not performed properly that misfortune can occur (Mead, 2003), in some instances the value placed upon an aspect such as wairua will ensure that the obligation to maintain its observance or preservation (in this case of wairua) is fulfilled.

"For me to nurse my client means from the time I start with them living right through even when they die, to me its not over. I have been challenged, Why did you go to that, she's dead? I said, as far as I know in Maoritanga (Maori culture) she's still alive. Her wairua is still with us until we've put her down, until I know she has safely gone home. And so I'm still working with her people. So that's it for me, I've learnt that's what makes us different, we go right across, it's about living and death. Until I know I've been to a tangi (funeral) then I'm happy. Then I know I've done my job" (participant C3).

The kaitiaki role requires guidance and support for ongoing development and sustenance. Often, in-depth discussions and sharing with tangata whaiora and whanau in practice reveal many facets that require further reflection, learning about and sound boarding of. Karakia (prayer) is one method to assist with this guidance, in general karakia helps to separate what might be considered harmful to a person or subject and will enhance the link with positive atua

(higher being) as well as encourage thoughts of healing and relief (Shirres, 1998).

“It was really important to have the ability to have karakia, whakawaatea and stuff like that after we’ve been through some really heavy sessions. Having the ability to access someone who could provide us with that from a staff point of view you know.” (participant B1).

“We pray for our tupuna (ancestors) when something heavy, maemae [painful] stuff’s coming for us, or around us.” (participant C4).

Whilst the emphasis has been upon the kaitiaki of wairua, the second component of *it’s about whanau* commences to extend an appreciation of what contributes to practising differently.

It’s about Whanau

The second focal point of *practising differently* is working with whanau and working from a whanau basis. Whanau (family) represent connections as well as a membership that are consolidated by whakapapa (genealogy), a common purpose or common history (Durie, 2001a). Whanau are a vital component to Maori wellbeing (Pere, 1984; Durie, 1994), and are interdependent upon the value of social and cultural beliefs (Durie, 2001a).

“Its about whanau, it’s about working with whanau, its automatically part of what we do.” (participant B1).

“The common thing (amongst Maori) is our tupuna. That’s our (Maori nurses and tangata whaiora) commonality. It’s our history.” (participant C4).

Being Maori, is linked to whanau, hapu and iwi, it is supported by ones kinship identity (Pere, 1984) that extends its worth onto ones professional role. Choices in life are affected by aspects of cultural and social positioning of whanau, although the choices made will in turn affect whanau.

“(I am) fulfilling the dream of my whanau and (I am) always reminded (of my whanau).” (participant A04).

“The expectations that I put on myself is that I do well because of them (whanau). I am the only one to go to University; it wasn’t an option for them. What I’ve been able to do what I’ve done enforces them (whanau), in a way that acknowledges them because I am here because of them not anything else.” (participant A03).

Maori identity is influenced by ones upbringing and whanau experiences will contribute to the establishment of values and beliefs about whanau. Past whanau experiences will be upheld and referenced as points in life that have influenced actions. These experiences with whanau are drawn upon to inform knowledge about the diversities amongst whanau and of whanau approaches. Inadvertently, some whanau experiences are pivotal in prompting choices to enter into nursing along with life decisions and actions.

“I was groomed by my [grandparents] they taught me everything I know.” (participant C3).

“I was brought up on a Marae [and] I saw my own whanau go through different things.” (participant A04).

“After the death of my whaea’s that was enough to stir me into thinking about assuming that I can do things better for our people.” (participant A02).

“That’s why I came into nursing because I felt we needed to work with our whanau.” (participant C1).

Relationships in whanau can be complex with expansive kin connections across a number of tupuna (Durie, 2001a). However, when bonds are formed, these must be kept strong by showing a face to these whanau members and nurturing the bond through the sharing of time and korero (talk) with them.

“A nurse on the [mental health] unit said to me I was the tangata whaiora’s second cousin, and I said No I’m her Aunty. (non Maori Nurse) said but, I said her Mother and I are first cousins, so therefore she becomes my niece, not me her cousin.” (participant C3).

Manaakitanga is a concept that portrays meanings of caring, sharing, respect and of hospitality toward others (Barlow, 2001; Mead, 2003). Caring is learnt early through the exposure and observation of whanau who have cared and supported other whanau members. Appreciating the place of manaakitanga when people are unwell or suffering informs behaviour that is assisting and supportive of people.

“I think back now learning from all my whanau, my Grandmother, they had mental illness back then but they didn’t say it was mental illness.” (participant C1).

“They were never isolated, we just called it porangi and at night we had to make sure they weren’t on their own.” (participant C2).

Traditionally, whanau were appreciated as the most convenient work unit with both men and women sharing tasks in normal daily activities (Mead 1997). In many instances, the whanau are still looked upon as an extended work unit and critical supports for tangata whaiora (Gibbs et al., 2004; Durie, 2005b).

“In the past, what I’ve found is if you support the whanau you don’t have to do a hell of a lot, because the whanau will do it all for you.” (participant C1.)

But there are diversities amongst Maori (Durie, 2005a), where the availability of whanau to tangata whaiora is minimal, thus impacting upon the possible support on hand. By working from a whanau base entails extending oneself out to support tangata whaiora and becoming substitute whanau with ongoing links.

“We work with [tangata] whaiora who don’t have whanau here because they come from other areas.” (participant C3).

“We become whanau; we are the whanau to the ones that haven’t got whanau.” (participant C4).

At the same time, some may not be comfortable with a whanau way of relating, in spite of this, support and encouragement are made available through the offering of closeness with the tangata whaiora. As well as the facilitation and creation of resources that this presence can provide.

“It is whanau, that’s one of the main pieces (of mental health nursing). We work with tangata whaiora who don’t even have whanau here. So we’re having to contact (their whanau) by phone.” (participant C3).

“You have contemporary Maori, sometimes they were never brought up that way or taught that way. You (still) have the opportunity to work with the whanau.” (participant C3).

It’s about whanau emphasizes the importance of whanau, their influence and on relationships, this has a close association with the following concept of connecting which will be discussed next.

Connecting

Connecting is the deliberate making of connections with people and places. It promotes shared knowledge and understanding that demonstrate an appreciation for what is occurring amongst people. It assists to reveal what may not have been previously known about a person or place prior to an encounter. Connecting is facilitative and involves a process of purposeful exploration and searching for links, which in turn enable an association with a person or a group of people or a place. For this to occur, it is important to hold a belief that connecting people is a positive effort and there will be benefits as a result.

“Having the knowledge that you need to connect is really important. It’s making and taking the effort to connect is really important. So that’s something that I think that’s important for Maori mental health nurses, is the connection thing.” (participant B1).

Connecting requires an investment of time and energy into people, and a willingness to apply ones whole self, of tinana (physical), hinengaro (mind), wairua (spirit) and whanau (family) to a relationship. By doing so, helps to provide a sense of understanding of what is happening to the tangata whaiora from all possible perspectives, as well as the ability to travel with them on their journey.

“We know everybody there, before we start and they know what we’re there for, what we’re all about. Then we hear all their interpretation of what’s happening, of how they got there. We listen to their journey and go with them on their journey.” (participant C4).

Connecting provides a way of expressing the worth of a person, completed by acknowledging their mana (power). Connecting is underpinned by a perspective that a person is not to stand alone but to be one, with one’s people, one’s land and one’s atua.

The deeper the oneness the more truly is mana tangata (power of the individual), mana whenua (power over ones land) and mana atua (power from the gods) (Shirres, 1997). To describe these further; mana tangata is a reflection of human expertise and requires an acknowledgement of their skills and knowledge. Mana whenua is a form of control and authority enabled by the group, hapu or Iwi to claim a particular area of land; this requires an acknowledgement of their status (Durie, 2005). Mana atua is the power and authority from a higher force (or god) which denote activities associated with wairua (Mead, 2003) such as the observance of tikanga. Together these broadly outline the usages of mana, which require a course of action between people that takes into account ones power and status.

“Whanaungatanga [relating], mana tangata [power of the person], all those kinds of things that come into it as soon as you meet someone.” (participant B1).

“You’ve got to look at the whole social dynamic and whakapapa [genealogy], mana whenua, mana tane, mana tangata, mana wahine

and then from there perhaps look to see if there is a clinical perspective in there.” (participant C2).

Meeting and greeting with people provides for interaction and special moments of engagement amongst people. Meeting tangata whaiora and whanau face to face is an important ritual of encounter, this may involve a range of responses such as a hongi (pressing of noses) a kiss on the cheek and or a handshake, or a smile. These are tailored signals of acknowledgement and will be performed in the initiation of korero (discussion), to appreciate the development or maintenance of a connection or signify the beginning or an ending of an encounter. In addition, formal and informal mihi (greetings) extend the ritual appreciation and acknowledge the mana of the person, their whanau and of the place.

“When we go into their [tangata whaiora] homes and they’ve got babies and all that, we will acknowledge the babies, not just with a formal handshake its sort of Hello Pepe!” (participant C4).

“You can connect in other ways like hongi all that greet and meet. Those are normally the first signs of being able to make contact within someone else’s world. Which ever way you meet and greet them I think is very important being a Maori nurse.” (participant A04).

“A whakatau [formal greeting], it’s something we just do naturally, introduce ourselves which is most important and making connections with the person.” (participant C2).

Looking after connections amongst Maori requires flexibility and regular opportunities to meet face to face and to repeat rituals of encounter. These reinforce the respect for the person and show outwardly that there is value in the relationship. Being detached from tangata whaiora is not a feature that is supported by the concepts of *its whanau*, *kaitiaki of wairua*, or by *being Maori*. But the practice of formal greeting and meeting rituals are faced with unfavourable impressions from some colleagues. Although, unlikely to alter the practice of these Maori mental health nurses, there is pressure from the discourse of the Pakeha world to rationalize the importance of this method of connecting.

“I remember the day when X challenged me she said that I crossed the boundaries when I hongi’d one of my tangata whaiora, I said to her that is our way of greeting it is not about boundaries in fact it is more ignorant of me if I didn’t do that.” (participant A02).

“I was giving a whaea a hug and these Nurses would be like (A01) you know when you do that, you’re going to split them because they are gonna come to you more you know!. That is really stupid; this is how we are, as you would when you are on the Marae.” (participant A01).

Speaking the same language and being there helps to form alliances with tangata whaiora and thus provides the Maori mental health nurse with an awareness of the way tangata whaiora communicate both verbally and non verbally. Signs that are suggestive that there are positive responses to this way of relating by tangata whaiora are comfort and peace especially in times of stress.

“Maori have a different type of English, straight away yes means no, it means yes. No is not necessarily no, it means yes, that’s the thing about Maori, you’ve got to understand Maori interpretation of English.” (participant C3).

“Some people can just sight you and it makes a difference, it’s about tangata. The energy you have without even speaking, it’s visual.” (participant C2).

“If Maori were on a shift you could pretty much guarantee that the ward was going to be really settled and it’s because most of the clients were Maori.” (participant B2).

Wairua plays a role in Maori experiences and is interlocked in their interactions and the surrounding environment (Pere, 1984), connecting with people and their setting is key to ensuring harmony and balance. This belief of wairua in connections is shown in the care and compassion for people; this contributes

to a trusting and non confrontational relationship with tangata whaiora, so that they can feel secure.

“I’ve worked in mental health for ten years and I’ve never had a violent incident occur. I’ve never been hit and I’ve never had anything like that go down. I’d like to think that it’s has something to do with the way I relate to my people, our people.” (participant B1).

“A good example, was when (participant C4) was working with an inpatient mental health unit about two years ago. Now (C4) you were working that ward and a good example that there was bugger all violence. Why? Because you had skilled Maori running that acute part of that unit.” (participant C3).

“Just that eye contact with another Maori and they calm.” (participant C4).

The mindful pulling together and linking of people is the ritual of connecting, done so despite challenges within an environment or of a perspective. Connecting grounds people to each other and to their environment, this is conducted in any situation to strengthen purpose for being.

“I find that even when I’m nursing somebody who, or working with somebody who doesn’t have the same kind of expectations, they’re isolated or they’re an immigrant or something like that that’s really taken them out of their world, or they’re so unwell that they’ve burnt all of their bridges all around them and all that. I still find I do the same stuff about trying really hard to find things that connect them, that connect them to the earth, and connect them to being alive and connect them to other people.” (participant B2).

Connecting does require (at times) interpretation and an explanation to others of its meaning so that colleagues can connect to the meanings amongst Maori and to the importance for connecting to people, whenua (land) and place. This requires a language to bridge the understanding of connecting to others especially to the Pakeha world, and at times requires creative imagery and

forms of expression to get the message across about the importance of connecting.

“I was in a big meeting with a whanau and the doctor’s were saying I don’t understand. What do you mean that’s where he comes from? I said his pito (belly button) is buried there. What? (says the doctor) I said it’s sacred, our trees are there, we plant something, but all of those things are sacred.” (participant C4).

A knowledge base about whanau, hapu and iwi equipped with the skills to make linkages to these, with tangata whaiora builds familiarity and resourcefulness. This enhances relationships with Maori and bears an appreciation for knowledge that is precious (taonga -treasures) within their lives as well as showing to the tangata whaiora that there is a genuine interest in these.

“Knowing part of their background is really important to know like where their whakapapa comes from so you know a little about the area what it that is familiar is. It’s about connecting, about making their eyes light up because hey this Nurse knows something about my area or if they don’t know I’m going to tell them.” (participant A04).

“You know what we call, ahuatanga or the characteristics or momo of that area, if I hear a clients name, straight away I put the name to an area and then I think what the characteristics are. You can tell from which area they come from.” (participant C3).

The distinction about connecting that is particular to a Maori way of relating to Maori is acknowledged by others. Usually, triggered by an inability to connect to Maori tangata whaiora and thus an inability to develop a meaningful relationship. An example is presented in this excerpt, where the mobilization of skills is requested to connect with Maori tangata whaiora.

“Often there were no Maori [staff] on the [inpatient mental health] unit, frequently I would be asked to go up and speak to some Maori [tangata whaiora]. [the request would be] Could you come and help us? Can you talk to the whanau? Can you talk to the client? Because

there was no one there to talk to them or wanted to talk to them.”
(participant B1).

Connecting is strongly associated with the other two concepts within *practising differently*, that are *its about whanau* and *the kaitiaki of wairua*. Collectively, these concepts integrate with each other to demonstrate how the Maori mental health nurse practises differently.

Summary

The importance of wairua is highlighted for good health (Durie, 2001a) and recognised in presence across life and death (Pere, 1984). The *kaitiaki of wairua* concept conjures names such as guardian, protector and keeper of wairua, and proposes that the observance, respect, facilitation and implementation of tikanga will fulfill its duty and ensure no harm to tangata whaiora, whanau and colleagues. There are significant risks to the wellbeing and treatment outcomes of tangata whaiora if wairua is neglected or minimised. Thus, impressing the importance of wairua through actions of monitoring, advocating and negotiating. The function of *kaitiaki of wairua* entails interpersonal reflection and wairua insightfulness to develop the necessary emotion and etiquette required for the actualization of the kaitiaki role. In addition, access to appropriate wairua support and guidance for the ongoing development and sustenance of the kaitiaki role has been highlighted.

It's about whanau draws attention to the meaning of working and living with whanau in an interactive way. Chapter three, closely aligns with this concept as kinship identity and whakapapa are important to *being Maori*. There is fluidity in *it's about whanau* that is suggestive of a rippling type interaction, viewed by the impact that whanau have upon each other and across all possible levels. Of which is then transferred across to a meaning of whanau and how whanau are responded to. The influences of whanau are significant, through upbringing and continual relationships with them. One example of influence is the understanding of manaakitanga, (that is to care, to share, to respect and to be hospitable) when caring

for unwell whanau members. *It's about whanau* also leads to an inclusiveness and expansion of relationships in practice that develop and extend supports out to tangata whaiora and whanau.

Connecting is the last concept that entails a belief in connecting people with people and to places. It is the deliberate action of connecting through meeting and greeting rituals of encounter and engagement, sharing, speaking the same language and broadly exploring and locating links. Flexibility is required in connecting to ensure the potential for new connections and the maintenance of current ones. Conducted in ways that upholds and enhance the mana of people, their place and of atua. Forming alliances with people by being there and showing an understanding of how people communicate verbally and non verbally as well, promote responses of calm, security and safety amongst tangata whaiora.

In many ways, these three concepts within this subcategory of practising differently are interlinked to each other and as an amalgam provide an overall impression of a blending of the Maori world into practice.

Chapter 6: He Korero - Discussion

Ko te mauri he mea huna ki te moana.

As Nukutawhiti arrived in the waka Ngatokimatawhaorua at the entrance to the Hokianga harbour, he cast his kura (feather taonga) into the sea to calm the waters.

[An adapted Ngapuhi whakatauki refers to the life sustaining source of the moana and appreciates the lessons of our tupuna.]

As discussed, when I commenced this study the focus was to explore what was occurring amongst Maori mental health nurses and dual competencies, however as the data collection and analysis progressed, this was not necessarily their focus. The theoretical explanation of Te Arawhata o Aorua emerged from ten Maori mental health nurses, informed by utilising a Maori centred approach to grounded theory. So this substantive theory focuses upon Maori mental health nurses, their interaction with two worlds and the emphasis upon their bridging of tension as a means of managing with this.

Two worlds is the core category that explains the Maori mental health nurses prime focus from hence they practice in. The Maori world cements both an individual and collective membership as Maori by providing a cultural context that is affirming of identity, whakapapa and meaning. The Maori world is underpinned by processes and procedures, of Maori values and beliefs that are socially and culturally integrative. The Maori world is the foundation to practice that supports the holistic philosophy and approach of Maori mental health nurses to tangata whaiora and whanau.

The Pakeha world represents location, skills and knowledge associated with pathological approaches and technical views to illness and treatment, vital to the Maori mental health nursing role. Knowledge, acquisition of skills and the participation in the Pakeha world is integral to ensure acceptance, credibility as a nurse and to be able to advocate for tangata whaiora. In addition, the Pakeha world prompts role, power and value indifferences for Maori. The *Tension* that is caused between the Maori and Pakeha worlds are due to its

incongruence of value and approach, reminded by verbal criticism of Maori, in some health settings and by actions of Pakeha colleagues that contest the holistic approach of Maori nursing practice.

Bridging the tension is the process that is undertaken by Maori mental health nurses to manage the issues associated with the two worlds. This is achieved by *going beyond and practising differently*. *Going Beyond* acknowledges the experiences of *being Maori* and the *enduring of constant challenges* as the philosophical basis for going the extra mile to meet the needs of tangata whaiora. The inner strength of the Maori mental health nurse is embedded within the Maori world, it is reiterated by a *declaration of I'm Maori* and supported by *pou mana* (stance of power) with *symbols* and *tikanga* that consolidate its links. Enduring constant challenge describe the underlying *resiliency* and *endurance* inherently required to *shift paradigms* of the two worlds.

Practising differently is the holistic philosophy and approach to practice that embeds an indigenous point of view. This focuses upon *kaitiaki of wairua* (spirituality), *it's about whanau* (family) and *connecting* as inter related elements. The immersion of tikanga Maori with its links to tupuna, matauranga Maori and underlying principles such as manaakitanga are also included.

The *kaitiaki of wairua* represents the role of the Maori mental health nurse as a *guardian, protector and keeper of wairua*, and proposes that the *observance, respect, facilitation and implementation of tikanga* fulfill this duty and ensures *no harm* to tangata whaiora, whanau and colleagues. In practice, wairua is attended to through actions of deliberate *monitoring of it, reaching out to it, advocating and negotiating for it*. The role requires *self reflection* and *wairua insightfulness*, and *access to support and guidance* for its ongoing development and sustenance.

It's about whanau links to *being Maori*. The deep sense and *meaning of whanau* and how whanau are responded to are *influenced* from *whanau experiences* and life's lessons. These shape ideas about *caring* and *manaakitanga* of others and prompt decisions and actions that transfer Inclusiveness and an *expansion of relationships* to others. *It's about whanau is*

a prime focus in developing relationships in practice which *develop* and *extend supports out* to tangata whaiora and whanau.

Connecting is a deliberate action of linking people with people and to places that *uphold* and *enhance the mana of people*, place and *atua*. It consists of *meeting* and *greeting rituals of encounter* and *engagement, sharing, speaking the same language* and *broadly exploring* and *locating links*. *By being there and showing understanding* forms alliances with people which hold importance to sustain.

Te Arawhata o Aorua brings together the conditions, challenges and actions of Maori mental health nursing. The basic social psychological process of bridging explains how two categories of *going beyond* and *practising differently* are integrated, forming a theory of Maori mental health nursing. Further discussion is presented on the elements that were highlighted within the theory.

This theory is supportive of indigenous nurses, for Maori nurses there is a recognition of the importance of being Maori within the workplace inclusive of cultural awareness and identity, the support of and access to Maori networks inclusive of matauranga Maori for the benefit of tangata whaiora and the adoption of Maori models of health (Simon, 2006). Also, Native American nurses overtly immerse their cultural world into nursing practice (Lowe & Struthers, 2001; Struthers et al., 2005; Sherwood & Edwards, 2006). Their nursing concepts invoke a holistic approach to health incorporating the spirit, the emotion, the physical and the family. The use of traditional knowledge entails the acknowledgement of relationship, respect, wisdom and values. As well as connection, viewed as the characteristic that assists to honour people in the past and of the present through sharing and anticipating, by building, taking risks, creating togetherness, cohesiveness, unfolding, interrelating with all, healing, interweaving and transforming. Other integral dimensions of care respect and trust complete seven dimensions of one Native American nursing model (Lowe & Struthers, 2001).

Furthermore, the theory highlights that holding onto one's cultural background (Durie, 2001; Jackson & Poananga, 2001) whilst participating in the Pakeha world is not rhetoric but a reality for Maori mental health nurses. Maori health

professionals (Ramsden, 2002; Close, 2005; Webster & Watene, 2003; Elder, 2008) and Maori mental health services (Boulton, 2005) understand the concept of two worlds however recognise the invasive discourse between these worlds and the mismatch that is evident (Elder, 2008). Inherent within this theory is the need to constantly make parallels between Maori ways of knowing and Pakeha notions and models of care (Webby, 2001).

Regrettably, though the tension of the two worlds for Maori is instantaneous upon their entry as nursing students. Revealed by the need to anticipate tension and stress and to act in roles required to protect, mediate and interpret for Maori regardless of their competency to do so (Ramsden, 2002). Although, Maori choose health as a vocation, the realization of these roles so early, demonstrate an exploitation of Maori by a health system that cannot connect to Maori tangata whaiora (McClelland & Williams, 2002).

At the same time, bridging the tension highlights the additional expectations of a Maori health professional role, the dual responsibilities of the two worlds and an expectation of being an expert in and dealing with Maori issues (Durie, 1997, Ratima et al., 2007). There is vulnerability amongst Maori, when there is an expectation from the Maori world, that they may not feel equipped to fulfill or if the Maori nurse has not defined their own Maori identity or if there is limited access to Maori knowledge or support to feel confident about being Maori or representing the views of Maori (Ramsden, 2002). This study did not find these reflections but is important to highlight as this can contribute to the tension of two worlds also.

The practice setting has an integral influence upon the Maori health professional's ability to be Maori (Ramsden, 2002; Simon, 2006; Ratima et al., 2007) and the choice of action required to manoeuvre in the two worlds. This suggests that the differential actions and behaviours toward the bridging process are primarily due to racism and discrimination in the workplace (Ramsden, 2002; Simon, 2006; Ratima et al., 2007) coercing the difference in ideology and power that underpin the two worlds. The findings in this study about tension were mainly identified as challenges and issues that were invoked by or from the Pakeha world (health professionals, setting, systems).

Furthermore, intolerance for the Maori world in practice disadvantages these Maori health professionals and no doubt will have subsequent consequences for Maori tangata whaiora requiring an appreciation of their culture in their health encounter. The collective failure of the system (workplace) to provide an appropriate place for Maori is institutional racism (Smith, 1999) and the tension experienced of the two worlds reiterates that racism is embedded within the practice setting of the Maori mental health nurse. This correlates with the overall position of Maori in Aotearoa who have been submerged by a dominant colonial culture that has constituted economical and social disadvantages (Thomas & Nikora, 1992; Smith, 1999) and contributed to a range of health issues.

The actions of bridging such as mediating, translating, protecting, and negotiating of the two worlds is deemed similar to Friere's (1976) *integrating* which describes the ability to adapt and adjust to an existing context, to manipulate its reality so that control can be exerted over the situation or environment. This is definitely synonymous with the Maori mental health nurses in this study.

The idea that Maori mental health nurses cope with tension by enduring constant challenge and being personally resilient was considered as a theoretical proposition. There is no sense of vulnerability amongst these Nurses, although they are prone to witnessing suffering and human distress as part of their daily working lives (Jackson et al., 2007). In this instance, action and values are organised in their adaptive responses which seemed to consist of positive emotions, innate qualities, access to resources and the synergies of the environment alluded to a set of resiliency skills that sustained them through the tension of the two worlds (Durie, 2005). This would be an area suggested to explore further, about the resiliency amongst Maori health professionals, from which could identify key components, to further assist with the coping with the tension of two worlds.

Upon reflection, much of Ramsden's (2002) work resonates with the findings of this study. That is, the antecedent to the development of cultural safety, thus reiterating its importance began with the Maori response to difficulties with the western based health service. Unfortunately, the findings in this study imply that similar issues of power imbalance between Maori and non Maori are still

present. Moreover, not only does this propel consequences for Maori tangata whaiora, but there is a direct impact upon Maori mental nurses and their practice. The concept of cultural safety formally recognises the unequal power relations between nurse and tangata whaiora and its consequences. In this instance, the transfer of this concept needs to be extended to the Pakeha world (health care setting, non Maori health professionals). So that culturally responsive practice to Maori and by Maori has the ability to operate within the two worlds and to be accepted.

Strategies to support Maori mental health nursing

To conclude based on the themes identified from the Maori mental health nurses and the theoretical explanation derived a number of recommendations. Three areas are categorized for health services, Maori nursing professional development and policy. These are presented in Table 5 with the subsequent discussion following.

Table 5.

Recommendations of Te Arawhata o Aorua (Bridging the Tension)

Focus	Theory supports
Health services	<p>An acknowledgement that:</p> <ul style="list-style-type: none"> - Maori Nurses practice across two worlds (Maori and Pakeha), - The blending of the Maori world into nursing practice will benefit Maori, - There are additional expectations of Maori mental health nurses, - There is institutional racism in practice settings.
Maori Nursing professional development	<p>Strategies to support :</p> <ul style="list-style-type: none"> - Nursing education at the undergraduate level to prepare Maori to work in the two worlds and to bridge the tension of two worlds, - Post graduate education and ongoing professional support that develops and sustains the necessary skills and knowledge to work in the two worlds.
Policy	<p>Strategies to improve:</p> <ul style="list-style-type: none"> - the understanding and acceptance of the Maori mental health nursing role, their method of nursing and required supports to maintain such a role. - Increase of Maori health workforce.

Recommendations to health services

Te Arawhata o Aorua revealed the practice of Maori nurses that inherently blended traditional Maori responsibilities and approaches with contemporary knowledge (Simon, 2000). This requires the specific acknowledgement and support of the health care setting to value this resource. The overall concerns if the health care setting do not acknowledge and support the worth of Maori nurses are best articulated as retention barriers which reiterate the difficulties (for Maori health professionals) as: not being able to be Maori within the workplace; being impacted by racism and discrimination; being isolated from other Maori health professionals; having dual responsibilities of two worlds and an expectation of being expert in and dealing with Maori issues (Ratima et al., 2007). The key strategies are to:

- Value Maori practice models and approaches,
- Acknowledge the dual responsibilities and value of Maori,
- Enable the increase of networks to and for Maori,
- Increase access to cultural resources and support,
- Eliminate the racism and discrimination in the workplace.

Recommendations for Maori nursing professional development

Simon (2000) has recommended the blending of the Maori world into undergraduate registered nursing training programmes, specifically incorporating Maori in their identity and ways of knowing and being, as key components to affirm Maori. Te Arawhata o Aorua may serve as a guide to nursing educators about the immediate support and preparation of skills required of Maori nursing students to work in the two worlds also.

In addition to the need for Maori to learn and understand both worlds suggests skill set and knowledge base required to empower Maori and to enable Maori nurses to participate across each world, thus acting as the conduit between Pakeha and Maori worlds. The suggested skill set consider bridging skills for roles that require mediation, critical debate, negotiation and advocacy, as these should not be taken for granted. This will require the access to clinical and cultural resources, and the acknowledgement of bridging may support Maori into their preparatory phase of becoming a nurse as well as support their ongoing professional development as Registered nurses.

The key strategies are to:

- Immerse Maori components into undergraduate nursing education for Maori,
- Affirm Maori knowledge, models of practice in nursing education and professional development,
- Provide support and guidance to Maori nursing students and Maori nurses with the development and support of bridging skills such as mediation, critical debate, negotiation and advocacy,
- Provide better access to cultural resources and support.

Recommendations for Policy

Lastly, Te Arawhata o Aorua offers a reality of the Maori mental health nurse and has revealed the variability in the employment context, of collegial support and of resource availability, hence the influence of these upon tension. This requires a revisit of policy and direction for Maori workforce development and service delivery to better understand and accept the Maori mental health nursing role, their style of practice and the required supports to sustain such practice. The strategy is to:

- Strengthen health service and workforce development strategies and investments to promote better understanding and further development of Maori health professional practice.

Further Research

There are two areas suggested for further research, these are based upon the learning's experienced from conducting this study.

- More Maori nursing research led by Maori nurses to provide further dialogue about practice. There is limited literature written by Maori nurses and the more information about Maori nursing practice will acknowledge its dimensions as well as inform others about it.
- A study of resiliency amongst Maori health professionals to determine a theoretical proposition of Maori endurance and coping strategies.

Limitations of the Study

Before closing, it is important to acknowledge the limitations of this study. The theory was developed based on the descriptions of registered nurses who identified as Maori and were members of Te Ao Maramatanga (College of Mental Health Nurses) and worked in mental health. Although the nurse's demographic characteristics were similarly distributed across three focus groups, the study was limited by the composition of the sample. So, there could be different meanings of two worlds or bridging the tension amongst other Maori mental health nurses who are not members of the college, in addition to other Maori health professionals.

There is minimal discussion about context, although some characteristics of the participants are included in the study and their practice settings revealed by the nurse's korero. So readers will make the decision about the transferability of this theory to their context, based upon their own meanings.

Although, there are methodological arguments about when to conduct a literature review (Glaser, 1978, 1998) with grounded theory, the dilemma was that at the time of the study there was limited literature and when the theory evolved, the literature rarely focused upon the issues identified by the nurses (Schreiber & Stern, 2001).

Conclusion

The significance of an indigenous worldview in nursing practice and delivery of health care cannot be overstated. By understanding the cultural impact upon health perspectives, values and roles will embrace Maori mental health nursing practice. Recognising the presence of other belief systems and that one world view does not negate the other is cultural competency (Durie, 2001b) plus equalizes the power shared in its attention that is cultural safety (Ramsden, 2002). This is vitally important in the goal toward overcoming the Maori mental health burden and to support Maori mental health nursing practice. In this instance, the conceptualisation of two worlds and the bridging of tension provides for a pre-established set of competencies which in turn have shaped behavioural dispositions and practice.

There has been recognition of national policy matching with an intention for a holistic approach to Maori health and for health workforce development through competency development. However, according to this theory, the policy and service decision makers will be faced with needing to form new responses to counteract the tension of the two worlds and to enhance the blending of Maori world into nursing practice.

E kore e ngaro, he takere waka nui
We will never be lost, we are the hull of a great canoe

References

- Abas, M., Vanderpryl, J., Le Prou, T., Kydd, R., Emery, B., & Foliaki, S A. (2003). Psychiatric hospitalisation: Reasons for admission and alternatives for admission to South Auckland, New Zealand. *Australian and New Zealand Journal of Psychiatry*, 37(5), 620-625.
- Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., & Normand, J. (2003). Culturally competent health care systems. *American Journal of Preventive Medicine*, 24(3), 68 -79.
- Arnold, C.F., & Bruce, A. (2005). Nursing practice with Aboriginal communities: Expanding worldviews. *Nursing Science Quarterly*, 18, 259-263.
- Ashton, J. (1992). Professor Eru Pomare – comfortably straddling two worlds. *Health*, 41(2),12-14.
- Australian Nursing and Midwifery Council. (2005). *National competency standards for the Registered Nurse*. Dickson, ACT Australia: Author.
- Bacal, K., Jansen, P., & Smith, K. (2006). *Developing cultural competency in accordance with the Health Practitioners Competency Assurance Act*. *New Zealand Family Physician*, 33(5), 305-309.
- Barlow, C. (2001). *Tikanga whakaaro: Key concepts in Maori culture*. Melbourne: Oxford Press.
- Baxter, J., Kingi, T.K., Tapsell,R., Durie,M.H., & McGee, M.A. (2006). Prevalence of mental disorders amongst Maori in Te Rau Hinengaro: The New Zealand mental health survey. *Australian and New Zealand Journal of Psychiatry*, 40, 914-923.
- Baxter, J. (2007). Mental health: Psychiatric disorder and suicide. In B. Robson & R. Harris (Eds.), *Hauora: Maori Standards of Health IV. A study of years 2000-2005* (pp. 121-139). Wellington, NZ: Te Ropu Rangahau Hauora a Eru Pomare.

- Baxter, J. (2008). *Maori mental health needs profile: A review of the evidence summary*. Palmerston North, NZ: Te Rau Matatini.
- Bishop, R. (1998). Freeing ourselves from neocolonial domination in research: A kaupapa Maori approach to creating knowledge. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 109-138). Thousand Oaks, CA: Sage Publications.
- Blumer, H. (1968). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice Hall.
- Boulton, A. F. (2005). Provision at the interface: The Maori mental health contracting experience. Unpublished doctoral thesis, Massey University, Palmerston North, New Zealand.
- Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57,181-217.
- Campinha Bacote, J. (1995). The quest for cultural competence in nursing care. *Nursing Forum*, 30, 4.
- Campinha–Bacote, J. (2002). The process of cultural competence in the delivery of health care services: A model of care. *Journal of Transcultural Nursing*, 13, 181-184.
- Canales, M.K., Bowers,B.J., & Norton,S. (n.d.) Becoming part of a community: Teaching strategies of Latina nursing faculty. *Nursing and Health Care Perspectives*, 21(3), 228-233.
- Charon, J. (1998). *Symbolic interactionism: An introduction, an interpretation, an integration* (6th ed.). New Jersey: Prentice Hall.
- Charmaz, K. (2005). Grounded theory in the 21st Century. Applications for advancing social justice studies. In N.K. Denzin & Y.S. Lincoln (Eds.),

The Sage handbook of qualitative research (3rd ed., pp. 507-536). Thousand Oaks, CA: Sage Publications.

Chenoweth, M. L., Jeon, Y. H., Goff, M., & Burke, C. (2006). Cultural competency and nursing care: An Australian perspective. *International Nursing Review*, 53(1), 34-40.

Close, B. (2005). Walking in two worlds. *Kai Tiaki Nursing New Zealand*. [ed. Not known].

Cram, F. (2001). Rangahau Maori: Tona tika, tona pono: The validity and integrity of Maori research. In M. Tolich (Ed.), *Research in ethics in Aotearoa* (pp. 35-52). Auckland, NZ: Longman.

Cram, F., & Smith, L. (2003). Maori women talk about accessing health care. *He Pukenga Korero*. 7, 1-8.

Cunningham, C. (2000). A framework for addressing Maori knowledge in research, science and technology. *Pacific Health Dialogue*, 7(1), 62-69.

DeSouza, R. (2008). Wellness for all: The possibilities of cultural safety and cultural competence in New Zealand. *Journal of Research in Nursing*, 13, 125-135.

Durie, M.H. (1994). *Whaiora: Maori health development*. Australia: Oxford University Press.

Durie, M.H. (1996). *Characteristics of Maori health research*. Paper presented at the Hui Whakapiripiri, Hongoeka Marae, Wellington.

Durie, M.H. (1997). Maori cultural identity and its implications for mental health services. *International Journal of Mental Health*, 26(3), 23-35.

Durie, M. H. (2001a). *Mauri ora: The dynamics of Maori health*. Auckland, NZ: Oxford University Press.

- Durie, M.H. (2001b). Cultural competence and medical practice in New Zealand. *Paper presented at the Australian and New Zealand Boards and Council Conference in Wellington*. Palmerston North, NZ: Massey University.
- Durie, M.H. (2005a). *Nga tai matatu, Tide of Maori endurance*. Australia: Oxford University Press.
- Durie M. H. (2005b). Whanau as a model for early intervention in conduct disorders. *A paper presented to Severe Conduct Disorder Conference*. Wellington: Massey University.
- El Badri, S. M., & Mellsop, G. (2002). A study of the use of seclusion in an acute psychiatric service. *Australian and New Zealand Journal of Psychiatry*, 36, 399-403.
- El Badri, S. M., & Mellsop, G. (2006). Aggressive behavior in an acute general adult psychiatric unit. *Psychiatric Bulletin*, 30,166-168.
- Elder, H. (2008). Ko wai ahau? (Who am I?) How cultural identity issues are experienced by Maori psychiatrists and registrars working with children and adolescents. *Australian Psychiatry*, 16(3), 200-203.
- Fisher, J. (2002). Fear and learning in mental health settings. *International Journal of Mental Health Nursing*, 11, 128-134.
- Foote, N. (1951). Identification as the basis for theory motivation. *American Sociological Review*, 16,14-21.
- Forster, M. (2003). Te Hoe Nuku Roa: A journey towards Maori centred research. *Ethnobotany Research and Applications*. Retrieved December 18, 2008 from scholarspace.manoa.hawaii.edu/handle/10125/130.
- Friere, P. (1996). *Pedagogy of the oppressed*. (M. Bergman Ramos, Trans.). London: Penguin. (Original work published 1976)

- Gibbs A., Dawson J., Forsyth H., & Mullen R.(2004). Maori experience of community treatment orders in Otago, New Zealand. *Australian and New Zealand Journal of Psychiatry*, 38, 830 -835.
- Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1992). *Emergence vs forcing: Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (2002). *The grounded theory perspective: Conceptualization contrasted with description*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (2003) *The grounded theory perspective II Descriptions Remodelling of Grounded Theory Methodology*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine Publishing.
- Happell, B. (1999). When I grow up I want to be a ...? Where undergraduate student nurses want to work after graduation. *Journal of Advanced Nursing*, 29(2), 499-505.
- Health Funding Authority. (1999). *Kia tu kia puawai: A purchasing guide*. Wellington NZ: Health Funding Authority.
- Health Practitioner Competency Assurance Act (2003)
- Health Research Council of New Zealand. (2008). *Guidelines for researchers on health research involving Maori*. Auckland, NZ: New Zealand Health Research Council.

- Henry, E., & Pene, H. (2001). Kaupapa Maori: Locating indigenous ontology, epistemology and methodology in the academy. *Organization Speaking Out*, 8(2), 234 -242.
- Jacelon, C. S. (1997). The trait and process of resilience. *Journal of Advanced Nursing*, 25, 123-129.
- Jackson, D., Firtko, A., & Edenborough, M. (2007). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: A literature review. *Journal of Advanced Nursing*, 60(1), 1-9.
- Jackson, J.M. & Poananga, A. (2001). *The two house model*. Wellington, NZ: Family Commission.
- Johnstone, M.J., & Kanitaki, O. (2007). An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context. *Journal of Transcultural Nursing*, 18, 247-256.
- Kempthorne, A. (2006). *Why do nurse graduates choose to work in the area of mental health?* An unpublished Master's thesis, Victoria University of Wellington, New Zealand.
- King, M. (1992). *Te ao hurihuri: Aspects of Maoritanga*. Auckland, NZ: Reed Publishers.
- Koltko-Rivera, M. E. (2004). The psychology of worldviews. *Review of General Psychology*, 8(1), 3-58.
- Krueger, R. A., & Casey, M. A. (2000). *Third edition focus groups a practical guide for applied research*. Thousand Oaks, CA: Sage.
- La Noue, D. (2000). *The spiritual legacy of Henri Nouwen*. New York: Continuum International Publishing Group.
- Lange, R. (1999). *May the people live: A history of Maori health development 1900 -1920*. Auckland, NZ: University of Auckland.

- Leininger, M. (2002). Culture care theory: A major contribution to advance transcultural nursing knowledge and practices. *Transcultural Nursing*, 13(3), 189-192.
- Leininger, M. (2007). Theoretical questions and concerns: Response from the theory of culture care diversity and universality perspective. *Nursing Science Quarterly*, 20(1), 9-15.
- Leishman, J. (2004). Perspectives of cultural competence in health care. *Nursing Standard*, 19(11), 33-38.
- Lowe, J., & Struthers, R. (2001). A conceptual framework of nursing in Native American culture. *Journal of Nursing Scholarship*, 33(3), 279-283.
- McClelland, A. (2006). How can nurses support Maori nursing students to succeed in a degree programme? *New Zealand Nursing Review*, 7, 7-9.
- Mahoney, J.S., Carlson, E., & Engebretson, J.C. (2006). A framework for cultural competence in advanced practice psychiatric and mental health education. *Perspectives in Psychiatric Care*, 42(2), 227-237.
- Manderson, K., & Allotey, P. (2003). Cultural politics and clinical competence in Australian health services. *Anthropology and Medicine*, 10(1), 71-85
- Mason, K., & Ryan, A. (1998). *The Psychiatric Report 1988*. The Committee of Inquiry into Procedures used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients.
- McKenna, B. G., Poole, S. J., Smith, N. A., Coverdale, J. H., & Gale, C. K. (2003). A survey of threats and violent behaviour by patients against registered nurses in their first year of practice. *International Journal of Mental Health Nursing*, 15, 56-63.
- Mead, H. R. (2003). *Tikanga Maori living by Maori values*. Wellington, NZ: Huia Publishers.

- Mealing, D., & Sawicka T. (1997). Living in two worlds: The history of a process. A conference presentation of the Museums Association of Aotearoa. *New Zealand Museum Journal*. 26, 2, 58-61.
- Mental Health Commission (1998). *The blueprint for mental health services in New Zealand*. Wellington, NZ: Author.
- Mental Health Commission. (2001). *Recovery competencies for New Zealand mental health workers*. Wellington, NZ: Author.
- Mental Health Commission. (2004). *Delivery of cultural assessment for Maori 2004*. Wellington, NZ: Author.
- Minichiello, V. (2003). *Handbook of research methods for nursing and health science* (2nd 3ed.). Sydney, Australia: Prentice-Hall.
- Ministry of Health. (1994). *Looking forward: Strategic directions for the mental health services*. Wellington, NZ: Author.
- Ministry of Health. (1997a). *Moving forward: The national mental health plan for more and better services*. Wellington, NZ: Author.
- Ministry of Health (1997b). *The national mental health sector standards*. Wellington, NZ: Author.
- Ministry of Health. (2002). *Te puawaitanga Maori mental health national strategic framework*. Wellington, NZ: Author.
- Ministry of Health. (2005a). *Tauawhitia te wero Embracing the challenge: National mental health and addiction workforce development plan 2006-2009*. Wellington, NZ: Author.
- Ministry of Health. (2005b). *Te tahuu: Improving mental health 2005-2015*. Wellington, NZ: Author.
- Ministry of Health. (2006). *Te kokiri: The mental health and addiction action plan 2006 -2015*. Wellington, NZ: Author.

- Ministry of Health. (2008). *Te puawaiwhero the second maori mental health and addiction national strategic framework 2008-2015*. Wellington, NZ: Author.
- Nursing Council of New Zealand. (2002). *Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing, midwifery education and practice*. Wellington, NZ: Author.
- Nursing Council of New Zealand. (2005). *Competencies for the registered nurse scope of practice*. Wellington, NZ: Author.
- O'Brien, A., P., Boddy, J., Hardy, D.J., & O'Brien, A.J. (2004). Clinical indicators as measures of mental health nursing standards of practice in New Zealand. *International Journal of Mental Health Nursing*, 13, 17-88.
- Olsen, M. E., Lodwick, D. G., & Dunlap, R. E. (1992). *Viewing the world ecologically*. Boulder: Westview Press.
- Pere, R. (1984). The health of the family. *New Zealand Health Review*, 4, 4.
- Pipi, K., Cram, F., Hawke, R., Hawke, S., Huriwai, T.M., Mataki, T., et al. (2004). A research ethic for studying Maori and Iwi provider success. *Social Policy Journal of New Zealand*, 23, 141- 153.
- Ponga, L.N., Maxwell-Crawford, K.M., Ihimaera, L.V., & Emery, M.A. (2004). *Macro analysis of the Maori mental health workforce*. Palmerston North, NZ: Te Rau Matatini.
- Ramsden, I. R. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu*. An unpublished doctoral thesis, Victoria University of Wellington, New Zealand.
- Rangahau, J. (1992). Being Maori. In M. King (Ed.), *Te Ao Hurihuri. Aspects of Maoritanga* (pp 183-190). Auckland, NZ: Reed Publishers.

- Ratima, M., Waetford, C., & Wikaire, E. (2006), Cultural competence for physiotherapists: Reducing inequalities in health between Maori and non Maori. *New Zealand Journal of Physiotherapy*, 34(3),153-159.
- Ratima, M., Brown, R., Garrett, N., Wikaire, E., Ngawati, R., Aspin, C., & Potaka, U. (2007). *Rauringa Raupa recruitment and retention of Maori in the health and disability workforce*. Auckland, NZ: Taupua Waiora Auckland University of Auckland.
- Richardson, F., & Carryer, J. (2005). Teaching cultural safety in a New Zealand nursing education program. *Journal of Nursing Education*, 44(5), 201-208.
- Robertson, P., Haitana, T., Pitama, S., & Huriwai, T. (2006). A review of workforce development literature for the Maori addiction treatment field in Aotearoa/ New Zealand. *Drug and Alcohol Review*, 25, 223-239.
- Royal, T.C. (2003). *The woven universe. Selected writings of Reverend Maori Marsden*. Masterton, NZ: Printcraft 81 Ltd.
- Ruwhiu, P., & Ruwhiu, L. (2005). Ko te pae o te atua mai I nga whakaaro hohonu nei, hei oranga mo te ira tangata. *Social Work Review*, 17(2), 4-9.
- Salmond, A. (1991). *Two worlds: First meeting between Maori and Europeans 1642 -1772*. Auckland, NZ: Penguin Books.
- Salmond, A. (1997). *Between two worlds: Early exchanges between Maori and Europeans 1773 – 1815*. Auckland, NZ: Penguin Books.
- Schreiber, R.S., & Stern, P.N. (2001). *Using grounded theory in nursing*. New York: Springer Publishing.
- Sherwood J., & Edwards T. (2006). Decolonisation: A critical step for improving Aboriginal health. *Contemporary Nurse*, 22, 178-190.
- Shirres, M.P. (1997). *Te tangata: The human person*. Auckland, NZ: Accent Publications.

- Simon, V. N. (2000). *Characterising Maori nursing practice*. A Master's degree dissertation, University of Waikato, Hamilton, New Zealand.
- Simon, V. N. (2006). Characterising Maori nursing practice. *Contemporary Nurse*, 22, 203- 213.
- Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples*. London: Zed Books.
- Spoonley, P. (1999). *The challenge of cross cultural research*. In C. Davidson & M. Tolich, *Social science research in New Zealand: Many paths to understanding* (pp. 51-61). Auckland, NZ: Pearson Education.
- Sporle, A., & Koea, J. (2004a). Maori responsiveness in health and medical research: Key issues for researchers (part 1). *The New Zealand Medical Journal*, 117, 1199.
- Sporle, A., & Koea, J. (2004b). Maori responsiveness in health and medical research: Clarifying the roles of the researcher and the institution (part 2). *The New Zealand Medical Journal*, 117,1199.
- St Clair, A., & McKendry, L. (1999). Preparing culturally competent practitioners. *Journal of Nursing Education*, 38(5), 228-234.
- Strauss, A. L., & Corbin, J. (1997). *Grounded theory in practice*. Thousand Oaks, CA: Sage.
- Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative research techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.
- Struthers, R., Lauderdale, J., Nichols, L., Tom Orme, L., & Strickland C.J. (2005). Respecting tribal traditions in research and publications: Voices of five Native American nurse scholars. *Journal of Transcultural Nursing*, 16(3), 193 -201.

- Tangaere, A. R. (1997). Maori human development in learning theory. In P. Te Whaiti, M. McCarthy & A. Durie (Eds), *Mai i Rangiatea: Maori wellbeing and development* (pp. 46-59). Auckland, NZ: Auckland University Press.
- Te Ao Maramatanga College of Mental Health Nurses. (2004). *Te Ao Maramatanga College of Mental Health Nurses Standards of Practice*.
- Te Puni Kokiri (1993) *Nga ia o te oranga hinengaro Maori*. Wellington, NZ: Te Puni Kokiri.
- Te Rau Matatini. (2006). *Kia puawai te ararau: The Maori mental health workforce development strategic plan*. Hamilton, NZ: Kaitoro Publishers.
- Webby, A. (2001). Developing safe nursing practice for Maori. *Kai Tiaki Nursing New Zealand*, 7(1), 16-17.
- Webster, J., & Bosmann –Watene, G. (2003) Walking in two worlds: A critique of the diagnostic and statistical manual of mental disorders from a perspective of Te Ao Maori. *Social Work Review*, 15(3), 8-11.
- Wilson, D. (2004). Nga kairaranga oranga The weavers of health and wellbeing: A grounded theory study. An unpublished doctoral thesis, Massey University, Wellington, New Zealand
- Woodroffe, A., & Spencer, M. (2003). Culturally and ethnically diverse communities: Building blocks for working relationships. *Child Welfare*, LXXXII(2), 169-183.

Appendix I

Ethical Approval



OFFICE OF THE DEPUTY VICE-CHANCELLOR
(Auckland & International)
Private Bag 102 904
North Shore MSC
Auckland
New Zealand
Deputy Vice-Chancellor (Auckland & International)
T 64 9 414 0800 extn 9517
Regional Registrar (Auckland)
T 64 9 414 0800 extn 9516
F 64 9 414 0814
www.massey.ac.nz

30 April 2007

Maria Baker
c/- Dr D Wilson
College of Humanities and Social Sciences
Massey University
Albany

Dear Maria

HUMAN ETHICS APPROVAL APPLICATION – MUHECN 07/015
"What is Occurring Amongst Maori Mental Health Nurses and Dual Competencies?"

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

A handwritten signature in purple ink that reads "Ann Dupuis".

Associate-Professor Ann Dupuis
Acting Chair,
Human Ethics Committee: Northern

cc: Dr D Wilson
College of Humanities and Social Sciences

Appendix II

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

What is Occurring Amongst Maori Mental Health Nurses and Dual Competencies?

Ko Whakatere me Maunga Pohatu nga Maunga, Ko Waima me Karae nga Awa; Ko Hokianga Whakapau Karakia te Moana, Ko Mahurehure me Ihutai nga Hapu , Ko Ngapuhi me Te Rarawa nga Iwi; ko Maria Baker taku ingoa.

Kia Ora koutou nga Rangatira ma;

I am a postgraduate student at Massey University, and as a part of the completion of my Masters Degree, I am undertaking a research project under the supervision of Dr Denise Wilson. My background is mental health nursing; and I am interested in exploring what Maori Mental Health Nurses views are about dual competencies; that is cultural and clinical competencies. I would like to invite Maori nurses who are members of Te Ao Maramatanga (College of Mental Health Nurses) to participate within focus groups to discuss dual competencies.

If you choose to participate in this research, a focus group will be created with other interested Maori mental health nurses. The focus group sessions should take no longer than two (2) hours and will be conducted by myself. The focus groups will be audio taped. Written informed consent will be obtained from willing participants prior to the focus group. Once the focus group discussions have been completed, the data will be transcribed. All personal information including names will be removed.

Confidentiality

All information obtained in this research will be treated with confidence. To ensure confidentiality pseudonyms/codes will be used instead of real names. Access to any data during the study will be restricted to me and my Supervisor (Dr Denise Wilson). All research information will be locked in a filing cabinet. My supervisor and I will be the only person with access to this. On completion of the research data will be locked and stored for a minimum of five years, and then destroyed by the Massey University School of Health Sciences.

Participation

Participating in this research is entirely voluntary. Participants have the right to withdraw up until the completion of the focus group interviews.

Distribution of Findings

The findings of the research will be submitted for examination and submitted as a thesis to Massey University's School of Health Sciences at Albany. A summary report of the findings of the research will be made available at the end of the project for all research participants if they wish to receive a copy. The research findings will be published in professional journals, and possibly at conferences. No information identifying individuals will be presented.

Further Information

If you require further information or have any issue with this research please feel free to contact either:

Maria Baker

or Dr Denise Wilson

School of Health Sciences – Auckland
Massey University
Private Bag 102 904
North Shore Mail Centre
Phone 021 373 428
E-mail mariab@nhl.co.nz

School of Health Sciences - Auckland
Massey University
Private Bag 102 904
North Shore Mail Centre
Phone 09 414 0800 ext. 9070
E-mail D.L.Wilson@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 07/015. If you have any concerns about the conduct of this research, please contact Associate Professor Ann Dupuis, Acting Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9054, email humanethicsnorth@massey.ac.nz.

DISCLAIMER

Te Ao Maramatanga is sending these participant forms on my behalf; your anonymity has been maintained throughout this process. If you want to be involved, please contact direct:

Maria Baker – 021 373 428
E-mail mariab@nhl.co.nz

Appendix III

Participant Consent Form

What Is Occurring Amongst Maori Mental Health Nurses And Dual Competencies?

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I..... (Participant)

confirm that I have read the Information Sheet and I have had the details of the study explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet, and:

1. I agree to not disclose anything discussed in the Focus Group
2. I agree to the focus group discussion being audio taped,
3. I agree to the information shared in the Focus Group being for the findings being published in a research thesis and in peer reviewed journals.
4. I understand that I can withdraw from this study up until the focus group interviews has been completed

I wish to receive a summary of the findings of this study (please tick)

Signature:

.....

Date:

Full Name - printed

.....

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application _07_/015__. If you have any concerns about the conduct of this research, please contact Associate Professor Ann Dupuis, Acting Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9054, email humanethicsnorth@massey.ac.nz