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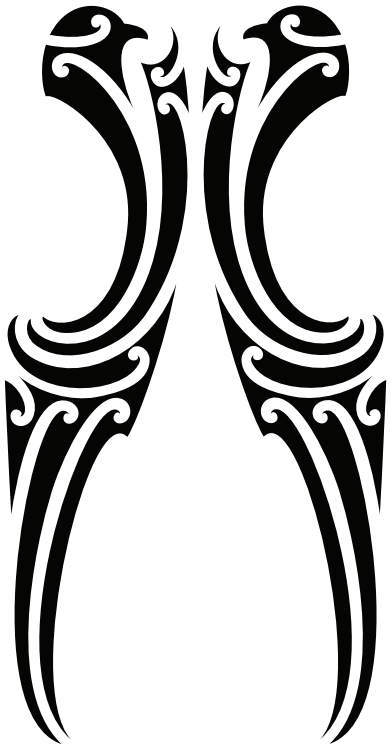
Whakataukī

Ko te manu e kai ana i te miro, nōna te ngahere.
Engari, ko te manu e kai ana i te mātauranga, nōna te ao.

The one who partakes of the flora and fauna, that will be their domain.
The one who engages in education, opportunities are boundless.



Ākonga

The concepts of Kotahitanga (togetherness, unity and collective action lifting each other up, identifying as one) and Poutama (the pursuit of knowledge) guided the design of the two tohu – 'Kaitiakitanga' and 'Ākonga'. The 'Ākonga' tohu, featured on the front cover of this journal, tells a story about how the kōrari (flower of the harakeke) feeds, sustains and supports the ākonga – manu. When 'Ākonga' is facing belly to belly, it shows the interaction of ākonga – learning and growing together.

MANUKORIHI WINIATA (Ngāti Raukawa, Te Āti Awa, Ngāti Awa, Ngāti Tūwharetoa) crafted our Tohu and is an established Māori artist.

Visit our website for more information on our tohu, www.whitireiaweltec.ac.nz/our-tohu

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The Place of Tangata Moana: The Whitireia Experience

EDITORIAL BY TANIA MULLANE, TAULAPAPA LOMA-LINDA L. TASI, TERAMIRA SCHÜTZ & LOHA ISAAKO-TOLOA

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This editorial aims to highlight the importance of Pacific peoples in Aotearoa New Zealand as tangata moana, and how being proactive Te Tiriti o Waitangi partners is essential to supporting better outcomes for Pacific peoples. This, we propose, can be achieved by retaining and practicing Indigenous values that reflect, complement and align with the uniqueness of tangata moana, whilst also respectfully supporting those of tangata whenua.

We suggest that this can be better achieved by acknowledging and celebrating the shared whakapapa, cultural and relational bonds of tangata whenua and tangata moana, created by historical migrational movement within the vastness of Te Moana-Nui-a-Kiwa, while retaining distinct indigeneity in their own right.

These historical relationships and shared whakapapa allow the natural occurrence of several things for tangata moana at Whitireia:

1. Exploration of how kaupapa Māori aligns closely with Pacific values and methodologies, rather than with Western, Eurocentric research methodologies. Any promotion of kaupapa Māori and Pacific frameworks and methodologies that support Māori and Pacific peoples allows us to take control of our own definitions, relationships and connections.
2. Context to the tuākana and tēina relationship that exists between Māori and Pacific peoples in Aotearoa, which to some extent is mirrored with the development of the Bachelor of Nursing Pacific (BNP) and the Bachelor of Nursing Māori (BNM).

On many occasions the BNP programme and team members have been personally and professionally challenged to justify the existence of a specific Pacific Nursing programme, in spite of over 450 BNP graduates now positively contributing to the nursing workforce. The need is undeniable, as we are the fastest growing population in Aotearoa. This means that, more so than ever, we will need health provision that reflects who we are, where we are from and how we identify ourselves.

I would like to welcome and introduce my Pacific whānau who work alongside me in the BNP to highlight their research and views that promote and advocate the importance of 'by Pacific for Pacific', and how we are holding strong to this position within the BNP. –**Tania Mullane**

The development of the BNP in 2004 was an inaugural and paradigm-shifting approach to nursing education in Aotearoa. The BNP curriculum uniquely integrates the diasporic and diverse Pacific ethnic traditional knowledge systems that inform nursing practice and health professionals in the

healthcare sector, in partnership with the Pacific communities across the motu.

Mentorship was a significant part of the inaugural BNP curriculum, and it was integrated and woven into the teaching, learning and assessment work. BNP students had to indicate who their mentors were prior to enrolment. Mentors include both cultural and academic support through connections with Pacific community and leaders, and Pacific registered nurses in Aotearoa.

Now, 20 years since the launch of the BNP at Whitireia, the new BNP Kuta Framework and curriculum developed in 2020 further integrates the roles of Pacific leaders in nursing and Pacific graduate experience in the health sector (Mullane et al., 2020). Mentorship for Pacific student nurses now continues with the increased number of Pacific registered nurses and leaders in the community. Pacific leadership for nursing encapsulates the vast diversity of knowledge and expertise among the existing and growing Pacific health workforce. For BNP graduates, their contribution to the health sector is gaining momentum and continuously being realised. As an intended outcome of the BNP degree programme, having more Pacific nurses in the sector delivering culturally relevant practice in addition to nursing expertise is a positive outcome for the Pacific community, who are still disproportionately represented in the need for healthcare support at all levels: primary, secondary and tertiary care. As current and future leaders, BNP graduates have a significant place in the healthcare sector, and their contribution to the health and well-being of all citizens of Aotearoa must be acknowledged. To navigate two or more paradigms of well-being, the competent and highly skilled BNP graduate diaspora are well placed to participate in the modern-day healthcare workforce (Tasi, 2022).

–Taulapapa Loma-Linda L. Tasi

Understanding and acknowledging Indigenous Pacific students' distinctive cultural contexts and backgrounds are critical to providing culturally appropriate pedagogy across the three years of the BNP programme. The BNP kaiako are designated to collaborate with Pacific ākonga, along with their whānau, and academic and cultural mentors in order to realise and understand the individualities of ākonga, including their cultural world views, knowledge, strengths, potentials and learning styles, as well as identifying their learning gaps. This collaboration and understanding of the pedagogical level and cultural knowledge of individual ākonga are important as these set the scene for the BNP kaiako to plan, design and implement a culturally appropriate and holistic teaching model to best support Pacific learners. The BNP programme has also extended this approach to 'Other Migrants' who have enrolled in the programme. Evidently, the implementation of the Kuta Framework (Mullane et al., 2021) in teaching the Bioscience-Nursing Praxis course has made a difference to ākonga understanding. Weaving the indigenous knowledge and world views of ākonga about body structures and functions, causes of diseases, health, well-being and illnesses with Western knowledge of medicine and nursing has naturally bridged the gaps in their learning. The weaving of the diasporic world views also makes learning easier as ākonga relate to their cultural perspectives and increase their understanding as they use their own Pacific ethnic nuances and languages in the first instance to find meaning in complex medical and nursing concepts. As a kaiako, I also use 'Te Kora' framework, a Kiribati research methodology that I developed to understand how I-Kiribati navigate health practices in Aotearoa (Schütz, 2017, 2022). 'Te Kora' is a Kiribati traditional string, made with two filaments of dry coconut fibres. The two filaments are rolled between the thumb and index finger on the thigh of the person who makes 'Te Kora' (Schütz, 2017). To contemplate 'Te Kora' framework as a Pacific pedagogy to support our BNP Pacific learners, I think of one filament as the Western nursing concepts, and the other filament as the cultural world views of ākonga and their indigenous perceptions of health, well-being and illnesses. The spinning or rolling of 'Te Kora' represents how ākonga navigate and make

sense of the two world views in their learning spaces and levels. I envision that when 'Te Kora' is loosely made, both the ākonga and kaiako will undo 'Te Kora' and find out why the end product is not strong. When this context is applied to the teaching–learning space, when 'Te Kora' is loose and poorly made it means that the ākonga is not prepared, confident and competent either culturally or academically in the nursing and health disciplines. When this happens, both the ākonga and kaiako must reflect on the teaching–learning approaches to ensure that the learning needs of the ākonga are met through the application of a holistic and culturally appropriate teaching model. This reflection is important in the evaluation phase, where the learning progress of nursing ākonga is evaluated in conjunction with the kaiako teaching approach to ensure that Pacific ākonga learning gaps are addressed, and that they receive the appropriate cultural and holistic teaching approach for success. **–Teramira Schütz**

PERSPECTIVE OF A NEW PACIFIC ACADEMIC

I am honoured to be part of the BNP kaiako team and to contribute to this editorial. My perspective is that of a new Pacific kaiako as well as ākonga, for there is so much to learn in my quest to be a competent Pacific kaiako in academia. My transnational journey to Aotearoa from the Tokelau islands is no different to those of many Pacific people, their Aotearoa-born children, and the children of the children of tangata o Te Moana-Nui-a-Kiwa. Many Tokelauans who live in Porirua first migrated in the mid-1970s. Today there are at least three to four cohorts of Aotearoa-born Tokelauans living in the Porirua region. This is an area that needs in-depth analysis, though it is safe to say that there is greater diversity and complexity among these cohorts as their number increases. Many have studied and completed the BNP at Whitireia Community Polytechnic since its inception in 2004. So, as I immerse myself in this new role, I am more aware of my place and that of my fanau as tangata moana in Aotearoa and in the context of Te Ao Māori world views. Tokelauan practices of mutual respect, and peaceful and harmonious living align well with Te Tiriti o Waitangi principles that guide the Kawa Whakaruruhau framework. These similar world views encourage and support practices that promote equity, diversity, inclusion and the rights of tangata whenua and all the people living in Aotearoa. It is pleasing to be in the knowledge that many Tokelauans and Pacific people alike have come through the doors of the BNP. For me so far, it is a liberating journey of self-discovery, reflection and appreciation of my place as tangata moana in contemporary Aotearoa. Fakafetai lahi. **–Loha Isaako-Toloa**

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Third-year Ākonga Reflections on the Bachelor of Counselling and Addiction Practice: Evaluating the Degree

STEVE HOGAN & LEE SMITH

Wellington Institute of Technology's (WelTec) Bachelor of Counselling and Addiction Practice (BCAP) is for ākonga who wish to be counselling and addiction practitioners. This study explores ākonga experiences of the dual-focus degree, their perspectives on the most significant course learning and suggestions for course improvements. Fifteen final-year ākonga completed a hard-copy survey with a nine-item, five-point Likert scale and five open-ended questions. The Likert response data is presented in table format, while a semi-deductive thematic analysis of the qualitative data was undertaken. The majority of ākonga rated placement learning, counselling modalities and cultural aspects of the course as the most significant learning that they would implement in their future clinical practice. Suggestions for course improvements were: providing free supervision, more face-to-face teaching and increased content on trauma, rainbow clients, children and young people. Given the coexistence of mental health concerns and addiction, more dual-focus courses are needed. Exploring ākonga perceptions of these relatively new courses can inform the course's development.

KEYWORDS: addiction; counselling; substance use disorder; tertiary education; undergraduate

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Each year, 25% of Aotearoa New Zealand's population experience mental illness or distress, rising to between 50% and 80% across the expected lifespan (New Zealand Government, 2018). People with mental health concerns are more likely to experience substance use disorders (SUDs) and process addictions (e.g., shopping or gaming) than those who do not. The government estimates that 12% of the nation's population will develop an SUD across their lifespan, with 70% of this figure having a coexisting mental health concern (Ministry of Health, 2018). Consequently, counsellors will likely have clients dealing with or recovering from addiction, or who are family members of those with addiction disorders. It is therefore imperative that counsellors should be trained to identify, refer and/or treat clients with SUDs and process addictions (Cavaiola et al., 2022). The early detection of addiction could enable those with SUDs to seek help earlier, reducing the negative impacts of addiction on themselves,

their whānau and society (Hagedorn et al., 2012). In 2018, the national cost of serious mental health concerns/illness and addiction was estimated to be $12 billion, which is likely to have increased (New Zealand Government, 2018).

Numerous international studies have been undertaken on developing counselling ākonga confidence, resiliency and self-efficacy through their placements, work with clients and supervision (Belser et al., 2018; Guindon, Myhr, & Renaud, 2022; Karis & Kim, 2022; Min, 2022; Saki & Şahin, 2012). Research has also found that counselling ākonga experience personal growth and enhanced interpersonal relationships throughout their counsellor education (e.g., Rak et al., 2003; Sounders et al., 2009). Much research also focused on exploring the mental wellbeing of counselling ākonga, as well as the effectiveness or ineffectiveness of personal counselling for some (e.g., Edwards, 2018; Richardson et al., 2018). Fewer studies focus on counselling ākonga experiences and learning from their undergraduate training, except for placements and supervision (Smith et al., in press). This is why some of the literature reviewed here can be considered somewhat dated.

When it comes to addiction, traditional moralistic discourses have led to the societal stigmatisation, incarceration and punishment of those with SUDs (Chasek, 2017; White, 2014). In the past two decades, however, a shift in attitudes towards addiction has occurred. Nowadays, addiction is framed as a disease rather than a moral failing. Yet, some people, including counselling ākonga, continue to view addiction as a behavioural flaw, a bad choice and/or a punishable offence (Dice et al., 2019; White, 2014). Such negative views are likely to compromise the recovery of clients with SUDs who seek counselling support (Cornfield & Hubley, 2020). Nevertheless, negative attitudes of ākonga can be changed through placements in addiction services, education and training, and regular supervision (Flynn, 2023; Gutierrez et al., 2020; Johnson, 2018).

In 2018, the New Zealand Government conducted a national inquiry into mental health and addiction (New Zealand Government, 2018). They found that although most mental health professionals enjoyed their work, many were burnt out and leaving the sector. They also found that wait times for those seeking treatment were too long, and some people who sought care were not treated with respect or dignity. The inquiry and other research studies identified Māori, Pacific, Rainbow communities, disabled people, migrants and refugees as groups with unmet mental health needs (Fenaughty et al., 2021; Fraser, 2022; New Zealand Government, 2018; Su et al., 2016). To better meet the needs of those with mental health concerns and SUDs, the New Zealand Government (2018) report stated that more services need to employ holistic models of health and well-being. Such models are embedded in the curriculum of the Bachelor of Counselling and Addiction Practice (BCAP), which was introduced at the Wellington Institute of Technology (WelTec) in 2018.

THE BACHELOR OF COUNSELLING AND ADDICTION PRACTICE

In 2018, the Bachelor of Addiction (three-year degree) and Bachelor of Counselling (four-year degree) were merged to form the BCAP. These programmes were combined because placement providers and the industry recognised how often clients presenting with mental health concerns also had an addiction component and vice versa. The BCAP is the only dual-focus national degree for ākonga who wish to become professional counselling and/or addiction practitioners. Unlike many counselling courses, which may have one or two papers focused on addiction, the BCAP is unique in that its aims and objectives focus equally on counselling and addiction practice. These two different, but connected, aspects of the mental health continuum are a current national concern (New Zealand Government, 2018). BCAP graduates are equipped with the necessary knowledge, skills and capability to adapt and respond to ongoing change in the counselling and addictions fields.

This research project aimed to explore ākonga experiences of the BCAP, their

perceptions of the most significant course learning, aspects of the course they would implement in their post-graduation clinical practice and suggestions for improving the course. The research question was 'what are BCAP ākonga experiences of the BCAP, their perspectives on the most significant course learning, what aspects of the course they would implement in their post-graduation clinical practice, and recommendations for change?'

METHODS

The researchers developed a survey containing nine-item, five-point Likert scale questions and five open-ended questions. The Likert scale is common in education research and convenient for gathering data, and the open-ended questions allow for ākonga to make more detailed comments (Rouder et al., 2021). All questions were developed by both researchers and informed by literature on, and experience in, counselling and addictions education.

Ethics approval was obtained from the Whitireia and WelTec Ethics and Research Committee (reference RP 335–2022) in April 2022. The first researcher is a tutor in the BCAP, while the second is not. To avoid a potential conflict of interest, the second researcher was the one to discuss the project with the final-year ākonga in class. After ākonga questions had been answered, an information sheet, consent form and hard-copy survey were distributed. A hard-copy survey was selected as they tend to have a higher response rate than online surveys (Ebert et al., 2018). The survey was to be completed in their own time, but ākonga asked to complete it in class. Some more engaged participants even completed it during their lunch break. A total of 15 final-year ākonga (74% of ākonga enrolled in the third-year) completed the survey. No demographic data is reported given the number of participants and therefore the higher potential for identification.

Rather than conducting a complex statistical analysis of the Likert response data (e.g., t-test or ANOVA), a simple sum of responses for each item was completed, with results presented in table format for easy readability (Table 1) (Boone & Boone, 2012). However, not all participants responded to each Likert item, so some response tallies do not equal 15. Although we don't know why this occurred, it could be a simple oversight, which is common in hard-copy surveys (Ebert et al., 2018). Nevertheless, five students chose not to respond to an item about whether their supervision was good, which may suggest otherwise.

The qualitative data was analysed using a semi-deductive thematic approach based on the constant comparative method (Maykut & Morehouse, 1994). Rather than utilising an online qualitative analysis programme, such as those used on large data sets (Cypress, 2019), the coding and analysis was done manually. Each completed survey was read multiple times where initial patterns occurring in the responses were identified (Maykut & Morehouse, 1994). The excerpts that were identified as exemplifying a pattern were colour-coded on photocopies of the hard-copy surveys. Computer files were created that corresponded to the identified patterns, and excerpts that illustrated these patterns were typed into the relevant file. If the excerpts were consistent, a theme was created. The numerous themes are presented in the following findings section.

FINDINGS

The Likert data is reported in Table 1. The overwhelming majority of participants strongly agreed/agreed with the statements 'I have enjoyed the BCAP course' (12 participants), 'After graduation I wish to have a career in counselling and addiction practice' (13 participants), 'Overall, the course content will be relevant to my future career as an addiction and/or counselling professional' (14 participants) and 'After graduation I will take the knowledge and skills I have learned in the BCAP programme and implement it in my practice' (14 participants). Fewer participants strongly agreed/agreed with the statements 'My supervision was good' (6 participants) or 'After graduation I wish to have a career in addictions' (8 participants).

Statement	Strongly agree/ Agree n (%)	Neither agree nor disagree n (%)	Strongly disagree/ Disagree n (%)	No response n (%)
I have enjoyed the BCAP course	12(80)	3(20)	–	–
After graduation I wish to have a career in addictions	8(53.3)	4(27)	2(13.3)	1(6.7)
After graduation I wish to have a career in counselling	11(73.3)	2(13.3)	2(13.3)	–
After graduation I wish to have a career in counselling and addiction practice	13(86.7)	2(13.3)	–	–
Overall, the course content will be relevant for my future career as an addiction and/or counselling professional	14(93.3)	1(6.7)	–	–
The BCAP course prepared me for my future career	11(73.3)	2(13.3)	1(6.7)	1(6.7)
My placement was valuble to my career	13(86.7)	1(6.7)	–	1(6.7)
My supervision was good	6(40)	2(13.3)	2(13.3)	5(33.3)
After graduation I will take the knowledge and skills that I have learned in the BCAP programme and implement it in my practice	14(93.3)	–	–	1(6.7)

TABLE 1: LIKERT SURVEY RESPONSES

Positive Comments about the BCAP

Although they were not asked about what aspects of the course they enjoyed, five participants made favourable comments about the BCAP in the open-ended questions. For instance, participants 3 and 13 respectively said 'Loved the course being both counselling and addictions, being exposed to both' and 'I feel like I have had more counselling training in my addiction placement than many other addiction practitioners'. Studying for the degree also made participant 5 aware that 'learning was ongoing', while participant 4 also reported that 'WelTec and its ethos have and provide a wonderful rhetoric [regarding] "lifelong learning"'. Participant 15 also said that WelTec 'has a few extremely seasoned, experienced, and highly knowledgeable tutors, which are a wonderful asset'.

Significant Learning

When asked what specific aspects of the BCAP they would implement in their future clinical practice, seven participants mentioned their placement learning. These comments are typified by the following excerpt from participant 7, 'Placement has been where most of my learning has happened for me'. Participant 5 also said that their learning from a placement 'in a kaupapa Māori organisation' was the most significant learning that they would implement in their clinical practice. Despite almost half of the participants listing placement learning, almost none specified what this learning was, though participant 11 said 'practical experience'. However, several participants made critical comments about their placement organisation.

For instance, participant 2 stated 'I've had huge inconsistencies in the number of hours I've been offered and what has been counted'. Participants 3 and 6 commented in more depth:

> *Placements are not following the handbook. I have not had a single placement that has followed the supervision, or hours of the placement. Placement costs $258 at the [District Health Board] for a blood test, this is a lot for a student to find. (P3)*

> *I found it difficult that I did my addiction placement first and most of the class did their counselling placement. So, when I was doing my counselling placement, I found that the classes were more addiction focused, which I already knew. If a class does the same placement type, at the same time, this wouldn't be an issue. (P6)*

Participant 10 also said that '[There] needs to be more preparation for student placements including systems, service structure, governance… education working with LGBT+ or cultural minorities/people with intersecting identities'.

Seven participants also listed counselling modalities (counselling methods) as the aspect of their learning that they would implement in their clinical practice. Some of these participants said that they would utilise 'all modalities learned' (P13), or that they 'enjoyed the variety of modalities' (P4). Others listed a specific modality, such as 'ACT [Acceptance and Commitment Therapy]' as an important aspect of their learning (P1).

Three participants mentioned that 'biculturalism' (P15), 'cultural knowledge' and 'Te Tiriti [o Waitangi] paper and marae visit' (P7) were aspects of their learning that would be the most useful in their career. As reported previously, participant 5 stated that their work placement 'in a kaupapa Māori organisation' was the most valuable aspect of their learning for their future clinical practice. However, when it came to recommendations for change, other ākonga called for 'more Te Ao Māori classes and focus' (P6), 'more Māori cultural practices and design into all papers' (P5), and more 'Māori ways of working' (P10).

Recommendations for Change

All participants identified areas for improvement in the course content or organisation of the BCAP, however, the most common response related to the cost of supervision. Participant 6 said supervision should be funded by WelTec, or that they needed some 'financial support' to pay for it. Similarly, participant 14 said 'Counselling supervision should be funded through the School. This is a huge financial stress on students and is a class-based issue that leads to less diversity of students [and] social workers get paid [on] placements so should counselling and addiction students'.

Two participants also stated that personal counselling should be mandatory for the ākonga. For instance, 'Personal counselling and mental health support needs to be made available to all attending students in all years' (P1) and 'Mental Health and wellbeing focus for students [and] personal counselling to be required once more to ensure safe practitioners' (P6).

When it came to the curriculum, some participants suggested that there needed to be more content on 'working with children' (P6), 'child and youth mental health training/theory' (P10) and counselling 'different age groups and genders' (P11). Two further participants maintained that the course needed more 'trauma informed perspectives' (P4), and a greater focus on 'addictions counselling […] and counselling modalities' (P13). Another two recommended more content on 'ethics [and] values work' (P1) and 'co-existing mental health problems […] practical counselling triads […] personal counselling… [and] assessment-intervention planning' (P8).

Three participants made suggestions for the course delivery, like including more tutor demonstrations and guest speakers. For instance, 'it would have been great to have counselling tutors who were prepared to demonstrate skills' (P4) and 'having more guest speakers would be great' (P14). Another two participants also discussed the need for more material/classes on trauma, including 'Guest speakers and tutors sharing their experiences

and how the sector is understanding trauma' (P14) and 'trauma training' (P12).

Given that the BCAP is a blended course (taught online and in person), some participants also made recommendations regarding the ratio of face-to-face and online classes. For example, 'Being a practical course, I think more face-to-face classes would be beneficial, where we can practice skills etc with the supervision of a tutor' (P12) and 'Keep Zoom classes to a max of two hours, one hour content and one hour practical. Zoom fatigue is real' (P14).

DISCUSSION

From an ākonga perspective, it appears that the BCAP is producing knowledgeable, skilled and clinically competent graduates, as evidenced by the 93% of participants who strongly agreed/agreed with the statement that 'course content will be relevant for my future career'. This can be considered as a speculative claim, given that ākonga were not employed in clinical practice at the time. A follow-up study is planned that aims to gather BCAP graduates' perspectives on how valuable the course content was for their clinical practice.

Some findings are consistent with previous studies on counselling education. For instance, many participants stated placement was where the most significant learning occurred (Baird, 2015; Folkes-Skinner et al., 2010; Kurtyilmaz, 2015; Rabees et al., 2020), while the costs associated with placements and supervision caused financial stress (Maidment, 2003). Other findings are unique to the BCAP's dual counselling and addiction focus. For example, 13 participants strongly agreed/agreed with the statement that they wanted a career in both counselling and addiction practice, rather than single scope counselling (11 participants) or addiction practice (8 participants). Although this was probably the motivator for why ākonga enrolled in the BCAP, this figure is pleasing given the national shortage of counselling and addiction practitioners (Nelson, 2016, 2017; New Zealand Government, 2018; Rucklidge et al., 2018).

Despite many participants also strongly agreeing/agreeing with the statement that their placement would be valuable to their career, one participant reported feeling unprepared for placements with LGBT+ clients and those with intersecting identities. This participant's comment can be seen as highlighting a lack of Rainbow content in the BCAP; however, many undergraduate ākonga have reported feeling unconfident and ill-prepared for placements (Baird, 2015; Kumary & Baker, 2008). Perhaps the participant's comment could be seen as drawing on this long-standing narrative in counselling education.

Approximately half of the participants also mentioned modalities as the most significant learning that they would implement in their practice. During their training, counselling ākonga are taught several modalities and will select those that personally appeal (Baird, 2015). Nevertheless, a counsellor is eclectic in that they will adapt their practice to fit their clients' personalities and desired therapy outcomes (Baird, 2015). Consequently, having a solid grounding in several modalities is highly desirable.

Several participants also listed the course content on biculturalism, Te Tiriti o Waitangi and a work placement in a kaupapa Māori organisation as their most significant course learning. Others recommended more content on Māori world views and tikanga. This finding is encouraging, given the need to provide culturally safe health, counselling and addiction care (Crawford, 2016; McLachlan et al., 2017; Pihama et al., 2017). For mental health services to better meet the needs of Māori, they firstly need to acknowledge the service users' status as tangata whenua (New Zealand Government, 2018). Under Te Tiriti o Waitangi, Māori are acknowledged as tangata whenua; partners and equals. This is a thread that runs through the BCAP. Ākonga learn about the impacts of colonisation on Māori (e.g., intergenerational trauma), while Māori models of health and aspects of tikanga are built into the curriculum. Ākonga also unpack traditional hierarchical therapeutic relationships, acquire knowledge of

Māori cultural perspectives and help support their clients' cultural identities. Monthly puawānanga kaitiakitanga (cultural supervision) meetings are also mandated. Ideally, such steps will help shape BCAP graduates into culturally safe counselling and addiction practitioners, but this will be a lifelong process (Crawford, 2016).

Some participants also stated that studying for the BCAP instilled a desire for lifelong learning. Many universities include lifelong learning in their list of graduate attributes; however, this trait is less emphasised in vocational education (Hammer et al., 2012). Perhaps this is because vocational education is traditionally considered to prepare graduates with the necessary skills to enter a trade (Hodge et al., 2020). However, the BCAP is a bachelor's course and therefore, as with other higher education courses, ākonga may acquire the knowledge that lifelong learning is necessary to keep up to date with contemporary knowledge and notions of best practice (Coll et al., 2019).

Some participants wanted more content on working with children, young people and trauma. However, it is unclear if these participants wanted more content on addiction in children/young people or how SUDs impact children/young people. There is variation between these two dimensions of addiction: if a parent/caregiver has an SUD this will impact their children, but if a young person has an SUD, it will impact their whānau (Lander et al., 2013). A more precise answer from the participants would have been ideal. Nevertheless, if a BCAP ākonga wishes to specialise in working with children and/or young people (e.g., school counsellor), then they will need to do so at a postgraduate level.

The qualitative comments show that the cost of supervision is a stress for many ākonga, which is a theme echoed in the literature (Maidment, 2003). Given that, as of 2024, the student allowance is $240.19 per week for ākonga under 24 years old (Ministry of Social Development, n.d.), it's unsurprising that some ākonga may struggle with funding for supervision. One participant also said that social work ākonga are paid on placement; however, this is not the case (Maidment, 2003). The researchers are unaware of any tertiary ākonga who receive payments on placement. But given the national shortage of counselling and addiction practitioners, the government may wish to consider funding the ākonga supervision and placements (Ministry of Health, 2016; Nelson, 2016; 2017). If they did, it would ensure the development of the nation's future mental health workforce, while providing ākonga from low socioeconomic backgrounds more opportunities.

Some participants wished for more face-to-face course delivery, rather than online. However, COVID-19 has changed the way teaching has traditionally been delivered, with many education institutions now opting for blended courses (Adel & Dayan, 2021). Online counselling is also becoming increasingly popular as a flow-on effect from national lockdowns, when it was the only form of counselling available (Hanley, 2020). Consequently, BCAP ākonga and those in counselling and/or addiction courses are likely to need both highly developed technological and counselling skills in their clinical practice.

EVALUATING THE RESEARCH

The research is limited because the survey only produced a limited amount of data. Future studies on undergraduate ākonga experiences of dual-focus counselling and addiction practice courses may wish to employ interviews or focus groups to gather more detailed data. Given the BCAP is the only dual-focus counselling and addiction degree on offer in Aotearoa, findings can be considered as having limited generalisability. However, study results also provide nuance to the large body of literature that generally focuses on counselling ākonga placements and supervision. The findings are also unique as they are positioned within the shift to blended learning post-COVID-19, and a dual-focus degree where ākonga can apply for registration through the New Zealand Association of Counsellors (NZAC) and the Addiction Practitioner's Association Aotearoa New Zealand (dapaanz).

CONCLUSION

There are several national tertiary education institutions that provide degrees in counselling or addiction, but not both. Given the coexistence of mental health concerns and SUDs, more education institutions may wish to establish dual-focus degrees. Findings of this study may be used to inform the development of such programmes, while also informing changes in the current BCAP offered at WelTec. The participants wished for more content on diversity of clients, a Māori cultural lens, more guest speakers, paid placements and supervision, and content on children, young people and trauma. Given the current rise of vocational education and shortfalls in government funding for tertiary education, some recommendations are unable to be implemented due to cost. However, some have already been implemented into the BCAP, such as having additional guest speakers. BCAP tutors are training the next generation of mental health professionals to work in a society with heightened levels of addiction and coinciding mental health concerns.

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Compassion Fatigue: The Real Emergency Paramedics Face

ABISHKAR PALMA & KAARYN CATER

Paramedics are regularly exposed to traumatic events, yet are expected to demonstrate empathy, compassion and clinical skill during every patient interaction. This can cause compassion fatigue which can lead to decreased compassion for patients and serious psychological and physical outcomes for clinicians. This comes at a high personal and financial cost for both the ambulance sector and the clinicians and individuals with sensory processing sensitivity who may be at greater risk of developing compassion fatigue due to their heightened responsiveness to environments. To address the research question 'Are paramedics looking after themselves, while they look after their patients?' international research from a range of fields was reviewed, including paramedicine, nursing, psychology and medicine. Job satisfaction, education and frequent monitoring of practitioners' mental health were identified as key protectors against compassion fatigue, with both ambulance management and clinicians playing an essential role in maintaining healthy work environments. Recovery from compassion fatigue includes maintaining a healthy work/life balance, and prioritising relational, mental, physical and spiritual health. Although no statistics are currently available for Aotearoa New Zealand's ambulance services, similarities to international work environments and anecdotal evidence suggest that many ambulance officers in Aotearoa may be impacted by compassion fatigue.

KEYWORDS: compassion fatigue; mental health; paramedic; prevention; recovery; sensory processing sensitivity

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Paramedics are regularly exposed to traumatic events, yet are expected to uphold high levels of compassion, empathy and clinical skill in every patient interaction. However, when paramedicine is discussed, terms such as 'burnt out', 'cynical' and 'fatigued' are becoming commonplace in Aotearoa New Zealand. To explore the issue, the following question was posed: 'Are paramedics looking after themselves, while they look after their patients?'. This paper considers international research from various fields, including paramedicine, nursing, medicine and psychology to explore compassion fatigue. It will explore the prevalence of compassion fatigue in the ambulance service, identify causes and consider ways to prevent and recover from compassion fatigue.

COMPASSION FATIGUE

Compassion fatigue is often confused with burnout, post-traumatic stress disorder or other stress disorders. However, it is separate from these and is often found in caregivers and healthcare providers due to the caring nature of their jobs (Fernando & Consedine, 2014; International Online Medical Council, 2023; Sinclair, Raffin-Bouchal, et al., 2017). While compassion fatigue and burnout are different, compassion fatigue is often a precursor to burnout (Bohman et al., 2022).

Compassion fatigue, known also as 'the cost of caring', is a type of secondary traumatic stress syndrome, where people experience symptoms based on exposure to others' trauma (Rauvola et al., 2019; Renkiewicz & Hubble, 2022). Compassion fatigue is when a person has a gradual or acute loss of compassion due to physical or mental exhaustion, following helping others during traumatic or stressful events (Bohman et al., 2022; Cornelius & Swayze, 2015; Huggard et al., 2017; Renkiewicz & Hubble, 2022). Compassion fatigue diminishes a provider's ability to empathise with patients and places strain on the clinician's professional and personal life (Dehghannezhad et al., 2020).

Compassion fatigue is caused by repeated exposure to others' pain, coupled with high levels of stress. There are specific factors that put clinicians at greater risk of developing compassion fatigue (Dehghannezhad et al., 2020; Renkiewicz & Hubble, 2022; Schmidt & Haglund, 2017). These include previous history of childhood abuse or trauma, stressful home life, poor coping skills or having high levels of empathy (Cornelius & Swayze, 2015; Dehghannezhad et al., 2020; Renkiewicz & Hubble, 2022). However, the greatest risk factor is the provider's working environment (Cornelius & Swayze, 2015; Dehghannezhad et al., 2020; Renkiewicz & Hubble, 2022).

Studies have found that that the prevalence of compassion fatigue increases over time and shift length (Dehghannezhad et al., 2020; McGrath et al., 2022; Renkiewicz & Hubble, 2022; Straussner & Senreich, 2020). Nevertheless, there is also research that suggests that clinicians can develop coping skills over the years, with length of service contributing to better coping skills (Dehghannezhad et al., 2020; Straussner & Senreich, 2020). Furthermore, the more satisfied a provider is with their job and the ways they have shown compassion to their patients, the less likely they are to experience compassion fatigue (Dehghannezhad et al., 2020).

Compassion fatigue can present in a variety of ways, from unethical behaviour and frustration to a lack of compassion towards patients. This comes about as the person experiencing compassion fatigue neglects their own well-being, and this can lead to physical, mental and spiritual exhaustion (Renkiewicz & Hubble, 2022; Showalter, 2010). Compassion fatigue can also lead to a clinician being unable to differentiate their own emotions from those of their patients (Thompson, 2013). Symptoms of compassion fatigue can mimic many other mental health conditions and can include changes in mood, self-care and substance use (The Ambulance Staff Charity, 2023; Powell, 2020).

Compassion Fatigue and Paramedicine

The two ambulance services in Aotearoa, Wellington Free Ambulance and Hato Hone St John, expect staff to practise in a compassionate way. Wellington Free Ambulance states on its job website that they provide world-class compassionate care, while the Hato Hone St John values state that staff are expected to 'stand side by side' and 'make it better' (Hato Hone St John, n.d.; Wellington Free Ambulance, 2023). However, compassion fatigue significantly impacts healthcare workers, including paramedics and other ambulance clinicians, and there is increasing international concern over the lack of compassion shown by some healthcare workers (Sinclair, Russell et al., 2017).

Multiple factors contribute to high levels of stress for paramedics, including workload, shift work, limited equipment and resources, and challenging and dangerous environments. Paramedics are also regularly exposed to traumatic events, often more so than other

healthcare providers, and shift work can limit downtime both at work and at home. Concern about compassion fatigue was raised before the COVID-19 pandemic, but the concern burgeoned during the pandemic when healthcare workers were practicing in extremely stressful work environments with an exponential rise in workloads (Bell et al., 2021; Gupta et al., 2021).

The majority of studies investigating compassion fatigue have focused on nursing and other caring professions, rather than paramedicine specifically. However, there is international research indicating that a significant number of paramedics are likely to experience compassion fatigue, with some studies indicating that nearly 50% of paramedics are likely to be affected by compassion fatigue at some stage in their career (Bohman et al., 2022; Renkiewicz & Hubble, 2022; Welding, 2021). Additionally, some literature from Aotearoa has found that high rates of compassion fatigue have been identified in the healthcare sector in Aotearoa, and paramedics are an integral part of this sector (The Ambulance Staff Charity, 2023; Brooks et al., 2022; Dehghannezhad et al., 2020; Schmidt & Haglund, 2017).

Practising paramedicine means focusing on others, and while compassion fatigue has a significant impact on patients, it also has considerable impact on the individual paramedic, their colleagues and the wider ambulance service (Cocker & Joss, 2016). Concerningly, international studies show that ambulance clinicians have a significantly higher risk of suicide than the general population (Hird et al., 2019; Vigil et al., 2018). In support of these findings, Renkiewicz and Hubble (2022) found that clinicians experiencing compassion fatigue are four times more at risk of suicide than those not experiencing compassion fatigue (Mars et al., 2020; Renkiewicz & Hubble, 2022; Vigil et al., 2018). Research shows that an increase in exposure to suicide can lead to an increase in suicidal tendencies (Mars et al., 2020; Renkiewicz & Hubble, 2022; Turecki et al., 2019). Furthermore, clinicians experiencing compassion fatigue are often not able to function optimally, which can lead to a reduction in self-worth and an increased need for counselling (Renkiewicz & Hubble, 2022; Sinclair, Raffin-Bouchal, et al., 2017).

Ambulance services operating with high numbers of fatigued staff are also at risk of experiencing negative consequences, including poor patient outcomes and poor overall staff well-being. Compassion fatigue comes with an increase in staff turnover, sick days taken and staff underperformance, and a decrease in patient satisfaction, resulting in complaints from patients and their families (Bohman et al., 2022; National Academies of Sciences, Engineering, and Medicine, 2018; Showalter, 2010; Sinclair, Raffin-Bouchal, et al., 2017; Sinclair, Russell et al., 2017). These factors contribute to increasing financial costs for the ambulance services at a time when they are facing decreased levels of funding (Bohman et al., 2022; National Academies of Sciences, Engineering, and Medicine, 2018; Showalter, 2010).

Regardless of the environment in which they work, paramedics are responsible for ensuring that patients receive excellent care. In order to deliver high-quality care, it is essential for the provider to establish a strong therapeutic relationship with each patient (English et al., 2022). Compassionate care leads to a therapeutic interpersonal bond between the provider and patient, and improves satisfaction for both parties (Younas & Maddigan, 2019). Therefore, when a clinician has depleted levels of empathy, or is experiencing compassion fatigue, they are less likely to be able to form therapeutic relationships. This has serious impacts for patients' safety, recovery, well-being and satisfaction (Kus et al., 2019; Maben et al., 2012; Parker et al., 2022; Pehlivan & Güner, 2017; Thompson, 2013; Younas & Maddigan, 2019). Further compounding the negative impact of compassion fatigue, patients may be less likely to reach out for help in the future if they have had a negative experience in the past (Rivenbark & Ichou, 2020; Schwei et al., 2016).

Preventing Compassion Fatigue

There are some key stressors identified that lead to compassion fatigue, however, steps can be taken to mitigate the negative impacts of compassion fatigue before the clinician and patient are affected. For example, job satisfaction has been shown to be one of the most important protectors against compassion fatigue. The more job satisfaction a clinician feels, the more compassionate they are likely to be; therefore, they are less likely to experience compassion fatigue (Dehghannezhad et al., 2020; Fetter, 2012). Increasing worker satisfaction is the responsibility of both the ambulance service management and the individual paramedic. Management can shape the working environment by helping with education, rewarding positive behaviours, providing adequate professional support and reducing workload (Dehghannezhad et al., 2020; Schmidt & Haglund, 2017). Given that heavy workloads have a significant correlation with staff experiencing compassion fatigue, it may be necessary to provide a variety of shift rosters to suit different circumstances, reduce shift lengths for ambulance staff, increase the number of ambulances to decrease individual workload or enforce longer breaks.

Debriefing and reflection are useful practices for processing stressful situations (Falon et al., 2022; Schmidt & Haglund, 2017) and increasing an individual's morale and job satisfaction (Schmidt & Haglund, 2017). There are various ways to debrief and reflect, but whatever the method, it can help paramedics be more prepared when encountering stressors in the future by providing insight that reduces stressors, thus reducing stress and the risk of developing compassion fatigue (Schmidt & Haglund, 2017). Management can also help create a culture where debriefing and reflection are valued as an essential part of every shift.

Team leaders and managers can lead by example and model best practice for debriefing and reflective practices. Creating a supportive environment where a person feels able to share their feelings means there is a high likelihood of other staff feeling encouraged to do so as well, particularly if someone in leadership models this behaviour. This means problems can be faced together and people are more aware of lapses in compassion (Thompson, 2013). There are a variety of effective debrief and group reflection tools in use in the healthcare sector, though this is beyond the scope of this article. However, one tool that is already used by ambulance services in Aotearoa is the MANERS template (See Appendix A) (National Ambulance Sector Clinical Working Group, 2023).

Actively monitoring staff mental health is another way ambulance management can help to reduce the possibility of compassion fatigue (Goetzel et al., 2018). This can be difficult as there is no empirical way to track an individual's mental health, however, recently a variety of tools have been created to help monitor staff mental health (Sinclair, Raffin-Bouchal, et al., 2017; Wei et al., 2016). The Professional Quality of Life (ProQOL) test is a self-care tool used to specifically identify compassion fatigue (See Appendix B) (Cavanagh et al., 2019; The Center for Victims of Torture, 2021). This tool has been created specifically for ambulance management to monitor staff but can also be used by individual clinicians to assess their state of mental health. However, if management is to formally monitor staff, steps need to be taken to create a positive and supportive environment that eliminates stigmatisation of poor mental health for practitioners in the ambulance service (Renkiewicz & Hubble, 2022).

A population group that is likely to be even more impacted by the stressors of ambulance work, and therefore more prone to suffering from stress, burnout and compassion fatigue, are individuals with the temperamental trait of sensory processing sensitivity (SPS) (Pérez-Chacónet et al., 2021, Redfearn et al., 2020, Shi et al., 2024). SPS is characterised by deep processing of information, high emotional reactivity and awareness of environmental nuances. The trait is evenly distributed, and 20–30% of the population is high in SPS (Bas, et al., 2021; Cater, 2022). People high in SPS are more

impacted by both positive and negative aspects of physical and social environments and are likely to experience more negative mental and physical health outcomes when exposed to adverse environments, such as stressful work conditions (Greven & Homberg, 2020). For individuals high in SPS, self-care and downtime are essential (Black & Kern, 2020; Cater, 2022), though it can be challenging to find time for these in hectic healthcare settings (Pérez-Chacónet al., 2021; Redfearn et al., 2020).

Education also plays a key role in mitigating the incidence of compassion fatigue. Some studies show that providing education to both pre-hospital and nursing staff about compassion fatigue helps reduce its prevalence (Bohman et al., 2022; Cocker & Joss, 2016). There are limited studies investigating the effectiveness of compassion fatigue education, and this could be a worthwhile future research direction.

However, even when managers create positive environments and provide adequate support for staff, clinicians must be prepared to take charge of their own specific circumstances. Mental health primarily relies on intrinsic factors and personal resilience for effective prevention and healing, surpassing the impact of external factors, especially when addressing common mental health syndromes. This holds true for compassion fatigue as well (Black, 2023; Herlambang et al., 2021; Hosseini et al., 2021; Schmidt & Haglund, 2017). Therefore, it is important for paramedics to balance their professional and personal lives, taking time to rest and relax, which leads to better overall mental and physical well-being (McHolm, 2006; Søvold et al., 2021; Welding, 2021). This includes things such as adequate sleep, physical activity and good nutrition (McHolm, 2006; Rodríguez-Romo et al., 2022; Søvold et al., 2021; Welding, 2021).

Recovering from Compassion Fatigue

The symptoms faced by those experiencing compassion fatigue are complex, nuanced and individual, and recovery must be holistic. While recovering from compassion fatigue is possible, it takes time, guidance and kindness from others and the individuals themselves (Showalter, 2010). Although compassion fatigue predominantly presents with mental and emotional symptoms, it affects the entire body, and healing requires a holistic approach (National Academies of Sciences, Engineering, and Medicine 2021; McHolm, 2006). Te Whare Tapa Whā is a holistic health model in Aotearoa that acknowledges that good health requires physical, emotional, spiritual and social well-being and is a useful framework when considering recovery from compassion fatigue. Te Whare Tapa Whā translates to 'the four-sided house' in English, and symbolises the four dimensions, or pillars, that are essential for overall health (Rochford, 2004). To be able to effectively continue to help others, clinicians must first acknowledge and meet their own needs and attend to all domains of personal health and well-being (Showalter, 2010).

A list created by Showalter (2010) shows some key areas which can help in recovery from compassion fatigue. This includes spending quality time with loved ones, pursuing interests outside of work, following a routine, maintaining a good diet and having adequate sleep and physical activity. A good routine can also help in recovery, and it may involve lifestyle changes or taking time off work to establish new therapeutic routines (The Ambulance Staff Charity, 2023; Showalter, 2010).

Self-awareness can also help heal compassion fatigue, with some studies showing that prayer, meditation or other spiritual practices can positively impact symptoms of compassion fatigue (Schmidt & Haglund, 2017; Showalter, 2010; Yoder, 2010). For example, a study investigating the experience of teachers of students with special needs found that the longer a participant prayed or practised mindfulness, the lower their ProQOL score was, and this was reflected in a reduction of compassion fatigue (Donahoo et al., 2017). Professional debriefing, including group sessions, may also be useful during this time. This can help create plans for coping in future situations (Schmidt & Haglund, 2017).

Due to the risk of negative mental health outcomes, people experiencing compassion fatigue should avoid making any major life decisions, including leaving the ambulance service, until they have taken time to completely heal (Showalter, 2010). It is also important for paramedics to understand that while the system they work in may be tiring, it is not their colleagues', their patients', or their own fault that they are experiencing difficulties (Showalter, 2010).

DISCUSSION

Ambulance work can be taxing, and ambulance providers in Aotearoa, Hato Hone St John and Wellington Free Ambulance, usually have ambulance officers working shifts of 12 hours. Typically, ambulance officers rotate on an eight-day cycle, with two day-shifts and two night-shifts followed by four days off (Corlett, 2021). Staff often use their first day off to physically recover by sleeping and this leads to decreased recreational time (Lawn et al., 2020; Showalter, 2010). Furthermore, many ambulance staff mention late finishes and irregular meal breaks because of an overloaded health system.

Ambulance training focuses on identifying and treating critical life threats; however, recent data indicates only around 15% of all patient encounters within the ambulance service in Aotearoa are considered high acuity (Todd et al., 2022). Given that only a small percentage of ambulance training focuses on low-acuity work, staff may feel a heightened level of stress or inadequacy when expending time and energy attending to low-acuity patients rather than those who urgently require attention (Renkiewicz & Hubble, 2022; Schmidt & Haglund, 2017). Furthermore, paramedics can become frustrated that low-acuity jobs take away from 'real' emergencies, thus reducing their compassion satisfaction. Paramedics frequently do not receive follow-up on patients, which can lead to reduced satisfaction levels as they may not see the good that they do. The heavy workload plus the potential reduction in satisfaction may significantly increase the risk of paramedics experiencing compassion fatigue, and this can be exacerbated for high-SPS individuals (Pérez-Chacónet et al., 2021, Redfearn et al., 2020, Shi et al., 2024).

While the stigma in Aotearoa and the ambulance service around asking for help for psychological issues has reduced in recent years, there remains a societal stigma. Almost 20% of New Zealanders report feeling discriminated against in their workplace due to experiencing poor mental health (Mental Health Foundation of New Zealand, 2023), and this can make ambulance officers hesitant to seek help. Organised debriefs and group reflections have traditionally only been conducted after potentially traumatic events, or by students who are required to engage in reflective exercises as part of their education (Evans et al., 2023).

In 2020, paramedics in Aotearoa became registered with Te Kaunihera Manapou Paramedic Council. This registration binds practitioners to the Paramedic Council's Code of Conduct, which requires paramedics to continually develop their reflective practice (Te Kaunihera Manapou Paramedic Council, 2020a, 2020b). As a result of this, reflective practice may become more commonplace in the industry, and this may result in an industry acceptance of an increased need for psychological support for ambulance officers. Reducing the stigma attached to mental health may encourage ambulance officers to seek help earlier, which may lead to a reduction in compassion fatigue for practitioners.

LIMITATIONS

There are several limitations identified in this review. First, there is limited high-quality, recent research available focusing specifically on compassion fatigue within ambulance services, with the majority of literature focusing on other helping professions, such as nursing. More literature investigating compassion fatigue in the paramedicine context is needed to illuminate the true severity of compassion fatigue for paramedics. Second, research in this field often utilises small sample sizes, therefore,

results may not be generalisable in larger groups of practitioners. Third, much of the research in the field of paramedicine is conducted internationally, so the findings may or may not be relevant in the context of Aotearoa.

CONCLUSION

This article investigated compassion fatigue within the ambulance service in Aotearoa. While research specific to New Zealand paramedicine is limited, this article has aimed to identify what compassion fatigue is, its prevalence in the ambulance service, and how to both prevent and recover from it. Compassion fatigue is frequently experienced in the healthcare sector, and international literature has found that a relatively high number of paramedics tend to suffer from it. Compassion fatigue is best prevented rather than healed, and increasing both job and compassion satisfaction has been shown to be beneficial in preventing compassion fatigue. Many of the same factors are beneficial in both the prevention and recovery of compassion fatigue, with self-care identified as a major factor in both prevention and treatment. Furthermore, ambulance service management can reduce the likelihood of practitioners developing compassion fatigue by providing appropriate resourcing, education and support for staff. Compassion fatigue comes at a significant health and financial cost to ambulance clinicians, patients and the paramedic industry, and can take a particularly extensive toll on individuals high in SPS. Future research should explore the cost of prevention and recovery from compassion fatigue for ambulance service personnel and the industry as a whole. Education is crucial for raising awareness of compassion fatigue, and for identifying mitigating factors that can protect paramedics from developing compassion fatigue in the first place.

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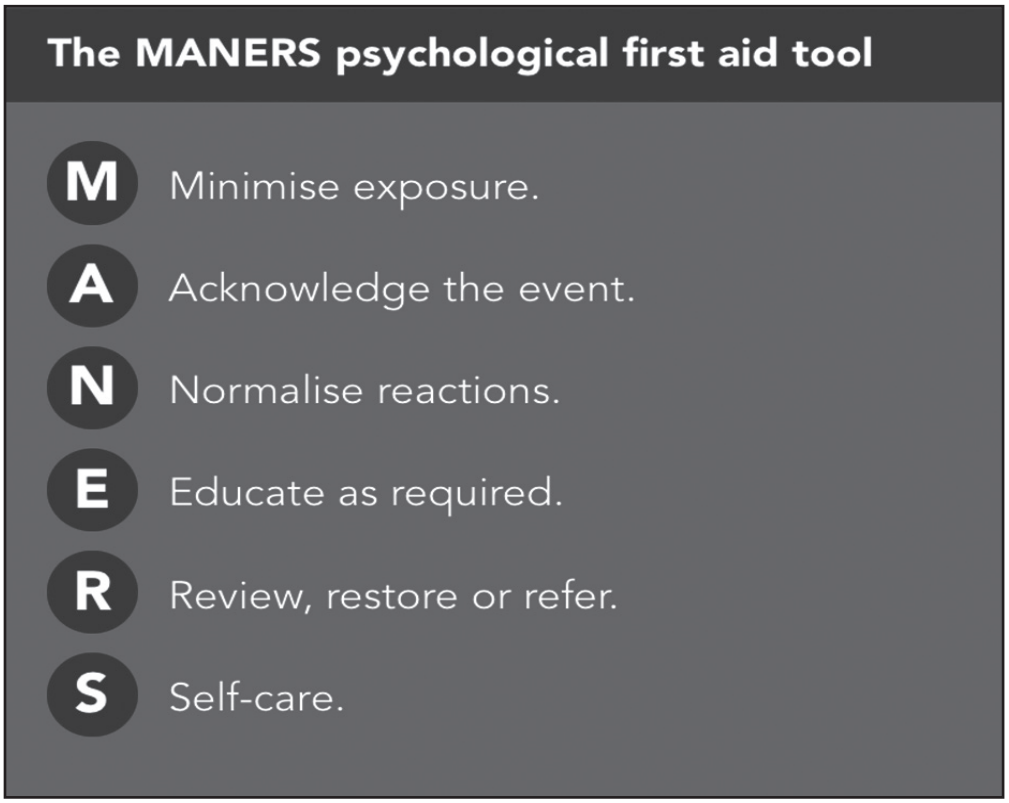
APPENDIX A: MANERS Psychological First Aid Tool



MANERS. (National Ambulance Sector Clinical Working Group, 2023).

APPENDIX B: PROQOL Compassion Satisfaction and Fatigue Tool

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

Compassion Satisfaction and Fatigue (ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

What is my score and what does it mean?

In this section, you will score your test and then you can compare your score to the interpretation below.

Scoring

1. Be certain you respond to all items.
2. Go to items 1, 4, 15, 17 and 29 and reverse your score. For example, if you scored the item 1, write a 5 beside it. We ask you to reverse these scores because we have learned that the test works better if you reverse these scores.

You Wrote	Change to
1	5
2	4
3	3
4	2
5	1

To find your score on **Compassion Satisfaction**, add your scores on questions 3, 6, 12, 16, 18, 20, 22, 24, 27, 30.

The sum of my Compassion Satisfaction questions was	So My Score Equals	My Level of Compassion Satisfaction
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

To find your score on **Burnout**, add your scores questions 1, 4, 8, 10, 15, 17, 19, 21, 26 and 29. Find your score on the table below.

The sum of my Burnout questions	So My Score Equals	My Level of Burnout
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

To find your score on **Secondary Traumatic Stress**, add your scores on questions 2, 5, 7, 9, 11, 13, 14, 23, 25, 28. Find your score on the table below.

The sum of my Secondary Traumatic Stress questions	So My Score Equals	My Level of Secondary Traumatic Stress
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Stamm, 2009. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). www.proqol.org

How are Registered Nurses Supporting the Physical Health of Service Users with Serious Mental Illness?

CARMEL HAGGERTY, AYLA CHAMBERLAIN, JUDITH HALL, VICKY JENNINGS & DANIELLE HANN

As experienced mental health and addiction educators we regularly reinforce to our undergraduate and postgraduate ākonga that each service user should be treated as a 'whole person', not just a diagnosis, especially since the life expectancy of service users with Serious Mental Illness continues to be below that of the general population. Holistic healthcare using Te Whare Tapa Whā framework (Durie, 1984) is not new to mental health nursing and is used extensively in the Whitireia postgraduate programme for nurses entering specialty mental health and addiction practice (Sculley & Smith, 2023). This ensures that taha tinana, the physical health component, is critically explored along with the other three pou, but this is not always reinforced in practice. A scoping literature review was undertaken to better understand how physical health issues are identified and managed in practice, and where current research places the role of Registered Nurses in supporting the physical health of service users in mental health and addiction services. The findings clearly identified a role for nurses in working alongside service users to assess and manage their physical health care, but unfortunately, there is still some reluctance to see this as a nursing responsibility in mental health and addiction settings.

KEYWORDS: attitudes; nursing practice; physical health; Serious Mental Illness

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Nurses working in mental health services have the greatest impact on the overall health and well-being of service users. These are the professionals that should be spending more time with service users and building therapeutic relationships that support all aspects of their well-being. Why is it then that the life expectancy of service users with Serious Mental Illness (SMI) continues to be below that of the general population for gender and ethnicity? What then is the role and responsibility of the Registered Nurse in supporting the physical health of service users? To better understand these questions, we conducted a scoping literature review to

investigate the current research available concerning the Registered Nurse's role in supporting the physical health of service users with SMI. The findings will provide evidence to support further research, which will contribute to ongoing education for mental health and addiction nurses in practice.

METHOD

Scoping Review

A scoping review explores the extent of the literature to answer a broad question and, in this research's case, to inform practice in a research area. The purpose of the review is to identify the evidence currently available and define key concepts or themes; this shows where there are gaps that could inform future research or clarify a research question. Scoping reviews are often used as a precursor to a systematic review of evidence (Munn et al., 2018).

Literature Review Eligibility Criteria

In order to be eligible, the literature had to be peer reviewed or from a relevant source, be written in English and involve the investigation of human participants' experiences and the role of physical healthcare for people experiencing SMI in a mental health care setting. Specific characteristics of the evidence sources were also used as eligibility criteria, such as, years considered, language and publication status. All relevant literature for the last 20 years was included in the initial review phase. This allowed literature that was published early in the service user movement, during workforce changes and the move to community care across the mental health sector to be included. The eligible literature included topics such as mental illness, nursing, physical health and metabolic syndrome. Studies from both qualitative and quantitative methodologies were included. Peer-reviewed English-language articles that met the key eligibility criteria were prioritised for inclusion. The databases searched were:

- ClinicalKey for Nursing
- Cochrane Database of Systematic Review (CDSR)
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- Google Scholar
- Informit Health Collection
- MEDLINE
- ProQuest
- Wiley Online Library

The research team was supported to develop their search strategy by an experienced librarian. The final search results were exported to Zotero, and any duplicates were removed.

Databases	Search Terms	Limitations	Search Number	Number Included after review
CINAHL Ultimate	'Physical health' AND 'Mental illness'	Boolean, Full text, 2003–2023, peer reviewed, English language, Research articles, Geographical: All Publication Type: Academic journal Sex: All , Age: Adult 19-44	394	Included: 11
ProQuest	'Serious Mental Illness' AND 'Physical health' AND 'Nursing' AND 'Metabolic' AND 'Diabetes' AND 'Cardiac'	Full text, Peer reviewed, 2003–2023, English, Source type: Scholarly Journals Document type: Article	4452 1709 421 365 143	Included: 1

Databases	Search Terms	Limitations	Search Number	Number Included after review
MEDLINE	"Serious Mental illness' AND 'Severe Mental Illness' AND 'Physical health' AND 'Nursing'	Boolean, Full text, 2003–2023, English, Human, All ages, Scholarly (peer reviewed) Journals, Publication type: Journal article	175 77	Included: 6
Wiley Online Library	'Serious Mental Illness' AND 'Severe mental illness' AND 'Physical health' AND 'Nursing'	2003–2023 Publication Type: Journals Open access content	147 67	Included: NIL
CDSR	'Serious Mental Illness' AND 'Severe mental illness'	Cochrane reviews, 2003–2023, Search word variations	50	Included: NIL
ClinicalKey for Nursing	'Serious Mental Illness' AND Severe mental illness' AND 'Physical health'	Full text, Open access, Peer reviewed, Journal, English, 2003–2023 Access type: only show content I have access to	1	Included: NIL
Informit Health Collection	'Serious Mental Illness' AND 'Severe mental illness'	Journal articles, Full text only, Psychiatric/Mental Health, Last 5 years	44	Included: NIL
Google Scholar	'Serious Mental Illness' AND 'Severe mental illness' AND 'Physical health' AND 'Nursing' AND 'Metabolic' AND 'Diabetes' AND 'Cardiac'	2003–2023	2530 2010 549 456 166 (2 were duplicates of a previous search)	Included: 1

TABLE 1: SEARCH STRATEGY AND RESULTS

FINDINGS

The literature clearly showed that there is poorer general health and a shorter life expectancy for service users with SMI, and that nursing staff have the greatest potential to make a substantial improvement to their physical health (Ewart et al., 2017; Gedik et al., 2020; Xuereb et al., 2020). Chang et al. (2011) stated that the 'highest reductions were found for men with schizophrenia (14.6 years lost) and women with schizoaffective disorders (17.5 years lost)' (p. 1). Kurdyak et al. (2017) discussed the

increased rate of diabetes in those with SMI compared to those in the general population. Robson et al. (2013) found that nursing staff in mental health services often have a lesser contribution to managing diabetes, but nurses who had post-registration training on physical health or had dual registration/experience were more positive about being involved in physical health care. Nasrallah et al. (2006), who undertook systemic baseline screening, noted that many service users diagnosed with schizophrenia went undiagnosed for metabolic disorders at admission, which then increased the risk of metabolic disorders once treatment commenced. This was reinforced by Ijaz et al. (2018), who suggested that existing dietary habits and lifestyle choices add to the risk of developing metabolic and cardiac conditions, therefore, service users with SMI are at a higher risk before ever commencing psychotropic medication treatment.

Ewart et al. (2017) explored the multifaceted barriers to good physical health care including the healthcare professionals, the healthcare system itself, the service users and their supports. They then linked these barriers to the social determinants of health and how they apply to service users with SMI, recommending that this link needs to be made in the training of health professionals in a more overt way. In their discourse analysis of three focus groups of mental health professionals, Lerbæk et al. (2019) found that participants described not responding to the physical needs of the seriously mentally ill, who were reported as being unmotivated, resisting intervention and not understanding why interventions regarding their physical health might be worthwhile.

However, most service users welcomed the interest in their physical health, even though physical health is under-reported by users and under-recognised by professionals (Phelan et al., 2004). Service users noted that some nurses did not prioritise physical health care and seemed too busy to help them address their physical issues. They expected that having their physical health needs addressed would be a low priority, and some nurses confirmed that this was because mental health was the priority. Some service users felt they were not being taken seriously because they have a severe mental illness (Gray & Brown, 2017).

Shorter life expectancy and poorer overall health occur alongside other issues impacting service users including poverty, the neglect of public services and being treated as second-class citizens due to a diagnosis of mental illness and/or experiencing a psychosocial disability along with accessibility issues (Ewart et al., 2017). The most prevalent health issues were diabetes, hypertension and smoking related issues (Çelik Ince et al., 2019), with people with severe mental illness at a two-times-greater risk of metabolic syndrome than the general population (Erginer & Günüşen, 2018). In research undertaken by Emerson et al. (2016), over 50% of participants had abnormal results with Body Mass Index (BMI), waist circumference, sleeping and exercise. In a study by Ganiah et al. (2017), 64.4% of nurses agreed that managing weight is a mental health nursing role. This supports the research by Wynaden et al. (2016), which found that the majority of the mental health nurses in the survey agreed they should help service users manage their weight, including giving nutritional information, and 71% agreed that they should give advice on how to prevent heart disease, but 49.7% didn't think they should provide exercise information.

In regard to cancer diagnosis rates in people with SMI, Howard et al. (2010) noted that the incidence of cancer in people with SMI was no different from the general population. However, early detection, equity of access to screening and treatment lead to poorer outcomes. Phelan et al. (2004) noted that only half of the females surveyed (n = 10) had gone for cervical screening in the last three years, as is recommended, and the other half had gone longer, had never had one or did not remember. Less than half of the females had

examined themselves for lumps on the breasts. There was some ambivalence regarding cancer screening. In Ganiah et al. (2017), most respondents agreed that it is not a mental health nurse's responsibility to check for cancer screenings in service users. However, Robson et al. (2013) recommended that all mental health nurses should take responsibility for this important aspect of health care to improve early detection and reduce the incidence of cancer. Furthermore, in Happell et al. (2014), nurses agreed that there needed to be a more person-centred view of service users' health and that mental and physical health should not be separated. Only seeing mental health stops physical issues being diagnosed, but some nurses are proactive in the provision of physical health care while others view it as less of a responsibility.

Although nurses were generally positive about their role (Özaslan et al., 2019), nurses with fewer years of experience and fewer assigned patients had more positive, health-promoting attitudes than those with more experience and higher patient load (Ganiah et al., 2017). Interestingly, research undertaken by Yalçin et al. (2019) noted that nurses' personal health behaviours, for instance under valuing medical check-ups and balanced nutrition, were not indicative of how they supported service users. In fact, the same nurses perceived the physical health of service users with mental illness to be very important, although their attitudes and self-confidence differed based on their educational background. Nurses that had higher education and more experience were more confident (Yalçin et al., 2019). Gray and Brown (2017) agreed, finding that nurses on acute mental health wards lacked confidence in providing physical health care and that more positive attitudes towards caring for service users' physical health were evident from nurses who had attended post-registration physical health training or had an additional adult/general nursing qualification. Practice nurses were positive about the inclusion of physical health in the primary care of mental health service users. One-third of the surveyed nurses chose 'neutral' when asked if providing physical health care should be a priority of primary care, with 58% of nurses agreeing that mental health service users require closer physical health monitoring than the general population (O'Brien & Abraham, 2021).

CONCLUSION

Mental health teams, especially mental health nurses, should not neglect the physical care of service users while providing treatment to those experiencing Serious Mental Illness. Through timely assessment and intervention, mental health nurses can help prevent physical health problems before symptoms emerge in individuals (Erginer & Günüşen, 2018). Programmes that support physical health care, and include nurses, can provide significant benefits for mental health consumers. Some nurses are proactive in the provision of physical health care while others view it as less of a responsibility. If we as Registered Nurses are going to effectively provide both physical and mental health care in partnership with service users, it is critical that these two views are reconciled.

The authors are now undertaking a research project based on this literature review to better understand the Registered Nurse's role in supporting the physical health of service users experiencing SMI within Aotearoa New Zealand. The authors have consent from Robson et al. (2013) to replicate their study within the Aotearoa New Zealand context, which will identify the current state of physical care for people with SMI. This will aid in the development of educational packages to support the four pou of Te Whare Tapa Whā – Hinengaro, Psychological; Tinana, Physical; Wairoa, Spiritual and Whānau, Family (Durie, 1984; Sculley & Smith, 2023) and support the nurses to provide a more holistic environment for our service users. The authors look forward to reporting their findings in the near future.

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What's in a Name? Challenges Vocational Educators Face with Diagnostic Labels Associated with Neurodivergence

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Neurodivergent learners report a range of negative experiences in higher education both nationally and internationally. These experiences can impact their well-being and sense of identity, as well as their personal, social and academic life. All learners have the right to receive equitable and appropriate education. However, academic literature reveals educator uncertainty about how to effectively cater for all neurodivergent learners. This paper reports findings from a qualitative research project conducted as part of the thesis component of the Whitireia-WelTec Master of Professional Practice. Six educators teaching in vocational education across Aotearoa participated. Their experiences and perspectives of neurodiversity were explored via semi-structured in-depth interviews. Three themes were generated, and this paper focuses on one of these: tension exists between educators' desire to avoid labelling learners and the recognised value of knowing their learners' diagnoses. The educators revealed an aversion to using diagnostic labels that are associated with disability and neurodivergence. In contrast to this, educators found that knowing learners' diagnoses and the associated labels was useful when planning and teaching. This paper aims to add to the discussion about the role both diagnoses and diagnostic labels can have in vocational education.

KEYWORDS: disabled learners; educators; neurodivergence; neurodiversity; vocational education

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Following the identification of a gap within academic literature, qualitative research was conducted to explore understandings and perspectives of neurodiversity in a small sample of vocational educators in Aotearoa New Zealand. Thematic analysis of participants' responses identified tensions regarding the use of terms and labels associated with neurodivergent learners. The study observed uncertainty and hesitancy among educators surrounding the use of

diagnostic labels concerning neurodivergent learners. Yet, educators also found such labels to be helpful for understanding, planning for and teaching their learners. The educators demonstrated ambivalence toward the use of diagnostic labels.

This paper begins by briefly introducing background information and terminology. This is followed by a brief overview of relevant literature, a description of the research design and the findings from the research interviews. The discussion then explores educators' language preferences, their uncertainty about using diagnostic labels and the role of diagnostic labels in planning and teaching. This paper concludes by proposing recommendations that could contribute to enhancing educators' understanding of diagnostic labels, thus reducing their uncertainty and increasing their comfort in using these labels.

BACKGROUND

Neurodivergent and Disabled Learners in Vocational Education in Aotearoa New Zealand

The learner population in higher education is becoming increasingly diverse. The sector is seeing increased enrolments of disabled learners, both nationally (Cleland, 2021; Ministry of Education, 2023) and internationally (Clouder et al., 2020; Grimes et al., 2017; Lipka et al., 2020). Dwyer et al. (2022) credit 'advances in diagnosis, awareness, and accessibility' (p. 3) for these suggested increases in enrolments. Currently in Aotearoa, neurodivergent learners are grouped under the label 'disabled learners'. According to Cleland (2021), 'disabled learners' includes learners with permanent impairments, impairments resulting from long- or short-term injury or illness, a learning disability, neurological or cognitive difficulties, mental health conditions and other hidden impairments.

Cleland (2021) reports that disabled learners are the most educationally disadvantaged cohort in Aotearoa. These learners report a variety of negative experiences, some of which include: a lack of disability-confident educators, learners feeling overwhelmed and learners showing reluctance to associate with disability support services (Cleland, 2021). In a recent study by Smith (2024), disabled learners reported receiving inconsistent support, environmental barriers and ineffective or unsafe advocacy. These reports from learners in Aotearoa are not unusual. Internationally, disabled learners have also reported a range of negative experiences in higher education, including high levels of anxiety alongside the challenges that come with their neurodivergence (Clouder et al., 2020). These negative experiences have been found to impact the wellbeing; sense of identity; and personal, social and academic lives of neurodivergent learners (Clouder et al., 2020; Syharat et al., 2023).

Defining 'Disabled Learners'

How the term 'disabled learners' is interpreted is influenced by understandings about how disability is caused. There are a range of models that shape the term, such as the medical model, the social model, the biopsychosocial model and the emerging neurodiversity model. In the higher education sector in Aotearoa, two models are typically drawn on to define 'disabled learners': the medical model and the social model. According to the Office for Disability Issues (ODI, 2022), the medical model of disability claims that disability is caused by individuals' impairments, therefore disabled learners are those with impairments. Conversely, the social model of disability claims that disabled learners are those who have an impairment but are disabled by environmental and societal barriers rather than by the impairment itself (ODI, 2022). Cleland's (2021) definition of 'disabled learners' aligns with the medical model.

Disabled people identify with the term 'disabled person' in different ways based on their personal understandings of what causes disability. The ODI (2016) explained that some disabled people see the term 'disabled person' as 'a source of pride, identity and recognition that disabling barriers exist within society and not with us as individuals'. The ODI also say that others identify more closely with the term 'person

with a disability' as they prefer to be 'recognised as a person before their disability' (p. 13). It is important to note that individuals' language preferences are not fixed and may change over time (O'Connor et al., 2018).

From Disability to Differences

Neurodivergence has long been associated with disability in the education sector in Aotearoa (Cleland, 2021; Ministry of Education, 2023). Neurodivergent learners can be disabled due to their condition, and those who are may not be disabled all of the time. According to Singer (1998), people with different neurologically based conditions, but who had similar experiences of exclusion, banded together to construct a new identity, distinct from disability, that more positively and comfortably aligned with their experiences and how they saw themselves. The neurodivergent community wanted to be seen as neurologically different, not disabled. This perspective led to the emergence of discussion surrounding neurodiversity. Judy Singer, an Australian sociologist, is credited for coining the term 'neurodiversity' in her 1998 honours thesis. In short, Singer (1998) saw 'neurodiversity' as an umbrella term for people who were neurologically different from the so-called neurotypical people, such as people with autism, attention deficit hyperactivity disorder (ADHD) or dyslexia diagnoses. She also recommended that neurodiversity should be seen and respected in the same way as other identity markers, such as ethnicity and gender. Armstrong (2010) asserts that 'instead of regarding traditionally pathologized populations as disabled or disordered' (p. 5), neurodiversity emphasises differences. He says that this shift has the potential to liberate neurodivergent people from prejudice.

Defining 'Neurodiversity' and its Associated Terms

Defining 'neurodiversity' can be challenging because the concept is still evolving (Dwyer, 2022; Ellis et al., 2022). Put simply, at this point in time, 'neurodiversity' describes the naturally occurring variations in the ways all of the human brains on the planet think and process information (Doyle, 2020; Ellis et al., 2022; Singer, 2023; Walker, 2014). Within the neurodiverse population, 'neurotypical' and 'neurodivergent' are two terms that are generally used when categorising people based on their neurological characteristics. 'Neurotypical' refers to individuals who do not have a diagnosed neurologically based condition (Casanova & Widman, 2021), and whose brain function aligns with the 'dominant societal standards of "normal"' (Walker, 2021, p. 40). The term was developed within the autistic community in the 1990s as a way of rejecting the term 'normal' (Singer, 1998). On the other hand, 'neurodivergent' was introduced in 2014 by neurodivergent activist Kassiane Asasumasu. Asasumasu aimed to provide a neutral term that was the opposite of 'neurotypical', because one did not exist (Foundations of Divergent Minds, 2023). According to Doyle (2020), 15–20% of the population is neurodivergent, a term that refers to individuals whose brain function differs from that of neurotypical people (Singer, 2019). Neurodivergence is strongly associated with neurologically based conditions, such as autism, ADHD and dyslexia (Cassanova & Widman, 2021; Doyle, 2020). However, Birdwell and Bayley (2022) also consider individuals with mental health conditions, such as post-traumatic stress disorder, and physical conditions, such as epilepsy, to be neurodivergent.

LITERATURE REVIEW

Educators' Understandings of Neurodiversity

A literature review was completed as part of a Master's research project during 2022–2023 to explore educators' understandings and perspectives of neurodiversity. Five international studies were identified as relevant: Ashcroft and Lutfiyya, 2013; Holmqvist et al., 2019; Lipka et al., 2020; Márquez and Melero-Aguilar, 2022; Sowell and Sugisaki, 2020, along with one Aotearoa-based study: van Gorp, 2022b. Overall, five themes were identified in the international literature:

1. Limited knowledge relating to neurodivergence
2. Limited training and preparedness for accommodating neurodivergent learners' needs
3. Challenges regarding learners' non-disclosure of disabilities
4. Limited understanding of inclusive education
5. Positive attitudes toward neurodivergent learners in higher education

None of the international studies used the term 'neurodiversity'. Various other terms were used in reference to neurodivergent learners, including: 'students with disabilities' (Ashcroft & Lutfiyya, 2013; Lipka et al., 2020; Márquez & Melero-Aguilar, 2022), 'students with learning disabilities' (Sowell & Sugisaki, 2020) and students with 'special educational needs' (Holmqvist et al., 2019). Ashcroft and Lutfiyya (2013) and Lipka et al. (2020) asked participants in their studies to define their respective terms, and both found that most participants had difficulty in doing so. Conversely, van Gorp (2022b) included the terms 'neurodiversity', 'neurodiverse', 'neurotypical' and 'neurodivergent'. Van Gorp's (2022b) Aotearoa-based study examined vocational educators' teaching practices for supporting the success of neurodivergent learners, within which she briefly explored participants' understandings of neurodiversity. Participants in her research explained that neurodiversity refers to the different ways the brain works and processes information, and it is associated with traits and diagnoses that can cause barriers in learning and interactions with others.

The 2022–2023 literature search strategy was replicated in 2024 to identify new, relevant literature since the original Master's research project. However, no new studies were identified that examined educators' understandings of neurodiversity. However, notably, the term 'neurodiversity' is becoming increasingly used in higher education-based literature. In the past few years, there has been a significant increase in academic educational research that uses the term 'neurodiversity'. Searching the phrase 'neurodiversity AND higher education' in the databases that Whitireia and WelTec subscribe to shows that the majority of results were published within the last five years. Approximately 75% of the total results were published in the last five years (April 2019–April 2024), with 21% of those being published in the last year (April 2023–April 2024). Comparatively, approximately 25% of the academic literature containing the term 'neurodiversity' was published before 2020.

The Effects of Diagnostic Labels

The original research project did not explore literature that examines educators' experiences with diagnostic labels associated with neurodivergent learners in higher education in Aotearoa and internationally. This was due to the original study not specifically seeking to examine labels used by the participants.

Literature highlights the overwhelming negative impact neurologically based diagnoses and associated labels can have on neurodivergent individuals. Carr-Fanning (2023) asserts that 'labels are not inherently negative' (p. 20). However, diagnostic labels undoubtedly carry the risk of stigma and discrimination, which can have a negative effect on neurodivergent learners' self-concept, mental health, and cognitive and emotional load (Carr-Fanning, 2023; O'Connor et al., 2018; Syharat et al., 2023; Thompson-Hodgetts et al., 2020). On the other hand, the literature also identifies some beneficial impacts that diagnoses and associated labels can have on neurodivergent individuals. Diagnosis can assist neurodivergent individuals in understanding and accepting their self-image and social identity (O'Connor et al., 2018), and associated labels can provide a way for them to easily explain their difficulties (Carr-Fanning, 2023). Syharat et al. (2023) state that many neurodivergent learners discovered strengths related to their diagnoses and found these strengths beneficial for their learning. Additionally, there is some evidence that neurodivergent individuals are becoming

more comfortable with receiving a formal diagnosis, learning that they are neurodivergent and sharing their experiences. For example, van Gorp (2022a) explained that receiving diagnoses for Irlen Syndrome and dyslexia enabled her to better understand herself and her challenging experiences in high school. She stated that she feels proud to call herself neurodivergent.

RESEARCH DESIGN

The research project was designed and conducted to meet the requirements of a Master of Professional Practice qualification. It received approval by the Whitireia and WelTec Ethics and Research Committee on 7 September 2022, reference number RP342-2022. The aim of the study was to examine vocational educators' understandings of neurodiversity and their teaching practices in relation to their neurodiverse learner cohorts. An interpretivist qualitative approach was employed to enable the examination of educators' shared perspectives and experiences. Six educators employed in vocational education across Aotearoa New Zealand were selected to participate in semi-structured, in-depth interviews. Open ended questions explored participants' understandings of neurodiversity, and its influence on their teaching practices in their own teaching contexts.

Participants

Participants represented five different polytechnics and institutes of technology from across Aotearoa. All participants had recently graduated with an adult teaching or adult education qualification at Level 5 or higher. For most participants, this was the New Zealand Certificate in Adult Tertiary Teaching (Level 5). One participant identified as neurodivergent, sharing diagnoses of Irlen Syndrome, dyslexia and ADHD. Another participant suspected he had undiagnosed ADHD and therefore may be neurodivergent. The remaining four participants identified as neurotypical.

FINDINGS

Braun and Clarke's (2006, 2022) thematic analysis framework was used to develop, understand and interpret patterns identified across the interview transcripts. Analysis of the information was carried out in six phases:

1. Familiarisation of information
2. Coding
3. Generating initial themes
4. Developing and reviewing themes
5. Refining, defining and naming themes
6. Writing the findings

Three themes were generated from participant responses and related to educators' understandings and teaching practices, tensions with diagnostic labels, and training and preparedness. This paper discusses one of those themes: Tension exists between educators' desire to avoid labelling learners and the recognised value of knowing their learners' diagnoses. Although this study did not specifically seek to examine labels used by the participants, this became a central finding. Before exploring this theme, it may be helpful to present how the educators in the study claimed to understand neurodiversity.

In the context of vocational education, the participants broadly understood neurodiversity to refer to the differences in the ways people think, process information and learn. They strongly associated neurodiversity with neurologically based conditions, such as autism and ADHD. Specific behaviours and characteristics that may cause challenges for learners, such as short attention span, were also associated with neurodiversity. Two educators recognised that neurotypical learners fit under the neurodiversity umbrella. However, the other educators were uncertain about how to describe learners with no neurologically based diagnoses. Not all educators were confident in their interpretations of neurodiversity, who it pertains to and how neurodivergence can manifest in different people or change over time and in different contexts.

Three participants acknowledged that the term 'neurodiversity' is new. Uncertainty was observed among the educators regarding their understanding of why 'neurodiversity' and its associated terms emerged. When asked what the purpose of the 'new' term is, several reasons were given. The most common reasons were that:

1. 'Neurodiversity' is a more friendly and engaging term that emerged to replace 'disability'.
2. Using 'neurodiversity' in place of 'disability' helps to reduce the stigma experienced by learners who have been labelled 'disabled'.
3. 'Neurodiversity', compared to 'disability', offers a more balanced view of learners' characteristics and experiences that includes both their challenges and strengths.

The emergence of 'neurodiversity' also elicited questions from these educators regarding the meaning and use of the term 'disability' and who it applies to.

DISCUSSION

These interviews found tensions regarding educators' comfort with labels corresponding to learners' neurologically based diagnoses. There was a sense that these educators were uncertain about what language to use when describing their neurodivergent learners. They revealed an aversion to labels such as 'disabled' and hesitancy regarding the use of diagnostic labels such as 'ADHD'. However, they also recognised how useful such labels can be for understanding their learners, as well as planning for, and teaching them. This paper discusses the various aspects of this tension: their language preferences, uncertainty about using diagnostic labels and the role diagnostic labels play in their teaching.

Language Preferences

The educators in the study described their neurodivergent learners in a variety of ways, including:

1. Listing characteristics, strengths and challenges they had either observed among their neurodivergent learners or that their neurodivergent learners disclosed
2. Using diagnostic labels, such as 'ADHD'
3. Using terms associated with neurodiversity, such as 'neurodiverse'

The educators indicated that they felt uncomfortable using the term 'disability' in relation to neurodivergent learners and shared their preference for language associated with neurodiversity. They claimed to be consciously shifting away from describing their learners as 'disabled' or 'having a disability', and towards terms they perceived to be more closely aligned with neurodiversity, such as 'neurodiverse' or 'neurodivergent'.

Two prominent reasons were identified that explain these educators' language preferences. Firstly, they had determined for themselves that terminology such as 'neurodiversity' has recently begun to replace 'disability' as it specifically relates to differences in brain wiring and function. In passing, they discussed the stigma that corresponds with being labelled as 'having a disability', a topic that has been well researched, including studies by Carr-Fanning (2023), O'Connor et al. (2018), Syharat et al. (2023), and Thompson-Hodgetts et al. (2020). They perceived terms such as 'neurodiverse' and 'neurodivergent' as more 'friendly', less stigmatised, and as better language options for describing neurodivergent learners than 'disabled' and 'disability'. Walker and Shaw (2018) indicate that educators' choice of language can provide insight into their underlying views towards a particular phenomenon. These educators shared their views that describing learners as 'neurodivergent' (or 'neurodiverse' which is the term they used in most cases) could help reduce the stigma experienced by neurodivergent learners who have traditionally been described as disabled.

Secondly, educators' language preferences appeared to be due to their belief that being neurodivergent does not automatically equate to being disabled. One participant stated,

'I don't think that people who are neurodiverse [neurodivergent] have a disability.' Another participant, who identifies as neurodivergent, stated, 'I never considered myself disabled.' Another participant explained that neurodivergent learners 'don't have a disability unless we make it a disability', suggesting that if educators provide the right environment and support for neurodivergent learners then they will not be disabled. The understandings shared by these educators about what causes disability aligns with the social model of disability. Additionally, most of the educators in this study acknowledged that their neurodivergent learners have strengths along with challenges. Therefore, they felt that 'neurodivergent' offers a more balanced view of neurodivergent learners' abilities compared to 'disabled', as 'disabled' is strongly associated with deficits. This opinion aligns with those of neurodivergent advocates and researchers, who assert that neurodiversity encourages consideration of both the strengths and challenges of neurodivergent people, rather than focusing only on their difficulties or deficits (Armstrong, 2010; Ellis et al., 2022). Interestingly, Monk et al. (2022) suggest that educators' language choices can positively influence change in both other educators and learners' attitudes towards the neurodivergent community. This claimed shift in educators' language usage when referencing neurodivergent learners could have a positive impact on the wellbeing of neurodivergent learners.

Uncertainty about What Language to Use in Association with Neurodivergent Learners

Educators were hesitant to use diagnostic labels to describe their neurodivergent learners. In the responses to the interview questions, educators often described specific learners' characteristics and challenges before they used diagnostic labels. The following excerpt from one of the educators in the study demonstrates hesitancy when asked who he had adapted the fonts on his PowerPoint presentation for: 'Probably people with [pause] who might struggle with reading and comprehension for whatever reason. So I guess if I were to choose an impairment, it would be someone who might have been diagnosed with dyslexia.' This visible hesitancy to use diagnostic labels may be explained with several reasons.

Firstly, diagnostic labels have traditionally been strongly associated with disability. As discussed, the educators in the current study did not equate neurodivergence with disability, and therefore may have avoided diagnostic labels in the same way they avoided 'disabled learner'. Secondly, their avoidance of diagnostic labels may stem from the stigma that they perceived relates to 'disability'. Additionally, the ODI (2016) implied that people who do not belong to a specific community, in this case, the neurodivergent community, may be unsure of which terms are appropriate and respectful when describing people who do belong to a specific community. This may provide an explanation for the hesitancy observed in how the educators in this study described their specific neurodivergent learners.

The Role of Diagnostic Labels for These Educators

The educators in this study demonstrated ambivalence towards the use of diagnostic labels. Most demonstrated an aversion to using diagnostic labels to describe their neurodivergent learners. Yet, they also acknowledged that knowing learners' formal diagnoses could be useful in certain contexts. Knowing their learners was deemed essential by these educators in order to enable effective teaching practices. The main methods they employed for obtaining information about their learners' specific learning needs and preferences included:

1. Informal observations of learners during class activities
2. Informal conversations with specific learners
3. Learners disclosing their own diagnoses and learning challenges.

These educators shared that they could not gain enough information about their learners' strengths and challenges to be useful for their planning and teaching. Therefore, they appreciated when their learners voluntarily

shared their diagnoses with them. Ashcroft and Lutfiyya (2013) found that some educators in their study showed discontent when their learners did not disclose a diagnosis as it hindered their ability to cater for those specific learners in their classes. Of course, learners disclosing their neurodivergence relies on them knowing they are neurodivergent, having a formal diagnosis, and being willing to share their diagnosis. Grimes et al. (2017) explains that learners can be reluctant to reveal their diagnoses for various reasons, including: refusal to be labelled, fear of stigma and discrimination, and not associating their condition with a disability. Knowing their learners' diagnoses was deemed beneficial for these educators in the following ways:

1. Discovering their learners' diagnoses filled gaps in their knowledge about their learners' challenges and learning preferences, which helped resolve queries they had about learners' characteristics and behaviours.
2. Diagnoses assisted the educators in classifying their learners.
3. Knowing learners' diagnoses supported them in planning for, and teaching, their specific neurodivergent learners.

The following excerpt from one participant demonstrates the advantage that learning about a specific learner's diagnosis gave her: '… actually being able to put it [her learner's challenges] in a box, it was almost like a light bulb moment for me.' After discovering the diagnosis, this educator was able to provide her learner with the right assistance to help her achieve success in her course. Carr-Fanning (2023) asserts that diagnostic labels can assist with identification of challenges experienced by individuals and can guide the support provided. It was clear that this participant benefited in these ways. Ashcroft and Lutfiyya (2013) and van Gorp (2022b) found that the educators that participated in their studies felt that knowing about the neurodivergence in the classroom made it easier to plan and teach.

While knowing their learners' diagnoses has advantages, it was also identified as a cause of some unease by the educators in the current study. Three educators acknowledged the unhelpful practice of categorising learners or 'putting learners into boxes'. Ellis et al. (2022) suggest that it is natural for humans to categorise and use labels to make sense of the world. In this case, the educators were trying to make sense of the learners in their classrooms for the purpose of professional planning and teaching. These educators were cautious about categorising learners using their diagnoses. They shared that they saw value in classifying them, but they also acknowledged the negative implications that can result from labelling, thus demonstrating their ambivalence.

An important consideration is that knowing a learner's diagnosis is only helpful to a certain extent. While discovering a learner's formal diagnosis can provide insight into how they may learn, there are variations within each neurologically based condition (Ellis et al., 2022; O'Connor et al., 2018). For instance, ADHD can manifest in many different ways (Moriah, 2023), meaning that two learners with an ADHD diagnosis can present differently from one another. Knowing a learner's diagnosis may be a helpful starting point from which further exploration with individual learners should follow.

It was clear that the educators in the current study were ambivalent about the use of diagnostic labels. They experienced internal tensions between the usefulness of knowing a learner's formal diagnosis and the potential negative impacts of using diagnostic labels to describe them.

RECOMMENDATIONS

This researcher is of the opinion that, as enrolments of neurodivergent learners in vocational education increase, it becomes more important for educators to understand how to effectively support them. Educators knowing what terminology to use in relation to neurodivergent learners, and how to use it,

is considered vital as language choice can have both positive and negative impacts on learners' well-being. This study found that although vocational educators felt that diagnostic labels were useful, they were hesitant and uncertain about using them. The changing landscape around terms associated with neurodiversity requires further investigation, contextualising and understanding. Therefore, critical analysis of the meanings, usages and implications of diagnostic labels on neurodivergent learners is recommended for educators. This has the potential to deepen educators' understandings, reduce their uncertainty and increase their confidence in using such terms and labels. It is recommended that vocational educators:

1. Explore labelling preferences of neurodivergent learners. Considering individuals' differing labelling preferences, it is important that educators pay attention to the terms specific neurodivergent learners use when referencing themselves and adopt such language. Additionally, as language preferences may change over time, learners would benefit from educators' conscious and continuous efforts to keep up to date with their individual language preferences, as well as efforts to critically engage with language developments at a societal level.
2. Examine the impacts that diagnoses and diagnostic labels can have on neurodivergent learners, including both the disadvantages and advantages.
3. Examine their own understandings of 'disabled learner' and other terms associated with neurodivergent learners. It could be beneficial for educators to investigate the academic and experiential terminology across all models and circumstances in this emerging field.
4. Practise normalising diagnostic labels, as well as terms such as 'neurodivergent learner'. Diagnostic labels can be functional. While they can come with negative connotations, when used in respectful ways that support and empower neurodivergent learners, there is the potential for learners to feel more comfortable in their learning environments.

While educators dedicating time to engage in critical analysis of the meanings, usages and implications of diagnostic labels is the primary recommendation here, it is only part of the solution. It is also recommended that educators apply their evolving understandings and knowledge about neurodiversity and neurodivergence in the teaching environment and continue to critically reflect on how it impacts their learners. Educators are responsible for developing and critically reflecting on their teaching practices. However, responsibility for professional development to address these actions also falls on tertiary education providers, the education sector and the wider disability sector, including the Ministry for Disabled People and the Office for Disability Issues.

CONCLUSION

This paper highlights some of the difficulties identified among a sample of six vocational educators regarding their understandings and usage of labels associated with their neurodivergent learners. They shared that they were constantly balancing uncertainty about the appropriateness of labels associated with disability and neurodivergence with the usefulness of such labels in their teaching practices. Language will continue to evolve, and new labels will continue to emerge, bringing new challenges in teaching environments. With the emergence of new terminology, knowing what language is respectful and appropriate when referencing neurodivergent learners requires continuous and meaningful attention. Ensuring the wellbeing and educational outcomes of neurodivergent learners is the ultimate goal. Critical analysis of labels, associated meanings and the implications for neurodivergent learners has been recommended as a way of enhancing educators' understanding and related practice, an initiative that will need to be supported by the wider vocational education sector.

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Trans-Inclusive Paramedic Practice: Translating Cultural Safety into Everyday Transgender-Affirming Care

RACHEL FAIRWEATHER, NOAH J. EARNSHAW & AMANDA BIRD

In the prehospital setting, paramedics are required to meet healthcare needs in a culturally safe manner. Transgender patients present with a unique subset of healthcare needs, and when these are not recognised it can result in trans patients delaying seeking help, being misunderstood and having unmet physical and mental health needs. The authors have undertaken a scoping literature review of research articles and policy and guideline documents, which have been published in the last eight years, to review the information and guidance available. Current studies highlight the significant lack of research, knowledge and understanding of healthcare provision for the transgender population. Furthermore, prehospital paramedic practice has little focus on this vulnerable and socially marginalised population. The literature reviewed identifies a clear link between cultural safety and competent paramedic practice, however guidance on how to apply it is in its infancy. The authors conclude that paramedics working with vulnerable populations have a moral responsibility to provide culturally safe and competent practice. Specialised training and continuing clinical education are essential to providing comprehensive gender-affirming healthcare.

KEYWORDS: cultural safety; gender identity; paramedicine; transgender; transgender-affirming; trans-inclusive

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> 'There's power in naming yourself, in proclaiming to the world that this is who you are. Wielding this power is often a difficult step for many transgender people because it's also a very visible one' (Mock, 2014, p. 144).

THIS LITERATURE REVIEW focuses on the parameters and practical provision of culturally safe paramedic care for transgender (trans) patients. The definition of transgender utilised in this review is someone whose gender identity and expressions are different from their gender assigned at birth (Grant et al., 2021). Conversely, cisgender (cis), 'refers to people having a gender identity matching the sex that they were assigned at birth' (Connolly, 2017, p. 152).

Veale et al. (2019) note the wide variation of gender identity terms that exist across cultures, including 'transgender, non-binary, transsexual, whakawahine, tāhine, tangata ira tāne, takatāpui, fa'afafine, fa'atama, fakaleiti, fakafifine, akava'ine, aikāne, vakasalewalewa, genderqueer, gender diverse, bi-gender, cross-dresser, pangender, demigender, agender, trans woman, trans feminine, trans man or trans masculine' (p. 1). Paramedics can struggle to comprehend this range of gender diversity (Barley & Tooms, 2019).

Similarly, the concepts of cultural competency and safety have been varied and vigorously debated. As a result, they have changed over time, and the historically ambiguous cultural competency and safety constructs have been replaced with increasingly explicit parameters requiring paramedics to examine their part in perpetuating health inequity and poor health outcomes when providing care for marginalised, vulnerable populations, including the transgender community (Carlström et al., 2021; Curtis et al., 2019; Davison et al., 2021; Garcia & Lopez, 2022; Grant et al., 2021; Kaphle et al., 2022; Kellett & Fitton, 2017; Kurtz et al., 2018; Lightfoot et al., 2021; Professional Association for Transgender Health Aotearoa [PATHA], 2022; Radix & Maingi, 2018; Tan et al., 2020; Westenra, 2019). The concept of cultural safety was embraced in nursing in Aotearoa New Zealand in 1992, where it was described as having a positive effect, including raised awareness, increased knowledge and a change in attitudes and behaviours (Ramsden, 1993). This arose from a number of hui held in 1988 which were aimed at addressing inequitable healthcare provisions for Māori patients (Papps & Ramsden, 1996). While some progress was made, the need to provide equitable healthcare for Māori was seen by some people as political correctness, rather than as an opportunity to remove sociopolitical barriers to healthcare. The notion of politically driven cultural safety raises questions around the thoroughness of application and motivation to commit to genuinely embedding this in individual practice (Ramsden & Spoonley, 1993). Further progress is highlighted by Curtis et al.'s (2019) suggestion that the concept of cultural safety is most strongly aligned with redressing health equity. When the need to address healthcare inequality is ignored, there is the potential for the end goal to be misconstrued as mastering cultural competence at an individual level, without considering the broader influences of power differentials and context.

Te Kaunihera Manapou Paramedic Council (2020b) defines cultural safety as:

> *The need for paramedics to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery … [and with the] awareness that cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care. (p. 2)*

An additional aspect has been included: cultural humility, where 'individuals learn to recognize their own experiences and identities and acknowledge the influence these have on their perceptions of others, in order to approach individuals without judgement and/or preconceived bias' (Ashley, 2019, as cited in Lightfoot et al. 2021, p. 15).

Legislative Protection for Transgender People

The establishment of the World Professional Association for Transgender Health (WPATH) in 1979 began a global focus on transgender healthcare (Coleman, 2017). Under this umbrella, Standards of Care (SOC) were outlined and defined by international clinical consensus. Fundamental principles of these SOC include demonstrating respect, providing gender-affirming and knowledgeable care, seeking informed consent and ensuring treatment matches the patient's needs (Coleman, 2017; Coleman et al., 2012). Reisner et al. (2015) describe gender affirmation as an 'interpersonal and shared process through which a person's gender identity is socially recognised' (p. 9).

However, in the 1980 Diagnostic and Statistical Manual, Third Edition (DSM-III), being transgender was pathologized as a gender identity disorder or as a childhood mental illness (American Psychiatric Society, 1980). Doctors and other medical professionals used this diagnosis to determine eligibility for such services as hormone treatment, surgery and resource allocation (Robles et al., 2022). The term gender identity disorder persevered and existed until 2013 when it was replaced with gender dysphoria, which refers to the dissonance between gender assigned at birth and gender identity (American Psychiatric Society, 2013; Drescher, 2015). Debate continues around the validity of categorising gender identity as a mental dysfunction in the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) and the distress caused by a dissonance in gender assigned at birth and affirmed gender identity (Robles et al., 2022). The definition of gender identification other than sex at birth as pathological, using the term 'gender dysphoria' outlined in the DSM-5, creates further barriers to healthcare (Davy, 2015; Bauer et al., 2009; Bockting, 2009; Garcia & Lopez, 2022; Yeonhee Ji, 2018). Definitions of gender dysphoria include the elements of 'distress associated with the experience of one's gender identity being inconsistent with the phenotype, or the gender role typically associated with that phenotype' (Wylie-Barrett et al., 2014, as cited in Connelly, 2017, p. 151).

Only more recently has the need for legislation protecting transgender people from discrimination been questioned. Heike Polster (2003) asked whether transgender people were adequately protected from discrimination under the existing New Zealand Bill of Rights Act 1990 and Human Rights Act 1993. The 2004 Human Rights (Gender Identity) Amendment Bill was heard, asking for gender identity to be a prohibited grounds for discrimination. Specific to healthcare, in 2008, Te Kāhui Tika Tangata Human Rights Commission published the results of their enquiry into discrimination experienced by transgender people in the report *To Be Who I Am*, which identified significant gaps in providing gender-affirming healthcare in Aotearoa. In 2018, comprehensive guidelines for gender-affirming healthcare in Aotearoa were developed (Oliphant et al., 2018), and the results of Counting Ourselves, the first national study of the health and well-being of transgender and non-binary people followed in 2019 (Veale et al., 2019). In November 2020, paramedic responsibilities under the Health Practitioners Competence Assurance Act 2003 were formalised with the Te Kaunihera Manapou Paramedic Council's Code of Conduct (2020a), incorporating cultural safety as a critical measure of clinical competence.

Until 2022, conversion or reparative therapies were utilised to 'cure' what was considered to be a pathological sexual or gender orientation, based on the DSM-III's definition. In Aotearoa and internationally, there was increasing resistance to such practices. Examples of this resistance included 'community building, trans pride, and normalising trans' (Hansen, 2020, p. 1). Individual dissent combined to create more organised community activism. In other words, transgender people became change agents rather than victims, which sparked the emergence of the trans liberation movement.

Over the past decade, there have been strides made in legal protections for transgender people. In 2015, the United States government, under the Obama administration, considered changes to regulations after the suicide of a transgender youth following conversion therapy. However, a year later Malta led the way, becoming the first country to introduce regulations banning conversion therapy into law (Byne, 2016). On 15 February 2022, the New Zealand Government passed legislation that banned conversion therapy on the basis of sexual orientation, gender identity and gender expression. Kris Faafoi, the then Minister of Justice, stated:

> *In banning conversion practices in New Zealand, we join other countries around the world in sending a clear message that all people, including young people, deserve to be protected, no matter their sexual orientation, gender identity or gender expression. All people, including rainbow communities, deserve to have their rights and dignity protected, and to live their lives freely just as they are. (New Zealand Government, 2022)*

RESULTS

Transgender-Affirming Care

The definition of cultural safety is described as a clinician's critical consciousness of their impact on health equity, their patients' health outcomes and their responsibility to mitigate the potential for discrimination, assumption and bias (Curtis et al., 2019; Kellett & Fitton, 2017; Kurtz et al., 2018). In a paradigm shift, the term cultural safety has been advocated for over cultural competence which was thought to promote an individualistic focus without reference to the imbalance of power between clinician and patient, or consideration of the dynamic and contextual sociopolitical influences (Ferguson, 2021).

Multiple authors mentioned the relationship between identification of the unique healthcare concerns of transgender people and professional healthcare practices which has the potential for adverse impacts and outcomes on the transgender population (Carlström et al., 2021; Davison et al., 2021; Garcia & Lopez, 2022; Grant et al., 2021; Jalali et al., 2015; Kaphle et al., 2022; Lightfoot et al., 2021; Ministry of Health, 2022; PATHA, 2022; Quaile, 2018; Radix & Maingi, 2018; Tan et al., 2020; Te Kāhui Tika Tangata Human Rights Commission, 2008; Westenra, 2019). These wide-ranging concerns included evidence of a higher incidence of mental health concerns (depression, anxiety, increased suicidality and addiction), socioeconomic hardship (poverty and homelessness), increased rates of disease (including prevalence of HIV), societal marginalisation and discrimination (actual and perceived) by healthcare providers, which negatively impacted patients' access to timely and appropriate healthcare and social services (Bauer et al., 2009; Carlström et al., 2021; Garcia & Lopez, 2022; Lightfoot et al., 2021; Radix & Maingi, 2018; Tan et al., 2020; Veale et al., 2019). It was noted that the standard of healthcare trans people received was inconsistent and poor, and that there was a lack of legislation protecting the human rights of the transgender population (PATHA, 2022; Minter & Daley, 2003 as cited in Bauer et al., 2009; Te Kāhui Tika Tangata Human Rights Commission, 2008).

Access to gender-affirming healthcare in Aotearoa is further limited by geographical location. The provision of gender-affirming healthcare in different regions, formerly operating under District Health Boards, varies widely, with some regions being completely unable to provide any gender-affirming non-surgical medical treatments (Fraser et al., 2019). Access to surgical interventions is frequently inaccessible without private funding as no public hospitals provide comprehensive gender-affirming care and waitlists for the limited amount of publicly funded surgeries can be decades long (Tan et al., 2023).

The Trans PULSE Project in Canada examined the barriers to transgender healthcare (Bauer et al., 2009). Erasure, defined as a 'condition of how transsexuality is managed in culture and institutions, a condition that ultimately inscribes transsexuality as impossible', is one schema by which those who are transgender are considered an anomaly, comprising passive erasure in which assumptions and a lack of knowledge are found, and active erasure relating to healthcare professionals' obvious discomfort or, at worst, refusal of service provision, resulting in marginalisation and vulnerability (Namaste, 2000, as cited in Bauer et al., 2009, p. 350). Similarly, marginalisation resulting from implicit and explicit forms of discrimination includes a lack of acknowledgment of individual identity and consequent feelings of invisibility (Bradford & Syed, 2019; Carlström et al., 2021; Kellett & Fitton, 2017; Radix & Maingi, 2018).

In an examination of language that perpetuates covert discrimination in relation to transgender health, Bradford and Syed (2019) studied the power of narratives, conceptualising cisnormativity as a process by which other gender identities are viewed as anomalies. Defining gender as a binary promotes the marginalisation of those who do not conform to cisnormativity (Bauer et al., 2009; Bockting, 2009; Bradford & Syed, 2019; Lightfoot et al., 2021; Radix & Maingi, 2018; Tan et al., 2020).

Another critical issue that was identified is that, when transgender patients access

healthcare, they fear discrimination based on previous negative experiences (Bauer et al., 2009; de Vries et al., 2020; Garcia & Lopez, 2022; Grant et al., 2021; Knudson et al., 2018; Lightfoot et al., 2021). Relating to the transgender population, the term 'minority stress' is used to refer to the unique stress that transgender people experience due to societal stigma and discrimination (Tan et al., 2020; Veale et al., 2019). Carlström et al. (2021) suggest that healthcare practitioners must recognise the vulnerability of the transgender community to 'violations of dignity' (p. 600), for instance use of their deadnames prior to transitioning.

Further to this, information practices create barriers to healthcare access for transgender patients by limiting accurate representation in data collection (Davison et al., 2021; Garcia & Lopez, 2022; Lightfoot et al., 2021; Radix & Maingi, 2018). Pega et al. (2017) note that the collation of 'high-quality gender identity data disrupt the familiar mantra of "no data, no problem, no action"' (p. 858). Clinician advocacy is central to improving healthcare outcomes for transgender patients (Kellett & Fitton, 2017; Lightfoot et al., 2021; Veale et al., 2019; Westenra, 2019). Specific training and education for healthcare practitioners in cultural safety was identified in the literature as being critical in caring for transgender patients (Carlström et al., 2021; Connolly, 2017; Davison et al., 2021; de Vries et al., 2020; Grant et al., 2021; Kurtz et al., 2018; Lightfoot et al., 2021).

Practical Application

A lack of research into the practical application of transgender-affirming healthcare is evident (Davison et al., 2021; Jalali et al., 2015; Lightfoot et al., 2021; Pega et al., 2017; Veale et al., 2019). Parameters of culturally safe transgender-affirming healthcare include the use of correct names and pronouns central to an individual's identity (Bauer et al., 2009; Davison et al., 2021; Garcia & Lopez, 2022; Lightfoot et al., 2021; Reisner et al., 2015). Marino et al. (2021) state, 'ask, don't assume' (p. 10). However, this alone is not enough. Reisner et al. (2015) outline the necessity of an informed consent model of healthcare which highlights the key role of gender affirmation in caring for transgender people, integrating community assessment, research, education training, advocacy and clinical care. Veale et al. (2019) state the importance of respecting and allowing informed decision-making and autonomy when working with transgender youth. Ashley et al. (2021) aligns the use of informed consent models with better health-care outcomes for transgender patients, through preserving patients' 'decisional autonomy' (p. 543), reducing distress and decrying pathologisation of the transgender and gender-diverse patients' health experience. Oliphant et al. (2018) describe the 'principle of Te Mana Whakahaere, [as] trans people's autonomy of their own bodies, represented by healthcare provision based on informed consent' (p. 88). Informed consent is key to cultural safety, as reports of privacy breaches appear common in the transgender population, both in relation to gender identity and assumption that patients are ready for their identity to be publicly known.

It was suggested that key aspects of providing culturally safe transgender-affirming healthcare are: creating a welcoming environment, gender-sensitive communication, understanding the diversity of marginalised population experiences, ensuring pathologisation and gatekeeping of resources are not accepted and engaging with the broader transgender community (Garcia & Lopez, 2022; Radix & Maingi, 2018).

Issues Transgender Patients Face

Cultural safety is recommended in the patients' history-taking, making them feel comfortable, accepted and understood; invasive questioning around unrelated topics driven by curiosity should be avoided (Connolly, 2017). Lightfoot et al. (2021) conceptualise cultural safety in clinical practice as possessing knowledge of gender-affirming interventions and the provision of tailored individual care.

What Can be Done and Changes Required

Cultural Humility

Lightfoot et al. (2021) identify that conditional to culturally safe and transgender-affirming care is the essential need for each individual provider to understand the 'depathologization of gender variance and … [adopting] cultural humility' (p. 4). The three defining attributes of this are 'patient-led care, trans-affirming culture and trans-competent providers' (Lightfoot et al., 2021, p. 15).

Power Imbalance

Fisher-Borne et al. (2014, as cited in Lightfoot et al., 2021, p. 2), Ramsden (2002, as cited in Westenra, 2019, para. 19) and Kaphle et al. (2022) highlight that key to reducing harm for transgender patients is the need for clinicians to critically reflect on and redress the power imbalance between the healthcare provider and patient.

Lack of Research and Data

Lightfoot et al. (2021) suggested that the focus on the LGBTQ+ population as one group overlooks the specific challenges faced by the transgender population in healthcare. Bauer et al. (as cited in Lightfoot et al., 2021) believe the process of erasure is in play when trans issues are neglected in 'health research, education, and policy broadly presented as "pan-LGBTQ+"' (p. 2). Concerning information practices, Davison et al. (2021) suggested that it is important that individuals can specify their terminology and identification. Te Kāhui Tika Tangata Human Rights Commission report (2020) states that poor response options when collating data limit diverse answers, which in turn reduces adequate diversity representation and targeted human rights. There was minimal evidence available when examining practical guidelines for culturally safe transgender-affirming healthcare for paramedics.

Policy and Guidelines

The Standards of Care, Version 8 provide international guidelines for delivering culturally safe healthcare to trans and gender-diverse people (Coleman et al., 2022). In Aotearoa, prehospital guidelines for paramedics are explicit about the new mandates, which require consideration of cultural safety and competency relating to gender identity (Te Kaunihera Manapou Paramedic Council, 2020a). Guidance specific to paramedic clinical practice when caring for trans patients comes from Connolly (2017) who outlines the need for sensitive history-taking and appropriate questioning, stating the need for 'a clinician that is open and aware of current challenges and changes facing the trans community' (p. 155).

DISCUSSION

Key Constructs and Definitions

The literature reviewed highlights how healthcare practitioners should not assume their patient's gender identity, as this should be disclosed by the individual. There was consistency in reporting the parameters of culturally safe paramedic practice, including that clinicians must critically appraise their own beliefs, bias and impact; they must also possess appropriate knowledge, attitudes and behaviour when interacting with trans patients.

Cultural safety is a critical component of paramedic competence and is referred to in Part C of Te Kaunihera Manapou Paramedic Council's Code of Conduct (2020a) and Standards of Cultural Safety and Clinical Competence (Te Kaunihera Manapou Paramedic Council, 2020b). These requirements are legally binding for paramedics with the Paramedic Council providing a formalised regulatory body to monitor and measure these standards.

Organisational Change

There was a paucity of research and evidence-based clinical practice with specific applications of cultural safety in the prehospital context when caring for members of the transgender community. Implications for ambulance services lie in ensuring they provide adequate response options when collecting patients' personal information. Coleman (2017) encourages us to think 'beyond the binary' (p. 71). Organisational practice also requires a reflexive approach involving transgender-led changes in paramedic practice.

Individual Recommendations

The key to culturally safe and increasingly competent gender-affirming paramedic practice is to possess specialised knowledge of transgender-affirming care; this should be a vital inclusion in the university curriculum and built on through continued clinical education and growing paramedic experience. There were significant gaps and limited evidence in the practical applications and tools for paramedics to provide culturally safe transgender-affirming healthcare. Nevertheless, critical reflection on cultural safety and humility is encouraged at an individual level (Westenra, 2019). Furthermore, a focus on advocacy suggests that healthcare providers should consider the impact of broader sociological factors (Curtis at el., 2019; Westenra, 2019). Supporting this, Tan et al. (2020) say that healthcare providers should promote 'equitable access to healthcare services and gender-affirming care for transgender people to attain the highest standard of health' (p. 12).

Recommendations for Future Research

Research is urgently needed into evidence-based practice examples with a prehospital focus to guide paramedics in how to deliver culturally safe, clinically competent, transgender-affirming care. Clinical education in the paramedic educational curriculum and ambulance service, focusing on acquiring skills in transgender-affirming paramedic practice, needs to be standardised to raise awareness of individual beliefs, attitudes and goals, furthering effective practical application on the road. Results of the Counting Ourselves survey included recommendations around ensuring the availability of 'training resources and trans-led initiatives' (Veale et al., 2019, pp. 114–115). Future research needs to involve the transgender community (Carlström et al., 2021). Collaboration ensures greater success in improving health outcomes for vulnerable populations (Kurtz et al., 2018).

Recruitment strategies for one study by Bradford and Syed (2019), which investigated the impact of the cisnormative narrative on transgender identity development, included using social media platforms, which meant that researchers could not control for specific demographics. An outcome of this was that some participants identified as non-binary, leaving hesitancy regarding whether the results also related to transgender people.

Limitations related to accurate data on transgender people and their health needs in Aotearoa were highlighted by Pega et al. (2017). They maintained that misrepresentation of transgender people's needs and experiences can occur because they are often grouped under the umbrella of the term 'gender diverse'.

APPLICATION

Paramedics have a legal and moral obligation to provide culturally safe and clinically competent transgender-affirming care. Te Kāhui Tika Tangata Human Rights Commission (2020) states that those with diverse gender identities 'have the right to the highest attainable healthcare' (p. 5). National practice guidelines require paramedics to respect cultural needs and values, which begins when we challenge our attitudes and reflect on our own bias towards those with diverse 'gender identity, sexual orientation and/or disability' (Te Kaunihera Manapou Paramedic Council, 2020a, Part C).

Cultural safety is referred to in the Standards of Cultural Safety and Clinical Competence for Paramedics, stating that patients must have full involvement in decision-making, if a culturally safe model of care is to be delivered (Te Kaunihera Manapou Paramedic Council, 2020b). Cultural safety within paramedic practice requires interaction with and knowledge of the sociopolitical issues faced by the transgender community, such as discrimination, and the resulting minority stress that leads to higher incidences of suicidality (Coleman, 2017).

Similarly, Westenra (2019) identifies the need for paramedics to think beyond their scope of practice and consider interwoven sociological variables, such as history, context and experience, that inform decision-making and impact cultural safety. She envisages cultural

safety as a step-by-step journey in which learning awareness paves the way to eventual cultural humility. Further to this, humility is described by Westenra (2023) as a dynamic state in which the clinician acknowledges the need for lifelong learning, and whose sensitivity and safety are judged solely by the receiver.

Radix and Maingi (2018) outline the impact of the organisational umbrella on cultural safety and competency as a necessary fusion between policies and structures, which encourage appropriate values, principles, attitudes and behaviours. Coleman (2017) describes clinical competence in providing culturally safe and appropriate healthcare to transgender people as 'dependent upon specialized training and continuing clinical education' (p. 70).

In Aotearoa, there is a growing body of research and guidelines on how to provide gender-affirming care in general healthcare, upon which we can build our own standard of culturally competent care in the prehospital setting. However, existing paramedic guidelines are in their infancy and further research is urgently needed to identify the needs of transgender people in prehospital paramedicine, which will require transgender-led consultation.

Practical Tools

Westenra (2023) outlines practical steps paramedics can take towards cultural safety. These include examining our beliefs and attitudes for implicit bias. Some practical elements of cultural humility include using expansive language, creating safe spaces for all patients, ensuring patient privacy and being an active advocate for the rainbow and gender-diverse community within our own sphere of influence (Westenra, 2023). Garcia and Lopez (2022) echo the need for overt signalling of culturally inclusive environments. Leonard et al. (2022) also identified that the attitudes of emergency personnel provided valuable insight into wider organisational policies and culture, and thus negative attitudes towards transgender patients need to be eliminated.

Barley and Tooms (2019) stress the need for clinicians to ask patients about their gender identity, but also that training is needed on how to do this sensitively. Questioning must be relevant, unintrusive and not driven by curiosity (Barley & Tooms, 2019; Garcia & Lopez, 2022). The 'trans broken arm syndrome' should be avoided; this is where a clinician 'incorrectly assumes that a medical condition results from a patient's gender identity or medical transition' (Wall et al., 2023, p. 1). Barley and Tooms (2019) add that best practice in the ambulance service is to use correct pronouns and gender identity in patient handover.

Garcia and Lopez (2022) assert that any physical examinations should be kept to a minimum to avoid distress. In the prehospital environment, this may include the application of electrocardiogram leads, which necessitates exposing the chest. It is paramount that these examinations are not neglected due to the provider's discomfort or inexperience with transgender patients (Hussain et al., 2023). Applying electrocardiogram leads is often medically necessary. It is important therefore to gain a patient's informed consent before exposing their chest and to ensure that this is undertaken in a private area (Hussain et al., 2023).

CONCLUSION

In Aotearoa, we have developed healthcare policies for providing culturally safe gender-affirming care, however, these are centred in the primary healthcare context, broader human rights legislation and the newly established paramedic's Code of Conduct (Te Kaunihera Manapou Paramedic Council, 2020a). None of these policies and legislation specifically mentions safe practice with the transgender population (Te Kaunihera Manapou Paramedic Council, 2020a, 2020b).

Cultural safety is necessary when paramedics provide healthcare for transgender patients, however, there is limited research, practical guidelines and focused paramedic training on how to do this and provide care that has no potential for harm. The knowledge possessed by

healthcare practitioners impacts the quality of care they can provide to transgender patients. Specialised training and continuing clinical education are crucial to developing culturally safe transgender-affirming paramedic practice. Further systematic reviews and targeted research are required to inform clinical decision-making around providing transgender-affirming care, as well as establishing how to measure the efficacy of clinically safe and competent paramedic practice through evaluation by our care receivers.

Carlström et al. (2021) include the following message from a transgender person: 'treat me with respect … accept me for who I am, treat me according to my needs, and meet me with competence' (p. 602). Finally, Bauer et al. (2009) remind us of the human cost: 'this is our lives' (p. 359).

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Tiaki Moemoeā: The Dreamkeepers' Role in Supporting Pacific Learner Aspirations

YVONNE KAINUKU & WENDY TRIMMER

A critical element in closing the gaps in health disparities for Pacific people living in Aotearoa New Zealand is the presence of a culturally appropriate health workforce (Heke et al., 2019). This article presents Tiaki Moemoeā (dreamkeeper), a key research finding, essential in developing a culturally appropriate healthcare workforce that addresses factors impacting the health and well-being of Pacific people in Aotearoa. The study explored the lived experiences of Cook Islands Māori nurses during their three-year training within a Bachelor of Nursing Pacific (BNP) programme in Aotearoa. The aim of the research was to collect and analyse stories from registered nurses about their experiences of culturally responsive pedagogy, and their connection to content relating to Pacific world views and Pacific ways of knowing while they were students. The study used the culturally specific Tivaevae Research Model alongside qualitative inquiry. An aim of the research was to recognise factors that supported the participants to successfully become registered nurses. As a result of the data collected, the theme of Tiaki Moemoeā will be introduced and interpreted, and the discussion will show how Tiaki Moemoeā can contribute to the transformational change in nursing education in Aotearoa.

KEYWORDS: education; nursing; Pacific; Tivaevae

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The term 'Pacific peoples' can be interpreted in a broad sense, referring to indigenous people from the South Pacific Island nations, or in a narrower sense, referring to Pacific peoples who reside in Aotearoa New Zealand (Ministry of Pacific Peoples, 2018). The narrower term relates to peoples who have indigenous ties to at least one of eight nations, including: Samoa, the Cook Islands, Tonga, Niue, Fiji, Tokelau, Tuvalu and Kiribati (Ministry of Social Development [MSD], 2016). The broader ethnic grouping 'Pacific peoples' allows the New Zealand Government to make high-level comparisons with other ethnic groups (MSD, 2016). Pacific peoples form the fourth-largest ethnic grouping, with over 380,000 people representing 8% of the country's population (Stats New Zealand DataInfo+, 2018). From this group, over 80,500 people identify their origins as Cook Island Māori, with 83% born in Aotearoa.

Much like the canopy term 'Pacific', the Cook Islands refers to 15 islands scattered over two million square kilometres of the South Pacific Ocean, with a total population of 14,800 people (Cook Islands Statistics Office, 2018). The Cook Islands' people carry the name Māori. 'We call ourselves Māori, our language is Māori and our culture is Māori. In truth, one is only a Cook Islander outside the Cook Islands' (James et al., 2012). In the context of the Cook Islands, 'ākono'anga (culture) is determined by papa'anga (genealogy). As in many of the Pacific Islands, Cook Island Māori cultural practices are rooted in traditional ecological knowledge, such as the preservation of food systems, self-determination and promoting reciprocity between living beings, all of which is necessary for community flourishing (Spencer et al., 2020). With this understanding, Cook Island Māori peoples' relationship with their genealogies, and their connections to the land and sea, offer further evidence of the critical roles that culture and indigenous knowledge have in everyday life (Spencer et al., 2020).

The Ministry of Health (2019) reports that Pacific peoples underutilise healthcare services across the preventative, primary and secondary sectors. Identified barriers to accessing healthcare include policies and procedures that hinder Pacific families being active participants in their family members' care (Brown, 2018). For example, one hospital had a strict policy that only allowed overnight stays for one parent or caregiver. Participants from Brown's study expressed being stressed, feeling alone and worrying their child would die overnight. Another identified barrier were the inconsistencies between District Health Boards (DHBs). One DHB might pay for the cost of a parent/caregiver's flights if a minor were to have treatment in a location away from home, while another DHB would not. Brown concluded that health systems, in particular hospitals, were seen as clinical environments constructed and driven by Western concepts, ideals and values, many of which clash with Māori and Pacific world views. While there has been some improvement towards addressing and reducing such barriers, there are still gaps in health and service outcomes between Pacific and non-Pacific people (Ryan et al., 2019).

It is commonly accepted that the ability to address the gaps in health disparities is hindered, in part, by the disproportionately low number of Pacific people in the health workforce (Wikaire et al., 2017). Health sector feedback gathered by the Ministry of Health (2014) identified that there are not enough Pacific health workers (including nurses) nor Pacific leadership to help Pacific communities thrive.

It is essential to not only recruit more Pacific, and specifically Cook Islands, nursing students, but to retain them to achieve the goals of the Ministry of Health's (2020) strategic plan, *Ola manuia*. It is also strongly argued that nursing curriculums and specific course content need to allow for an indigenous perspective to enhance success for Pacific tertiary students (Luafutu-Simpson et al., 2015; Penn, 2014; Tuitaupe, 2018). The same researchers have looked to the only dedicated Pacific nursing programmes in Aotearoa, the BNP programmes delivered by Whitireia New Zealand and Manukau Institute of Technology, referring to their approach as revolutionary. It is from within these programmes that this research sought to explore the factors that impact Cook Island Māori students during their journey within a BNP programme.

This study contributes to the growth and development of culturally responsive pedagogy and an enhanced workforce of nurses who appreciate the nuances of practicing in a culturally safe way. Ultimately, this research contributes to countering the trajectory of poor health outcomes for Cook Island Māori and all indigenous Pacific peoples living in Aotearoa.

RESEARCH METHODOLOGY AND METHODS

Futter-Puati and Maua-Hodges (2019) assert that a context-specific research model must support research involving Pacific peoples, families and communities. Anae (2019) agrees that the use of context-specific models demands that research carried out with Pacific peoples and

communities is ethical and methodologically sound. Using such models decolonises and re-indigenises research agendas and outputs. The term 'indigenous behaviours' is a concept that expresses the complexity of social values and etiquette specific to culture, gender and class groups or subgroups. It explores how values can have their own intricate cultural protocols, like 'respect' having language, rituals and dress codes. Respect, like other social values, embraces complex social norms, behaviours and meanings, as one of many competing and active values in any given social situation (Denzin & Lincoln, 2017).

The Cook Islands Māori research framework Tivaevae (Maua-Hodges, 2001) not only provides context-specific components, but also supports qualitative research approaches. The Tivaevae research model employs four key stages within the process of designing, developing and delivering a research project, including:

1. 'akapapa | conceptualising and planning research activities,
2. 'akaruru | data collection methods,
3. pakoti | to cut, analyse and interpret data,
4. o'ora te tivaevae | presenting the report/ findings (Futter-Puati, 2017).

Further to the four key stages used within the Tivaevae Model, Futter-Puati (2017) stresses five crucial values that are important to Cook Islands Māori people. The model is grounded in the values of taokotai (collaboration), tu akangateitei (respect), uriuri kite (reciprocity), tu inangaro (relationships) and akaari kite (a shared vision), which are woven throughout each stage of the research process (Te Ava & Page, 2018). These values are essential to the design and implementation of any research project involving Cook Islands people (Futter-Puati, 2017).

'Akapapa – Conceptualising and Planning Research Activities

The 'akapapa stage requires careful planning, familiarity with literature, methods and theories, as well as a clear understanding of the project goals (Futter-Puati & Maua-Hodges, 2019).

During this stage, ethical approval was sought and granted from both the Whitireia Ethics and Research Committee and the Cook Island Research Ethics Committee.

'Akaruru – Data Collection Methods

The 'akaruru stage was crucial to defining the selection criteria of participants. The chosen participants were nurses of Cook Islands Māori heritage who had graduated from a BNP programme in Aotearoa more than three years ago. To mitigate any risk of the researcher having prior knowledge of potential participants, it was decided that the selection criteria only include those who graduated more than three years ago from the same school in which the researcher currently worked.

Recruitment of Participants

Participants were sourced initially from the Cook Islands Nurses Association Aotearoa and through alumni of both tertiary institutions offering the BNP programme. These networks sent out a flyer via their private Facebook pages, reaching over 800 members. However, this was not as successful as anticipated given only one person who could have met the participant criteria responded. Recruitment attempts were then made by collaborating with past and current lecturing staff (from each programme). Through their valued and trusted relationships, participants were sourced, including two living in the Cook Islands.

Data Collection – Interview Process

Qualitative inquiry aided in accomplishing one-on-one interviews using semi-structured questions. Interviews were offered by way of either face-to-face or via an online option, which were negotiated between the participants and the researcher. The researcher transcribed the interviews and sent a draft to the participants to verify their responses.

Open-ended questions (see appendix) were tailored to explore culturally responsive methods of teaching and learning, the connection to Pacific world views and engagement. The

participants were asked about their experiences and how they felt supported or challenged to express their cultural identity while in the programme. They were also asked if there was anything that stood out to them that impacted their learning journey, and if they had any recommendations for how the institutions could support Cook Island Māori nursing students in a BNP programme.

Four participants were interviewed for this research, all participants were female and had successfully completed their nursing education through a BNP programme. Two of the participants live in Rarotonga and were interviewed face-to-face in the Cook Islands. The other two participants were interviewed in Aotearoa. The participants were working in varied roles within the health-related sector.

The conceptual framework of the Tivaevae model and the practical methods guided the research approach, data collection and robust analysis.

Pakoti – To Cut, Analyse and Interpret Data

To support pakoti, the third stage (Futter-Puati, 2017), the data analysis process used Braun and Clarke's (2012) reflective approach to thematic analysis, known as reflexive thematic analysis (RTA).

The data was analysed using the RTA six-phase process. The first phase involved familiarising oneself with the data by listening to the transcribed interviews. Any patterns or trends that emerged were noted, and personal thoughts and feelings about the data were documented. In the second phase, initial codes were generated by categorising participants' responses under headings for each question. This allowed for possible similarities and differences to be identified, and coding was conducted by highlighting statements and using general words to describe the narratives. The third phase involved generating themes using a thematic map. In the fourth phase, potential themes were reviewed using key questions proposed by Braun and Clarke (2012), such as: 'If it is a theme, what is the quality of this theme (does it tell me something useful about the data set and my research question)?' and 'What are the boundaries of this theme (what does it include and not include)?'. It was confirmed that there were fully realised themes, with patterns of shared meaning underpinned by a central organising concept. The fifth phase involved defining and naming the themes in relation to both the dataset and the research question. Three themes emerged, each containing sub-themes. Finally, in the sixth phase, a report was produced that provided context for the research results using existing literature. The relevance of the findings and the value of nursing programmes specifically tailored to Cook Island Māori and other Pacific learners were highlighted.

O'ora te Tivaevae – Presenting the Report / Findings

O'ora te tivaevae is the fourth and final stage in the process of Tivaevae methodology, in which researchers present their findings and offer recommendations. Centralising the Tivaevae Research methodology in this project was essential and enabled compatibility with non-Pacific research methods. The intertwining of these research approaches proved successful in ensuring that the participants voices were given authority and reverence.

RESULTS

The key themes that emerged from analysis included (1) Piri'anga toto, (2) Tiaki Moemoeā and (3) 'Akapapa'anga; 'akono'anga Māori (Cook Islands Māori culture) (refer to Table 1).

The theme of Piri'anga Toto considers family as a major positive influence in successfully becoming a nurse. Smaller cohorts created a sense of community and support, offering what the participants described as a 'family oriented feeling'. Participants reported that having access to equitable support through resources such as financial assistance was invaluable during their time of study.

The second theme, Tiaki Moemoeā, identifies the essential elements relating to culturally responsive pedagogy, where culturally relevant role models utilise innovative and interactive teaching

Major themes	Sub-themes
Piri'anga Toto	• Family – 'my why' • Supportive and smaller cohorts – 'no-one left behind' • Equitable support – ringfenced financial resource
Tiaki Moemoeā	• Culturally responsive pedagogy, delivered by culturally relevant lecturers • Embedded pastoral care • Pacific role models - industry leaders and champions
'Akapapa'anga	• 'Akono'anga Māori – Cook Islands Māori culture • Personal attributes – resilience

TABLE 1: THEMES AND SUB-THEMES

methods, and offer embedded pastoral care approaches. Tiaki Moemoeā will be discussed in more detail below.

Thirdly, 'Akapapa'anga identifies and highlights the importance of specific content knowledge that is inclusive of both Cook Islands and the broader Pacific world views, ways of knowing and epistemologies. The research identified the powerful impact that content knowledge has on the learner. Within this theme, 'Ākono'anga Māori (Cook Islands Māori culture) was found to have strong effects on a learner's self-identity, personal growth and development, with the ability to imbue pride and confidence in one's cultural being and sense of belonging. Furthermore, personal attributes of a learner were found, highlighting students' characteristics that have not only assisted with their academic aspirations, but helped them become champions and leaders within the health sector, combating and advocating for issues concerning inequities.

DISCUSSION – TIAKI MOEMOEĀ

This discussion focuses on the themes of Tiaki Moemoeā and identifies essential elements that engage learners along their journey. Tiaki Moemoeā is the literal translation of 'dreamkeeper' in the Cook Island Māori language. Under this theme, the practices and characteristics of positive teaching influencers, such as lecturing staff, proved to be a major supportive contributing factor for Cook Island students to successfully become registered nurses.

During the interview stage of this research, the researcher was inspired by what the participants described as lecturers who were like family members, likening them to parents and aunties who would go above and beyond in supporting them. This, and other examples the participants shared, echoed the reflections written in Gloria Ladson-Billing's book, *The Dreamkeepers* (2022). In this book, she shares empirical findings based on the stories of eight teachers and her reflections on being a teacher of African American descent in the United States. Her explorations from within these stories set out to identify what supported African American students to persevere and prevail in their

educational pursuits. Ladson-Billing showed that the pedagogical practices of teachers made all the difference toward student academic success.

The findings related to Tiaki Moemoeā and its sub-themes of culturally responsive pedagogy, embedded pastoral care and Pacific nurse role models have the potential to contribute to transformational change for all nursing education training in Aotearoa. The following sub-themes could support better outcomes for the Pacific nursing workforce and Pacific people's health status.

1. Culturally Responsive Pedagogy

Culturally responsive pedagogy recognises and values students' diverse backgrounds and experiences, and incorporates this understanding into teaching practices (Ladson-Billing, 2019). Participants identified that lecturers used various interactive teaching approaches, such as practical/hands-on methods. These various approaches encouraged discussions, particularly about Pacific ways of being. Such discussions provided opportunities for the identification of similar and diverse world views, rather than assuming a hegemonic world view, and were deemed empowering by participants.

It has been accepted that Eurocentric pedagogy falls short of adequately preparing students for the increasingly diverse and interconnected world (Gay, 2018). Gay asserts that by valuing and integrating diverse perspectives, we can better equip students for the challenges of the twenty-first century. Eurocentric pedagogy often perpetuates cultural biases and reinforces dominant narratives, leaving little room for diverse perspectives. This approach can alienate and disengage students who need to see themselves reflected in the curriculum (Gay, 2018). Current research by Ladson-Billings (2019) agrees with Gay's (2018) results that culturally relevant teaching enhances student engagement and academic achievement, and can promote critical thinking and a sense of social responsibility in students, particularly for students of colour.

Further to identifying elements of culturally responsive pedagogy was the recognition of having culturally relevant lecturers delivering content. Participants identified that all their lecturers who were of Pacific heritage, and some (but not all) non-Pacific teaching staff, demonstrated the ability to understand and appropriately apply cultural values and practices that are essential to Cook Islands Māori and the broader world views of Pacific peoples. Participants gave examples of how lecturers demonstrated their understanding of Cook Islands and Pacific cultural competency. Culturally safe lecturers, both Pacific and non-Pacific, were those who went the extra mile by advocating for and championing the students, the BNP programme and the wider Pacific community. One such example was a lecturer encouraging a participant to place her family's needs before her clinical placement arrangements. Another participant said a lecturer proactively created opportunities for placement, which benefitted the broader Pacific community (Kainuku, 2023).

Ladson-Billings' (1994, as cited in Ogundipe et al., 2022) pedagogical principle 'Teacher as facilitator' is similar to the findings of Ikiua (2018). Ikiua characterised Pacific education pedagogy as collaborative learning, respecting diverse perspectives and having a focus on experiential and contextualised learning that draws on the lived experiences of learners.

The findings of this study mirrored the role of 'Teacher as facilitator'. Engaging and effective lecturers within the BNP programme were those who were able to apply teaching methods that facilitated discussions, and were not only culturally responsive, but seen as ethnically relevant to the programme.

'By Pacific for Pacific'

A 'By Pacific for Pacific' approach has proven effective within other studies (Elk et al., 2020; Ikiua, 2018; Tuafuti, 2016). In support of the findings in this research, when compared to non-Pacific lecturers, Pacific lecturers demonstrated the ability to provide a style of teaching that incorporated Pacific world views, values, beliefs and protocols into their lessons

with ease and confidence. This finding also revealed that content relating to cultural ethnicity was delivered more effectively by lecturers who reflected that ethnicity. Tuafuti (2016) defined Pacific-responsive pedagogy as a framework for teaching and learning grounded in Pacific cultures, values and ways of knowing.

Cook Island Māori Cultural Capital

Cultural capital refers to the non-financial assets that individuals possess, such as knowledge, skills and education, that can be used to gain social and economic advantages (Pierre Bourdieu, 1986, as cited by Bamblett et al., 2019). This concept has been widely studied in sociology and has significantly impacted individual success and social mobility (Bamblett et al., 2019). Overall, understanding cultural capital is vital for individuals and society, as it can help to explain disparities in social and economic outcomes. By recognising the value of non-financial assets, we can work towards creating a more equitable society (Bamblett et al., 2019). The findings from this research draw on the concepts of cultural capital of which Bamblett et al. (2019) emphasise the importance of ethnic-specific teaching methods and content. All participants agreed that Cook Islands Māori content, such as Cook Islands' healthcare models and nursing assessment tools, needs to be scaffolded into the curriculum teaching content. In addition, it was also identified that participants desired Cook Islands Māori content to be delivered by lecturers who are of Cook Islands Māori heritage. They deemed these lecturers most likely to possess cultural capital, traditional practices, beliefs, customs and values that have been passed down from generation to generation.

2. Embedded Pastoral Care – 'I felt safe'

Pastoral care approaches have been identified as supporting the normalisation of academic learners' help-seeking behaviours and creating a sense of belonging instead of isolation and exclusion (Christensen et al., 2019). Many students face significant challenges when confronted with the additional pressure studies bring, particularly finding a balance between competing responsibilities of family, church, community, employment and finances (Southwick et al., 2017; Ten Hoeve et al., 2017).

Participants in this study identified that feeling safe across all aspects of learning, environmental or in relationships with others, instilled and enhanced confidence. In part, the sense of safety was attributed to the pastoral-care approach extended by lecturers within the BNP programme, particularly lecturers of Pacific descent. They were opportunistic and responsive in initiating and encouraging 'help-seeking' behaviours from students. In many ways, the lecturers were described as 'going above and beyond' and being proactive in their pursuit of offering and linking pastoral-care support to students. All participants from this study gave examples of how lecturers proactively involved themselves in student absences, such as initiating discussions to prompt peers to encourage re-engagement.

Descals-Tomás et al. (2021), whose research focused on the impacts of pastoral care from teachers, showed outcomes that impacted positively on student's self-belief in their ability to succeed in their academic pursuits. Descals-Tomás et al. (2021) also suggest that offering pastoral care impacts the student's motivation to engage in their learning more than teaching content knowledge. Teachers can improve students' beliefs and goals, so they should encourage students to manifest engagement behaviours. In addition, Descals-Tomás et al. (2021) recommend that working on students' beliefs with teacher support can be a promising approach to improving student motivation and learning. These findings are congruent with the evidence provided by Ruzek et al. (2016) relating to the emotional support offered by teachers, which impacts positively on student motivation and engagement.

Teevale and Teu (2018) reveal the importance of utilising and accessing help when needed. They identified that Pacific students who used Pacific-centric student support services while at university achieved higher academically than

students who did not. Teevale and Teu also discovered that Pacific students encountered peer backlash for using Pacific student support services, generating subsequent negative impacts upon future help-seeking behaviours. To counter peer backlash, they recommend including cultural competency training for university staff who work with and engage with Pacific students, whether in teaching or support services; and curriculum development to ensure academic content includes aspects of the Pacific world (Teevale & Teu, 2018).

3. Pacific Role Models – Enablers 'they played a huge role'

Pacific learner success in workplace environments requires supportive relationships with facilitators to create a motivating learning experience (Ryan et al., 2017). Facilitators of learning support are essential catalysts for participation and achievement, continuation and completion (Ryan et al., 2017). In this study, the Pacific nurses that participants encountered during their clinical placements were seen as inspirational, affirming and supportive role models.

Further to the positive encounters participants had with Pacific nurses, they also asserted that seeing Pacific nurses, particularly those in charge nurse positions, dissipated the negative and unwarranted presumptions held by others. For the participants, Pacific nurses were essential beacons of inspiration, motivation and aspiration as class lecturers and role models during clinical experiences. The positive impact of role models is evident in Jack et al.'s (2017) research of undergraduate nursing students, which concludes that role modelling is an effective way to support learning and leads to student satisfaction within both clinical and university environments. Further, the participants' points in Jack et al.'s study regarding Pacific nurses are vital to discuss, as these behaviours of affirmation and support towards Pacific nursing students are in stark contrast to what is seen in Western nursing environments (Jack et al. 2017). The findings from both Jack et al. and this research show stark differences to McCarthy et al.'s (2018) integrated literature review. In that review, 13 of 16 studies showed that a large portion of nursing students' stress stemmed from challenging relationships with clinical colleagues and educators. Significant stressors included lack of support, empathy and understanding, and feeling ignored, unwanted, rejected, exploited and intimidated by clinical colleagues.

Nursing literature (Anderson & Morgan, 2017; McKenna & Boyle, 2016; Tee et al., 2016) frequently highlights an ongoing issue with respect and communications between nursing and midwifery staff, clinical educators and students in clinical settings. McCarthy et al. (2018) suggests that there are still ongoing negative and unsupportive relationships between students and clinical colleagues during clinical placements, which is not a new phenomenon. Clark (2011, as cited by McCarthy et al., 2018) refers to these negative encounters as 'incivility', where harmful behaviours have a negative impact on others, either physically or psychologically.

Eka and Chambers' (2019) systemic review concluded that there is a lack of consensus on what constitutes incivility, which has led to authors proposing several terms such as uncivil behaviour, disruptive behaviour, vertical violence, horizontal violence and bullying. However, these terms all encompass undesirable and disturbing behavioural acts such as disrespect and undermining others, academic dishonesty and bullying. Findings from the same review also revealed that studies investigating incivility in nursing schools were done in Western cultures, with a smaller amount performed within non-Western cultures. It was recommended that because of cultural differences, the findings of the studies conducted in the West were not transferrable to other cultural backgrounds (Eka & Chambers, 2019). Anderson and Morgan (2017) describe the situation of incivility in the nursing profession, as 'a continuation of a destructive culture where nurses persist in eating their young' (p. 377).

RECOMMENDATIONS

The research findings have yielded strategies that could be adopted by tertiary institutions, educators, nursing programmes and the wider healthcare sector, not only for Cook Island Māori nursing students, but for all Pacific learners. More specifically relating to the theme Tiaki Moemoeā, the researcher proposes pedagogical approaches for educators and programme content delivery. These include:

- integration of Cook Island Māori and Pacific world views throughout all nursing education curriculums,
- ethnic-specific nursing programmes adopting a 'by Pacific for Pacific' approach to ensure better outcomes for students. Participants in this study gave multiple examples of how Pacific lecturers and nurses, compared to non-Pacific lecturers and nurses, made a difference in terms of support and the participant's ability to engage in teaching content made a difference in terms of support and the participant's ability to engage in teaching content. The participants also said that during clinical placements, Pacific nurses acted as the role models in encouraging them to finish their degrees, and made them feel 'needed',
- being Pacific culturally competent. The researcher has created the Kaveinga Āpi'i: Kuki 'Āirani cultural competency self-assessment tool. Kaveinga Āpi'i translates, from the Cook Islands Māori language, to 'teaching guide'. Kaveinga Āpi'i was adapted from the Ministry of Education's (2018) cultural competency framework, Tapasā. The recommended use of Kaveinga Āpi'i is for educators to measure their culturally responsive pedagogy. As an educator, it is important to have a strong appreciation of cultural competency to provide a safe and inclusive learning environment. Kaveinga Āpi'i can help educators identify areas where they may need to improve their understanding and how to best meet the needs of Cook Islands Māori students. By regularly evaluating one's own cultural competency, work can be done towards becoming a more effective and inclusive teacher for all students. Prior to using Kaveinga Āpi'i, it is critical that educators complete and review the training offered through the Tapasā workshops. Further to this, it will be important to ensure content delivery also includes the important conversation of anti-racism and equity in relation to the broader need for a Cook Islands Māori and Pacific nursing workforce,
- ensuring smaller cohort sizes for a family-oriented feel. Finally, in relation to pedagogical approaches, it is highly recommended that programmes dedicated to both Cook Islands and Pacific learners fiercely maintain their position on cohort sizes. Smaller cohort sizes support a family-oriented learning environment in which both students and lecturers can engage, build and maintain quality relationships.

CONCLUSION

This study validates and highlights the need for ethnic-specific nursing programmes that provide culturally safe and supportive environments and aid in successful academic achievement. Culturally responsive pedagogical approaches delivered by culturally relevant lecturers have been shown to engage learners and instil opportunities for personal growth and development. By supporting Pacific student nurses, we can increase diversity in the nursing workforce and improve healthcare outcomes for Pacific communities.

A number of recommendations have yielded from the theme Tiaki Moemoeā. Ideally any person in a teaching role, particularly when teaching Pacific learners, needs to ensure they are being Pacific culturally competent. Although increasing the supply of Pacific lecturers and nurses will not detract from the influence of non-Pacific lecturers, nurses and non-Pacific school-based decision makers, it is recommended that Pacific culturally competent training becomes a prerequisite for all staff who work with and engage with Pacific students.

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APPENDIX 1: Questions used to guide the semi-structured hui in the 'akaruru stage

Pure/introductions

Begin:

- Tell me about who you are (background, ancestral ties, when did you graduate as a RN, what has been your journey since graduating)?
- Tell me why you chose the BNP programme over the other degree programmes offered?
- Did your experience live up to your expectations of the programme?

Key questions highlighted from objectives

Culturally responsive methods of teaching and learning (about the programme):

1a. Was there anything that stood out to you that impacted your learning journey?
1b. Can you elaborate on the elements you have mentioned and at what level of importance were they for you?

Connection to Pacific World views:

2a. How do the concepts of Pacific World views and Pacific ways of knowing connect with you?
2b. While in the programme, did you feel Kuki 'Āirani world views and ways of being were acknowledged and valued within the broader concept of Pacific, if so, how?
2c. Were there experiences you encountered during your student journey, whereby you felt supported or challenged to express your cultural identity?

Engagement (what supported them):

3a. Was there anything, during your training that assisted you in the growth and development of your own personal identity?
3b. Any recommendations for supporting Kuki 'Āirani nurses in a BNP programme?