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Original Research | He Rangahau Motuhake

The Unique Role of Mental Health Nurse Practitioners to Improve Healthcare Access: A Qualitative Study

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Nursing Praxis in Aotearoa New Zealand

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The prevalence of mental health and substance use disorders is growing in Aotearoa New Zealand, with rising unmet need and health services under immense pressure. Nurse practitioners (NPs) have the potential to transform healthcare delivery and improve healthcare access and health equity. However, little is known about how they work and deliver services. This qualitative descriptive study explored how mental health nurse practitioners from diverse healthcare settings across Aotearoa New Zealand delivered care to improve access to mental health and substance use services and promote health equity for individuals, families, and communities. Ten mental health nurse practitioners from across Aotearoa New Zealand and from diverse secondary, primary and community settings participated in individual interviews, face to face or by zoom. The interviews were transcribed and thematically analysed. Three key themes were identified: 1) Being there: The unique role of nurse practitioners; 2) Bridging nursing and biomedicine: A foot in both camps; and 3) Working collaboratively across teams, places and spaces. Each nurse practitioner had developed their own unique model of service delivery, working creatively and flexibly to deliver services which were culturally appropriate, trauma-responsive and holistic to individuals and whānau (families) underserved by mainstream services. They created strong collaborative relationships with a range of service providers and moved seamlessly between health sectors. Investing in the mental health nurse practitioner workforce and facilitating them to create innovative and alternative models of care will help to address health need and transform service delivery.

Te reo Māori translation

Te tūranga ahurei o te mātanga tapuhi hauora hinengaro i te whakapikinga o ngā ratonga, hei whakapiki i te tomopai: He rangahau ine kounga i mahia i Aotearoa New Zealand

Ngā Ariā Matua

E tupu ana te putanga mai o ngā hē hauora hinengaro, whakamahi taruhea hoki i Aotearoa, ā, kei te piki ngā hiahia kāore i tutuki, kei te tāmia hoki ngā ratonga hauora e ngā pēhanga o te wā. Mā ngā mātanga tapuhi (NPs) e whakumu pea te āhua o te horanga taurimatanga hauora, e whakapiki hoki te taurimatanga, me te tautika hauora. Ahakoa tērā, he iti noa iho ngā mea e mōhiotia ana mō te āhua o tā rātou mahi me tā rātou hora ratonga. Nā tēnei rangahau ine kounga whakaahua i tūhura i pēhea te hora taurimatanga a ētahi mātanga tapuhi hauora hinengaro mai i ngā horopaki taurima hauora huhua puta noa i Aotearoa hei whakapiki i te tomopai ki te hauora hinengaro, ki ngā ratonga whakamahi taruhea me te whakapiki i te tautika hauora mā ngā tāngata takitahi, mā ngā whānau me ngā hapori. Tekau ngā mātanga tapuhi hauora hinengaro mai i ngā tōpito o

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Aotearoa me ngā horopaki tuarua, tuatahi, hapori huhua hoki, i whai wāhi ki ngā uiuinga takitahi, ā-kanohi, ā-ipurangi rānei. I tuhia katoatia ngā uiuinga, ā, i tātaritia i runga i ngā tāhuhu i puta. E toru ngā tāhuhu matua i tautohutia 1) Te noho tata: Te tūranga ahurei o te mātanga tapuhi hauora hinengaro; 2) Te whakapipiri i te ao tapuhi ki te ao tākutatanga auraki: He waewae i tētahi ao, he waewae anō i tētahi; me te 3) Te pāhekoheko whakawhiti noa i ngā tira, i ngā wāhi me ngā taiwhanga. Kua oti tāna ake tauira hora ratonga te whakawhanake e ia mātanga tapuhi hauora hinengaro, kua mahi tahi i runga i te auaha me te pīngawingawi ki te hora ratonga hāngai ā-ahurea, urupare ki te kōhuki, arowhānui hoki ki ngā tāngata takitahi me ngā whānau, kāore i tukua ki a rātou e ngā ratonga hauora auraki. I hangaia e rātou ētahi hononga pāhekoheko pakari ki te huhua o ngā kaihora ratonga, ā, he rōnaki noa tā rātou whakawhiti i waenga i ngā rāngai hauora. Mā te haumi ki te ohu kaimahi mātanga tapuhi hauora hinengaro me te āwhina i a rātou ki te hanga tauira auaha, tauira rerekē hoki, e āwhina te whakatutukitanga hiahia hauora, me te whakaumu horanga ratonga.

INTRODUCTION

There is a global imperative to increase investment and prioritise mental health to not only reduce the economic burden on nations and families but to promote sustainable development and realise human rights, equity, and social inclusion (World Health Organization [WHO], 2025). The WHO have argued that "Changing where, how, and by whom mental healthcare is delivered" (WHO, 2022, p. 252) is one of three transformative paths to better mental health. The nurse practitioner (NP) workforce provides an opportunity to positively transform healthcare delivery and improve health outcomes, particularly for diverse, underserved, Indigenous, and marginalised populations (Carryer & Adams, 2017; Rosa et al., 2020; Stellflug & Auerbach, 2025; Weissinger et al., 2024). This paper explores how mental health NPs (MHNPs) delivered care to improve healthcare access and health equity for people living with mental health and substance use (MHSU) issues.

Prevalence rates of psychological distress, diagnosed mental health disorders, and substance misuse have nearly doubled since 1990 and have profoundly impacted individuals, families, communities, and nations (Santomauro et al., 2026; World Health Organization [WHO], 2025). The COVID-19 pandemic, economic and political tensions, climate change, and natural disasters have all contributed to a crisis in MHSU resources, systems and services (Kambeitz & Meyer-Lindenberg, 2025; WHO, 2022). In Aotearoa New Zealand (NZ), escalating cost of living, increased poverty and food insecurity, school abstinence, higher rates of unemployment, and reduced access to healthcare and community services have negatively impacted mental wellbeing (Ministry of Health, 2024; Te Hiringa Mahara [Mental Health & Wellbeing Commission], 2025a, 2026).

Māori (the Indigenous peoples of Aotearoa New Zealand), Pacific peoples, youth and people with disabilities are experiencing much higher unmet mental health and addiction need since 2018, with the system described as being "under immense pressure" (Te Hiringa Mahara, 2025b, p. 6). Mental health and wellbeing are further compounded for those with intersectional minoritised identities (race, gender, disability, poverty, education) (Fleming et al., 2024). As with the majority of health indicators, Māori experience a greater burden from MHSU issues, accentuated through socio-economic disparities, reduced healthcare access, institutionally racist processes, and a lack of culturally appropriate services (Palmer et al., 2019; Pohatu & Kake, 2024). Māori are more likely to be admitted and re-admitted to hospital, be in seclusion, compulsorily treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act), admitted into forensic services, and incarcerated (Drown et al., 2018; New Zealand Government, 2018; Pohatu & Kake, 2024). The resourcing, structure, and funding of the MHSU health system in Aotearoa New Zealand has been described as being not fit for purpose (Every-Palmer et al., 2024; New Zealand Government, 2018; Te Hiringa Mihara, 2025b).

In Aotearoa New Zealand, mental health conditions that cause serious functional impairment (severe mental illness) was estimated by psychiatrists to have risen by nearly 40% over the last decade, affecting approximately 5% of the population (Every-Palmer et al., 2024). At the same time, health workforce shortages and vacancy rates have intensified, including shortages of psychiatrists (New Zealand Government, 2018; Te Hiringa Mahara, 2025b). However, there is an over-reliance on prescribing medications rather than seeking alternative approaches to MHSU care and focusing on mental health and wellness (Malhotra, 2025; New Zealand Government, 2018; WHO, 2022). Developing new approaches to care, drawing on non-pharmacological interventions and treatment modalities, and building culturally appropriate community-based services that are well integrated across health and other services and sectors, is essential (Every-Palmer et al., 2024; New Zealand Government, 2018; WHO, 2022).

Nurse practitioners provide holistic healthcare services embedded in a social justice paradigm alongside their advanced biomedical clinical skills (Adams et al., 2024; Browne & Tarlier, 2008; Rudner, 2021). They are well positioned to contribute to a more accessible and responsive MHSU system, particularly for Māori, and other underserved communities. In Aotearoa New Zealand, the NP scope of practice (regulated by the Nursing Council of New Zealand [NCNZ]) describes NPs as independent and autonomous practitioners who are fully authorised prescribers, able to assess, diagnose, and refer to specialist services, and unlike some international jurisdictions, do not require physician oversight (Adams & Carryer, 2023; NCNZ, n.d.). All NPs are expected to be able to assess

physical and mental health. Mental health NPs (MHNPs; known as psychiatric-MHNPs in some jurisdictions) specifically provide treatment and care to those with moderate and severe MHSU issues across a diverse range of hospital, primary healthcare, community, and residential care settings. However, MHNPs represent only 6% of the 1000 strong NP workforce (NCNZ, 2024, 2026) and little is known about how they deliver services.

Evidence from a scoping review of 24 studies from the United States showed MHNPs worked in various settings, with diverse population groups, delivering both pharmacological and other therapeutic interventions to patients living with MHSU issues (Weissinger et al., 2024). Care delivered by the MHNPs was found to be effective and patients were highly satisfied with the care received (Weissinger et al., 2024). Turi et al. (2023) synthesised evidence from 17 international studies on the effectiveness of NP care for patients with MHSU conditions in primary healthcare settings. NPs delivered evidence-based care, achieving health outcomes similar to physicians, and found collaborative care was associated with reduced symptoms (Turi et al., 2023). While both Turi et al. and Weissinger et al. identified the need for more high-quality evidence, there is a growing body of evidence showing how MHNPs form strong therapeutic relationships, provide timely person-centred care, deliver non-pharmacological interventions, work collaboratively, and ensure a holistic approach to care (Phoenix et al., 2016; Scheydt & Hegedüs, 2021; van Dusseldorp et al., 2023; Wand et al., 2015).

AIMS

The aim of the study was to describe how MHNPs working in diverse healthcare settings across Aotearoa New Zealand delivered care to improve access to MHSU services and promote health equity for individuals, families, and communities. The intent of is this knowledge is to inform health policy, funders, health organisations, NP educationalists and NPs.

DESIGN AND METHODS

This study used a descriptive qualitative design (Doyle et al., 2020) to describe the experiences and perceptions of the care delivered by interviewing 10 MHNPs in Aotearoa New Zealand. Qualitative descriptive design enables exploration of phenomena without the need to advance theoretical or conceptual understanding (Doyle et al., 2020). This design allows for differing views and experiences to be expressed by participants, acknowledging the uniqueness of human experience, and ultimately has the intent of contributing to knowledge to improve practice and health outcomes (Chafe, 2017; Doyle et al., 2020). Our study sought to gather data from participants working in a range of different contexts from across Aotearoa New Zealand, with the hope of identifying ways and contexts in which NPs work to deliver MHSU services.

Reflexivity

Given the contextual nature of qualitative research, researchers need to engage in reflexivity to ensure the trustworthiness and credibility of the research (Olmos-Vega et al., 2022). Reflexivity is defined as a "set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise and evaluate how their subjectivity and context influence the research process" (Olmos-Vega et al., 2022, p. 242). It is a process of interrogating researchers' assumptions and practice (Braun & Clarke, 2022). Throughout the research process the lead researcher (TM), kept a reflexive diary using the categories of personal, interpersonal, methodological and contextual reflexivity (Walsh, 2024). Importantly, as a group, we kept asking ourselves - "What are we learning? What is new? What is surprising?" – to challenge any existing preconceptions held. Central to reflexivity is transparency and for this reason we include a positionality statement.

Positionality

The authors are all registered nurses, three of the four authors have white European ethnicity and one author identifies as Māori, all living in Aotearoa New Zealand. TM and SA migrated to Aotearoa New Zealand over 20 years ago. The lead researcher (TM) undertook this study to complete their Master of Nursing. TM has worked in mental health services for 33 years, having been a frontline mental health nurse for most of those years. Over the past eight years, TM has held various nursing leadership and management positions within secondary mental health services in Auckland and describes witnessing unprecedented increase in the demand for MHSU services, a workforce struggling to meet demand, and MHSU service users often receiving inadequate and fragmented care. HB is a mental health nurse and academic with a particular interest in advancing the nursing profession to meet the healthcare needs of service users. EK is a Māori nurse and doctoral student with experience in primary healthcare and contributes to research that focuses on Māori nurses, specifically NP workforce and Māori health outcomes. SA is an academic focusing on research which explores the contribution of NPs, particularly in the space of advancing workforce and health equity. We have taken the position (grounded in evidence) that NPs are a high-quality advanced workforce with the capability to deliver services to meet the healthcare needs for local communities.

Participant Sample

A purposive sampling strategy (Tajik et al., 2024) was used to recruit 10 MHNPs from across Aotearoa New Zealand to participate in the study. Invitations were sent out through Nurse Practitioners New Zealand, Te Ao Māramatanga New Zealand College of Mental Health Nurses, and through contacts of the research team. At the time of the study 44 NPs were registered with the NCNZ as MHNPs (NCNZ, 2024). The intent was to recruit MHNPs from a diverse range of clinical practice settings, including pri-

mary healthcare, residential care, secondary and tertiary services, and non-governmental organisations from across the country. We ensured invitations reached Māori NPs, and Pacific NPs who are underrepresented in the nursing workforce (NCNZ, 2024). Those NPs interested in participating were sent a participant information sheet. Ten MHNPs participated in the study.

Ethics

Ethics approval was granted by the Auckland Human Research Ethics Committee (Ref. 22476, October 2022). The central ethical concern was in relation to the participants being identifiable given the small number of MHNPs working with diverse groups in Aotearoa New Zealand. This was made clear to all participants. The risks were mitigated by providing broad descriptors of the participants' demographics and excluding specific information relating to ethnicity, employer or geographic area (Table 2) and ensuring the research was strengths-based and seeking solutions.

Data collection

Data was collected between November 2022 and February 2023. Participants were interviewed using a semi-structured interview schedule. The key areas of exploration were: how MHNPs delivered care within their practice setting; how they integrated their work with other services and providers; and how they worked with Māori, Pacific peoples, and other underserved communities to improve access and equity. Interviews took between 30 and 60 minutes and were audio-recorded with consent. TM undertook all except one interview by a participant known to TM, who was interviewed by SA. All bar one interview was conducted via zoom. Interviews were transcribed verbatim by a professional transcriber.

Data analysis

The research question was suitable for reflexive thematic analysis (RTA) as it sought to explore the contribution of MHNPs to improving access, equity and health outcomes, and their sense-making of their context and practice (Braun & Clarke, 2022). Braun and Clark describe RTA as a method where the researcher's role and subjectivity in knowledge production is reliant on their ability to deeply reflect on and engage organically with the data. In this sense, Byrne (2022) argues that it may not be possible to conduct an exclusively inductive or deductive analysis. Reflexivity is central to good quality analysis, recognising existing knowledge and experiences (Braun & Clarke, 2022). Coding requires the dual processes of immersion in the data and space for reflection to allow for insights, inspiration and interpretation (Braun & Clarke, 2022). Themes are then actively created by the researcher through their systematic engagement with the data, intersecting data with the analytic process and their subjectivities (Braun et al., 2019; Braun & Clarke, 2022).

A social justice lens (Adams et al., 2024; Rudner, 2021) was applied to our analysis as we were specifically seeking knowledge about improving healthcare access and health equity. The analysis followed the six key steps described by Braun et al. (2019) - familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and writing the report. Initial coding was undertaken by TM, with SA reviewing transcripts and the coding. As a research group, we reviewed and revised the initial themes to identify patterns of shared meaning (Braun et al., 2019).

FINDINGS

Ten NP participants were interviewed from across Aotearoa (New Zealand). Seven were from the North Island and three from the South Island. There were seven females and three males. The sample included MHNPs who identified as Māori, Pacific peoples, Asian, with the majority being white European ethnicity. Table 1 provides a brief description of each participant's practice setting and the MHSU patient groups with whom they work.

Three main themes and subthemes are shown in Table 2.

Being there: The unique role of nurse practitioners

Through every interview with the MHNPs in this study, the uniqueness of their role was apparent. The participants used their full scope of NP practice to deliver services in ways different from medically-centric models of healthcare delivery. Laura summed this up:

> I think what is different is that we've come from a nursing discipline which keeps us aligned to the patient. So, there's not the power disparity... We have that skillset to really be able to work alongside the patient but with that expertise to be able to autonomously and independently assess and start treatment. [Laura]

Two subthemes were identified within this theme.

Filling the gaps: Establishing innovative models of care

With relatively few MHNPs in Aotearoa New Zealand, the participants had all forged new roles to meet gaps in health service provision. Each participant had created a model of care to meet the needs of those patients and families within their particular service. Often, their motivation to become a NP had arisen from identifying an unmet need through their earlier work as a registered nurse:

> Before I started working as a nurse practitioner, I used to do a school-based clinic where I travelled around the schools seeing young people that do not meet the criteria to be referred [for secondary services]. They are not presenting in crisis but are presenting to the school counsellor needing mental health support.

Kenzie described how youth often have difficulties accessing their primary care provider. Becoming a NP with prescribing authority enabled Kenzie's to provide the holistic support required.

Table 1. Participant pseudonym, practice setting and patient group

Pseudonym	Practice setting	Patient group
Alex	Primary healthcare	High and complex needs. High Māori population. High deprivation and poverty levels. Police liaison including for those under the Mental Health (Compulsory Assessment and Treatment) Act 1992, home visiting, and includes primary care services. Adults aged 18 to 65.
Blake	Health New Zealand - secondary mental health hospital-based services	Emergency department triage, particularly for those not meeting criteria as severe mental health crisis. Referral and liaison with community services and health providers. Adults aged 18 to 65
Casey	Primary healthcare	Mild to moderate and moderate to severe; and primary care services. High Māori population, and those marginalised and underserved, including ex-prisoners, sex workers, gender diverse. High deprivation and poverty levels. All ages across the lifespan.
Chris	Health New Zealand - secondary mental health community-based services	High and complex needs. Patients in residential care or supported living in the community, many under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Protection of Personal and Property Rights Act 1988. Adults aged 18 to 64 years
Dale	Primary healthcare	Mild to moderate and moderate to severe needs. Specialist MHSU service to support primary care providers. Adults aged 18 to 65
Jessie	Health New Zealand - secondary mental health community-based services	High and complex needs. Acute mental health and outreach. Liaison with primary healthcare. Mild to moderate needs. Adults aged 18 to 65
Kenzie	Health New Zealand - secondary child and youth mental health services.	High and complex needs and mild to moderate needs. High Pacific population. High deprivation and poverty levels. Community-based and school services. Youth aged 10-24.
Laura	Health New Zealand - secondary drug and alcohol services.	High and complex needs. Community and hospital setting, including outreach. Adults aged 18 to 65
Ricky	Health New Zealand - secondary drug and alcohol services.	High and complex needs. Outreach services and community clinics. Liaison with primary care. Adults aged 18 to 65
Teagan	Primary healthcare	High and complex needs and mild to moderate needs. High Māori patient group. High deprivation and poverty levels. All ages across the lifespan.

Health New Zealand is the employer of those MHNPs working in the national health sector; Primary healthcare refers to all those employed outside of Health New Zealand, with, for example, Trusts, Māori or Pacific Health providers, or general practices.

Table 2. Main themes and sub-themes

Main Theme	Sub-themes
Being there: The unique role of nurse practitioners	*Filling the gaps: Establishing innovative models of care;* *Flexibility to improve healthcare access*
Holistic care: Bridging nursing and biomedicine	*A foot in both camps* *Holistic physical and mental health care*
Working collaboratively across teams, places and spaces	

Jessie, who worked with secondary mental health services in the community, identified a gap in services that existed for adults who initially presented in a crisis, and once settled, still required follow-up to prevent relapse:

> It's that group of people who come up [to the acute service] in crisis. The crisis kind of settles and then they go back out [to the community] into the same arrangement they had before the crisis came up, but without learning any new tools before the next crisis. So that was a specific gap identified at the time which was filled by a nurse practitioner. [Jessie]

Chris, employed through Health New Zealand in the mental health team, developed a business case to "work alongside" non-governmental organisations (NGOs) to provide NP-led psychiatric services for both residential and supported accommodation providers who had patients with severe chronic and complex mental health and addiction issues. Many of these patients were under the Mental Health (Compulsory Assessment and Treatment) Act (1992) and the Protection of Personal and Property Rights Act (1988):

> I'm available all day every day. For two of the [residential] services, I go in everyday to see them and others

> [NGOs] at least weekly. If they need me, I will get myself out there to see anyone who needs to be seen and deal with any crisis, which means that admission rates [to acute mental health services] are really low. [Chris]

Chris described how having a "person with my skillset" was highly valued by the largely unregulated healthcare workers.

Alex created a role employed by an NGO (non-governmental organisation) working with offenders and whānau (families/family groups) in the community and at the police station in the custody hub (where people who are arrested or on remand are housed overnight):

> I work alongside the [Family Harm Unit] and go out and do home visits to high risk whānau [and] to meet with offenders… I mostly do mental health and addiction assessments, but I also have changed the conditions of my scope [of practice] and I can now do physical health as well which has been quite beneficial for that population. [Alex]

Casey changed the conditions on their NP scope of practice to enable them to provide both mental health and physical healthcare in general practice. Casey provided primary care services to individuals and whānau with moderate to severe MHSU issues and who are further marginalised in society, for example, gender diverse, homeless, ex-prisoners, sex workers, as well as ethnically prioritised populations (Māori and Pacific peoples). Casey estimated that "about 40% of patients have pervasive trauma histories from childhood." The practice was filling a significant gap in providing healthcare access for those "underserved" (Casey) by mainstream primary care.

Teagan described the breadth of their role in primary healthcare, working across the age span:

> I do a lot of work with children… ADHD, autism, [and] parents needing more support. And then lots of teenagers who are struggling with their identity, and depressed, and have hard home lives; and adults. My daily work is with whānau who've had massive amounts of trauma… people who have drug and alcohol addictions and depression, and stress. And they are often very poor, they often have very little education, they've been through the criminal system, or just come out of prison, and a big cohort who are homeless.

Teagan also saw people over 65 years for cognitive screening and mood assessment.

Flexibility to improve healthcare access

Having "complete and utter flexibility and autonomy of timetable [is] a huge advantage" (Chris). The participants described how flexibility and autonomy enabled them to build relationships with, for example, general practices, NGOs, schools, and other community service providers. Given that the communities served by the participants were "underserved by health generally" (Alex), connecting them up with appropriate services was key to improving their health literacy and wellbeing. Having the ability to work across service teams and boundaries and "go wherever to see the patient" (Laura) was critical:

> One of the advantages is that I can work across tertiary, secondary, or even primary sectors. I'm all about improving access and reducing barriers, so I'm happy to go out to NGOs and see people. I'm happy to go to people's homes and see them. Up in the hospital or at our clinic, or at our rural clinics, or virtually via Telehealth. [Laura]

This was quite different from the doctors who, Laura said, would "stick to their clinics".

Holistic care: Bridging nursing and biomedicine

Evident from the descriptions provided by the participants was the opportunity afforded to them through their scope of NP practice to bridge nursing and medicine in ways which they believed improved health and wellbeing for their patients and communities. Two subthemes were identified within this theme.

A foot in both camps

Alex described that by having a "foot in both camps," meant NPs were "uniquely placed" to do those "higher-level assessments and treatment" and at the same time work in an outreach capacity, "thinking creatively and putting together packages [of care] around people." This, Alex stated, was due to NPs being "more approachable, by and large" and "less intimidating" than doctors. With their broad scope of practice, the NPs described how they were able to bridge biomedicine and nursing, ultimately improving access to healthcare:

> It [NP role] offers a lot of flexibility in terms of sitting in that area between nursing and medical, and in what was traditionally considered to be the medical profession. So, it forms a bridge between the two professions if you like. And it brings them closer together. I think that as a nurse practitioner we do the things that doctors can do. So, we can make a prescription, but we're also going to ask the question, can you afford to fill the prescription? How are you going to get there? … So, we've always got our nurse's hat on whenever we're seeing people. You know, you can't take the nurse out of a nurse practitioner. [Jessie]

Participants often described their work in comparison to their medical colleagues. Teagan described how NPs focus on the patient and their needs and wants, whereas doctors are often constrained by "their medical input, regardless of what the patient wants." Teagan described how whānau were "often quite confused about the words the medical profession use, or the statements, or the criticism they feel from the medical world." Teagan "work[ed] to improve health literacy" and to ensure whānau did not feel "embarrassed" to ask about something. Kenzie reflected:

> Every time I see patients, I ask myself what makes me different from a psychiatrist? I have to say it's that holistic approach that I bring. That biopsychosocial ap-

> proach. We bring our nursing knowledge at the same time. The therapeutic alliance and relationship that we can develop and maintain and sustain with our patients is what makes us different. [Kenzie]

Being patient centred and working within a "partnership model, seeing people as individuals [and] being solution-focused" (Chris) was a common thread throughout all the interviews:

> So, look, it's massive and I think people, including our medical colleagues, are seeing our worth because they know they get this package with a nurse practitioner that they don't even get with their senior colleagues. I mean I have huge respect for the expertise of many of my medical colleagues, but we have very different skillsets. [Laura]

Holistic physical and mental health care

People living with MHSU issues have poorer physical health outcomes and reduced access to physical healthcare (Chan et al., 2023) adding further complexity to holistic healthcare for this group of patients. Within this broader theme of bridging nursing and medicine, the participants spoke of their role in optimising physical health for people living with MHSU issues:

> We've known over the years that physical health has often been the part left out, especially in the addictions area. And there are not a lot of models that take that into context for mental health and addiction. So, for me it was an area that has lent itself well to the nurse practitioner role. [Ricky]

Laura outlined the role of not only prescribing for physical conditions but deprescribing (discontinuing medications):

> When we're looking at the physical side of health, we're also looking at the place of medications and considering what must happen … in response to therapeutic care. And a lot of de-prescribing happens in that space. [Laura]

All the patients under Chris's care had high and complex needs, many with comorbid mental and physical health issues. Chris spoke of providing both "on the hoof and formal education" to proactively support the NGO staff and patients to identify issues early and maintain both physical and mental health:

> The population I work with don't prioritise their health. If they don't have insight into their mental health, they probably don't have insight into their physical health. So that's a key thing. Liaising closely with the general practitioners, getting them to specialist appointments, following up and making sure they have the metabolic monitoring they need, following up their blood results. [Chris]

Chris spoke further about ensuring patients attended screening, such as for prostate and breast cancers, and raised the importance of NPs advocating for these patients who often had little family support. By working within both medical and nursing paradigms, NPs were able to bring a holistic approach to their work, connecting with other services and improving health outcomes.

Working collaboratively across teams, places and spaces

Meeting the needs of patients with moderate to severe MHSU issues, including for those who too often did not meet criteria for specialist or tertiary MHSU services, was a gap filled by the NPs by working creatively and collaboratively. Because of challenges accessing primary care services, many patients with MHSU issues would instead attend local emergency departments (EDs). Laura spoke about a consult liaison service they developed to address a gap that existed for people presenting to ED services with drug and alcohol issues. Through this initiative, Laura was able to "build up those relationships across teams":

> I was instrumental in developing relationships with other services. So, for example I established an alcohol and drug consult liaison to the main hospital. And through that I was able to develop a relationship with ED. I would attend the emergency department meetings [of regular attendees]. We had mental health, GP liaison, ambulance, and the ED team all around the table, whoever needed to be there. It was a weekly meeting [to discuss] concerned patients who were regularly presenting to ED. This was the revolving door stuff, but we were able to determine who was going to take the lead on developing the treatment plan for the patient. [Laura]

In another region, Blake spoke of how patients would often attend the ED and be turned away as they were deemed ineligible for tertiary services. By working within the ED and triaging those with MHSU issues, Blake was able to develop a plan of care, including prescribing treatments and liaising with local community and health service providers, ensuring appropriate follow-up.

Ricky, who worked out of hospital secondary services, providing outreach and liaison with primary care, described a common scenario with people presenting to ED with drug and alcohol issues. Patients were often commenced on a withdrawal regime by ED staff and then discharged within 24-48 hours. Discharging patients at this time in their withdrawal journey was not considered safe and even potentially life-threatening when they were physically and mentally vulnerable and without adequate support and follow-up. As a result, Ricky, with their in-depth knowledge of the nature of withdrawal and treatment, initiated an integrated model of care with ED and the wards to address the problem:

> With the NP role, I've been working in developing those relationships with the medical teams within that environment. It's being there. Being able to go into the department - as emails just don't work in this space. It's being able to go in, talk to them [staff], do assessments with them when we can and that's what changes practice. [Ricky]

The participants acknowledged the value of connections with other NPs, both in PHC as well as in specialist MHSU services. Alex described the pushback from secondary services when referring a young man who was acutely psychotic and paranoid, yet through their connections with other NPs were able to get the patient access to care:

> So, I spoke to my nurse practitioner colleague who works on that [secondary services] team. And that was a godsend. She said yeah, we can accept the referral and from that point we were able to work collaboratively with this very unwell young man… So, I'll often be a bit creative and contact some of my nurse practitioner colleagues and get help, "What do I need to do with this? This is what I think it is, this is what I've done so far, what do you think?" [Alex]

Working within a Kaupapa Māori framework (a Māori-centred approach delivered for Māori by Māori) supported Teagan to conduct holistic assessments using Te Whare Tapa Whā, a Māori model of health and wellbeing (Durie, 1985) to then connect whānau with other community resources and services:

> I work within a Kaupapa Māori model, so I've kind of combined a bog-standard psychiatric assessment with Te Whare Tapa Whā. I move through each of the four walls, Taha Wairua [spiritual], Taha Whānau [family and social], Taha Tinana [physical], and Taha Hinengaro [mental and emotional]. And that's how I roll out my assessment and my work is holistic. Like often whānau will get referred in for their mental health, but they don't have a whare [house], or they don't have somewhere to sleep. And no-one can be well if they can't sleep, so we must get them a house, or accommodation, and then move onto the assessment. So, it's a holistic model, which I like. [Teagan]

Alex spoke of the value (and ease) of working with community providers and their willingness to be creative and flexible in their work:

> To be completely honest the community providers are easier to work with and are more willing and flexible in their approach. They are willing to try and do things slightly differently and are not rigid.… So, they might ring me and say, "I need a hand with this detox, can you help?" And so, I'll see the person and we'll work out a cunning plan. And then I'll often do the prescribing and then oversee what happens while they're followed up by that service. So, we try and do quite a nice wrap-around, collaborative kind of approach. It doesn't always work but for the most part it's pretty good. [Alex]

Kenzie, whose work included youth, showed how she navigated complex health and social systems and connected with other key organisations to support the patient:

> And I have to say every single patient that I've seen, I either contact the school, whoever is providing care for the young person at the school, a general practice or someone from a non-government organisation as well. Especially those that are providing youth mentors, social support. So, it's very important that we connect with those services… It's one of the most vital and important parts of my role. [Kenzie]

What was evident from all participants was their ability and willingness to work collaboratively with a range of health, social, and education services showing their deep understanding of the importance of connectiveness and partnership with patients and all services involved in their wellbeing.

DISCUSSION

This qualitative study has reported on how MHNPs in Aotearoa New Zealand delivered healthcare across a diverse range of practice settings and contexts to improve healthcare access for people living with MHSU disorders. Ten experienced MHNPs participated in interviews revealing how they worked flexibly and creatively to fill gaps in health service provision to improve healthcare access and health equity for their communities. Each had developed their own model of service delivery, reflecting the health needs of the communities they served. They drew on their own strengths, used available resources effectively, and made connections locally with other healthcare, social, and community services to deliver holistic care. The MHNPs in our study clearly demonstrated the transformative potential of the NP role to offer meaningful and effective solutions to MHSU delivery.

All the NP participants exemplified the value of being autonomous practitioners, choosing where and how they engaged with their patients and whānau. All too often, NPs find themselves constrained by institutional processes and policies together with biomedical models which limit their potential (Adams & Carryer, 2023; Harris & McKinlay, 2025). However, the MHNPs in this study showed how they used their agency to enact their full scope of practice as autonomous practitioners and by doing so delivered holistic models of care which moved MHSU services beyond mainstream psychiatry-led care. Core principles of the MHNPs' models of care included embedding cultural care, relational and trauma-responsive practice, equity-focused principles, and promoting and maintaining holistic health and wellbeing for people in their communities. Such approaches are affirmed in national recommendations for MHSU services (Ministry of Health, 2026; Synergia, 2025; Te Hiringa Mahara, 2025a), demonstrating how MHNPs were leading the way in service transformation.

The MHNP, Alex, described having a "foot in both camps," operating as nursing-biomedical hybrids that blend the relational, holistic and cultural foundations of nursing with biomedical diagnostic and treatment skills (Adams et al., 2024; Browne & Tarlier, 2008; Chulach & Gagnon, 2016; Komene et al., 2025). They described how they averted crises, reduced hospitalisations and readmissions, promoted health literacy, and supported people to live well in their communities, aligning with evidence on MHNPs from elsewhere (Turi et al., 2023; Weissinger et al., 2024). Through their work they navigated complex health systems and engaged widely across health, social, school education, justice, and housing sectors. The MHNPs ex-

pressed their hybridity as liberating, being able to fulfil their commitment to the nursing paradigm and social justice. Their experiences are synonymous with hooks' (1984/2015) discourse regarding the margin as a space of resistance and possibility. In the margin, the MHNPs developed novel roles working beyond mainstream health boundaries to provide necessary and often highly complex healthcare to reach severely underserved, marginalised, and impoverished individuals and communities.

Fundamental to the MHNPs' practice was ensuring care provided was relational, partnership-based and culturally safe. Health practices that prioritise cultural models of care are known to be effective in improving health outcomes for whānau Māori, by delivering care aligned with Māori values within a relational context (Komene et al., 2025; Wilson et al., 2021). Māori, and Pacific, NPs are underrepresented in the workforce (NCNZ, 2024), despite Māori, and Pacific peoples, experiencing higher levels of psychological distress and greater unmet need (Te Hiringa Mahara, 2026). Growing the Māori, and Pacific, NP workforce and embedding models of healthcare which integrate diverse worldviews and practices is critical if Aotearoa New Zealand is to advance health equity.

Evident from the MHNPs descriptions of their practice was firstly, their ability to manage highly complex and serious MHSU presentations and episodes of care, such as acute psychosis, identity crises and depression, community detoxification and managing severe withdrawal symptoms; and secondly, how they attended to the physical health needs of their patients. MHNPs are educated to address and promote both physical and mental health and in our study they spoke of how they managed co-morbidities, including long-term conditions and metabolic disorders, and facilitated health screening. People living with severe MHSU issues have vastly higher rates of morbidity and mortality, with early deaths mostly caused by physical disorders (Chan et al., 2023), highlighting the necessity of integrating physical and MHSU services (New Zealand Government, 2018). Several of the MHNPs had developed roles in primary healthcare promoting collaborative and holistic integrated care, often managing patients who, despite high levels of psychological distress, did not meet referral criteria for specialist care. Literature describes the breadth of NP practice and a role which extends well beyond clinical management and includes leadership for care coordination and shared team decision-making, service integration and development, and advocacy and policy (Harris & McKinlay, 2025; Rosa et al., 2020; Scheydt & Hegedüs, 2021).

Yet despite the extraordinary contribution from MHNPs shown in this study and elsewhere (Turi et al., 2023; Weissinger et al., 2024), the growth of MHNPs in Aotearoa New Zealand has been slow despite the growing prevalence of MHSU issues, a workforce shortage of psychiatrists, and the critical need for alternative models of care (Te Hiringa Mahara, 2025b). Attention needs to be paid to the successful development and integration of the role into clinical settings across all levels of the health sector and health organisations (Adams et al., 2024; Porat-Dahlerbruch et al., 2022). It is time the Aotearoa New Zealand health system proactively invested in developing the MHNP workforce across regions and health organisations, recognising MHNPs' potential for meeting the diverse health needs of MHSU users throughout local communities.

Strengths and limitations

Rich data was collected for this qualitative study through semi-structured interviews with MHNPs and included Māori, and Pacific, participants. However, transcriptions were not member-checked. As a research group we undertook peer debriefing to reflect on interpretations of the data. Limitations include that the data was collected in 2023 from a small purposive sample of 10 MHNPs in 2023 and presents a snapshot of the diverse approaches undertaken by MHNPs.

Concluding statement

This study qualitatively explored how MHNPs in Aotearoa New Zealand delivered care to improve access and promote health equity and social justice for people living with MHSU issues. The MHNPs optimised their autonomous role and enacted their agency to create unique, alternative and integrated models of care towards achieving international and national recommendations for mental health and wellbeing (Ministry of Health, 2026; WHO, 2022). They delivered holistic, culturally safe care across diverse and underserved settings, delivering MHSU care and promoting mental health and wellbeing. Organisations providing health services are encouraged to recognise and enable MHNPs to develop and integrate service delivery models which are innovative, flexible and collaborative. By doing so, the transformative potential of NP-led care can be realised to improve health outcomes of local communities.

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Conflicts of interest

None.

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