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Whitiwhitia i te ora!

Culture and Occupational Therapy: A Māori Case Study

A thesis presented in partial fulfilment of the requirements for the degree of Master of Philosophy in Māori Studies at Massey University, Palmerston North, New Zealand.

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Philosophy

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New Zealand.

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2010

KARAKIA WAEREA

Whitiwhitia i te ora!
Whitiwhitia i te ora!
Ka ea ki runga
Ka ea ki raro
He tipua he tawhito
He ioio nui, he ioio roa
He ioio atua Tane te Wananga
Houhia te uru ora
He ueue tawhito, he ueue tipua
He ueue atua
Rongomai atua
E hua to tino
E hua to aro
E hua to ariki ē
Kia tapatapa tu
Kia tapatapa rangi
Ki nga rangi nao ariki
Ki nga rangi tatara
Kia eke tiritiri o nga rangi
Tuturu o whiti whakamaua kia tina, tina
Haumi e, hui e, tāiki e!¹ (Jury in Wairarapa Moana Trust, 2007).

This karakia waerea was gifted to me by whānau to use in this research. It was used by Te Matorohanga to clear the marae ātea when the Māori Parliament met at Papawai in the mid 1800's. It was recorded by my great great Uncle Whatahoro Jury (Ngāti Muretu, Ngāti Moe) (Whatahoro) as part of mātauranga Māori he wrote down in te reo over that time. This karakia threads right through the thesis as does the influence of my whānau especially Whatahoro. The journey he took in walking in two worlds that of his Māori mother and Pākehā father has inspired me in my journey and in my use of dual - cultural clinical practice in occupational therapy.

¹ This karakia has not had macrons inserted as the original did not have them. To gain the right meaning the karakia must be listened to and left to the hearer to interpret along with whenua understandings. This also has not been translated and has meanings in the Wairarapa but these belong to te ao Māori and so remain in te reo.

ABSTRACT

This master's research reports the findings of a mixed methodology study based on qualitative and quantitative data that considers culture in occupational therapy practice from a Māori perspective.

Health perspectives of Māori and occupational therapy are explored and similarities identified. Tangata whaiora responsive practice (client-centred), holistic and wairua (spiritual) views are mutual themes. Whenua/taiao and environment also held great significance for both Māori and the profession, though occupational therapy modified the environment to enable safety, whereas Māori negotiate with the environment prior to making it safe. The major differences, in perspectives, were the recognition of whānau and the interdependent relationships so critical to whānau and whānau ora, with occupation identified as a significant perspective not supported as so significant to Māori practitioners. The implications of these differences were explored in this dissertation.

Eighteen occupational therapists self-selected to participate in a questionnaire given out at a professional conference workshop on culture, and this was forwarded to further participants who expressed an interest. Some of the respondents self-identified as Māori. Five specialists were identified to interview: three occupational therapists, two Māori health specialists, one an occupational therapy specialist who was Pākehā. A professional workshop of around 24 participants, self identifying as Pākehā, also contributed to the identification of health perspectives. The final source of information came from the researcher's participation in numerous hui of varying sorts where Māori health was forwarded. Where appropriate, and in order to provide greater substance and depth to the research, selected quotes from these sources are used. These are further designed to bring a more personal feel to the research and to illustrate how the various concepts impact on lives and ultimately influence practice.

Traditional practice and Māori understandings of occupation were also explored as were the development needs of Māori occupational therapists as minor themes to the key findings.

Providing holistic occupational therapy care to Māori in a respectful and collaborative way will provide opportunities for the profession to have a positive impact on the health of individuals, their whānau and, in turn, their communities, hapū and iwi.

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This thesis has been a journey of discovery not only for me but also for my family, and when whānau work to support a dream it is amazing what can happen.

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I would also like to thank especially the participants of this study without whom there would be no research. It was exciting having each one of you as part of my research with your varied thoughts and insights.

This research is an offering to Kaiwhakaora Ngangahau (Māori Occupational Therapists) for having a passion to provide culturally relevant practice to Māori whānau.

Jane Hopkirk

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CHAPTER ONE: WHITIWHITIA I TE ORA

Whitiwhitia i te ora!

Whitiwhitia i te ora!

Ka ea ki runga

Ka ea ki raro.

Introduction

Culture and Occupational Therapy: A Māori Case Study.

The overwhelming suggestion of this study is that culture is vital to enabling wellbeing for occupational therapy tangata whaiora², especially Māori. The vast majority of Māori who use occupational therapy services are seeing Pākehā practitioners because currently there are few Māori practitioners. Māori tangata whaiora are also even less likely to have interventions from a te ao Māori perspective. This thesis considers the relevance of culture in occupational therapy practice from a Māori case study. In doing this it explores relationships between Māori and occupational therapy perspectives identifying what participants of this research thought were common health perspectives and what were key Māori health perspectives for occupational therapy. Māori occupational therapists do hold different perspectives in comparison with their Pākehā colleagues. As indicated by the number of Māori being seen by Pākehā there is a desperate need for more Māori occupational therapists and so the workforce development needs of Māori practitioners who participated in this research were identified also.

Literature indicated that the most effective interventions for Māori appear to be where there is a cultural match between Māori practitioners and tangata whaiora and where interventions are provided for Māori from their world view. Therefore the need to evidence effective practice for Māori by occupational therapists and the profession as a whole is self evident.

Health is of significance to individuals not only because it is the basis for wellbeing; it also enables them to choose to follow occupations that have value

² Servicer user - “a person seeking health” (Te Rau Matatini, 2006, p. 7).

to them (Kawachi, 2002). Occupational therapy is a profession that assists tangata whaiora across the illness and disability sector to consider what they 'do' and want to 'do' in their life, and how to manage their illness or disability to achieve this. This is a fundamental need of all humans to 'do' in order to survive. The challenge is to ensure enablement of 'doing' is framed in a culturally appropriate way.

There are 21 Māori occupational therapists identifying (registered and unregistered) on the Occupational Therapy Board of New Zealand data base, representing 1% of the profession (Personal Communication Occupational Therapy Board of New Zealand, 2010). Further details of current practice were not available. Within the profession Māori practitioners are still developing their competence in Māori occupational therapy. Because there are few Māori practitioners there is only emerging or yet to be developed dual practice – cultural/clinical, interventions that are specific both for Māori and occupational therapy. Therefore the exploration of Māori occupational therapy dual practice, at the time of this research, was still premature.

To undertake this research the most effective way to start debate and provide evidence for practice for Māori occupational therapists was to gather research from as many fields as possible. To this end, a number of information gathering techniques were used which included:

- a questionnaire for workshop participants at a national Occupational Therapy professional conference, including contacts arising from that
- questioning hui participants considering the future development of Māori in occupational therapy
- consideration of current literature
- information from various hui
- feedback from the national occupational therapy professional workshops
- interviews with Māori occupational therapists
- interview with an occupational therapy specialist and
- interviews with Māori health specialists.

Additionally the work of Iwama (2006b), who has been challenging occupational therapists to consider the cultural constructs of the profession itself and in particular the theories that drive the profession, has enhanced discussion and supported this research. Iwama (2006) has identified world views embedded into theory:

a concern for this profession lies in the maintenance of ideas and concepts that is out of sync with our clients' real worlds of meaning. A profession that places the blinkers on alternative views and constructions of meaning in daily life stands to trivialize itself into extinction, and thus fall far short of occupational therapy's magnificent promise (Iwama, 2006b, p. xviii).

In order to consider the impact occupational therapy theory may have on Māori, this research identifies common health perspectives held by Māori and occupational therapy, seeking to analyse the significance they may have for effective practice. In the absence of local discourse, it also aims to create a platform for further dialogue, to support the work of Māori practitioners and to ultimately improve the care delivered to tangata whaiora. This first chapter introduces the reader to the topics of this research.

The thesis will seek to answer the research question Do cultural perspectives impact on occupational therapy practice: a Māori case study? Māori perspectives are explored and discussed, drawing from the Māori health and mental health sector.

Background

Internationally there is concern for the health of indigenous peoples (Ring & Brown in Durie, 2006). Six percent of the world population consists of indigenous peoples and they are experiencing early mortality from specific disease and injury compared to non-indigenous peoples. The United Nations Permanent Forum on Indigenous issues (5th session) has instigated a programme of action in 2006 (Durie, 2006). Māori are not excluded from this group, also suffering higher rates of morbidity and mortality compared to the Pākehā population (Kingi, 2005).

Within the *Draft Declaration of the Rights of Indigenous Peoples* adopted in 2007 by the United Nations, indigenous peoples have the freedom to participate fully in society without deserting their culture or identity (Durie, 2004a).

Durie (2004a) proposed that:

indigenous peoples should have access to the indigenous world with its values and resources, access to the wider society within which they live, access to a healthy environment and a degree of autonomy over their own lives and properties (Durie, 2004a, p. 6).

Certainly significant support is given to the importance of culture in health. What are the challenges seen currently to application of this to theory? Why do some struggle to provide culturally responsive practice?

The small number of Māori occupational therapists within Māori health can create an environment which is isolating, despite the fact that support and resources might be available. The integration of cultural practise in occupational therapy has developed in a somewhat ad-hoc manner, though has sought to build on intuitive experience and tikanga Māori wherever possible. However there are challenges to strengthening cultural interventions such as:

Māori health perspectives and tikanga are little used or understood by the profession or the practitioner

- There is a paucity of international evidence of effective occupational therapy interventions for indigenous peoples
- There is a lack of national literature on Māori interventions in occupational therapy, effective or otherwise
- There is a pattern of occupational therapists who identify as Māori who do not enter into the Māori health sector, struggle to practise dually and do not remain in the profession long. They leave a lack of experienced practitioners to develop practice or mentor new occupational therapists

- The profession is based on theory derived from the western/euro-centric individualistic tradition, separate from the environment i.e. secular, views often vastly different to indigenous thought
- The profession requires effective framing of occupational therapy paradigm for indigenous perspectives with the models often based on 'doing' rather than 'being' and
- Services struggle to understanding the specific role occupational therapy has to offer tangata whaiora.

Iwama (2006a) reflects concerns over challenges:

occupational therapists in New Zealand must have wondered at times how to relate the conceptual meaning and explanations of human occupation based on Euro-Western psychological and social norms, into the day to day realities and experiences of their clients – especially those of Māori heritage (Iwama, 2006a, p. 1).

Durie (2004b) identifies differing perspectives of health found within clinical settings, supporting Iwama's comments:

indigenous knowledge cannot be verified by scientific criteria nor can science be adequately assessed according to the tenets of indigenous knowledge. Each is built on distinctive philosophies, methodologies, and criteria (Durie, 2004b, p. 1138).

At an international level occupation therapy has originated out of western thinking and theory with Iwama (2006a) stating:

in Western occupational therapy, we often proceed with our assumptions that the entire world values and celebrates doing for its self-actualising effect. We see little wrong with the dualism of doing and becoming (Fidler and Fidler, 1978). Many other cultural groups ... view our reality as a collective-orientated ethic with 'belonging' and our connecting to nature and ancestors as the shared social ethos. The vision of occupational therapy with its promise of individual enablement

and empowerment is often both confusing and excluding (Iwama, 2006a, p. 2).

Consideration of the western influence found in occupational therapy, and therefore the limitation of the profession to respond effectively to indigenous groupings, has huge implications for practice. Rather than the often pointless debate on the merits and faults of either paradigm Durie (2004b) suggests that practitioners should explore the interface between both to instead open the door to new knowledge that encompasses both worlds.

A few Māori occupational therapists are endeavouring to provide culturally appropriate and professional specific Māori interventions with tangata whaiora. Hopkirk (2006) suggests:

O[ccupational] T[herapy] recovery processes for service users based on 'doing'... is not the context of many Māori service users I have been providing services for. For most of the service users issues of belonging: who they are from, who they live with, who they relate to and who they identify with, are what is significant for them...'activities of daily living' only have meaning or purpose for Māori when set in their worldview. So in my own practice whakapapa, identifying with whānau, karakia, tikanga ... need to come first.... The meaning of the day, its contents and the significance of each part of it only then can be examined ... the acknowledgement of the often 'doing' aspect of O[ccupational] T[herapy] possibly being incongruent with indigenous paradigms certainly has some challenge for my current practice.... Any tools currently used with Māori service users require clinical skill and cultural adaptation to make them at all useful to Māori. This article for me has been significant [in] reinforce[ing] my positioning of activity in a setting of Māori O[ccupational] T[herapy] practice. It is great to have further discussions on what we do, how we do it and especially how can we do it better! (Hopkirk, 2006, p. 5-6).

Durie (2003b) too considers the need for effective, culturally considered, practice:

improved responsiveness requires health services to recognise the significance of culture to health and to adopt methods that actively engage patients – through appropriate language, respect for custom, the use of culturally validated assessment protocols and outcome measures, and the employment of indigenous health workers (Durie, 2003b, p. 408).

The occupational therapy profession has much to learn on how to integrate dual practice to provide effective interventions for Māori tangata whaiora. There is a small but growing body of literature which highlights the need to consider (at the very least) cultural perspectives. Moreover the profession needs to assess the impact these perspectives may have on the work of practitioners. As noted, this research aims to build on the existing pool of literature, to introduce a uniquely Māori perspective, and to ultimately inform how approaches to the care of tangata whaiora can be better understood.

Māori Health

The Indicators of Health Status

From the 2006 census Māori are currently 14.6 of the population (Statistics New Zealand, 2007). Māori needs in health are partially identified by the *2001 Household Disability Survey (2001)* where 21% of Māori live with disability, when age-standardised this impairment increases to 24% for Māori compared with 16.7% for Pākehā (Ratima & Ratima, 2007).

More recent data seen in the Ministry of Health's *A portrait of health: key results of the 2006/2007* (Ministry of Health, 2008) shows large disparities in health for Māori when compared to the general population. It is reported that access to health services has improved for Māori but the disparities have yet to reduce. Specific details of access to occupational therapy services are yet to be published.

Māori are also expected to continue to and even increase in need to access health services in the future as the population ages (Statistics New Zealand, 2007). This access required of providers places:

an added onus on providers of services to Māori, that not only shall clients be equipped to participate in mainstream New Zealand society, but they should have the opportunity to participate in Māori society, to belong to Māori institutions, and importantly to remain Māori. The costs of disability are high; they should not include cultural alienation (Ratima, et. al. 1995 in, Ministry of Health, 2002, p. 13).

Participation in activities of value to the individual is of particular interest to occupational therapy as are roles held. In considering the results from *Te Rau Hinengaro: New Zealand Mental Health Survey* (Oakley Browne, Wells, Scott, 2006) of particular concern was that one in six reported one or more days out of role due to 'all health' reasons.

Te Rau Hinengaro: New Zealand Mental Health Survey (Oakley Browne et al., 2006) completed in 2003/2004 of nearly 13,000 New Zealanders, of which 2,595 were Māori, has identified that ill health from all causes had significant impact on participants. The survey found high incidence in mental illness with 50.7 percent of Māori interviewed having had experience of mental illness at some time in their life, with 29.5 percent reporting having experience in the previous year and 18.3 percent in the previous month (Baxter, 2008). Baxter (2008) identifies higher hospitalisation rates for Māori compared to Pākehā with a 3.5 times greater rate for Māori admission due to schizophrenia than non-Māori. Even when adjustments are made for income, age and education achieved, Māori continue to present with mental illness disproportionately. Baxter (2008) also reports that:

findings for contact with services in *Te Rau Hinengaro* highlight considerable unmet need and further reinforce previous expressed concerns that increased access to appropriate and effective health services to meet Māori mental health needs is required ... that under half of Māori with serious disorders in the past 12 months, had any contact with the health sector (Baxter, 2008, p. 137).

At a more specific level the need for effective mental health services is indicated when looking at the use of mental health services by Māori. In 2003

17.2% of people who accessed mental health services were Māori whereas Māori in fact comprise only 15% of the population (New Zealand Health Information Service, 2006, p. 13 & 93). A survey of New Zealand households including Māori population revealed that 50.7% of Māori had a mental disorder over their life time up to interview, with 29.6% meeting the criteria for severe mental illness (The New Zealand Mental Health Survey , 2006, p. 176).

As indicated by Durie the:

disparities between Māori and Pākehā standards of health are mirrored by disparities between Māori and Pākehā in the workforce (Durie, 1999 in Ponga, Maxwell-Crawford, Ihimaera & Emery, 2004, p. 5).

A competent, capable Māori health workforce is crucial to providing appropriate care to Māori and their whānau (Ministry of Health, 2007).

Huriwai, Sellman, Sullivan & Potiki, (2000, in Te Rau Matatini, 2006) note the clinical outcomes for tangata whaiora are improved when matches between consumers and workers occur. Along with this match is the provision of services responsive to Māori.

Māori Perspectives of Health

Māori perspectives of health stem from mātauranga Māori and te ao Māori. There are many meanings of mātauranga Māori but for this thesis the one that is closely aligned refers to:

traditional and customary knowledge systems and Māori world view, 'that bank of information built up by generations of tipuna Māori upon which their survival was based ... a way of considering issues from a Māori cultural viewpoint' (Mohi in Williams, 1997, p. 15).

Māori still see traditional perspectives as significant. The Nielson Company (Kingi, 2007) completed a survey of 1500 Māori identifying that seventy five percent of the participants identified that traditional values were very significant to them - an increase of twenty five percent on a similar survey

completed in 2004. Also of importance was a significant increase in those who saw strong positive role models within their culture increase from four to six out of ten (Kingi, 2007). Given these findings the need for Māori health perspectives to be understood and used in a clinical context becomes even more important.

There are a variety of models based in te ao Māori at use in health services in New Zealand. Some of the common models are Te Whare Tapa Whā (Durie, 1998), Te Wheke (Pere, 2003), Te Pae Mahutonga (Durie, 2003a), Pa Harakeke, and Whanaungatanga (Milne, 2001).

Te Whare Tapa Whā developed by Durie (1998) in the 1980's reflects the four sides of a house all of equal importance to maintain the integrity of the whare (Kingi, 2008). The four components are:

- Wairua – spiritual dimension
- Tinana – physical dimension
- Hinengaro – mental dimension and
- Whānau – family dimension.

Te Wheke developed in 1983 by Rose Pere has eight components (Kingi, 2008):

- Wairuatanga – Spirituality
- Hinengaro – Mental well-being
- Taha Tinana – Physical well-being
- Whanaungatanga – Extended Family
- Whatumanawa – Emotions
- Mauri – Life force
- Mana Ake – Unique identity and
- Hā ā Koro mā ā Kui mā – Inherited strengths.

Ngā Pou Mana is based on the Southern Cross, a constellation of stars in the southern hemisphere (Kingi, 2008). This is a useful tool particularly for Social and Economic Policy Development with concepts of:

- Whanaungatanga – extended family;
- Taonga tuku iho – cultural heritage;
- Te ao tūroa – physical environment; and
- Tūrangawaewae – source of identity.

Common perspectives as demonstrated above are all fundamental, holistic, integrated, interdependent, and culturally grounded (Kingi, 2008).

The use of karakia ‘Whitiwhitia i te ora’ through this thesis assists to centre the document on the principles of tipuna used by Te Matorohanga. Like the models described previously it is also designed to provide a cultural substrate, to introduce a Māori flavour and to add substance to the research. This karakia was given to me for use in this thesis to guide the process, both in its use as a karakia and in its suggestion of how to approach this research.

These Māori models coupled with the karakia are used as an “arataki” or guide. They have fundamentally informed the development of the thesis and additionally shaped its findings and focus. This approach, so early in the thesis, is uncommon but for Māori researchers it is a necessary process and will ensure that the outcomes for Māori are positive.

Occupational Therapy

Occupations can be defined as a series of activities and everyday jobs which may be identified, prearranged, valued and hold meaning to people and people groups (Townsend & Polatajko, 2007).

For tangata whaiora:

occupational therapists have the time to appreciate the extraordinariness of everyday living ... we appreciate how very special being able to live your own life is when you can't make your own cup of tea, when you can't drive a car, when you can't go to school and play because of illness, injury or disability. That is when occupational therapy comes in and shines and lets you do the ordinary things that are in fact very extraordinary (Te Rau Matatini, 2009, p. 13).

Further definitions add:

enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life (Townsend & Polatajko, 2007, p.372).

The World Federation of Occupational Therapy (2008) broadens the definition to include the supportive or restricted place environment, such as physical, social, attitudinal and legislative environments, can have on participation. As part of relating to environments, occupational therapists change the environment to support participation. As Iwama (2006b) states, indigenous occupational therapists would add culture to this definition of occupational therapy. Only under definitions that include social environment is culture acknowledged by the profession (Iwama 2006b).

Tangata whaiora are dynamically involved in the therapeutic process, and outcomes of occupational therapy are various, client-driven and considered in terms of satisfaction arising from participation (World Federation of Occupational Therapy, 2008).

To understand the how culture impacts on occupational therapy a brief exploration of the profession and its origins are necessary.

Occupational Therapy History

The foundations of the profession were based on the notion that a profession based on a systematic, theoretical and scientific basis of occupation was a valid form of treatment (Dunton 1919 in Hooper, 2006). Occupational therapy is derived from the “understanding that what people do can affect their health status” (Wilcock, 2005, p. 88). There have been continuing calls over the years to keep central the notion of occupation (Pargam, 1998; Reilly, 1962 in Hooper, 2006) and to guard against the defining of the profession by the medical model of science (Frieland, 1998; Rogers, 1982 in Hooper, 2006). According to Wilcock (2005) occupation is one of the six rules for health ‘Regimen Sanitatis’ based on a series of practices of: “people’s physical,

mental, social and rest activity, their eating and drinking patterns, and the environments in which they lived and worked” (Daremborg, 1870; Risse 1993 in Wilcock, 2005, p. 88). Based on Hippocratic medicine these health rules were reintroduced into Europe via Arabia during the early Middle Ages (Wilcock, 2005).

This concept of health was replaced in the twentieth century by pharmaceuticals and understanding of physiology and surgical methods. The paradox of the decline in the model was that it was the time that the formation of occupational therapy occurred. It is reported that the profession’s major origins came not from the exploration of new technologies but because people were surviving longer and therefore requiring restoration to health and / or making full use of their functional capacity, which was not accomplished by the current medical skills (Blom-Cooper, 1990 in Wilcock, 2005). The profession was given its name in America and progressed to occupation as a therapeutic intervention with research on occupations and the scientific sharing of this knowledge (American Occupational Therapy Association, 1967 in Wilcock, 2005).

The history of mental illness care prior to the twentieth century was undertaken in two major places, one within homes and secondly asylums (Schwartz, 2005). Many were chained in stables or cages or sent to work houses, as in England. Since the middle ages asylums have been available in Europe but tended to be places to avoid. In the nineteenth century moral treatment instigated by Pinel (1809 in Schwartz, 2005) introduced service provision based on humanitarian and therapeutic philosophy, where organized schedules and occupations would assist to facilitate this. This therapy travelled from Europe through to America with several asylums having craft rooms, gardens, and recreational areas. The provision of care found within the asylums however led to an over use of them and ultimately their demise. By the early twentieth century there was a change in views away from the therapeutic environment to the science of the brain pathology which would provide the information required to develop a cure with the dominance of Freud and Jung views (Wilcock, 2005).

The first Occupational Therapy Society was founded in America in 1917. William Rush Dunton (1917 in Hooper, 2006) presented a paper describing the foundation of occupational therapy in the moral treatment movement launching the profession. He was a psychiatrist and supervisor of occupational classes at Sheppard hospital.

With industrialisation, people moved from care of self or local community to the importance of care of society and their place as one of many in this. People moved further away from being self sustaining and dependant on their local environment for survival. In this process came estrangement from faith and alienation of self from the production process. In this process the separation of the individual occurred, causing anomie - instability in society (Personal Communication Watters, 2009).

The proliferation of crafts at the time had been instigated in England as a rebellion to industrialisation, and signalled a return to a 'simpler way of life' (Schwartz, 2005, p. 62). It was considered that:

handcrafts have a special therapeutic value as they afford occupation which combines the elements of play and recreation with work and accomplishment. They give a concrete return and provide a stimulus to mental activity and muscular exercise at the same time, and afford an opportunity for creation and self-expression (Schwartz, 2005, p. 62).

The occupational therapists task was to engage patients in crafts they were interested in, to produce something of value to them and that would also meet their therapeutic need. Schwartz (2005) reports Dunton presenting a medical perspective of activity to the medical community to justify its use, which resulted in elaborate activity analysis. This led to occupational therapists legitimising their therapeutic interventions by documenting effectiveness scientifically.

The next significant player in occupational therapy was Adolph Meyer, considered the instigator of occupational therapy because of his appointment as a tutor to train occupational therapists. His view was that 'nurture and nature' were both of equal importance. His approach considered performance

and occupational history along with biological and neurological data. In a paper written in 1922 he recorded his views of the 'philosophy of occupational therapy'. He describes his view of our make up as:

our body is not merely so many pounds of flesh and bone figuring as a machine, with an abstract mind or soul added to it. It is throughout a living organism pulsating with its rhythm of rest and activity.... Our conception of man is that of an organism that maintains and balances itself in the world of reality and actuality by ... acting its time in harmony with its own nature and the nature about it (Meyer 1922a in Schwartz, 2005, p. 64).

Meyer was of major significance to the foundations of theory and identified 'instincts, habits, interests and specific experiences and capacities, and advocated that the wholesome pluralism of practical life should not be surrendered to medical ideology (Henderson, 1951 in Wilcock, 2005, p. 89).

Meyer postulated the link that engagement in occupation enhanced and maintained healthy living.

The definitions of the profession have progressed over the years with early definitions reporting it as a medically prescribed intervention to apply occupation and recreation to physical or psychological disorders to promote recovery, develop new habits and prevent loss of function (Board of Control, 1933 in Wilcock, 2005). In the 1950's the definitions were formulated from a medical outlook of occupation rather than earlier holistic health perspectives. The 1960's were based on patients' home and work demands with emphasis on wellbeing, independence, initiative, responsibility, judgment and resettlement. Since then there have been further developments to the profession in recognition of social or developmental problems (Grove, 1977 in Wilcock, 2005). Most recently concepts such as client-centred, partnerships, culture and economic needs, occupational justice, problem solving, lifestyle, technological influences and supporting of people's well-being through 'enabling meaningful occupation' have all been defined (Wilcock, 2005).

Meyer saw opportunities, not prescriptions, as useful in recovery, and was a proponent of habits to support recovery, suggesting some disorders responded well to habit training. In order to continue the provision of this view he appointed the first woman to train occupational therapists - Eleanor Clarke Slagle (Schwartz, 2005). Slagle had done a course in the early 1900's in curative occupations for training of attendants of those who were 'insane'. The presiding theory of this training was habit training (Schwartz, 2005).

From these roots arose the profession of today with all the associated theory, assessments and interventions. It is known that Māori access occupational therapy but only in small numbers, and current data seems scant. However research completed over ten years ago evidences that occupational therapy could be more favoured by Māori.

Māori Access to Occupational Therapy Services

Access rates of Māori to occupational therapy services are very difficult to obtain, it is suspected because they are not collected. However kaumātua use of health services in 1999 does give some indication of access ten years ago. The data indicates that Māori accessed occupational therapy services at a greater rate (4.5%) than their Pākehā counterparts.

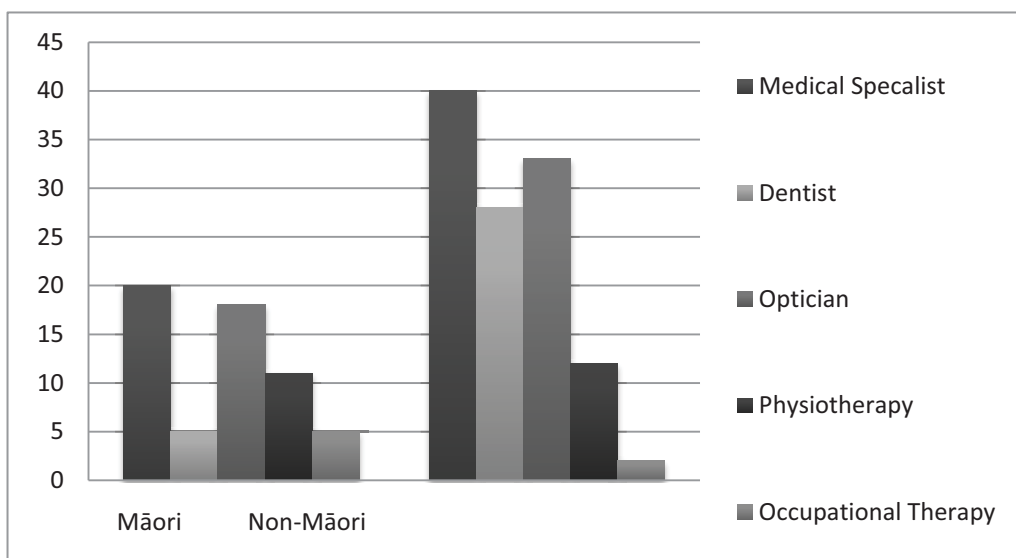


Figure 1 Māori and Non-Maori Visits to Other Health Professionals

Source: (Hirini, Flett, Kazantzis & Long, 1999, p. 11).

Most Māori who use occupational therapy services see non-Māori practitioners and are even less likely to have interventions from a Māori world view (Jeffery, 2005).

A growing concern in the occupational therapy profession has been expressed through hui, mentoring relationships, national conferences and associated meetings. The concern includes the low numbers of Māori currently practising and the length of time any stay in the profession. This shortage directly affects the professions ability to provide Māori tangata whaiora with effective interventions. Currently research such as this is without a doubt urgently needed.

The following chapters unquestionably have a bias towards a mental health perspective as was intended, based on the background from which I sit as a researcher. Following in this thesis is a chapter exploring the health perspectives highlighted by the literature review of Māori and occupational therapy health. The next chapter lays the foundation of the research methodology used to gain the data constructed here. The data is detailed next, followed by an exploration of the data culminating in the conclusion and recommendations.

CHAPTER TWO: CULTURAL COMPETENCE

He ueue tawhito, he ueue tipua
He ueue atua
Rongomai atua.

Introduction:

The previous chapter provided a basis for the thesis by describing its key focus and significant issues. Chapter two introduces the notion of cultural competence. These ideas, while touched on previously, are discussed here in greater detail and in recognition of the fact that they inform the fundamental structure of the research, its direction and focus.

The link between culture and health has received some considerable attention both internationally and within Aotearoa (Durie, 2001a; 2004a; 2004b; 2006a, 2006b, 2007; Durie, Gillies & Kingi, 1995; Iwama, 2004; 2006a; 2006b; Jeffery, 2005; Jungersen, 2002; MacKinnon, 2005; Ng, Ho, Wong & Smith, 2003; O'Brien, 2006).

This chapter explores a definition of culture and health, traditional Māori health perspectives are considered and then colonisation, followed by health from a post-settlement perspective. In this section consideration is given to workforce, cultural competence, cultural safety, and cultural effectiveness. Some discussion follows on occupational therapy theory constructs, Māori occupational therapists practice, Māori access to occupational therapy services and international occupational therapy perspectives of culture and health, finishing with Aotearoa occupational therapy perspectives.

Occupational therapy is a profession most often accessed in secondary health services such as District Health Boards (DHBs) but in fact is relevant for tangata whaiora from the primary to the tertiary health spectrum. The profession is expert at assisting tangata whaiora to participate in their communities at all levels from engaging in their own care, their whānau activities and responsibilities, their employment or similar and their wider communities. Culture is a significant component of this, so being responsive

to such an important part of who people identify themselves as is crucial to enhancing recovery.

Occupational therapy needs to consider this element of practice further to influence effective relevant interventions for tangata whaiora of Māori descent. Iwama (2006b) issues a challenge to the profession stating that occupational therapy has not come to terms fully with provision of services for different people groups. The profession explores the relationship between ill-health or disability and everyday life. Occupational therapy seeks meaning for tangata whaiora in everyday life but has relied too long on the professions ideology and understanding of occupation. The origins of this thinking arose from western understandings of these notions. He describes the significant role independence plays in the profession as the goal the profession strives for, for all tangata whaiora. This contrasts with indigenous people's goal that often is seeking greater interdependence (Iwama, 2006b).

Kingi (2006) suggests Māori do not fare any better than other indigenous peoples. Gaining better outcomes in interventions is more likely when time is taken to introduce the nature of health issues in an interview setting. He also states that it may actually be many sessions before the full extent of the problem is identified. When a relationship is developed is when information on the health problem is more likely to be shared (Kingi, 2006). Te Reo Māori signs, information booklets, culturally relevant art and posters are all ways that can assist to make those attending a service feel more welcomed and that their Māori perspective will have some understanding in the service. Māori can feel uncomfortable too if required to give their name before an introduction process occurs, and likewise seeking immediate eye contact may cause Māori to feel they are being disrespectful. Both of these could be interpreted as symptoms of a psychiatric illness e.g. depression, paranoia. Durie (1998) also notes that often what and how information on health issues is given to a tangata whaiora, can be related to concerns of non-compliance. Practitioners have:

the fundamental task ... to promote and protect health and well-being, to assist and aid recovery and to ensure that the best possible health outcomes are achieved. This is a constant and indiscriminate objective – one which is blind to ethnicity or nationality, culture or identity, socio-economic or demographic profiles. The mistake however is when these generic objectives for health and well-being are translated into generic approaches for health service delivery, treatment, and care. Aligned with this is the flawed assumption that treating people the same will somehow translate into similar health outcomes (Kingi, 2006, p. 158).

In order to consider a beginning point for this research, consideration of definitions of the key terms were explored.

Definitions

Definition of Culture

There is no one single definition of culture so several definitions for the purposes of this dissertation are explored here:

Indigenous peoples' concept of health and survival is both a collective and an individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical, and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present, and future co-exist simultaneously (Durie, 2003c, p. 510).

Further definitions refer to the way people in a group understand each other and convey that to each other. They may be conveyed verbally but are often 'taken for granted' with multiple levels of groups operating at once such as age groups, sexual orientation, professional groups, or even organisational culture as found for example in a hospital service itself (Durie, 2001a).

Geertz (1973), a leading anthropologist, suggested culture was about symbolic action. He defined culture as:

an historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which [humans] communicate, perpetuate and develop their knowledge about and attitudes toward life (Geertz, 1973, p. 89).

Culture is seen not in individual perspectives of race or ethnicity but is identified as a concept as well as a dynamic process. So when considering culture from an indigenous occupational therapy perspective seeking the:

common markers of distinction that people ascribe to categories of objects and phenomena as well as to the dynamic process by which these distinctions and categories are created, maintained and transmitted [must be sought in the therapeutic process] (Iwama, 2006b, p. 8).

Definition of Health

A definition of health is not just the absence of ill-health as is supported by the medical definition, but as stated by World Health Organisation (WHO) 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (World Federation of Occupational Therapy, 2008, p.100).

The Kawa model (Iwama, 2006b), an indigenous occupational therapy response to frame practice in another world view differing from the euro-centric view prevailing in the profession, portrays health and life as integral, not separate entities. Illness is not, in this model, seen as an issue separate to the person to be dealt to, as often supported by the medical model.

The definition of health and culture for the purposes of this research now opens the way to explore the concepts of health seen in Māori health perspectives and occupational therapy. In order to have an understanding of Māori health perspectives it is necessary to briefly examine the context in which those perspectives arose, both from a Māori and occupational therapy view, and the current growth of those perspectives to the ones of today.

Māori Perspectives of Health

Traditional Māori Perspectives of Health

Contemporary models of Māori health are typically based on traditional concepts, interpreting these in ways which account for modern circumstances. Understanding traditional Māori health perspectives provides insight into how models of Māori health have evolved and more broadly how these concepts influence modern practice.

Within Aotearoa pre-colonial whānau used karakia to protect the health of iwi and hapū (Wairarapa Moana Trust, 2007). The karakia that guides this research is, as described, a karakia used to spiritually clear a space.

There were several wānanga at Papawai in the late 1800's but of significance for this discourse is the wānanga held to request the writing down of tohunga teachings so their knowledge would be stored for future generations.

The leaders and healers of the tribe were taught in pre-colonial times in the whare wānanga where their knowledge was developed and honed to use for protecting the tribe and ensuring the survival of the whānau. Tohunga were the health practitioners in traditional Māori communities with their knowledge developed in the whare wānanga of the iwi. In understanding the health perspective of Māori an exploration of traditional concepts is required, and thus the whare wānanga.

Whare Wānanga

In ancient times Māori learnt their place in the world and through this whare life was directed and had value and meaning through an oral tradition (Whatahoro in Metge, 1967; Robinson, 2005; Smith, 1913; Thornton, 2004). Whānau were mentored and directed by tohunga who cared for the iwi, with chiefs and kaumātua who cared for the hapū/whānau. With colonization of Aotearoa came the loss of the traditional wānanga and with it went access to training and many of the practices that protected everyday life.

Traditionally children started learning from their families, especially grandparents. They learnt whakapapa, waiata, karakia and the skills of their

whānau such as carving or weaving. Competition was promoted to encourage tamariki to grow up to be proud and fierce but within the lores of tapu and noa. As they grew they learnt the skills of their gender and the spiritual management to go with that skill (Metge, 1967).

Robinson (2005) reports a whare-kura being the first school of sacred knowledge and being at tribal rather than hapū level. Selection was done by the most knowledgeable tohunga mainly based on being of noble birth, though intelligent youth with good memories were also selected. The learnings were preservation of the knowledge of ancestors originating in the knowledge of Hawaiki. Knowledge of whakapapa, place names, plant use and adaption to life in Aotearoa were all part of the training.

Pohuhu, a tohunga from the Wairarapa, describes seven levels of wānanga (Robinson, 2005). Tests would allow initiation into the next level and certain skills/powers attained at each level. Several priests supported the teaching so when one tired another would step in (Pohuhu in Thornton, 2004).

Māori Society and Health Concepts

Metge (1967) goes on to say that Māori society was driven by values and lores that arose from a spiritual understanding of the universe and environment, using rituals to negotiate these. The reflection of such concepts occurs in models previously identified and used today like 'Te Wheke' and 'Te Whare Tapa Whā'.

Kia mārama anō koe: He wā tō ngā mea katoa- tō Papa, tō Rangi.
Kāore he mea e taea te kī nō Papa anake, nō Rangi anake. Kua oti ngā mea katoa i ā rāua me tō rāua whānau te whakaatu ki tāna wāhi, ki tāna wāhi, o ia āhua, o ia āhua ... ka kite koe, kua whāiti te atuātanga ki a lo anake (Whatahoro in Smith, 1913, p. 1&2).

You must also be quite clear in this point: everything has a space of its own – of the earth (Papa) and of the heaven (Rangi). There is nothing of which it can be said it belongs to the earth alone, or to the heavens above. Everything has been assigned a place by those two and their

family, of whatever kind it may be.... You now see that all god-like functions centred in Io alone (Smith, 1913, p. 6&7).

The belief that all things have a spiritual or life force required tangata to negotiate their place with atua to secure benefits and avoid disasters. Tapu protected tangata from harm and breaking of tapu could result in damage, illness or death. Natural resources and all living things were considered tapu, so a process of management occurred noting that as their significance in the community increased so did their level of tapu.

The existence of life force in everything and the place it has in Māori world view shows the integrated life lead by hapū and iwi with their surroundings. Tangata held a place in the environment, but equal along with all the other parts of the environment, as health was seen as an integral part of communities and families as well as individuals. This world view was taught through the whare wānanga through oral recital and application. Robinson (2005) records many examples of the teachings, with examples such as lifting tapu in an area where a leg was broken so after a period a fire was set in the place and negative influences lifted with karakia, water, leaves used, then kai cooked to return the place to noa. Robinson (2005) speaks of the role of the tohunga mediating between the gods and tangata.

This is an example of how a people-group responded to managing the boundaries and risks of whānau living on the whenua, by developing many practices like the use of tapu, noa, rahui and karakia to keep the boundaries between tangata and the environment safe for the whānau (Durie, 2001a).

The arrival of Pākehā to Aotearoa signalled the beginning of change of health practice amongst Māori and other ways of being, with not all for the good.

Health Effects of Colonisation

This move from traditional practices must be remembered in the context of the times when much of import to Māori was lost. For example in the Wairarapa, loss of land ownership, access to eeling (a major food source and trade item)

and access to traditional homes, and the lack of hospital or schooling facilities, were all pertinent.

As a government report from 1868 described:

the physical and moral condition of the Native race in this district has, I believe, considerably deteriorated ... venereal diseases and others connected with them are very common – the energies of the people are ill directed – the young of the race are growing up entirely uneducated and untrained, while the vice of drunkenness is unfortunately prevalent among old and young. Their social habits are, in my opinion, of a lower character than when in a more savage state; they have lost a great deal of the energy which they formerly displayed, and have acquired little else than the vices of civilization (AJHR, 1868 in Thornton, 2004, p. 15-16).

Thornton (2004) reports the tohunga recording the depressed mood about 'things Māori' being prevalent at the time. It was in response to such a setting that the retention of identity was secured in part by the writing down of oral tradition.

Whatahoro reported in 1891 that the promises of health care had not lasted and that Māori were too far away from offered services to receive care and had to pay European doctor fees when they did access. It reports Māori as suspicious of European medicine, few Māori coming forward for vaccinations, and the lack of a hospital as promised by Grey when land was sold (Garwith, 1997).

With the coming of early settlers Māori were exposed to new diseases. In fact in early 1832 Busby (New Zealand Resident) reported to his superiors in England that the effect of uncontrolled colonisation was the 'miserable condition of the natives' which 'promised to leave the country destitute of a single aboriginal inhabitant' (Kingi, 2007, p. 5). The concern to protect Māori resulted in an agreement or exchange of Māori authority for Crown protection occurring with the Treaty of Waitangi. One of the significant intents of the Treaty of Waitangi was to protect the health of Māori.

Despite the intent of the new authority set up to enact the Treaty, Māori continued to decline significantly from an estimate of 150,000 in 1800 to 42,000 in 1896. Moreover it is significant that population decline was accompanied by a loss of cultural beliefs and practises to western systems (Kingi, 2007). With this change the loss of traditional safe practises occurred, and the colonial replacements either were not applied or were ineffective.

The additional effects of loss of ownership of fifty nine million acres of whenua with the self sustaining way of life it supported and loss of control and of culture practices, all impacted on Māori in the late 1800s (Kingi, 2006). Even in 1908 the introduction of the Tohunga Suppression Act forbidding the Tohunga practices added to the loss of protective health practices for Māori (Love, 1997).

This picture was repeated in many countries around the globe at this time such as South America and the Pacific Islands where autocratic colonial governments stomped down on cultural practices, with capitalism and positivism especially unchecked in this decade.

History continued to show a disturbing negative impact on health but some significant positive health steps were undertaken in health in the 1900's with determination from Māori like Pomare, Buck, Ngata (the Young Māori Movement); Te Puea; Ratana; and the Māori Women's Health and Welfare League (Kingi, 2006).

These leaders of the time were able to influence iwi and hapū to embrace the health practices of use in the new climate where Pākehā and Māori had to live side by side.

Tino Rangatiratanga

In the time since the work of the early Māori health leaders Māori health has improved, with self determination and resilience assisting to achieve this. A significant catalyst to this was the 1984 hui held throughout Aotearoa by Māori to determine health in their own terms, cumulating in the Hui Whakaoranga. Durie (1998) reminded those present of the sentiments of Sir Apirana Ngata in

1949 to 'embrace new technology whilst seeking the strengths and dignity of the teachings of our ancestors (Love, 1997, p. 6). From that hui has arisen many initiatives that have contributed significantly to health for Māori. As Love (1997) indicates, mental health services have developed specialist kaupapa services in Aoteroa which are responses to integrate Māori practices with clinical care for Māori. However similar developments in other health services have not been seen except within the primary health sector.

It is also important to acknowledge there were significant responses by Māori for further development for Māori, seen in the Tino Rangatiratanga movement where the sovereignty of Māori was attested to in multiple ways. A significant enabler of culture, to Māori, has been the restoration of language. Smith (2006) identifies the development that was determined by Māori with the opening of Te Kōhanga Reo movement, which has driven the alternative innovations in education right through to the tertiary sector.

Educational reform is a sensitive process involving systems and people in an ongoing series of change processes. What Māori communities have learned is that engagement in these processes can influence what happens and how it happens (Smith, 2006, p. 258). The spin off from this development for health is the revitalisation of language and, through that, the increase of access to te ao Māori and practice that traditionally restored wellbeing. This has also resulted in the supporting of identity as Māori and associated confidence to stand in their place in their world.

Current Māori Health and Workforce Issues

Despite these gains Māori continue to have poor health as supported by *He Ritenga Whakaaro: Māori experiences of health services* (Jansen, Bacal & Crengle, 2009). Over half of those surveyed had some ill health, with a quarter reporting an ongoing illness of some kind, and a third preferred Māori health services. Māori currently make up 14.6% of the Aoteroa population but continue to have poorer health than Pākehā (Statistics New Zealand, 2007). As stated this cannot continue:

if Māori are to live longer, have healthier lives, and fulfil their potential to participate in New Zealand society, then the factors that cause inequalities in health need to be addressed (Ministry of Health, 2002a, p. 2).

Not only are Māori presenting with poorer health rates but Māori health practitioners are also few and far between. This is reflected in occupational therapists as well as the health workforce as a whole, as identified by the Minister of Health Hon. Tony Ryall:

the Ministry of Health has confirmed the health system faces major challenges: increasing demand for health services with worsening finances and a workforce crisis (Ryall, 2008, p. 1).

There is a shortage of Māori occupational therapists as well as a lack of Māori occupational therapy interventions that are culturally specific. The health services of today are driven from a very euro-centric perspective. Durie (2004b) identifies differing perspectives of health found within clinical settings, supporting Iwama's theories on euro-centric health care and especially in occupational therapy. Any tools currently used with Māori tangata whaiora require clinical skill and cultural adaptation to make them at all useful to Māori (Hopkirk, 2006).

Policy makers have responded to poor Māori health statistics and developed policy to drive responsive health services for Māori. *He Korowai Oranga: the Māori health strategy* establishes the path for Māori health development in both health and disability. This strategy provides the framework which informs services of their responsibility to support the 'health status of whānau'. Two pathways are to affirm Māori approaches and improve Māori outcomes (Ministry of Health, 2002).

The 'New Zealand Public Health and Disability Act' (The New Government, 2000), has identified a purpose: to see the improvement of health and disability outcomes for all and to lower disparities by improving the health of Māori. Health services, health professions and practitioners need to continue to respond to the health needs of Māori.

In the area of disability occupational therapists have skill of significant use to tangata whaiora, especially if with culturally appropriate tools. Occupational therapists support tangata whaiora to participate in meaningful everyday living despite disability, injury or illness. The development of cultural competence of occupational therapists is identified in *Te Umanga Whakaora* (Te Rau Matatini, 2009) as a significant need of the profession.

Cultural Competence

With the passing of the Health Practitioner Competency Assurance (HPCA) Act (New Zealand Government, 2003) all professional health practitioners are required to prove proficient practice. Registration bodies have set their scope of practice with each including a cultural element.

Core competencies are a combination of attributes including knowledge, skill, experience and attitude benchmarks that enable a staff member to perform and complete tasks to a proficient standard within an area of practice. Various New Zealand health bodies have identified core competencies in the disciplines of ... Occupational Therapy (Tassell, 2004, p. 34).

Professional competencies are the skill sets that define them as a specific profession, and hence the delivery of skills within those scopes of practice.

In response to concern at the numbers of Māori accessing health services, Māori practitioners want to provide appropriate and effective interventions for whānau which include the use of te ao Māori, kawa and tikanga integrated into clinical practice. In many ways these approaches are designed to build to the cultural concepts described previously and to create a therapeutic environment which is more in sync with the expectations of Māori (Durie, 2001b). In support of this view:

clinical competence cannot be separated from culture. Culture influences how behaviours and symptoms are perceived understood and responded to, by both whānau and mental health workers. Māori culture is important to Māori mental well-being. A secure identity is a

prerequisite to good mental health, and culture is part of identity. Cultural identity depends not only on having access to that culture and heritage, but also on being able to express one's culture and have it endorsed within social institutions such as health services (Durie, 2001 in Te Rau Matatini, 2006, p. 51).

There are Māori competencies in use in professions such as the:

- Takarangi Addiction framework developed by Matua Raki (Ihimaera, 2006);
- Huarahi Whakatū for Māori nurses developed by Te Rau Matatini; and
- Huarahi Whanake for Māori mental health support workers also developed for the sector by Te Rau Matatini.

Māori competencies are derived from te ao Māori especially the marae. There are core concepts that are widespread throughout Aoteroa, and then there are tangata whenua tikanga which are localised. Advanced practice takes tikanga knowledge and demonstrated experience of using this in applied interventions within the sector (Ihimaera, 2006).

Cultural competence must also be explored alongside the concepts of cultural safety and cultural effectiveness for tangata whaiora receiving these services.

'Cultural Safety'

No discussion within Aotearoa on culture in health can fail to acknowledge 'cultural safety,' a term of note to the nursing profession (Ramsden, 1991). This concept arose out of a health context where Māori were not responding well to health care. This promoted a power shift in practice for practitioners away from the delivery of health care to tangata whaiora to the tangata whaiora defining the way they wanted culturally appropriate care. Te Kaunihera Tapuhi o Aotearoa/The Nursing Council of New Zealand defined cultural safety as:

the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on one's own cultural identity and recognises the impact of the nurse's culture on his or her

own nursing practice. Unsafe cultural practice is any action that diminishes, demeans, or disempowers the cultural identity and well-being of an individual (Wepa, 2003, p. 340).

Wepa (2003) talks of a three step process to achieve cultural safety starting with 'cultural awareness', 'cultural sensitivity' and then 'cultural safety'. So in this model the initial stage is the bringing of personal understandings, experiences and preconceptions to explore awareness. Consideration of the elements includes training by Māori on use of the Treaty of Waitangi, racism awareness, and Māori perspectives (Wepa, 2003).

Dual Practice

Cultural competence is crucial for all practitioners to support effective health provision of services to Māori. Cultural competence in and of itself requires application to benefit Māori tangata whaiora. More fluent and extensive use is where Māori practitioners bring their own tikanga and kawa to the therapeutic relationship using a mix of interventions from both cultural and clinical domains, called dual practice in the context of this research.

For many indigenous tangata whaiora clinical interventions alone are not enough unless aligned and supported by interventions from their world view. Dual practice sees Māori practitioners integrating diverging systems, a challenging day to day reality, in health in Aoteroa (Durie, 2001a). Māori values, meaning, contexts and practices are integral to effective health care for tangata whaiora.

In order for responsive services to be developed and maintained Māori dual practitioner need to:

- be strong in their Māori identity;
- be able to access mātauranga knowledge and implement it into tikanga; and
- participate in supportive clinical communities where knowledge, reflection and best practice examples can support integration of practice.

This is a lifelong commitment that resonates with Durie's (2001b) discourse on secure cultural identity. Integrated dual practice is a tool to enable practitioners to be responsive to:

- health needs of Māori;
- health perspectives they subscribe to;
- the protective factor identity provides;
- the retention of tikanga in practice; and
- use of indigenous knowledge to facilitate learning for practitioners.

Māori interventions such as the use of Māori health models, e.g. te whare tapa whā, have become more of an accepted part of service provision and dual practice (Durie, 2001b; Ihimaera, 2006; Kingi, 2005).

To enable more practitioners in the occupational therapy profession with these dual practice competencies, initial workforce development needs to be addressed in the area of cultural competence.

Workforce Development and Māori Responsiveness

There still remains a need for the tertiary education sector to provide effective options for advanced practitioners in Māori health to support effective interventions. In the 'guideline for purchasing personal mental health services for Māori' it states required of services are:

- Cultural affirmation: specific Māori cultural values and practices used in treatment;
- Clinical inputs: interventions based on professional standards of care and treatment;
- Health outcome measures: measurement of outcome which reflect Māori holistic views of health;
- Māori priorities: mental health priorities identified by Māori (Durie, Gillies & King; 1995, p. 1).

These identify the need to develop capable services to provide what is required, but of course a workforce able to deliver clinically competent, culturally relevant care is going to be more effective than one that does not.

Elder (2008) in her article discusses the significance of identity in health especially for Māori. Durie (2003a) supports this, stating good health for indigenous peoples is a secure identity and conversely loss of identity is a causative factor in mental illness. Research supports the protective influence a secure Māori cultural identity has for taitamariki, especially from the perspective of suicide attempts (Coupe, 2005 in Elder, 2008). Elder (2008) interviewed five Māori psychiatrists and registrars with experience working with tamariki, taiohi and whānau, and found there were feelings of 'mismatch' between training to become psychiatrists and their own Māori cultural identity, especially with the need to continue the process of whakawhanaungatanga in the clinical setting. Two recommendations arose out of the research, that of the need to support Māori in training to manage the experience of 'mismatch' and the secondly the requirement of cultural competence when working with whānau. Effective communication through ways that enhance cultural identity and arrive at outcomes of use to tangata whaiora is not only a requirement of Māori clinicians but, as Elder (2008) suggests, all in health practise. As accounted:

Māori users of mental health services do not have identical needs or identical cultural perspectives but in all likelihood many will share world views that are not dissimilar, and knowingly or unknowingly will expect those views to be understood by others.... Increasingly, services will be challenged to deliver programmes that resonate with Māori, while at the same time ensuring that evidence-based clinical interventions are applied to best effect (Durie in Ihimaera, 2006, p. 5).

Durie (in Ihimaera, 2006) identifies interventions must be understandable to those who are offered them, in order to support effective outcomes:

Best Practice in applied Māori ... health depends on a workforce that is committed to best health outcomes for Māori based on internationally recognised clinical professional standards underpinned by indigenous values, concepts of healing, and approaches to health (Ihimaera, 2006, p. 17).

After consideration of Māori perspectives of health for this research occupational therapy views also need to be explored ensuring they are more responsive to Māori need. Māori perspectives in health are held most strongly by the few Māori practitioners in the profession.

Culture and Occupation

Occupational therapy is little understood by other health professionals and the general public. Wilcock (2005) reflects that this is also similar to the awareness the population has between the link of 'health to occupation'.

Occupation has different meanings in different settings and cultures. Occupational therapists consider it to be all that people engage in, in order to survive (Wilcock, 2005). This includes the ability to meet instinctive needs and learning capabilities, 'to be and become according to individual talent and societal opportunities;' (Wilcock, 2005, p. 92) and to adapt to the challenges found within environment, society, and biologically. These include perspectives like:

occupation calls upon and allows expression of the particular mix of complex human characteristics and capacities that have enabled humans to survive healthily and successfully as a species throughout time (Wilcock, 2005, p. 92).

Consideration of occupation has led to Stevenson's (1987 in Wilcock, 2005) proposition that theories of human nature need situating in theories of the universe and the nature of people. He found, especially in evolutionary science, evidence to support this, that without occupation (except for extreme cases of disability) and the engagement in daily complex, self or social behaviours, survival was not a given. Thus the link between occupation and survival and health is evident (Wilcock, 2005).

Hooper (2006) suggests that the profession has over the years kept its epistemology the same, though language, practice and education and knowledge development have changed. The foundational knowledge remained stable, thus limiting the ability of the profession to self-define, and

Baum suggests moves to “encompass personal independence, social integration, and community integration” (2003, in Hooper, 2006, p. 47).

Hooper goes on to talk of the challenge Reilly (1962 in Hooper, 2006) put to the profession of the central construct of believing that people can use their hands with the direction of the mind and will to influence the state of their health.

Especially in the last few decades researchers have explored the foundations of knowledge of the profession, considering occupation and ‘biological need, (Clark, 1997; Wilcock, 1998; Wood, 1996 in Hooper, 2006) identity (Christiansen, 1999 in Hooper, 2006), competence (Mc Cuaig & Frank, 1991 in Hooper, 2006), adaption (Wood & Burke, 1996 in Hooper, 2006), and the relationship between occupation and environments (Law, Cooper, Strong, Stewart, Rigby & Letts, 1996; Rebeiro, 2001; Wood, 1998 in Hooper 2006).

When consideration of what Māori occupational therapy interventions may be arising from, being ‘Māori first and an occupational therapist second’ is the place to start (Te Rau Matatini, 2009, p. 14). Extensive development of Māori occupational therapy practice is yet to happen but the weaving together of dual practice will develop an expression of occupational therapy that is uniquely Māori.

A handful of Māori occupational therapists are creating culturally appropriate and professional specific Māori interventions with tangata whaiora as described below:

being at the beach with tangata whaiora facilitated pūrākau (stories) being told of tipuna related to the setting. When these stories are used in this way they then can be considered for their application to the present, and as an example of how great difficulties in the past were overcome by tipuna (Te Rau Matatini, 2009, p. 15).

Utilising the pōwhiri model of practice with tamariki and whānau ensured the creation of a safe place for kōrero and assisted the building of relationships. In using this model the time is taken to negotiate the relationship with the whānau and the tamariki, and the

practices that will keep the tamariki and all safe. The space used for this was not often the space provided at hospital services but often a place the tamariki feels on safe ground e.g. playground. This model is not time bound to the clock but is rather determined by the time required to achieve the negotiations, till all feel safe in the relationship, when further interventions can then progress (Te Rau Matatini, 2009, p. 16).

Stevenson (in Wilcock, 2005), in considering theories, suggests humans require a diagnosis of what is wrong with them and a prescription to correct this, when in actual fact the connection between health and occupation is the issue and exploration and interventions to address the occupational health constraint are needed. She states:

individual potential for and engagement in differing occupations results from genetically inherited capacities coupled with what individuals learn, particularly early in life, from the familial, socio-cultural and natural environments in which they live (Wilcock, 2005, p. 93).

Australasian Faculty of Occupational & Environmental Medicine (2010) recently released a position paper on the *Realising The Health Benefits Of Work* and stated that in 2007, 1 in 8 New Zealand households had no one in work.

The Ottawa Charter for health also identifies the relationship of health to activity:

to reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life not the objective of living (World Health Organisation, 1986 in Wilcock, 2005, p. 95).

A term expounded by many occupational therapists arising from Wilcock (Iwama, 2006b) conceives practice in the terms of 'doing, being and becoming'. This reiterates the understanding occupational therapists have of

'doing', activity, and the framework that what a person does is what they are and what they 'become' (Wilcock, 1999).

International Response to Culture in Occupational Therapy

In researching literature related to this thesis it is evident that there are some practitioners in occupational therapy writing about culture, however only two writers of note identified themselves as coming from an indigenous perspective. One is Iwama, the lead researcher of the only known non-western model of occupational therapy practice published in the world. The other is Jungersen, a Māori occupational therapists of Ngāi Tahu descent, who published in 2002. In a personal communication from Iwama he confirmed the almost total lack of indigenous writers in occupational therapy internationally. Aotearoa also suffers from the same dearth of literature in occupational therapy on the subject from a Māori perspective. This lack of literature highlights the need to provide further research on this topic of importance for Māori.

The next section of this chapter explores Iwama's challenges and Jungerson's Māori perspectives.

Kawa Model and Discussion

As stated by Iwama 'the issue of power and meaning in, and the challenges presented by diversity must be dealt with' (Iwama, 2007, p. 18). The development of the Kawa model arose from Japan where occupational therapy practitioners struggled to make the theories of occupational therapy fit the tangata whaiora they were providing services for.

Consideration of this identified differences in the world view of the profession compared to those in Japan. The world view influences truths held by those of that view. There is a belief in health that if the parts are pulled apart and examined bit by bit they will inform us of the whole, thus explaining science and biomedicine. The holders of this view often see culture as a component of an individual, an identifying feature of another person. Three fundamental differences were identified when comparing western with Japanese views:

- The very different views of where mankind is situated in the world.
- The euro-centric view has peoples in control of themselves as individuals and the environment around them.
- Most indigenous views hold peoples as of equal status as all things in the environment, possibly because of their dependence for survival on the environment (Ehrmann, 1972 in Iwama, 2007).

The Eurocentric view focuses on an individual's ability to decide and direct their pathway with a hierarchical flow through society. Japan on the other hand has an interdependent relationship between people, where collective agreements and views are upheld and the self is de-centred (Iwama, 2006b). Truth is not singular and constant in this context but is multiple and varied from a social view (Burr, 1995; Gergen, 1985 in Iwama, 2007).

In western thinking, through 'doing' a person actualises themselves in that what they do is what they 'become', whereas in Japanese culture the connection and the relationship or the 'being' in the community drives the 'doing' (Iwama, 2007). In this context roles are allocated to members of the collective and in Japanese culture no one individual is considered greater than the collective.

The Kawa model is based on the river and relates to the journey of life from the start to the end. Along the journey of life there are influences and factors guiding the journey. It is a model situated in an environment with the river, the water is the life force that is supported by the banks, moulded by rocks in its path and joined by logs on the way. The river bed and banks are seen as the relationships and environments that support the journey of life. The rocks are the obstacles or health issues a person may have in their journey and the logs either constrict the flow or they can ram rocks away or break them up to assist the flow of water and thus life. The model is used to describe a person's place within their environment, or journey, and uses metaphor to give purpose to, or reframe the view of enabling better life flow in the river's journey (Iwama, 2006b).

Aotearoa Perspectives

Jungerson, a Māori occupational therapist, has written her occupational therapy perspective on Kawa Whakaruruhau – Cultural Safety developed by Ramsden (1991). This identifies the context of Māori within Aotearoa society and speaks of the need to be culturally safe when providing health services to a people group already marginalised in their own country. This requires practitioners to:

understand themselves, their own cultural identities, their attitudes, values and beliefs and how those influence their working relationship with others in the context of family, social and work groups. This perspective also involves broader socio-political understandings, such as the impact of a culture of poverty on occupation, and an ability to critically analyse the taken for granted assumptions about the nature of the social world people live and work in. An understanding of the individual, the environment and the occupation are essential ingredients of cultural safety for occupational therapists (Jungersen, 2002, p. 6).

The history of colonialism in New Zealand, power relationships and the assumptions practitioners can hold, need understanding and reframing so Māori who access occupational therapy services drive the cultural practices they require. Occupational therapists providing services to Māori will have better outcomes when they have working partnerships with Māori and both respect and accord equal value to a Māori world view (Jungersen, 2002).

Other Aoteroa Occupational Therapy Literature

There are several other articles written by New Zealanders from a Māori perspective on culture that have some significance for this research.

In 2005 (Gray & McPherson, 2005) a study was completed on 13 practising occupational therapists on 'attitudes to cultural safety for Māori' tangata whaiora. It was found that maturity and personal experience influenced attitudinal change and gaining of culturally responsive knowledge. Training at

the undergraduate level or at the practise level did support basic competency but was not as effective as expected.

One article is a challenge to the profession to be responsive to the many Māori accessing mental health services. Jeffery (2005) suggests that services in New Zealand depend on knowledge generation based on a technical-rational approach. The current evidence for practice, and standardised assessments or guidelines fail to account for differing world views, perceptions of health or ill-health that are found in Māori accessing services in her opinion. This creates a real barrier to Māori tangata whaiora where standardised assessments and interventions are based on Pākehā populations and often non-Aotearoa populations.

Conclusion

This chapter has defined culture and health, considered Māori and occupational therapy perspectives of health and identified the few indigenous perspectives published. Māori concepts of health are holistic, interdependent, dependant on the environment, engage spirituality, are whānau, hapū and iwi driven with practices and beliefs to support. Occupational therapy is centred in doing, the importance of occupation for health, independence, self-determination, and in breaking down the components of the parts to enable the action. The context is now far broader but still centred, except for one exception, in the euro-centric world of its origins. The work begun by Iwama (2006b) in the development of the Kawa model has challenged the profession internationally to consider differing world views in the provision of services to indigenous populations. This research hopes to add to that developing body of knowledge.

CHAPTER THREE: RESEARCH METHODOLOGY

E hua to tino

E hua to aro

E hua to ariki e.

Introduction

This research was undertaken to fundamentally examine the research question. This chapter describes the various methods used in this research and how they were employed to meet the objectives of the study.

Māori Research Considerations

Conventional approaches to research often stress the need for clear and clinical approaches to research design. This is seen as a means through which research processes and procedures can be articulated and provides confidence that the study has been conducted in a manner which is able to generate information which is accurate and valid.

For Māori however, this approach is sometimes out-of-sync with how research is formulated and how research methods are in fact designed and developed. To this end, Māori methods of inquiry are often derived from philosophical bases which draw together multiple strands of unique Māori history and culture, pedagogy, lore, cosmology and epistemology.

Well before the arrival of the western cultures and influence, Māori had in fact developed extensive ways of organising knowledge. Māori *cosmological narratives*, for example, illustrate well Māori ways of thinking and broader approaches to knowledge creation. The story of Tāne, as a simple illustration, describes his journey through the heavens in search of the three baskets of knowledge. While the story itself is simple enough, it reveals an inherent desire for greater understanding as well as the emphasis Māori have placed on growth, development, and knowledge acquisition.

Within my own whānau similar knowledge philosophies are evident.

Whatahoro wrote down the special knowledge usually only entrusted to those

of the whare wānanga of Ngāti Muretu at the request of Tohunga and whānau when this knowledge was threatened by colonisation. This recording was only in te reo Māori and never translated by him into English. The use of the information by Percy Smith showed a research process, used at that time and often used since, but which placed Māori under a microscope as if a rare species to be examined and dissected, to then be reframed according to the understanding of the examiner - non-Māori. Walker (1996, p 167) claimed Percy Smith 'violated the traditions he recorded by condensing them into European conceptions of history and linear time'.

This type of analysis however limits the realities found in a Māori world view such as spirituality, world view, whānau and communities to name a few (Kingi, 2002). Indigenous knowledge does conceptualise the world in a holistic way, not necessarily needing to weigh, measure and quantify (Huxley, 1958 in Mercier, 2007). Indigenous knowledge seeks to find understanding and accepts that measurement of all things cannot occur with measures, tools and machines of people's making. Spirit, wairua, and mauri may be immeasurable in empirical terms but that does not mean it is not able to be 'quantified if the right instrument is properly attuned to it' (Mercier, 2007, p. 25).

It is important to recognise however, as Whatahoro and many others did, that the knowledge and practices of early settlers were useful for Māori (Durie, 1998; Mercier, 2007). We sit in a current context now where both knowledge systems, and even others, are interwoven in the daily lives of Māori.

The danger in this whāriki is that indigenous knowledge is dismissed as not significant or alternatively assimilated into western scientific knowledge. Indigenous knowledge has been spiritualised, cultural-ised but not intellectualised by western based scientists traditionally (Mercier, 2007).

Mercier (2007) discusses a pyramid that conceptualises levels of knowledge where the base holds data; the next level up is information, knowledge the layer above, topped by understanding of wisdom. In considering Māori knowledge Mercier (2007) argues that western knowledge base is heavily

centred on data and information where as Māori knowledge is centred on knowledge and wisdom/understanding.

The validity and utility of Māori knowledge, Māori methods, and Māori approaches in inquiry have underpinned the development of this thesis and in particular how the investigation was undertaken. And, while there are a number of ways in which Māori perspectives and paradigms might be included within the design of any research investigation, the eight principles below have been used as broad research principles. They in themselves do not represent the total array of knowledge available – nor in fact do they profess to do so. However, and for this investigation, they have offered a pragmatic way in which Māori approaches and perspectives can be incorporated within the design of the research and in a way which is consistent with the overarching principles of Māori development. Key elements included were:

- aroha ki te tangata – respect for people
- kanohi kitea – the seen face stating the importance of face to face
- titiro, whakarongo ... kōrero – look, listen ... speak (from Te Atārangi the adult Māori language programme)
- manaaki ki te tangata – share and care for people, be generous
- kia tūpato – be cautious
- kua e takahia te mana o te tangata – do not trample over the mana of people
- kua e māhaki – don't flaunt your knowledge and
- aroha ki te tangata – respect for people (Smith, 1999, p 120).

Research Design and Methodology

While this investigation is underpinned by a range of philosophical and cultural consideration, more pragmatic issues have also informed its development and the various activities which were undertaken. The following section describes these.

Aims and Objectives

The overall aim of this research was to explore the research question Does cultural perspectives impact on occupational therapy practice: a Māori case study? Particular objectives included the exploration of:

- health perspectives of Māori and occupational therapy
- a framework to support effective cultural responsiveness to Māori accessing occupational therapy services and
- recommendations to the sector.

Methods

The data for this research was collected using a variety of methods allowing an integration of multiple views and perspectives. These included:

- analysis of literature
- active participation in occupational therapy development for Māori
- questionnaire for occupational therapists
- structured interviews
- attendance at Hui and
- consultation with experts.

Analysis of Literature

Māori health perspectives were identified by performing a Cumulative Index of Nursing and Allied Health Literature (CINAHL) through EBSCOhost Alert Notification. Searches requested were occupational therapy and culture and/or indigenous. Searches were also undertaken in Māori health perspectives and Māori health aspirations in Index New Zealand, Massey University Library, Web of Science and Google Scholar.

This research has been informed by the direction given in policy documents identifying health needs of Māori and especially Māori health perspectives. Further literature has been explored to identify the importance culture has in health with discussion on Māori and occupational therapy health perspectives. References are shown throughout the thesis with the full references in the reference section at the completion of this dissertation.

Active Participation in Occupational Therapy Development for Māori

As the project leader in the development of an accelerated workforce development strategy, I consulted regularly with Māori occupational therapists and these consultations have informed this research. Considerations of the health perspectives found in the profession were identified along with some of the challenges they pose for those of Māori descent. The relationship with the sector has also added to the thinking in this research, with issues discussed such as cultural competence, workforce development, professional responsiveness to Māori, and cultural development of practitioners to name a few.

Committee participation occurred in:

- Whaiora – Iwi Hauora service in Masterton
- Advisor to New Zealand Association of Occupational Therapists and
- Appointed member of Occupational Therapy Board of New Zealand.

Questionnaire

Attendees at a workshop of the New Zealand Occupational Therapy Conference 2008 self-selected to complete a questionnaire on occupational therapy health perspectives, with Pākehā and Māori both participating in this part of the research. Further interested participants over the September - December period 2008 included Māori occupational therapy leadership and staff from the occupational therapy training programmes. The latter were not seen face to face.

Structured Interviews

Interviews were completed with five participants consisting of two Māori occupational therapists, two Māori health specialists and one occupational therapy specialist.

All interviewees who were approached for an interview agreed, and were given the option to withdraw at any stage of the interview if they wished. Interviews were started with the offer of a karakia which three people accepted. The interviewees were all selected and interviewed face to face

except for one participant who due to the illness of the interviewer was interviewed over the phone.

When interviewing face to face the ability to use the total communication cues of interviewees assisted to ensure the information was correctly received. The questions were asked of participants and notes were taken at the time, with all but one interview being audio recorded. Clarifying questions were used in addition to the identified questions and where further pursuit of a concept was required. The look, listen and speak process was used in interviews.

Participants' knowledge was treated with respect and with tupato or caution, with their thoughts informing the results of this thesis. Smith (1999) explains kaupapa Māori research as being based on the researched Māori seeing a positive difference after the research. Spoonley (1999) states that Māori require control over the research process and the ability to stop the research at any stage when it ceases to be in their interests. This was available in this research, but no one chose to do this.

Attached is the consent form see Appendix 3.

Manaaki ki te tangata – share and care for people, the generous expression of this was demonstrated in the use of environments that were in settings of choice for the interviewee. Refreshments were given to interviewees and a small koha given in respect of their sharing. Cost associated with their attendance at the interview for travel was reimbursed. All were keen to participate because of their desire to see occupational therapy practice knowledge enhanced. The reciprocity of sharing and koha was understood by participants and their ability to request information from the researcher understood and at times used. Koha is about reciprocity and a significant part of Māori kaupapa as Durie (2001a, p. 78) states is 'to strengthen ties and create mutual obligations'. As the project requires gifting of knowledge to the project so the researcher also needed to acknowledge and return the gift. However it is acknowledged that purchasing the knowledge is not intended or appropriate (Sporle, 2004).

A set of questions was identified with the first six establishing a demographic profile. The questions were specifically designed to establish views of culture and health, and health perspectives from a Māori and occupational therapy perspective.

Kaua e māhaki – don't flaunt your knowledge was used in this research by ensuring information shared through this research was explained to all participants with this on the questionnaire and in the information sheet given to interviewees. How it will be shared, and who it will be shared with, was negotiated at the establishment of the project. The researcher has not identified individuals or who the information came from in the dissertation. The Māori health community is small and the fact that this research was planned for Māori occupational therapists, an even smaller group, is also an identifying factor. A confidentiality form was used to define the research role and signed by all participants of the interviews.

For the interviews audio recordings were made of each session with numbers not names identifying sound clips. Discussion at the consent stage occurred about what would happen regarding the keeping of their information and the destroying or returning of transcripts and tapes at the end of the required (by Massey) five year period. All audio recordings are kept on a passworded computer and the questionnaire and notes taken in the interviews are, when not in use, locked in a filing cabinet.

Information sheet see Appendix 4.

Hui and Seminars

Another source of information for this research was attendance at numbers of hui where perspectives of Māori health and occupational therapy were discussed. A few further hui I attended were where Māori occupational therapists discussed practice. A look, listen then speak kaupapa was used.

In order to hear firsthand the collective views of Māori and of health experts, the researcher participated in and led a number of hui, seminars, workshops and conferences shown in Table 1.

Table 1 Hui, Workshops and Conferences

Date	Event	Groups	Number	Themes
September 08	NZAOT Professional Conference	Occupational therapists, Māori occupational therapists	27	Cultural perspectives in occupational therapy
September 08	Hui Auckland	Māori occupational therapists	11	Workforce development needs of Māori occupational therapists Best practice
November 08	Reference group hui for Te Rau Matatini	Māori occupational therapists, a tangata whaiora advisor and Kaumātua	10	Workforce needs themes identified from the hui discussed and identified further and further best practice examples discussed
November 08	Trustee hui Whaiora Hauora	Iwi Hauora Māori health leaders in the community, whānau members, Kaumātua	10	Hauora governance issues; Iwi health development
January 09	Reference group hui for Te Rau Matatini	Māori occupational therapists, tangata whaiora advisor and Kaumātua	10	Workforce development and further best practice examples discussed

Date	Event	Groups	Number	Themes
February 09	Trustee hui Whaiora Hauora	Iwi Hauora Māori health leaders in the community, whānau members, Kaumātua	10	Hauora governance issues; Iwi health development
February 09	Hui Māori practitioners	Māori practitioners, Kaumātua, Tangata Whaiora,	16	Māori health, practice in health
March 09	Occupational Therapy Sector meeting	Occupational Therapy Board of NZ, NZ Association of Occupational Therapists, Head of Auckland University of Technology Occupation Science and Therapy Programme and the head of Otago Polytechnic Occupational Therapy School.	10	Consultation on workforce development priorities.
March 09	NZAOT leadership	NZAOT council members	10	Occupational Therapy leadership and development.
April 09	Hui Māori practitioners	Māori practitioners, Kaumātua, Tangata Whaiora,	15	Māori health, practice in health, best practice examples, Māori models

Date	Event	Groups	Number	Themes
May 09	Health leaders hui	Māori Mental health manager, Māori health leaders, Māori health practitioners	10	Workforce development, Māori health, Māori mental health
May 09	Reference group hui for Te Rau Matatini	Māori occupational therapists, tangata whaiora advisor and Kaumātua	10	Workforce development and further best practice examples discussed
August 09	Launch occupational therapy workforce plan	Māori leaders, occupational therapy sector leaders, occupational therapists, Māori occupational therapists, ministerial representatives	50	Best practice for whānau, Māori occupational therapy workforce development, strategy development.
September 09	Launch Māori suicide prevention tool	Māori mental health leaders, SPINZ organisation, practitioners and health promoters	150	Healthy whānau, practitioner interventions.
October 09	Occupational therapists professional workshops	Occupational therapists, leaders, educators and managers	15	Occupational T and Māori perspectives of health.

Consultation with Experts

Expert consultation occurred in this thesis primarily through three groups of experts. The Māori occupational therapy profession have only emerging expert Māori cultural practitioners. For this thesis two interviewees were selected due to their experience working in a Māori health team. Two were selected for their Māori expert knowledge of Māori health and dual practice and the last interviewee was selected to have a specialist occupational therapy perspective. The Māori health experts were selected for their leadership in the field of Māori health and dual practice. The occupational therapist, who was Pākehā, was selected due to their expertise in occupational therapy and their commitment to be responsive to Māori in their leadership.

Interviewees were approached either face to face, through telephone or in one case through e-mail. A suitable time and place was arranged where the interview took place. All but one interview was held face to face due to ill health of the interviewer. The information sheet was further clarified and the consent form signed.

In all the hui there was active participation of the researcher. The hui attended considered Māori health perspectives, as did both the launches. The occupational therapy meetings considered occupational therapy perspectives, along with the professional conference and workshop. So with the researcher's participation in all these hui, workshops and conferences the thinking of the researcher was developed and therefore informed this research.

This research seeks to validate Māori knowledge contained in individuals, to organise it and to learn from it (Smith, 1999). It seeks to use applied research as defined as research that seeks to find 'practical outcomes' (Davidson & Tolich, 1999). Qualitative research is also seen as a vehicle to gain insight into how participants view their world and how they sort that world into reality for them (Riley, 2000). This research proposes to move 'from observations through generalisations to theory generation' (Davidson et al, 1999, p.18).

Ethical Considerations

To ensure that the research was undertaken in an ethical and safe manner an application was made to the Massey Human Ethics Committees prior to the commencement of the research. This process was important in that it gave confidence that the research was sound and that the participants (in particular) would not be exposed to any potential harm. At another level, this process also allowed the research to be critiqued through external review. As a consequence a number of considered modifications to the research methodology were made see (Appendix 2).

Analysis of Data

I have used Māori methodology to consider Māori health perspectives with occupational therapy rather than using a western framework. It consists of:

- aroha ki te tangata – respect for people.
- kanohi kitea – the seen face stating the importance of face to face.
- titiro, whakarongo ... kōrero – look, listen ... speak (from Te Atārangi the adult Māori language programme).
- manaaki ki te tangata – share and care for people, be generous.
- kia tūpato – be cautious.
- kua e takahia te mana o te tangata – do not trample over the mana of people.
- kua e māhaki – don't flaunt your knowledge (Smith, 1999 p 120).

So the process of gaining information used this process but it was also used in analysing the data with the face to face discussions with my Māori supervisor. Respect for the information obtained was given utmost importance, ensuring all information is recognised and honoured for its contribution to the data. This data is not about my knowledge but about the knowledge shared and my role as a researcher is to look and listen, with the speaking coming after the research is finished. The knowledge gained in this research is considered by Māori to be an extension of them and continues to have life even though it is in a research thesis, so respect for them, and caution about how the information is interpreted and portrayed is crucial.

Finally it is not for me as the researcher to flaunt my knowledge but to be as accurate as possible in terms of portraying the information given.

CHAPTER FOUR: DATA PRESENTATION

Kia tapatapatu

Kia tapatapa rangi

Ki nga rangi nao ariki

Ki nga rangi tatara.

Quantitative Data

Two sets of quantitative data were collected, one from the 18 respondents to the occupational therapists questionnaire and the other from five interviewees (n=23). This chapter encapsulates the quantitative data principally in a single graph, the details are found in Appendix 6. There is also a data set from a workshop on culture and occupational therapy perspectives, of health which was treated as a single perspective and not included in the quantitative and qualitative data. In line with the methodology above, this chapter is both descriptive and analytical. This approach provides the most appropriate and feasible way in which multiple perspectives can be presented and analysed. Appendix 5 provides a table displaying the sets of questions asked of participants. This data was collected to gain a picture of the participants and their settings. Where possible, some of the data has been related to data such as population similarities and common professional issues. There is mental health experience bias in the data as stated at the start of this research.

All but two of the 23 participants were occupational therapists being Māori health experts. Māori responses have been extrapolated from the data.

Ethnicity

Ethnicity was identified by participants and is displayed here in a series of figures showing a cumulative figure (Figure 2) including the questionnaire, the interviews and Pakeha and Māori responses.

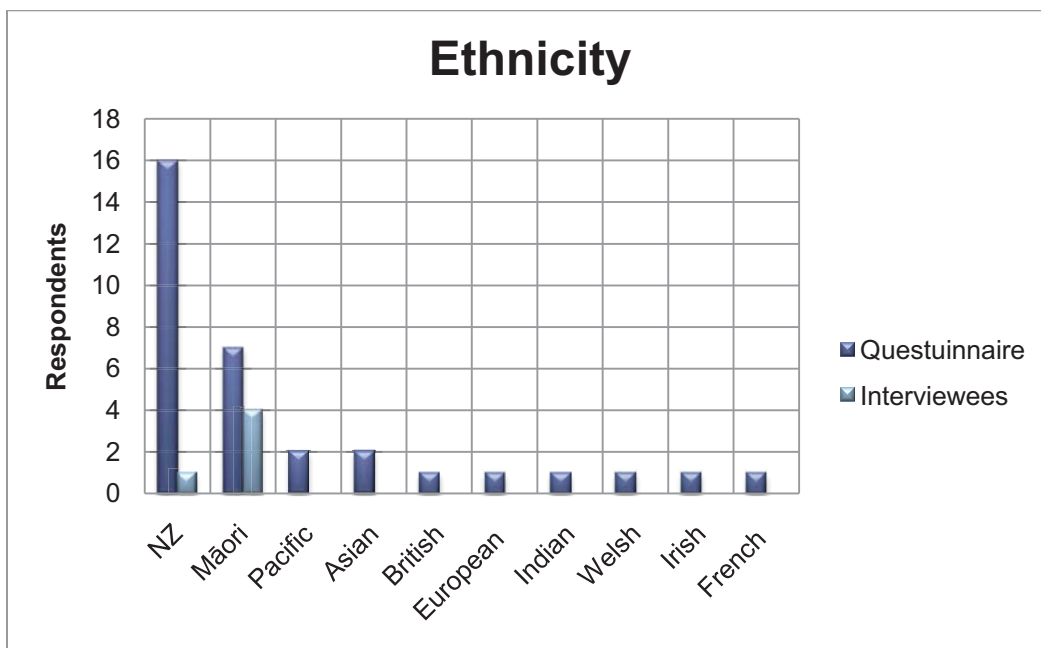


Figure 2 Ethnicity n=23

There were multiple responses for some participants identifying their ethnicity, resulting in the 33 responses with one respondent identifying seven ethnic groups. The largest number of respondents reported New Zealander as their ethnicity, with Māori reporting next highest in the responses. Pacific and Asian were equal with two respondents each, and French, European, Irish, Indian, Welsh, and British with one respondent each.

In comparison all the interviewees identified as Māori alone except for the one New Zealander participant. The two Māori specialists were included in this data.



Figure 3 Numbers of identified ethnicity n=23

Of interest in this data was the number of ethnicities identified (Figure 3) in both the questionnaire and interviewees. One person identified seven ethnicities, two identified three, five identified two and fifteen respondents identified one. The single identification was the most common response.

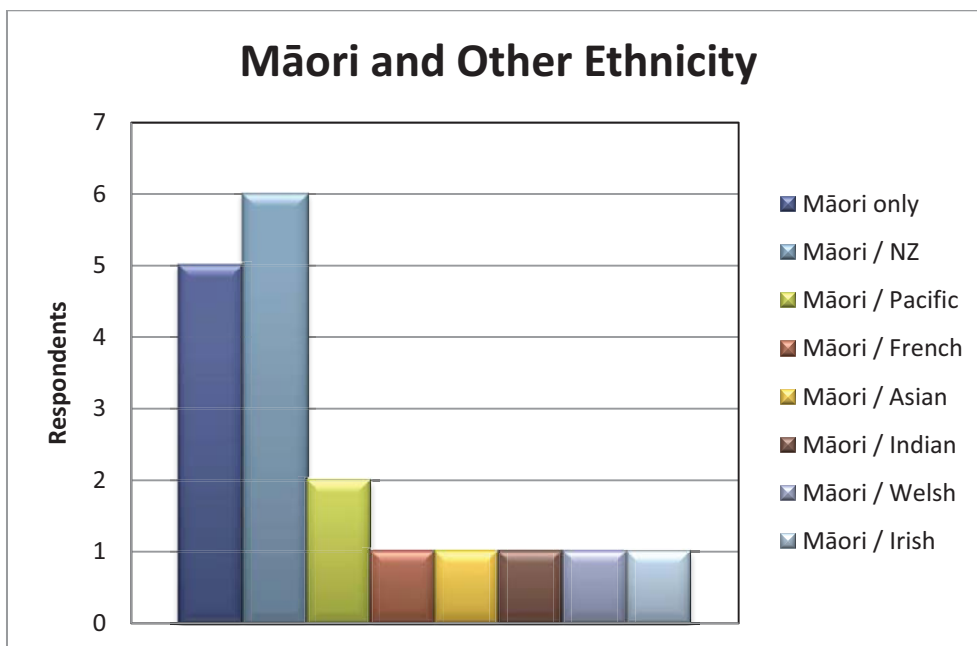


Figure 4 Māori and other ethnicity n=11

Figure 4 identifies only Māori respondents with other ethnicity and includes all Māori respondents from the questionnaire (n=7), and from the interviewees (n=4). The most common was New Zealander, with Pacific next with two respondents, followed by French, Asian, Indian, Welsh and Irish also being identified once each. The two non-occupational therapists identified as Māori alone.

Analysis:

New Zealander was the most identified ethnicity with Māori next. This was 39% of the respondents and does not reflect the current percentage of Māori in the occupational therapy profession of only 1%. This is not surprising however given the research was seeking Māori perspectives of health in the profession. In this percentage calculation the two non-occupational therapy specialists were removed.

Multiple responses were given to this question with seven the most identified by one participant. The identification of seven ethnic origins indicates the complexity of ethnicity and culture for individuals to integrate into their identity.

It was interesting that some Māori also identified themselves as New Zealanders too. A further exploration of this to ascertain if this is associated with a secure Māori identity would be of interest in future research. One respondent in the questionnaire responded as Māori only, whereas four of the interviewees identified this. This data may indicate a lack of identity as Māori or conversely be recognition of the Pākehā streams in Māori whakapapa in today's world. Nine Pākehā respondents identified New Zealander alone.

Employment Setting

This question identified the work places that participants were currently engaged in: District Health Board (DHB), Tertiary Education Institutes (TEI) identified here as university, non-governmental organisations (NGO), home as a care giver of children, in private practice, studying and lastly education where children with disability receive interventions. Displayed are the statistics showing the employment settings of those from the questionnaire, the interviewees, and Māori and Pākehā settings (Figure 5).

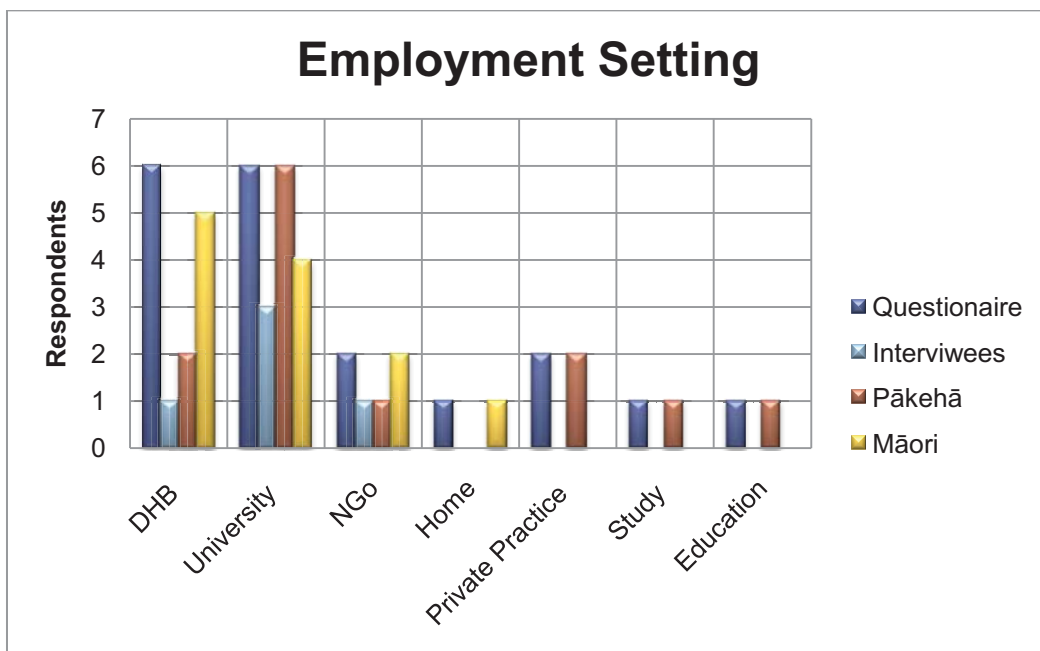


Figure 5 Employment setting n=23

Six questionnaire respondents reported working in the DHB and university setting with two each in NGO and private practice and one at home, in the study and education sector. Of those who were interviewed one worked in a DHB, three worked in a university setting and one worked in an NGO setting.

Inclusion of data to see where the Māori respondents were situated revealed the DHB as the most common setting followed by university. Two of the interviewees were not occupational therapists so have not been included in the Māori responses part of the data.

Analysis:

Nearly the full range of services that Pākehā occupational therapists were employed in is covered by the graphs above, with the only major omissions the Ministry of Social Development and ACC as reported by the New Zealand Health Information Service (2005). However ACC practitioners' contract services to ACC so would respond as private practice participants. Māori however in this data are mainly in DHB with only one in university or NGO and one at home. The actual work practice within each setting was not explored in this questionnaire.

There also appears to be a large number of respondents who were in a university setting compared to other participants. This questionnaire was given to participants of a workshop at the professional conference. From this conference a member from each of the two occupational therapy faculties took the questionnaire back to their TEI's for respondents to complete. Given the research emphasis found in such settings this may account for the high response rate from this sector. There are two Māori identified as working in the university setting one was a questionnaire respondent and the other an interviewee.

The inclusion of one participant engaged in mahi kāinga (work at home) was encouraging as often there is a proportion of the profession engaged in childcare who sometimes do not return to the occupational therapy workforce (Ministry of Health, 2006). Their perspective is valuable to this research.

In comparison, the responses of active occupational therapists who responded to the Annual Workforce Survey in 2004 (New Zealand Health Information Service, 2005) showed the top three employment settings were DHB – 641, private practice – 190 and Schools (education) – 116, with TEI's placed only eighth highest employer with – 26. This ranking excluded the unidentified group (New Zealand Health Information Service, 2005).

It is interesting that most Māori from this data are located in a DHB setting and are therefore predominantly in a mainstream-driven service. Of the occupational therapist respondents only one Māori reported working in the NGO sector, information was not obtained on whether this was a kaupapa service or not. This may be a reflection of employment availability rather than a preference for mainstream services. At the time of writing the only Māori employment setting known to employ Māori occupational therapists is in the DHB kaupapa Māori mental health teams (Te Rau Matatini, 2009).

Highest Qualification

The qualification of respondents was explored in the figure displaying the questionnaire, interviewees and Māori and Pākehā data (Figure 6).

Of the 18 questionnaire respondents all were asked if they held a New Zealand Registration for Occupational Therapy (NZROT) and then what their highest further qualification was. All had an occupational therapy qualification with all but six having further qualifications. However two of the interviewees did not hold an occupational therapy qualification. The interviewees' highest qualification was reported as one holding an occupational therapy degree, one a post graduate certificate, one a Masters, and two PhD's. One PhD and the Masters in the interviewees were held by the non-occupational therapists.

The most common additional highest qualification for the questionnaire after NZROT was a Master's with Post graduate certificate next, Doctorate following. A Post Graduate Diploma was not reported to be held by any.

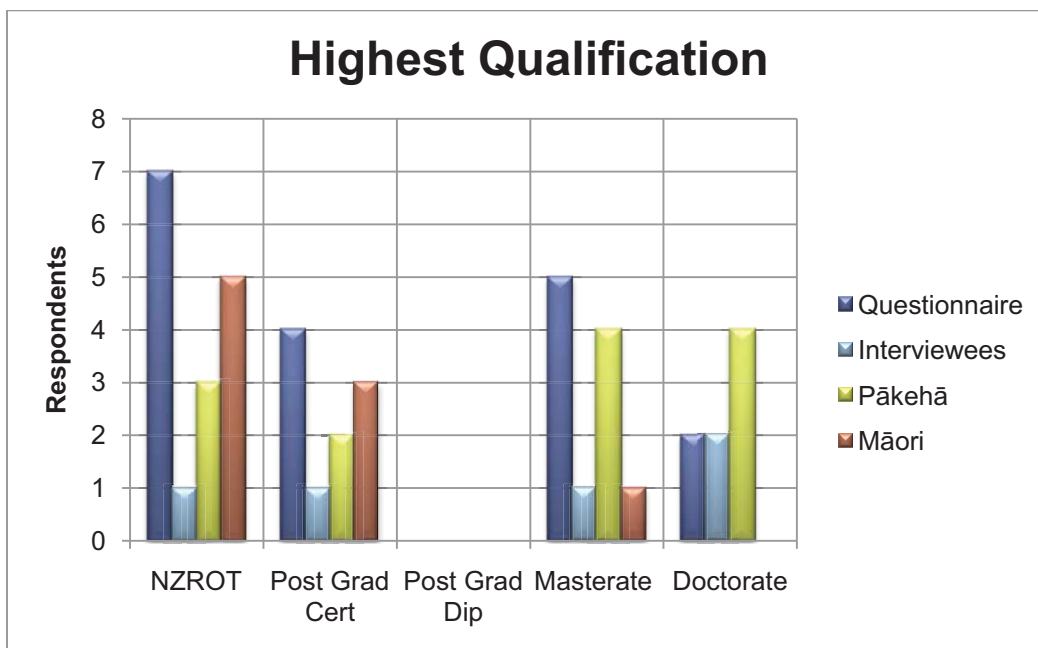


Figure 6 Highest Qualification n=21

A comparison was made between Māori and Pākehā in Figure 6. Māori predominantly reported their highest qualification was an NZROT (four respondents). One respondent had a Post Graduate Certificate and one a Masters qualification. Removed from this figure were the two Māori interviewees who were not occupational therapists.

Analysis:

This data shows that of the nine Māori occupational therapists only five had further qualifications compared to their 12 Pākehā counterparts where nine had achieved a higher qualification.

This small study may reflect the general population but further information from a larger cohort is required to confirm these findings. The high number of respondents working in the university setting may also influence the Pākehā qualification achievement.

Any comparison to larger national figures was not possible due to lack of national recorded data.

Experience in Mental Health

The participants in the questionnaire, interviews and Māori and Pākehā data (Figure 7) reported on their years of experience in mental health work setting, their responses are displayed in the following figure.

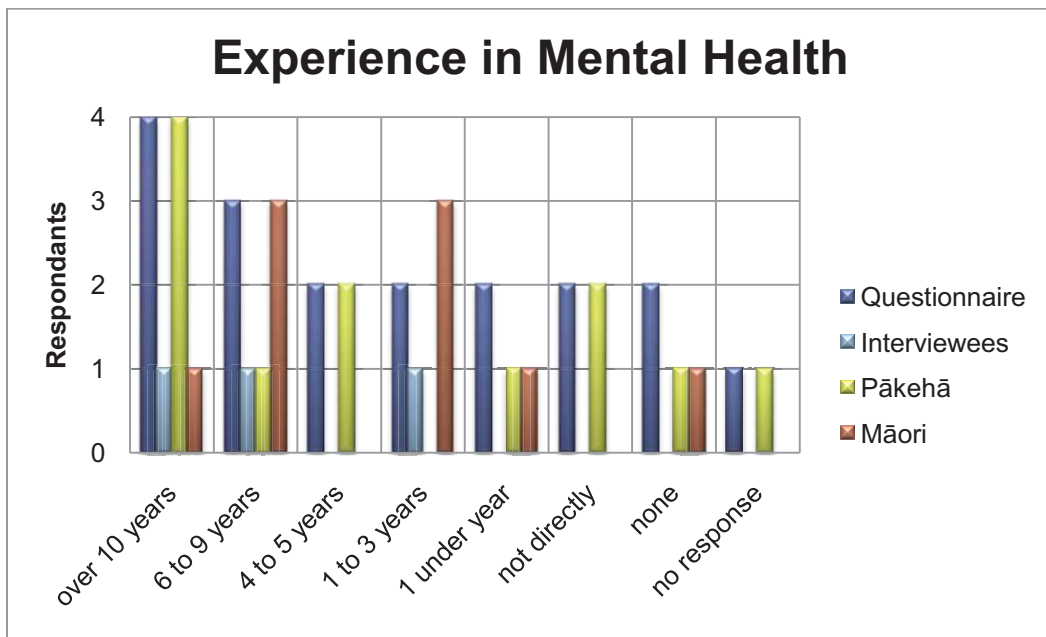


Figure 7 Experience in mental health n=23

Participants were asked to indicate how long they had worked in mental health. Out of the 18 respondents to questionnaire one did not respond to this question. The most common answer was 10 plus years with four respondents reporting this, followed by three reporting six to nine years, and the next groupings of four to five years, one to three years. Two reported under one year and two with not directly. One made no response.

One of the interviewees had ten years or more experience in mental health, one had six to ten years experience and one had one to three years experience. The two non-occupational therapy participants were removed from the interviewee data as their responses distorted the data but both had 10 plus years.

A comparison between Māori and Pākehā experience in mental health was identified. Of the nine Māori occupational therapy respondents all but one had direct experience in mental health. One Māori compared to four non-Māori had ten plus years experience, three Māori compared to one Pākehā had six to nine years experience: and three Māori but no Pākehā reported one to three years experience. One Māori and one Pākehā reported less than one year. Two Pākehā responded not directly. No Māori reported four to five years, not directly and no response.

Analysis:

Occupational Therapists have two major settings of practice, mental health, with the origins of the profession stemming from here, and physical health. This question was asked to see what mental health experience respondents had to situate this research within the mental health setting acknowledged at the beginning of this research. Experience in physical health was not established in this research.

This study shows that of the 21 responding participants (excludes the two non-occupational therapists) all but four had experience in mental health and over half of the respondents of 13 had four plus years experience, leaving nine with three or less years.

Interestingly two of the interviewees identified that in their university settings they included their teaching of mental health related subjects to students as mental health experience. Whether this was consistent with other research or not was not established in this study.

Age of Respondents

All those who participated in the questionnaire responded to the question of their age, but this was not asked of the interviewees so no comparison is made with them (Figure 8).

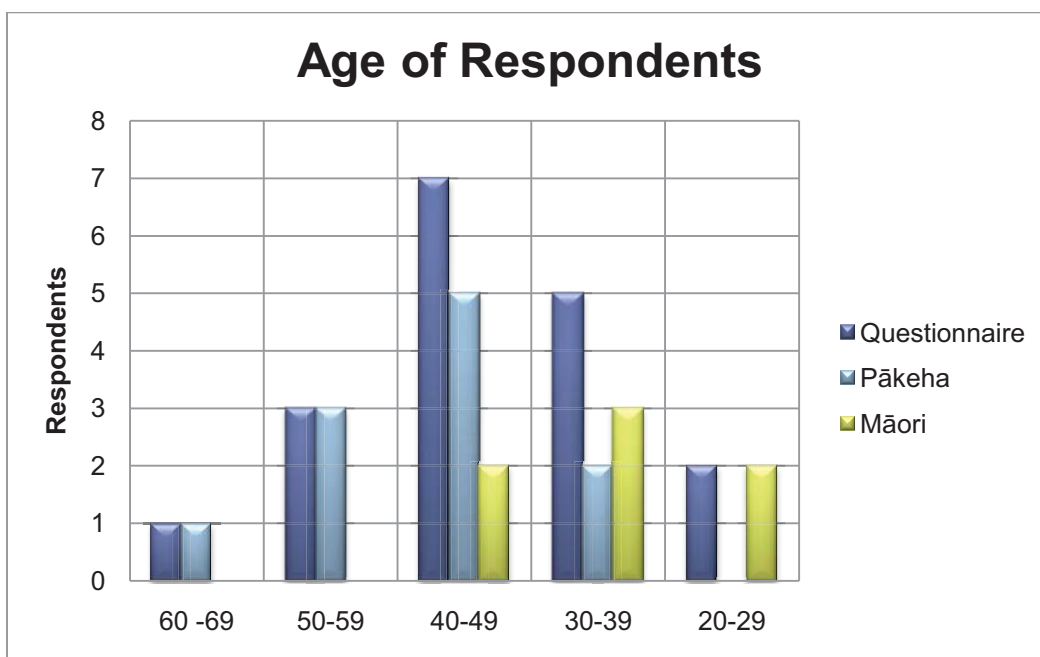


Figure 8 Ages of Respondents n=18

Participants were asked to indicate what age group they belonged to. As suggested in the figure the most common age was 40 to 49 with 30-39 second, 50 to 59 third, 20-29 fourth and the 60 to 69 age group only having a single participant.

Māori in this data are younger than the Pākeha participants with no reports of Māori practitioners in the two older groups.

Analysis:

The Interviewees were not asked this question face to face as it was considered by the researcher inappropriate in such a setting.

Research supports the findings of this data. The current health and occupational therapy workforce being situated in this age group poses a risk to the ongoing provision of health services due to the aging of the profession (Ministry of Health, 2006). Māori data reveals a younger Māori population in the profession paralleling the population trends for Māori compared to the general population. This has advantages in that the youthfulness of the

population may have more energy, new ideas and recent professional knowledge, but is balanced with a possible lack of experienced and resilient practitioners to mentor and support the newer practitioners.

Services to Māori

This data related to participants' provision of services to Māori, from the questionnaire, interview respondents and Māori with Pākehā data (Figure 9).

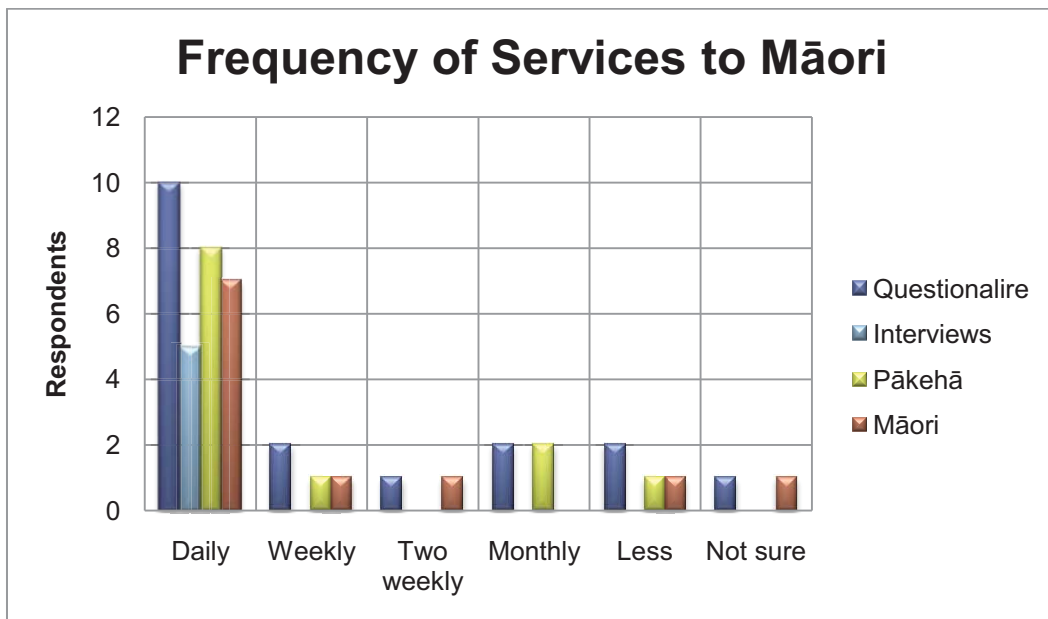


Figure 9 Frequency of services to Māori n=23

Ten questionnaire respondents provided services to Māori on a daily basis. Two participants reported weekly, monthly, and less than monthly with one each reporting two weekly and not sure. All the interviewees reported services to or for Māori on a daily basis.

Those who identified as Māori all responded to all the possible responses except for monthly. The largest group of participants who identified as Māori work on a daily basis with Māori, and there were just single responses to weekly, two weekly, less than monthly. One respondent reported being not sure.

Analysis:

This data indicates that most Māori are being seen by Pākehā occupational therapists with eight practitioners who are Pākehā working with Māori on a daily basis and one reporting weekly. Three reported working on a monthly or less basis with Māori. This equates to a lesser chance of Māori tangata whaiora having a Māori practitioner. Given the disproportionate number of Māori occupational therapists that participated in this research compared to the normal occupational therapy population this figure is expected to be over stated in this data. Thus Māori are more likely to have a Pākehā occupational therapist. Two Māori were not working regularly with Māori or were unsure of how often they were working with Māori.

Nine Māori occupational therapists provided data for this research providing 42% of the participants. In comparison with the occupational therapy profession this is an inflated rate, with only 21 Māori occupational therapists or 1% of the occupational therapy profession being Māori (Personal Communication Occupational Therapy Board of New Zealand, 2010). However this still indicates 61% of Pākehā are providing service to Māori on a daily basis, from this data.

Given this research was based on Māori concepts of health, and participants were self-selecting in coming to a Māori occupational therapy workshop, their responsiveness or relationship with Māori was more likely to be higher than the normal occupational therapy population. However Māori are accessing health services more frequently than Pākehā at about 17% and as we know the current occupational therapy workforce only has 1 % Māori.

This data does show that most of the Māori respondents are working day to day with Māori, which may indicate a preference to work with their own whānau.

Summary of Quantitative Data

The data has described for us a picture of the respondents. 23 participated in this research: 21 were occupational therapists and 11 were Māori, consisting

of four interviewees and seven in the questionnaire. Two of the Māori respondents were not occupational therapists so the Māori data is a total of nine at times, to encapsulate Māori occupational therapy data.

Seventeen participants identified themselves as New Zealander's and 11 as Māori (two non-occupational therapists). Eight reported more than one ethnicity and one reported neither Pakeha nor Māori ethnicity (n=23). One reported up to seven ethnic groups. Five identified themselves as Māori only and six said Māori/New Zealander.

Most participants were employed in a university setting with DHB the second most reported. Māori practitioners were however more likely to be in the DHB with five of the nine Māori occupational therapists respondents reporting this as their place of work.

Māori practitioners in this research had lower qualifications with a Masters the highest reported qualification, with one respondent achieving this. The most common was holding an NZROT alone.

The Māori respondents were younger than the occupational therapy population, reflecting similarities with the population in New Zealand.

Fourteen of the 21 occupational therapy participants had worked in Mental Health for more than one year with three reporting one to three years, two reporting four to five years, four reporting six to ten years and five stating ten years plus. Māori practitioners were not so experienced in mental health with only one having ten years plus experience, three reporting six to ten years, and three reporting one to three years.

The frequency respondents worked with Māori saw 15 of the 23 respondents working on a daily basis with Māori. Māori practitioners were less likely to work with Māori in this data, especially if the two non-occupational therapists were removed. Pākehā reporting in this research had a 38% likelihood of working with Māori and Māori reported only a 23% chance of working on a daily basis with their own.

Qualitative Data Questionnaire

The question of how relevant cultural perspectives are to occupational therapy was answered by all participants in the questionnaire, out of a 1-5 rating with 1 as not important through to 5 recorded as extremely important. All participants identified culture as being 5; that is extremely important in occupational therapy practice.

Through this section of the data there are more than one response per participant depending on what they thought was a significant response. These replies were then matched to similar responses and the ones most commonly held were reported on.

The presentation of this data following is initiated with the question, seen as the heading, followed by a graph depicting the key information, then a description of the data. It concludes with analysis of the information.

Is Culture Significant For Practice? And Why?

Further to the selection of the importance of culture, the question was followed with, why? 15 of the 18 questionnaire participants responded to this question, and of those five identified themselves as Māori. Of the three who did not respond to why, two were Māori.



Figure 10 Why culture is important in occupational therapy n=15

The responses recognised the cultural perspectives that tangata whaiora have as the most important reason for identifying culture and reported in this data supports responsive practice (Figure 10). Nine of the 15 answered in this way and of those nine, four were Māori. Some descriptors evidencing this follow:

“Cultural perspectives are often central, recognised or not, to a person’s involvement in occupation and the world around them” (Participant 18),

“culture is core to a person and because we deal with the 'whole person' we need to be very culturally aware” (Participant 12),

“culture is foremost in all interactions so to form my therapeutic understanding/alliance the O[ccupational] T[herapist] must connect with the person’s culture [and] context” (Participant 17).

Descriptions of being holistic in occupational therapy practice and understanding practitioners’ own cultural contexts were also identified in this question.

The two first equal issues were responsiveness and cultural context. Cultural context included that which we all participate in tangata whaiora and practitioner. Four Māori identified this theme also. This was acknowledged particularly with the occupational therapy practitioners themselves focusing on both cultural safety and cultural competence.

“Our culture encompasses our beliefs and values. What we believe is good health vs. 'bad' health influences how who and why we practice” (Participant 13).

Culture was described as ethnicity, religion, not just individualistic, and it included values and beliefs.

Five respondents identified Māori as significant reason to include cultural contexts in occupational therapy. The ‘Treaty of Waitangi’ was reported by two participants as crucial as to why culture is important, identifying the bi-cultural nature of Aotearoa and therefore the need to account for that in services to Māori:

“We are working within ... [a] bi-cultural commitment (T[reaty] O[f] W[aitangi]). To practise effectively ... requires facilitation of cultural competency and commitment, and principles of justice and equity” (Participant 6).

Similarities in responses were seen in this question between Māori and Pākehā occupational therapists with equal importance being given to the components of culture as to the client centeredness nature of culture.

Analysis:

The fact that the questionnaire group was a self-selecting one arising out of a workshop on culture means it would be expected that only those who were interested in culture, and especially in Māori culture, would have filled in this questionnaire. A more reflective view of the profession may be gained in a larger study which is outside the scope of this research.

The significance for occupational therapy practice identified here was the place culture has when working with tangata whaiora. The equally relevant factor was the cultural contexts all occupational therapists also have. This is a significant finding and a protection for Māori accessing occupational therapy services. This data did not measure how cultural perspectives were understood or applied by the occupational therapy participants. Only five respondents indicated the obligation to Māori including the Treaty of Waitangi in their responses indicating a lesser importance of this for the respondents in cultural considerations. Whether the understanding of the uniqueness of the cultural relationship here in Aotearoa was understood is unclear and has not been identified in this research.

Three who identified themselves as Māori did not complete the question of why culture was important in the profession. It is unclear why this occurred. Māori can hold cultural knowledge as sacred and therefore keep information on knowledge to themselves. There is no indication whether this is the case here or not. This has meant the Pākehā perspective of why culture is important is stronger in these particular responses than the Māori perspective.

The therapist's own cultural basis was acknowledged and awareness of the impact that could have on responsiveness to tangata whaiora. There was evidence of implementation of the principles of 'cultural safety' (Ramsden, 1991) in responses above, though no reference to that especially. The need to be culturally competent was clearly stated alongside 'cultural safety'. This took the understanding of bias through to a practical level with perception of the tangata whaiora view being paramount and requiring the practitioner to have cultural competence skills to be responsive.

Participants were not asked the definition of culture so is only inferred in the responses. Culture was not just identified as ethnicity alone and had broad interpretation. Values and beliefs were acknowledged with other not so common identifiers of collective and individualistic perspectives, and another view was that culture can be dominated by western views.

What Do You Think Are Core Health Perspectives for Occupational Therapy?

Participants in the questionnaire were asked what core health perspectives occupational therapists perceived the profession to have.

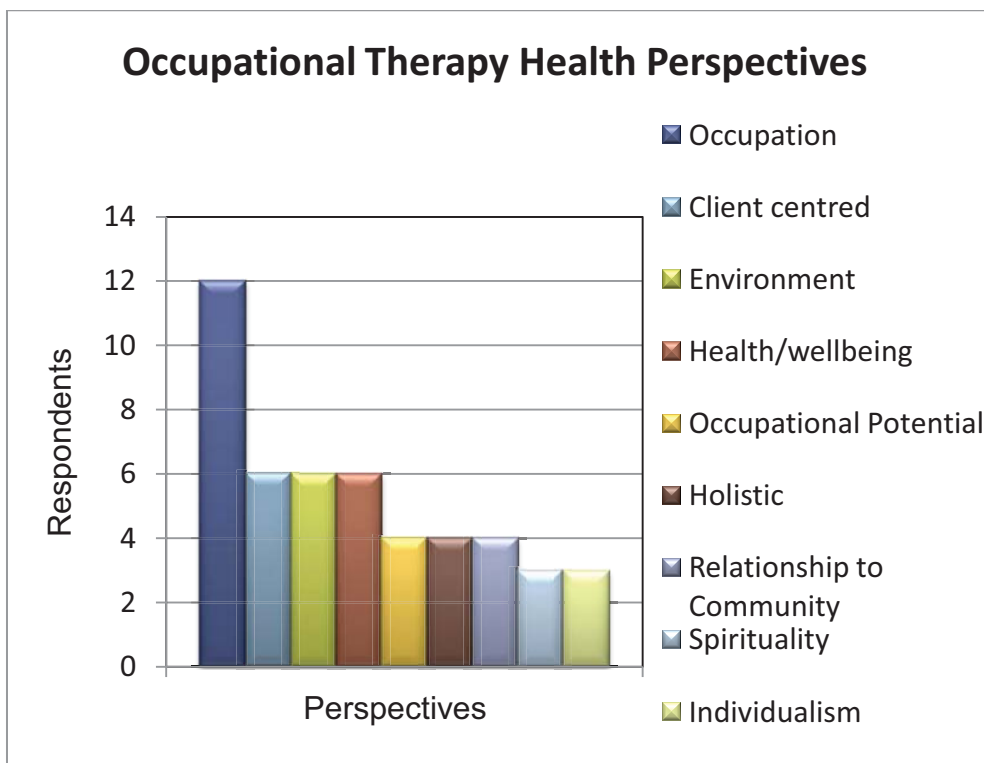


Figure 11 Occupational Therapy Health Perspectives Questionnaire n=18

The responses (Figure 11) were grouped into the most common response, falling into nine themes:

- Occupation as performance or doing was the most identified perspective (12 of the 18 respondents), which included occupation as:

an activity, meaningful, distracting from illness/disability, being occupied, acting as a determinant of health, enhancing or detracting from wellness, supporting function and performance. Occupation as an action was identified nine times, doing was identified five times, enabling four times, meaningful three times and activity and function only mentioned once each.

“occ[upational] therapy is about function [and] occupational performance - Defining health by this perspective allows us to consider what occ[upational] performance issues are important for our clients [and] support them to meet their needs. Sometimes this is clear cut [and] sometimes it isn't. Often it is determined by a medical approach. The medical approach [is] so prevalent in O[ccupational] T[herapy] services” (Participant 15).

- Client-centred³ and driven practice was identified by six participants.
“acceptance of others as they are - respect for difference” (Participant 5).
- Environment was identified six times with some descriptions of the context a tangata whaiora was situated in: ‘where you are’ (Participant 3), the people and physical environment, the place the tangata whaiora was ‘looking at the context the person is living/working/playing within’ (Participant 8) and is a tool for the profession to develop ‘environmental accommodations’ (Participant 17) for the tangata whaiora or ‘change environments’ (further description of this was not given. Participant 13). One participant saw environment as not just a tool but related that it can be a contributor to disability:
“That disability is created by our environment (physical, social, cultural and institutional)” (Participant 7).

³ This thesis uses tangata whai ora to describe clients but in this context ‘client centred’ is a term used in the occupational therapy profession and is a key perspective so ‘client’ is kept in this format when described.

- Health was identified six times by four participants with wellness and well being additional to those by a further two participants.

“What you do and where you are and where you are from [is] intrinsically linked to health” (Participant 3).

- Occupation potential for tangata whaiora was a concept reported by four respondents. This explored concepts like: what is possible, reaching full potential, where occupational justice prevails, where enablement occurs, and respect for difference is acknowledged.

“Enable people to reach their occupational potential” (Participant 1).

- Holistic service provision was also identified six times, mainly with no explanation of what that meant, except one participant added ‘being open to new ideas’ (Participant 16). One expressed this in response to what they thought core occupational therapy health perspectives were:

“holistic approach and looking at the context the person is living/working /playing within and how this influences meaningful occupations for each person considering physical, emotional, spiritual, psycho aspects of each person I work with” (Participant 8).

Another theme that came through four times was the relationship with the community This was seen expressed in community contexts, community integration, the inclusion of this in occupational therapy service provision with whānau and family, linked to client and community centred and “community participation/citizenship” (Participant 17).

- Another theme that came through four times was the relationship with the community This was seen expressed in community contexts, community integration, the inclusion of this in occupational therapy service provision with whānau and family, linked to client and community centred and supporting “community participation / citizenship” (Participant 17).
- The other concept identified three times was spirituality.

“Holistic view incorporating spirituality, family, etc” (Participant 2).

- Individual context was identified three times but only by two people.
“individualism, doing, -maybe sad but I think these are two driving concepts in o[ccupational t[h]erapy and is a barrier to], occupation enablement” (Participant 14).

Of those respondents who identified as Māori (n=7) the most common answer were client-centred perspectives. They did not identify occupation on its own as a perspective except three of the seven Māori participants who wrote ‘occupational performance’ (Participant 15), ‘occupational justice’ (Participant 18) and ‘doing occupation’ (Participant 13). The last response most aligns to the occupation described by the Pākehā participants. This may indicate that relationships are more significant to Māori than activities, occupation or doing.

The next common response from Māori occupational therapists was holistic health perspective. Of the five responses three of these were from Māori. This perspective would also align with Māori perspectives where holism is considered by Cunningham, Durie, Kingi (Durie, 2001; in Kingi, 2002) to be central to te ao Māori, a Māori world view.

Environment had two responses from Māori respondents.

Meaningful activity, client gains, health, and community centred were all mentioned by one therapist each only. Two participants answered with one or two word answers so only one perspective was identified by each of them compared to others who gave multiple responses. They included recovery and holistic application. One identified occupational therapy perspectives that did not align to their perspective:

“occ[upational] therapy is about function [and] occupational performance - Defining health by this perspective allows us to consider what occ[upational] performance issues [that] are important for our clients [and] support them to meet their needs. Sometimes this is clear cut [and] sometimes it isn't. Often it is determined by a medical

approach. The medical approach [is] so prevalent in O[ccupational] T[herapy] services - especially those in DHB's, [and] is not something I consider a core health perspective" (Participant 15).

One identified the use of occupation to strengthen the loss of identity tangata whaiora can present with, and a reconnection to identity through occupation is affirming:

"Holism ... → Holistic view → change environments,

lose identity →,

Spending time doing occupations" (Participant 13).

Perspectives described by Māori practitioners were identified from the data and extrapolated out to show the graph below.

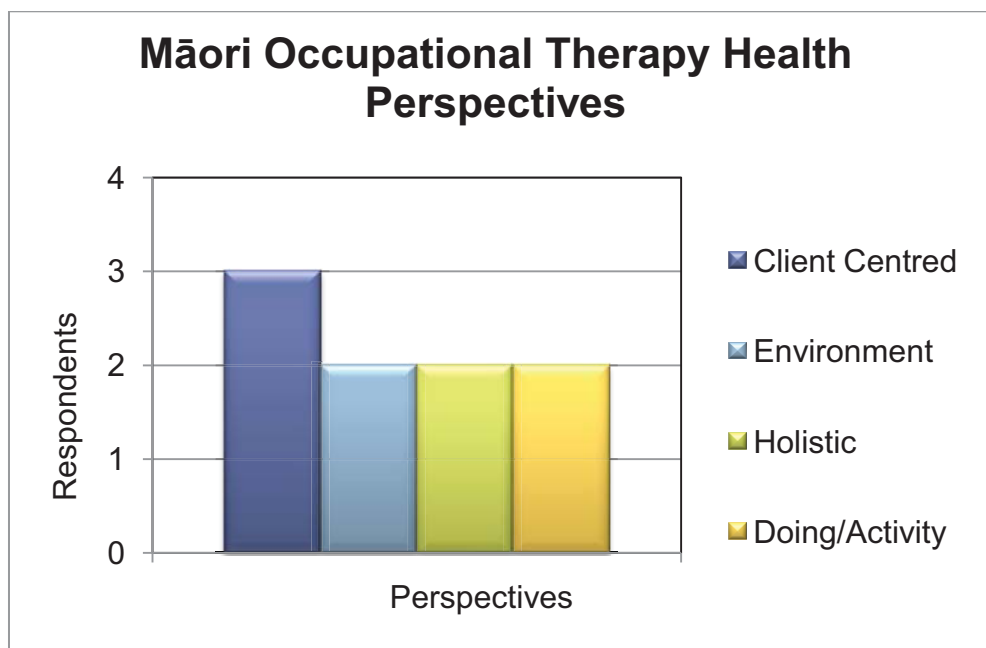


Figure 12 Māori occupational therapy n=7

Māori occupational therapists identified client-centred practice, with three of the four participants, noting this (Figure 12). The significance of the environment was identified by two, as was holistic care and the importance of

doing or meaningful activity. Listed below are examples of client-centred comments relating to, environment, holistic models and care and finally mention of doing or activity:

“Support/facilitation of client needs/gains etc. Environment both human [and] physical” (Participant 4).

“Holism

→Canadian Model” (Participant 13).

“Treat people as a whole [and] be open to new ideas. Letting clients guide intervention process” (Participant 16).

“being client and community centred - occupational justice - the importance of meaningful activity” (Participant 18).

Analysis:

There appears to be a significant difference of opinion of Pākehā and Māori practitioners as to what core occupational therapy health perspectives are. 12 of the 18 respondents identified occupation or forms of occupation as significant. Of those only two were Māori. Māori however identified client-centred as the most significant perspective with three of the four identifying this, though this may not be significantly different given the small number of respondents. Occupation as a word was identified 11 times, doing/do five times, activity and function once.

Holistic care is seen in some models of occupational therapy but not all. Here it is contextualised by two participants to include the spiritual nature of tangata whaiora. One states that this involves being open to the tangata whaiora perspectives.

The next most identified themes were all identified each six times - client-centred, environment, and health/wellness/holistic. These three themes would be supported in occupational therapy literature as significant to the profession though health/wellness is often an implied perspective assumed as

foundational to the profession's beliefs. Client-centred is commonly understood to be the provision of occupational therapy interventions at the 'client's' or tangata whaiora⁴ direction. This occurs when the therapist informs the tangata whaiora of the options available through occupational therapy and follows up on the chosen decision. The use of environment here in this context was important for six respondents, but two situated the tangata whaiora in an environment as a setting as opposed to the natural environment that Māori see themselves as being part of. Another two saw this as the adaptation or alteration of the environment to support participation.

Occupational potential and community were mentioned four times each. Occupational potential referred to the possibilities open to tangata whaiora for wellness, for use of the occupational therapy interventions to enable participation in meaningful activity. Enablement was used only twice but is a word used frequently in occupational therapy to describe what practitioners do.

Spirituality and individualism were identified twice so are not as significant as the above perspectives. Māori perspectives would include spirituality, so show the need for more alignment from the profession in order to be more responsive. Individualism would also be seen as contradictory to the collective nature of Māori, but given it was only identified twice may not be as significant a perspective as originally thought within the profession.

This question did not ask what perspectives were when working with Māori, though the Māori case study context was known, which may have altered the viewpoint given. However this question was targeted to understand the fundamental concepts of occupational therapy perspectives separate from a necessarily Māori approach and compare them with Māori health views.

⁴ Some terms in this thesis would normally require 's on but where this is a Māori word this has not been done in acknowledgement of the normal te reo practices and a desire to not anglicise Māori words.

Does Culture Play A Role In Your Practice?

All 18 respondents saw culture played a part in their practice.

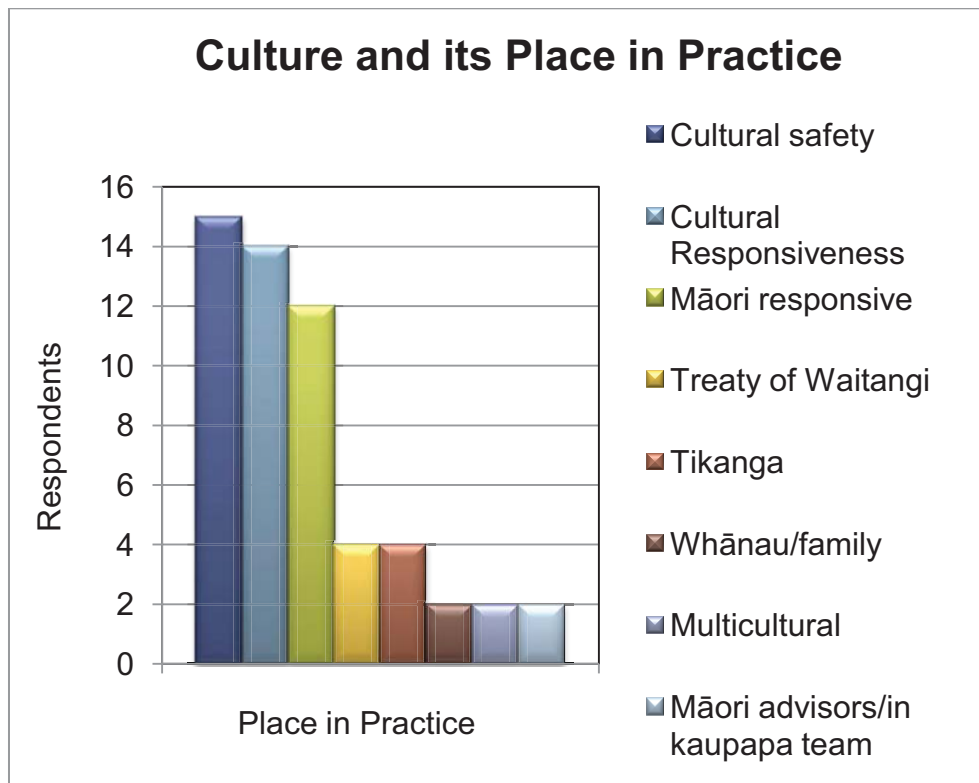


Figure 13 Culture and its place in practice n=18

Respondents to this question of how culture played a part in their practice identified eight themes of note:

- 15 expressed the need for practitioners to have a cultural awareness of their own:
“cultural perspectives are the lens through which I view my practice. I am aware that another perspective exists [and] look for differences to ensure I am not assuming things for clients. My own cultural perspectives help me feel confident in my personal commitment to my profession and to my responsibilities to people in my community” (Participant 15).

- 14 indicated the awareness of the client’s cultural perspectives required for effective practice:

“Asking people what’s important for them and how things need to be done” (Participant 9).

- 12 identified Māori perspectives as significant with seven of those respondents of Māori descent.

“I work in a Māori M[ental] H[ealth] Team and we have cultural practices that we ritually do. There are key cultural things we have to do when we are with clients as well → and need to have culture in mind when developing assessments and intervening” (Participant 12).

Another Māori participant indicated:

“Culture influences who we are as people and the meaning we give to our occupations” (Participant 10).

- Four wrote of the treaty having a role in their practice,

“Treaty workshops’ idea of decolonisation, occupational justice, respecting others. Culture is part of every interaction with every person” (Participant 3).

- Four indicated tikanga had a place in their practice such as this respondent who reported using cultural competencies such as:

“Concrete things [like] removing shoes, getting pronunciation as accurate as I can, be aware of [the] family using [the] 'front' door. Avoid [putting my] bag on [the] table, sit on chairs, 'sharing chat' incorporating in interview using family and family roles, [and] moving at their pace” (Participant 2).

- Two respondents identified whānau/family:

“incorporating in interview - using family” (Participant 2).

- A response from two identified multi cultural practice. One respondent reported multi cultural context in education of occupational therapy students:

“Within this context multiple cultures (NZ and international) need to understand different culture/beliefs values [and] norms [and] influence on learning/O[ccupational] T[herapy] education for individuals from varied cultural context. [I] need to be able to understand these differences and teach/facilitate in ways that can promote/ enable optimal students' learning and experience and retention of ethnic minority students” (Participant 6).

- Also noted by two was the use of Māori advisors or teams to support occupational therapy practice by:

“Work[ing] collaboratively with Kai Manaaki. Practice Tikanga M[ā]ori e.g. mihi in Meetings, waiata, karakia. [I am m]indful of my own culture [and] world view and its influence on my practice” (Participant 1).

One respondent who used Māori advisors was Pākehā and one who acknowledged the team was Māori.

Analysis:

There were three themes that had significant responses of 15, 14 and 12 respectively with the second tier of responses only having four and two responses. The smaller responses were still reported here due to their significance. The first with 15 of the 18 response identified the need for cultural safety or an understanding of their own cultural perspectives they bring to interactions with tangata whaiora. The next most identified was 78% (n=14) claiming client responsiveness was crucial to practice. The third common response at 67% (n=12) was Māori perspectives.

It is encouraging to see the profession having such an understanding of their own cultural perspectives if this group is representative of the profession.

Practitioners' own cultural perspectives were identified more than the need to be responsive to tangata whaiora in this response.

Māori respondents consisted of seven of the total. If Māori are removed from responding to 'Does culture play a role in your practice?' six of the 11 Pākehā respondents did not indicate Māori specifically as playing a role in their practice.

List Māori Health Perspectives You Think Are Significant For Use In Your Practice.

This next section of data was for Māori occupational therapists to complete. Of the seven Māori who completed the first page of the questionnaire six completed the second with one Pākehā also. For the purposes of this study the information from the Pākehā was removed from this data to ensure a clear picture is portrayed.

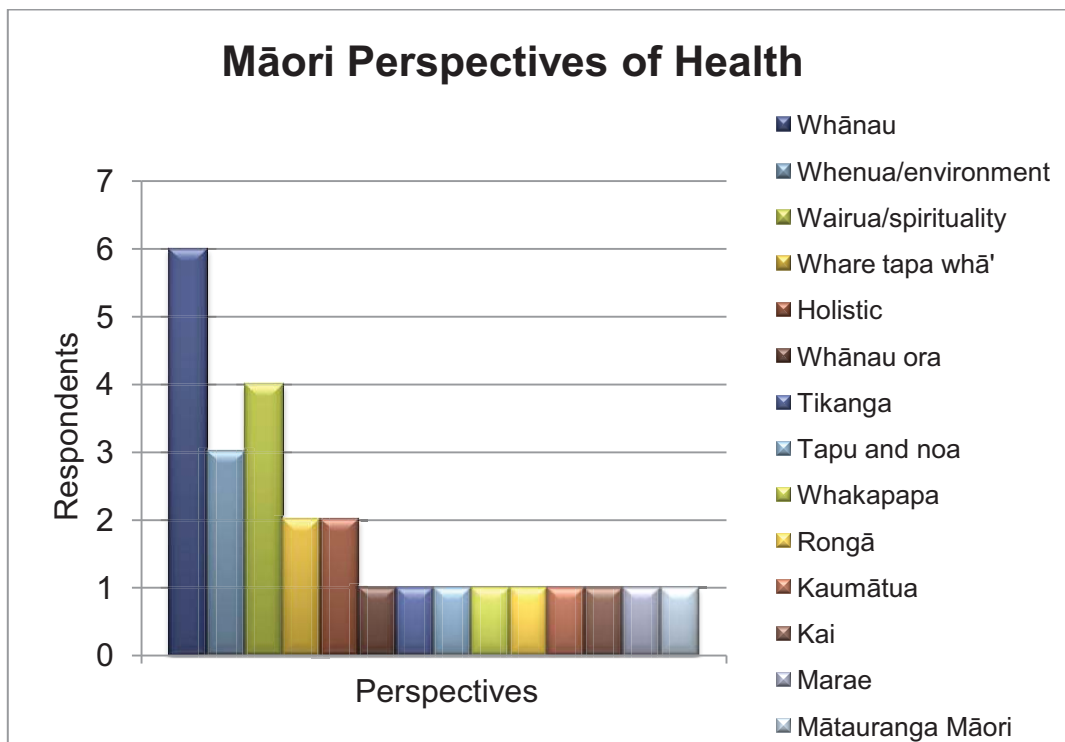


Figure 14 Māori perspectives of health identified n=6

Common Māori health perspectives identified by the six Māori occupational therapy respondents were (Figure 14):

- Whānau was the most identified with four respondents, six if you include the whānau aspect of 'Te Whare tapa whā'.
- Whenua, environment and haukāinga was identified by three respondents.
- Spirituality/wairua was identified by two respondents but with the concepts sitting in 'Te Whare Tapa Whā' it increases to four.
- 'Te Whare Tapa Whā' was identified twice with 'whānau ora' only being noted once.
- Holistic was identified by two.
- Mātauranga Māori concepts were identified: whakapapa, mātauranga Māori, rongoā, tapu and noa, tikanga, kaumātua, kai, and marae and "Hauora (total well being) as the essence of being occupied" (Participant 18) were all once each.

Occupation or similar words were only used by one Māori occupational therapist. The whānau collective nature of Māori was recognised in this data with the most responses. The next most common response was spirituality, followed by the environment or land relationship the third most responded to.

Analysis:

Māori health perspective identified whānau as the most common perspective expressing a significant Māori world view. The link to wairua/spirituality, whenua/taiao and environment, 'Te Whare Tapa Whā' and holistic care expresses the significant perspectives Māori occupational therapists have. The understanding of these terms was not elaborated on in the responses.

The identification of whenua/taiao signals the link to the land that Māori have where the name means land, placenta, and afterbirth. This link is taken seriously and the placenta of new babies is buried back on their home land to ensure their connection remains (Royal, 2005-2010).

Spirituality is a significant perspective as it would not routinely be used in practice except when using the very few models and tools found in the

profession that acknowledges this. Holistic care reflects the perception Māori have of all things working together and interrelated.

What Barriers Prevent Integrating the Māori And Occupational Therapy Perspectives into your Practice and Why?

All but one responded to the question above. The one that did not answer felt they were encouraged to incorporate Māori perspectives in their role so did not identify barriers.

“From a non-Practice perspective as an educator I find Māori perspectives are encouraged within my teaching” (Participant 18).

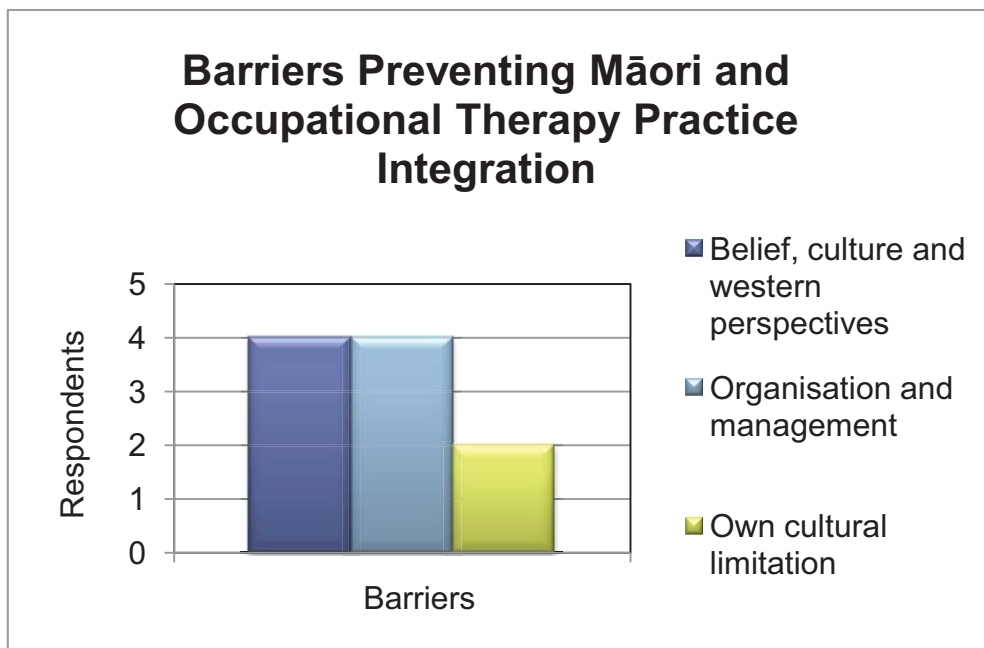


Figure 15 Barriers preventing Māori and occupational therapy practice integration n=6

Of those who identified barriers (Figure 15) the two most common responses were the beliefs, culture and western perspectives of occupational therapists and the organisation/managers or other practitioners which were identified by four respondents illustrated by:

“In my department - other people’s ignorance and the notion that knowing about the Tiriti o Waitangi means knowing about cultural safety/or issues, therefore [they seem to think they] don’t have to consider other things/do things differently” (Participant 15).

Four respondents identified organisations, management and processes that Māori occupational therapists work in as not supportive of Māori practice such as:

“Organisation expectations, management, policy” (Participant 11).

Two people identified their own limitations as a barrier; one was their lack of te reo and confidence in their cultural practice:

“Not speaking Te Reo Māori, I don’t approach interventions using tikanga. My own fears [of] not wanting to impose [is a barrier]” (Participant 15).

One identified the limits of time found in practice contexts which is also a management/organisational issue:

“High case loads - reduced time” (Participant 13).

Analysis:

The barriers to dual practice identified here were very driven by perceptions of peers as well as managers, and organisations plus services. There were basically two major themes here and one minor one of Māori occupational therapy practitioners own competence. The importance of the employment setting and the support found there could be a test for retention of occupational therapists who wish to apply dual practice. The competence of practitioners Māori and Pākehā was also evident through this research as a challenge to the provision of effective services to Māori.

Do You Have Access To Māori Culture Yourself? And If Yes How?

This question was loosely based on Durie’s (2001) model of Māori identity. It assumes self-identification in this research, which describes access to cultural resources, access to Māori physical resources and access to Māori social

resources (Durie, 2001, p. 55). Strong identity is seen when all connections of identifying strongly as Māori, whenua and whānau come together.

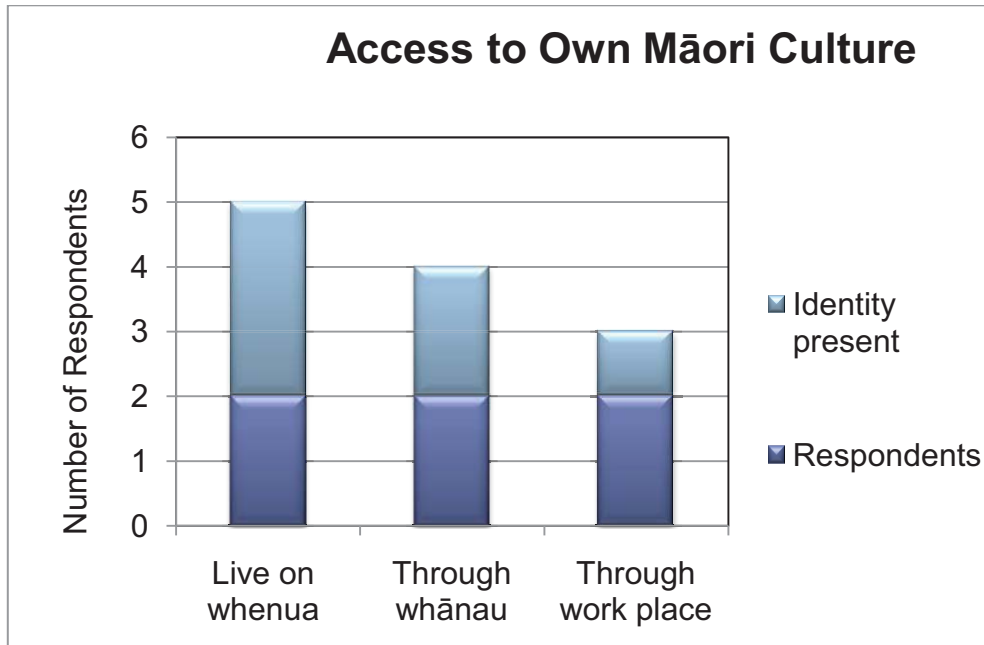


Figure 16 Access to own Māori culture n=6

When asked if the respondents have access to Māori culture themselves they all responded 'yes' with a variety of connections.

Māori occupational therapists have a range of access to culture with two respondents in each of the three categories of living on whenua, through whānau and through their work place (Figure 16).

An indication of how closely they were linked to their culture is showed by having three points of contact. Participants identifying as Māori was the first point, with this plus whānau adding two points of contact and thirdly where identity, whānau and whenua (in this case living on their own tribal land) were all reported. These three indicators of secure cultural Māori identity come from a model developed by Durie (2003).

Two lived on their own papa kāinga and reported being involved closely with whānau and hapū with one respondent reporting being:

“Closely associated with [my] marae. [I] live in [my] M[ā]ori community on papa kainga. [I am] associated with a number of whānau, hapū organisation” (Participant 10) and

“daily I have communication with my tipuna. I am involved with the iwi [and] hapū trust [and] societies for my iwi/hapū. Culture is a living entity made up of all the experiences from home. Contact with my whānau, discussions on iwi politics, hui, waiata are all a part of my life and keep me close to my Māori cultural roots” (Participant 15).

Two reported access through whānau with one mentioning the kohunga reo

“through my whānau. Through my son's kōhanga reo” (Participant 13).

A further two reported access through their work places and who they worked with:

“Yes via strong O[ccupational] T[h]erapy service] ... structures and via the [services] mechanisms of understandings with local rūnanga” (Participant 18).

One wrote of their visit to their whenua reporting that they:

“Visit homeland 2-3 times a year” (Participant 12).

Analysis:

The indication from this research is that two of the six participants regarded themselves closely linked to their whenua. Many of the practices used from a Māori world view have arisen because of the close relationship between Māori and the environment especially the whenua (Kingi, 2002). If links to whenua are compromised then the Māori practices of those restricted from access could also be compromised. The participants were not asked how happy they were with those links and if they would like to be more connected to whenua and whānau.

There appeared three links in this research with those who firstly identified themselves as Māori and followed some tikanga, with some association

through work, several through whānau and two attached to whenua. Those who had connections with all three were more likely to have a stronger identity than those who had less. This was not measured more specifically however.

What are the Three Most Significant Things That Could Support You in Your Development as a Māori Occupational Therapy Practitioner?

What attributes can support development of Māori occupational therapists was confirmed by five of the six respondents with two equal responses.

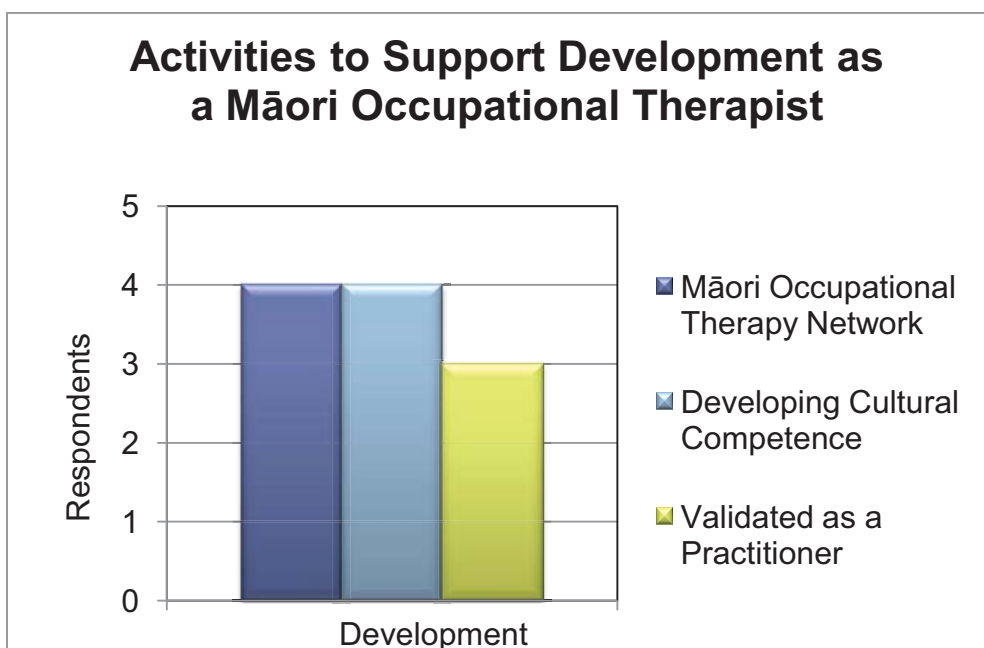


Figure 17 Activities to Support Development as a Māori Occupational Therapists n=6

The first factor identified by the respondents was having access to other Māori occupational therapists as evidenced by:

“- being able to hui regularly with other Māori OTs to develop pathways for ourselves and future O[ccupational] T[herapist]s

- retreat/wananga⁵
- support sounding board for ideas e.g. establishing a writing group” (Participant 13).

The opportunity to develop cultural capacity in a variety of ways was the other equally identified response with four of the six respondents reporting this.

“Developing myself as a Māori (my journey)” (Participant 12).

The other significant theme was the validation of Māori occupational therapists as practitioners with added skills:

“To be seen that being a Māori male O[ccupational] T[herapist] is not the same as any other O[ccupational] T[herapist] and that Māori O[ccupational] T[herapist]’s have [an] important role” (Participant 16).

Learning, like Te Reo or engaging in post graduate study, was also seen by two practitioners as useful to their development.

Analysis:

The need to have regular communication with other Māori occupational therapists came out strongly from this question. Networking, hui, spending time together, wānanga, retreat, writing groups, listening to others and sharing practice were some of the identified issues. There was also the theme of developing competence as a Māori practitioner through sharing practice, developing pathways, and therefore also enabling self determination. This topic and the workforce development needs were explored far more effectively in *Te Umanga Whakaora an accelerated Māori occupational therapy workforce strategy* (Te Rau Matatini, 2009).

⁵ Where Māori words are quoted from the data and macrons are not included they have been not corrected in this research to support ease of reading.

What Are The Most Significant Workforce Development Needs for Māori Occupational Therapists?

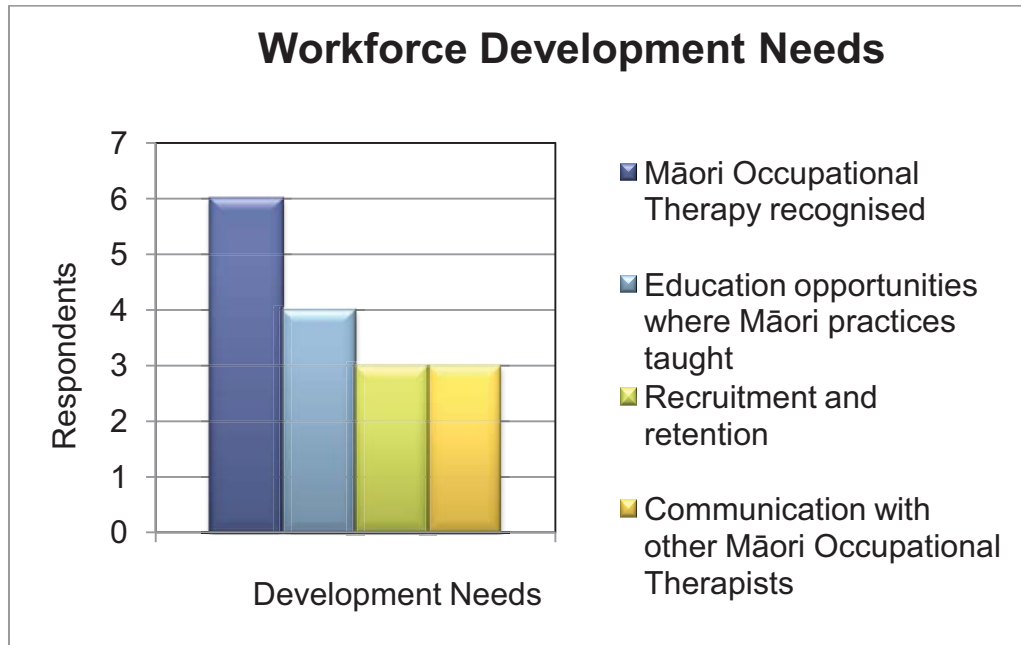


Figure 18 Workforce Development Needs n=6

When requested to give an opinion on workforce development needs for their practice, Māori occupational therapists all identified the importance of acknowledgement as a significant group in the profession (Figure 18), as described:

“To be well supported [and] recognised for their skills. I believe we have a special skill set. This tends to allow us to build relationships well with not just Māori.... More encouragement for Māori to be active in universities” (Participant 16).

Education opportunities to develop cultural competence as undergraduate and as post graduate students for application to practice were identified four times as shown:

“Schools being able to teach Māori students appropriately” (Participant 12).

Recruitment and retention was identified three times:

“Getting Māori into the courses. Making the courses culturally safe for Māori” (Participant 13).

Equally reported was the sharing of practice with other Māori practitioners and students, with mentoring identified as one support for that

“communication between Māori O[ccupational] T[herapists]” (Participant 18).

One question proposed by a participant was:

“Lack of clarity re how Occ[upational] Therapy fits with a Māori cultural world view - Development of education papers to address these issues. Occupational therapy is a tool – how do we apply it within a cultural setting? Is it a useful tool to Māori?” (Participant 15).

This poses some research questions for further study of this matter.

Analysis:

Māori practitioners within the profession need to identify as a group: every answer validated this. Participants’ responses included: occupational therapy as a tool, how do we apply it to Māori; we need a stronger collective voice; we need ‘representation within institutions’ (Participant 11).

The next identified theme was having access to educational opportunities, all wanting Māori practice delivered at an undergraduate and post graduate level. This is a significant finding in this research obviously emphasising a current need not fulfilled within the profession.

The final two themes were equal with two participants each identifying recruitment with retention and mentoring.

Summary

This section summarises the qualitative data of the questionnaire participants. There were two sections here where all respondents filled out three questions which were followed by a Māori only section of four further questions.

All 18 participants thought culture was an extremely important part of occupational therapy provision of service. In response to why they thought this, the two most common responses were because of the cultural context all are situated in and to be responsive to tangata whaiora needs.

Core health perspectives were identified for occupational therapy led by 'occupation' with 12 responses, then client-centred, environment, health and wellbeing all equally next. This same question was also analysed to see what responses Māori occupational therapists responded to and if that was different to their Pākehā colleagues. They identified client-centred as the most significant followed by environment, holistic and activity all equally second.

Culture had a place in all participants practice through cultural safety which was identified the most by 15 respondents, cultural responsiveness by 14, and Māori responsiveness by 12.

The following data only included Māori responses. Māori health perspectives were identified first with whānau the highest with all six respondents identifying this. Wairua/spirituality was the next most identified perspective with four and whenua/taiao/environment next with three. 'Whare tapa wha' was identified twice as was holistic views.

The barriers to integration of Māori perspectives into practice were seen to be the belief, culture and western perspectives in the profession and organisational and management barriers to cultural practice.

A significant indicator of identity and possible cultural competence can be the access Māori have to their own culture. Two participants reported living on their whenua; two reported they had access through whānau to their culture; and two reported access through their work place. These same respondents

were asked to identify their strength of identity, contact with whenua, and whānau thus showing a triangulation of Māori cultural identity. Of the six respondents three reported all three links of identity, land and family relationships indicating strength in their Māori identity. Two indicated meeting two of the criteria, those of identity and family and one indicated only meeting one, that of identity.

When asked what could support Māori practitioners four indicated development of a Māori occupational therapy network and cultural competence and three indicated being validated as a practitioner.

Workforce development needs highlighted by respondents were overwhelmingly that Māori occupational therapists be recognised with all reporting this. Education opportunities to learn Māori tikanga came next along with recruitment and retention and communication with other Māori occupational therapists.

Qualitative Data Interviewees

This next section of the data reports on the responses from the five interviewees two of whom were Māori hauora specialists and one of whom was an occupational therapy specialist but not Māori and two who were Māori occupational therapists.

The sections are introduced with the questions posed which are listed as the heading, followed by a graph with the key findings of each question. The section concludes with an analysis.

From Your Perspective what are Key Māori Aspirations? Why?

Though the question asks what Māori aspirations, are all interviewees responded to this from a health perspective.

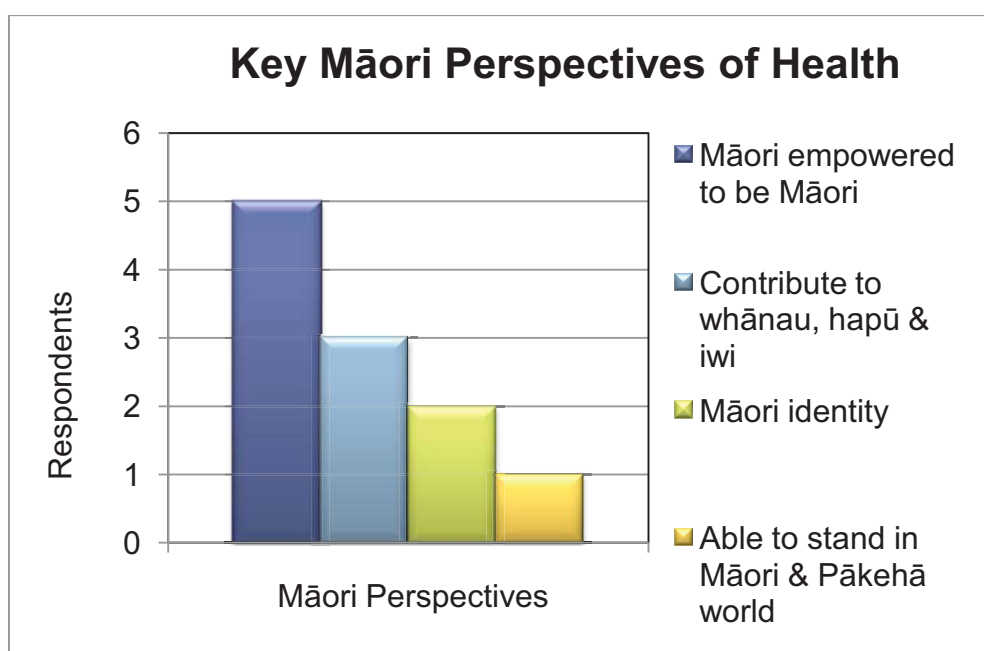


Figure 19 Key Māori perspectives of health n=5

The common view held by all five interviewees (Figure 19) was that Māori aspire to be “Māori [and] able to live in Aotearoa as Māori’ (Interviewee C). This included having the same health standards as every other New Zealander. One person acknowledged the international place Māori aspire to

'to be able to be full citizens of the world' (Interviewee A) being no more bounded or restricted than anyone else. A further comment was "having the opportunity to express being Māori" (Interviewee B).

Three interviewees spoke of aspirations of belonging, contributing and participating to whānau, hapū and iwi or a community of significance.

"Whānau knowledge [is] crucial to supporting the healing of whānau. Health is Māori development which is whānau development" (Interviewee D).

"Māori want to be productive, participate and contribute to whānau, hapū and iwi" (Interviewee E).

Two spoke about Māori identity and concluded that having their own beliefs, strengths, weaknesses, opportunities, and realising selected potential were important and had unique characteristics. As stated by one interviewee

"being Māori and accepted and appreciated as Māori [with my] own beliefs and characteristics that make [me] unique" (Interviewee E).

One wanted to:

"aspire to stand up in two worlds ... stand in Māori world and beside others, stand up in two worlds" (Interviewee E).

The need for whānau to be able to access wairua and tikanga to support their aspirations for being Māori was also expressed.

The role of supporting Māori development and having the resources to do this in education, employment, social status, with the choice of accessing the occupation of choice for all Māori, was also identified.

A Pākehā who was interviewed stated that this was not their place to determine what Māori aspirations are, but they reported needing to have some understanding of what Māori health aspirations may be in order to be responsive to Māori.

Analysis:

The overwhelming result was the valuing of Māori. This was expressed differently by each participant but was the common theme that all identified. Most included all Māori but one identified the valuing of Māori occupational therapists in particular.

The second most identified theme was contribution to whānau, hapū and iwi. This appeared to be a major motivator for the interviewees and reinforces the role held by Māori, collective and interdependent nature of Māori.

Māori identity supporting Māori aspirations was only supported by two of the five participants as significant.

The importance of Pākehā understanding Māori health aspirations was emphasised by the Pākehā participant in order to be responsive to Māori tangata whaiora.

What are some of the Challenges Involved in Merging Māori and Western Health Perspectives?

The literature review completed in this thesis indicated a dual process of practice and so the interviewees were asked if they saw cultural and clinical practice merging.

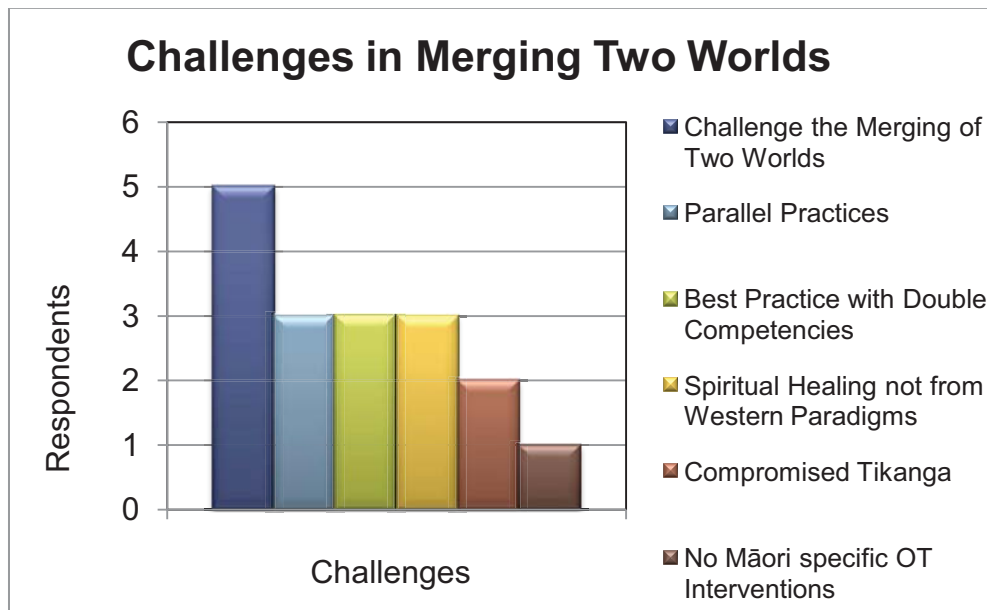


Figure 20 Challenges in merging two worlds n=5

All interviewees questioned the merging of two diverging world views (Māori and western) in order to provide integrated practice (Figure 20). This was stated by one participant as a:

“philosophical challenge to merge Māori concepts into western health models. It is putting less into bigger. Both [are] hybrid. [Practitioners] must use both i.e. best O[ccupational T[herapy] practice need[s] to be used but empathetically ... things Māori are completely ordinary so merging seems strange. When accessing O[ccupational T[herapy] services Māori shouldn't feel strangeness” (Interviewee C).

There was reinforcement from three participants for the parallel provision of care with the best of occupational therapy practice and the relevant cultural

tikanga being used in a complementary fashion. The use of both is reliant on empathetic practitioners who have the skills to navigate between both worlds with those of Māori descent accessing occupational therapy services. There is a need not only for Māori occupational therapists to do this but also Pākehā. One participant positioned this as:

“This involves negotiation, as not all O[ccupational] T[herapy] or tangata whaiora are able to understand the other’s world view. Occupational therapy works across [a] wide sector from broken arms to depression with wide causes to all. Therefore the knowledge base of each continuum O[ccupational] T[herapy] practice and cultural practice is required. Both need to access right service and require

- what is the evidence for use;
- resources and who provides;
- attitudinal response“ (Interviewee A).

The next most identified challenge with three respondents was the use of best practice from occupational therapy and cultural practices. For many Māori, tikanga is part of everyday life and so locating this in practice seems strange but ‘when accessing occupational therapy services Māori shouldn’t feel strangeness’. Māori interventions are hard to qualify within a western paradigm despite this appearing to be preferred by health professions. One interviewee spoke extensively about the entrance into services with:

“no one size fits all. Getting the balance, depending on whānau and their cultural identity and might alter what [the practitioner might] bring into the room [like] talking, working how to meet whānau – mihi, dialogue about why [they are] in the service, [and or] flexible as to what needs are (Interviewee E).

They noted that providing comfortable environments was essential to support effective interventions. When considering appropriate care the perspectives

of whānau should be explored, the environment and community they come from as well as the holistic perspective a diagnosis may sit within.

Māori spiritual issues are not usually healed by Western based therapy, + as reported by three interviewees. The desire to see more recovery through the use of the 'healing of the spirit' was expressed. An example of this was described:

“Western cognitive interventions do not necessarily heal Māori spiritual issues. [Therefore there is a] need to see more recovery through the use of healing the spirit. Link [the tangata whaiora] back to land, to beach – where Māori go to restore, to heal [it] can be back to land [or] beach” (Interviewee B).

Two of the practitioners interviewed reported that there always seems to be a compromise of kawa and tikanga when a service is provided within a 'western' based health service such as a DHB. Māori within these services have to negotiate even harder with the systems and practices in order to provide effective services to tangata whaiora accessing occupational therapy services. The pressure of providing occupational therapy and cultural interventions was reported as not always being understood by management, or other Pākehā practitioners. A participant reported that Māori practitioners:

“Don't operate as well as other practitioners because [they are] dual competent e.g. another clinician said 'if a client wants cultural go to [Māori mental health service named], if [they] want clinical go to the mainstream' (Interviewee E).

The pressure of providing interventions based on occupational therapy competencies is heightened when cultural competencies are added to practice. Compounding effective interventions is the often complex nature of Māori presentation to services as expressed by two participants.

Further challenges are faced by Māori occupational therapists because of the lack of Māori specific professional evidence. One participant talked about occupational therapy interventions requiring development to support the

effectiveness of occupational therapy for Māori tangata whaiora. This is compounded when practitioners ask the question “what is it to actually be a Māori occupational therapist?” (Interviewee E).

What Does Occupation/Doing Mean for You?

Reported below in Figure 21, are common terms for ‘occupation.’ The most frequent explanation was the use of ‘do or doing’ with four respondents commenting: “all things we do” (Interviewee A), occupation by three, like “to occupy us” (Interviewee A), and activity “O[ccupational] T[herapy] rehabilitate and restore ability to carry out occupation or activity” (Interviewee C), productivity and participation once each “productive achieving participation” (Interviewee E). Whānau was used “whānau important” (Interviewee C) twice with relationship being identified by one as similar to this theme. ‘Client driven’⁶ and empowering was used twice, “client driven goals [are a] priority” (Interviewee C). Also on four responses occupational potential was described as: “O[ccupational] T[herapy] means being able to realise full potential” and “occupation [is the] essence, is being, to promote health, to be stimulated. ‘Occupation of being human’” (Interviewee A).

⁶ This is another occupational therapy term again not being transposed by tangata whai ora.

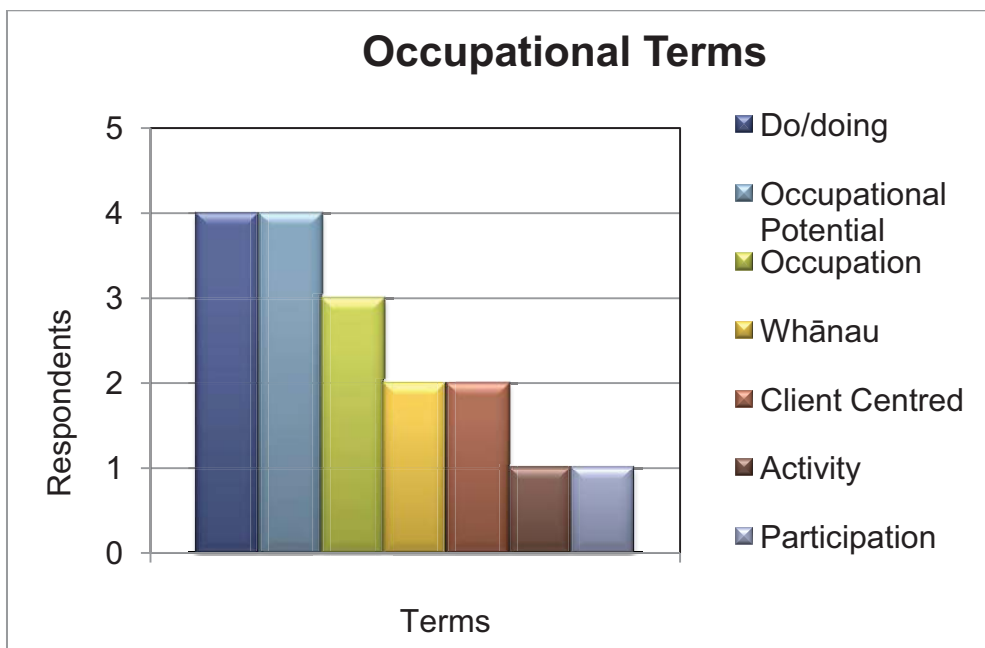


Figure 21 Occupational terms n=5

Part of the data also showed some of the respondents' meanings for the terms as seen in Figure 22.

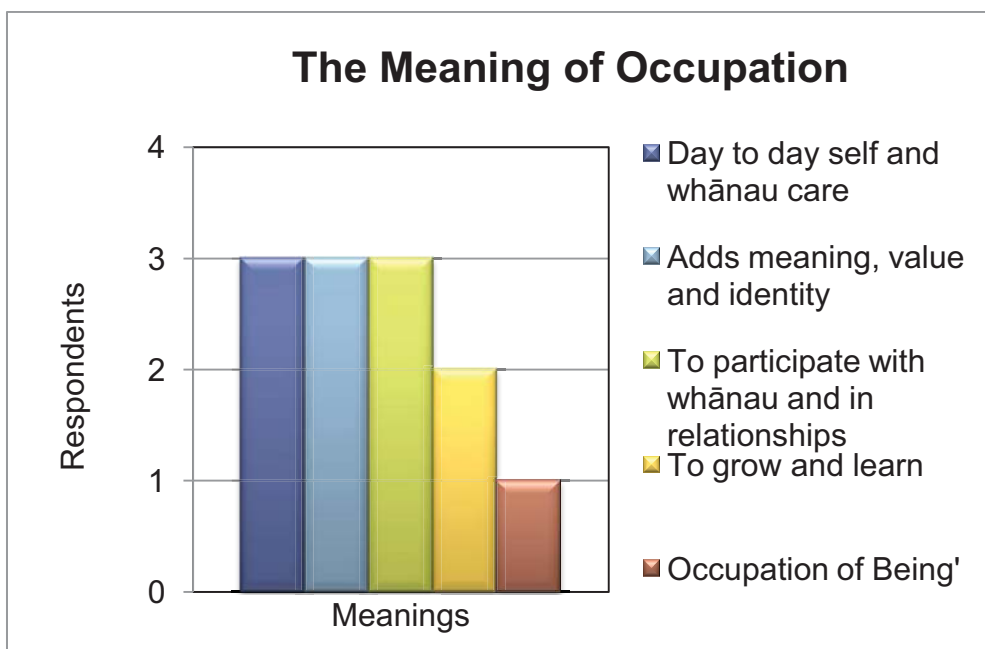


Figure 22 The meaning of Occupation n=5

Three respondents believe the place occupation has primarily is the ongoing day to day activities all engage in, to sustain self such as: “it is the work [of] doing things day to day for self and others, whānau” (Interviewee D). One respondent described occupation as a basic requirement:

“we are all humans [and] have been created requiring brain stimulation, [to] eat, sleep, reproduce so at that level [we are] all same but we also need to be amused, entertained, comfortable [in] all things we do to occupy us ... because they add meaning and interest and stimulate relationships, quality, and care” (Interviewee A).

Three commented on the need to have meaning valued with one going on to talk of beliefs, identity and dreams as significant as described:

“what I do in a day is a moving thing influenced by goals and values and dreams I have and part of my make-up. Identity, values, beliefs and dreams [are] all who I am” (Interviewee B).

Whānau and relationships were also identified by three of those interviewed as significant to occupation or doing but should not be assumed however for example, in a: “Māori setting whānau [is] important to most Māori but also not so important to a sector [of the Māori population]” (Interviewee C).

Two people identified the growing and learning part of self.

One participant identified the “occupation of being human” (Interviewee A).

Is There Anything Not Explained by Occupation/Doing or Activity in Your World View?

One respondent thought there wasn't anything unexplained by occupation, doing or activity in their perspective. Spirituality was identified three times by respondents, pre- contemplative thought three times and being twice. There are components that may or may not all have activity associated with them.

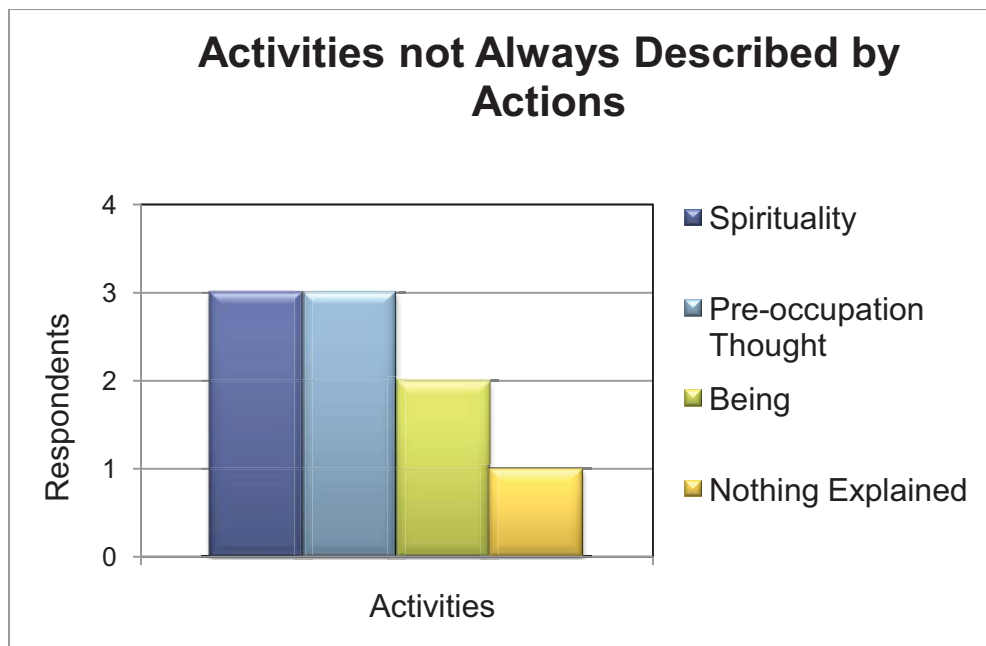


Figure 23 Activities not always described by actions n=5

Descriptions were given to a variety of spiritual concepts (Figure 23). One identified a Māori world view that used “karakia” (Interviewee D) and comments such as the:

“Spirit [is] unique a life force I can't describe [it] but [it] drives all in the way we 'do'. It is the fire within – what you [show of it] will depend on what you do with it and feed it. Journey, spirit, activity, [and] meanings [are] all combined (Interviewee A).

The use of, and acknowledgement of, spirituality in self and as a modality of care was agreed as an:

“inner guide sets [the] standard [providing a] feeling [of] opportunity and getting [the] best for others. Spirituality [is] working with and being open to it [so] the provision of care [is] where spirituality [is] addressed [and] not ignored” (Interviewee D).

The other equally identified concept was pre-contemplative thought where activities such as “problem solving” (Interviewee A), “internal thoughts are pre-occupation state [and] processing takes place connecting to what is around” (Interviewee B).

Then a very occupational therapy term of ‘being’ was identified by two respondents, described as: “‘being’ innate does relate to ‘doing’. ‘Doing’ follows the concept of ‘being’” (Interviewee E) or “reflecting and connecting to nature may not have actions [and is] like ‘being’ in the moment” (Interviewee B).

Did Māori Have an Understanding of Occupation/Doing In Pre-Colonial Times? If So How?

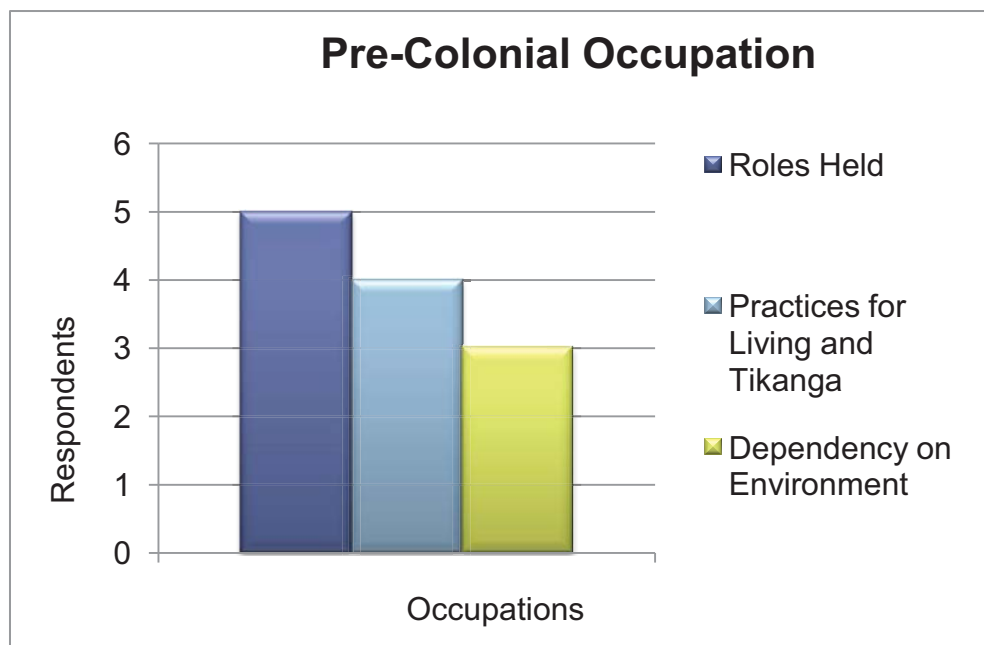


Figure 24 Pre-Colonial Occupation n=5

All five respondents identified, in the pre-colonial collective community, the place roles had rather than activities:

“there were roles of mother, father and grandparents contributing to the greater good and [they] learnt what [was] good at pre-colonisation periods. [A] child learnt ... [of] leadership roles, kai garden[s], health, [and] spiritual well being ... pre-colonial times all c[a]me across [in] waka consisting of similar hapū, wise men, knowledge communicators with all having a role” (Interviewee D) and

“Whole set of things people did [pre-colonial with roles] unevenly distributed and certain people had different skills, tasks, training, therapy, to function [and] to do. Occupation and doing [was] part and parcel of life of what [they] did traditionally. [The] world [was] joined up by working, seasons, [with the] frame work different to today for doing and roles” (Interviewee C).

One respondent stated that our perceptions of pre-colonial times require:

“Discussion on how [to] get these roles because [they were] biased by whoever has recorded information and culture and practices” (Interviewee C).

Practices and rules for living were guided by tikanga reported four respondents:

“pre [colonisation] models of Māori health [had a] holistic view of health. Health [was] joined by occupation and function and holistic perspective. [A] holistic view meant different things 100 yrs ago” (Interviewee C).

The next most identified theme with three respondents was the need to live close to the seasons and be in tune with the environment in order to sustain the community such as:

“lived close to the seasons – food, cycles, sustainable patterns, weather patterns e.g. tītī trading. Cycle of occupation with very rhythmic

- Day
- Year
- Decade

e.g. gather pounamu 3-4 years” (Interviewee A).

What Do You Think Are Core Health Perspectives For Occupational Therapy?

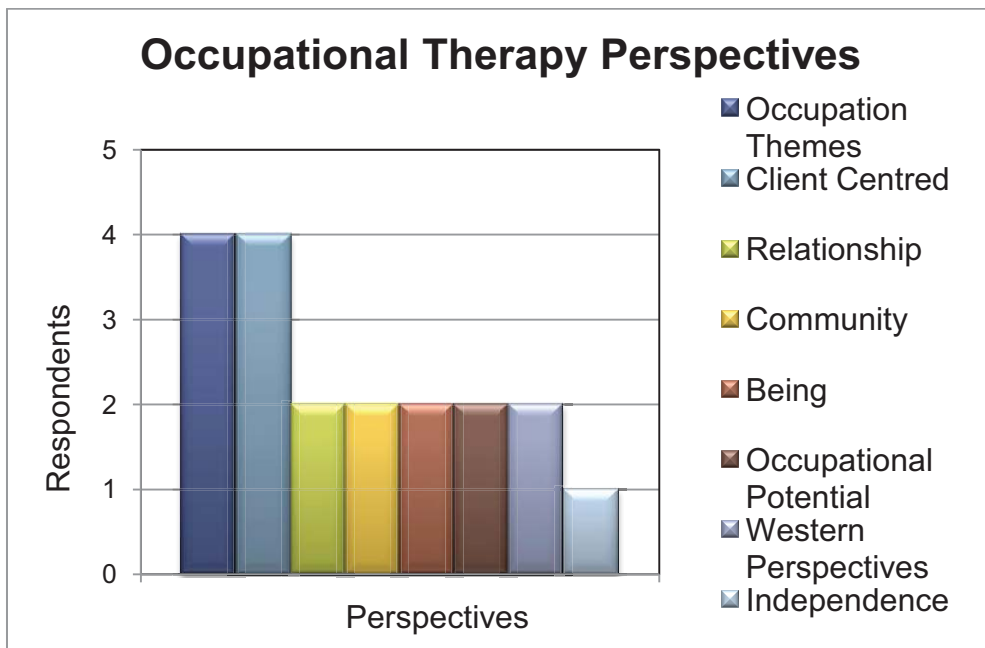


Figure 25 Occupational Therapy Perspectives n=5

Identified perspectives were reported as found in Figure 25. The term occupation encompassed several themes and these are demonstrated below in Figure 26 as a sub-set of occupation all included in the one term in ‘occupational themes’.

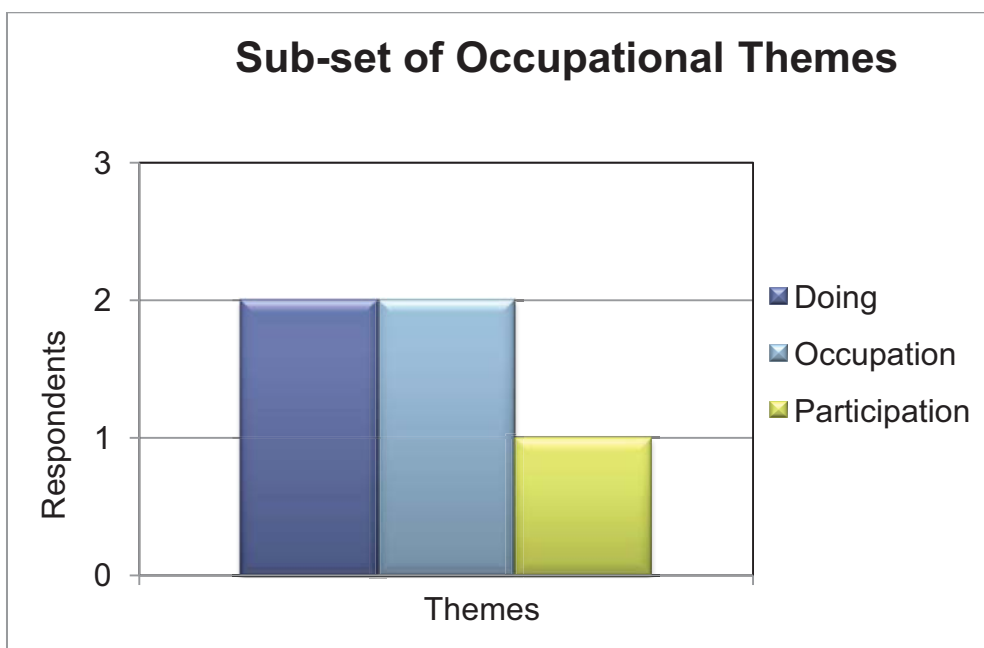


Figure 26 A Sub-set of occupational themes n=5

Four interviewees identified occupational themes consisting of two stating occupation, two doing and one participation, and one choosing doing and participation (Figure 26).

The similar response was also given for client-centred perspective: “Client-centred” (Interviewee B) and “able to do the things you want for yourself” (Interviewee E).

Two identified the place relationships have in occupational therapy perspectives, particularly around the therapeutic relationship between the tangata whaiora and the practitioner such as: “relationship sets [the] flow [to] enable participating” (Interviewee B).

Community was identified by two respondents as significant as expressed by one: it is “universal [as] all do [participate] in community” (Interviewee A).

‘Being’ was identified by two respondents with one stating: “opportunities to be” (Interviewee B).

A similar response from two participants was occupational potential where one stated: "enable participating which is about living [despite] how barriers affect lives" (Interviewee B) or occupational potential "leads achievement, thriving" (Interviewee E).

The last double response was western centred perspectives such as:

"Currently interventions remain very western not self determined like standardised assessments language barriers compared with Michael Iwama's metaphor for life on the kawa model the river. E.g. volition/choice crucial" (Interviewee B).

Environment was not referred to except in the context of loss of whenua by one participant: "from an occupational therapy perspective loss of land equates to loss of occupation e.g. titi" (Interviewee A).

Independence was mentioned as a historically significant occupational therapy perspective but only by one respondent. They stated: "independence historically [is a perspective, though] not a personal view [of mine]" (Interviewee B).

How Could Occupational Therapy (Treatment And Care) Be More Responsive to The Needs of Māori?

Two participants in the previous question, on the perspectives of occupational therapy, had started to discuss this question so the information from both participants was brought into this section of the data after discussion with them. One of the same participants had also responded to this question in the pre-colonial times answer which was also transferred here too.

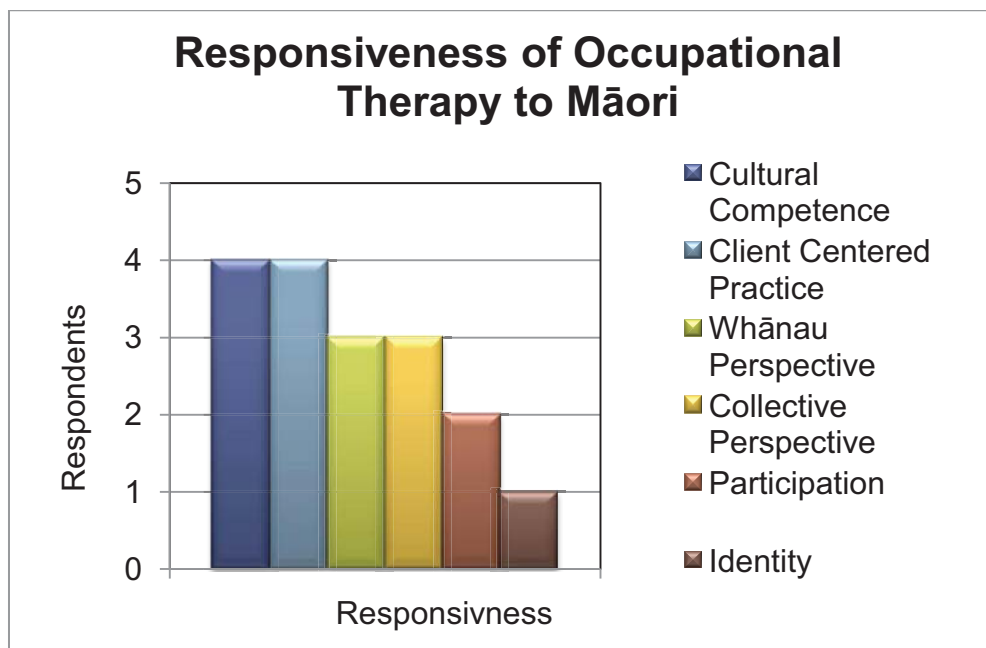


Figure 27 Responsiveness of Occupational Therapy to Māori n=5

Respondents identified six themes (Figure 27) of to cultural competence, client-centred practice, whānau perspective, collective perspective, participation, and identity that could support responsive practice to Māori. These themes are all described under their sub-headings following.

CULTURAL COMPETENCE

Cultural competence was the first equal identified theme to increase the responsiveness of occupational therapy to Māori tangata whaiora. Four of the five possible respondents identified this. There was reasonable discussion on these both for Māori occupational therapists and Pākehā such as: “depends

on the O[ccupational] T[herapist]’s competency to work with indigenous perspectives” (Interviewee E). This theme covered cultural safety with one respondent leading on with “cultural safety leads to cultural fluency” (Interviewee D) where the first is driven by the wishes of the tangata whaiora and the second has the practitioner having cultural skills themselves. One respondent reported that:

“How Non – Māori [need to have] cultural safety

- dual practice
- evidence [of] Māori O[ccupational] T[herapy] fluency [and] living [the] culture practices” (Interviewee D).

Another respondent stated on cultural competence that:

“All clinicians must have patient focused cultural[ly] responsive competences to use with all clients [as] every person is different to you therefore [you] must be sensitive to difference seeing the clients own perspective and be aware of yours. Culturally competent clinicians adopt a Māori world view in their practice e.g. “Durie who treats all who he sees as Māori, that is focused on cultural competence. If you do this, make a good job of it” (Interviewee C).

There were also responses on what is effective cultural competence for Māori occupational therapists where the current lack of research limits competence. Having a specific Māori occupational therapy model, and sharing together best practice all supports competence.

This respondent thought a development of a Māori occupational therapy model was significant and would:

“require a collective approach [to] clarify what we do/bring, what is innate [and] capture this in the model [with a] a way of communicating [and with an] expression of what practice [is]. Currently interventions remain very western not self determined, like standardised assessments [have for Māori] language barriers compared with

Michael Iwama's metaphor for life on the kawa model the river e.g. volition /choice crucial" (Interviewee B).

Another participant also was very clear that if occupational therapists adopt a Hauora model of the world they must consider what this means for the practitioner. They need to listen to other practitioners and work out "what does that mean? What am I going to do differently tomorrow than what I do today?" (Interviewee C). This respondent stated that it was important to develop competence among each other and "don't practice on clients" (Interviewee C). The learning to be culturally competent and effective in this setting is a given and needs to happen. The respondent also identified Therapists often talk of overload preventing cultural responsiveness but under the regulatory bodies of the Health Practitioners Competence Assurance Act, (HPCA Act) (New Zealand Government, 2003) this is a requirement. Training and courses were suggested to be effective ways of developing this.

A further aspect to cultural competence was stated as needing to add to resources you have and expressed this as: "what [you] put in [your] kete" (Interviewee C). This same respondent suggested that a practitioner needs to strengthen themselves identifying the use of spiritual domains within themselves and in practice. They stated it is not just skill based, it requires the practitioner to give part of themselves to enable whakamana in tangata whaiora.

Māori practitioners using hauora perspectives along with a western therapy (occupational therapy) need to be able to articulate what their core practice is and how they do this. The tangata whaiora need to know what the practitioner can do and what is beyond their capability so they don't come up short with tangata whaiora wants. This respondent went on to give an example of this e.g. a Māori midwife who has prospective tangata whaiora coming to her for Māori births but they want to find out about them and learn about their culture. Problems arise because these prospective parents don't know what they are asking and if a Māori birth is right for them.

This same participant also identified that problems arise when the practitioner is learning their culture too. A good practitioner knows what they can do and what they can't and can check what the tangata whaiora need, their goals and expectations, before they engage in any intervention. Tangata whaiora become dissatisfied when the intervention they think is promised is not delivered. This is where mainstream use by Māori occurs because at least if the tangata whaiora goes to a Pākehā GP (General Practitioner), - for example they know the GP has no cultural competence and don't expect this of them. They then add to the range of services they access by going elsewhere for mirimiri or rongoā. Another respondent discussed the need to identify limitations to occupational therapy practice. Because of the holistic perspective of the profession there could be a temptation to try to provide interventions to tangata whaiora when a referral on to more appropriate cultural supports would provide better outcomes.

They also went on to highlight the need for practitioners to understand responses they may be getting from Māori tangata whaiora where a “critical balance between spiritual, interdependence and whānau dimensions” (Interviewee C) is needed to be understood. This respondent gave the example of how often Māori are termed non-compliant and:

“non-compliance research shows [Māori are] non-compliant for very rational reasons like [they] stopped taking [their] diuretic [the] day before being on [the] paepae so [they] don't embarrass themselves having go [to the] bathroom half way through. When practitioners understood [the] reason for non-compliance with O[ccupational] T[herapy] intervention then ... [practitioners] can find [a] solution. Does O[ccupational] T[herapy] respond to rational reasons of not using interventions? Do O[ccupational] T[herapists] respond as a profession to why interventions are not as effective as [they] could be?” (Interviewee C).

CLIENT CENTERED PRACTICE

Four of the interviewees identified client-centred practice as significant, with comments such as: “Tangata whaiora are the expert” (Interviewee B), “asking Māori clients what [their] needs ... and expectations are is really important” (Interviewee C), “need to be client driven and go back to [the] client asking where to from here” (Interviewee D) and “engage with [the] Māori community [to find out] what Māori need” (Interviewee B).

Another respondent also challenged Māori occupational therapists to establish what is relevant to who you are working with and how to provide what they require. Tangata whaiora should be free to think as they wish, participate more, be diverse, indigenous and have access to activities of meaning to them from their culture. There is a need for occupational therapists to recognise they are accountable to those who they work with and for.

WHĀNAU PERSPECTIVES

The whānau driven nature of Māori was reported by three of the participants. The relationships with tangata whaiora were highlighted here to be different when in a Māori setting with comments such as relationships with:

“Tangata whaiora ... link into the nature of the relationships [where there is] reciprocal relationships. People don't do it - most clinicians [don't allow reciprocity]. When entering a whānau and community if you are part of that then your relationship is going to be stronger [because] the links [are] already made. You may do things that appear not directly related to treatment but will long term impact positively e.g. a client who lots of O[ccupational] T[herapists] visited wouldn't talk about [their] issue until [a] Māori O[ccupational] T[herapist] went in and they cooked kai together, then they[the tangata whaiora] opened up and talked about the issue. It was the third session this occurred on. [Practitioners] need to consider the outcomes and how to best [to] achieve those. Build on relationships [with the] whānau.... [This tangata whaiora could] Run [the] organisation [of a] hangi when

originally [they] couldn't leave the house, [had previously] smashed [the] house [and] staff [were] afraid of them.... Go with the flow, Te Wa, sitting on the steps taking the time to do what [was] required to form [a] relationship" (Interviewee B).

The relationships can often include whānau links where there is an understanding of the reciprocity side to the relationship, and a different approach to engagement. However one participant highlighted the need to retain ethical boundaries for the tangata whaiora.

Identified was the need to take time to build the relationship before treatment is engaged and an example of sharing kai and using, te wa' (take time) was used to show how tikanga can open therapeutic relationships. The call for development of best practice for Māori occupational therapy practice was identified in this area.

COLLECTIVE PERSPECTIVE

Three interviewees brought to this research the collective nature of Māori and its significance for practice. One participant in another question also answered this extensively so this has been placed here too. The first participant identified that independence is a western concept, and dependence is also not ideal to develop in practice, stating both cause harm if they get out of balance or are at extremes. They suggested that the practice for collectively focused practitioners might be a development of another world view where tangata whaiora move in recovery through a series:

“→ Dependence

→Interdependence

→Intra-dependence" (Interviewee A).

Occupational therapy "needs to support interdependence of Māori. [The] Goal of western health is independence [whereas the] goal of Māori health is interdependence. Optimum physical health, mental health is optimum cultural

function. [There is a] critical balance between spiritual, interdependence and whānau dimensions” (Interviewee C) was stated by a respondent.

A further participant suggested that Māori occupational therapy might want to:

“develop ... collective principles and collective practices [such as]

- Whakawhanaungatanga – access resources, Kaumātua, communicate, [use of] occupation
- Wairuatanga – acknowledge [of practitioners] own, tangata whaiora expression of this (Interviewee D).

PARTICIPATION

“Participation is the point” (Interviewee A) with one respondent identifying this in this question but another interviewee identifying this in another question so the data has been brought together here.

The first respondent stated that occupation is the means used by occupational therapists to achieve the ends. They also thought that when that focus is lost the point of the profession is lost, stating:

“Occupation is the means, occupation is the ends. Are we using participation to facilitate recovery? Participation is the point.

O[ccupational T[herapy] of integrity uses means as well as ends.

O[ccupational] T[herapy] derailed when [the profession] separated these” (Interviewee A).

This respondent thought occupational therapists “sometimes make change [and] O[ccupational T[herapy] sometimes make [opportunities] possible” (Interviewee A).

This was reinforced by another participant who reinforced the value of participation:

“An example was then shared of elderly Māori reporting an optimistic view of health unless they are unable to participate. They notice only when they are unable to participate in cultural practices. Cultural

practice is an occupation. [They] want to still participate so [they] balance morbidity, optimum mental balance, and independence in [their] lives” (Interviewee C).

IDENTITY

Identity is promoted as a core enabler of recovery but was only reported by one respondent. The significant aspect of building identity is in the finding of something they didn't know they had resulting in the “restoration of being” (Interviewee C). This adds more tools for clients to use to get well: as their identity is strengthened so their recovery advances. This respondent identified that

“some kaupapa services limit access by stating you need to be a ‘good’ Māori first – this limits all those who don't know practices or protocols. Identity is the discovery of something you never had before – sometimes a bad experience ... [results in] people ... [not] returning to look [at their identity]. Services can recognise this and support [identity growth] but safely using cultural safety” (Interviewee C).

What Barriers Prevent the Integration of Māori And Occupational Therapy Health Perspectives Into Practice?

The respondents to this question only included four respondents as one felt they had covered this topic in earlier questions. Tools were identified to help reduce the barriers that prevent the integration of Māori and occupational therapy health perspectives into practice.

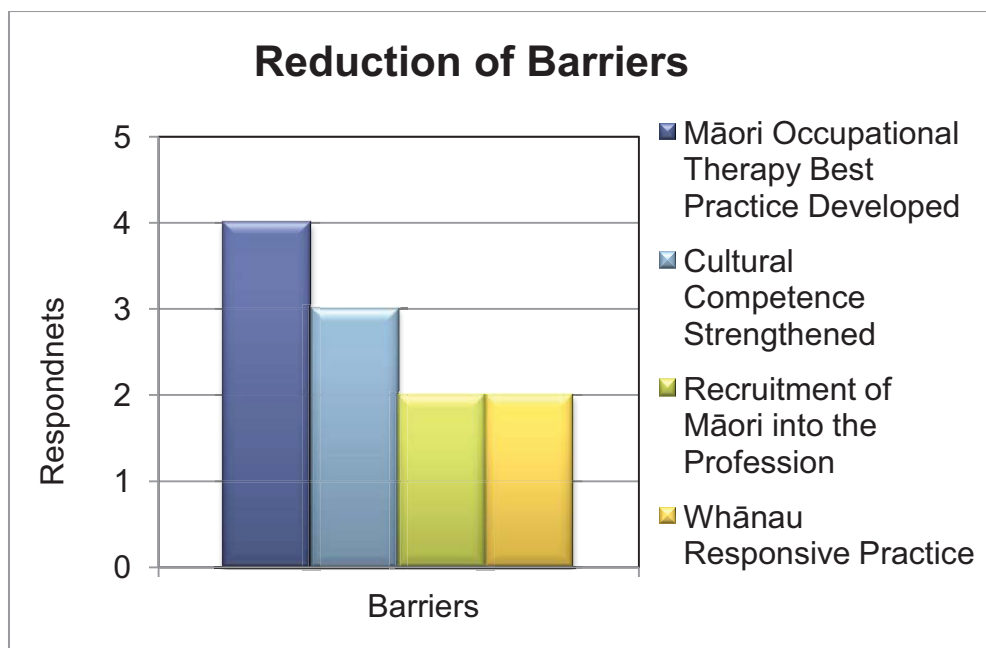


Figure 28 Reduction of Barriers n=4

All four respondents (Figure 28) recognised the need to develop Māori occupational therapy best practice, identifying that Māori interventions are needed to support Māori recovery. These were termed in the following ways: “know how to respond” (Interviewee A), and “know practice does happen and works but [best practice] knowledge needs to be shared” (Interviewee E). This last respondent also went on to say Māori practitioners are limited currently because of the “non-existence of evidence that Māori occupational therapy practices ... [provides] effective practice” (Interviewee E). One respondent thought that the “Hauora view of O[ccupational] T[herapy] fit well” (Interviewee C) with Māori perspectives. They stated that occupational therapy perspectives also acknowledged the “part and parcel of [a holistic]

world” (Interviewee C) that Māori hold. The same respondent also recommended that “Māori health perspectives [are the] superior view” (Interviewee C).

Three respondents saw barriers in competence with one identifying Pākehā competence suggesting that: “every Pākehā [who] worked in health had six full weeks immersion in Māori. Basic [cultural] competencies required as professionals looks at everyone’s views” (Interviewee A). Māori competency was discussed by two, one saying it “means understanding the boundaries – philosophical boundaries may match but how [does this] fit in [the] current services and what is practice also required [to support this]? So be realistic about what O[ccupational] T[hery] can do and what [it] can’t do” (Interviewee C).

Māori working “by Māori for Māori” (Interviewee A) and the issue of recruiting enough Māori to the profession was acknowledged by two respondents.

Statements were made like we:

- “need own kind providing service. Everyone needs to fit in a community feel able and part of it;
- need [to be] part [of the community to] know how to respond;
- more Māori therapists working in, by Māori for Māori services;
- more Māori for Māori in mainstream;
- more Māori for Māori in providing supervision and support;
- more Māori O[ccupational] T[hery] in each and all services” (Interviewee A).
- “Small Number” [of Māori] (Interviewee D).

The last barrier found by two respondents was the need to be part of a community and whānau and therefore provide for that in practice. One respondent stated that: “everyone needs to fit in a community, feel able and part of it [and use being] part of [a] community to support ... recovery”

(Interviewee A). The implications for practice was the “collective requires whānau” (Interviewee D) which was noted as “cultural therapists do kaupapa and whakamana” (Interviewee D) with tangata whaiora and that occupational therapy standards and services need to support a community perspective.

Workforce Development Priorities for Māori Occupational Therapists?

This question was asked of the Māori practitioners and identified development priorities for them (Figure 29).



Figure 29 Workforce development Priorities n=5

Occupational therapy was defined by one participant as a profession mainly full of middle class women, who have had an interrupted career, who put family before work, tend not to dominate and often don't seek positions of power.

Four of the five participants recognised having a supportive profession and work place with “support from occupational therapy bodies ... and management” (Interviewee E) as significant. One also acknowledged “therapists often talk of [case] overload preventing cultural responsiveness. This is a requirement of [registration] bodies to ... [manage] this” (Interviewee

C). One in this theme also identified “institutional racialism [coming from] Pākehā middle class” (Interviewee A). This was supported by another participant who wanted a “safe place to work being able to be Māori” (Interviewee B) in that place. They noted the need to “educat[e] other staff on what [are] appropriate expectations of us (Māori occupational therapists) [and] what others will expect is a barrier to identifying as Māori” (Interviewee B). This same respondent also reported being “denied opportunities to develop connection” (Interviewee B).

A workforce development need from four contributors was strengthening Māori occupational therapists’ cultural identity. The leadership is not coming from the Māori community to encourage rangatahi into the profession and to keep them safe and strong in their identity while they develop as practitioners. Another stated that “having other Māori staff linking together [was] strengthening” (Interviewee B). They also stated the need for “opportunities to reconnect” (Interviewee B).

Best practice development was acknowledged by three with the suggestion the profession’s “intellectual maturate [does] not [have a] strong theory base [or an] ... evidence base [and a] lack of research” (Interviewee A). This same respondent thought western theory was a barrier to Māori health. A further respondent thought “key concepts of understanding [of] know[ing] whānau iwi and their needs and know community” (Interviewee D) was crucial. The practitioner’s own development of best practice they thought should consider:

- “Wairua, - own journey
- Clinical – O[ccupational] T[herapy] practice [is] clear [to the practitioner and] sit[s] with culture
- Professional practice - how well [they] integrate
- Responsibility to tangata whaiora
- Māori occupational therapy [should] not stay at one level [they need to be on a] pathway [to] learn, write and share.” (Interviewee D).

The need to “hui, talk, time to write or talk about what [Māori occupational therapists] do, [to] develop identity and purpose” (Interviewee E) were important steps to building best practice.

Three interviewees reported the need for recruitment of Māori into the profession, with one affirming the need to recruit Māori for all parts of the profession and two participants identifying the need for recruitment of Māori men in the profession. One had comments on “overcoming barriers to entry” (Interviewee B). They considered access and equity in entry into the profession for Māori as significantly different because issues such as poverty, low literacy and poor numeracy reduced access. The location of Māori is often not where occupational therapy schools are located either. This contributor considered that “education is becoming more flexible. Māori with whānau have difficulty accessing training because [of whānau] commitments” (Interviewee B). Two participants indicated as important the support for occupational therapy students to ensure they qualified. One wanted to know if there was “accountability of schools on why [Māori are] not making it through?” (Interviewee E).

Two respondents saw training in cultural practice as important for the development of the workforce with one suggesting in addition Māori research methods and cultural supervision.

Do You Have Any Other Comments You Would Like To Make?

Occupational therapists are “good at making things happen” (Interviewee A). Comment from one participant was on defining an alternative practice where Māori occupational therapy practice will show the complexity of normative practice and stimulate debate on what is effective practice rather than what are the stated philosophies of the profession. This respondent encouraged the profession to remain pragmatic and warned that “what is included in practice could be challenged” (Interviewee C).

Summary

This data was from the five interviewees consisting of three occupational therapists of which two were Māori and one Pākehā and two experienced

Māori health practitioners. The key Māori health perspective that was identified was to be empowered to be Māori, with all reporting this as significant. The next most significant perspective was, for three respondents, contributing to whānau, hapū and iwi.

The merging of Māori and Pākehā interventions or competencies was not supported by any of the respondents with the reference made to parallel processes, best practice with double competencies, and spiritual healing not from Western Paradigms all acknowledged equally.

When asked what occupation meant for the participants, most reported terms such as do/doing, occupational potential equal with four responses each, and occupation with three responses. Occupational meaning seemed to be day to day self and whānau care; it adds meaning, value and identity. Participation in whānau and in relationships had three responses each; with two identifying growth and learning. Occupation does not explain all that is significant in a Māori world view with spirituality and pre-occupation thought and 'being' identified.

Consideration of occupation in pre-colonial times revealed participants view that all believed roles held were more significant than activities as such. Tikanga was identified next with four responses and three identified the dependency on the environment required to sustain themselves.

Exploration of core occupational therapy perspectives was considered next. The predominant perspectives, was that Occupational therapy be client-centred.

Being more responsive to the need of Māori tangata whaiora was presented in the data; this required cultural competence and client-centred practice as the two most important views, with whānau and a collective perspective next.

Barriers to preventing effective practice could be reduced by the development of Māori occupational therapy best practice as reported by all participants, with three who thought barriers could be reduced by cultural competence growth as well.

Supportive environments, strengthening cultural identity, followed by best practice and recruitment were acknowledged to be a workforce development priority by the participants.

Health Perspectives Occupational Therapy Workshop

At a workshop for occupational therapists, health perspectives of occupational therapy and Māori views were considered by predominantly Pākehā practitioners. The information in this section is only perceptions expressed as a collective group within the workshop. The perspectives of the workshop participants as individuals were not expressed, as participants were not asked to rate their top three priorities. This however still adds to previous perspectives given in this paper (Figure 30).

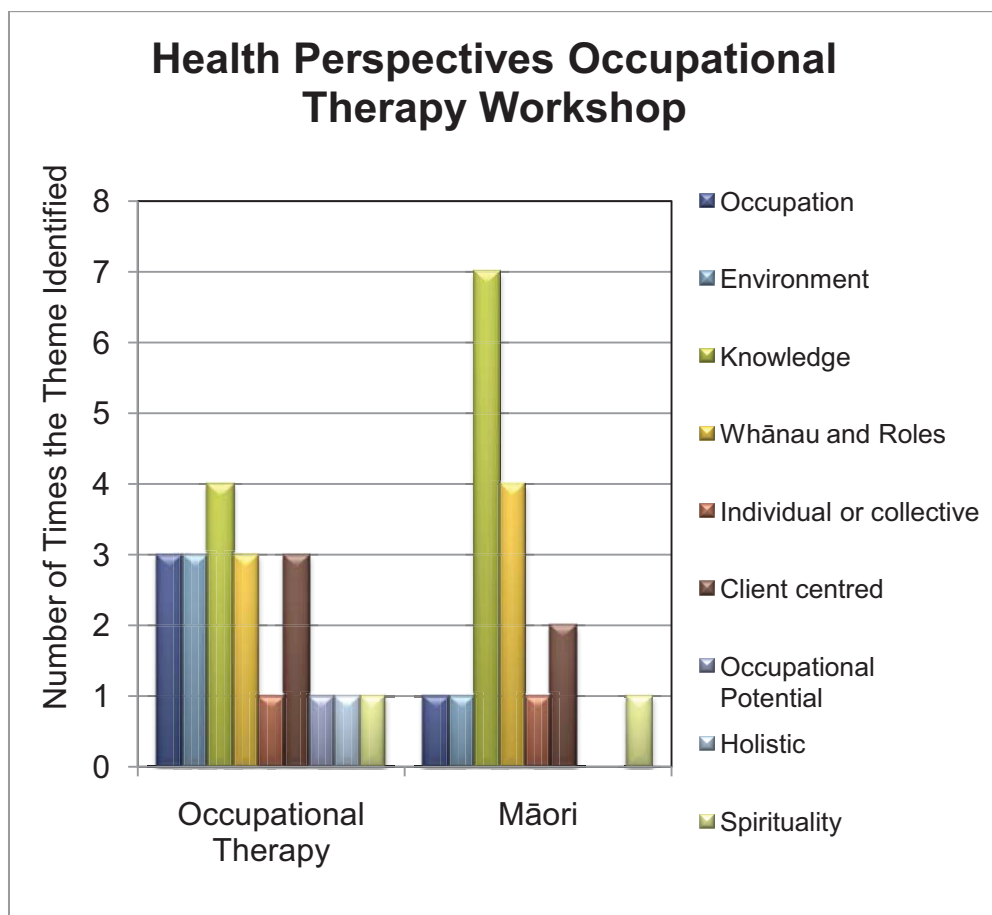


Figure 30 Health Perspectives Occupational Therapy Workshop n=24

The two views of occupational therapy and Māori health perspectives were different but both identified knowledge consisting of occupational therapy theory knowledge and Māori practices, whakapapa, time, ceremony and 'Te Whare Tapa Whā' (Durie, 1998) as the most significant health perspective. Next identified was whānau and roles. This perspective was the second theme for Māori but for occupational therapy this was the second equal with occupation, environment and client-centred perspectives. Client-centred was third in the Māori perspectives.

Individual themes seen in both perspectives were spirituality. Occupational therapy themes which were only identified once were occupational potential, holistic and individual. Under Māori themes were seen collective, occupation, and environment. Holistic care was not identified in the Māori view however 'Te Whare Tapa Whā', which could be seen to be a model of holistic care, was, but themed elsewhere.

Analysis:

It is interesting that both occupational therapy and Māori views of health see knowledge as the most significant health perspective. This theme was not identified in the same way in the questionnaire or the interviews.

It was reported that the professional knowledge of occupational therapy was significant but that some theories used in the profession held differing values to others with some identifying spirituality and holistic views and others not. Spirituality and holistic models were noted to be more likely to reflect Māori knowledge or world views. The expertise of the profession to support wellness was identified in the theory of occupation where occupation and all that people do was identified as the specialist tool through which the profession enables wellness. The knowledge base identified for Māori was broader than health or even occupation and health, identifying the processes or tikanga, ceremony and time varying from Pākehā understanding of time. The Māori health model identified was 'Te Whare Tapa Whā' (Durie, 1998).

There are many understandings and levels of Māori knowledge and occupational therapy knowledge not described or even touched on due to the

limited time of the workshop and the focus on health perspectives not knowledge.

Whānau and role was acknowledged as the second most important theme. There are slightly differing perspectives of family or whānau, with occupational therapists seeing the impact illness or disability had on the family, care associated with the individual and the family and the roles the tangata whaiora had. Māori point of view however appeared to be perceived to be much more around the aligning of the tangata whaiora and whānau together in interventions e.g. whānau as one of the key cornerstones of Te Whare Tapa Whā (Durie, 1998). Next identified was the place and role for all in a Māori view, relationships held across life spans with moko -grandchildren just as significant as Kaumātua to Māori and the importance of how relationships were built using face to face, and the community operating together.

The third most identified theme for Māori perspectives were client-centred. Occupational therapy outlooks included independence, belief people can change, volition/choice, and goal setting. Māori angles saw whānau participation in wellness, collective and connection. These views show the differences in world views and show the need to understand the collective nature of Māori and the need to allow inclusion of whānau in occupational therapy interventions. This ensures goal setting and life choices can be supported by the whānau, can be collective, and the connection can empower participation in the whānau.

The two views that were explored were contradictory when an individualistic view of tangata whaiora came from an occupational therapy view compared to the collective perspective attributed to a Māori view.

CHAPTER FIVE: INFORMATION ANALYSIS

Kia eke tiritiri o nga rangi
Tuturu o whiti whakamaua kia tina, tina
Haumi e, hui e, tāiki e!

Introduction

The data generated from this research showed an overwhelming response, from all participants, that culture was extremely important to health. It highlighted the nature of dual practise that involved the two world views of mātauranga Māori and occupational therapy that are integral to Māori occupational therapy but not necessarily obvious to all occupational therapists. While all participants acknowledge the significance of culture, further information was sought on whether Māori perspectives were imperative, and what was required to support these in occupational therapy services.

Questioning both Māori and non Māori produced three significant common perspectives of tangata whaiora - responsive practice, spirituality and holistic views. A further perspective related to environment was strongly held by both groups, but from slightly differing angles. Occupational therapy modifies the environment to support participation as do Māori but Māori negotiate with their environment prior to modifying it for their use, acknowledging the 'belonging to' and 'one with' that they feel.

The perspective strongly acknowledged by all Māori participants in contrast to occupational therapy perspectives was the whānau/whakawhanaungatanga nature of Māori and Māori wellbeing.

Foundational to Māori responsive practice was traditional or contemporary Māori understandings of occupation or activity. The final corner post of the data was the empowerment of Māori occupational therapy practitioners to support responsive practice to Māori tangata whaiora of occupational therapy services.

Over the course of this investigation, a number of significant issues have emerged, informing our understanding of how health perspectives are shaped by Māori views. The following section is based on the themes identified above, providing further insight into these critical issues. Quotes from respondents are introduced periodically and are designed to highlight issues by adding substance to the research.

This chapter initially considers the role of culture as part of practice. It fundamentally draws from the interview and questionnaire data and as such relies less on previous work, literature, and established discourse. Thus much of it is new knowledge, not previously explored, or at least undocumented.

Themes

The primary theme is the place culture has in occupational therapy practice. This is supported by the interface between Māori and occupational therapy health perspectives which identify client responsive practice, wairua/spirituality, and holistic views, environment/whenua/taiao and the crucial role of whānau that Māori perspectives have. Lastly there is a consideration of traditional and contemporary understanding of occupation and finally exploration of Māori practitioners being validated.

The Place Culture Has In Occupational Therapy Practice

When the data from both the questionnaire and the interviews are considered concurrently it is clear that culture is vitally important for occupational therapy services.

“Cultural perspectives are often central, recognized or not, to a person’s involvement in occupation and the world around them”
(Participant 18).

Occupation was influenced by culture as reported:

“Culture influences who we are as people and the meaning we give to our occupations” (Participant 10).

No definition of culture was provided to ensure that no pre-conceived bias (as to what constituted culture) was introduced. Participants identified facets of culture to include the cultural context of people; identity of individuals, identity as Māori, cultural responsiveness, understanding one's own cultural capability, cultural safety, the western influence in health, and multicultural recognition. One description was:

“Culture is a living entity made up of all the experiences from home. Contact with my whānau, discussions on iwi politics, hui, waiata are all a part of my life and keep me close to my Māori cultural roots”
(Questionnaire Participant 15).

The significance for occupational therapy practice identified in the data was the cultural contexts that all have, including occupational therapists. Thus they demonstrated an awareness of the need to be culturally safe in their practice. This is a significant finding and a protector for Māori accessing occupational therapy services. The fact that only five respondents indicated the relationship of Māori culture or the Treaty of Waitangi to practice here in Aotearoa could indicate these respondents perceived a lesser importance of bi-cultural responsiveness in cultural considerations. The Māori participants extended this further, expressing that Māori aspire to be “Māori [and] able to live in Aotearoa as Māori’ (Interviewee C) taking the cultural safety view further to a culturally fluent position where Māori can receive service from Māori and embedded in a Māori way. One practitioner describes what this means to them:

“I work in a M[ā]ori M[ental] H[health] Team and we have cultural practices that we ritually do. There are key cultural things we have to do when we are with clients as well” (Participant 12).

The therapist's own cultural basis was acknowledged as most significant. It was important therefore not to allow it to prevent responsiveness to tangata whaiora. There was evidence of implementation of the principles of ‘cultural safety’ (Ramsden, 1991) in responses, though no reference to this in

particular. It is encouraging to see the participants having such an understanding of their own cultural perspectives such as:

“cultural perspectives are the lens through which I view my practice. I am aware that another perspective exists [and] [I] look for differences to ensure I am not assuming things for clients. My own cultural perspectives help me feel confident in my personal commitment to my profession and to my responsibilities to people in my community” (Participant 15).

There was one however who reported some occupational therapists having a lack of cultural awareness as described:

“In my department - other peoples’ ignorance and the notion that knowing about the Tiriti o Waitangi means knowing about cultural safety/or issues, [and] therefore [they] don’t have to consider other things/do things differently” (Questionnaire Participant 15).

The responsiveness required for Māori - since they are the significant other population and treaty partners - was not as well recognized by participants as the previous two aspects with only five of the 11 Pākehā respondents indicating Māori specifically playing a role in their response to practice.

“Within this context multiple cultures (NZ and international) need to understand different culture/beliefs, values [and] norms [and] influence on learning/O[ccupational] T[herapists’] education for individuals from varied cultural contexts. Need to be able to understand these differences and teach/facilitate in ways that can promote/enable optimal students' learning and experience, and retention of ethnic minority students” (Participant 6).

It is interesting that the practitioner’s own cultural perspectives were identified more than the need to be responsive to tangata whaiora.

The overwhelming result from the interviewees was the importance of valuing Māori views. As stated by an interviewee, Māori aspire to be:

“able to live as Māori, live (not die early) [and] to be able to be full citizens of the world [with the] choice to choose [a] profession. Māori should be no more bounded [or] restricted than anyone else” (Interviewee A).

The Interface between Māori and Occupational Therapy Health Perspectives

The similarities between Māori and occupational therapy perspectives of health identified tangata whaiora responsive practice, spirituality and holistic views. The environment was also a similar perspective with both acknowledging its modification, but with Māori belonging to the environment and therefore negotiating the processes they use before modifying it. The perspective of whānau was not recognised as significant for occupational therapy but was crucial in the Māori perspective.

Tangata Whaiora Responsive Practice

Both Māori and occupational therapy perspectives noted the significance of ‘client-centred’⁷ practice or responsive practice. This was demonstrated through comments such as:

“If we are providing client-centred practice then the cultural perspective of the client is essential to recognise. Engaging people in the therapeutic processes means engaging them from their perspective or the intervention won’t be successful” (Questionnaire Participant 15).

It was reported that the tangata whaiora perspective was paramount and required the practitioner to have cultural competence skills to be effectively responsive:

“All clinicians must have patient-focused cultural responsive competences to use with all clients [as] every person is different to you therefore must be sensitive to difference seeing the clients own perspective and be aware of yours” (Interviewee C).

⁷ ‘Client centred’ is a term used extensively in occupational therapy so has remained in this form only in this context instead of being replaced by tangata whai ora used elsewhere in the thesis.

This also took the understanding of the practitioner knowing their own cultural bias and the effect it could have on not seeing clearly the tangata whaiora view: Respondents reported views like needing to:

“Provide culturally safe and client-centred practice. To be aware of possible differences in values/beliefs” (Questionnaire Participant 7).

The relationship involved in a therapeutic process was also seen as crucial to client-centred practice expressed as:

“Tangata whaiora are the expert and links into the nature of the ... reciprocal relationships.” (Interviewee B).

Two of the significant responses that underpinned client-centred practice were Māori empowerment and the occupational therapy perspective of occupational potential. Māori empowerment was seen as a crucial perspective in gaining wellness. This was demonstrated by

“Where working with clients that are culturally compromised [the practitioners needs to] judge all practices that are used to support current client so [they are] strengthen[ed] and empower[ed]” (Interviewee E).

The care provided by occupational therapists requires negotiating cultural practices that are relevant and empowering for tangata whaiora. The use also of appropriate Māori services to achieve empowerment was mentioned as well as the breaking down of tasks to make it possible for them to do it for themselves.

“Network [with] and access [to] ... Māori services [that are] appropriate for clients. [Practitioners can] open doors for Māori if empowering [them, you] can't do all for them [but] put steps in [so they achieve]” (Interviewee D).

The most common element of this concept from a Māori view was the rangatiratanga concept of empowering Māori to be Māori in their responses to recovery. As seen above in the comment, access to appropriate Māori

services can support this and this may include Māori social services, sports groups, marae, as well as health services. Māori aspire:

“to be able to be full citizens of the world [with the] choice to choose profession, [to be] Māori [and to be] no more bounded [or] restricted than anyone else” (Interviewee A).

Cultural competence and cultural safety were seen as significant tools to empowering Māori to make effective use of occupational therapy services as described:

“Māori practitioners using Hauora perspectives versus a new western therapy ... need to articulate what [their] core practice is. If as a Māori O[ccupational] T[herapist] you adopt Hauora practices [you] need to articulate how you do this. [Practitioners n]eed to say to clients what [they] can do [and] what [they] cant [by being] straight up so [you] don't come up short with [the] client's wants e.g. [a] Māori midwife who has people coming to her for Māori births but they don't know about them they just want to find out about them and learn about their culture. Problems arise because they don't know what [they are] asking and what [their] needs are really. Problems arise when clinician[s are] learning [their own Māori] culture too. [A] Good practitioner knows what [they] can do and what [they] can't and can check what the client's needs goals and expectations are before [they] engage in intervention. Clients [are] not happy if what is promised is not delivered. At least if [they] go to Pākehā GP one in 50 know he has no cultural competence so go elsewhere for mirimiri or rongoā” (Interviewee C).

The researcher considered that occupational potential was seen as a similar theme to Māori empowerment in this data but the occupational therapy perspective could be said to be clinically bound with the other culturally bound, and therefore to some extent at odds with each other. Occupational potential appeared in this data to be focused on what could be achieved for occupation by the tangata whaiora. Māori empowerment was supportive of enhancing Māori culture and practice. Occupational potential seemed to

focus on performance and had stronger links to the practitioners view whereas Māori empowerment focused more on participation with less of a practitioner-driven focus. Occupational potential was identified in the data by:

“reaching full potential - community participation /citizenship. - enabling occupations via increase [of a] person’s capability” (Questionnaire Participant 17).

Māori empowerment was thought to be:

“Community which is participating and contributing to community/whānau give back to whānau and participate in relationships. [it includes the] upholding and building of Mana” (Interviewee B).

“[having the] same standards of health as every other New Zealander - no disparities [and] Māori able to live in Aotearoa as Māori and enabled to do that” (Interviewee C).

Spirituality Views

It was seen that the professional knowledge of occupational therapy held theories of differing values to others with some models identifying spirituality and other models not. This was expressed by a participant as:

“Value spirituality – though does depend on the model used” (Workshop Perspective).

Models that included spirituality views were noted to be more likely to reflect Māori knowledge or world views.

As a perspective of occupational therapy a participant reported that spirituality was important due to its meaning to the tangata whaiora:

“Occupation, spirituality, doing things that are meaningful to the person” (Questionnaire Participant 10).

Spirituality was not always described by occupation and therefore could be a significant enabler not supported in the interventions provided, as stated:

“Not everything is covered by the word occupation. Spirituality [is] not always explained by occupation” (Interviewee B).

However it was seen as crucial to a Māori world view and facilitating recovery as reported by a participant:

“Spirit [is] unique – life force – [I] can’t describe [it], but [it] drives all [people] the way we ‘do’. It is the fire within – what you feed will depend on what you do with it and feed it. [it is a] journey, spirit, activity, meanings all combined” (Interviewee A);

and also

“Māori world view [includes] karakia. Wairua [is an] inner guide [that] sets [a] standard, [initiates] feeling [gives an] opportunity and [facilitates] getting [the] best for others.... The provision of care where spirituality [is] addressed not ignored” (Interviewee D).

Closely aligned to the spirituality view expressed by participants was the holistic perspective.

Holistic View

Holistic care, as with spirituality, is not seen in every model of occupational therapy. In this context holistic is consideration of all aspects that tangata. tangata is a part of nature – a crucial part of nature and not apart from it. Here it is contextualised to mean several concepts starting with:

- spirituality and family:

“Holistic view incorporating spirituality family etc” (Questionnaire Participant 2);

- in a collective frame:

“Valuing of individual and “holistic” approaches to enabling participation and occupation within individuals/community contexts” (Questionnaire Participant 6);

- Considering a wide focus when providing care:

“holistic approach and looking at the context the person is living/working/playing within and how this influences meaningful occupations for each person considering [the] physical, emotional, spiritual, [and] psychosocial aspects of each person I work with” (Questionnaire Participant 8); and

- the pre-colonial view was holistic:

“pre models of Māori health [had a] holistic view of health. Health [was] joined by occupation and function and holistic perspective. Holistic view meant different things 100 yrs ago. Today we see kids wanting to use play station and middle aged women wanting to use internet [this] doesn't alter that they are Māori. Post colonial is sectorial [whereas] pre-colonial was holistic (Interviewee C).

One participant discussed the negotiation between a holistic view and a health system as:

“Problematic when [a] holistic view [is] interacting with [a] health system which is primarily physically based. System of delivery separates into professions e.g. physio[therapy] and o[ccupational] t[herapy], and conditions which compromise holistic provision of care. Empathetic, holistic view [of a] client recognise[s the central] place [of the] client and inform[s] practice” (Interviewee C).

This same Interviewee cautioned practitioners about the holistic nature of occupational therapy, recommending practitioners retain this view but ensure they recognise when their scope of practice does not fit the needs of Māori and facilitate access to an appropriate service:

“Need to recognise whose role it is to support. Need to seek other services to fill need - recognise O[ccupational] T[herapy] limits.... The client is put in danger if [practitioners] try to provide services outside of scope of practice. {Practitioners need to be} clear on role as occupational therapists rather than think O[ccupational] T[herapy]/practitioner [can] do it all [so there is] balance between

provision of services and not doing what not skilled to do. If need expressed the response needs facilitating but by appropriate service. Traditionally public health nurse used to go into homes and do what [was] required e.g. dishes, clean up, identify mental health issues etc. In the bean counting climate of today it is easy to compartmentalise and stick to role despite [a] need being expressed. Gone are the days when someone was joining the gaps. O[ccupational] T[herapists,] depending on the level of engagement, are in the position of seeing gaps but must remember [their] limitations” (Interviewee C).

The next concept held by both occupational therapy and Māori but from slightly differing perspectives, was the environment.

Environment and Whenua/taiao

The use of environment was similar in that it is a significant health perspective and crucial tool to support wellbeing when modified to do so. Māori however come from the from the perspective of being part of, belonging to the environment whereas occupational therapy saw the context of the tangata whaiora situated in an environment that was occupied, controlled and adapted as needed. It was reported in three variations:

- As a core health perspective:

“Support/facilitation of client needs/gains etc [in relation to the] environment both human [and] physical” (Questionnaire Participant 4);

- As a risk to wellness:

“That disability is created by our environment (physical, social, cultural and institutional)” (Questionnaire Participant 7); and

- Enabling wellness:

“enabling occupations via increase [of a] person’s capability and environmental accommodations” (Questionnaire Participant 17).

Māori practitioners however saw the relationship of whenua/taiao as part of who they were as a person, acknowledging a close relationship with and linked to the past. They identified:

- A traditional view

“Connected to nature and environment and land to sustain, to meet basic needs - in flow. Your being was taken from around you” (Interviewee B).;

- Current view:

“Daily I have communication with my tipuna. I am involved with the iwi [and] hapū trust [and] societies for my iwi/hapū” (Participant 15).

The link to the land was more than just sustaining but a link to spirituality and healing as stated:

“Western cognitive interventions do not necessarily heal Māori spiritual issues. Need to see more recovery through the use of healing the spirit. Link back to [the] land to [the] beach – where Māori go to restore, to heal [it] can be back to land, [or] beach” (Interviewee B).

The most identified Māori perspective was whānau and whānau ora which did not correlate to any occupational therapy perspective significantly.

Whānau and Whānau Ora

Māori health perspective identified whānau as the most common perspective across all data though this was not identified by all Māori occupational therapists. As stated whānau are crucial to a Māori view:

“Māori want to be productive, participate and contribute to whānau, hapū and iwi” (Interviewee E).

Whānau was reported to be significant in several different ways. As shown above whānau is an aspiration to belong to, to participate in and to contribute to. It is also one of the cornerstones of “Te Whare Tapa Whā” (Durie, 1998) and mentioned by two participants (Questionnaire Participant 13 and 16).

As a tool to heal whānau knowledge is described below:

“Whānau knowledge [is] crucial to supporting the healing of whānau.
Health is Māori development which is whānau development”
(Interviewee D).

This description identifies the knowledge from family relationships, the understanding of how healing can occur in a family context and how it can occur in a particular family’s context. Whānau need occupational therapy services but they understand the tools that not only best help the individual requiring occupational therapy but also what is required for them as a group to support wellness. This wellness is not for the individual alone but for the whole group. One in the whānau group being unwell means the whole group is unwell, the understanding of this coming from a whānau ora perspective (Ministry of Health, 2002). The flow from whānau to hapū to iwi was acknowledged here in this research by:

“Contact with my whānau, discussions on iwi politics, hui, waiata are all a part of my life and keep me close to my Māori cultural roots”
(Questionnaire Participant 15).

Whānau ora is crucial to any provision of services to Māori because it can help a:

“Māori team interrelate [to,] strengthen [the] broader whānau so [the team] sees and provide services to adults more often and as a team [we] have a readiness ... [to] look at ... whānau issues straight away”
(Interviewee E).

This same respondent continued to say that children in their service go through a different process to mainstream, being very whānau focused so:

“kids [are managed] ... differently [we] start [with] needs not [being] as ... honed in as mainstream on illness/disability [but] work more holistically start[ing with] whānau first then [the child compared to] ... mainstream [who] may only use [a] social skills group as an

intervention [whereas the] Māori team still do [a] full assessment and intervention” (Interviewee E).

The interviewees found, in occupational therapy, a profession that was more responsive to a Māori world view. One respondent saw the profession here in Aotearoa having a:

“Hauora view of O[ccupational] T[herapy which] fits well – [as] part and parcel of [a Māori] world. Māori health perspectives [must be the] superior view. [This] means understanding the boundaries – philosophical boundaries may match but how [does the practitioner] fit [these] in current services and what practice is ... required? So be realistic about what O[ccupational T[herapy] can do and what [they] can't do” (Interviewee C).

Above we see the main considerations of this research. Following are two associated areas that arose out of the research: that of traditional and contemporary knowledge of occupation and enabling of Māori practitioners.

Traditional and Contemporary Knowledge of Occupation

The need for practitioners to stand in two worlds emerged from this data, requiring dual culturally and clinically competent practitioners. Part of mātauranga Māori was described in this context of tikanga, the traditional Māori community roles members engaged in, relationships, cultural competence and best practice specifically for Māori receiving occupational therapy assessments, interventions or models. Occupation therapy knowledge was seen from a Māori perspective here to refer to occupation being defined as: meaning and value gained from occupation, doing, activity, participating, growing and learning from occupation, day to day activity and being.

In order to understand the perspectives of Māori views of occupation, in its broadest sense, a consideration of mātauranga Māori must start the discourse. Mātauranga Māori knowledge was identified and included whakapapa, mātauranga Māori, rongoā, tapu and noa, tikanga, kaumātua,

kai, and marae, to identify some elements. Participants saw its significance by making statements like:

“[In] pre-colonial times all [Maori] came across [in] waka consisting of similar hapū, wise men, [who were] knowledge communicators with all [in the tribe] having a role” (Interviewee D).

Repeatedly through the interviews was the understanding of bringing the mātauranga Māori view into practice, so two bodies of knowledge and the associated two worlds could impact on occupational therapy practice for Māori. One participant wanted to:

“aspire to ... stand in [a] Māori world and beside others, [to] stand up in two worlds’ (Interviewee E).

The expertise of the profession to support wellness was identified where occupation and all that people ‘do’ was identified as the specialist tool through which the profession enables wellness. This is the other side to dual practice. However exploration of the term occupation from a Māori perspective was required to ensure cultural understanding of key professional concepts. The core focus was identified as:

“Occupation is the means occupation is the ends. Are we using participation to facilitate recovery? “Participation is the point”. O[ccupational T[herapy] of integrity uses means as well as ends [when providing care]. O[ccupational T[herapy is] derailed when [it] separated these” (Interviewee A).

The knowledge base identified for Māori was broader than health, identifying the processes or tikanga, ceremony and time varying from Pākehā understanding of time and a model of Māori health concepts such as ‘Te Whare Tapa Whā’⁸ (Questionnaire Participant 13 and 16).

There was an emphatic negative response to the suggestion of integrating Māori practices into occupational therapy provision of care with all the

⁸. Durie, 1998

interviewees of the opinion that the concept of dual practice is more appropriate, stating that there is a:

“philosophical challenge to merge Māori concepts into western health models. It is putting less into bigger (culture being the bigger in this case). Both [are] hybrid. [Practitioners] must use both i.e. best O[ccupational T[herapy] practice need[s] to be used but empathetically. ... Things Māori are completely ordinary so merging seems strange. When accessing O[ccupational] T[herapy] services Māori shouldn't feel strangeness” (Interviewee C).

The participants considered that each body of knowledge stands on its own, each with its own merits:

I “don't like the question because to merge Māori [and] clinical practice is not right. [I] prefer the parallel idea where both ... health views are respected” (Interviewee A).

In response to not feeling strange when accessing occupational therapy services the notion of dual practice, so Māori can feel their world view, is understood, respected and is crucial. The idea was supported by this statement:

“this involves negotiation as not all O[ccupational] T[herapy] or tangata whaiora are able to understand the other's world view. Occupational therapy works across [a] wide sector from broken arms to depression with wide causes to all. Therefore the knowledge base of each continuum [of] O[ccupational] T[herapy] practice and cultural practice is required” (Interviewee A).

Services to Māori can be western-centred and can run the risk of being ineffective, with Māori not engaging in services or not continuing to remain in services as stated:

“perspectives in [an] indigenous world where evidence sits with people who are western – scientific [oriented]. Māori do their talking with their feet; this is their evidence. Māori evidence is kanohi te kanohi ...

Western treatment [is] what [is] presented [to tangata whaiora and] therefore [results in a] compromised health picture for Māori. The [care needs to be a] process of engaging and negotiating ... [Māori] will slip through [the] gaps [with] late presentation.... Western systems need to champion for Māori” (Interviewee D).

Following the consideration of dual practice, the understanding of mātauranga Māori and what roles and activities were considered significant to Māori were explored. Knowledge or understanding that comes from a Māori world view “mātauranga Maori, [such as] rongoā, [or] kōrero” (Questionnaire Participant 11) flows through the data from participants.

The knowledge systems of Māori in pre-colonial times were perceived by participants to involve their whānau with:

“Roles [that] were defined and tikanga dictated” (Interviewee B).

In a more current context knowledge of the past has been retained to support the continuance of Māori ways of being. This was demonstrated in this research by one interviewee who thought that:

“Key concepts of understanding [support the] know[ing of] whānau, iwi and their needs and know [their] community.... Clinical O[ccupational] T[herapy] practice [needs to be] clear with [how it] sits with culture” (Interviewee C).

Application of tikanga or Māori ways of practising Māori knowledge is also important as confirmed:

“A greater understanding of tikanga is vital for providing good interventions to cater to ... needs e.g. Flax weaving” (Questionnaire Participant 16).

To conclude this section a consideration of occupation was required. There appears to be a significant difference of opinion in this data, suggesting Māori have a different perspective of their profession’s core occupational therapy health perspectives than Pākehā. Pākehā practitioners acknowledged

occupation or forms of occupation as the most significant perspective of practice:

“[The] classification of occupation looks [as] if it exists in all cultures ... if being occupied [is the defining element]. Balance [is] important → in occupation → in society. Māori [participated in] occupation – [a] universal [practice as] all ‘do’, all [have an] ingredient in [their] community [making it] universal” (Interviewee A).

The influence from a western scientific view has however led to a dissection of activity:

“Separation of occupation is a product of the western world. Analysis and synthesis blend” (Interviewee A).

The very day to day nature of occupation was expressed as:

“It is the work [of] doing things day to day for self and others” (Interviewee D).

There is no doubt it is an effective facilitator of recovery as stated:

“O[ccupational t[herapy is] rehabilitative and restore[s] ability to carry out occupation or activity. O[ccupational] t[herapy] means being able to realise full potential” (Interviewee C).

Māori respondents had some views on occupation but did not identify this as the most important perspective to them, having responses more similar to the statement below:

“Occupation essence is being, to promote health, to be stimulated. ‘Occupation of being human’ occupation is an expression of identity of who I am. It is different things at different times. What I do in a day is a moving thing influenced by goals and values and dreams I have and part of my make-up. Identity, values, beliefs and dreams [are] all who I am” (Interviewee B).

The Final Consideration In The Data Was The Support Of Māori Occupational Therapy Practitioners. How Should Māori Practitioners Be Supported And Validated?

Given some of the findings of this research about the youthfulness of Māori occupational therapy practitioners compared to the rest of the profession, the need for validation and support becomes vital to develop Māori responsive practice.

When considering the importance of best practice for Māori occupational therapy specific interventions or models, the respondents thought that for occupational therapy but especially for Māori practice the:

“Current interventions remain very western not self determined ... [and as such the] standardised assessments [in current use have] language barriers compared with Michael Iwama’s metaphor for life on the *Kawa Model* the river e.g. volition/choice [is] crucial [for Māori tangata whaiora]” (Interviewee B).

The barrier to implementation of dual practice was seen by Māori practitioners to be driven by perceptions of peers and managers, organisations and services. One respondent reported their barriers as:

“organisation expectations, management policy [and] culture of organisation” (Questionnaire Participant 11).

Further comments identified barriers of:

“Lack of resources and money” (Questionnaire Participant 12);

“service processes and protocols. High case loads - reduced time” (Questionnaire Participant 13);

“Institutional racism [from] Pākehā middle class [occupational therapists and managers]” (Interviewee A); and

“constant pressure to be one or the other [Māori or occupational therapy practitioner] when integrating practice. Others [I] work with

might not understand what [I am] doing like management, and Pākehā workmates that these two worlds need to walk together. Comments from others like ‘good at cultural stuff’ with it feeling like therefore you don’t have ‘the clinical stuff’. Don’t operate as well as other clinicians because [I am] dual competent e.g. another clinician said ‘if [the] client wants cultural go to [Māori mental health service named], if [they] want clinical go to the mainstream’. As a clinician it is hard to prove clinical expertise because of the complexities of cultural issues often found in clients of Māori services. This leaves the Māori clinician wondering if they should make it [occupational therapy interventions not responsive to Māori] fit? I struggle with no template, what is it to actually be a Māori O[ccupational T[herapist]’ (Interviewee E).

Tools to support validation were perceived to be:

“Training in kaupapa Māori research, cultural supervision [and] having other Māori staff linking together [to] strengthen ... [one another and having a] safe place to work being able to be Māori. Education [for] other staff on what [are] appropriate expectations of us [Māori occupational therapists as this] ... is a barrier to identifying as Māori for some. [Māori practitioners are often] denied opportunities to develop connection” (Interviewee B);

“more Māori therapist[s] working ... for Māori services, more Māori for Māori in mainstream, more Māori for Māori in providing supervision and support, more Māori O[ccupational] T[herapy] in each and all services” (Interviewee A);

“Money, support from Pākehā O[ccupational] T[herapy], management” (Questionnaire Participant 16);

“Funding – getting people to come into [the] profession and stay – recruitment and retention” (Interviewee D); and

“Therapists often talk of overload preventing cultural responsive[ness]. This is a requirement of (Regulating) Bodies to [protect competency development in] this” (Interviewee C).

One saw a need to gain:

“Support from occupational therapy bodies, support from Māori occupational therapists, acknowledgement of [cultural practices] importance for whānau, hapū and iwi,[of] ... occupational therapy and management [and a] need [to] hui, talk, time to write or talk about what [we] do, develop identity and purpose” (Interviewee E); and

“O[ccupational t[herapy] schools support Māori there with accountability of schools on why not making it through? What keeps them and why leave?” (Interviewee E).

Implementation of cultural practice was seen as a challenge, with implications for the profession:

“Challenging for practice [and] an alternative practice will highlight the complexity of normative practice and as the profession engages in what effective practice is rather than what philosophies of the profession state. Must remember what is practical but what is included in practical could be challenged” (Interviewee C).

The importance of the employment setting and the support found there could be a challenge for retention of occupational therapists who wish to provide dual practice.

Conclusion

This data has identified new information for the profession. It was not known that Māori practitioners saw client-centred as the most significant perspective of occupational therapy whereas Pākehā identified occupation as their most common perspective. It was suspected that there was a fundamental difference because the approaches used by Māori do appear very different.

The reinforcement of the links to Māori health perspectives with emphasis on spirituality, holistic views, client-centred and environment, with some modification, was also encouraging in supporting responsive practice.

The final consideration was the significance whānau and whānau ora have to Māori practitioners. This was the major point of difference from occupational therapy perspectives.

CHAPTER SIX: CONCLUSION

Whitiwhitia i te ora!
Whitiwhitia i te ora!
Ka ea ki runga
Ka ea ki raro
He tipua he tawhito
He ioio nui, he ioio roa
He ioio atua Tane te Wananga
Houhia te uru ora
He ueue tawhito, he ueue tipua
He ueue atua
Rongomai atua
E hua to tino
E hua to aro
E hua to ariki e
Kia tapatapa tu
Kia tapatapa rangi
Ki nga rangi nao ariki
Ki nga rangi tatara
Kia eke tiritiri o nga rangi
Tuturu o whiti whakamaua kia tina, tina
Haumi e, hui e, tāiki e! (Jury in Wairarapa Moana Trust, 2007).

This chapter of the thesis is introduced with a karakia waerea which is a specific type of prayer used to clear space and time and set the scene for things to come. It may seem strange to introduce this at the end of the thesis, rather than the beginning, in that it would make more reasonable sense to present it as a preliminary guide to the research or an introductory platform or base. However, the conclusion of this thesis signals the start of new opportunities and expanding greater horizons. The knowledge gained from this work is in fact designed to create new and innovative pathways forward,

to identify possible trajectories, and ultimately to contribute to future gains and aspirations.

To contemplate the future Māori often reflect on the past, in order to predict what patterns might emerge or what frameworks would be useful. History has provided many examples of Māori and early settlers producing children from their union. From the beginnings of being half Pākehā and half Māori there seemed to be many who took on the culture of the new settlers, leaving their Māori heritage behind. Whakapapa of the author of this thesis is of this vein, though Whatahoro, a great great uncle, left a heritage of walking in both worlds. His journey is relevant for the discussion of this research as he was brought up speaking both English and Māori. He was not only one of the three last trainees in the Wairarapa Whare Wānanga at Papawai but also was a ward of Governor Grey, so was educated in reading and writing English and Māori. One of his impacts in history is as a scribe for the Tohunga of the Wairarapa. His Father wrote in Māori to him encouraging him to record what was passed on to him⁹. The following is quoted from the English copy of the letter:

“To my son J. A. Jury What[a]horo,

Many times have I listened, and asked noted learned Elders of the Māori people about the Great Migration- the canoes and the journey- from Hawaiki to New Zealand. One of these was Rukupo, whom is related to Wiremu Pere (William Perry). He use to bring Kumera, pork, and corn for your Mother.

You were born on the 4th February 1841 at Turanga-nui. (Gisborne). In 1853 I decided to send you to school....

⁹ The original is in my possession but very difficult to read so this is copied from the translation of the letter also of the same time as the original. The Māori version is a taonga that belongs to more than just myself or even my direct whānau and has a Mauri of its own which does not belong in this Masters. This is typed as it is with spelling mistakes and no macrons used except where square brackets used.

My son I want you to trace your ancestors. On this subject I will not be of any help to you. Take heed of what your elders will pass on to you, digest them thoroughly then record them in writing.

I am an Englishman, my father was English and my mother was Scottish. I was born on the 11th April 1808. I was a runner in the Navy from 1824 – 1833 whereon I was discharged through illness. I spent two years in hospital. In 1837 Doctors advised me go to Sydney (Australia) and the same year I arrived in Sydney. I stayed there one year then cam[e] to New Zealand. Arrived at Auckland 1838. In May I stayed with a Minister Te Wiremu (Williams) at Gisborne. On the 7th October 1839 I married Te-Aitu-o-te-rangi. November 1839 we stayed at Rauka-Kaka milling timber for Williams, to build a church and also a homestead. March 1842 Pehi Tuapakihirangi arrived to get us, you were then 1 year and a few weeks old.

Arrived Wairarapa 11th April 1842. Stayed at Te Kopi-a-whenua (Te Kopi) with a friend named Dick Prouse. On the 7th May 1844 Dick was drowned trying to save Te Kai-o-te-kokopa whom was also lost. Stayed at Ngakina-totara in 1846....

Your mother died of measles in 1854, buried at Nga-puke 15 March 1854. I was away shearing sheep at Bidwells when she died....

My wish is for you to do your utmost to trace your ancestors back to Tama te nui. ; Ngati-Kahungu being your tribe. How pleased I would have been had Tautapa still been alive, he was very good as far whakapapa (Geneology) was concerned, then I would have been able to write some of it down. I once heard him at Te Kopi and marvelled at his power of holding his audience.

These few words[] is all I have to offer you given by my hand this 18th day of March 1876.

Your father,

J. M. Jury

N.B. I have copied this letter with the assistance of Thomas Young (Interpreter) Government Department in the year 1877” (Jury, 1877).

This précis (albeit brief) of my own whakapapa and history is also important to this thesis. Like the karakia waerea it serves to lay a platform for the investigation – signalling who I am and where I am from. To Māori, knowledge of one’s whakapapa also raises the prospect of bringing to bear the past on the present so that future aspirations might be considered within a broader context. To this end, my whakapapa and history have inevitably informed the development of this thesis and my broader aspirations for this work.

Context

This research is fundamentally designed to ascertain the relevance of culture to occupational therapy practice. It is, by default rather than design, the seminal exploration of Māori occupational therapy, and highlights why investigations of this type are so crucial to the development of occupational therapy knowledge. Reviews of the literature established a very strong link to culture and health both from a Māori view and from an occupational therapy perspective. Although there was very little indigenous literature available, it is hoped that this study will make a contribution to the existing discourse. The study has been informed by a kaupapa Māori research approach. And, while there is no single view of how kaupapa Māori methods might be applied there is little doubt that the outcomes are consistent with Māori aspirations and the research was designed to make a broader contribution to Māori development.

While the research has revealed a number of insightful considerations it has highlighted above all else the pivotal place for all participants that culture had in contributing to wellness within Māori and Pākehā alike. To this end, there is little doubt of the role culture might play in informing best practice and best possible outcomes.

Through the karakia, the clearing of the place such as the marae atea in order to move on is vital. This is also necessary to achieve wellness that the

identification of 'strangers' or illness needs to occur so they can be dealt to and removed from causing ill health.

Dual practice could be the acknowledgement of the pathways that lead to wellness. Use of dual practice could be seen to be similar where the negotiation and navigation between two views are explored and the rules for relationship are laid down by the tangata whaiora as tangata whenua of their marae, thus situating them as central in the framework demonstrated by tangata whaiora/client-centred practice.

In this framework a Māori world view is paramount, with the negotiation process coming from and remaining in mātauranga Māori. Mātauranga Māori continues to be 'that bank of information built up by generations of tipuna Māori upon which their survival was based...a way of considering issues from a Māori cultural viewpoint' (Mohi in Williams, 1997, p. 15). This thesis has in a small part attempted to build on the bank of information from my own tipuna to consider the Māori cultural view. Of course mātauranga Māori is far more significant and broader than anything considered in this thesis.

Implications for Occupational Therapy

This study further reveals that culture is a significant contributor to wellness for anyone seeking occupational therapy services. This research is seminal to informing occupational therapy practice, as it is the first of its kind in Aotearoa and has implications for other indigenous populations. Due to the absence of international literature from indigenous occupational therapists it is anticipated that this research will be useful in guiding other researchers to seek their truths on how to more effectively provide appropriate occupational therapy services to their own people.

The research was very conclusive with all participants supporting that tangata whaiora of occupational therapy should not be denied the protection and enabling of their cultural views when striving for wellness.

The significant concepts of the research have been inserted into a pictorial framework of the whare found on the marae. It depicts the central place of

culture, the common perspectives of the profession and Māori health perspectives, identifies the key Māori perspective of whānau and is supported by the lesser findings of traditional and contemporary Māori understandings of occupation and Māori practitioner development.

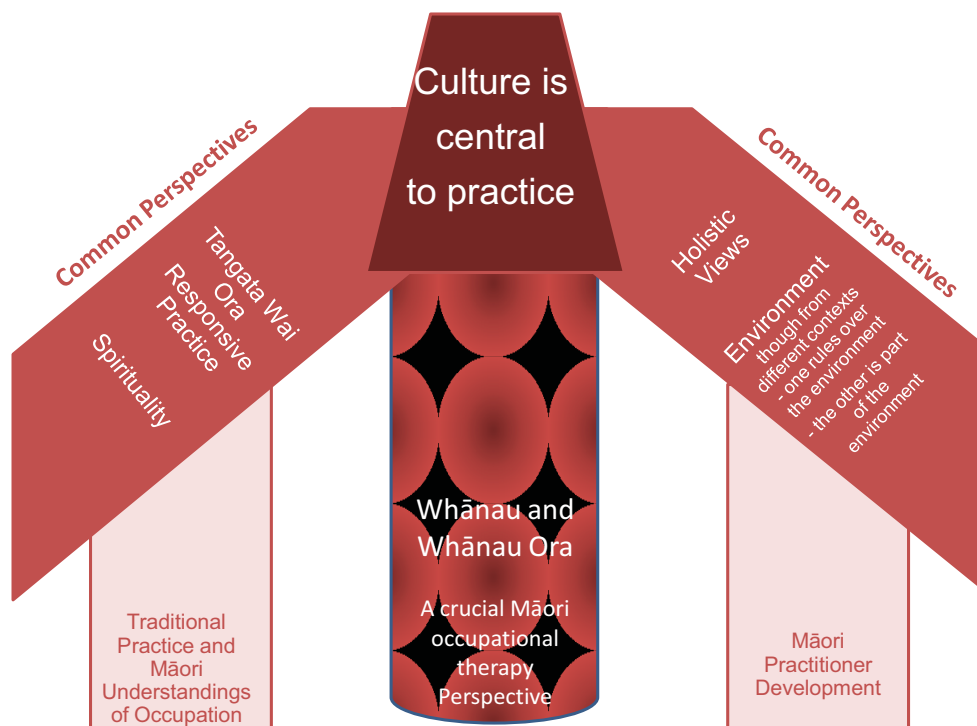


Figure 31 Framework

There was significant enthusiasm by practitioners to be culturally safe in practice, which suggests the profession's requirements and training is being effective at developing this within the profession.

Māori practitioners were also just as steadfast that cultural perspectives must be the prominent perspective, with occupational therapy viewpoints secondary. They also noted that dual practice, where cultural and occupational therapy practices are running together, is the most important way to provide effective services.

Occupational therapy was seen to be a profession that could respond to Māori health perspectives because of similar concepts of tangata whaiora responsive care, spirituality and wairua, holistic views, and environment and whenua. Culture was identified as an occupation. In many respects the fundamental concepts were neither at odds, nor inconsistent, with each other.

Key differences were occupation and whānau. Occupation was not reported by Māori as a key concept whereas whānau and tangata whaiora responsive care were. This research showed that Māori are interested in belonging, and in relationships especially with whānau, so approaches to occupational therapy service provision need to be from within this context, not from the profession's predominant context of occupation. This is significant to practice and application of practice, as health provision is very much based on single participants, with whānau very much a secondary consideration depending on how much time the practitioners have to include this element. For any Māori accessing services there must be a priority to include whānau in care plans to produce effective outcomes, at the client's determination of course.

Occupational Therapists Who Identify As Māori

The place Māori practitioners held in the provision of hauora occupational therapy care in this research was seen as vital. The significant factor was to have a profession that is responsive to its indigenous population.

An important way to progress this is to identify, protect and nurture those who identify as Māori and who are already in the profession, taking special note of the youthfulness of these practitioners. It was reported that these practitioners need to be valued and supported by other practitioners in incorporating dual world views into practice. Associated with this was the need to support cultural competency development in multiple ways. The meeting of Māori occupational therapists to establish relationships to support one another and develop best practice and cultural competence was seen as crucial.

The relationship with Pākehā occupational therapists was also seen as central for the professional and practice knowledge they hold and the role they often

have as manager, service leader, leader or educator. To this end, a comprehensive and inclusive approach is recommended.

Best Practice Development

The development of the cultural competence of Māori occupational therapists in the profession was seen to be significant.

The discovery by Māori practitioners of one's own culture and their immediate response to apply it to practice was not recommended. The protection of Māori tangata whaiora needs to be retained and practice opportunities need to be found in other forums, not applied immediately to tangata whaiora, such as hui and noho.

All Māori practitioners interviewed as part of this research expressed the challenges they had utilising the tools of occupational therapy practice to achieve effective outcomes for Māori tangata whaiora. They discussed language differences and world views that were in contrast. When considering the different health perspectives of Māori and the profession, the real differences were identified. The profession reported occupation as a key health perspective, and then tangata whaiora responsive practice. Significant perspectives of Māori health were however identified as whānau and whānau ora, and tangata whaiora responsive care linked to Māori empowerment.

The research reports a need for further development in Māori responsive care by the profession. Māori practitioners want more interventions of value to Māori and more tools to draw on from a Māori world view. This will require development of Māori practitioners and cultural competencies specific for the profession. Research will also be a key facilitator of best practice development. In particular, new and innovative “culturally cognisant” practice frameworks are needed. Other professions, particularly mental health, have for some time developed models of care which account for cultural perspectives. There remains an opportunity to do so with the occupational therapy sector, but to do so in an informed and evidence-based manner. It is anticipated that this research will contribute to this process.

Training

Access to te reo, tikanga and kawa training to develop cultural competence was acknowledged. Māori occupational therapists also saw the need for access to dual applied practice papers as well as relevant and informed research.

Recruitment and retention of Māori to the profession reinforced the need for appropriate access strategies. Issues of literacy, financial barriers and support while undergoing study require consideration to increase the numbers of Māori in the profession.

Māori practitioners interviewed in this research reported the strength gained from having a collective group and place where they could share and develop as practitioners.

The inclusion of whānau in care provision requires a broader theory base informing care and assessment processes. The application of this in practice also requires different approaches. The respect of Māori knowledge at the interface of wellness, and the world view that arises from this knowledge, needs to be laid out in the training of the upcoming practitioners, along with cultural safety and treaty responsibilities.

It was noted that most Pākehā practitioners were very aware of their own cultural biases and used cultural safety in their approach to clients. However the 'Treaty of Waitangi' responsibility to recognise the partnership, protection, participation and inclusion of this in appropriate ways in practice was not generally reported. This was a major concern for the researcher. However, not understanding the Treaty of Waitangi responsibility could mean practitioners only respond to Māori tangata whaiora in the same way they do to any of another culture. This could miss the point of indigeneity and biculturalism and the health needs seen currently in the Māori population.

Services

Occupational therapy has a holistic perspective of health which is a strong enabler for Māori accessing services. The implications of this for services is

significant, as is the role the profession could play in supporting Māori to participate in their communities, Whānau ora was seen as the priority for Māori perspectives of health, and the profession has much to offer with its understanding of participation in community to support the enablement of wellbeing.

Whānau was an important perspective that has consequences for services, practitioners must ensure they have processes and practices in place that will encourage whānau participation by supporting the wellness of the whole whānau not just the presenting whānau member.

The other area of implication for services is the recognition of the dual practice Māori occupational therapists can provide. Sometimes this is provided through the time and space required within practice for Māori responsive practice and different ways of doing things, such as a pōwhiri to welcome the tangata whaiora to the service. It will also impact on the professional development needs of this practice development. Some current Māori practitioners find this not recognised despite being employed for these skills in kaupapa services. Those who manage and lead Māori practitioners are in a unique position of supporting this development of best practice knowledge by encouraging the above, improving access to post graduate training, engaging in research and facilitating access to conferences that support both clinical and cultural development. Managers also must recognise the collective nature of their Māori occupational therapy professionals, and that their needs and world view as Māori will be different to other occupational therapy practitioners. Managers have responsibilities under the Treaty of Waitangi to respond differently to Māori occupational therapists and indirectly to tangata whaiora of services.

Policy

The significance the profession sees in supporting participation and continued relationships despite illness or disability has implications for policy.

Occupational therapy offers health services and communities interventions that could be real enablers of Māori and support the drive to keep people

participating in their communities for longer and fulfilling the 'Whānau ora' aspiration of well families participating and interdependent.

Recommendations:

While possibly beyond the scope of this investigation it made sense, in a developmental manner at least, to consider the potential implications of the research and how it might inform future directions. This idea is in fact consistent with broader Māori research objectives and, in that, investigation on or with Māori should at least attempt to consider the implications for Māori and Māori development. The following recommendations are therefore put forward:

- that cultural perspective for occupational therapy services is a crucial enabler for wellness and needs to be provided for in care, especially for Māori;
- that the cultural safety model reported in this research to be used by practitioners continues to be understood and applied in the profession with more emphasis on the significance of the Treaty of Waitangi;
- that the cultural competence of the profession, and Māori practitioners in particular, is developed further;
- that recruitment and retention of Māori occupational therapists within the profession are enhanced with special care for the youthfulness of Māori practitioners;
- that the health perspectives found in this research of spirituality, tangata whaiora responsive practice, holistic views, and environment, facilitate work with Māori tangata whaiora in positive ways;
- that whānau responsive practice is developed within the profession to further recognise and understand Māori knowledge and world view;
- that hui and noho are supported to enable the development of best practice;
- that professional development opportunities are available to develop cultural competency;

- that research opportunities are accessible to Māori occupational therapists;
- that Māori occupational therapy practitioners have space and time for development of dual practice within the services; and
- It is certain that the profession of occupational therapy has much to offer the health sector because of its emphasis on participation and potential enablement of whānau ora for tangata whaiora of occupational therapy.

Concluding Thoughts

Notwithstanding the limitations of this study and its relatively narrow focus, it has introduced new ideas and concepts. Alternative ways of viewing practice have been identified and more fundamentally the role that culture plays in training, service delivery, outcomes, and policy design. To this end, the significance of the research should not be underestimated nor should the relevance of the perspectives which have been presented. With the dearth of information on the relationship between occupational therapy and culture it will also make academic contributions, provide indigenous insights, and further strengthen (perhaps) broader aspirations for autonomy.

In a wider sense it is hoped that the research might ultimately bring about positive change and enhance the potential outcomes of tangata whaiora. While the multiple and more pragmatic objectives of this thesis have been described previously, it is, essentially, an investigation of how the lives of Māori might be enhanced. Although this thesis will not, on its own, provide the ultimate solution, it will certainly contribute to a broader process of development, it will create new horizons of insight, new challenges, new perspectives, and new opportunities for Māori health development. Kia Kaha, Kia Maia, Kia Manawanui !!

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APPENDICES

Appendix 1: Glossary

ahi-kā	symbolic phrase for 'home fires kept burning'
ariki	paramount chief, high chief, lord, leader, firstborn in a high ranking family
aro	to heed, pay attention to, take notice of, comprehend, understand
aroaha	love
atua	ancestor with continuing influence, god, deity
ē	used to conclude a traditional song
hapū	sub-tribe
hauora	health
he	a, an, some
hinengaro	mind, thought, intellect, consciousness, awareness
houhia	to bind together, lash together, make peace
hua	product, value, finding, result, outcome, asset, gain
hui	meeting/gathering
Io Matua Kore	highest spiritual (God) being
iwi	tribe
kaha	strong
kaimahi Māori	Māori worker
karakia	prayer, incantations
karanga	call
kaumātua	respected tribal elder (male or female)
kaupapa	purpose
kaupapa Māori	for Māori, by Māori
kāwanatanga	right to govern
kia	be, let be
koha	gift of appreciation
kōrero	talk, speak
kōrero pūrākau	traditional Māori stories
kotahitanga	oneness, united
kurī	dog
mahitahi	cooperativeness
mahi whakairo	Māori carving arts
mākutu	illness attributed to a cultural violation
mana	control, prestige, influence
manaaki	caring in a reciprocal manner
manawanui	determination, stout hearted, patient
manuhiri	visitors
marae	symbol of cultural identity meeting houses
marae ātea	the ground in front of the whare nui where interactions take place between peoples
māramatanga	enlightenment
matakite	seer
mātauranga Māori	Māori knowledge

mate Māori	Māori illness
Mauri	life principle (essence)
mihimihi	introductions
moemoeā	dreams, future goal, vision
motu	island
ngā taonga tuku iho	cultural treasures, knowledge, handed down
noa	safe
noho	reside, sit
nui	big, plentiful, numerous, important
ora	wellbeing
oranga	facilitate complete wellbeing
ōritetanga	equality
Pākehā	New Zealander of European descent
pakeke	adult
papa kāinga	home, home land
poutama	denotes pathways to higher learning and skills
pōwhiri	welcome ceremony
pūmanawa	personal traits, characteristics
punga	fern
rangatahi	youth
rangatiratanga	chieftainship
Rangi(nui)	sky father
rangi	heavens, heavenly realm
rongoā	traditional medicines, remedies
Rongomai	god of healing
Rongo maraeroa	god of peace
rōpū	group
taiao	environment
tamariki	children
Tāne te Wānanga	god of learning
tangata whaiora	service user - “a person seeking health” ¹⁰
taha wairua	spiritual dimension
tangata whenua	indigenous people of the land
tangihanga	funeral
tapu	a state subject to risk, address with caution
te ao Māori	the Māori world
te ao tawhito	the old world
te hunga ora	the living
te whare tapa whā	four cornerstones of health
teina	younger sibling
te reo Māori	the Māori language
tikanga	custom, protocols, procedures
tinana	physical
Tino rangatiratanga	self-determination, autonomy
tipuna	ancestor
tītī	mutton bird
tohunga Puna Ora Māori	traditional healer

¹⁰ Te Rau Matatini, (2006, p.7)

tuakana	older sibling
tūrangawaewae	place where one stands
umanga	occupation, pursuit
wahine	woman
waiata	song
wairangi	overly excited, infatuated, foolish
whaikōrero	formal speeches
whakamomori	great sense of sadness
whakaora	restore to health
whānau	family
whanaungatanga	relationships
whakapapa	genealogy
whakataukī	proverbial saying
whakawhanaungatanga	affirmation of bonds and relationships
whenua	land

Appendix 2: Ethics Approval



Massey University

7 July 2008

Jane Hopkirk
267 Naenae Road
Naenae
LOWER HUTT

OFFICE OF THE ASSISTANT
TO THE VICE-CHANCELLOR
(Research Ethics)
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Dear Jane

Re: Whitiwhitia I Te Ora! Culture and Occupational Therapy: Exploring the Interface – A Māori Perspective

Thank you for your Low Risk Notification which was received on 4 July 2008.

Your project has been recorded on the Low Risk Database which is reported in the Annual Report of the Massey University Human Ethics Committees.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis that it is safe to proceed without approval by one of the University's Human Ethics Committees.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor Sylvia Rumball, Assistant to the Vice-Chancellor (Research Ethics), telephone 06 350 5249, e-mail humanethics@massey.ac.nz".

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to provide a full application to one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

Sylvia V Rumball (Professor)
**Chair, Human Ethics Chairs' Committee and
Assistant to the Vice-Chancellor (Research Ethics)**

cc Dr Te Kani Kingi
Research Centre for Maori Health and
Development
Wellington

Prof Chris Cunningham, Director
Research Centre for Maori Health and
Development
Wellington

Massey University Human Ethics Committee
Accredited by the Health Research Council



Appendix 3: Consent Form

Te Mata o Te Tau

Office of the Deputy Vice-Chancellor (Māori)

04 3800621 or temata.massey.ac.nz

c/o Research Centre for Māori Health and Development

Massey University

Private Box 756

Wellington

PARTICIPANT CONSENT FORM

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

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I agree/do not agree to photos being taken.

I agree/do not agree to information from these interviews being used to support the development of a Māori occupational therapy workforce plan in partnership with Te Rau Matatini.

I wish/do not wish to have all my audio recording returned to me or deleted after (Date).

I wish/do not wish to have data placed in an official archive.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: Date:

Jane Hopkirk wants to thank you for participating in this research.

Appendix 4: Information Sheet

Te Mata o Te Tau

Office of the Deputy Vice-Chancellor (Māori)

04 3800621

c/o Research Centre for Māori Health and Development

Massey University

Private Box 756

Wellington

New Zealand

temata.massey.ac.nz

INFORMATION SHEET

Researcher Introduction

Jane Hopkirk is the researcher with Te Kani Kingi providing supervision.

Jane Hopkirk

Te Kani Kingi

021 938181

04 3800621

04 4739591

This research is intending to examine cultural perspectives of occupational therapy and to compare these with international and indigenous perspectives. It further seeks to explore the impact of these cultural perspectives on occupational therapy practice in New Zealand.

This research is for the fulfilment of a Masterate thesis in Arts with Māori Studies Department at Massey University.

Definition of Occupational Therapy

‘Occupational therapy enables people to identify and overcome the barriers that prevent them from participating in the activities they need or want to do

within their communities' (NZAOT, Occupational Therapy Board of New Zealand, 2007).

Participant Recruitment

There are three ways in which the information for this research will be collected - two research questionnaires and one series of more informal interviews:

The first questionnaire will be given to occupational therapists, Pākehā who attended a workshop on cultural at the occupational therapy conference 2008

The second questionnaire will be given to Māori occupational therapists who were contactable through e-mail or were known to researcher and wished to respond and thirdly, selected interviews will take place with experts in the field. The researcher will draw on her experience in the area to identify suitable respondents ($n=5-7$). A small koha will also be provided for time and input.

Project Procedures

The data will contribute to a Masters thesis. If interviewees agree, information will further be used to support the development of a workforce development plan for Māori occupational therapists in conjunction with Te Rau Matatini.

The data will be transcribed by an employee of the researcher or the researcher who has signed a confidential agreement.

Data will be stored in a locked cupboard and destroyed after seven years.

A summary of the project findings will be offered to all interviewees prior to submission of thesis.

Participant involvement

Interviews are expected to take one and half hours and will be face to face or over the phone if desired. Notes will then be taken of the interview with main points fed back to interviewees for checking at the time of the interview and post interview. The interviews will be sound recorded only.

Participant's Rights

The following Statement of Rights must be included:

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study (prior to a month out from submission of the thesis [July 2009 expected]);
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.
- I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

Confidentiality of all participants will be maintained.

Committee Approval Statement

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the Massey University's Human Ethics Committees. The researcher named above is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher, please contact Professor Sylvia Rumball, Assistant to the Vice-Chancellor (Research Ethics), telephone 06 350 5249, e-mail humanethics@massey.ac.nz .

Jane Hopkirk wants to thank you for participating in this research.

Appendix 5: Questions Asked

Respondents	Questions
Questionnaire Interviewees	Work setting: DHB, NGO, private practice, and or other Work setting
Questionnaire Interviewees	Qualifications you currently hold for this position: NZROT, NZOT degree, and/or other. What post graduate qualification/s do you hold? Qualifications you currently hold:
Questionnaire Interviewees	Experience in mental health in years: None, Under 1, 1-3, 4-5, 6-10, or over 10.
Questionnaire Interviewees	What group(s) do you identify most closely with? Māori, Pacific, NZ European, Asian and or Other.
Questionnaire	What age are you? Under 20, 20-29, 30-39, 40-49, 50-59, 60-69, 70-79, or 80 over.
Questionnaire Interviewees	Provide services for Māori on average: Daily, Weekly, Two weekly, Monthly, 3 Monthly, 6 monthly, Less or Not sure. How often do you work with Māori? Two weekly, Monthly, 3 Monthly, 6 monthly, Less or Not sure.

Questionnaire	How relevant are cultural perspectives to occupational therapy Not Very 1 2 3 4 5 Very (circle)
Interviewees	Why? From your perspective what are key Māori aspirations?
Questionnaire	What do you think are core health perspectives for occupational therapy?
Interviewees	What are some of the challenges involved in merging Māori and western health perspectives?
Questionnaire	Does culture play a role in your practice? Yes/No if yes how?
Interviewees	What does occupation/doing mean for you?
Questionnaire	List Māori health perspectives you think are significant for use in your practice?
Interviewees	Is there anything not explained by occupation/doing or activity in your world view?
Questionnaire	What barriers prevent integrating the Māori and occupational therapy perspectives into your practice and why?
Interviewees	Did Māori have an understanding of occupational/doing in pre-colonial times? – If so, how?
Questionnaire	Do you have access to Māori culture yourself? And if yes how?
Interviewees	What do you think are core health perspectives for occupational therapy?
Questionnaire	What are the three most significant things that

Interviewees	<p>could support you in your development as a Māori occupational therapy practitioner?</p> <p>How could occupational therapy (treatment and care) be more responsive to the needs and expectations of Māori?</p>
Questionnaire Interviewees	<p>What are the most significant workforce development needs for Māori occupational therapists?</p> <p>What barriers prevent the integration of Māori and occupational therapy health perspectives into practice?</p>
Interviewees	<p>What are the most significant workforce development needs for Māori occupational therapists?</p>
Interviewees	<p>Do you have any other comments you would like to make?</p>