Exploring Māori and non-Māori mental health nurses' perceptions of Te Whare Tapa Whā

A mixed methods study looking at Māori and non-Māori mental health nurses' perceptions of Te Whare Tapa Whā within the Waikato region.

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Pepeha

Ko Taupiri te maunga,

Ko Waikato te awa,

Ko Tainui te iwi

Ko Rukumoana te marae

Ko Ngati Haua te hapu

Ko Samantha Teinakore toku ingoa

Abstract

Background: Te Whare Tapa Whā is a well-recognised Māori model of health and wellbeing which is embraced within the health system in Aotearoa/ New Zealand. Although it can be applied in different specialties, the impacts generated from this model were first noticed in mental health, as this model was created by Mason Durie who is a psychiatrist. Research has shown this model provided an opportunity for Māori to have a voice in their health.

Objective: This study aims were to explore mental health nurses' perceptions of the Māori Health model, Te Whare Tapa Whā, and how their beliefs and values may impact them implementing this model into their care.

Methods: A mixed methods approach was utilised for this study. Phase one was about gathering quantitative data, collecting statistical data through surveys. The first phase helped with the formulate interview schedule, which was the beginning of the next phase. Phase two was semi structured interviews which helped with the gathering of qualitative data. Data were analysed using descriptive statistics and thematic analysis.

Participants: Mental health nurses within the Waikato region were the participants for this research study. A survey was distributed to mental health nurses in the Waikato area and 53 responded. After the survey, semi structured one on one interviews were conducted with the researcher. Total of 8 interviews; (n = 6) Māori mental health nurses and (n = 2) Non-Māori mental health nurses.

Results: The survey showed that more than half the nurses had a positive perspective on Te Whare Tapa Whā and felt it was good for nursing care. They were able to identify barriers to implementation. There were mixed responses on feeling supported to use Te Whare Tapa Whā in the workplace. Four over-arching themes were identified from the interviews . These were; Māori, clinical practice, organisation level and individual factors.

Conclusion: Overall, all mental health nurses had a positive perception of Te Whare Tapa Whā and the impacts it can have on nursing care. Most identified barriers which can impact whether they can actually use it in practice. Māori and non-Māori nurses had different depths of knowledge, cultural worldviews and clinical practice experiences, creating complexities with implementation. These beliefs, perceptions and experiences were highlighted in this study.

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To God be the glory

Contribution

I the student undertook all aspect of this study under the direct guidance of my supervisors. This entailed conceptualising the study, identifying the study question, designing the study, collecting and analysing the data, and writing the thesis report.

Table of contents

List of tables and figures

Glossary

Kanohi – te – kanohi – face to face

Hapu -sub-tribe

Hauora - wellbeing

Iwi -tribe

Kaitakawaenga - cultural support team at the hospital

Karakia - prayer

Kaupapa Māori - something that is delivered from a Māori, approach, principle and ideology

Kohanga - Māori preschool

Mahi - work

Manaakitanga - hospitality, generosity, kindness

Mātauranga Māori - Māori knowledge

Mirimiri - massage

Noa-a state of normality; when the scaredness is lifted

Pepeha - a semi set structure which a person uses to introduce who they are

Rongoa -Māori medicine

Tangata whaiora - person seeking wellness, service user

Tangi - funeral

Tapu - sacred or prohibited

Te Tiriti o Waitangi/Te Tiriti - Treaty of Waitangi

Te Whatu Ora - New Zealand Health. The merging of the District Health Boards into one health system which is now known as Whatu Ora

Tikanga - practice or procedure

Tohunga - skilled person, chosen expert, healer

Waiata - song

Whakapapa - genealogy

Whakawhanaungatanga - building connections

Whānau – family

(Source: Te Aka Māori Dictionary (https://maoridictionary.co.nz/).

Chapter I. Introduction

Te Whare Tapa Whā is a well-established Māori health model which was created by Sir Mason Durie in 1984 (Pitama et al., 2007). Since its development, Te Whare Tapa Whā has impacted the way Māori non-Māori nurses provide care for Māori, particularly within mental health. Te Whare Tapa Whā provides an indigenous worldview within a predominantly westernised health system to promote the importance of holistic care in Aotearoa/ New Zealand. The reason I chose to explore this topic was due to both personal and clinical experience. It is evident that the mental health system has a large population that identify as Māori, with 'being Māori' coming from individualised perspectives. There are those who grew up in kohanga, are immersed in tikanga and mātauranga Māori their entire lives while others have little exposure to their traditional Māori culture but want to learn more. It is important health professionals understand this concept, as cultural values and identity play an important factor in nursing care. Health disparities and inequities are prevalent within Māori communities, leading to poorer health and increased rates of avoidable early mortality.

Before the 1980's mental health care was delivered solely from a western biomedical perspective, and was dominated by that, but recently a Māori perspective is being more recognised (Durie, 2011). This thesis explores the perceptions of Māori and non-Māori mental health nurses of Te Whare Tapa Whā. A mixed methods study was conducted, utilising a survey and interviews to collect data. The intention of this study was to understand the views, perceptions, and beliefs of mental health nurses, and how they impact them implementing Te Whare Tapa Whā into their nursing care. Nurses play an important role in the care of tangata whaiora as they spend a lot of time with them building rapport and advocating to make sure their voices are heard. The current chapter will look at nursing, particularly looking into the development of mental health nursing and key areas that have influenced it like, colonisation, Māori health and models of health with a focus on Te Whare Tapa Whā.

Background

1.1 Nursing

Nursing is one of the oldest health professions, and nurses make up the largest proportion of the professional health workforce. The nursing workforce It's a workforce that is dominated by the female population due to its perception as a nurturing role, but over time care has become more advanced and continues to encourage men to join the workforce (Curtis et al., 2009). Some of the changes that have occurred include expanding skill sets and medical knowledge. Through this development, modern nursing is based on the fundamental practices such as the nursing process and professional governance by nursing organisations which ensure safe practices are upheld. As mentioned by Zamanzadeh et al. (2015) the term 'nursing process' was first introduced in 1955 by Hall but a framework was not created until 1961 by Orlando who was a nursing theorist (Orlando, 1972). Since then, the term 'nursing process' has been evaluated and interpreted by different authors and scholars, which has shaped it into the concept used today. The nursing process is a systematic guideline for client focussed care which consists of five steps; assessment, diagnosis, planning, implementation, and evaluation (Bastable, 2021). Just as nursing in general has evolved, so too have the practices and standards of mental health nursing.

1.2 Mental health nursing

Those experiencing mental illness can feel stigmatised and stereotyped, branded for their mental health problems, which has been a problem for centuries (Hinshaw, 2007). Well into the eighteenth century, in Europe, mental illness was equivalent to a crime, placing those who were mentally unwell in the same category as a prisoner (Durie, 2001). It took time for a shift in the approach to mental health, but as the world started to change, so did New Zealand. As stated by Durie (2011), as early as 1844 New Zealand started to build asylums throughout the country, some being attached to prisons and others intended for the general public. Although this shift was a huge movement, it shows that society still correlated mental illness to crime, creating a new but more freeing type of imprisonment. Asylums were a place of security more than safety, serving the interest of society and less

for the individual being admitted, providing nonspecific treatment which nowadays most are considered barbaric practices (Durie, 2001). Mental health was not understood, and had not been properly defined yet, as it was more of a place for those societally different.

Over time, slight progression was made as terminology changed from asylums to psychiatric hospitals, in the hopes to reduce stigma (Durie, 2001). As described by Durie (2011), psychiatric hospitals were often located rurally and often not identified as a place of healing, continuously reinforcing that mental illness was not like other illnesses. Mental health was looked down on, criminalised and used to remove people from society, but more change happened in the 1970s. During this period, the mental health system saw another change, where psychiatric hospitals started to de-institutionalise and community care started to surface and provide the necessary care in the community (Durie, 2011; Tudor et al., 2018). This meant that people were not hidden away from society, but able to be provided support for their mental health and still be more connected to others and their daily lives. Overall, recognising these changes for the population has proven to be important for the evolution of mental health, but unfortunately it has not worked well for all, especially Māori.

The trends for Māori since de-institutionalisation have been less than favourable, resulting in more admissions and the presence of mental health being more concerning. For example, before 1970s admissions for Māori into psychiatric hospitals were lower than non-Māori, but between 1980s -1990s there was a spike in admission rates for Māori which was alarming (Baxter et al., 2006). So, although theoretically deinstitutionalisation should have decreased rates, it had an opposite effect. The cause for this is not straightforward, but something more complex. Furthermore, Baxter et al. (2006) noticed a specific pattern for admission referrals, that it was most likely though the justice system than primary or secondary health care. In conclusion, all these changes that impacted positively on the majority in society, meant more Māori were being admitted, through the justice system, reinforcing old beliefs and connections of mental illness and criminals.

1.3 Policies and the reshaping of the health system

In New Zealand, the health system is going through extensive changes, moving away from District Health Boards (DHBs) and merging into Te Whatu Ora (Health New Zealand) (Future of Health, 2023). This will mean health will operate one system for all of New Zealand. In the He Ara Oranga report (2018) explained how the last mental health inquiry was conducted in 1995-1996 after concerns were raised, which led to the move towards deinstitutionalisation. This was a major shift for mental health in New Zealand, but despite the positive impacts there continues to be poorer outcomes for certain groups such as Māori. In the He Ara Oranga report, a recommendation which was suggested to be handled with urgency was establishing a mental health commission to monitor the mental health system (He Ara Oranga, 2018). In order to monitor, a Service Quality Framework has been created and been broken into six domains to evaluate different aspects of service quality (Ministry of Health., n.d.). Since the development of this role, a report has already been published. The shift stems from a mindset change, from illness approach to a wellbeing approach (He Ara report, 2018). These are reflected in the Commissioner's report. Two frameworks have been created, He Ara Oranga Wellbeing Outcomes Framework, looking at Wellbeing from a Te Ao Māori perspective and a shared perspective, and the Pathways to Support framework which measures how services met the populations needs (New Zealand Mental Health and Wellbeing Commission, 2021).

1.4 Māori within mental health

Mental health continues to be a big concern for Māori, with statistics still showing that Māori are disproportionately struggling. Wilson and Baker (2012) revealed that from the national survey that more than 50% of Māori struggle with health issues relating to their mental wellbeing. Further statistics showing that Māori are 3.7 times more likely to be placed on a community treatment order, 3.2 times more like to be placed on an inpatient treatment order and 5.1 times more likely to be secluded (Ministry of Health, 2020). Māori have different experiences within the mental health system on all levels of interaction and engagement compared to non-Māori. Different experiences can be seen in; diagnosis, acuity, admissions, readmissions, and forensic mental health cares (Rangihuna et al., 2018).

These differences create barriers to allow Māori to have better mental health outcomes, making it harder to receive the care and treatment they need to recover.

Māori are highly represented as tangata whaiora or person seeking wellness, but are disproportionally represented in the nursing workforce. This was seen in the statistics gathered in 2019 by the Nursing council of New Zealand. In March 2019, there was a total of 54,091 nurses, out of 51,700 registered nurses 8% identify as Māori and out 2,391 enrolled nurses 10% identify as Māori (Nursing Council of New Zealand, 2020). Looking at this in contrast with the total Māori population which is 850,500 (16.7%) is disproportional (Statistics New Zealand, 2020). These statistics represent the total nursing workforce in all areas. In mental health, there are 716 Māori nurses, working in both inpatient and community settings (Nursing Council of New Zealand, 2020). Although nursing practice has particular standards, Māori have their own set of tikanga, which shape and create Māori nursing practice. An important aspect of this is being recognised as Māori and working in a Māori manner (Brannelly et al., 2013). Although nurses are all governed under the same standards of practice, these differences are What make Māori nurses different from non-Māori.

1.5 Colonisation and the effects on mental health

Axelsson et al. (2016) acknowledge that in order to achieve equitable health outcomes for Māori, there needs to be an understanding of What causes inequities. These causes can be traced back to colonisation. Prior to colonisation, Māori lived a collectivist lifestyle. With colonisation, came a shift in health from a communal concern to the responsibility of an individual (Johnstone & Read, 2000). Māori were forced to adapt, a change that continues to result in Māori facing disparities and inequities, especially health.

When the British explorers came across Aotearoa, coming into contact with the indigenous population, a treaty was created, Te Tiriti o Waitangi. Te Tiriti is an agreement between the British Crown and Māori, to help maintain the peace so that they could live together. However, the English translation was illegitimate, leading to the British and Māori agreeing to different terms and conditions. This allowed the colonial rules to be legalised as pointed

out by Jordan et al. (2021), further described colonisation as the catalyst, for exploitation, marginalisation and land confiscation by the British (Moewaka Barnes & McCreanor, 2019). Following the signing of Te Tiriti Māori began to lose a sense of direction and self, resulting in increased loss and hardship amongst tangata whenua. Moewaka Barnes and McCreanor (2019) reiterated that the period from 1860 to 1890 was a traumatic time for Māori. More recently the effects of colonisation are becoming more recognised including the effects on indigenous populations. However, this interpretation of colonisation can be controversial, with some people calling colonisation a historical event, instead of recognising that the effects are still continuously affecting Māori (Axelsson et al., 2016).

Colonisation is seen as an act of dominance, with elements of elimination and coercive exploitation as a motive (Paradies, 2016). For Māori this has been evident since the signing of Te Tiriti, where society is dominated by a westernised perspective. Colonial dominance was explored by Jordan et al. (2021), who mentioned that colonisation was a way to ensure Māori language, worldviews and tikanga were not practised, but now we recognise the need to embrace bicultural practices that Māori and western are both valid. Although the impact of colonisation is seen in multiple systems, it is prevalent in the health system, with Māori having high mortality rates and poorer health outcomes (Axelsson et al., 2016). A speciality recognised by Wilson and Baker (2012) is the surge since the 1970s of mental health problems for Māori, identified as a major health concern.

1.6 Models of care

Westernised models of care continue to dominate the health system, even with their evolution to become more holistic like the biopsychosocial model, they maintain limitations to help Māori. In recent decades, there has been a multitude of Māori models of health, with a handful gaining traction nationally. These include Te Wheke, Pounamu and Meihana model. Te Wheke, known as the octopus, the head representing whānau and the eyes represent wairua, and the eight different components of health equivalent to each tentacle (Love, 2004). Te Pounamu was created as a Māori model for mental health, which looks at assessment and treatment, targeting six areas in respects to Te Tiriti to empower tangata whaiora (Maana, 2003). The Meihana model, is an extended version of Mason

Durie's Te Whare Tapa Whā, which hopes to fuse clinical and cultural practice to increase Māori health outcomes on the assumption that the clinician has a basic understanding of cultural safety and competency (Pitama et al., 2007). Although these models are embedded with Māori values and perspectives, they provide complexities and depths that not all non-Māori nurses may have been educated on or exposed too. Although we can have aims to incorporate these Māori models in nursing practice in the future, currently now might not be the time.

According to Brannelly et al. (2013) they recognise the importance of Kaupapa Māori services and mainstream services, as some Māori feel more comfortable within the mainstream environment but still need to be given culturally appropriate treatment. Although some of these models outlined recognise mātauranga Māori, they come with complexities that can be challenging for non-Māori nurses to understand, making it less likely to be implemented into their practice. A Māori model of health that respects mātauranga Māori, provides a simplistic insight into Māori health perspective and can be easily incorporated into any situation or setting is Te Whare Tapa Whā.

1.7 Understanding Te Whare Tapa Whā

As described by Durie (1985) Māori perceive health as a four-sided concept which represent the basic necessities of life. Sir Mason Durie was able to take the Māori worldview, gather information for the hui at the marae, and turned it into the model which health professionals know as Te Whare Tapa Whā (Durie, 2011). Te Whare Tapa Whā is represented as a Wharenui (meeting house); which consists of four dimensions. There is spirituality (taha wairua), physical (taha tinana), mental (taha hinengaro) and family (taha whānau), which give a holistic and comprehensive overview of an individual's wellbeing. The first component is taha wairua, which not only acknowledges religion or higher power, but extends to someone's mana and those who have recently deceased (Durie, 1985). The second component is taha hinengaro, which looks at the mental wellbeing, focussing on emotions, thoughts and behaviours. The third component is taha tinana, physical health, which is more familiar to westernised health professionals. Lastly is taha whānau, family.

For Māori, family differs from the westernised construct. Family is not limited to immediate relatives but includes those who are not related by blood.

Te Whare Tapa Whā was the first indigenous Māori model in Aotearoa to be well recognised and utilised within mainstream services in the early 1980s (Pitama et al., 2007). An important concept of Te Whare Tapa Whā is that if one wall or dimension is damaged, it puts the individual at risk of becoming unwell. It provided a foundation for other Māori health models to be created; either building on Te Whare Tapa Whā or encompassing the same principles. For example, there is the Meihana model which took the original dimensions and added two addition elements to it (Pitama et al., 2007). Although it is a Māori health model, it is important to realise that it can apply to all tangata whaiora of all ethnicities.

1.8 A Māori health model – appropriate for all

Te Whare Tapa Whā is referred to as a Māori model of health, designed to help health professionals understand What health and wellbeing means from a Māori worldview. Although this is true, Te Whare Tapa Whā is a model which can be appropriate for all. This is highlighted by Matapo-Kolisko (2021), which acknowledges it being a Māori model, it also recognises that any individual can resonate and relate to these factors of health. Every individual can relate to the factors described in Te Whare Tapa Whā, especially tangata whaiora within the mental health system. Indigenous philosophies promote the personalised and holistic approach, which can be relatable to all New Zealanders (Durie, 2011). Within mental health there is a high population of Māori within the mental health system in New Zealand, but mental health nurses also recognise that ethnic diversity that they deliver care to. By having models that incorporate Māori values and perspectives, but is appropriate for all, allows mental health nurses to give high standard quality of care to everyone. Furthermore, this thinking is emphasised in (McNeil, 2009) which described Te Whare Tapa Whā as an all-inclusive model. Holistic style of care and examining the person as a whole, can improve care for all ethnicities.

1.9. Conclusion

Nursing, in particular mental health nursing has evolved over time, which was intended to improve tangata whaiora outcomes, but unfortunately this did not happen for Māori. These changes were seen in the delivery of care and in the policies that shape our mental health system. A change within health that changed delivery of care and was a milestone for Māori was the introduction of Te Whare Tapa Whā. It gave insight into how to best look holistically at care for Māori in a simplistic but effective way. This model gave Māori a voice within mental health and provided a perspective of how Māori saw health and wellbeing. However, it was important to realise that although it was a Māori perspective, the aspects in the model could be relatable to any culture or ethnic group. Due to the simplicity, it also provided a space for evolution for the model itself to grow and develop, which researchers have done. Te Whare Tapa Whā has played an important part for overall health and wellbeing, Māori mental health and how mental health nurses will provide care for Māori.

This thesis will explore mental health nurses' perceptions of Te Whare Tapa Whā and how this may impact their nursing care. The research questions to be addressed are; What are the different perceptions of Māori and non-Māori nurses of Te Whare Tapa Whā, how well do Māori and non-Māori nurses understand Te Whare Tapa Whā and how does Māori and non-Māori nurses' perceptions of Te Whare Tapa Whā affect how it is implemented into nursing care. This chapter has introduced the research topic of Te Whare Tapa Whā. In the following chapter an integrative literature review is provided, exploring the current literature around this topic, identifying the gap and need for this research. This is followed by the exploration of the methodology and methods which will guide this research, outlined in the methods chapter which explains the approach and steps taken to complete this research. In the last two chapters, the findings are analysed and interpreted, which provoke reflective thinking and recommendation in the discussion chapter.

Chapter II: Literature review

2.1 Introduction

The purpose of a literature review is to investigate literature and summarise the current understanding of a topic (Toronto & Remington, 2020). It is guided by a systematic process, which allows the researcher to critically analyse and correlate findings and identified gaps within the current literature. This provides researchers the appropriate rationale for why their study is important and needs to be conducted. There are several different approaches in which a literature review can be under-taken, but one of the most common nursing approaches is the integrative review (Whittemore & Knafl's, 2005). This chapter presents an integrative review of the literature that focussed on mental health nurses' perceptions' of Te Whare Tapa Whā. An integrative approach provided a wide and diverse context of knowledge, included literature that was empirical or theoretical, or both (Toronto & Remington, 2020). Four themes were identified in the analysis of literature, and are described in this chapter.

2.1.1 Problem identification

The questions for the literature review were the following:

1. How does Te Whare Tapa Whā impact Māori mental health?
2. What has contributed to Māori mental health in the past and currently?
3. What can mental health nurses do for Māori mental health?

2.1.2 Aim

The aim of this integrative literature review was to identify and explore the research that had already been carried out about Te Whare Tapa Whā within mental health, and identify any gap within current literature.

2.1.3 Methods

This integrative literature review used a methodological approach based on Whittemore and Knafl's (2005) framework. This framework provided a systematic and logical approach

to understanding the literature available and identifying the gaps within the current literature. The review process was; problem identification, literature search, data evaluation and data analysis.

2.1.4 Search strategy

A systematic search of four databases was completed: Pubmed Central, Medline, Cochrane Library and CINAHL which was conducted in May 2022. Search terms were based on the researcher's current knowledge of the topic and discussed with supervisors and librarians. Key search terms included:

- Te Whare Tapa Whā
- Indigenous models
- Perceptions
- Beliefs
- Views
- Nurs*
- Nurse
- Mental health
- Mason Durie
- Māori health

No limit was placed on publication date as Te Whare Tapa Whā within mental health has been studied minimally.

2.1.4.1 Inclusion criteria

Mental Health, Māori Mental Health, Te Whare Tapa Whā, indigenous, New Zealand, Māori, nurses, perception OR views OR beliefs, attitudes, nurs* and indigenous health models. Due to research that mentioned Te Whare Tapa Whā being scarce, especially regarding mental health, the search was broadened to include Māori mental health.

2.1.4.2 Exclusion criteria

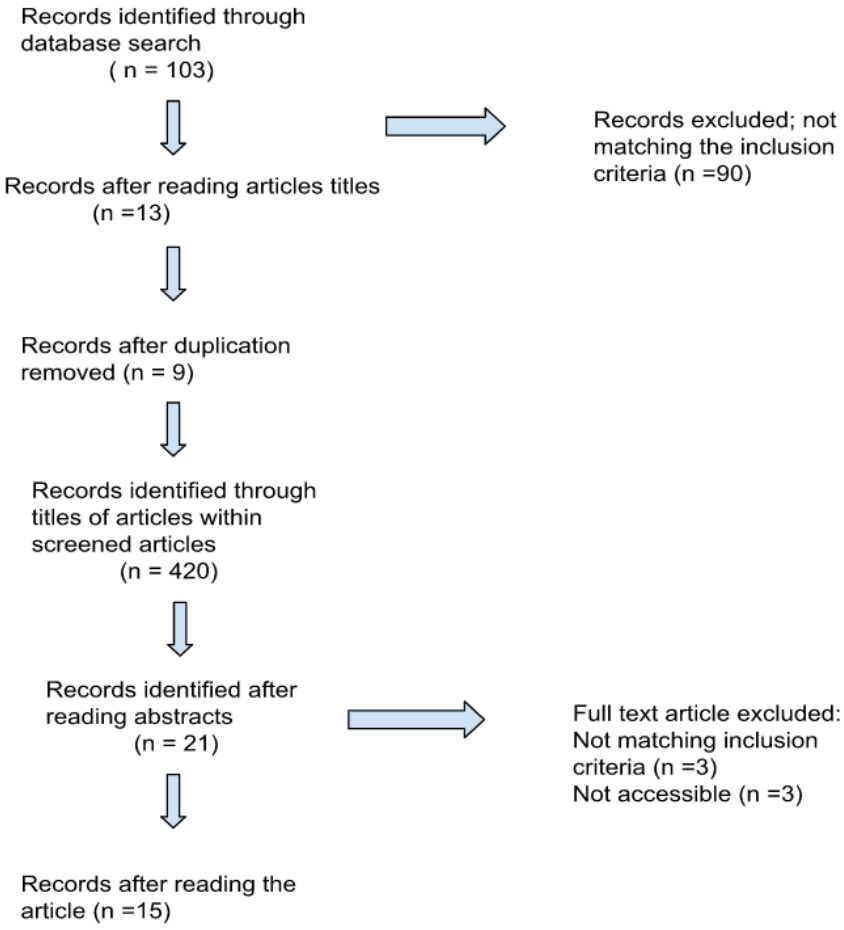
Mental health was not the main focus, indigenous populations outside of Aotearoa, focused on Pacific people, sole focus tangata whaiora/whānau

2.1.5 Selection of articles

The selection process of articles followed the PRISMA guidelines (Moher et al., 2009). This can be seen in the Figure 2.1 below.

Figure 2.1

Study selection



2.1.6 Results

Four databases were searched and there was a total of (n= 103) articles. From the initial articles, (n= 90) were excluded as they did not met the inclusion criteria. This was established from reading the title of the articles, resulting in (n = 13) remaining. Duplicates were removed and the full articles were read, and (n=9) were identified as relevant for the literature review.

Due to limited amount of articles, the final (n=9) article reference lists were screened. Out of the (n = 420) references found from the nine articles, (n = 21) appeared to be relevant. The abstracts were read and (n = 3) were found to not match the inclusion criteria and another (n = 3) were not accessible. This left (n = 15) articles, which the full articles were read, and a further (n = 10) were identified as relevant for the literature review.

A total of 19 articles were included in the integrative literature review. The articles ranged in publication dates, between 1986 and 2021. It was interesting to discover that majority of the articles did not including Durie in the authorship (n = 12), with a handful published by Mason Durie alone (n = 5) and minimal with Mason Durie in conjunction with other authors (n = 2).

A list of the included studies is shown in Table 2.1.

Table 2.1

Table of Studies

Author and year	Title	Purpose and aim	Population, design, data and analysis	Main results
Wilson, D., Moloney, E., Parr, J. M., Aspinall, C., & Slark, J. (2021).	Creating an Indigenous Māori- centred model of relational health: A literature review of Māori models of health	Looking into indigenous Māori models of health and wellbeing; identifying the principles and values and how this could help develop a Māori-centred relational model of care	A qualitative literature reviewing 9 Māori models of health and wellbeing PRISMA guidelines utilised	-Four themes were identified: Whanaungatanga, Whaka whanaungatanga and social-political health context - Māori view health holistically - Importance of building relationships with not only with the individual, but there whānau too
Williams, A. D., Clark, T. C., & Lewycka, S. (2018).	The association between cultural identity and mental health outcomes for indigenous Māori youth in New Zealand	Exploring relationships between Māori cultural identity, ethnic discrimination and mental health for Māori youth	Anonymous randomised cross sectional study, New Zealand Secondary school students (12-19 years old) in 2012, data collected through surveys	- Strong cultural identity means you are more likely to experience good mental health for Māori youth - Ethnic discrimination impacts Māori youth mental health - Encouraging strong cultural identity and avoiding ethnic discrimination in programmes, policies and practices can improve equity for Māori youth mental health
Marie, D Forsyth*,D.K & Miles, L.K (2004)	Categorical Ethnicity and Mental Health Literacy in New Zealand	The study explored the assumption that Māori and non-Māori hold different beliefs about aetiology of illness and health	Surveys randomly sent to individuals in the general and Māori Electoral roll. Vignette character (who displayed minimum DSM-IV	No evidence to support this claim about the difference for Māori and non-Māori when looking specifically at depression, but explored explanation on why they got the outcome they did. 1.Te Whare Tapa Whā does not accurately represent Māori beliefs about health, especially depression. 2.Dual model of health used in Aotearoa and how health helped with Māori cultural resurgence

		pathways. Focus on major depressive disorder	symptoms) was created for the participants to explore in this research	3. The use of the term 'Māori and non-Māori' as categorising ethnicity, and causes issues conceptually and methodologically.
Durie, M. (2011)	Indigenous mental health 2035: future takers, future makers and transformational potential	Review the progression of indigenous mental health over the past 25 years and looking into the future for the next 25 years ahead	Looking into literature which showed Māori development since 1984 and using literature to look at the challenges ahead	- Exploration of positive progress by looking at life expectancy, Māori workforce, incorporation of Māori knowledge, improvements in cultural identity and community awareness of health -responding to change and active planning was seen a potential way to achieve indigenous goals -a possible solution for future advancements is integrated approaches and family involvement
Hatcher, S., Coupe, N., Wikiriwhi, K., Durie, S. M., & Pillai, A. (2016).	Te ira Tangata: A Zelen randomized controlled trial of a culturally informed treatment compared to treatment as usual in Māori who present to hospital after self-harm	Recognition of high suicide and self-harming rates amongst Māori and using this study to trial a package intervention which was delivered in a culturally appropriate way and see if outcomes improved at one year.	Māori who presented to Emergency Department (ED) within intentional self-harm Double consent Zelen randomised controlled trial. Measured using the Beck Hopelessness scale at one year	-For the intervention group; there was statistical significance greater change in hopelessness scores at the 3 month mark, but not at 12 months - Intervention group was less likely to present for other reasons excluding self-harm after 12 months
Baxter, J., Kani Kingi, T., Tapsell, R., Durie, M., Mcgee, M. A., & New Zealand Mental Health Survey	Prevalence of mental disorders amongst Māori in Te Rau Hinengaro	Prevalence of mental disorders amongst Māori, specifically aggregated disorders, 12 months and lifetime	Aotearoa mental health survey between 2003 and 2004, nationally representative face to face household survey of adults (16 and over).	-Lifetime prevalence (any disorder) was 50.7% in Māori, 12 month prevalence in Māori was 29.5% and 1 month prevalence in Māori was 18.3% - Most common 12 month and life time prevalence is anxiety - Top 3 most common disorder with a 12 month prevalence is anxiety, mood and substance, while for lifetime prevalence most common disorders were anxiety, substance and mood

Research Team. (2006).			Fully Structured diagnostic interviews	- 12 month prevalence in relation to comorbidities was; one disorder is 16.4%, two disorder is 7.6% and three of more disorder is 5.5% - 12 month prevalence was more common is Māori females and in younger age groups. - Disorder prevalence higher in households with low incomes and educations
Durie, M. (2011)	Indigenizing mental health services: New Zealand experience	Looking at mental health services and how Māori culture, practice and perspective have influenced the shift since 1980	Theoretical paper	- Since 1980, moved from a monocultural approach to bicultural; by including Māori language, perspective, frameworks, treatment and care - Including Māori providers - Increasing the Māori workforce - Getting Māori into more leadership roles; which is crucial for change
O'Hagan, M., Reynolds, P., & Smith, C. (2012)	Recovery in New Zealand: An evolving concept?	Looking at recovery concept, and the recent expansion terms that come under recover: whānau ora and well-being	Theoretical paper	- New Zealand has helped the recovery approach evolve, but still needs practice to be fully embedded into mental healthcare - In the future, the word recovery might not be the guiding principle, but other terms which are compatible (e.g. whānau ora, well-being) could be used instead -Whānau ora, underpinned by Te Whare Tapa Whā, is not just about the individual but about families being supported to achieve health and wellbeing - Well-being for all, including those struggling with mental illness
Mathieson, F., Mihaere, K., Collings, S., Dowell, A., & Stanley, J. (2012).	Māori cultural adaptation: of a brief mental health intervention in primary care	Investigating an adapted cognitive behavioural therapy (CBT) intervention for near threshold mental health syndromes for Māori in primary care. Then examine its acceptability and effectiveness	Semi structured interviews of clinicians informing Māori patients of adaptions made to the intervention. Clinicians trained in delivery Self-identified Māori between aged 18-65 years old, experiencing stress	-The Māori adaptations that were made included; building relationships emphasised, spirituality, Māori language and self-management books about changes to imagery. - Both patients and clinicians had positive feedback and rated the intervention favourably - This study showed that there is potential for improvement in primary care by using talking interventions using both the original and adapted version - Māori being orators in nature aligns with the overall principle of the brief intervention, especially the Māori adaption.

			and scored 35 or greater on Kessler-10. Patients and Clinicians and patients satisfaction measured by questionnaire and semi structured interviews. Post intervention mental health status checked at 2 weeks, 6 weeks and 3 months.	
Clark, T. C., Le Grice, J., Moselen, E., Fleming, T., Crengle, S., Tiatia-Seath, J., & Lewycka, S. (2018)	The Health and Wellbeing of Māori New Zealand secondary school students in New Zealand: Trends between 2001, 2007 and 2012	Monitoring over time and describe the health status of Māori compared to European secondary school students	Anonymous surveys of secondary school students in New Zealand, conducted in 2001, 2007 and 2012	-In 2012, Māori students had seen improvements since 2001 in areas like health, family and school. - However, prevalence of inequities still evident in health (both mental and physical) and socioeconomic status - poverty is a major precipitator to inequities
Lawson-Te Aho, K., & Liu, J. H. (2010).	Indigenous suicide and colonization: the legacy of violence and the necessity of self determination	Exploring looking at Māori, indigenous suicide from an alternative perspective, collective instead of individualised and the impacts of colonisation	Theoretical paper	-Māori youth still have higher suicide rates than non-Māori - The negative impact of colonisation on Māori health and the need for restoration - Māori perspective of individualised health being interconnected with the collective - Importance of cultural identity and Whakapapa

Clark, T. C., Robinson, E., Crengle, S., Fleming, T., Ameratunga, S., Denny, S. J., ... & Saewyc, E. (2011).	Risk and protective factors for suicide attempt among indigenous Māori youth in New Zealand: The role of family connection.	Investigating What risk and protective factors are associated with Māori suicide attempts and if family connection impacts depressive symptoms and suicide attempts in Māori youth	Māori secondary youth, aged between 12-18 years old Surveys – 523 item, anonymous, self-reported questionnaire about health and wellbeing, done in 2001	-The identified the following risk factors: depressive or anxiety symptoms, a family member or close friend commit suicide, adolescent years (12-15 years old), witnessed violence and being uncomfortable in NZ/European settings - Family connections were associated with fewer suicide attempts, but the in regards to moderating, the study concluded it did not moderate the relationship between depressive symptoms and suicide attempts - Explaining family connection as a coping mechanism not a moderating variable
Brougham, D., & Haar, J. M. (2013).	Collectivism, cultural identity and employee mental health: A study of New Zealand Māori.	A study exploring collectivism for Māori within a workplace and how that effect impacts their mental health, specifically anxiety and depression	336 Māori employees were surveyed Regression analysis was used	-high collectivism and cultural knowledge lead to lower depression or high cultural knowledge and language skills leads to lower anxiety and depression - connection between anxiety, collectivism, cultural language and/or knowledge
Durie, M. H. (1985).	Māori perspective of health	Exploring Māori health perspective and western perspective	Theoretical paper	- Exploring What 'health' is -Looking at Māori perspective of health, and how it is depicted by Te Whare Tapa Whā - Acknowledging the difference between western beliefs regarding health compared to Māori - families importance in regards to health - The dimension of 'socioeconomic status'
Sachdev, P. S. (1989).	Mana, tapu and noa: Māori cultural constructs with medical and psycho-social relevance	A discussion of the concepts within Māori culture; mana, tapu and noa	Theoretical paper	-They are all interrelated concepts -Aetiology and management of illness from a Māori perspective and how they are linked to these concepts - It is important for health professionals to understand when working with Māori patients - Tapu, noa and mana not only rule health but also help in social constructs

Incayawar, M., Wintrob, R., Bouchard, L., & Bartocci, G. (2009).	Psychiatrist and traditional healers: unwitting partners in global mental health	Looking into Māori health knowledge and traditional healing like Tohunga	Chapter of a book	- Tohunga played a pinnacle role in health and helping people heal. They have their processes in how they deal with a situation -colonisation leading to the Tohunga suppression act - Tohunga roles have been reintroduced but have evolved from traditional times
Thomas, D., Arlidge, B., Arroll, B., & Elder, H. (2010).	General practitioners' views about diagnosing and treating depression in Māori and non-Māori patients	A study investigating general practitioners (GPs) views on depression; risk factors, recognising depression and when medication or other treatments are appropriate	23 semi structured interviews with GPs in Auckland, Māori and non-Māori GPs	-From this study a framework developed which consisted of strategies GPs used to diagnose and treat depression -Concluded that a possible reason for ethnic difference when diagnosing was stigma attached to admitting depression for Māori - The need to create good relationships, leading to effective communication to talk about feelings
Durie, M. (2001)	Mauri ora	Looking at Māori Health	Book	Explored the important aspects that affect Māori health; and Māori lives in relation to culture, identity and socioeconomics
Durie, M. (1998)	Whaiora	Looking at Māori Health	Book	A documented encounter of Māori health development over the last century but focussing on the last 15 years

2.1.7 Analysis

Thematic analysis was utilised during the integrative literature review in order to identify the different ideas within the current research and organised into main themes. Thematic analysis is about recognising, analysing and revealing patterns within data (Toronto & Remington, 2020). Braun and Clarke (2006) describe thematic analysis process in six steps; becoming familiar with data, creating initial codes, finding themes, reviewing the themes, defining and naming the themes and complying it into a report. The six step steps of the thematic analysis can be seen in Table 2.2.

Table 2.2

Thematic analysis

Steps	**Results**
Familiarisation with the data	All articles were read, where initially a document was created with copy and pasted phrases and sentences were taken out and correlated together under each article or book title
Creating initial codes	Another document was created with a more refined breakdown of the articles, where important messages that were copy and pasted were looked at again and summarised into simple sentences, making the formulation of the initial codes.
Finding themes	From these codes; initial themes were identified. The following were the initial themes evident in the current research. • Historical trends within New Zealand Mental Health system • Inequities for Māori within mental Health • Cultural identity • Colonisation • Collectivism • Biculturalism • Providing care for Māori • Suicide and self-harm amongst Māori • Tapu and noa • Spirituality in mental health • Western vs Māori perspective of Mental Health

Reviewing themes	Acknowledged by Braun and Clarke (2006), this step is about taking the initial themes and refining them and rationalising them. In this step, it became apparent that the initial themes were interconnected, with some being sub themes that could be formulated into one.
defining	This step was about finding the appropriate themes that could represent the different sub themes which all held weight and value in this integrative literature review. A map was created to visually represent the defining step.
reporting	From the analysis, four main themes were identified; colonisation and its effects, the importance of cultural identity, collectivism and biculturalism and providing care for Māori.

2.1.7.1 Colonisation and its effects

Māori and Europeans have always had a complex relationship since the Europeans colonised Aotearoa (Brougham & Haar, 2013). Colonisation was the bi-product of Te Tiriti o Waitangi in Aotearoa which had hugely impacted Māori. Māori underwent a lot of changes which continue to significantly impact contemporary Māori in important areas like health (Clark et al., 2018; Wilson et al., 2021). As explained by Wilson et al. (2021) and Williams et al. (2018), colonisation lead to the loss of land, language and self-identity, leaving a trail of hopelessness and changes in traditional ways of living. For Māori who viewed their wellbeing holistically, this cascaded in poorer outcomes in areas like education, health and socioeconomic status.

Māori knew the importance of health and had a public health system which was communally understood, reflecting the value of balance between people and the environment (Durie, 1998). The concept of tapu and noa supported Māori with their way of living, protected and empowered them to live safely amongst each other, but also in harmony with the environment. As explained by Sacdev (1989) tapu represented scaredness, but also something unclean respectively in accordance with the situation. It gave a sense of vulnerability, so that people knew to be more cautious. However, if something was noa, it signified a sense of returning back to normal, the caution is no longer needed and it is safe (Sacdev, 1989; Durie, 2001). People would have moved through both states interchangeably, and it was situation dependant if it was seen as a positive or negative.

For mental health, Māori commonly explored supernatural causation for psychological illnesses such as a violation against tapu (Marie et al., 2004). When a violation occurred, Māori would turn to traditional Māori healers, known as Tohunga. Tohunga were usually iwi-based healers, and underwent vigorous training, specialised to be able to identify the cause and advise the appropriate treatment needed (Marie et al, 2004; Sacdev, 1989, Incayawar et al, 2009). There were different types of remedies available which included; Karakia (prayer), mirimiri (massage) and rongoa (medicine). In 1907 the Tohunga

suppression act was passed, and it remained valid until 1964 (Durie, 2001). The availability of Tohunga allowed Māori a choice, where they could seek traditional care, western medical care or a combination of both. When Tohunga were removed it led to limited choices, which resulted in Māori being led away from traditional ways of living and created disconnection from traditional practices. This created a follow-on effect of distrust of westernised practices and ways of being. The health system had made a conscious effort to ensure Māori perspectives on health were recognised but this has unfortunately not been as prevalent as it should have been, considering the inequities for Māori who presented with poorer health comes, especially mental health. It was hard to measure the impacts of colonisation on an individual level, and the continued trauma can be invisible to others, but on a population scale the historical trauma was multigenerational and could be seen in the statistics for Māori mental health (Lawson – Te Aho & Liu, 2010). It could be seen in the prevalence, acuity and complexities of mental health conditions.

Literature continued to raise the concerns of inequities experienced by Māori, particularly the mental health of certain demographics of Māori. As expressed by Baxter et al (2006), there was statistically higher rates of mental disorder in Māori women compared to Māori men. However, multiple articles were concerned about youth. Literature expressed concerns with the Māori youth and suicide rates which continue to be alarming (Baxter et al., 2006; Clark et al., 2011 & Lawson – Te Aho & Liu, 2010). For example, Māori youth are 1.9 times more likely to commit suicide that non- Māori (Lawson – Te Aho & Liu, 2010). As explored by Clarke et al. (2011) exposure to a family or friend who have committed suicide was a risk factor, the study found Māori students had a higher rate of knowing someone who committed suicide, which could be explained by cultural practices of a tangi (funeral) which is commonly a community grieving process. Clark et al. (2018) and Durie (2011) predicted and acknowledged that Māori are a youthful population. Concerns about Māori youth, society and the mental health system needed to addressed but the concerns appear to remain.

2.1.7.2 Importance of cultural identity

As stated by Marie et al (2004) historically the New Zealand was predominantly distinguished as either Māori and non-Māori, or Pakeha and non-Pakeha. When the British arrived in New Zealand Te Tiriti was created to bring peace, but instead it erupted, and colonisation occurred. Since Te Tiriti, British have pursued the assimilation of Māori into European lifestyle (Durie, 1998). This resulted in loss of Māori land, language and sense of identity, which led to the near extinction of Māori. It was recognised in the Hunn report in 1961 (Hunn, 1961) which welcomed the ideology of integration and saw assimilation in the near future which infuriated Māori and left academics who questioned the current worldview with the suggested biculturalism (Durie, 1998). Being recognised held importance, how Māori and European explained health, in particular mental health. Their worldviews had different complexities and understandings, which meant they could not be understood in the same way. Health professionals were being encouraged to acknowledge different perspectives and distinguish accordingly (Marie et al., 2004).

Our identities are moulded at an early age; grown and shaped into individuals over time (Brougham & Haar, 2013). There are many facets to an identity which made up an individual, and for Māori they have their own uniqueness which plays a role in this. Identity for Māori is intertwined in an individual's Whakapapa which helps them trace back to where they were from, the core of their identity (Lawson - Te Aho & Liu, 2010; Brougham & Haar, 2013). The correlation of strong cultural identity and the positive impacts it could have on mental health is evident in literature.

According to Brougham and Haar (2013) and Williams et al. (2018) , when an individual is culturally grounded, collectivism is embraced and positive relationships are formed. This can lower anxiety and depressive symptoms. This coincided with how Māori historically worked a collectivist lifestyle, like iwi and hapu. Māori used Whakapapa to solidify who they were, let others know who they were and also made connections with those around them. This tikanga was embedded in a person's ingoa and waiata, which are good for their overall wellbeing. Research suggests that it is considered a protective factor for an

individual's mental health, and that an imbalance in this could cause deterioration (Lawson - Te Aho & Liu, 2010). This is evident for contemporary Māori, who struggle with cultural identity, and are not able to navigate how to fit into society's stereotypical ideology of What Māori were and could not find a safe space to explore it. Pre-colonisation, Māori freely passed down knowledge to generations, but since colonisation it has left gaps in multiple generations who were frowned upon and punished for being Māori. Since then Māori have struggled to regain this knowledge. It was acknowledged by Williams et al. (2018) who noted that colonisation impacted traditional cultural structures followed by hopelessness and loss. When colonisation happened, there was a loss of land and language, followed by loss of identity, and left a lot of Māori unsure who they were.

2.1.7.3 Collectivism and biculturalism

It was seen in multiple pieces of literature that Māori functioned in a collectivist lifestyle. This lifestyle was ideally the best approach for Māori mental health (Wilson et al., 2021; Clark et al., 2011; Durie, 1985; Lawson-Te Aho & Liu, 2010, O'Hagan et al., 2012; Broughham & Haar, 2013). The Māori perspective of health is whānau based; the individual's health is a reflection of the community's (Wilson et al, 2021; Durie, 1985; Lawson-Te Aho et al, 2010). Unfortunately, the health system continued to be dominated by the westernised point of view, which was biomedical and individualistic, the opposite of the collectivistic model followed by Māori (Durie, 1985; Brougham & Haar, 2013). This continued trend does not meet the needs of the Māori population, and it reinforced the inequities that remained. An example in mental health was a study done on suicide prevention, which resulted in research that supported the need for collective response (Lawson- Te Aho & Liu, 2010). If collective response to mental health was used, as identified before, if the individual improved it had a catalyst effect on the whānau and community.

Health was predominantly provided from a westernised, biomedical approach which is described as an individualised and reductionist worldview (Wilson et al., 2021; Marie et al., 2004). A westernised view of mental health believed that mental illness derived from a

physical disturbance or a chemical imbalance, which could usually be fixed by pharmacological interventions (Marie et al., 2004). This means, health professional would place focus purely on this aspect and utilise the appropriate medication accordingly. It was recognised that in some cases this is needed and worked well, but when looking after Māori, it needs to be approached in a more holistic manner, so a Māori perspective was essential. This can be understood when looking at practices like; tapu and noa, tohunga and other traditional healing practices (Marie et al., 2004; Sachdev, 1989; Incayawar et al., 2009; Durie 2001).

The mental health system in New Zealand has undergone transformation, which needed to be made. It was important to recognise that New Zealand is among a limited amount of countries who have tried to make amends for their indigenous population (O'Hagan et al., 2012). However, those changes have not necessarily had favoured outcome for Māori. As identified by Durie (2011) those patterns were not unique to Māori but could be seen for indigenous populations all over the world. The system changed after colonisation, had put Māori at a disadvantage and contributed to them feeling disconnected. However, in the most recent decades, the system had seen a shift, from monocultural to bicultural (Jordan et al., 2021) and saw a change in the mindset and a particular focus to improve Māori mental health.

2.1.7.4 Providing care for Māori

As mentioned by Durie (1985) Aotearoa's health system needed to be more sensitive to Māori values and beliefs. Two values that held importance to Māori were cultural identity and connectedness. As acknowledged by Wilson et al. (2021) and Mathieson et al. (2012) they questioned identity and its value, and identified that Whakapapa and whenua are important to start the process of whakawhanaungatanga, which eased a consultation. By doing that a trust was built and aligned with Māori tikanga. It was important to approach with caution when asking about identity, as outlined early colonisation caused a sense of disconnection, and left Māori culturally diverse. Health professionals should be culturally aware of this effect, had common knowledge about Māori worldviews, and provide

individualised care for that tangata whaiora (Mathieson et al., 2012). For Māori, What kind of Māori you were was not defined by blood quantum as mentioned by Williams et al. (2018), therefore health professionals should not be used as a measure either.

Care should be provided not only to the individual who is in the consultation but also the whānau. Māori needed whānau orientated care, because for Māori health one person's health was a reflection of the collective (Durie, 1985). Clark et al. (2011) showed that Māori felt uncomfortable in westernised dominated culture, explored further by Wilson et al. (2021) which Māori had described as unfriendly and culturally unusual, which made it hard to trust health professionals, and they judged to engage with health services based on their own or a whānau members perspective. An example was seen in the Te Ira Tangata study, where the main themes expressed were being judged or their past experienced caused doubt to seek help (Hatcher et al., 2016). This reiterated the notion that when a health professional engaged with Māori to remember it is not just the individual in front of them but the whole whānau and community.

As health professionals it is important that cultural safety and awareness is acknowledged. This included; different style in communication, practices and cultural needs. As identified by Thomas et al. (2010), communication and trust were important when doctors tried to diagnose mental illness, but health professionals needed to recognise that Māori have different styles compared to non-Māori. When the conversation is adapted to the individual in a culturally safe manner it would remove some of the barriers for Māori not speaking about mental health, as mental illness can only be diagnosed if people admit their thoughts, feelings and behaviours. Another way a space is made culturally safe is for biculturalism to be practiced, like ensuring that elements of mātauranga Māori were included. Mātauranga Māori guided Māori for their practice of hauora centuries, and if health professionals could have adapted some of the teachings, especially in regard to therapeutic relationships, it could help to be engaged and ultimately improve health outcomes (Wilson et al., 2021).

2.2 Discussion

This integrative literature review was conducted to explore mental health nurses' perceptions of Te Whare Tapa Whā, but was expanded to Māori mental health and implications of Te Whare Tapa Whā within mental health care. My initial search indicated that the study topic was the first of its kind. However, the expanded search in literature strengthens the understanding of Māori health, and the understanding of why nurses need to have a an appreciation for Te Whare Tapa Whā. The key concepts that were identified through the thematic anaylsis was; colonisation and its effects, the importance of cultural identity, collectivism and biculturalism and providing care for Māori. This review looked at articles that were focussed on Aotearoa due to the model beingp based on the Māori perspective, who are the indigenous people of Aotearoa.

The literature for this review was collected from a range of sources. It consisted of; three books, six theoretical papers, one qualitative review of different indigenous models, two mixed methods studies, five surveys or questionnaires, one interview study and one double consent zelen randomised controlled trial. Although different methods were utilised and conducted over several years, common themes and ideas were found within the different pieces of literature.

The most common themes evident throughout all literature was acknowledging that Māori perspective of health differs from western perspective and that inequities are seen in Māori compared to non-Māori, especially when it comes to health. Most of the literature, at least acknowledged the effects of colonisation and explored how it negatively impacted Māori in many areas, linking to the current inequities of poor mental health outcomes. It appeared that the theoretical papers and books had a wider focus, looking at Māori mental health progression over a long period of time, looking at the changes in their approaches to health and how that changes with the westernised perspective. These pieces were able to provide capture the historical changes for Māori health, identifying the benefits and deficits of these decisions. However, in the other pieces of literature there is evident concern for Māori youth and their mental health. The literature also highlights important aspects of care

which can implicated to improve the outcomes and interactions with Māori. For example, providing a collectivist outlook of care, which means looking after the individual who presents and their whānau.

This provoked critical thinking to reflect on how Māori mental health has developed and the knowledge about the model Te Whare Tapa Whā. This allowed the researcher to identify a gap and literature and What needs to be studied in order to progress. The gap that was identified was that there is no literature in regards to mental health nurses' perceptions of Te Whare Tapa Whā and this needs to be explored.

2.3 Implications for further study

literature about Te Whare Tapa Whā in the context of mental health is negligible, especially literature looking at how nurses' perceptions of this model and how it affects nursing cares. As gathered from this literature review, there is a notable gap in research in regards to Te Whare Tapa Whā within the context of mental health and nurses' perceptions of it. As a result, this research study will focus on Māori and non-Māori nurses' perceptions of Te Whare Tapa Whā and use of the model in clinical practice.

2.4 Strengths and limitations

This literature review did not include articles that were centred around all indigenous populations, but only articles that were focussed on New Zealand Māori. Although the researcher recognises the richness gathered worldwide from literature, they felt it was important to capture the uniqueness of What happened specifically for Māori and that gathering research centred around Māori would give more context and understanding. This was important as the focus of this thesis was looking into the Māori health model, Te Whare Tapa Whā. The research included both recent and historical literature due to the specificities of the search. There was also a potential bias from the researcher even though there were two supervisors from an academic and cultural aspect who guided and helped with the finalising the literature review findings.

2.5 Conclusion

The initial review of the literature was to investigate What research had already been completed and identified the indigenous model Te Whare Tapa Whā in mental health and how mental health nurses' perception of this model affects their care. Currently there is literature looking into Te Whare Tapa Whā in the context of health but research is scarce in the context of mental health. The literature may provide an overview of Te Whare Tapa Whā in mental health, but it does not go into in-depth detail about how it affects quality of mental health nursing care. Even more so, mental health nurses' perceptions of holistic care and how their values and beliefs affect their nursing is minimal. Therefore, when investigating these two concepts, there appears to be a gap which is the purpose of this study. This research is small-scale and aimed to provide a starting point for further research into this topic to be done on a larger scale and more in depth.

Chapter III: Methodology

3.1 Introduction

This chapter will discuss and explore different theoretical models and principles that were considered to address the questions raised within this research topic. The research used a mixed methods approach and used Māori tikanga to guide the methods Qualitative and quantitative methods alongside were used to explore Māori and non-Māori mental health nurses' perceptions of Te Whare Tapa Whā. More specifically, understanding these perceptions was considered to give an understanding how effectively Te Whare Tapa Whā is being implemented into holistic care.

3.2 Paradigms

Over the decades, there has been many debates about paradigms and discussions about which hold superiority for research (Johnson & Onwacbuzie, 2004). Paradigms hold importance within research because they set the ideology, beliefs and values that will shape how a researcher approaches their topic. Paradigms are important in different areas of research, from anthropology to nursing. Historically, research was conducted utilising one of two paradigms, positivist or non-positivist, with positivist being the dominant paradigm (Pachauri, 2001). Positivism is normally associated with quantitative research due to its ideology. Positivism looks for an explanation of the world through scientific verification which can be gained from empirical knowledge (Bonache, 2021). This allows researcher to gain perspective and understanding through an objective lens. Positivist, alongside non-positivist paradigms, have played an important role within research but as research has grown other approaches have developed. As acknowledged by Johnson and Onwacbuzie (2004), although researchers once believed that qualitative and quantitative methods should not be mixed, a third research paradigm is acknowledged which encompasses both types of research styles. This paradigm the paradigm of pragamatism, which supports a mixed methods, the approach utilised in this research.

Mixed methods is the chosen approach for this research, as utilising two approaches can help overcome limitations and strength the support of the hypothesis. Furthermore, it allows the

researcher to understand the question better, especially when concerning complexities like the health system (Kaur, 2016). When looking into health, it is important to have subjective data, like thoughts and feelings and objective data, such as numerical information on perceptions. Collecting both forms of data allows the researcher to look at the research from a holistic standpoint (Kaur, 2016). The intended outcome for this research was to understand mental health nurses' perceptions of Te Whare Tapa Whā, which in future may impact how the DHBs nurses approach nursing care. According to Kaur (2016), it has been identified that mixed methods is the appropriate choice for areas of development and expansion of ideas.

3.3 Qualitative

Despite being recognised for being thorough, qualitative research has been overlooked and under-utilised (Vishnevsky & Beanlands, 2004). Qualitative research is a non-numerical data collection which gathers subjective data on people's beliefs, experiences and attitudes of a particular topic (Pathak et al., 2013). Qualitative data ultimately gives power to the individual part of the study, allowing a more in depth understanding from their perspective. Qualitative data can be collected though; interview, observational, audiovisual or written materials (Orb et al., 2001). For this study, qualitative data will be collected through interviews. As described by Orb et al. (2001) the researcher needs to be mindful of possible problems that might occur and affect the qualitative data collection; relationship between participant and researcher, the design of the study and the researcher's interpretation of the data. Keeping these in mind when conducting qualitative research allows the researcher to collect appropriate data and ensure that participants' voices are truly heard.

3.4 Quantitative

As mentioned by Vishnevsky and Beanlands (2004) historically quantitative research was the predominant method within nursing literature. Quantitative research is about exploring a topic or concept by looking at a relationship, the correlating variables in the form of numerical data (Butina et al., 2015). As explained further by Watson (2015), quantitative research is deductive; measuring data, doing an analysis and summarising it into a

services, and how disproportionate the proportion of Māori mental health nurses is. I started reflecting on What I had noticed at mahi and wondered What I could do to improve our services. In 2020 I completed my postgraduate certificate, which lead me down the path of research and further education. With my ignited passion to improve the system for tangata whaiora and their whānau presented by the opportunity to part-take in the honours programme, I knew this would lead to opportunities where I could make a difference. As a Māori mental health nurse, I knew the importance of holistic nursing care, which I felt is depicted well in the model Te Whare Tapa Whā. I felt it was important to explore, as even though it is a Māori model it is relatable to all ethnicities. I am now in my third year of practice in the position of primary mental health nurse for Te Pukenga/Wintec. This remains my current place of mahi. My professional experience helps me to gain a better understanding of mental health nurses' perception of Te Whare Tapa Whā and how this may affect holistic care for our tangata whaiora and their whānau. This will be achieved through engaging in the completion of my thesis through the honours programme.

3.5 Mixed methods research

Mixed methods research has several different definitions, but according to Tashakkori and Teddlie (2003) it is about data collection and analysis using qualitative and quantitative approaches. It allows the researcher to gain two different types of data, providing a wider scope of understanding of their chosen topic. It is becoming prevalent over time that research is becoming more complex, and it is beneficial having collaborative approaches to provide in-depth research (Johnson & Onwacbuzie, 2004). As mentioned earlier, mixed methods have been identified as useful for health research. The goal for mixed methods is to is provide a wider scope of knowledge and increase validity (Schoonenboom & Johnson, 2017).

Mixed methods has a range of different designs, either parallel or sequential manner (Cronholm & Hjalmarsson, 2011). Parallel design is when the two parts of a study are conducted simultaneously with each other while sequential is conducted one after the other. In this research, the paradigm emphasised the equality of both, utilising the design of sequential studies. This is when quantitative or qualitative data is collected first and then is

used to shape the next collection and analysis stage accordingly (Creswell et al., 2004). The first stage of the research used quantitative data collection through surveys, followed by qualitative which used semi-structured interviews. The first phase was designed to help shape, solidify and validate that the second phase, conducting interviews was done effectively. Furthermore, according to Kettle et al. (2011) by doing quantitative followed by qualitative sequentially was sensible method as it provided a higher probability of maximising responses from respondents.

3.6 Māori-centred research

When looking at research, Māori knowledge has not always been easily integrated into the paradigms utilised in today research (Cunningham, 2000). Research is based on westernised knowledge and belief systems and conducted off those values. Cunningham (2000) recognises that researchers try to fit Māori knowledge into western terms, when both should be acknowledged as equal. Māori participation can vary, as can the utilisation of the knowledge. Cunningham (2000) has identified four different types of research; research not involving Māori, research involving Māori, Māori-centred research and Kaupapa Māori research. The type of research conducted for this study was Māori-centred research.

Māori-centred research is when Māori participation is usually involved at all levels, with Māori knowledge being applied to the research but governed by westernised standards (Cunningham, 2000). The researcher identified this as the most appropriate type of research, as there was 50% Māori participants involved, the lead researcher is Māori, a supervisor who provides cultural guidance, investigating a Māori model of health for the topic and Māori knowledge and values guiding the study. Although Māori knowledge and participation was held with high importance in this research, a Kaupapa Māori approach was not utilised because the research was not solely focussed on Māori but having the two worlds integrated together.

3.7 The researcher

I did my undergraduate studies at the University of Auckland, completing Hikitia Te Ora (Certificate of Health Science) in 2016 followed by the completion of my Bachelor of Nursing

in 2019. During my undergraduate studies I was supported by many different organisations like Kiaora Hauora, MAPAS (Māori and Pacifica admission Scheme), Whākapiki Ake, Te Kaunihera, Grassroots and the University of Auckland School of Nursing. They all provided me with leadership opportunities, networking and chances to influence further health professionals which allowed me to grow and start shaping me into the future Māori nurse I knew I could become. After completion, I started working as a mental health nurse, as a new graduate at Waikato hospital. Although I have not been there long, I have learnt many critical skills, like leadership and effective communication, which I continue to develop. While in my first year of mahi, I realised how many tangata whaiora come through mental health and how it is integrated in research is mentioned, focussing on the concept of Māori centred research. Lastly a detailed of the researcher's interest and position is outlined.

3.8 Conclusion

The purpose of this chapter was to explore methodological issues, with particular emphasis on the mixed methods approach. The underpinning understanding of mixed methods was explored, including an outline of quantitative and qualitative research. As well as this, Māori knowledge conclusion. Quantitative data collection is not as straight forward as qualitative data collection, and can be collected in different ways, some that are easily measured while others are not (Watson, 2015). For example, weighted measurements in comparison to people's feelings or beliefs. For this study, the quantitative data were collected through surveys. The technique utilised for the survey distributed was Likert scale. The following chapter outlines the research methods used in this study.

Chapter IV: Methods

4. 1 Introduction

This chapter outlines the methods used for the research, including research design, data collection and analysis process (Abutabenjeh & Jaradat, 2018). The mixed methods design of the study is discussed in relation to the research paradigm of pragmatism. The use of reflexivity is explained and an outline of issues involved in researching Māori health issues is provided. This is followed by a detailed description of how the quantitative and qualitative findings are formulated. Ethical issues encountered in the research are discussed, and the chapter concludes with a link to the discussion provided in the following chapter methods is an outline of a researchers process which consists of three elements; data collection, analysis and dissemination of findings.

4.2 Research paradigms

Research paradigms provide different worldviews, which researchers use to guide and formulate their studies (Corry et al., 2019). There is multiple different paradigms which have been created over time, but the three major research paradigms are; positivism, post positivism and pragmatism. As explained by Davies and Fisher (2018) positivism is based on a singular belief, and an objective approach is taken for this study and is conducted in order to tests a hypothesis. In order to achieve this, the researcher must remain impartial during the whole study. Positivist uses a quantitative method (Davies & Fisher, 2018). This raised questions, which lead to the development of post positivism. According to Corry et al. (2019) Karl Popper challenged that a researcher not having an influence on the research was impossible, exploring the others viewed the researcher's role, leading to the paradigm post positivism. With this paradigm, researchers will use triangulation, which is about using different approaches for one study so that it can strengthen the study (Davies & Fisher, 2018). For example, researcher will use qualitative and quantitative methods. However, pragmatism feels that traditional paradigms negatively impacts research and limits creativity (Davies & Fisher, 2018). As mentioned further by Halcomb (2018)

pragmatism is less about philosophical guidelines and focuses on picking the best approach necessary for the study.

Mixed methods aligns with pragmatism and is the best paradigm to support a mixed method approach (Halcomb, 2018). As stated by Bressan et al. (2017) mixed methods is about finding solutions to a research topic in a practical manner and appeals to many nurse researchers. Therefore using pragmatism with a mixed method approach felt like the most appropriate choice for this study. The reason the mixed method design was chosen was that it provides insight from different perspective as qualitative and quantitative data is gathered. In nursing, data needs to be looked at from all perspectives and mixed method designs have been growing as a usual approach not only just in nursing but healthcare in general (Bressan et al., 2017). Therefore, mixed methods was the design approach utilised for this study.

4.3 Reflexivity

Ethical conundrums are a part of research, and could potentially impact the direction of the research. Although reflection and reflexivity could sometimes be used analogously, however reflexivity can be defined as having a self-awareness of one's self and respond accordingly to the thoughts and feelings that arose during the study (Corlett et al., 2018). For example, reflexivity could be utilised to manage the influences that could potential sway the research. Some of those influences included; a mental health nurse who researched mental health nursing or prior relationships with participants. The researcher was aware of some of these influences while others were discovered throughout the research process, but the researcher had regular meetings with their supervisors so that accountability could be kept and managed potential conflicts if they arose. In particular, when the researcher felt culturally challenged they would seek support from their cultural supervisor. For example, Māori culture is on a continuum and the researcher would discuss with the cultural supervisor when their own cultural worldviews were challenged.

4.4 Research in Māori contexts

Mentioned in an earlier chapter, Māori centred research was utilised instead of Kaupapa Māori research as it appeared more appropriate for this study. As outlined by Smith (2015) Kaupapa Māori research was based on the philosophy for Māori, by Māori and with Māori. The researcher considered using Kaupapa Māori research, but Māori centred research appeared more appropriate. The rationale for this decision were that research needed to be broadened and needed to include non-Māori nurses point of views. Although Te Whare Tapa Whā is a Māori model and a large portion of the tangata whaiora identify as Māori, majority of the mental health nursing workforce is non-Māori. However, Kaupapa principles were still acknowledged and embraced in the Māori centred approach. For example, Whakawhanaungatanga was embraced through karakia and manakitanga. Karakia was offered to interviewees to help set the tone for a safe space. While manakitanga was embraced by offering kai during kanohi te kanohi interviews and the researcher would ensure flexibity for the interviews, as they acknowledged the privilege of having them part of their research. Whether a relationship is pre-existing or new, whakawhanaungatanga was important and is a key practice amongst Māori (Smith, 2006).

4.5 Research methodology

As described by Bloomfield and Fisher (2019) quantitative research is described as an objective approach which variables are examined and tested, and hypotheses are trialled. This approach gathers numerical data; looking at trends and statistically significant findings in regard to the topic being explore. As mentioned earlier, quantitative is primarily influenced by positivism. However, there is another approach which is qualitative research. Qualitative, which as outlined by Safdar et al. (2016) is an approach that is about understanding a phenomenon or topic by understanding an individual's perception, values and beliefs in regard to this topic. As mentioned earlier qualitative aligns with the constructivist approach. However, if these research approaches alone do not gather enough data, a combination of both approached can be utilised, called mixed methods (Safdar et al., 2016). As stated by Abutabenjeh and Jaradat (2018) mixed methods is about the collection of quantitative and qualitative data. Mixed methods are an approach that gave a broader

depth of knowledge compared to focussing on one aspect of data. These three approaches all have their own aspects and dynamics, and depending on your study would determine the best approach.

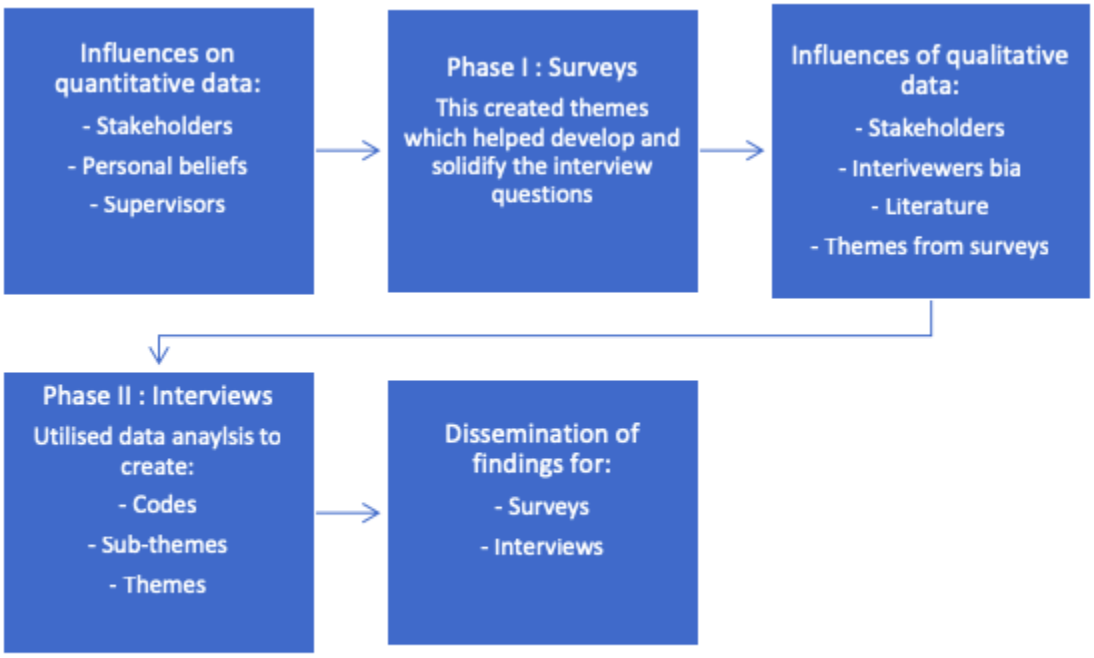
4.6 Methods

4.6.1. Study design

The study employed a mixed methods sequential design, including a survey and one to one interviews, as shown in Figure 4.1.

Figure 4.1

Study design



4.6.2 Study setting

Mixed methods were the approach for this study. It was broken down into two phases; phase I was quantitative and phase II was qualitative. The research was conducted within the Waikato District Health Board (WDHB)[1] region and the study focussed on getting the

[1] In 2022 the former District Health Boards were replaced with a new national health authority Te Whatu Ora. At that time Waikato District Health Board became Te Whatu Ora Waikato.

mental health nurses' perception of Te Whare Tapa Whā. According to Te Whatu Ora Health New Zealand (2023) Waikato DHB looks after more than 435,000 people, with 23% of the population identify as Māori which is larger than the national average of 16%. Waikato Mental Health services are either inpatient services which is the Henry Rongomau Bennett Centre (HRBC) and community services which ranges in specialties and needs. For all the Waikato services they are based on geographical locations; north rural, north central, south rural and south central.

4.6.3 Sampling

The initial intention for the survey of Māori (n=50) and non-Māori (n=50) mental health nurses, and for the interviews was an even amount of Māori (n = 4) and non-Māori (n =4) mental health nurses. The initial aim was to get an even amount of Māori and non-Māori mental health nurses for both surveys and interviews, but this was hard to follow through with. This resulted in a larger population of non-Māori in the surveys (n = 38) and Māori nurses in the interviews (n = 6). The researcher wanted Māori and non-Māori mental health nurses because although Te Whare Tapa Whā is a Māori model, most of the mental health services are mainstream services and based on westernised beliefs, so all views and perspectives were relevant to gain a true picture.

4.6.4 Recruitment

The surveys were e-mailed to mental health nurses via contracted members of the DHB who were independent of the study. The email consisted of an outline of the research, the researchers email if they had any further questions and the survey link that was conducted using Qualtrics. The recruitment was harder than anticipated by the researcher, which was why multi members were sending out the email to mental health nurses.

For the interviews; contracted members of the DHB who were independent of the study, would send out an email to potential participants to invite them to be a participant in the research study. In the email will be attached a participant information sheet (Appendix 3) and a written consent form (Appendix 7) which they will fill out and send back if they wish

to proceed with the process. It will also have the health and disabilities advocate number If they wish to know more about their rights in terms of the research. Also, if potential participants wish to contact the researcher for additional information, they have the right to do so. A reminder email will be sent after 2 weeks if there are not sufficient responses from the potential participants.

4.6.5 Instruments

The survey questions were compiled together; drafted, reviewed and finalised by the researcher, supervisors and two colleagues outside of the research to ensure they were articulated in an appropriate and cultural safe way. The first question was asking for consent as a way to provide written informed consent for the researcher. The survey was semi structured, with the initial questions gathering demographic but non-identifiable information, followed by four simple questions knowledge and learning of Te Whare Tapa Whā. This led into a collection of 18 statements which was answered using the Likert scale to gather the nurses' perspectives and beliefs of Te Whare Tapa Whā in the context of mental health nursing care.

A draft was compiled of the interview questions, developed with the guidance of the supervisors. These were developed as a brainstorm of What questions the researcher felt would be good for the study but also to give the Waikato University ethics committee an idea of the direction. These questions were not only guided by the researcher and supervisors, but also current literature and the survey trends. The researcher also found that after the first interview, some questioned needed to be further refined and played in a more chronological order to be asked. This formulated the finalised questions and order (Appendix 1). This interview was still utilised for analysis as only small changes were made to the interview schedule and provided valuable information. This whole process was under the guidance of the supervisors at all times.

4.6.6 Data collection

The survey was completed anonymously by participants via Qualtrix. It was sent out via email, which the participants could fill out at any time. Qualtrix is a survey software that stores and correlates the data.

For the interviews they were conducted one on one, either kanohi te kanohi or via zoom. They were semi structured interviews, which lasted between 30 – 45 minutes each. They were conducted in private spaces so that the interviewee felt they could speak freely. The researcher would provide kai for the in-person interviews and ask each interviewee if they wish to start with a karakia. Firstly, the interviewees would be notified and checked it was acceptable for the researcher has two forms of recording in case of technical difficulties arose. The researcher would then thank the participate for taking part, ensure they filled out the consent form and asked if they were ready to begin. The research had an interview guide which was utilised in the interviews (Appendix 1).

4.6.7 Analysis

The data for the surveys were analysed using descriptive statistics, to give visual representation of the data and summarise some key features from the dataset. Some variables were; gender, ethnicity, years of experiences, currently clinical practice and their nursing position. These were important factors to take into consideration to see if these factors might have affected an individual's perception. There was also a set of 18 questions which were formatted using a Likert scale, which were grouped into trends to analyse easier. All of the survey data was analysed using the SPSS system.

Interviews were transcribed using the otter software which allowed the researcher to ensure that the recordings were accurately represented. Once they were transcribed, they were sent to the researcher supervisors the review. The transcripts were then downloaded into the NVivo system to complete a thematic analysis. Thematic analysis can be as a broad term can be described as finding patterns and themes within qualitative data (Lester et al., 2020). Through NVivo while using thematic analysis, the researcher was able create codes

from the transcripts, which were grouped into sub themes. Those sub themes were grouped together again into overarching themes.

4.7 Ethics considerations

Informed consent was crucial for the ethnics of a research study. For the surveys, emails were sent out by individuals that were independent of the study to possible participants with a brief outline of the study and the researcher's email if the individual wanted to know more about the study (Appendix 2). The first question on the survey was asking about consent to ensure written consent was attained. In regards to the interviews, those who expressed interest in participating in the interviews were sent out a participant information sheet (Appendix 3). It outlined; who the researcher was, the reason for the study, what would have been expected of them, confidentiality and support services available to them.

Another ethical consideration was the potential for the researcher to have an existing relationship with the people who participated in the interviews. I was not the person that made the initial contact with participants, but may recognise who the interviewer was after they read the participant information sheet. I used reflexivity to manage conflict or differences in opinion, and was supported from my supervisors throughout the study. If they got uncomfortable during the interview, they had the options of it being terminated or withdrawal. As discussed by McConnell-Henry et al. (2010) the researcher is privileged if there was an already established relationships between the interviewee and interviewer, it was just important that the interviewer had strategies in place if conflicts or concerns arose.

Ethics approval was needed from Waikato District Health Board (DHB) For ethics approval from the Waikato DHB, it required consultation and approval from Te Puna Oranga (DHBs Māori Health Services) and the operational director associated with the research area. Te Puna Oranga provided some recommendation that they wanted the researcher to think about (Appendix 4). The researcher was able to provide an appropriate response, which

results in both the DHB and Te Puna Oranga giving their approval. University of Waikato had their own standards and requirements. When the University of Waikato ethics application was sent, the committee requested some amendments which the researcher replied accordingly to (Appendix 5). Once they were happy an approval letter was sent from Waikato University needed permission from the Human Research Ethics committee (HREC (Health) 2021#33) (Appendix 6).

4.8 Methods summary

This chapter has described the methods used in the research. The methods of this approach were broken into two phases, surveys and interviews. The data collected from these phases allowed the researcher to gather the information needed to inform and give insight into the research topic. The data was gathered from mental health nurses within the Waikato region. Phase I gathered quantitative data through surveys that were constructed using Qualtrics, and was sent out via email for nurses to fill out anonymously. Data was then analysed through SPSS and analysed using descriptive statistics. Phase II gathered qualitative data through semi structured interviews that were conducted as one on one either in person or via zoom. Data was analysed using thematic analysis in order to identify codes, which were grouped into subthemes and further grouped into overarching themes. During this process, the researcher ensured to use reflexivity which helped limit the impacts of bias on the process of analysis.

Chapter V: Findings

5.1. Introduction

This chapter discusses the findings from the analysis of the qualitative and quantitative data. The first section describes the first phase, the quantitative data, where demographics are discussed, and trends are identified. The second section describes the second phase, the qualitative data, where the results of the thematic analysis are explored, and the themes are outlined.

5. 2 Quantitative findings

For this research, the first phase of the study consisted of gathering quantitative data. This was conducted through surveys and a descriptive design used to understanding the following findings. Descriptive is when about looking at different variable and interpreting them (Bloomfield & Fisher, 2019). The first questions of the survey were demographic identified, which those variables were explored. A Likert scale was made up of 18 questions, which were organised into trends and discussed further.

5.2.1 Response rate and ethnicity

Surveys were distributed to 300 nurses within the Waikato region. Of the 300 surveys distributed, 53 were returned for a response rate of 17.6 %. In terms of ethnicity, participants were classified as Māori if they identified as both Māori and New Zealand (NZ) European. When analysing the findings for ethnicity, a prioritising method of identifying ethnicity as described by Yao et al. (2022) was applied. The largest group were NZ European 34% (n = 18), followed by Māori 28% (n = 15). A significant minority of 26% (n = 14) identified their ethnicity as other.

Table 5.1

Ethnicity

Ethnicity	Frequency	Percent
NZ European	18	34.0
Māori	15	28.0
Tongan	1	1.9
Chinese	1	1.9
Indian	4	7.5
Other	14	26.4
Total	14	100

5.2.2 Employment

The majority of the surveys (73.6%; n = 39) were completed by mental health nurses who worked within the inpatient setting. Out of the 53 surveys, 3.8% (n = 2) did not identify whether they worked in the inpatient or community setting.

Table 5.2.

Employment setting

Employment setting	Frequency	Percent
Community	12	22.6
Inpatient	39	73.6
Missing	2	3.8
Total	53	100

5.2.3 Position of respondents

The majority of respondents (92.5%; n = 49) were registered nurses, with a small proportion (5.7%; n= 3) of enrolled nurses.

Table 5.3.

Position of respondents

Position	Frequency	Percent
Registered nurse	49	94.2
Enrolled nurse	3	5.8
Missing	1	1.9
Total	53	100

5.2.4 Clinical experience

Over half the respondents were mental health nurses with five or less years' experience (52.9 %; n=28). However it is important to recognise that although the largest group(47.2 %; n=25) had 1-5 years' experience and a significant proportion (32.7 %; n = 17) had greater than 10 years' experience.

Table 5.4

Years of experience

Years of experience	Frequency	Percent
< 1 year	3	22.6
1-5 years	25	
6-10 years	7	
> 10 years	17	
Missing	1	3.8
Total	43	100

5.2.5 Knowledge of Te Whare Tapa Whā

Of the 53 respondents 77.4% (n=42) stated that they had heard of Te Whare Tapa Whā, with only one respondent reporting that they had not heard of the model. Perhaps surprisingly, 10 respondents did not complete this question. Of the 43 respondents who completed the question 97.7% (n=42) had heard of Te Whare Tapa Whā.

Table 5.5

Knowledge of Te Whare Tapa Whā

Heard of Te Whare Tapa Whā	Frequency	Percent
Yes	42	77.4
No	1	1.9
Missing	10	18.9
Total	53	100

5.2.6 Learning about Te Whare Tapa Whā

A further question asked respondents where they had gained knowledge of Te Whare Tapa Whā. This item received 92 responses, indicating that many respondents had learnt about Te Whare Tapa Whā in more than one setting, with the most frequent setting being undergraduate education (69.9%; n=37).

Table 5.6.

Learning about Te Whare Tapa Whā

Learning about Te Whare Tapa Whā	Frequency	Percent
Undergraduate studies	37	69.9
Postgraduate studies	13	24.5
Online	8	15.1
Self-taught	7	13.2

Inservice education	6	11.3
Conference	7	13.2
Seminar	7	13.2
Other	7	13.2
Total	92*	na

* Some respondents reported multiple sources of learning

5.3 Survey results

The full results of the survey are shown in Table 5.7.

Table 5.7

Survey results. Perceptions of Te Whare Tapa Whā

		Strongly disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly agree n (%)
1	I often use the Te Whare Tapa Whā model within my nursing practice	1 (1.9)	5 (9.4)	18 (34)	15 (26.4)	14 (28.3)
2	I feel that Te Whare Tapa whā has a positive impact on the care of tangata whaiora (service users)	0(0)	3(5.7)	9 (17.0)	12(22.6)	29(54.7)
3	I feel confident using Te Whare Tapa Whā in my practice	2 (3.8)	4 (7.5)	16 (30.2)	16 (30.2)	15 (28.3)
4	I find Te Whare Tapa Whā helps me engage with Māori tangata whaiora	1 (1.9)	4 (13.2)	13 (24.5)	15 (28.3)	20 (37.7)
5[1]	Te Whare Tapa Whā helps me engage with Māori tangata whaiora whānau	1 (1.9)	7 (13.2)	10 (18.9)	13 (24.5)	21 (39.6)

6	I can correctly identify the four walls of Te Whare Tapa Whā	2 (3.8)	1 (1.9)	11 (20.8)	13 (24.5)	26 (49.1)
7	I understand the differences between the four walls of Te Whare Tapa Whā	3 (5.7)	9 (17.0)	14 (26.4)	25 (47.2)	2 (3.8)
8	I understand the importance that if one wall falls, then an individual's wellbeing is out of balance	1 (1.9)	1 (1.9)	7(13.2)	13 (24.5)	31 (58.5)
9	I have identified barriers that stop me from implementing Te Whare Tapa Whā into my nursing care	4 (7.5)	6 (11.3)	11 (20.8)	13 (24.5)	17 (32.1)
10	I feel supported in my workplace to implement Te Whare Tapa Whā into my nursing care	1 (1.9)	10 (18.9)	15 (28.3)	15 (28.3)	12 (22.6)
11[1]	I feel that Te Whare Tapa Whā is the most appropriate model to be utilised within mental health care	4 (7.5)	2 (3.8)	12 (22.6)	14 (26.4)	20 (37.7)
12[1]	I feel that Te Whare Tapa Whā helps nurses understand Māori tangata whaiora better	1 (1.9)	0 (0)	12 (22.6)	14 (26.4)	25 (27.2)
13[2]	I feel confident explaining Te Whare Tapa Whā to other health professionals, service users, or their whānau	0 (0)	7 (13.2)	15 (28.3)	11 (20.8)	18 (34.0)
14[1]	I feel Te Whare Tapa Whā is a model that is appropriate for all, not just Māori	2 (3.8)	1 (1.9)	7 (13.2)	14 (26.4)	28 (52.8)
15[3]	Te Whare Tapa Whā gives me a better understanding of holistic care for tangata whaiora	1 (1.9)	2 (3.8)	6 (11.3)	11 (20.8)	30 (56.6)

16[2]	The four walls of Te Whare Tapa Whā are enough to capture holistic care of tangata whaiora	3 (5.7)	5 (9.4)	16 (30.2)	10 (18.9)	17 (32.1)
17[2]	All mental health nurses should use Te Whare Tapa Whā in their practice	1 (1.9)	3 (5.7)	11 (20.8)	11 (20.8)	25 (47.2)
18[1]	I would like to learn more about Te Whare Tapa Whā and how I can implement it into care of tangata whaiora	2 (3.8)	3 (5.7)	10 (18.9)	12 (22.6)	25 (47.2)

Table 4.1. Nurses' knowledge and experience of Te Whare Tapa Whā
[1] Missing data n =1.
[2] Missing data n = 2.
[3] Missing data n = 3.

5.3.1. Using Te Whare Tapa Whā

It is interesting to note that items one, three and thirteen have the lowest rates of agreement for questions related to using Te Whare Tapa Whā. These three items relate to; using Te Whare Tapa Whā and to mental health nurses' confidence. Although over half agreed or strongly agreed with these three statements, it appears to be less conclusive as a good portion of mental health nurses (28% or more) were unsure, shown in their 'neutral' responses. However responses to items related to the utility of Te Whare Tapa Whā (2, 4, 5, 15) suggest that mental health nurses have positive perceptions of implementing Te Whare Tapa Whā within nursing care when working with tangata whaiora and whānau. For each of these items, which focus on the impact of Te Whare Tapa Whā on practice, the large majority of respondents agreed or strongly agreed. This is extremely prevalent for question two, 77.3% (n = 41) and fifteen, 77.4% (n = 41).

5.3.2 Knowledge of Te Whare Tapa Whā

Most mental health nurses can correctly identify the four walls of Te Whare Tapa Whā (item 6) and understand that if one falls then wellbeing is compromised (item 8). However

item 7, which asks about the differences between the four walls, is not so straight-forward. Just under half of the mental health nurses state they understand the difference between the four walls 47.2% (n = 25), followed by neutral 26.4% (n = 14) and a significant minority 22.7% (n =12) disagreed or strongly disagreed that they understood the effect of one wall of the Whare falling.

5.3.3. Service support

Item nine is negatively framed, so if mental health nurses agree or strongly agree is a that indicates lack of service support for use of Te Whare Tapa Whā. Of the 53 respondents, 56.6% (n = 30) identified that they have barriers to implementing Te Whare Tapa Whā into their nursing care, while 18.8% (n = 10) disagree and the remainder were neutral. For item ten, just over half of the mental health nurses 50.9% (n = 27) identified that they feel supported using Te Whare Tapa Whā in their workplace, while the other half do not feel supported or are unsure.

5.3.4. Beliefs and attitudes about Te Whare Tapa Whā

Items 11, 12, 14, 16, 17 and 18 examined beliefs and attitudes about Te Whare Tapa Whā. Responses ranged in levels of agreement but more than half of the mental health nurses agreed with the statements indicating positive perceptions about use of Te Whare Tapa Whā and its appropriateness in clinical practice, and openness to further professional development in this area. Question fourteen had the strongest agreement of (79.2%; n = 42 agreed or strongly agreed that Te Whare Tapa Whā was an appropriate model for all, not just Māori), followed by question eighteen (All mental health nurses should use Te Whare Tapa Whā in their practice) showing 69.8% (n = 37) agreement and question seventeen (All mental health nurses should use Te Whare Tapa Whā in their practice) showing 68.0% (n = 36) agreement. However on Item 16 (The four walls of Te Whare Tapa Whā are enough to capture holistic care of tangata whaiora the rate of agreement only just reached 50%, with a significant minority of 30.2% (n=16) making a neutral response.

5.4 Qualitative findings

Semi structured interviews were conducted with participants who were mental health nurses within the Waikato region. The interviewees provided insight into mental health nurses' perception and beliefs in regard to Te Whare Tapa Whā and how it might impact nursing care. Eight interviews were undertaken. Six participants identified they were Māori and two identified they were non-Māori. Participants ranged in areas of expertise, years of experience and positions. The interviews were audio recorded on two different devices and transcribed by the researcher using the otter software. Transcripts were analysed using methods of thematic analysis (Braun & Clarke., 2006). In the initial reading of the transcripts, 157 codes were identified. The transcripts and codes were further assessed and were refined to 40 codes. These codes were grouped into 12 sub themes, which were further grouped and placed into the four main themes that were evident from the interview transcripts. These four themes were; Māori influence, individual factors, organisation level and clinical practice. Within each theme there were three subthemes as shown in Figure 5.1, which outlines the process for analysis of the qualitative data.

Figure 5.1 *Thematic analysis*

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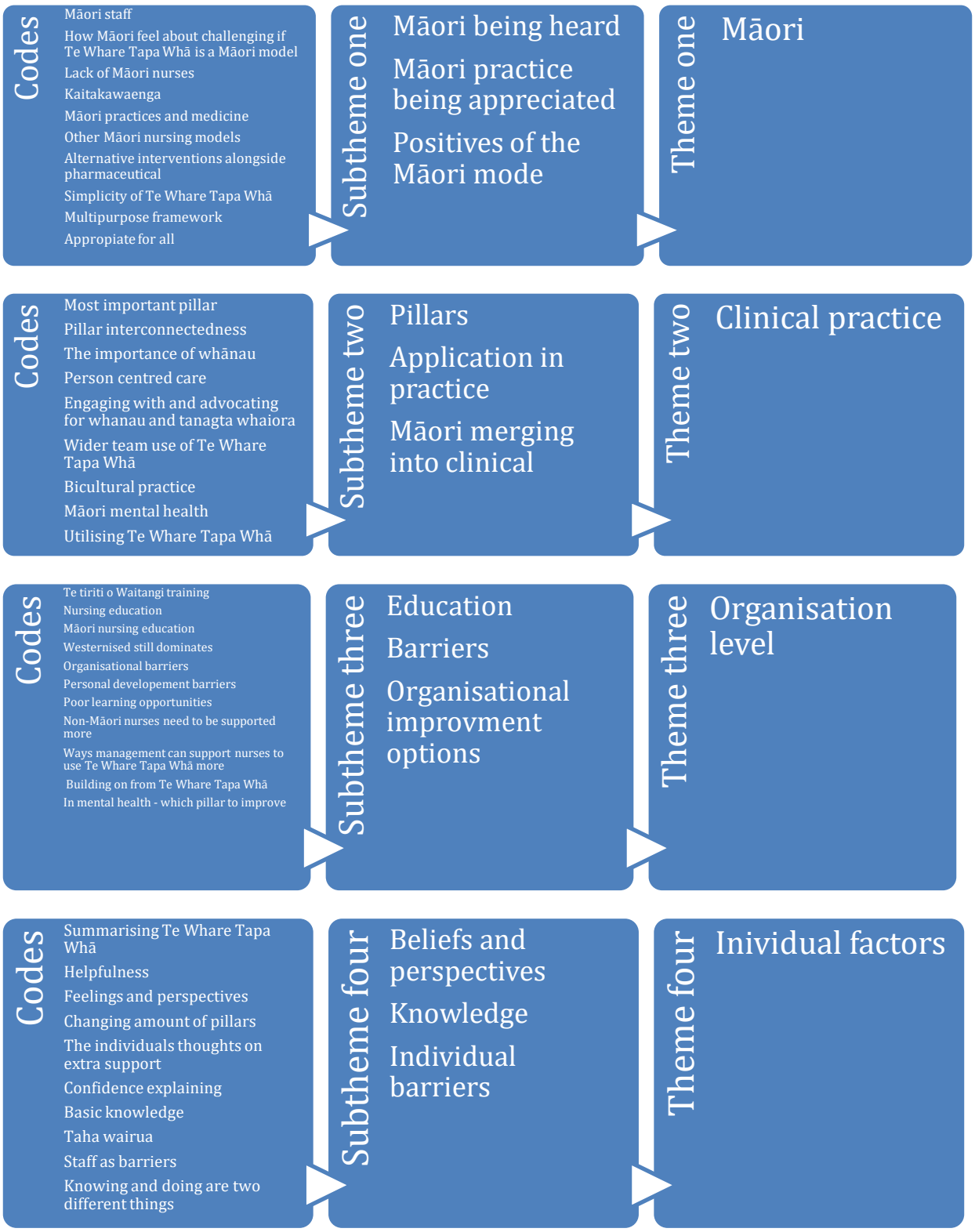

5.4.1 Māori influence

5.4.1.1 Māori being heard

This subtheme focussed on how Māori are heard within mental health care, and of the importance of Māori voice within health care. Māori voice is reflected in Te Whare Tapa Whā but that does not mean that the model is seen as meeting all the needs of Māori. Participants talked about What barriers might stop someone from implementing Te Whare Tapa Whā. One Māori participant identified how as the only Māori nurse in their practice setting they observed racism within that setting.

"I think I can't speak of it to now, but I could speak as to when I was earlier in my nursing, and the barriers was being mostly in a westernised structure. Being the minority group, being the only brown face, the only Māori nurse… I still come across quite a lot of conflict actually and being my unique great Māori nurse self. I think most of this is just addressing it or seeing it for What it is, which is racism."- Interviewee four

The issue of the attitudes of nurses towards Māori tangata whaiora was also evident in concerns about the cultural safety of international graduates. The nursing workforce is multicultural, and there is a need to support internationally qualified nurses for culturally safe practice in the context of Aotearoa.

"A lot of the times our international nurses irritate the patient more and then for someone like me I have to go and deescalate because the patient is now agitated at the staff member, this happens quite a lot."- Interviewee seven

In response to a question about keeping the approach same for Māori and non-Māori, one Māori participant emphasised the contribution of their Māori cultural identity.

"…What my point of difference is that I'm uniquely me, I'm uniquely Māori and I happen to be a nurse." Interviewee four

Another Māori participant spoke of the importance of Māori caring for Māori.
"Māori caring for Māori is important to me" Interviewee six

Participants mentioned other Māori models of health that were potentially useful in clinical practice.

"…the Pounamu model, there was an extension of Te Whare Tapa Whā, which was specifically created for mental health. I love that model but I also know that that model would be too much for many people to grasp at this time." Interviewee four

Participants were challenged about research which questioned if Te Whare Tapa Whā was considered a Māori model, a Māori participant reflected on this challenge.

"Well I'd like to know who wrote that research. I mean, my whānau, when you look at the dimensions, these are the most predominant things that you will see. I would challenge that as to well, you tell me What you think reflects a proper Māori model of care for health. " Interviewee five

5.4.1.2 Māori practices being appreciated

In this subtheme it is evident that Māori staff and practices are crucial for the implementation of Te Whare Tapa Whā. Seven of the eight participants mentioned Kaitakawaenga, and recognised the importance of the Kaitakawaenga role and its positive impact in delivering nursing care.

"So with that korero; I had a talk to Tane and he's in agreeance, he wants the Kaitakawaenga to come in and have a talk to him. And that's how I bring it up with my colleagues because if you talk to the person then it's a slam dunk. It's not a decision that I've made in isolation." Interviewee two

Another participant also considered that greater cultural support was needed.

"More kaitakawaenga available. That would be of course good for our service users, but then it would also be good for staff as well to have sessions with them." Interviewee eight

There are many Māori practices and medicines, which all participants recognised and were able to acknowledge provided benefits.

"I think just like the psychiatrists are experts in the arenas. So too are our Tohunga, our cultural supports, so they should have the same stature or the same creditability within that arena." Interviewee four

Another participant commented on the contribution of kuia and kaumatua to care of tangata whaiora.

"I've seen some amazing support provided by kuia and kaumatua. How they can just make people feel at ease or bring them to a place where they are able to korero." Interviewee two

A Māori participant acknowledged cultural knowledge passed on down from their whānau.

"The rongoa has been practiced for hundreds and hundreds of years. And even like my mother bought up on a farm, born on a farm you couldn't go to town if you had an injury, Grandpa [would] fix everybody."- Interviewee five

All participants were supportive of alternative interventions being used alongside Māori. This Māori participants was able to articulate the joining of Māori culture into nursing practices working alongside western beliefs.

"Absolutely, I agree. You know, I'm not one to push pharmaceuticals. I know I'm a registered nurse but being Māori I know that there's other ways, natural ways of health. Those things like; walking exercise, looking after ourselves, self-care. Those are all part of alternatives as well actually."
- Interviewee six

5.4.1.3. Positives of a Māori model:

Te Whare Tapa Whā was seen as making many positive contributions to nursing care, providing benefits for all tangata whaiora. Six participants commented on its simplicity and conceptual framework.

"It's simple, it's got some really good conceptualisation behind it." Interviewee one

"What I love about this model, is it is very simple, it's not complicated. So I see its value in mental health and addictions."- Interviewee five

Another participant spoke of applying Te Whare Tapa Whā in maintaining their own wellbeing, indicating that its positive effects extend beyond the clinical interface.

"I also use it for my own well-being I've got a wellbeing plan that I have on my office wall. It's got all of the things under the dimensions that I need to do to keep my wellbeing good … I've also used it in my supervision around the wellness for those who I supervise." Interviewee five

Another benefit of Te Whare Tapa Whā is its role structuring assessment and planning care.

"It's really good for assessment, but it's really good to set objectives with. Like when we're setting patient goals, these are the things we need to think about, we need to think about things in all of these areas." - Interviewee one

Te Whare Tapa Whā was seen as a model with benefits for all tangata whaiora, not just Māori.

"I think that it helps me gain a picture, a holistic picture of the person by using that particular model. Not just for Māori but for everybody."- Interviewee two

"… it applies across different groups of people in different cultures. It'd be an international kind of model. I think it's just fabulous." Interviewee three

"It's the same, it fits in for everybody. We've been having quite a few international to be honest with you and it fits the same." Interviewee seven

5.4.2 Clinical practice

This theme relates to the application and different ways that Te Whare Tapa Whā can be applied to clinical practice. The subthemes include pillars, application in clinical practice and Māori merging into clinical.

5.4.2.1 Pillars

All four pillars of Te Whare Tapa Whā were seen as contributing to clinical care.

"I think they're all important... so I wouldn't say that one particular one's important, or more important than the others. But there may be one pillar that comes to the forefront a little bit more than the others. Maybe you've got things going on with your whānau and then that becomes more to the forefront compared to others. Yeah it interchanges." Interviewee two

One participant made a comparison between Te Whare Tapa Whā and the well-established Western model of Maslow's hierarchy of needs.

"Do you know Maslow's hierarchy, because actually, if your physical health isn't good, then you can't really live a spiritually strong life or you can but it's much tougher. So, one way of qualifying What is the order of importance of these things as Maslow's hierarchy." Interviewee one

Although all four pillar were seen as important, one participant described how the importance of one pillar over another might be seen at different times.

"They're all important, but we just prioritize What's important on the day when they come in etc." Interviewee seven

The coexistence of the four pillars was emphasised by another participant

"I couldn't say one is more important than the other because they coexist. They all matter and I couldn't definitively say that one is more important than the other." - Interviewee six

This coexistence was reflected in the comment of another participant who emphasised the need to focus on which of the four might need support at a particular time.

"We all know that they all interconnected and if one isn't as strong as the other, then that's the one that we need to focus on." Interviewee four

One suggestion was that the current model of Te Whare Tapa Whā could be extended.

"So I do think that Te Whare Tapa Whā, like I said earlier, is a great starting point, but it's not the end." Interviewee four

A possible extension of the model involved the development of a fifth wall.

"Mason Durie sounds like he was the man. And he made a huge difference for Māori health. So I'm sure he had good intentions. And maybe it's just the fact that he started this conversation, and we've developed so much that now we do need something with the fifth pillar." Interviewee three.

Social issues were suggested as a modification by another participant.

"It could be better but I'm guessing six to seven maybe seven. ...(interviewer asking how to improve the score)... If there was like another pillar, like the social side of things, because a lot of people that come into mental health, a lot of it can be caused by social issues and things like that." Interviewee eight

While modifications were proposed at least one participant was cautious about changes.

"I think that we could probably nowadays build on things. As in we already have the floor there but then we can be more specific about certain things. But definitely not any less than that. " - Interviewee seven

5.4.2.2 Application in practice:

This subtheme of clinical practice captures the clinical utility of Te Whare Tapa Whā. For this participant they acknowledged the importance of whānau.

"I think taha whānau is probably the most important because without those people who gives you hope, you know, who's there to stand beside you, who's there to support you and help you through your day. That whānau could be relatives, It could be friends, it could be mental health people, whoever you deem as your whānau." Interviewee five

While this participant expressed a similar view, shedding light on why it needs to be improved.

"I think for the people in my service, connection with whānau needs to be improved. A lot of people have burnt their bridges, and had been kicked out of their homes. So they're homeless, they don't have the support. And I think that having someone to look out for you will be there for you, helps with all the other pillars." Interviewee three

Te Whare Tapa Whā was seen by one participant as drawing attention to different possible explanations for clinical symptoms.

"I saw a lot of people who were hearing voices, who aren't psychotic but in fact the psychiatrist will know that evidence says that 1 in 10 people who hear voices are psychotic. So most people aren't, you just have to remind yourself of that there are other explanation for this thing that your seeing in front of you." - Interviewee one

Working with Te Whare Tapa Whā can be implemented in not only formal settings, but other more casual ones too.

"So instead of sitting in an interview room, maybe you sit on a bench outside, maybe you sit and you both have a cup of tea, like, the interaction is just more casual."- Interviewee three

For another participant Te Whare Tapa Whā created the possibility to advocate for tangata whaiora specific concerns.

"If I'm hearing that they're saying they're having concerns with that, then I would advocate accordingly."-Interviewee seven.

The nurse's role in communicating understandings generated from using Te Whare Tapa Whā was another aspect considered important.

"I definitely pass on whānau concerns to the treating team. I don't have any hesitation or concern about that." Interviewee three

Te Whare Tapa Whā was seen as creating a context for care that acknowledged the experience of tangata whaiora and whānau.

"I'll always come with the lens that we're in a privileged space to receive the narratives that we receive. Interviewee four

Because of the utility of Te Whare Tapa Whā in mental health, the possibility of implementing Te Whare Tapa Whā in other contexts was identified.

"Probably one of the best models for mental health and addictions nursing but it could go across all of the disciplines. It would be really good if our consultants and medical team use this model, because it's more of a holistic rather than a medical type model, sickness based ideas." Interviewee five

5.4.2.3. Māori merging into clinical

This subtheme captures the contribution of Te Whare Tapa Whā but also notes that further work is needed to fully meet the mental health needs of Māori tangata whaiora. For one participant, her confidence in Te Whare Tapa Whā meant that the model became an automatic way of understanding tangata whaiora needs.

"Honestly, if I look at somebody walking in the door, the model I think of immediately is Te Whare Tapa Whā and then of course, the nursing process." Interviewee five

The language supporting Te Whare Tapa Whā should be more widely heard in order to fully apply the model in practice. This participant was speaking in regards to Te Reo Māori.

"So What I mean by that is, the language should be spoken more often, the words should be used more often." Interviewee one

Application of Te Whare Tapa Whā was seen as needing to reflect the needs of different iwi, rather than being a unitary model for all Māori.

"There's the tohunga, and this would be for the options that are available from where these people are from. Not always, because you're in Tainui, so you use What Tainui has to offer, but you know, like doing a little bit more research into What they might offer in their own rohe."
- Interviewee two

Another participant noted that changes are needed in Māori mental health, suggesting a view that Te Whare Tapa Whā could contribute to those changes.

"I can't really see significant changes in Māori mental health, think it's pretty bad actually."- Interviewee two

Te Whare Tapa Whā was seen as introducing some wider dimensions to clinical practice.

"I think it's given more awareness for sure, especially about spirituality, and how important kaupapa Māori is." Interviewee eight

The above perspective was supported by the view of two participants who noted that Te Whare Tapa Whā is currently underutilised.

"I think it's been underutilised... So maybe it's just not be utilised how it was envisaged visit by Mason Durie." Interviewee two

"I think that does need to be utilized more within this current structure, considering it's been around for so long." Interviewee four

5.4.3 Organisational level

With this theme the focus shifts from perceptions of Te Whare Tapa Whā and its application in practice, to structural factors outside the immediate clinical interface, that participants saw as relevant to the application of Te Whare Tapa Whā.

5.4.3.1. Education

This subtheme relates to participants'' experiences learning about Te Whare Tapa Whā. The comments reflected learning about Te Whare Tapa Whā in undergraduate education, and on the ideal characteristics of education about Te Whare Tapa Whā. Comments reflected reliance on undergraduate programmes to introduce students to Te Whare Tapa Whā. In one case there was a sense of scepticism about how well undergraduate programmes performed this task.

"I think we rely, especially with the student nurses, we rely on their schools to teach them and we're having a lot of students come through that don't even know their basic medications of psychiatric health." - Interviewee seven

One participant discussed her experiences in a *Bachelor of Nursing Māori programme, which offered a solid grounding in* Te Whare Tapa Whā.

"Well, I trained in the Bachelor of Nursing Māori programme. So that was What underpinned all of our nursing, medical or wherever that we went because our curriculum was structured around Te Whare Tapa Whā." - Interviewee four

Education in New Zealand programmes was contrasted with the educational background of internationally qualified nurses, who do not always have education in Te Tiriti o Waitangi or cultural safety.

"When we're getting foreign nurses training in New Zealand, that is a real opportunity to really drum Te Whare Tapa Whā, so it becomes a normal way of thinking and for those nurses who have trained overseas who are coming, that there'd be some form of program for them. And as part of like a compulsory learning for them." - Interviewee five

The impact of internationally qualified nurses' limited education in cultural care was noted in clinical practice.

"We have to de-escalate them and a lot of the international nurses are either not confident in that or they are not aware that they agitate people in how they present information or how they say things and that's a barrier to health as well and them being discharged." Interviewee seven

For education in Te Whare Tapa Whā to be effective it needed to be delivered in a supportive manner, or risk discomfort among non-Māori.

"Until it delivered in a way that is not perhaps challenging to non-Māori, because sometimes we do have sessions at Waikato with Tupuna Oranga, certainly about the Treaty, that make non-Māori feel uncomfortable. An actual fact, me as Māori, attending one with a multicultural group, I felt uncomfortable for them."- Interviewee five.

5.4.3.2 Barriers

Participants identified a range of barrier to applying Te Whare Tapa Whā in their practice. These included domination of practice by westernised models, commitment of services, staffing and service support. Lack of cultural safety training was an issues noted with some internationally qualified nurses. There was concern that available resources related to Te Whare Tapa Whā lost some of their cultural validity due to being 'anglicised'.

I've done a little bit of reading about Te Whare Tapa Whā and I know that there is some kind of debate within Māori sort of academia around whether Te Whare Tapa Whā is a little bit kind of anglicised in that regard. I'm sure it is, but that's really helpful in some ways, because it means that people who aren't Māori like me, can make it feel quite meaningful quite quickly, because we kind of understand that concept."- Interviewee one

Translation of Māori resources into English also had the potential to limit the validity of that material.

"I mean, again, you can get anything in English and translated to Māori, it's not necessarily Māori model but Mason Durie sounds like he was the man." Interviewee three

Western clinical tools were seen as dominating practice, and had not been modified to reflect or embody Te Whare Tapa Whā.

"We can easily implement westernized formats or learnings, DASA and SBAR and change those but yet, we still haven't managed to incorporate What that looks like (referring to Te Whare Tapa Whā)..." Interviewee four

Even for those nurses committed to implementing Te Whare Tapa Whā the pressure to conform to Western models detracted from the application of Te Whare Tapa Whā.

"So I would write my notes according to Te Whare Tapa Whā but as the years have gone by, because we have to kind of conform to Whatever system that is currently, I guess, Whatever system that the CNS has have at the moment, and at the moment, it's SOAP we have to comply to that." - Interviewee seven

Although clinicians might have a good understanding of Te Whare Tapa Whā, barriers might arise from tangata whaiora who perhaps might not share the clinician's understanding.

"So I guess What I'm saying is that some of the barriers will come from people, rather than for me as a clinician." - Interviewee one

Other comments focussed on whether the nature of clinical services could adequately reflect a Māori model of health, like Te Whare Tapa Whā. In particular one participant commented whether mental health services could implement Te Whare Tapa Whā outside a kaupapa Māori service.

"It's not an advanced kind of system and it's not individualized. It's not a kaupapa Māori ward, so we don't have those facilities or it's not the right context to be using anything that's too intense or advanced in Māori to be honest. I think that we could do better definitely, but we don't want too much because look at the majority that works there."- Interview seven

Time constraints were another potential barrier to practising according to Te Whare Tapa Whā.

"A lot of the times I don't feel I'm able to give a professional opinion. And then I just have to be straight up with the judges and say due to the time constraints, I'm not able to give you an opinion about their current mental health risk, or I'm not able to give you What the background story is from this Tane."- Interviewee two

Time and other constraints are particularly evident during upsurges in the Covid pandemic.

"I suppose even talking of COVID times now, when they limited whānau visiting, and things like that. That would have had a huge impact on people who are going through really hard times." - Interviewee eight

An additional barrier was staffing which especially impacted capacity to attend training in Te Whare Tapa Whā.

"The barriers to attending staffing, staffing, staffing, staffing. No barriers, just staffing. Which affects your ability to be released, which affects your ability to go and on those education days. Yeah, staffing." -Interviewee three

Workforce issues were also noted by another participant

"Our structure or our current workforce having trouble growing their own practices, and that's a huge thing." Interviewee four

One participant was very explicit in noting the difficulties in being released from clinical care to attend training in Te Whare Tapa Whā.

"Currently, staffing. I would say that I am about 40 hours under my education hours because I can't get released. Yeah, and it's been like that for over a year because they can't release me from work because I work the back shifts and it's been like that for a while but I can't get anyone to cover ... I don't know What I am going to do because they can't release me because there is no staff. So I will have to go online and try and do catch up and try and do What I can basically."- Interviewee seven

For another participant there was a sense of little support for education.

"I don't remember doing it at all, at the DHB.I don't think the DHB support education at all, I can't tell you the last education course I went on except for spec." - Interviewee three

Participants' commented on the difficulties observed for internationally qualified nurses (IQNs) in providing care that reflected the tenets of Te Whare Tapa Whā.

"We have a lot of non-Kiwi nurses, some really great nurses, but they come from a different culture so they have a different philosophy of care, model of care. That's great in their lives I suppose, and their culture."- Interviewee five

"I see that on our ward at the moment when we talk about Whākamoemiti. Our nurses come from many different cultures, are not having an understanding of why it is that we're doing that.." Interviewee four

5.4.3.3. Oganisational improvements

This subtheme highlighted areas of organisational improvements that participants felt could help with better implementation of Te Whare Tapa Whā into nursing cares. Comments were made in regards to clinical leaders. One participant suggested incorporating words affiliated with Te Whare Tapa Whā.

"It's about making sure that all your charge nurses, your ACNMs and your CNS have got those words and can use them."- Interviewee one

While another participant encourage getting management to have education sessions about Te Whare Tapa Whā.

"There's also the clinical nurse specialists. They don't provide in service education. Which they could I think and the role and our ward use to do like monthly education sessions long time ago and that the staff to other staff thinks that they were skilled at, again like that would reduce the barriers of being released.." - Interviewee three

One suggestion continuous in-service education could better support application of Te Whare Tapa Whā.

"I would like to see personal development about Māori history and Te Whare Tapa Whā incorporated in either orientation of working with the DHB. Sessions throughout working in the DHB. Not like an audit but like a refresher, and that it should be compulsory. Because we care for Māori, and the majority are Māori people that we care."- Interviewee six

Another participant reflected on their previous mahi and What worked well, suggesting it might help other organisations implement Te Whare Tapa Whā.

"So all their management, all the kuia and thee kaumatuas, were able to support anybody new into the organisation about any model of care that they will utilise…When we had our orientation, we would always share the models of care, both of them, but go into more so for Te Wheke model but acknowledged Te Whare Tapa Whā and What that meant to our organisation." Interviewee two

5.4.4 Individual factors

In addition to the comments that could be organised into common themes, a number of other perceptions of Te Whare Tapa Whā were identified by participants. These have been grouped into the theme of individual factors, and three subthemes.

5.4.4.1 Beliefs and perspectives

A number of participants expressed a range of individual beliefs and perspectives. One commented on the holistic nature of Te Whare Tapa Whā.

"So it's Māori model of care and it's a holistic model of care from a Māori perspective. That looks at all aspects of their well-being and who they are as a person." -Interviewee two

Seeing similarities and links with the biopsychosocial model of health.

"I kind of talk about the fact that actually there are different ways of formulating our understanding of people and the Te Whare Tapa Whā actually matches quite nicely the biopsychosocial model." Interviewee one

Ease of application of Te Whare Tapa Whā was also noted.
"I find it very helpful or very easy to do." Interviewee six

Te Whare Tapa Whā was seen as a very important model for Māori health, providing fundamental concepts for helping tangata whaiora.

"I love Te Whare Tapa Whā. I like the thought of a Māori concept of wellness. I think it's spot on in terms of wellness, Māori health." Interviewee six

"I think for my practice it's the fundamentals as to helping the patient. Although I may not call it that anymore, I'm fully aware that's What I'm looking for." Interviewee seven

The model was also seen as providing a structure to guide nursing practice.

"I think if we have those as headings, and there's lots of subheadings underneath, then that may probably cover anything else but I think those as the main headings. I think they're pretty good." Interviewee two.

Te Whare Tapa Whā was seen as part of nursing practice, even if that wasn't consciously understood.

"In summary, I think it's entwined in our practice, whether people like, know that or not, which is a really good thing." Interviewee three

5.4.4.2. Knowledge:

Participants spoke of developing their knowledge of Te Whare Tapa Whā. One of the participants expressed the importance of being proactive.

"I'm quite proactive in terms of my training. So if I want to know something, I'll just go and look it up or I'll talk to somebody or I'll find it. I wanted to be able to speak Māori. So I enrolled in classes. So I think those opportunities are there for people who want to take advantage of them." - Interviewee one

Another participant reflected on the limitations experienced by non-Māori in understanding Te Whare Tapa Whā.

"Look I don't explain it as a Māori because I'm not, and I don't have that really in depth understanding about it. But I certainly understand the concepts that drive it" Interviewee one

The experience of having limited knowledge of Te Whare Tapa Whā was shared by another participant.

"The basics, like I think that two sentence thing. I think it'd be better if I knew the Māori words for the pillars as well. I don't know if confidence is the word but I've got a bit of an understanding I guess." Interviewee eight

Using personal experience was identified as a way of extending knowledge.

"Absolutely. I would sit down with any of my colleagues and work with them through it and just use me as an example to do like the wellness plan or wellbeing plan." -Interviewee five

Knowledge of Te Whare Tapa Whā was seen as proceeding from the basis of the model developed by Mason Durie.

"Yes, and it depends on you know where you research. I know it came from a number of people that contributed in terms of marae and hui but it was Mason Durie that kind of made it famous and developed it into well What we all know it as." Interviewee four

Other reflections included the structure of the Whare, including the floor as a fifth component.

"Also not to forget the foundation if you think of the foundation, like your values, and I don't know it might be you're family culture. Without that, you can't stand the building either… So you know the floor. So they've actually like five components to it." Interviewee five

Knowledge of Te Whare Tapa Whā, in particular Taha Wairua, recognising that people can look at it differently and how it connects with them. Four participants talked about it further.

"I like to hear people's interpretation of it, you know, like where they might take something really deep. Interviewee two

"Our spiritual side connects us to those that have already gone. Our spiritual health is anything that lights up your core, you know, whether they Whatever it is." Interviewee four

"…for me Taha Wairua is caring for our spirituality, Māori spirituality, so thats karakia. That's incorporating tikanga practices; washing your hands after seeing Te Papaku, making sure pillows aren't on people's feet. That's different aspects of it. Māori practices. That's What I believe spiritual." Interviewee six

"Really, when I think about that question, I also think about our transgender. When I'm thinking about their spiritual and who they are, that's not just physical. It's not just mental health. It's also who they are. So that comes under that, gender fluid patients. So just being respectful about their pronouns and stuff helps with the spirituality and their wairua." Interviewee seven

Te Whare Tapa Whā was seen as promoting understanding of ancestral connections.

"Understanding people's Whakapapa, understand where people are from, religion and just that stuff." Interviewee eight

For two participant there was concern that nurses' level of knowledge of Te Whare Tapa Whā was a barrier to implementation. This was sometimes related to personal factors experienced by nurses.

"Lack of understanding and maybe not even acknowledgement that it's even going to make a difference or add value to how they practice." Interviewee two

"We many of our nurses can get caught up in their emotional turmoil in What's going on in that space that they actually feed in to that energy." Interviewee four

Having a shared understanding and commitment from all members of clinical teams was seen as important.

"As there are push backs from other clinicians, then it becomes a challenge. Like if you and I, had our korero, and I'm your nurse, I can apply it, but then we go the next step up to treatment. If the treating team aren't on the same page. Then there may be some conflict." Interviewee five

Consistency in applying the Te Whare Tapa Whā model was another issue noted. In some cases, talk about Te Whare Tapa Whā was simply talk, and did not lead to application. Part of the solution to this was to have all members of clinical teams educated in the concepts of Te Whare Tapa Whā.

"I've interviewed a lot of people. We've got this specific set of questions. And you know, the cultural component of the interview. You're asking, where they always say, how does Māori tikanga fit in to the way that you practice, for example. They say the three P's but it actually comes to the practice on the floor. You never see it. I mean, it's like a lip service. It's like you're just saying it to get the job, but then you don't actually practice." - Interviewee three

"But not just teaching them but ongoing demonstration of, because I could teach anybody a model but whether or not they apply it is a different thing…. Because when you talk about it and don't integrate it, people don't get it. It's about bringing it to life in the teaching sessions." Interviewee five

"I think the problem is teaching everybody how to implement them." Interviewee six

5.5 Conclusion

The analysis of the quantitative and qualitative data captured a snippet of insight of Māori and non-Māori mental health nurses' perspectives of Te Whare Tapa Whā. The descriptive analysis of the quantitative data broken down to show the demographics of the participants and provided trends four trends in regards to Te Whare Tapa Whā. The identified trends were; Using Te Whare Tapa Whā, Knowledge of Te Whare Tapa Whā, Service support and Beliefs and attitudes about Te Whare Tapa Whā. Thematic analysis was utilised to formulate an understanding of the qualitative data. The data was analysed for codes, which were grouped into subthemes and further refined into overarching themes. These were Māori, Clinical practice, Organisational level and Individual factors. These findings allowed the researcher to have a good understanding of mental health nurses' perceptions of Te Whare Tapa Whā, which helped answer the research questions and provoked further discussion which is presented in the discussion chapter.

Chapter VI: Discussion

6.1 Introduction

This is the first research study to investigate mental health nurses' perceptions of Te Whare Tapa Whā. This study is significant because since the development of Te Whare Tapa Whā, and it becoming well known by health professionals in Aotearoa, there has been no research on this topic. The aim of this research was to explore mental health nurses' perceptions of Te Whare Tapa Whā and how this impacts nursing practice within the Waikato region. This chapter will discuss; exploration of the research questions, further investigation of the findings, strengths and limitations, implications and reflections.

The first section will explore the research questions which guided the study of exploring mental health nurses' perceptions of Te Whare Tapa Whā. Through completing this research, the researcher was able to get a better understanding of the research questions and explored relevant literature accordingly. The research questions were;

1. What are the different perceptions of Māori and non-Māori nurses of Te Whare Tapa Whā?

2. How well do Māori and non-Māori nurses understand Te Whare Tapa Whā?

3. How do Māori and non-Māori nurses' perceptions of using Te Whare Tapa Whā affect how its implemented into their nursing care?

6.2 Research questions

6.2.1 What are the different perceptions of Māori and non-Māori nurses of Te Whare Tapa Whā?

There is a collective agreement between Māori and non-Māori nurses that there is a need for a model likeTe Whare Tapa Whā within mental health because it is a good fit due to its simplicity and adaptability. Both groups can see its importance within nursing practice and were able to give examples of when they have utilised it. However, it was intriguing that consensually all nurses felt that Te Whare Tapa Whā was a model that was embedded in

their practice and something that they used all the time, not just with Māori but with everyone. All nurses were able to recognise that their needs to be a presence of Māori practices to enhance and implement Te Whare Tapa Whā to a high standard. The nurses also all acknowledged that having Māori staff, clinical or non-clinical can be of benefit. Nurses from all cultures can recognise its value and the positive impact it can have on tangata whaiora, whānau and nursing care. This model is holistic because it gives a clear picture of the person as a whole, guiding conversation and helping identify What pillars are lacking, making it easier to identify which pillars need attending too. Mental health nurses are able to acknowledge the interconnectedness of the pillars which contribute to the overall hauora of tangata whaiora.

6.2.2 How well do Māori and non-Māori nurses understand Te Whare Tapa Whā?

It appears that both Māori and non-Māori have a basic knowledge of Te Whare Tapa Whā, being able to recognise and name the pillars and who created it. The survey results showed an agreement that nurses understood the model. However, when questioned around their confidence about implementing the model, this was incongruent with their understanding, which raises the question about the level of understanding of the model. The findings found that Māori were able to demonstrate a deeper level of knowledge, having a more comprehensive understanding of the model. Participants discussed how Māori nurses and staff were needed to support the application of Te Whare Tapa Whā for non-Māori nurses.

6.2.3 How do Māori and non-Māori nurses' perceptions of using Te Whare Tapa Whā affect how it is implemented into their nursing care?

For all mental health nurses their perceptions, beliefs and experiences influence the type of nurse they want to be and how they practice nursing care. Te Whare Tapa Whā is built on Māori values and beliefs of health, which makes it an easier concept for Māori to understand and implement. Māori nurses report that it is embedded in their practice and expressed a strong belief that Te Whare Tapa Whā is a positive guide that can help nursing care. However, non-Māori nurses have also expressed the helpfulness of this model and see the need for it. Non-Māori nurses could have formed these perceptions from personal

experience, cultural beliefs, nursing education or other influences. Whereas Māori nurses can align Te Whare Tapa Whā with their ways of living, both as a nurse and in other aspects of their life. The principles of Te Whare Tapa Whā for Māori are easily applicable to themselves and their worldview.

It's important to acknowledge that not only do your own perceptions affect how Te Whare Tapa Whā is implemented, but also your colleagues affect how you can implement Te Whare Tapa Whā into nursing care. Although nurses try to maintain continuity of care, this is not always the case in the hospital setting. For example, a tangata whaiora can have three different nurses in one day. It was mentioned by some of the Māori nurses that these can be barriers to implementation of Te Whare Tapa Whā as different nurses have different perspectives. As nurses, their own attitudes, beliefs and perspectives can determine how and What care is delivered, which could be different from the previous nurse or the nurse working the next shift. This reinforces the need for everyone to be working in unison in order to achieve the collective goal. To achieve this; all nurses need to have a good understanding of Te Whare Tapa Whā to guide and drive collective nursing care.

6.3 Appreciating What Māori knowledge and staff can bring to clinical practice

Mental health nurses are all governed and held to the same standards of practice, but it is important to recognise that Māori mental health nurses work differently to non-Māori. As acknowledged by Te Rau Ora (2023) and Wilson et al. (2012) Māori nurses' practice encompasses a mix of western medicine and Māori culture. This is evidently seen in the Māori model Te Whare Tapa Whā, which depicts holism and Māori practice. Since Māori are able to apply a clinical-cultural lens to practice, it makes Māori staff, particularly nurses, vital for improving tangata whaiora outcomes. The findings suggested that Māori nurses who had Te Whare Tapa Whā or other Māori nursing models embedded in their practice were able to demonstrate person-centered care more easily. Even those who were non-Māori but understood and could apply models like Te Whare Tapa Whā felt the positive impacts it had on their practice, especially with Māori. If nurses did not feel confident in a situation, it was very prominent that they would reach out to non-clinical

staff like Kaitakawaenga. Kaitakawaenga were confident working from a Māori perspective and encouraging holistic care perspectives like Te Whare Tapa Whā. This worked complementarily as they could help with the merging of clinical and cultural practice, which mimics the practice displayed by Māori mental health nurses.

Literature continues to recommend more Māori nurses to drive equitable outcomes and ultimately improve Māori mental health (Maxwell-Crawford & Matatini., 2011). However, the reality is that this needs to be a long-term goal as this can only happen over time. It's important to keep this as a goal, as both literature and the findings from this study highlight the unique approach that Māori mental health nurses and other staff bring to nursing care. However, there are ways to embrace and incorporate Māori beliefs and practices into mental health nursing. These could consist of; more Kaitakawaenga, Te Whare Tapa Whā education sessions or having more matauranga Māori available. Some of these ideas were highlighted by the participants from the interviews.

Although having more Māori mental health nurses seem unattainable currently, nurses can use Te Whare Tapa Whā as a guideline for culturally responsive, clinical practice. Some of the reasons discussed in the findings and literature state that Te Whare Tapa Whā is liked for its simplicity and multipurpose abilities (McLachlan et al., 2017). One multipurpose ability that was reiterated by all nurses in this research, was that Te Whare Tapa Whā was applicable to anyone and everyone within mental health services.

6.4 Utilising Te Whare Tapa Whā to bridge the gap

As mentioned earlier, Te Whare Tapa Whā has been around for a long time, approximately 40 years. According to Theunissen (2011) Te Whare Tapa Whā is a holistic health framework which was created so non-Māori health professionals could have a better understanding about Māori wellbeing, and get guidance on how to support Māori through utilsing this framework. This provided non-Māori nurses a chance to add a new level of depth to their care for Māori. This was further explained by the creator of Te Whare Tapa Whā Mason Durie, where he expressed how getting Māori perspective of health gave them a voice in a realm that they previously had none (Durie, 2005). Even though the initial

intentions were good, both Māori and non-Māori have lost sight on the origins of this model, which may have contributed in the stagnated advancements with this model.

Māori see Te Whare Tapa Whā as their voice in a western dominated system, which could be a factor in why Māori want to safeguard the model in order to maintain its "Māoriness" and remain 'our' model. This can be seen in literature, such as McLachlan (2017) where questions were raised about it being a Māori model. When challenged with this question some nurses can understand this perspective while others were highly offended by these remarks. For non-Māori nurses, whānau and society, they see Māori reaction to these concerns as defensive, angry and even racist towards non-Māori. While sometimes a Māori perspective can seem frightening and feel like a challenging concept for non-Māori, and the way they portray these feelings can come across as arrogant, dismissive and racist to Māori at times. These mindsets can create barriers to therapeutic relationships before it has even begun, further contributing to inequities.

What was evident through the research was that although mental health nurses see the value and importance of having a Māori model like Te Whare Tapa Whā, there is still room for improvement in understanding the model and maximise the potential impact it can have on nursing care. In order to move forward, Māori and non-Māori nurses need to collaborate together and come to a mutual understanding so that they can work together to serve tangata whaiora as best as they can.

6.5 Level of understanding by IQNs of Te Whare Tapa Whā

The nursing workforce continues to be in a shortage crisis, as New Zealand continues to entice nurses from overseas to come work in Aotearoa. The amount of International qualified nurses (IQNs) that are coming to work in Aotearoa has grown exponentially in the last decade, making up 25% of the nursing workforce (Brunton & Cook, 2018; Rebecca Mowat & Jarrod Haar, 2018). As Rebecca Mowat and Jarrod Haar (2018) reports, Aotearoa has the highest percentage of IQNs in the Organisation of Economic Cooperation and Development (OECD) (Jenkins & Huntington, 2016). Although this is good to maintain numbers, there are some unaddressed concerns that come with such a high proportion of

IQNs, one being the cultural differences. Literature brings to light how cultural difference affect a nurse's perception of how care should be delivered, and causes difficulties in the work place if not addressed appropriately (Brunton et al., 2018; Rebecca Mowat & Jarrod Haar, 2018). This was highlighted in the findings of this research that if there is not an adequate understanding of New Zealand history, Māori culture and Māori models like Te Whare Tapa Whā it can hinder nursing care and work dynamics. Although a sample of IQNs were not identified in this study, the research explored how IQN's perceptions and beliefs affect their nursing care.

The model Te Whare Tapa Whā could possibly be the model that could address those concerns and give an adequate understanding of culture within the mental health context. Through teaching Te Whare Tapa Whā, topics like Māori culture and te Tiriti o Waitangi can be explored, and how it links to mental health. As mentioned by Rebecca Mowat and Jarrod Haar (2018) the Nursing Council of New Zealand (NCNZ) has requirements that need to be met in order to be eligible to work as a nurse in Aotearoa. One of the standards was the completion of a competency assessment program (CAP). CAP is a course that has been developed to help IQNs understand health from a New Zealand content (The Nursing Council of New Zealand, 2020). Although there is a New Zealand health context course, there may need to be more emphasis on Māori health and the model Te Whare Tapa Whā or creating a Māori cultural standard of its own.

6.6 Strengths

There were some strengths identified which the researcher felt benefited the study. First was that this is the first research of its type. Recognising a gap and formulating a pathway for further research to be developed, especially with government and health system highlighting the need for attention to mental health and Māori health (Patterson et al., 2018). This research provides a starting point for further research to be developed.

A second strength was the knowledge and experience the researcher brought to the project as a Māori nurse, conducting a study on a Māori model of health. With the researcher being a Māori nurse, it allowed the researcher to bring cultural and clinical knowledge into the

study. The researcher felt that this gave them an advantage on how to formulate the survey and interview questions to ensure in depth research was gathered to give a better understanding of the topic.

Third was having a cultural supervisor to seek support from during the study. Having a cultural supervisor was crucial as the research was following a for Māori, by Māori with Māori approach, as well as incorporating non-Māori. All these elements challenged the researcher on different levels culturally, so having a tuakana during this process elevated the research to ensure it was delivered to a high standard ensuring cultural validity.

Lastly, despite having minimal Māori nurses within mental health, there was a high number of Māori participants in the survey and interviews. The researcher felt this was important to get the Māori voice heard through this research as Māori mental health nurses see things different from others and their perspective is usually difficult, to obtain. However the researcher acknowledges that it is important to include Māori and non-Māori in order to highlight similarities and differences in perspectives and beliefs.

6.7 Limitations

When conducting research, it is important to recognise that limitations will occur and as researchers it is important to accept that. Limitations are acknowledged weaknesses that occur within a research and might impact the outcomes of the research (Ross & Bibler Zaidi, 2019). The first limitation was the time pressures that were an inevitable part of a masters project. The amount of work expected in the timeframe creates limitations and can affect the quality of the research study that is produced.

The second limitation was that the research was only conducted in the Waikato DHB compared to getting perspectives nationally. Realistically for this study it was easier to conduct the research in Waikato, but this means that the findings might not be applicable to other places in Aotearoa. It is important to recognise that different populations have different needs, so although an overall recommendation could be applicable to all of Aotearoa, respecting differences is important to keep in mind and is not made evident in this study.

The third limitation is the amount of surveys that were collected. Although the numbers collected were sufficient in the analysis of this study, it did not allow the use of inferential statistics. Inferential statistics is about building on descriptive statistics, which gives more definitive answers about the study questions (Stapor, 2020). Due to limited amount of survey data, while acknowledging time constraints it meant that inferential analysis was not able to be done in this study, and a more in depth understanding which would have been beneficial could not be achieved.

6.8 Reflections on the research process

This research has been the most challenging and insightful journey I have encountered. When I first entered the nursing workforce, I felt like I entered with an untainted and fresh lens of the mental health system. I was only working a few months before I started brainstorming on how things could be done better. Doing the nursing master's program with Waikato University provided me with the opportunity to turn my ideas into a reality, as I knew change could only be made if proven through research. Being a Māori nurse myself, I knew the importance of Te Whare Tapa Whā and how it can make holistic care easy and practical. I knew my beliefs and perspectives shaped by worldview on this topic and I wanted to explore if others felt the same way.

My research did not come without its trials, as I was working full time, starting a new mahi, buying my first Whare while still figuring out What kind of nurse I wanted to be. I learnt a lot about myself as a person, being Māori and being a nurse. I have learnt a lot about research and the skills it takes to complete something so complex. There are definitely things I would do differently, but I would not have changed my research process for anything. I was never alone in my research; but had the support of many around me, whether it was participants, my supervisors or family and friends who made this research possible.

6.9 Implications for clinical practice

In regard to clinical practice, this study has highlighted a need for changes to happen in practice. These changes would benefit the mental health system, those it serves and those who work within it. Some recommendation for clinical practice recognised within this study are; need for more Māori staff, recognising the different style of nursing Māori bring and for nurses to emphasise the use of Te Whare Tapa Whā. A great example given by a participant was to specifically stating the use of Te Whare Tapa Whā in the clinical notes. This would give a clear indication on how nurses feel Te Whare Tapa Whā is applied and their knowledge of understanding.

6.10 Implications for education

As seen in this study, there are different areas of education where Te Whare Tapa Whā can be taught; whether it is through tertiary, mahi or your own research. Recognising the different places to learn is important. However in the surveys and interviews of this study there was an emphasis placed on undergraduate education. A recommendation would be to do interviews with undergraduate nursing students and investigate if Te Whare Tapa Whā is being taught and how. Also, through this study education during employment was highlighted as another important time that it can be taught. Therefore, another recommendation could be gaining ideas on how in-service education could be taught and how it can be taught throughout employment appropriately. Education barriers were recognised, so a study that investigates further and finds appropriate solutions would be beneficial.

6.11 Implications for research

Although it is important to give the perspective of those who look after tangata whaiora, it is equally important to get the tangata whaiora perspective on Te Whare Tapa Whā. This research gave insight into how mental health nurses feel about Te Whare Tapa Whā and how the application can impact nursing care. However, in order for a model to be successfully implemented, both the nurses and tangata whaiora need to have similar views

and beliefs about Te Whare Tapa Whā. A recommendation for further research would be to seek tangata whaiora perspectives on Te Whare Tapa Whā and how it can impact their wellbeing. It would be beneficial to not only view the tangata whaiora themselves but their whānau too, because by applying this model to nursing practice not only affects the nurse and tangata whaiora, but the whānau too. Therefore there is power in knowledge, and getting their voice too could impact nursing care positively.

This study was completed by gathering the voices of mental health nurses within the Waikato region. Another recommendation for research is expanding the investigation and getting the perspective of Te Whare Tapa Whā of nurses around Aotearoa. A study of mental health nurses in Aotearoa would give a more in-depth and conclusive understanding of nurses' perspectives, and could be expanded to explore how tertiary nursing programmes could affect this.

6.12 Conclusion

This study was conducted to look at Māori and non-Māori mental health nurses' perceptions of Te Whare Tapa Whā. It was completed using a mixed methods approach which the researcher felt was the most appropriate. A through literature review was conducted and identified that there was a gap in the understanding of mental health nurses' perceptions of Te Whare Tapa Whā. Qualitative and quantitative data was gathered through surveys and interviews which was able to give insight into mental health nurses perspective. The data was analysed using descriptive analysis and thematic analysis which highlighted some key trends and themes. The findings alongside literature was used to answer the research questions and provoked further discussion. It also helped to identify other possible recommendations which was identified by the research, supervisors or participants throughout the study. This study showed that mental health nurses have positive perceptions of Te Whare Tapa Whā and the impacts it can have on nursing cares. It is imperative that nurses are provided the opportunity to grow their knowledge and understanding for the greater good of mental health. Then one day we may come a point where we can further grow our practice and build from this model.

Appendix 1
Interview questions:

Thank you for agreeing to participate in this research. The research is aimed at exploring nurses' perceptions of Te Whare Tapa Whā. In answering the questions in this interview please do not use clients' names or other identifying details. Please do not describe details of care that could lead to individual clients being identified.

1. Te Whare Tapa Whā is a Māori model of health, which represents four pillars. Can you name the four pillars? (in English, Māori and/or both)

2. Who created Te Whare Tapa Whā and when was the model established?

3. What's are your feelings and perspectives of Te Whare Tapa Whā?

4. If you were to explain Te Whare Tapa Whā to someone, how would you summarise the model in 1-2 sentences?

5. Would you feel confident enough to explain Te Whare Tapa Whā to your other colleagues? Why or why not?

6. Can you give an example of when you utilised Te Whare Tapa Whā with a Māori client?

7. In referencing to the above example, do you approach a non-Māori client the same way or do you slightly change the approach?

8. (depending on their answer) Why do you change/keep your approach the same for different tanagata whaiora?

9. Do you believe this model can be utilised for all tangata whaiora?

10. On reflection, What barriers/ What potential barriers may stop you from using Te Whare Tapa Whā model in your nursing cares? (For example; not enough time in the shift, lack of knowledge, feeling its not relevant.

11. How helpful do you find this Māori health model when engaging with Māori clients and their whānau? How would you place that on a scale of 1-10, 1 being not helpful and 10 being the most helpful. Why did you pick that number? What could be done to improve your score.

12. What do you believe is taha wairua (spiritual health) can that impact someone's mental health? Could it be used in a positive and negative way?

13. How confident are you to raise your concerns to the treatment team if they believe the main issue is mental health but you believe it may be something else? (e.g. spiritual imbalance)

14. What are your feelings towards alternative interventions alongside pharmacological treatment?

15. How does your DHB support your learning about this model?

16. What can the DHB do to support you if you wanted to do some PD sessions on Te Whare tapa Whā?

17. How would you feeling about extra support to help enhance your knowledge about Te Whare Tapa Whā?

18. How do you feel about all the pillars, What do you think is the most important, and why?

19. In mental health; which pillar do you feel needs more attention (physical, spiritual and family) and how could this be improved?

20. Did you find your learning during your training about Te Whare Tapa Whā helpful? Why or why not?

21. Are the four pillars of Te Whare Tapa Whā sufficient? Do we need more or fewer pillars?

22. I agree/disagree that this model is appropriate to implement in my nursing cares?

23. Nowadays there are multiple different types of indigenous models, do you think Te Whare Tapa Whā is the most beneficial Māori model or is there a better one we can utilise in our nursing cares?

Appendix 2

Survey information email

Te Whare Tapa Whā is a holistic Māori model recognized and utilised in health care around Aotearoa (New Zealand). This model is something that is taught within the undergraduate programme and is used within the Waikato Hospital, which helps nurses' look at individual's care holistically. The researcher (Samantha Teinakore) is a mental health nurse with the Waikato DHB and is a student at the University of Waikato doing her BNurs (Honours) programme. Samantha wishes to explore mental health nurses' perceptions of the mode Te Whare Tapa Whā, and how their perceptions may impact how a nurse applies this model into their practice.

Samantha's interest is to know What mental health nurses feel about the model as it is important to take into consideration all facets of life that may be affecting an individual's mental health. Furthermore, through the survey, Samantha will explore whether mental health nurses think Te Whare Tapa Whā is the most effective model for the care of tangata whaiora and is it being taught in undergraduate and DHBs correctly.

At the beginning of the survey, there will be a question asking if you consent to this survey being used in Samantha's research project, please answer this before emailing back your completed survey. Completing this survey is voluntary and will in no way affect your current or future career in any way.

If any further questions, please feel free to email the researcher Samantha Teinakore on;
st433@students.waikato.ac.nz

Appendix 3

Research Project

Māori and non-Māori mental health nurses' perceptions of Te Whare Tapa Whā

Participant Information Sheet

Introduction:

Te Whare Tapa Whā is a holistic Māori model recognized and utilized in health care around Aotearoa (New Zealand). This model is something that is taught within undergraduates' programme and utilised within the Waikato District Health Board, as it helps nurses to look at an individual's care holistically. You are invited to participate in a study that explores mental health nurses' perceptions of Te Whare Tapa Whā and how nurses' beliefs and values may impact how or if a nurse applies this model into their practice. This study will be conducted by Samantha Teinakore and supervised by Dr. Anthony O'Brien (University of Waikato) and Nicky Nelson (Waikato DHB). Your participation will involve a short survey.

Ko Ko Taupiri te maunga,
Ko Waikato te awa,
Ko Tainui te iwi
Ko Rukumoana te marae
Ko Ngati Haua te hapu
Ko Samantha Teinakore toku ingoa

I am a Registered Nurse working in mental health for the Waikato District Health Board. I finished my New Graduate year in 2020 and I am continuing with my post graduate studies. Please read the following information to inform your decision to consent to this research. Your participation is completely voluntary and if you do not wish to take part in the research it will not affect your current or future career in any way.

Why are we doing this study?
My name is Samantha and I am conducting a research project for my qualification, Bachelor of Nursing with Honours. My research project will look at mental health nurses perceptions of Te Whare Tapa Whā and how it may impact their delivery of care to tangata whaiora (service users). My interest is in

seeing individuals understanding of the model and if this is the most effective model to utilise in mental health practice.

What your participation will include:

If you consent to participating in this research it will entail completing a survey, where you will answer series of questions about Te Whare Tapa Whā, your understanding and feelings towards this Māori health model and how it may be implemented into your clinical practice. Some intended outcomes from these surveys are to gain a grasp if mental health nurses think this is the most effective model for tangata whaiora and whether it is mental health nurses feel they are getting appropriate education about it. The survey will be conducted via Qualtrics. It will take approximately 5-10 minutes to complete.

Although the mental health nurses involved may have no direct benefit from this study, it will hopefully shape how future holistic care is looked at and the type of models we utilise within our care. Furthermore, sometimes the best learnings and benefits come from reflective thinking and practice, which participants will do during this study.

What will happen at the end of the study:

The information from your surveys will be compiled with information from others, will be analysed and common themes will be identified. This will be written up as a research thesis and submitted to the University of Waikato. This information may also be disseminated to colleagues in the field of healthcare by presentations at conferences or in journal articles.

Confidentiality:

Neither your name nor any identifying information will be used in any documents associated with the research, such as the research report or subsequent publications.

Thank you for taking the time to read the above information about my research and considering to participate in my project. I appreciate your time.

Ngā mihi,

Samantha

My email is: st433@students.waikato.ac.nz

Appendix 4

Te Puna Oranga Māori Research Review Committee

19 July 2021

Re: Māori Consultation for 'Māori and non-Māori mental health nurses' perceptions of Te Whare Tapa Whā.'

Name of Applicant: Samantha Teinakore

Tēnā Koe Samantha,

Thank you for submitting the above research proposal to the Waikato DHB Te Puna Oranga Māori Research Review Committee for Māori consultation. The research application has been reviewed in order to support and prompt the researcher to think about how this research will improve health outcomes and eliminate inequity for Māori living within the Waikato DHB region.

1. The Committee acknowledges the researchers for collecting ethnicity data as part of a demographic background of the participant to improve data collection for Māori in order to improve Māori health outcomes and reduce inequity for Māori.

2. The Committee encourages the research team to actively recruit equal numbers of Māori and Non-Māori. Any Research that involves Māori participation would require sufficient face to face time for fully informed consent to occur. Inclusion of the whānau of the Māori participant should be encouraged to support the continued engagement of the Māori participant in the research process.

3. The Committee encourages all research that involves participation of individuals, especially Māori participants to fully inform them regarding the detail of tissue collection. One consent form for the current use of Tissue. One consent form for the future use of tissue (this should be clear to the participant).

4. Studies using retrospective data must respect Māori data as outlined in Te Mana Raraunga: ***5.1 Respect***. *The collection, use and interpretation of data shall uphold the dignity of Māori communities, groups and individuals. Data analysis that stigmatises or blames Māori can result in collective and individual harm and should be actively avoided.*

   Reference: Te Mana Raraunga: Principles of Māori Data Sovereignty. Brief #1 | October 2018. https://static1.squarespace.com/static/58e9b10f9de4bb8d1fb5ebbc/t/5bda208b4ae237cd89ee16e9/1541021836126/TMR+Ma%CC%84ori+Data+Sovereignty+Principles+Oct+2018.pdf (Accessed August 2019)

5. If cultural issues arise for the Māori participant during any research, they will inform the research team during the study that an issue has occurred. Cultural issues may not be obvious to the participant or the researcher prior to commencement of the research.

6. The Committee encourages the research team to continue to consult with Te Puna Oranga, Māori Health service at any time, should they have any further queries.

7. Feedback regarding this research is appreciated and can be shared back to the Kaunihera Kaumatua via Te Puna Oranga Māori Health Service

The Committee endorses this research proposal with the consideration of the above cultural recommendations where appropriate and requests the researcher to collect ethnicity data for all study participants seen at Waikato DHB for our own internal records.

Dr Nina Scott
Te Puna Oranga-Māori Health Service

Appendix 5

To The Chair, HREC

Thank you for the consideration of my project. Māori and non-Māori mental health nurses' perception of Te Whare Tapa Whā. I appreciate your feedback and I hope that I am able to clarify your questions of concern below.

Te Whare Tapa Whā is explained, but there is limited rationale for the specific research questions – i.e., exploring Māori and non-Māori nurses' knowledge, attitudes and beliefs. The research questions are very broad and it is not clear how the current design will beable to answer all of these (e.g., whether Te Whare Tapa Whā is being taught correctly).
In addition, no information about the content of the survey or potential interview questions are provided in the Appendix.
Te Whare Tapa Whā is a prominent model utilised within nursing, but there is little research about the model and nursing, and even less about mental health and nursing. Therefore, there is a gap in understanding mental health nurses' perceptions of the model and how it affects them wanting to utilise it in care. My research will investigate how mental health nurses feel about the model and whether nurses are using it to provide holistic care. Through this, I hope that this can identify a need for further research about how we can best teach it and if we can be more effective with our implementation into care. The focus on the correct teaching of Te Whare Tapa Whā has been removed.
It is unclear who will be targeted for survey and/or interview. Will this be the same potential pool or not?
The targeted population for my interviews and survey is mental health nurses within the Waikato District Health Board. I will be researching both Māori and Non-Māori mental health nurses. The pool will be potentially the same for both the interviews and surveys as the target populations are the same.
More explanation is needed given the potential for participants to be colleagues, beyond this statement: "Taking this into consideration, I will be [sic] using reflexivity to manage conflict or differences in opinion and seeking support from my supervisors throughout the study." Exactly how will these dual relationships be managed? Is there capacity for an alternative interviewer? Overall the dual roles are insufficiently outlined and mitigated. Related to this, you state that the research does not involve sensitive information, but Mental health nurses are discussing their work with vulnerable populations. Again, dual roles are not addressed in the consenting process.
I recognise that there is a chance I may know or be colleagues with the interviewee. The interviewee will know the name of the researcher/interviewer before coming to the interview as it will be on the participant information form. If the person has concerns about the conflict of interest (i.e. knowing the researcher) they will not be included in the interviews. As this is an honours project there is no capacity to offer an alternative interviewer.
In terms of the sensitive information, the mental health nurses during the interviews will be asked not to give direct examples or to disclose personal information about clients, but will be asked to give generalised examples that will not elicit any specific information about individuals. Any potentially identifying details will not be included in the research report or any outputs.
"For the surveys, completing the survey will be regarded as consent (This will be explained on the survey form)." Instead, consent is usually included as a first item on the electronic survey.
I have added this question to my survey, as the initial question.
An outline of the semi-structured interview with guide questions needs to be attached to the application.
I have attached them in my email. These are my drafted questions, and the final copy will be completed at a later date. Final questions will be developed following a full review of the literature.
A copy of the intended survey with all questions should be attached to the application.
I have attached the email. These are my drafted questions, and the final copy will be completed at a later date. Final questions will be developed following a full review of the literature.
For the interviews, a consent form will be the means of recording." This is very unclear. Given the research involves audio recording of interviews, written consent is required.
I will be obtaining a written consent for audio recording from participants before proceeding with the interview.
The overall process is unclear. Initially it is proposed that an email with Participant Information Sheet (PIS) be sent, and those interested contact the researcher. Yet on Q18. It states that the survey will be sent to mental health nurses.
For the surveys, an email with a participant information sheet and survey form will be sent out to Waikato district health board mental health nurses. Nurses who complete the survey will return their survey anonymously to a DHB administrator In the initial email, participants are made aware that they are able to contact the researcher prior to answering the questions if they wish to seek more information.
Please provide some detail as to the role Nicky Nelson will have as a cultural advisor. What cultural competency does Nicky Nelson have that makes her suited to this role?
Nicky Nelson is a Nurse Educator who holds the portfolio of Cultural support for Nurses. within the professional development unit Waikato District Health Board. She Whakapapas to Rangitaane and Ngati Kahungunu. She has also completed her Masters with the University of Auckland using Kaupapa Māori methodology.

The mention of support for distress (PIS) is not mentioned elsewhere in application and needs elaboration.
As my research may trigger an emotional response during the interviews, it is important for participants to know where they can seek help if they feel they need someone to talk to in regards to their rights when participating in the research. This will be outlined in the PIS and will include EPA services, the participant's own Kaumatua or Chaplain services or such services that can be supplied through the DHB.
Consider potential ethical issues associated with your pre-existing relationships. How will you address these issues in your project?
In my participant information sheet, I will state that I am the researcher and will make sure participants know I am the one doing the interview. If they get uncomfortable during the interview, I can either terminate the interview, or they can withdraw from the researcher if they feel it is best.
The study arises off the shoulders of Te Whare Tapa Whā. Given that premise, Please consider koha for participants. You may find the attached Decision Tree helpful in deciding to offer a koha.
A koha of kai will be offered during the interviews to create a safe space, and ensure the environment transitions from tapu (sacred) to noa (normal). This will support the process of whānaungatanga, which will enable the participants to feel comfortable and create an environment where they can speak freely. It also respects the value manakitanga.
I attached my amended application, and appendices outlining the survey and intended interview questions.
Thank you for your time and consideration,
I look forward to hearing from you.

Appendix 6

The University of Waikato
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Hamilton, New Zealand

Human Research Ethics Committee
Roger Moltzen
Telephone: +64021658119
Email:humanethics@waikato.ac.nz

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

Appendix 5

15 June 2021

Samantha Teinakore
DHECS
By Email st433@students.waikato.ac.nz

Kia ora Samantha

HREC(Health)2021#33 : Māori and non-Māori mental health nurses' perceptions of Te Whare Tapa Wha

Thank you for your responses to the Committee feedback.

We are now pleased to provide formal approval for your project.

Please contact the committee by email (humanethics@waikato.ac.nz) if you wish to make changes to your project as it unfolds, quoting your application number with your future correspondence. Any minor changes or additions to the approved research activities can be handled outside the monthly application cycle.

We wish you all the best with your research.

Regards,

Emeritus Professor Roger Moltzen MNZM
Chairperson
University of Waikato Human Research Ethics Committee

Appendix 7

Participant Consent Form

Project title: Māori and non-Māori mental health nurses' perceptions of Te Whare Tapa Whā
Please note that this form will be held for a number of xx years
Principal Investigators: Samantha Teinakore and Anthony O'Brien
I have read and understood the Participants Information Sheet and What this study entails. I have had the opportunity to discuss this study and I am satisfied with the answers I have been given.

- I understand that the interview is voluntary and that I have chosen by choice to part-take. I know can withdraw my consent at any time, and this will in no way affect my present or future career in health.
- I have a copy of the Participant Information Sheet and I know whom to contact if I have any questions or I wish to make a complaint.
- I understand that my participation in this study is confidential and no material identifying information will be used in any reports on this study.
- I understand that I have the right to change my mind and withdraw from this study at any time, or refuse to answer any questions without giving a reason.
- However, I also understand that three weeks post interview that I can no longer withdraw the information received from/provided in my interview
- I agree to have my interview digitally recorded and that I can have a copy of this supplied to me or and / or a copy of any written transcript. I can also request information to be deleted or removed from these mediums within a three week time frame from receiving the copies.
- I understand that I can stop the digital recording at any time during my interview
- I have had time to consider whether I wish to take part. I have had the opportunity to use family / Whānau support or a friend to help me ask questions and understand the project.
- I wish to receive a summary of the research (tick) ☐

  Address or email for summary:

Please note this form will be held by the University of Waikato for five year

I _____(full name) hereby consent to take part in this study.
Participant Signature: _____
Date: _____

Name of researcher: Samantha Teinakore
Contact email: st433@students.waikato.ac.nz
Project explained by: _____
Signature:_____
Date:_____
This project is approved by the Waikato Human Ethics Research Committee for a period xx years (#xxxxxx).

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