SciMedCentral

Annals of Psychiatry and Mental Health

Research Article

Making Time: Deeper Connection, Fuller Stories, Best Practice

Hinemoa Elder[1]*, Paula Kersten[2], Kathryn McPherson[3], Lyn Dawson[4], Harry Harrison[5], Jaquie Harrison[6] and Adrienne Poulter[7]

[1]*School of Graduate Studies, Te Whare Wānanga o Awanuiārangi, New Zealand*
[2]*Head of School of Health Sciences, University of Brighton, United Kingdom*
[3]*CEO, Health Research Council of New Zealand, New Zealand*
[4]*Blueprint for Learning, New Zealand*
[5]*Whakawhiti Ora Pai, New Zealand*
[6]*Te Hiku Hauora, New Zealand*
[7]*AUT University, New Zealand*

***Corresponding author**
Hinemoa Elder, Te Whare Wānanga o Awanuiārangi and University of Auckland. Po Box 334, Oneroa, Waiheke Island, Auckland 1971, New Zealand, Tel: 6421644462; Email: hinemoa@xtra.co.nz

Submitted: 28 July 2016

Accepted: 29 August 2016

Published: 30 August 2016

ISSN: 2374-0124

OPEN ACCESS

Keywords
- Food
- Gift
- Geneology
- Process of establishing relationships
- Prayer

Abstract

This study explored the experiences of nurse-researchers involved in a study investigating the validation of the Strengths and Difficulties Questionnaire (SDQ).

The parent study involved nurse-researchers providing home-based assessments in 225 Māori homes. Four of these nurse-researchers, more usually involved in clinical work, took part in a focus group exploring their research role working with Māori whānau (extended family). Semi-structured prompts were used. The focus group was recorded and transcribed. Thematic analysis was undertaken.

Both Māori and non-Māori nurse participants highlighted the significance of making time within their assessments. Making time, a collaborative activity with the whānau of the child being assessed gave the participants the impression that it enabled whānau to share more of their stories. Making time to acknowledge, and deliver, Māori cultural practices lead to a richer and more fulfilling process. Participants described adding this experience of making time to their clinical practice as a result of their involvement.

Nurses involved in this study reflected on the value of making time to build connection with whānau. These findings are important in adding to existing knowledge about the importance of how culturally competent practice improves working with whānau. This theme could be explored in other qualitative studies in order to determine how 'making time' is experienced by clinicians from other disciplines, and by whānau themselves, as well as in clinical settings to improve models of care.

INTRODUCTION

Māori tamariki (children), similar to indigenous children from around the world, are recognised as facing health disparities that frequently begin in pre-school years[1-3]. Nurses play a crucial role in supporting whānau (extended families) to identify their strengths and challenges and to work towards oranga (health) [4,5]. The experience of Māori nurses, particularly in mental health are well documented [6,7]. However, the experience of both Māori and non-Māori nurses working with Māori whānau in hybrid clinical-research roles has not been reported. This study explored those experiences.

Māori

Māori are the indigenous people of Aotearoa New Zealand. In the most recent New Zealand Census of Population and Dwellings, held in 2013, 668,724 respondents reported being of Māori descent, almost 17.5% of the New Zealand population [8]. The Census also found that Māori continue to be a young population with approximately 33% under 15 years old [8]. Tamariki (child) health and wellbeing is therefore a significant matter for New Zealand given that serious mental disorder is more likely to first present in younger people [9].

Background

We recently carried out a study of the validity of the Strengths and Difficulties Questionnaire (SDQ) [10] for the screening of 4 and 5 year old tamariki [11]. The SDQ is one of the tools used in the New Zealand before School Check (B4SC) [12]. The B4SC aims to promote health and wellbeing in preschool children by screening for behavioural, developmental or other health concerns that may affect the child's ability to learn in the school environment

in early childhood. Using focus groups and interviews we conducted a qualitative interpetative descriptive study as part of that study interviewing a total of 65 parents and teachers from Māori, NZ European, Asian, Pacific and other cultures which we have reported elsewhere [11].

The study employed both Māori and non-Māori nurses to conduct home visit 'gold standard' assessments of two hundred and twenty-five Māori four and five year old tamariki. Regular debriefings with the nurse-researchers were undertaken during which they raised questions about their roles as Māori and non-Māori. In addition, one of the issues raised by the study centre's Māori Advisory Committee was the recommendation to only appoint Māori nurses to the nurse-researcher role. The authors sought wider Māori opinion with community partners, Māori researchers and practitioners. The views elicited included that the key issue for best outcomes from a whānau (extended family) perspective was that the best person for the job should be involved, Māori or non-Māori. In addition, the legal requirement for all practitioners to be competent to work with Māori whānau was put forward as a reason to involve both Māori and non-Māori nurse-researchers. The study aimed to reflect what was happening in practice, this being with practitioners with a wide array of cultural identities which added further to the importance of Māori and non-Māori involvement. The limited numbers of Māori nurses to provide these roles in the community was again cited as a reason to include Māori and non-Māori. In adition, there was recognition that the Māori nurses recruited had difffering experiences of being Māori and one of the Māori researchers (HE) led the training to support these varying needs for cultural support. This qualitative sub study was therefore undertaken to more formally investigate these issues.

METHODS

Nine nurse-researchers were employed on the study; three Māori, six Non- Māori (of whom two had a Māori spouse). The nurse-researchers had been orientated to the research project with a series of interactive workshops where a comprehensive view of child development from the perspective of Te Ao Māori (the Māori World View) was presented [13]. Subsequent to this training, the nurse-researchers made telephone contact with whānau who had expressed interest in participation and took healthy kai [1] to the home as a koha [2]. Home visits took between 30 and 170 minutes with an average of 80 minutes (SD=24 minutes). All nurse-researchers were invited to take part in a focus group on completion of the study. Four of the nine agreed to participate and provided informed consent. The focus group was facilitated by the first author and co-facilitated by the second author. Semi-structured prompts were used. The topics came from the de-briefing sessions previously held with the nurse researchers throughout the parent study. The focus group was audio-taped and transcribed verbatim. Thematic analysis was employed, using an inductive approach [14]. The transcripts and data interpretation were sent to participants for member checking. One participant requested a change to one sentence in the transcript, however, this did not substantially change the meaning of the sentence. In addition, we conducted a targeted analysis of our other study focus group and interview data (n=65) [11] to check for resonance of themes from the nurse focus group data with data from whānau themselves. Data presented are anonymised to protect participant confidentiality. Codes are used for participants with *N* reflecting nurse participant and *W* reflecting whānau.

The study was approved by the institutional ethics committee.

RESULTS

The four participants included one Māori, two NZ European and one Australian- born nurse-researchers. All were nurses experienced in mental and pediatric health.

One overarching theme was identified: the role of making time. Several aspects (or sub-categories) of this concept were identified: making time enabled stories to emerge; making time was the way nursing practice should be; making time for cultural practices led to deeper connection; making time led to talking about strengths; and making time was a practice for clinical work that participants took from their experience in this study.

At the core of the idea of making time was a jointly created experience of the whānau and the nurse-researcher, as in, "we made time". "Like there is no time pressure…there was always other stories that came out because we made the time for it." N1 "Yeah it took quite a bit of time to get the full story and understanding of how it all works… just being. And it felt like, that's the way it should be. I enjoyed that. And I have taken that on to my practice … it's like the missing component." N3 Making time for cultural practices was identified as leading to deeper, authentic connection associated with openness from whānau.

"Because I am from up in that area the whakapapa took ages and we just had to make that whakawhanaungatanga connection before we even started." N4 "I could make connections as well like from when my grandparents grew up and my great grandparents relationship with Māori when they first came to New Zealand, I really enjoyed it…Having that time to get in at a deeper level." N3

"I think it's about being authentic. My karakia was actually corrected by a child on one occasion. My pronunciation. It's about being authentic too, you know. And being comfortable with yourself." N2

"Making time also led to a clearer identification of strengths, rather than focusing on difficulties or perceived pathology. I guess that's what spending time with people teases out, the strengths within a whānau about resources that can help and you don't necessarily need to get respite nurses in at all. You know what I mean, just spending time to find what are the strengths rather than just looking at the problems." N3

Rigour

Given this small sample of nurse-researcher participants, we undertook a targeted analysis of the transcripts of our larger qualitative study with parents, (n=65). We found many instances of the centrality of taking time in these data too. Although these data will be reported on more fully elsewhere [11], a few data extracts are provided below from Māori whānau:

W2 "I would prefer to sit down and talk about it even if they ask me the question rather than me just reading it."

W1 "someone who actually had the time so they actually took

the time to do this"

W1 "rather than just a quick visit and tick the box"

W3 "The nurse or whoever taking charge has to spend a bit more time"

W7 "And it took her a while when the nurse came, it took her a while to suss her out."

DISCUSSION

The central ideas that were explored regarding the importance of making time are consistent with other research [15]. Importantly, our findings are akin to other work that underlines the potency of cultural competency in working with Māori [7].

All participants voiced in different ways the importance to them of being able to make time with whānau and the resulting benefits. They reflected that making this time was a "missing" piece of their clinical work where they expressed their sense of pressure to do things more quickly. This resonates with other research findings where tensions are apparent between mainstream practices and training and indigenous health workers ways of knowing and connecting in order to better meet Māori needs [6,7,16-18]. Time is well recognized in Māori and other indigenous research and practice as being culturally bound, and integral to optimal outcomes [15]. Our study has highlighted that non-Māori nurse-researchers also recognized the importance of making time, and in fact, being involved in the research facilitated that recognition, particularly for the non-Māori nurses. This is an important finding in the Aotearoa New Zealand context for a number of reasons. The significant disparities in Māori health compared to non-Māori [3] mean that Māori practitioners alone cannot provide for these needs. Culturally safe and dually competent non-Māori health workers are needed to ensure that Māori health needs are appropriately responded to. Our finding that making time to ensure cultural practices such as whakawhanaungatanga and karakia, provides helpful detail for practitioners about how these competencies need to be applied.

The New Zealand Health Practitioners Competence Assurance Act 2003, section 118 states that the function of authorities such as organizations that provide registration to health workers is "to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession"[19]. The partnership relationship between Māori and the Crown, underpinned by Te Tiriti o Waitangi means that both non-Māori and Māori health workers must be competent to work with Māori whānau [6,20] . Recently reported detail about the content of culturally competent assessments provides additional context [21]. What our findings add is the importance of the time factor, without which the content issues may not be adequately addressed, may be misinterpreted or may be missed completely [16].

Perceived (or actual) restrictions on the time health workers have is well recognized as a barrier to person-centred care [22]. However, our findings indicated that making time during assessment was possible even in a one-off assessment, leading it to be a shared activity. The importance of time at the beginning of an interaction resulted in the "formation of a partnership" between practitioner and whanau, as found also by others [18] (page 1001).

This study is limited by the small number of participants. The study is also limited by the small number of Māori in the focus group. This could have contributed to less emphasis on Māori cultural aspects of experience by the participants. However, participants came from a range of backgrounds and all had much to say about their reflections in regard to cultural aspects of their experience. Our study did not set out to explore the impact of making time from the whānau perspective. However, demonstrating a connection with patients is increasingly considered key to engaging patients in their healthcare [18], and evaluating outcome in future work is warranted. Our review of other data from Māori in the larger study's focus groups found similar themes suggesting that the idea of making time was of broader consideration. Focusing on this theme of making time and the degree to which this is perceived to be occurring by both clinicians and whānau could be very helpful in tailoring future research projects and developing whānau-centred clinical models of care.

CONCLUSIONS

A focus group of one Māori and three non-Māori Nurse-researchers reflected on making time with whānau as a, "missing" piece of their clinical practice in the context of conducting home visit assessments of tamariki at their whānau home. While this is a small sample the theme was consistent with ideas expressed in the transcripts of parents of Māori children interviewed as part of the larger project. These findings are consistent with others that show that making time in the assessment phase has significant benefits both to the 'index patient' or client and their whānau and the health workers themselves [18]. We recommend that the theme of 'making time' be considered when evaluating current practice in Before School Checks as well as in future research in this area.

We thank study participants for sharing their experiences with the research team. This study was supported by the Ministry of Health of New Zealand (grant number 341088).

Relevance for clinical practice

Nurse researchers on our study found that 'making time' was an important strategy for engaging with the study participants. However – they reflected that this was not their experience of clinical work. Time pressured clinical interactions may risk diminished quality of information sharing, and therefore reduced impact of, and satisfaction with the interaction for both whānau and clinician. These findings suggest a wider applicability where early investment of time with whānau, including making time for cultural practices can contribute to better, richer and more valuable interactions which in turn lead to more accurate assessments and management recommendations.

REFERENCES

1. King M, Smith A, Gracey M. Indigenous health part 2: the underlying causes of the health gap. Lancet. 2009; 374: 76-85.

2. Bramley D, Hebert P, Tuzzio L, Chassin M. Disparities in indigenous

health: a cross-country comparison between New Zealand and the United States. Am J Public Health. 2005; 95: 844-850.

3. Robson B, Harris R. Hauora: Maori standards of health IV. A study of the years 2000-2005. Wellington: Te Ropu Rangahau Hauora a Eru Pomare; 2007.
4. Wills R, Morris MK, Hedley C, Freer T, Morris H. Improving school readiness with the Before School Check: early experience in Hawke's Bay. NZ Med J. 2010; 123: 47-58.
5. Clendon J, Dignam D. Child health and development record book: tool for relationship building between nurse and mother. J Adv Nurs. 2010; 66: 968-977.
6. Baker M, Levy M. E toru nga mea. Pimatisiwn A Journal of Aboriginal and Indigenous Comunity Health. 2013; 11: 471-483.
7. Wilson D, Baker M. Bridging two worlds: MÄori mental health nursing. Qual Health Res. 2012; 22: 1073-1082.
8. Statistics New Zealand. Census 2013 Wellington; 2013.
9. Oakley-Brown MA, Wells JE, Scott KM. Te Rau Hinengaro. Wellington: Ministry of Health. 2006.
10. Goodman R. The Strengths and Difficulties Questionnaire: a research note. J Child Psychol Psychiatry. 1997; 38: 581-586.
11. Kersten P, McPherson K, Elder H, Dudley M, Vandal A, Nayar S, et al. A validation and norming study of the strengths and difficulties questionnaire in the New Zealand context. Final report for the Ministry of Health. Auckland: AUT University, 2013.
12. Ministry of Health. The B4 School Check. A handbook for practitioners. Wellington: 2008.
13. Ministry of Education Training Unit. Atawhaingia Te Pa harakeke. Nga Rawa Mo te Rito o Te Pa Harakeke. Wellington: Early Childhood Education. 2007.
14. Todd NJ, Jones SH, Lobban FA. "Recovery" in bipolar disorder: how can service users be supported through a self-management intervention? A qualitative focus group study. J Ment Health. 2012; 21: 114-126.
15. Elder H. Indigenous theory building for Maori children and adolescents with traumatic brain injury and their extended family. Brain Impairment. 2013; 14: 406-414.
16. Elder H. Ko wai ahau? (Who am I?). How cultural identity issues are experienced by Maori psychiatrists and registrars working with children and adolescents. Australas Psychiatry. 2008; 16: 200-203.
17. Koptie S. Irihapeti Ramsden: the public narrative on cultural safety. First Peoples Child and Family Review. 2009; 4: 30-43.
18. Bright FA, Boland P, Rutherford SJ, Kayes NM, McPherson KM. Implementing a client-centered approach in rehabilitation: an autoethnography. Disabil Rehabil. 2012; 34: 997-1004.
19. Parliamentary Counsel Office.
20. Durie MH. The Treaty of Waitangi and health care. NZ Med J. 1989; 102: 283-285.
21. Balaratnasingam S, Anderson L, Janca A, Lee J. Towards culturally appropriate assessment of Aboriginal and Torres Strait Islander social and emotional well-being. Australas Psychiatry. 2015; 23: 626-629.
22. McPherson KM, Kayes N, Weatherall M; Members of the Goals-SR Research Group. A pilot study of self-regulation informed goal setting in people with traumatic brain injury. Clin Rehabil. 2009; 23: 296-309.

Cite this article

Elder H, Kersten P, McPherson K, Dawson L, Harrison H, et al. (2016) Making Time: Deeper Connection, Fuller Stories, Best Practice. Ann Psychiatry Ment Health 4(6): 1079.